# AN INVESTIGATION INTO THE EFFECT OF A STAFFING STRATEGY ON PATIENT CARE IN A SELECTED HOSPITAL IN KWAZULU-NATAL

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**of the requirements for the**

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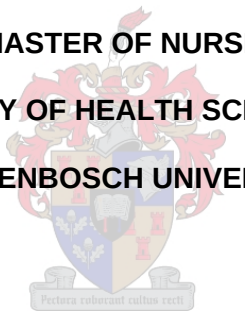


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**DECLARATION**

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

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## ABSTRACT

The South African Nursing Council believes that “quality nursing practice is based on adequate knowledge, skills or competencies, ethically and scientifically based comprehensive and holistic patient care, timely, accurate and complete or comprehensive recording” (SANC, n.d.). The aim of professional regulation is to protect the public from unsafe practices and to ensure quality services (SANC, n.d.).

A shortage of nursing staff resulted in the implementation of a staffing strategy of increasing the work hours of nurses by ten hours a week. Patient complaints and unacceptable patient incidences resulted in it becoming essential to evaluate the effect of this strategy on patient care. As a goal of this study, the researcher decided to investigate the quality of patient care before the implementation of the strategy and the effect of the strategy on patient care after the implementation.

The objectives of the study were set to determine whether

- The patients were assessed according to activities of daily living and psychosocial data;
- The nursing diagnosis was done
- Nursing interventions are prescribed for each problem identified
- The patients’ records were utilised to enhance individualised patient care and to ensure responsibility and accountability for patient care
- The evaluation of patient progress was done according to the different prescriptions and interventions at least twice in 24 hours
- A written final report for discharge criteria and health education was provided
- A comparison of the quality of nursing care delivered before and after the implementation of the staffing strategy exist

### Research question

What is the effect of an implemented staffing strategy in a selected hospital in KwaZulu-Natal on the quality of care delivered?

### Research methodology

A non-experimental, descriptive design with a quantitative approach was applied.

**Population and sampling**

The target population for the study was patient care records of patients who were hospitalised during 2003.

A non-probability convenience sample for a retrospective audit of a total of 372 patient care records over a period of 12 months was audited. An evaluation of the records was done and a comparison was drawn between the results obtained before and after the implementation of the staffing strategy. For both periods, 186 patient records were audited. The pilot study included the audit of 40 files.

Reliability and validity were assured with a pilot study and the use of experts in nursing management, quality assurance, research methodology and statistics. The researcher audited the patient files personally.

Ethical approval was obtained from Stellenbosch University and the ethics committee of the hospital. All principles related to ethics, such as confidentiality and anonymity, were maintained. Neither patient names were used nor the name of the hospital or wards from which the records were used. Codes were used to identify the hospital wards. The hospital was informed in the letter requesting consent to conduct the research, that the researcher intends publishing the findings of the research.

**Data analysis and interpretation**

Statistical associations using Chi-square tests were carried out to determine the significance between the various variables. The results of this study were presented in percentages, tables and histograms. Findings obtained showed that the quality of nursing declined after the strategy. Documentation of patient records was incomplete and did not meet legal requirements.

**Recommendations**

The implementation and maintenance of a quality assurance programme, human resource management, the on-going use of the nursing process and record keeping should be emphasised in the clinical practice environment and in the formal education environment.

## OPSOMMING

*Die Suid-Afrikaanse Raad op Verpleging glo dat "die grondslag vir gehalte verplegingspraktyk deur voldoende kennis, vaardighede of bevoegdhede, eties- en wetenskaplik-gebasseerde omvattende en holistiese pasiëntsorg, en tydige, akkurate en volledige of omvattende rekordhouding gelê word" (SARV, g.d.). Die doel van professionele regulering is om die publiek teen onveilige praktyke te beskerm en om gehalte diens te verseker (SARV, g.d.).*

*'n Tekort aan verpleegpersoneel het gelei tot die implementering van 'n personeelstrategie waarvolgens die getal werksure van verpleegpersoneel met tien uur per week verhoog is. Klagtes van pasiënte en onaanvaarbare voorvalle met pasiënte het genoodsaak dat die effek van hierdie strategie op pasiëntsorg geëvalueer word. Vir die doel van hierdie studie het die navorser besluit om ondersoek in te stel na die gehalte van pasiëntsorg voor hierdie strategie geïmplementeer is en die effek van hierdie strategie op pasiëntsorg ná implementering.*

Die doelstellings van die studie was om te bepaal of

- Die pasiënte in ooreenstemming met hulle daaglikse lewensaktiwiteite en psigososiale data beraam is
- Die verplegingsdiagnoses gemaak is
- Verplegingsintervensies voorgeskryf word vir elke probleem wat geïdentifiseer is;
- Die pasiënte se rekords gebruik is om geïndividualiseerde pasiëntsorg te verbeter en om verantwoordelikheid en toerekenbaarheid vir pasiëntsorg te verseker;
- Die evaluering van die pasiënt se vordering ten minste twee maal in 24 uur gedoen is volgens die verskillende voorskrifte en intervensies.
- Geskrewe finale verslag vir ontslagkriteria en gesondheidsopvoeding verskaf is
- Daar 'n vergelyking tussen die gehalte van die verpleegsorg gelewer voor en na die implementering van die personeelstrategie bestaan.

**Navorsingsvraagstuk**

Watter effek het die implementering van 'n personeelstrategie in 'n gekose hospitaal in KwaZulu-Natal op die gehalte van sorg wat gelewer word?

**Navorsingsmetodologie**

’n Nie-eksperimentele, beskrywende ontwerp met ’n kwantitatiewe benadering is toegepas.

**Populasie en steekproef**

Die teikenpopulasie vir die studie was pasiëntsorgrekords van pasiënte wat in 2003 gehospitaliseer is.

’n nie-waarskynlikheid convenience steekproef vir ’n terugwerkende oudit van ’n totaal van 372 pasiëntsorgrekords oor ’n tydperk van 12 maande is geouditeer. ’n Evaluasie van die rekords is gedoen en ’n vergelyking is gemaak tussen die resulate wat verkry is voor en ná die implementering van die personeelstrategie. Vir albei tydperke is 186 pasiëntrekords geouditeer. Die loodsondersoek het ’n oudit van 40 van hierdie lêers ingesluit.

Betroubaarheid en geldigheid is verseker met ’n loodsondersoek en die hulp van kundiges in verplegingbestuur, gehalteversekering, navorsingsmetodologie en statistiek. Die navorser het die pasiëntlêers persoonlik geouditeer.

Etiese goedkeuring is van die Universiteit Stellenbosch en die etiekkomitee van die hospitaal verkry. Alle beginsels wat verband hou met etiek, soos vertroulikheid en anonimiteit, is gehandhaaf. Nog pasient name, nog die naam van die hospitaal of die saal name van waar die rekords geneem is, is gebruik. Kodes was gebruik om die hospitaal sale te identifiseer. Die hospital was in kennis gestel in die brief vir toestemming om die navorsing te voltooi, dat die navorser van plan is om die bevindings van die studie te publiseer.

**Data-analise en interpretasie**

Statistiese assosiasies met behulp van Chi-kwadraattoetse is uitgevoer om die beduidendheid van die verskeie veranderlikes te bepaal. Die resultate van hierdie studie is in persentasies, tabelle en histogramme voorgelê. Die bevindinge dui aan dat die gehalte van verpleging afgeneem het ná die implementering van die strategie. Dokumentasie van pasiëntrekords was onvolledig en het nie aan die wetlike vereistes voldoen nie.

**Aanbevelings**

Die implementering en die behoud van ‘n gehalteversekerings program, personeel bestuur, die deurlopende gebruik van die verpleegproses en rekordhouding moet in die kliniese praktyk omgewing en in die formele verpleegonderwys omgewing benadruk word.

## ACKNOWLEDGEMENTS

Many people contributed to my fulfilling this dream:

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# CHAPTER 1

# SCIENTIFIC FOUNDATION OF THE STUDY

## 1.1 RATIONALE OF THE STUDY

The legislative framework within which safe nursing-care practices for nurses and midwives are stipulated is contained in the Nursing Act (South Africa, 1978). The Scope of Practice, regulation 2598 and regulation 387 Acts and Omissions as promulgated by the Nursing Act (No 50 of 1978) guide the practice of the professional registered nurse. In the event that the registered nurse contravenes these regulations, such a nurse may be held legally accountable for her/his actions or omissions. The registered nurse should adhere to the nursing regulations guiding her/his clinical practice and provide safe nursing care (Searle, 2000:116-133).

In delivering health care services, the work and the identity of nurses have been associated, over a period of time, with the daily care of the sick, as individuals or groups, in a personal and human manner. It is the core function of any nursing organisation to provide quality patient care. The efficacy of the organisation is determined by the manner in which these tasks are divided and coordinated. The organisation is thus responsible for ensuring that optimum productivity is achieved by training, rewarding and motivating its employees to complete the tasks as determined to promote efficacy (Dienemann,1998:359; Muller, 2004:199-220).

Every employee is a unique individual who brings with her/him unique demographic characteristics, education and training, as well as work and life experiences. The responsibility then lies with the organisation to ensure that individuals are selected and placed according to their individual skills into the correct positions so that optimum productivity and quality are achieved. When considering the entire process of recruitment, selection, interviewing, placement and training of individuals, it is very clear that organisations have a huge investment of both time and money in its employees. In the health care setting, this includes the nursing staff, in addition to all other categories of staff. The nursing staff component makes up the largest portion of staffing in an acute health care organisation (Muller, 2004:257).

For the hospital under study, which has 147 beds with an occupancy rate of 68% to 70%, the approved nursing establishment is 190 posts. The number of students being trained in this institution is 100 to 120 at a given time. These numbers exceed the current number of staff

required to supervise the students. Despite the number of posts allocated for nursing, the institution is unable to fill these posts appropriately.

This situation is aggravated by the resignation of at least 2% of staff per month, with an accumulative effect. Each person who leaves the organisation leaves at least a two-month hiatus in the staffing of the department in which that individual worked. Vacant posts, which result from resignations, may not be filled immediately, resulting in an increased workload on those left behind. The monetary cost to the organisation in replacing an individual can be as much as three times that person's salary (McGuffin, 1999:56; Muller, 2004:268-270).

Furthermore, absenteeism is creating added problems in the workplace as it influences productivity. According to Botha (2007:9), absenteeism is costing the South African economy 19 billion rand per annum and many organisations are scrambling for 'miracle cures' for it.

The most acceptable turnover rate is quoted as 5% to 10% (Booyens, 1998:370). Although varying percentages of vacancy rates, voluntary terminations and turnover are stated in the literature, it is also clear from the abovementioned that the figures have not changed markedly in the present decade where developing countries experience vacancy rates of more than 40% ("Read about nurse migration", 2006: 30(1):8). Globally, highly skilled nurses are being attracted to developing and more affluent countries, resulting in a brain drain. This phenomenon has not been significantly quantified (Department of Health, 2006).

The burden of disease in South Africa has a direct impact on staffing in the hospitals, not only because of the increase in patients affected with HIV, but also because of the escalation of negative lifestyle choices, as pointed out by Norman (2007:31), such as unsafe sex, interpersonal violence, alcohol and tobacco abuse, hypertension and elevated cholesterol risk.

In South Africa, especially in KwaZulu-Natal, nurses are lost through death as a result of full-blown Aids, pulmonary tuberculosis (TB), multi-drug resistant TB, extreme drug resistant TB and complications of anti-retroviral treatment, exacerbating the problem further (Cullin, 2003:31). The researcher has also experienced this phenomenon in the hospital in which she works. During the period June 2003 up to and including November 2005, four professional nurses, three enrolled nurses and four enrolled nursing auxiliaries have passed away whilst still employed by the hospital and registered or enrolled with the South African Nursing Council. It was estimated that 910 100 individuals will die from Aids and its complications, 1 788 587 will be affected with the virus and 324 456 will be sick with Aids in 2007 (Dorrington, Bradshaw & Budlender, 2002:20).

Another factor that adversely influences the work environment is that the majority of nurses train as enrolled nurses at the hospital. After completion of this programme, most of the trained enrolled nurses embark on a further two-year training programme to bridge to professional nurse's level. This does not solve the staffing and skills problem of the institution because these professional nurses require additional study leave for further specialisation.

According to Dienemann (1998:201), "The numbers and types of unlicensed health personnel will increase." In South Africa, this equates to enrolled nurses and enrolled nursing auxiliaries, and even home-based care practitioners that are not regulated, registered or enrolled by the South African Nursing Council. Dienemann's (1998:201) argument that "[t]rends indicate a lower ratio of registered nurses to patients" is evident in the institution where the researcher is employed.

In addition, factors such as poor conflict management, the low morale of staff and poor teamwork aggravate the work environment further, leading to a high turnover rate in the workplace (Muller, 2004:175). As a nurse manager, the researcher has observed the low staff morale caused by the failure to fill vacant posts and the increase in the stress levels of the remaining employees. The researcher furthermore observed that this affected the quality of patient care delivered in the institution. Patient and family complaints increased, and negative incidents and patient falls escalated. Documentation of patient care and interpretation of patient problems created much concern. According to the SCOPE OF PRACTICE of a registered professional nurse and ACTS AND OMISSIONS, as described in Searle (2000:123-129; 119), a nurse will be held accountable for her own nursing actions and any negligence may result in disciplinary action by the South African Nursing Council (SANC).

Due to the problems described above, it became critical for management, especially nursing management, to assess the situation and to introduce new management strategies to manage and solve the problems. Discussions were held with all the stakeholders and it was decided to implement a staffing strategy to allow nurses to work an additional ten hours per week on a voluntary basis. Subsequently, it was decided that only employed enrolled nurses and registered nurses who hold at least midwifery as an additional qualification and registration would be allowed to work the extra ten hours a week.

This was in compliance with Section 5 of the Basic Conditions of Employment Amendment Act no 75 of 1997 (c8), which allows an employee, in this case a nurse, to work an extra ten hours per week.

## 1.2 PROBLEM STATEMENT

In view of the above, it has become critical to investigate the effect of this staffing strategy as applied in this health service. With reference to the rationale, the following question arose as an indication for the research: What effect did this strategy have on patient care?

## 1.3 GOAL OF THE STUDY

For the goal of this study, an investigation into the effect of a staffing strategy in a selected hospital in KwaZulu-Natal was conducted by evaluating patient record audits.

## 1.4 OBJECTIVES OF THE RESEARCH

With reference to the research question, the following objectives were set for the research:

- To determine whether the patients were assessed according to activities of daily living and psychosocial data.
- To determine whether the nursing diagnosis was done.
- To determine whether nursing interventions are prescribed for each problem identified.
- To determine whether the patients' records were utilised to enhance individualised patient care and to ensure responsibility and accountability for patient care**.**
- To determine whether the evaluation of patient progress was done according to the different prescriptions and interventions at least twice in 24 hours.
- To compare the quality of nursing care delivered after the implementation of the staffing strategy with the quality of care before the implementation of the strategy.
- To determine whether a written final report for discharge criteria and health education was provided; and
- To make recommendations based on the scientific evidence obtained in this study.

## 1.5 RESEARCH METHODOLOGY

### 1.5.1 Research Design

Burns and Grove (2007:270) describe a research design as a "blue print" used in conducting a research study that maximises the control over factors that could possibly influence the validity of the findings. A non-experimental, descriptive design with a quantitative approach

was applied to investigate the staffing strategy implemented at the selected semi-private hospital in KwaZulu-Natal.

### 1.5.2 Population and Sampling

A population, as described by Burns and Grove (2007:509), is all the elements included in a sample that meet the criteria and is sometimes referred to as a target population. For the purpose of this study, the researcher retrospectively evaluated patient care by auditing the records of patients who were hospitalised for the period January 2001 to November 2005. A non-probability, convenience sample is used. A comparison is drawn between the results before and after implementation. The strategy was implemented in June 2003.An average of 372 patient records were audited, i.e. 186 for the period January 2003 to May 2003,before and 186 for the period June 2003 to November 2003, after implementation. The hospital has six wards. Nursing records from all six wards were examined in the study. Some characteristics of the wards are as follows:

- Ward A is a male surgical ward with 30 beds.
- Ward B is a female surgical ward with 23 beds.
- Ward C is a maternity unit with 30 beds.
- Ward D is a paediatric unit with 10 beds.
- Ward E is a male medical ward with 21 beds.
- Ward F is a female medical ward with 30 beds.

The staff of wards A, B, D, E and F include nurses in training as enrolled nurses and bridging to professional level. The maternity ward only has student midwives, enrolled nurses and professional registered nurses and midwives

### 1.5.3 Instrumentation

For the purpose of this study, the researcher used an audit instrument designed by the quality assurance nurse employed at the hospital, but adapted for this study. The audit instrument is based on the phases of the scientific process in nursing, namely assessment, nursing diagnosis, planning, implementation, evaluation and discharge. Nurse experts in nursing management and in quality assurance validated the instrument before use.

### 1.5.4 Reliability and Validity

Burns and Grove (2007:552) describe reliability as an instrument that consistently measures what it is supposed to measure. Validity is the extent to which an instrument accurately

reflects the abstract construct being examined. The reliability and validity of this study are supported by a pilot study conducted on 10% (40) of the number of patient files evaluated in the actual study. The researcher conducted the evaluation of the patient records, and a research methodologist, statistician and nurse expert were consulted.

### 1.5.5 Pilot Study

A pilot study was conducted on patient files before and after implementation of the strategy. A total number of 40 (10%) files were evaluated. The pilot study was done to test the instrument for any inaccuracies and ambiguity. The files used for the pilot study are not included in the actual study.

### 1.5.6 Ethical Considerations

The Committee for Human Research at the Faculty of Health Sciences Stellenbosch University granted permission for this study. Ethical approval was also obtained from the ethics committee at the particular hospital where the research was to be conducted. All principles related to ethics, such as confidentiality and anonymity, were maintained. Neither patient names were used nor the name of the hospital or wards from which the records were used. Codes were used to identify the hospital wards. The hospital was informed in the letter requesting consent to conduct the research, that the researcher intends publishing the findings of the research.

### 1.5.7 Data Collection

The researcher adapted an audit instrument to audit the patient records and the researcher evaluated the records (Annexure A). Data collection took place over a period of six months.

### 1.5.8 Data Analysis and Data Presentation

Basic descriptive statistical analysis was done using the SPSS computer programme. Various statistical associations was carried out using the Chi-square test on 95% confidence level. Data is presented in the form of graphs, tables and frequencies.

### 1.5.9 Recommendations

Based on the scientific evidence of this study, recommendations are made to policy-makers and hospital authorities.

## 1.6 CONCEPTUAL FRAMEWORK

Burns and Grove (2007:189) describe a conceptual framework as a brief explanation of the theories, concepts, variables or parts of theories that will be tested by the study. In adapting the quality audit instrument, structure, process and outcome criteria are taken into consideration (Booyens & Minnaar, in Booyens, 2004:311).

Booyens and Minnaar (in Booyens, 2004:311) define structural criteria as criteria that are necessary for achieving the desired outcome of the institution. The structural criteria in this study are the issues surrounding the lack of staff and the lack of adequate skills to perform to the required level. In order to address this problem, the management of the hospital under study introduced a strategy that increased the number of person-hours available. This strategy required that nurses could voluntarily work an additional ten hours per week.

For the purpose of this study, the researcher will use the following theories and legislation as a theoretical framework.

- Donabedian's framework, namely structural, process and outcome standards;
- The South African Constitution, 1996, Act 108, Chapter 2, on Basic Human
- Rights;
- Batho Pele Principles;
- Nursing process;
- The Nursing Act no. 50 of 1978; and Nursing Act no. 33 of 2005;
- Scope of Practice R2598; and
- Acts and Omissions R387.

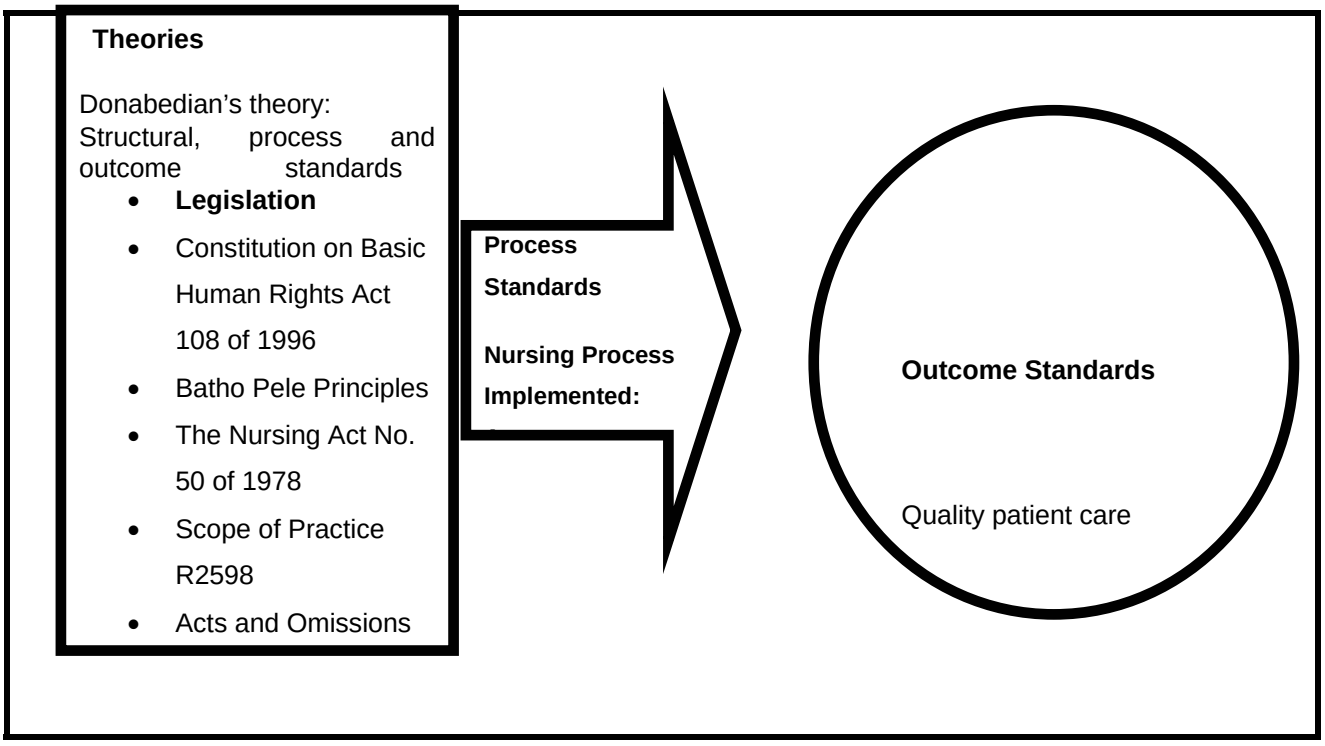


**Figure 1.1: An illustration showing conceptual framework for this study based on Donabedian's theory** I

## 1.7 STUDY LAYOUT

*Chapter 1: Scientific foundation of the study*

In this chapter, the rationale of the study is discussed and the problem statement, goal and objectives of the study, research methodology, conceptual framework and operational definitions are described.

*Chapter 2: Literature study*

The literature review presented in this chapter includes the scientific nursing process, legislative control, including nursing practice, patient rights, labour management legislation, and quality assurance in the work place.

*Chapter 3: Research methodology*

In this chapter, research methodology is described, including population and sampling, reliability and validity, ethical considerations, instrumentation, pilot study data collection, data analysis and interpretation.

*Chapter 4: Data analysis and interpretation*

The results of the study are presented, analysed and interpreted in this chapter.

*Chapter 5: Recommendations*

The thesis is concluded and recommendations made based on the scientific evidence of the research.

## 1.8 OPERATIONAL DEFINITIONS

**Absenteeism**

Time away from work (Gillies, 1994:283, quoted in Booyens, 1998:355) that may be allowed, i.e. due to illness, maternity leave, family responsibility leave or annual leave, or not allowed, i.e. truancy or labour-related problems, such as illegal strikes.

**Extra ten hours**

Section 5 of the Basic Conditions of Employment Amendment Act no 137 of 1993 (c8) allows employees to work an extra ten hours per week. The normal legislated workweek is a 40-hour week.

**Income**

Money received, especially on a regular basis, for work. (The Concise Oxford Dictionary, 2006).

**Job satisfaction**

**P**aid regular employment that meets the expectations, needs, or desires of the employee. (The Concise Oxford Dictionary, 2006).

**Lack of skills**

Absence or deficiency of skills, i.e. the ability to complete a specific task successfully. (Hersey & Blanchard, 1993:407). Inability to perform may be related to a lack of adequate educational training, or it may be related to the inability to perform the technical acts required by the job.

**Legislation**

The system of laws recognised by a country or society to regulate the actions of its members and enforced by the imposition of penalties. (The Concise Oxford Dictionary, 2006).

**Patient rights**

Rights of patients receiving care, based on the constitutional rights laid down by the Bill of Rights, in Section 7 of the Constitution of South Africa, Act 108 of 1996 (c2) (9). The PATIENTS' RIGHTS CHARTER was formulated by the South African Department of Health in 2002. Provision of safe, quality nursing care — nursing care must cause no harm, and must be at a standard expected by patients, management and the nursing profession.

**Productivity**

**"**[T]he action of producing a lot, the creation of economic value and the production of goods or services" (McGuffin, 1999:120).

**Standard of care**

A documented description of the expected level of performance. Standards are measurable characteristics of excellence and are the basis for measuring actual performance or service delivery (Muller, 1998:242-244).

**Supervision**

The evaluation of the effectiveness of a service. It is a democratic process that ensures that all resources are used optimally, errors are corrected and standards are maintained. It involves two-way communication (Jooste, 1996, in Booyens, 2004:286).

**Work ethic**

The principle that it is one's duty and responsibility to achieve success through hard work and frugality. (The Concise Oxford Dictionary, 2006).

Explanations for broad definitions from The Concise Oxford Dictionary (2006).

## 1.9 CONCLUSION

In this chapter, the researcher described the rationale for the study with reference to the various factors that may influence patient care. The goal, objectives and the intended research methodology were also described.

# CHAPTER 2

# LITERATURE REVIEW: NURSING PRACTICE

## 2.1 INTRODUCTION

The objective of a literature study is to clarify the research project and that necessitates a thorough literature study on the research topic and related issues (Terre Blanche & Durrheim, 2004:18).

The Constitution Act 108 of 1996 recognises the basic human rights of all South Africa's people. Furthermore, the Nursing Act No. 50 of 1978 and the Nursing Act no. 33 of 2005 as promulgated control nursing practice. The professional registered nurse is held accountable for all actions and omissions in terms if this act. In 1997, the White paper on transforming public service delivery, i.e. the Batho Pele paper, was introduced. This paper emphasises improving service delivery in the public sector and delivering quality service to all South Africans.

## 2.2 NURSING PRACTICE

The Nursing Act no. 50 of 1978 and the Nursing Act no. 33 of 2005 as promulgated control nursing practice in South Africa. According to Searle (2000:36-37), a nursing act ensures that societies approve of the nursing profession by providing for regulation of their profession through an act of parliament. The act ensures that the nursing profession provides ethically competent nurses. It ensures professional exclusivity by excluding unregistered or enrolled people from working for gain.

The act protects the public of South Africa from harm and negligence perpetrated by South African nurses. It furthermore allows for the formation of a statutory body, The South African Nursing Council (SANC), to control nursing practice and training in South Africa. Every practicing nurse must know and implement the regulations related to the act such as the Scope of Practice and Acts and Omissions. The South African Nursing Council, following a professional conduct enquiry, may suspend or revoke the registration or enrolment of a nurse found to be negligent (Muller, 2004:57). Apart from every nurse who has to take responsibility and accountability for her/his own practice, the nurse manager is held equally responsible for the management of nursing care in totality. As the representative of the employer, she/he ensures that the nurse is provided with a safe working environment and has a clear job description to enable her/him to deliver quality care to patients (Searle, 2000:268).

The South African Nursing Council policy statements, Standards for Nursing Practice and the Public Services Code of Conduct spell out the behaviour required from public service managers and employees regarding their treatment of one another and of the public.

Nurse managers may be held liable along with the employer, or as an individual for professional malpractice or criminal acts. Muller (2004:55) supports the definition of vicarious liability that infers that the employer is legally responsible for the harmful or negligent acts of its employees. The legal system generally holds that if an employee is practicing within the scope and course of the contract of employment and is negligent, then the employer is responsible for the payment of any claims incurred. In the event that an employee acts beyond the scope of practice, intentionally harms a patient, or performs a criminal act, the employer is not responsible. Health care organisations are increasingly held accountable under the legal principle of vicarious liability. The implication is that the employer then has a legal liability to provide adequate facilities, i.e. staff and equipment (Verschoor, Fick, Jansen & Viljoen , 2005:52).

Muller, Bezuidenhout and Jooste (2006:492) agree that employers are further responsible for monitoring the competence of care delivered and should actively intervene on behalf of the patient when care is below the acceptable standard. This includes monitoring the quality and quantity of staff necessary to provide the required care. In order to provide safe and adequate staffing, nurse managers are faced with retention of existing staff, as more and more nurses are leaving full-time employment for part-time employment, thus shifting employment status. Current work environments in hospitals around the world include increased pressure and stress related to job security, workplace safety, lack of managerial support and support from colleagues, controls over practice, work scheduling, including self scheduling, leadership and inadequate staffing (Mafalo, 2006:20).

A nurse manager has the responsibility to inform the chief executive officer or medical superintendent when understaffing or staff with inadequate skills put patients at risk. Patient safety includes the prevention of medico-legal hazards and litigation against the employer due to negligence, such as patient falls and medication errors. Research has shown that patients' care is improved when registered nurses have a major input in their care. Negative incidents have been lessened when there are higher numbers of registered nurses in the staffing mix (Zondagh, 2004:21). Employers and nurse managers who ignore such information become liable for the adverse results caused by a lack of remedial action. (Geyer, 2006:46).

## 2.3 PATIENT RIGHTS

A Patient Rights Charter was formulated by the South African Department of Health in 2002. The charter was formulated to comply with the Bill of Rights, as enshrined in the Constitution of South Africa, Act 108 of 1996 in Chapter 2. The Bill of Rights (1996) provides for a healthy and safe environment, which infers a safe and therapeutic environment in the hospital. Socio-economic rights are provided for in that it is stated that each person has the right to access to health care. The state is therefore obliged to make sure that all people have equal access to health care services. No person may be denied emergency health treatment if the resources are available.

The Patient Rights Charter (2002) is part of the national strategy to ensure that the quality of health services delivered to the population is improved. The principles of the charter are as follows:

- Confidentiality and privacy, i.e. confidentiality of information and patient privacy are to be respected;
- The public have a right to informed consent;
- A second opinion;
- Choice in health care provider (a named health care worker) or institution;
- Continuity of care;
- The right to complain;
- Participation in decision making; and
- Patients have the right to refuse treatment (Muller et al, 2006:7-8).

The goal of the Patient Rights Charter is to ensure a standard of patient satisfaction, to protect the rights to health and health care, to increase accountability and transparency, and to obtain commitment in both the public and private sectors (Muller, 2004:72-73). The implication is that health care organisations are obliged to provide a healthy and safe environment as well as access to the health care consumer. The patient has the right to expect the nurse manager to inform the hospital management in writing each time there are insufficient nurses to provide quality care (Geyer, 2006:46). The patient rights that affect this study are the provision of a healthy and safe environment, and access to care. Patients have a constitutional right to expect that nurses will inform the hospital management, in writing, each time there are insufficient nurses to provide quality care (Geyer, 2006:46).

## 2.4 THE NURSING PROCESS

The nursing process is defined by Young, Van Niekerk and Mogotlane (2003:15-16) as a systematic process which consists of interaction with each individual patient. The phases of the nursing process are assessment, nursing diagnosis, planning, implementation, evaluation and record keeping.

### 2.4.1 Assessment phase

The assessment phase relates to the patient or client. In this phase, data relating to the extent to which each identified need is or is not met is collected. The information collected in this phase may be subjective or objective. In subjective assessment, either the patient or the nurse can express their feelings, values and beliefs in respect of the care. Where assessment is objective, it is grounded in scientific measurement and can be verified by other people.

### 2.4.2 Nursing diagnosis

According to Beretta (in Hinchliff, Norman & Schober, 2003:122), the nursing diagnosis is made based on the subjective and objective information obtained during the assessment phase. It states the patient's problems as expressed by the patient and the nurse and the observations made. It identifies the functional elements that affect the patient's health and her/his response to nursing care. Problem statements as explanations of identified, related factors are the components of the nursing diagnosis. The problems may be actual problems found or potential problems that may develop later.

### 2.4.3 Planning phase

The nurse plans are formulated by deciding what nursing actions will meet the patient's needs. A nursing care plan is designed for each individual patient. Planned nursing interventions are prioritised. Objectives are the desired outcomes of the planned nursing care and should solve the problems identified (Young et al, 2003:186,187).

### 2.4.4 Implementation phase

The implementation phase requires the nurse to put into practice her/his knowledge and skill to determine what care to give and how to care for the patient (Young et al, , 2003:16). In this phase, the nursing care plan is put into action. However, the nursing care plans must be checked and evaluated by a professional registered nurse before they are implemented.

Documentation is critical throughout the nursing process, as they must be visually available to all nursing staff so that the care is continuous (Young et al, 2003:191-194).

### 2.4.5 Evaluation phase

During the evaluation phase, the nurse is required to continually reassess the degree to which the patients needs have been met, determine if there are any new needs expressed by the patient and observe how the patient is responding to the care given. The evaluation enables the nurse to determine how effective the entire process of caring for the patient is.

The premise of the nursing process is that it allows for the creation of holistic, individualised care for each patient (Young et al, 2003:182,194). The purpose of the nursing process as stated by Fryer (in Hinchliff, Norman & Schober, 2003:31) is to encourage decision making and problem solving as skills. Benner's work in the 1980s suggested that the development skills of nurses were not always accompanied by an understanding of the theory. The nursing process is an accurate instrument, and as such has benefits to the patient and the nurse.

According to Young et al, (2003:1182-183), the benefits include:

- Individualised care;
- Decisions based on the problems identified;
- Goal setting to rectify problems;
- Continuous and co-ordinated care is ensured;
- Standards of nursing care can be evaluated;
- A written plan ensures that the delivered care is consistent;
- The nurse's thinking and nursing activities are focused;
- Inexperienced nurses are enabled to satisfy the patient's needs within the limits of her/his scope of practice;
- Evaluation gives flexibility, allowing for changes as the patient's needs change;
- Patients' participation in their own care is made possible;
- Quality assurance is facilitated; and
- It serves as a teaching tool.

## 2.5 QUALITY ASSURANCE

*Quality assurance originated as early as 430 B.C. when Hippocrates devised scientific rules: "I have written this down deliberately believing it to be valuable to learn of unsuccessful experiments and to know the causes of their failures" (Dolan in Muller, 1988:42). The first documentation of assessing care dates back to Florence The first documentation of assessing care dates back to Florence Nightingale, who initiated a process by which standards were set for nursing. The care provided was compared with standards and action was taken to bring about change. As a profession, nursing has an ethical responsibility to ensure the delivery of quality care, which is based on safe, advanced, efficient and acceptable care. Quality assurance can therefore be defined as the evaluation of nursing care (Muller, 1988:42)*.

The International Council of Nurses requires a system of governance for the professional nurse that provides for, among others, high standards of personal and professional growth and performance of nurses (Muller, 1998: 31-33; SANC, n.d.). In South Africa, the South African Nursing Council (SANC) is the body commissioned by parliament through the Nursing Act to regulate nursing practice, nursing education and nursing education institutions. This includes the minimum requirements for education and training with a view to registration, and provides ethical rules and regulations of practice. The South African Nursing Council gets its mandate from the government of the day, the South African people and the profession (SANC, n.d.).

### 2.5.1 Standards for nursing practice

According to the SANC mission statement,

> The South African Nursing Council will, by developing and controlling standards of practice within the framework of the National Health Care Policy through the process of consultation, transparency, democracy and inclusiveness in a sound professional and administrative manner, ensure that the highest quality of ethically based nursing care is rendered to all people in the Republic of South Africa.

The South African Nursing Council also believes that "quality nursing practice is based on adequate knowledge, skills or competencies, ethically and scientifically based comprehensive and holistic patient care, timely, accurate and complete or comprehensive recording." According to the SANC, the people of South Africa have, as a

> fundamental human right, the right to a nursing service, which creates and maintains a disciplined, safe, compassionate and caring nursing environment, which takes appropriate action to safeguard patients when their care and safety is endangered by any person or circumstance, which is committed to the development of professional knowledge and skills as essential component of a health service, which respects and promotes the principles of an accessible, acceptable, affordable, equitable and efficient health care service for the patient or family, group or community within the content of life or cultural world and life – span, from conception to death.

Furthermore, the SANC is responsible to serve the people of South Africa by "setting, promoting and controlling the standards of nursing and midwifery education and practice, monitoring and enhancing the maintenance of ethical standards" (SANC, n.d.). Professional self-regulation to ensure performance quality is at the centre of the relationship between the profession and society. The nursing profession has to accept that society has the right to quality services. The aim of professional regulation is to protect the public from unsafe practices and to ensure quality services. Professional regulation takes the form of licensing practitioners, registration of practitioners, certification of qualifications and accreditation, where qualified agents designate persons, programmes or practices as having met specified standards. Standards play a major role in these processes that standard setting is often used synonymously with regulation.

The objectives of the South African Nursing Council include promoting and maintaining the health standards of the people of South Africa, and establishing and improving the standards of education, practice and professional conduct for nurses, midwives and nursing auxiliaries. The obligations of the South African Nursing Council to persons on its register are to

> establish and recommend standards for the profession in the form of definitions, ethical codes, education and service requirements; periodically review and revise standards of education and service to ensure that they are relevant to practice standards; ensure that curricula and evaluation measures like examinations and performance reviews are relevant to set standards; ensure that nursing service standards reflect changing health care needs and enhance professional capacities; promote universal standards of performance and foster professional identity and mobility to the fullest extent compatible with local and international needs and circumstances (Standards for Nursing Practice South African Nursing Council Policy Statements, n.d., s1).

The people on the register have an obligation to maintain standards of personal and professional conduct that will reflect favourably on the profession. Nevhutala (2004: 31) points out that the quality of nursing practice is an ethical issue, and that virtues and qualities such as compassion, wisdom, openness, honesty and competence are the traits or habits of character that predispose a person to do what is right.

Employee organisations, e.g. the Democratic Nursing Association of South Africa, have the responsibility to promote the professional development of nurses to ensure that their members maintain good standards of nursing care. Employers have the right to join in monitoring these standards, subject to public sanction and nurses' contribution in meeting those standards.

Professional regulation is a form of quality control that guarantees a specific level of competence of practitioners and services, but it also affords legitimacy to nurses by recognising their place within the country's health system.

Safe staffing is defined as an appropriate number of staff with a suitable mix of skills levels who are available at all times to ensure that patient care needs are met and that hazard-free working conditions are maintained (Mafalo, 2006:20). The following are included in this definition: quality of care delivered, the nurse's working environment, nurse training, skills and skills mix experience.

### 2.5.2 Measuring quality assurance

Dannenfeldt (1998:220) states that there are two major aspects of quality assurance to measure or evaluate the nursing care delivered and to improve the quality of care delivered to patients. Mahoney (in Jensen, 1996:51) argues that the key factors in a quality management system include:

- Leadership enabling people to perform;
- Knowledge of customer expectations to ensure satisfied customers;
- Strategic planning with follow through actions;
- Development and management of human resources;
- Empowerment and involvement of employees achieving world-class results;
- Using valid statistical procedures; and
- Use of benchmarking and improved relationships and input from suppliers.

Professional nurses are responsible and accountable for the quality of the care delivered to their patients. They must be involved in the quality assurance process and an advocate for good quality care. Patients expect quality nursing care and the employer expects cost-effective quality nursing care (Muller, 2004:53).

Standards with set criteria are developed and used to measure the outcome of nursing care. These standards must be clear and concise, and specific statements must be worded in terms of actions and behaviour required for the intended outcomes.

### 2.5.3 Quality in health care

Quality in health care provision is described as acceptability, accessibility, appropriateness, effectiveness, efficiency and equity, and it is stated that nurses need to collaborate and work as a team to provide the quality of care they have set to be the acceptable standard (Frank et al, 1997:13). Acceptability in this situation involves giving patients the required information so that they can be involved in the decision making with regard to their treatment and follow-up care. It also includes identifying patient viewpoints and expectations with reference to the health care provided and meeting their expectations. Furthermore, it involves recognising the patient's right to control the distribution and recording of information regarding her/his illness as well as the confidential nature of the information obtained from the patient.

Providing adequate skills and knowledge to patients when they need it is also a form of accessibility. Maintaining quality through training and education requires maintaining technical excellence, but also assists in promoting teamwork. In-service education and orientation improve nurses' performance and ability to work as a team to provide quality care. Leadership makes the difference. The nurse manager is the central figure in the delivery of high quality patient care as she/he provides the human and material resources for providing quality patient care. Lastly, a supportive and trusting nurse manager is the key to facilitating an environment in which quality patient care can be delivered (Frank et al, 1997:14).

Appropriateness is regarded as providing care to meet the patient's physical, psychological and social needs, as well as adjusting the care provided to the age of the patient, her/his knowledge and abilities.

Effectiveness includes measuring and monitoring if the desired health care objectives are met, and whether equipment is correctly used for maximum benefit of the patient.

Efficiency is regarded as using time to meet the various needs, the skilled use of equipment and medication and the availability of equipment and medication when they are required.

Equity ensures that there is no discrimination against any group of people on the grounds of gender, disability or race. It also includes organising special services to meet the patient's specific needs (Frank et al, 1997:14-16).

### 2.5.4 Donabedian's Theory: Structural, process and outcome standards

Standards are usually divided into structure, process and outcome standards. Each of these interacting elements contributes to the quality of nursing care. An improvement or deterioration in any of the three tends to influence a change in the other two (Gillies, 1989:516).

#### *2.5.4.1 Structural standards*

Structural elements include physical setting, nursing philosophy, unit objectives, organograms, financial resources, equipment, accreditation of institution, expectations and attitudes of patients and employees.

#### *2.5.4.2 Process Standards*

Process standards include the steps of the nursing process of assessing, planning, implementing and evaluating (Gillies, 1989:516). These standards are concerned with the delivery of patient care, the assessment of patients, the planning of care and the implementation of care (Muller, 204:2004-205). The actual care delivered is compared with or measured against the standards. Auditing is another control measurement or assessment instrument to evaluate the quality of care as shown by the nursing records. A nursing audit committee to assess the quality of nursing care through retrospective examination of patient records after discharge can use an audit instrument. This type of audit is based on the assumption that what has been documented in the nursing records has been done. Good documentation reflects good care. It is an evaluation of the nursing process and the extent to which the seven functions of the nurse as performed and recorded are measured.

#### *2.5.4.3 Outcome standards*

Outcome standards are changes in patient health status as a result of nursing intervention, such as patient satisfaction.

### 2.5.5 Audit instrument

The audit instrument usually consists of three sections: patient and institution identification; questions about institutional policy; and procedure. There is a chart review schedule and question about each of the seven nursing functions and a final quality score and related judgments by the reviewer.

Quality and costs go together. It is expensive to rectify errors when work is not done correctly from the beginning. When quality is evaluated, the evaluation should be acceptable to the standards and criteria of clinical care, and to the standard for professional practice as well as standards for administrative policies and practices.

Standard setting and evaluation should accompany those activities of care with the greatest impact on the results of patient care, such as high-risk nursing actions, e.g. the administration of medication, discharge of patients, record keeping, the patient's progress and infection control. Booyens and Minnaar (2002:309) state that high-risk activities are those where leaving them out would result in patient trauma, death or legal prosecution. They also believe that problem-prone activities are those which could be a problem to the patient, staff and the organisation.

Once the scale has been determined, the information must be collected to secure the measurement required. The data collection should be timely, accurate and inexpensive. It can be done by interview, observation or a review of the records. A person competent in judging the appropriateness of the information must collect the data and only a nurse can audit nursing actions (Dannenfeldt, 1988:28-29).

The instrument is designed, validated and tested before the formal evaluation is done. Validity is the degree to which the instrument measures what it intended to measure and reliability refers to the consistency with which an instrument measures what is to be measured. The reliability of an instrument can be determined by testing if two people using the same instrument to measure the same object or phenomenon come to the same conclusions with regard to quantity or quality. The greater the agreement of scores of the two people using the same instrument, the greater the reliability of the conclusions reached with regard to quantity or quality.

Once the data has been collected, the results must be evaluated against structure, process and outcome standards. The degree to which the identified standards have been met is a basis for pinpointing the strengths and weaknesses of nursing practice. The gaps must be identified and the actual problems that caused the deficiencies must be found. Thus,

questions such as “what existing practices are there to prevent the problem from occurring?” and “why are practices not effective?” are asked (Booyens & Minnaar, 2002:328-330).

In analysing the data, simple scoring and descriptive measurements are adequate, e.g. central tendency or frequency distribution. Unless the quality assessment data is communicated to the nurses delivering the direct care, their immediate supervisors and the organisations management in a form that stimulates practice correction, the measurement of nursing practice is of no value.

### 2.5.6 Evaluation

Evaluation as a part of professional accountability and quality assurance is a means to achieve accountability in professional practice (Dannenfeldt, 1988:29-30). The auditing of nursing records has developed from checking for the dates and times of documentation to checking for evidence of care rendered according to set criteria. Record keeping is one of the first things to be neglected when there are too few nurses to do the work. Nurses often fail to record tasks performed and observations made because they must complete their tasks before the end of a shift, thus neglecting their legal responsibility to their patients and to themselves. Incomplete records consequently result. If an action, effect or finding is not recorded, it is regarded as not done. The result of such failure to record data is that the quality of the care delivered to patients is not credible, and the nurses expose themselves to the potential of being accused of negligence (Geyer, 2006:46). A review of the deficient charts found by the auditor gives the nurses involved the insight into problems relating to recording and care delivery.

In determining the quality of nursing care, the use of a variety of instruments is recommended as the most effective approach. There are weaknesses in each method used on its own. If a process approach, such as a nursing audit, is combined with an outcome approach, such as questionnaires, and structured data, such as that provided by the nursing audit, then there is some possibility that the shortcomings of the individual instruments will be compensated for by the advantages of the other instruments used. The results thus reinforce each other, and it is then reasonable to assume that the results are valid.

## 2.6 RECORD KEEPING

The South African Nursing Council has directed that recording must not be taken for granted in the phases of the scientific nursing process, but must be taught as an integral part of the process (Searle, 2000:140-141). Accurately kept records are a nurse’s best defence against personal liability and vicarious liability (Verschoor, et al., 2005:45). Records provide a

foundation for planning medical and nursing care, and for assessing and evaluating diagnostic procedures, treatment and patient care. It serves as a guide to the daily management of the patient and her/his problem, and as a means of communication between the various members of the interdisciplinary team. Patients trust that nurses will ensure their protection through the information in the written record of her/his care. The lack of accuracy, whether accidentally or purposefully, in recording patient care will result in nurses betraying the trust of the patient (Searle, 2000:262).

Records provide a basis for continuity of care, evidence of a change in the condition of the patient, which may be an improvement or deterioration, and are proof that care has been carried out. Patient records reflect how the patient responded to the care (Troskie, in Booyens, 2004:352). It is a reasonable expectation that a nurse must inform the attending medical practitioner of any significant change to the patient's condition. In the event that a nurse may fail to report any change in the patient's condition, she may be deemed to be negligent (Verschoor, et al., 2005:45). Record keeping is a professional responsibility that is often neglected.

Evidence of care that is given to a patient will only be identified in the patient's nursing record (Muller.2004:63). The nurse thus has both a professional and legal responsibility to record all nursing interventions accurately and completely. (Muller.2004:63). Record keeping is an essential requirement for effective use of the nursing process. Recording occurs at each phase of the nursing process. The records are legal documents and must show accurate and honest nursing activities performed, reflect accountability and provide proof that the nursing care was in fact carried out. It must be accurate, correct and reflect the truth, and it must show the time a statement was made and must be signed by the person making the entry (Young et al, 2003:195).

The standards for keeping legally acceptable nursing records are that entries should be legible, have the date and time of each event, signed in full with the nurse's qualification against each entry and only use abbreviations approved by SANC (Muller, 2004:63). Nursing records relating to patient care may be used in evidence during litigation or during a preliminary hearing of the SANC. Such documents can either prove or disprove negligence. Hence, nursing records must be an accurate and current reflection of nursing events as they occur (Troskie in Booyens, 2004:349).

## 2.7 ACCOUNTABILITY

Accountability is defined as the responsibility of the nurse as an individual practitioner for her/his acts and/or omissions during caring for a patient. It implies that nurses will be judged in accordance with the professional standards, norms and values. Searle (in Muller. 2004:53) contends that accountability is required to oneself, the patient, the employer, the judiciary and the South African Nursing Council.

Muller (2004:64) further states that nurses must be able to account for their actions and omissions in any situation and take responsibility for the consequences of their actions within their scope of practice (Muller, 2004:55). Patients expect quality nursing care and the employer expects cost-effective quality nursing care (Muller, 2004:53). Organisational managers are held accountable for the quality of care delivered (Muller et al, 2006:492). Ability, responsibility and authority are the conditions for accountability. Nurses must therefore have the skills, knowledge, attitudes and values to be able to perform a nursing act (Muller, 2004:56). The knowledge that nurses must have is clearly set out in the Scope of Practice Regulation, R2598 (Muller, 2004:56).

If a nurse neglects to carry out the professional responsibilities prescribed by the SANC, she can be deemed to be negligent and as a result cause harm to the patient. The consequence of a nurse not being responsible may be professional-ethical discipline by the SANC in terms of the acts or omissions, R387. The SANC may take disciplinary action (Muller, 2004:57).

## 2.8 LABOUR MANAGEMENT LEGISLATION AND REGULATIONS

Workers may be recruited in traditional positions by individual contract, or work through an outsourcing contract and are in reality employees of another organisation, e.g. a nursing agency, or “moonlighters” employed by a similar organisation (Muller et al, 2006:264).

Nurse managers must therefore know and understand the type of employment of each nurse delivering patient care. A challenge to traditional employment is the growing practice of outsourcing, i.e. using temporary nurses to balance the staffing requirements. Dienemann (1998:201) states, “Nurse managers need to know the direct cost of outsourced personnel may be higher than if care had been performed by in-house personnel.”

Employers are reducing labour costs, which results in providing inadequate staffing causing an unsafe patient care. Nurse staffing levels are an important working condition issue for nurses. It is believed to be a factor in the provision of quality nursing care and patient

outcomes. Safety and quality care are directly related to the number of registered nurses and the skills mix of direct care nursing staff (Zondagh, 2004:20).

According to the Basic Conditions of Employment Amendment Act (BCOEA) No 75 of 1997, employees have an ethical responsibility to themselves, their families, their employers and their patients to keep to the requirements of the BCOEA by making sure that they have enough rest to perform competent, safe nursing care to the patient. Safe quality nursing care becomes impossible when nurses are exhausted (Geyer, 2004:39). The nurse manager must be educated and knowledgeable as to the contents of this legislation in her/his day-to-day practice and ensure that unit supervisors comply with these basic requirements of the law, as the nurses' dependent function (Muller et al, 2006:227).

The legislation that regulates hours of work in South Africa in the private sector only is the Basic Conditions of Employment Amendment Act no 75 of 1997. The White paper for the transformation of the health system in South Africa (1997) explains how the Department of Health envisages providing quality care to all and it describes patients as customers who may find other care providers if they are unsatisfied with the care they receive. To deliver the care that will satisfy the patient/customer, it is further stated in Section 1.1.2(e)(i) of the abovementioned paper, it is necessary to "promote the optimal use of skills, experience and expertise of all health personnel." Furthermore, "the skills mix of staff establishments should be improved." These statements imply that every nurse manager has to apply innovative staffing strategies in healthcare organisations to utilise the skills, experience and expertise of existing staff to provide the required nursing care.

Rationalisation of staff resources is the key to any efficiency gains in the hospital system (Muller, 2004:253). In many instances, the deficit of professional nurses in the skills mix in an organisation is so big that the organisation has to depend on non-professional nurses to perform tasks normally performed by professional nurses. Recent research shows that this practice results in compromised patient safety. It also shows that if the ratio of professional nurse to patient improved, negative patient and nurse outcomes are reduced (Zondagh, 2004:20). Muller (2004:258) supports the argument that hospitals with safe staffing levels can show financial savings, while insufficient staffing leads to extra costs through increased staff turnover and the necessity to hire temporary nursing staff. The long-term investment in recruiting permanent nursing staff results in cost saving in recruitment and retention of staff. Recent studies show that failure to recruit and retain sufficient professional nurses result in elevated stress levels in nurses and a reduction in the quality of care delivered to patients, as well as increased costs for hospitals (Zondagh, 2004:20).

Another factor aggravating the situation is that the retirement age of nurses is set at 60 in South Africa. Statistics released by the SANC (2006) reflect that at least 50305 (22,5%) of registered nurses are expected to retire by 2016 (“Where are the Nurses?” 2006:30(4). It further shows that the nursing profession is shrinking, while the migration of nurses to other countries remains a situation causing concern. However, according to Muller (2004:258), the concern remains the reduction in professional nurses with post-basic registrations as well as the decreasing number of midwives on the register. This situation is further aggravated by the reduction in or decline in numbers of students registering for the four-year programme in nursing, whilst the bridging course has become the primary source for producing professional registered nurses with an increase of 101%. (“Where are the Nurses?” 2006: 30(4). This automatically reduces the pool of registered nurses with a second or third additional qualification.

## 2.9 CONCLUSION

The importance of legislative control, the nursing process, record keeping, productivity, labour budgeting and quality assurance were discussed and related to the research. The literature also served as a basis in the adaptation of the research instrument.

# CHAPTER 3

# RESEARCH METHODOLOGY

## 3.1 INTRODUCTION

The methodology forms the core of the research project. It describes the scientific basis of the research process as regards its planning, structuring and execution (De Vos,Strydom, Fouche, Delport, in De Vos., 2003:5). The researcher consequently uses either a qualitative or quantitative approach, or a combination of the two, which is called triangulation (Burns & Grove, 2007:24, 61).

## 3.2 GOAL OF THE STUDY

For the purpose of this study, an investigation into the effect of a staffing strategy in a selected hospital in KwaZulu-Natal was conducted. According to De Vos et al (2003:107), a goal or objective can be defined as the end towards which effort or ambition is directed.

## 3.3 OBJECTIVES OF THE RESEARCH

With reference to the research question, what effect did this strategy have on patient care?, the following objectives were set for the research:

- To determine whether patients were assessed according to activities of daily living and psycho-social data.
- To determine whether the nursing diagnosis was done.
- To determine whether the patients' records were utilised to enhance individualised patient care and to ensure responsibility and accountability for patient care**.**
- To determine whether the evaluation of patient progress was done according to the different prescriptions and interventions at least twice in 24 hours.
- To determine whether a written final report for discharge criteria and health education was provided.
- To determine whether a comparison of the quality of nursing care delivered before and after the implementation of the staffing strategy exist

## 3.4 RESEARCH METHODOLOGY

### 3.4.1 Research Design

For the purpose of this study, a quantitative, non-experimental, descriptive approach was used to evaluate the patient records. Burns and Grove (2007:270) describe a research design as a “blue print” used in conducting a research study that maximises the control over factors that could possibly influence the validity of the findings. A non-experimental, descriptive design with a quantitative approach was applied to investigate the staffing strategy implemented at the selected semi-private hospital in KwaZulu-Natal.

According to Burns and Grove (2007:540), in a non-experimental study the independent variables are not manipulated and the milieu is not controlled. Quantitative data was obtained by means of an audit instrument. The most important consideration in descriptive studies is to collect accurate data and to describe it very carefully

### 3.4.2 Population and Sampling

A population, according to Burns and Grove (2007:509), is all the elements included in a sample that meet the criteria and is sometimes referred to as a target population. For the purpose of this study, the target population was patient records. A non-probability convenience  sample of boxes containing patient records for the periods January 2003 to May 2003, and June 2003 to November 2003 was selected. All files in a particular box were then audited. An average of 372 patient records were audited, i.e. 186 for the period January 2003 to May 2003,bbefore and 186 for the period June 2003 to November 2003, after implementation. The strategy was implemented in June 2003.

A retrospective audit of a total of 372 patient care records of patients who were hospitalised over a period of 12 months during 2003 was conducted. An evaluation of the records was done and a comparison was then drawn between the results obtained from the records before and after the implementation of the staffing strategy. For both periods, 186 patient records were audited.

The hospital has six wards. Nursing records from all six wards were examined in the study. Characteristics of the wards are as follows:

- Ward A is a male surgical ward with 30 beds.
- Ward B is a female surgical ward with 23 beds.
- Ward C is a maternity unit with 30 beds.

- Ward D is a paediatric unit with 10 beds.
- Ward E is a male medical ward with 21 beds.
- Ward F is a female medical ward with 30 beds.

The staff of wards A, B, D, E and F include nurses in training as enrolled nurses and bridging to professional level. The maternity ward only has student midwives, enrolled nurses and professional registered nurse and midwives.

### 3.4.3 Instrumentation

For the purpose of this study, the researcher adapted an audit instrument used at the hospital based on the phases of the scientific process in nursing, namely assessment, nursing diagnosis, planning, implementation and evaluation, and discharge. A nurse expert in nursing management and in quality assurance validated the instrument.

#### *3.4.3.1 Audit Instrument (Addendum A)*

The audit instrument was based on the phases of the nursing process. The necessary criteria or indicators were set for each phase. The audit instrument was divided into the following steps, based on the objectives of the study:

- Initial patient assessment on admission to the unit;
- Patient care plan in place within 24 hours after admission based on the findings of the initial assessment, which include identification of relevant problems and expected outcome;
- Nursing interventions and prescriptions in place according or relevant to prioritised problems;
- Implementation of the planned nursing care according to the identified nursing care plan; and
- Legal requirements relating to patient documentation.

Assessment was thus done to determine if the nursing care was planned and executed appropriately and according to the specific requirements of the nursing process. Documentation of the following was assessed as well:

- Any evidence that the appropriate people were informed of any change in the patients' condition, for example recording of date and time that the medical practitioner was informed.
- Required documentation from the informed people to corroborate the nursing entries.
- Evidence that any adaptations to the nursing care plan was made when the patient's condition changed.
- Evidence of the recording of activities carried out as well as the effects of the activities.
- Evidence of nursing recordings at least twice in a 24-hour period.
- Legally acceptable documentation of the death or discharge of the patient from the unit.
- A record of the patient's final diagnosis.
- Evidence of health education given to the patient and/or the family on discharge.
- Recorded evidence of medication given to the patient to take home on discharge.

The acceptable standard result for all variables and the instrument total score was set at 95% by the researcher.

### 3.4.4 Reliability and Validity

Utilisation of research instruments cannot be separated from the concepts of validity and reliability. Validity and reliability are quantitative criteria applicable to quantitative research. Validity and reliability can be claimed when the researcher continuously describes, explains and makes assumptions and also justifies procedures, statements and practices (Brink, 1996:45-55). Burns and Grove (2007:552) describe reliability as an instrument that consistently measures what it is supposed to measure. Validity is the extent to which an instrument accurately reflects the abstract construct being examined. The reliability and validity of this study were supported by a pilot study that was conducted on 40(10%) of the total number of patient files planned for the actual study. The researcher managed to audit all the patient records without any field workers. A research methodologist, statistician and nurse experts in management and quality assurance were consulted for the validation of the instrument and content of the study.

### 3.4.5 Pilot Study

A pilot study was conducted on patient files before (20) and after implementation (20) of the strategy. A total number of 40 (10%) files were audited. The pilot study was done to test the instrument for any inaccuracies and ambiguity. The files used for the pilot study were not included in the actual study.

### 3.4.6 Ethical Considerations

The Committee for Human Research at the Faculty of Health Sciences, Stellenbosch University, granted permission for this study. Ethical approval was also obtained from the ethics committee at the particular hospital where the research were to be conducted. Furthermore, confidentiality and anonymity were maintained throughout the data collection. Neither patient names were used nor the name of the hospital or wards from which the records were used. Codes were used to identify the hospital wards. The hospital was informed in the letter requesting consent to conduct the research, that the researcher intends publishing the findings of the research.

### 3.4.7 Data Collection

An audit instrument adapted by the researcher was used to evaluate the patient records. The researcher did the evaluation personally (Annexure A). Data collection took place over a period of six months.

### 3.4.8 Data Analysis and interpretation

A statistician was consulted for assistance with the statistical analysis. Basic descriptive statistical analysis was done by using the SPSS computer program. Various statistical associations between variables were carried out using the Chi-square test on 95% confidence level. Data is presented in the form of graphs, tables and frequencies.

### 3.4.9 Study Limitations

There were no limitations in this study.

## 3.5 CONCLUSION

The research methodology was explained and discussed in Chapter 3, which included the goal, objectives, research approach, population and sampling data collection and analysis and interpretation.

# CHAPTER 4

# DATA ANALYSIS AND INTERPRETATION

## 4.1 INTRODUCTION

According to De Vos *et al.* (2003:223), data analysis is a technique that can be applied by breaking down data into component parts to obtain answers to research questions. Furthermore, a critical part of any research project is the presentation and discussion of the results in a systematic and logical manner and the accurate representation of the analysed data.

## 4.2 DESCRIPTION OF STATISTICAL ANALYSIS

The data is presented in the form of frequency distribution tables and histograms as exploratory descriptive analysis. A follow-up confirmatory analysis to test for equality of proportions across the levels of the variables was carried out using the Chi-square test for equality of proportions (one-way tables). The Chi-square test for independence was also used to test for associations between the various variables. However, no significant results were obtained.

P-value is the measure reported from all tests of statistical significance. It is defined as the probability that an effect at least as extreme as that observed in a particular study could have occurred by chance alone. If the p-value is greater than 0.05 by convention the chance cannot be excluded as a likely explanation and the findings are stated as not statistically significant at that level. A 95% confidence interval was applied to determine whether there is an association between variables.

## 4.3 DATA ANALYSIS AND INTERPRETATION

### Section 1: Introduction

Table 4.1 shows the analysis of the number of patient files audited. The boxes from which the files were drawn were drawn randomly. In this particular hospital, files are placed into boxes in no specific order. The researcher was guided by only a date after the file was drawn from the box. She then categorised the files according to the wards.

The total number of files audited was 372.

**Table 4.1: Showing the number of files audited per ward pre- and post-implementation**

| NAME | PRE-IMPLEMENTATION FILES AUDITED (N = 186) | POST-IMPLEMENTATION FILES AUDITED (N = 186) |
|---|---|---|
| WARD A | 33 (18%) | 21 (11%) |
| WARD B | 25 (13%) | 43 (23%) |
| WARD C | 26 (14%) | 36 (19%) |
| WARD D | 40 (22%) | 18 (10%) |
| WARD E | 39 (21%) | 17 (9%) |
| WARD F | 23 (12%) | 51(27%) |

**Section 2: Assessment**

The patient is assessed according to her/his activities of daily living, and psychosocial data.

VARIABLE 1: THE NURSING ASSESSMENT FORMAT COMPLETED WITHIN 24 HOURS OF ADMISSION

Figure 4.1 shows that the majority of the wards were most likely to complete the assessment of their patients within 24 hours pre-implementation of the strategy; however, after implementation, Ward C (100%), D (100%) and F (98%) were more likely to complete an assessment of their patients within the first 24 hours. The standard is that all patients admitted are assessed within 24 hours.

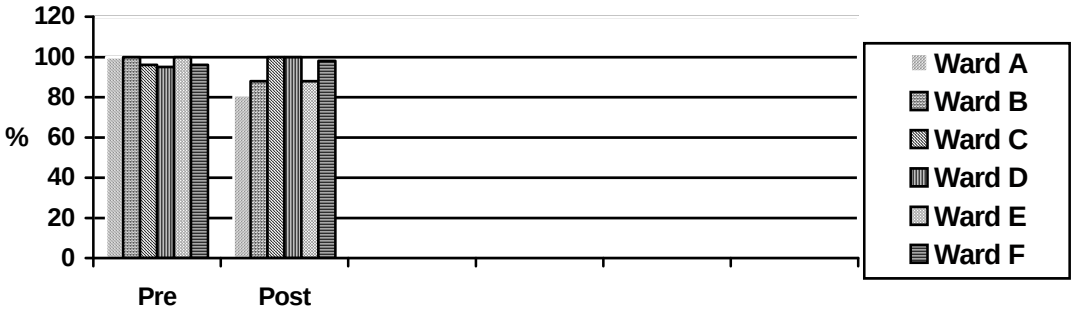


**Figure 4.1: Assessment within 24 hours of admission. N = 372.**

VARIABLE 2: INFORMATION ENTERED IS RELEVANT TO QUESTIONS ASKED

Figure 4.2 shows that the majority of the wards were more likely to have entered relevant information to the questions asked pre-implementation of the strategy in comparison to post-implementation, where Ward C and D were most likely to complete the documentation. According to the researcher, professional nurses in these wards mostly do documentation. In Ward C, only professional registered nurses document patient care (3.4.2). In Ward D, 50% of the registered professional nurses have a post-basic qualification.

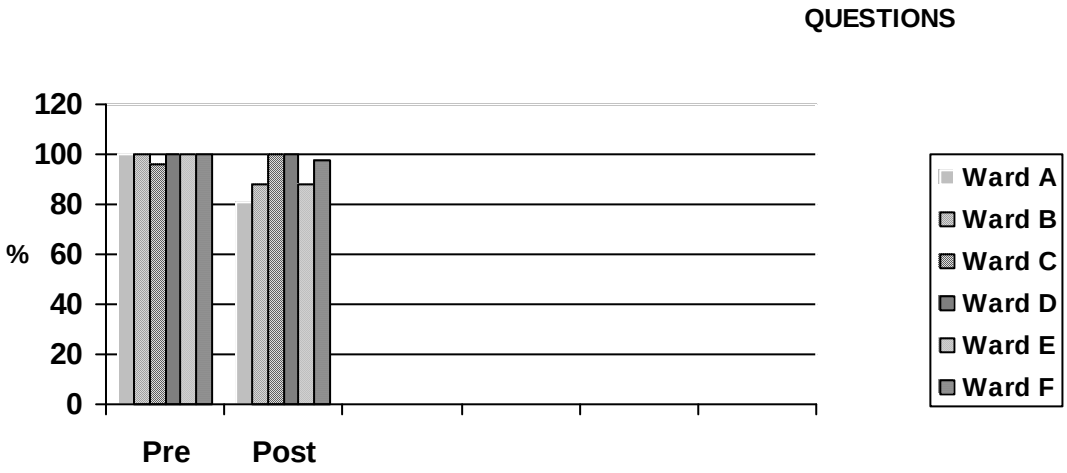


**Figure 4.2: Information entered is relevant to questions asked. N = 372.**

VARIABLE 3: ALL SECTIONS OF THE FORM HAVE BEEN COMPLETED

Figure 4.3 shows that all the wards were most likely to have completed the assessment document pre-implementation, while most wards were less likely to have completed the documents as required post-implementation. It was identified that the information required about the discharge of the patient was incomplete. Only professional registered nurses who worked in Ward C obtained 100% pre- and post-implementation.

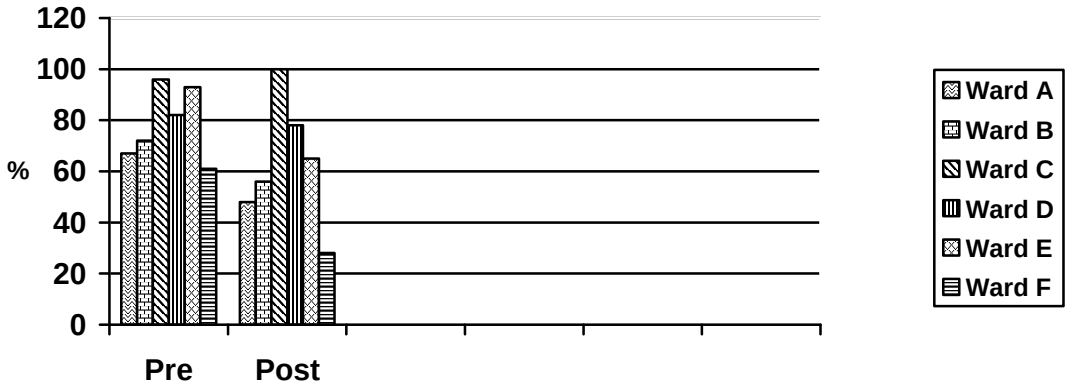


**Figure 4.3: All sections of the assessment form have been completed. N = 372**

**Section 3: Nursing diagnosis**

The patients' problems are identified, itemised and recorded together with the expected outcome.

VARIABLE 4: THE CARE PLAN HAS BEEN WRITTEN WITHIN 24 HOURS OF ADMISSION

The majority of wards were most likely not to have completed a care plan within 24 hours after admission. Ward C is the only ward that will most likely write a care plan within 24 hours.

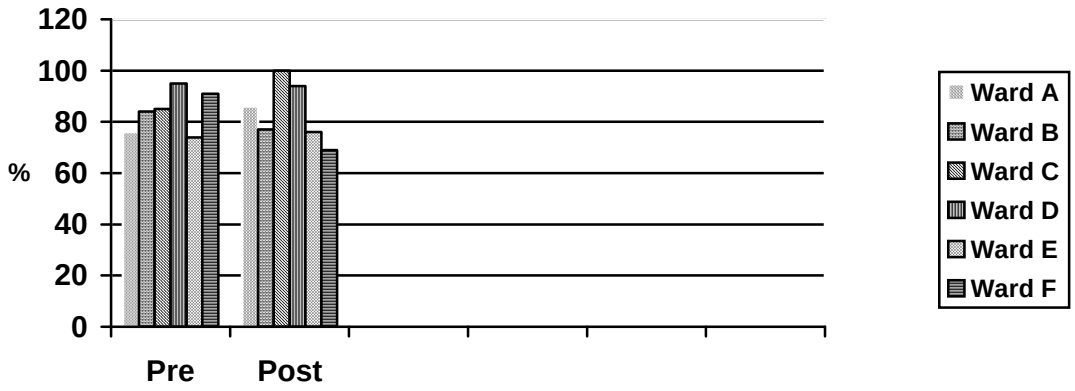


**Figure 4.4: Care plan has been written within 24 hours of admission. N = 372**

VARIABLE 4.5: NURSING PROBLEMS ARE BASED ON THE ADMISSION ASSESSMENT FINDINGS

Figure 4.5 shows that the majority of the wards were most likely not to have based the nursing problems on the assessment findings, while there is an improvement in Ward C (89%) and D (83%) post-implementation the majority of nurses are most likely not to identify nursing problems based on the admission findings.

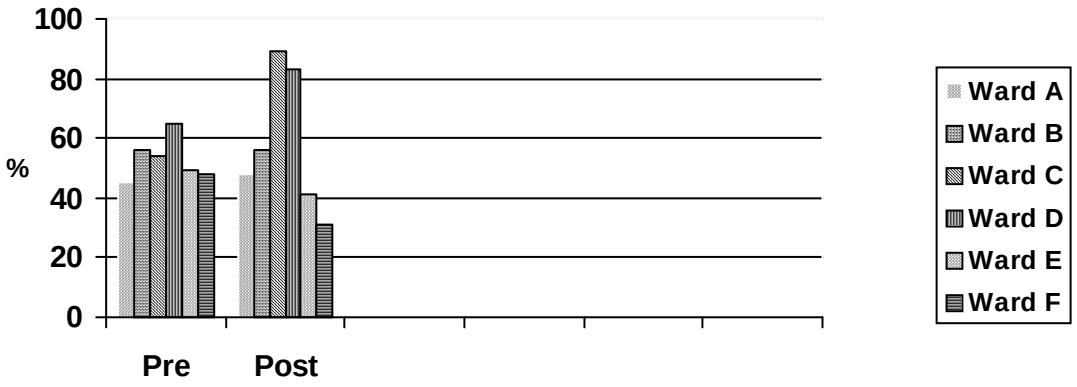


**Figure 4.5: Nursing problems are based on the admission assessment findings. N = 372**

VARIABLE 4.6: IDENTIFIED PROBLEMS ARE PRIORITISED

Figure 4.6 shows that the majority of the wards were most likely not to have prioritised the nursing problems identified in the assessment findings; post-implementation, only Ward C and D show a slight improvement, but these results are still unacceptable. The majority of nurses are most likely not to prioritise the identified nursing problems based on the admission findings.

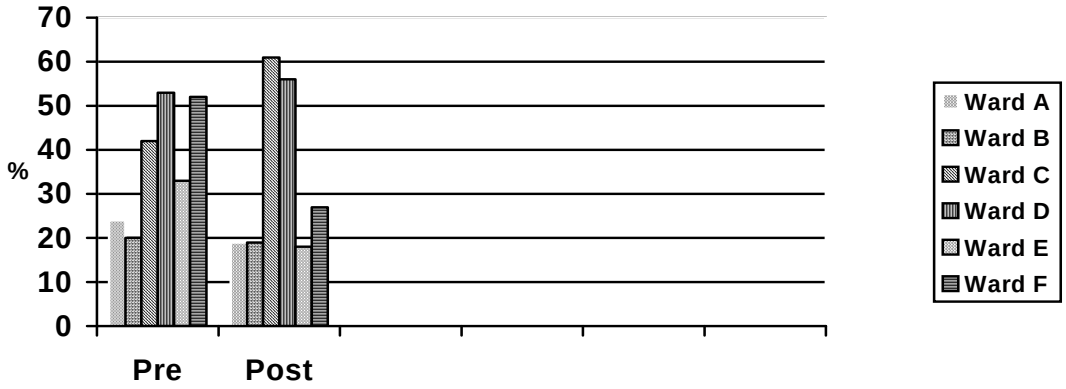


**Figure 4.6: Identified problems are prioritised. N = 372.**

VARIABLE 4.7: AN EXPECTED OUTCOME IS LISTED FOR EACH PROBLEM

Figure 4.7 shows that the majority of the wards were most likely not to have listed an expected outcome for each problem pre-implementation. Only Ward D (100%) was most likely to have listed an expected outcome for each problem post-implementation. Ward D improved in the post-implementation phase from 88% to 100%.

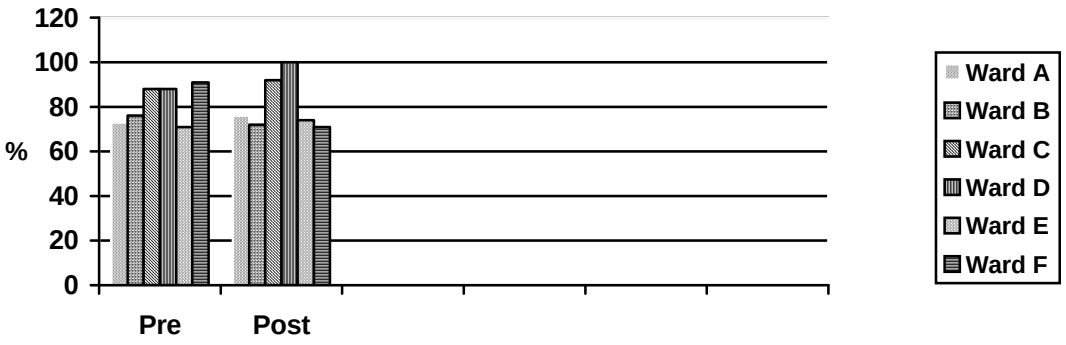


**Figure 4.7: An expected outcome is listed for each problem. N = 372.**

VARIABLE 4.8: THE RECORD COMPLIES WITH LEGAL REQUIREMENTS OF RECORD KEEPING SUCH AS NO ABBREVIATIONS, LEGIBLE SIGNATURES

Figure 4.8 shows that the majority of the wards were most likely to have complied with the legal requirements of record keeping pre-implementation, but deteriorated post-implementation.

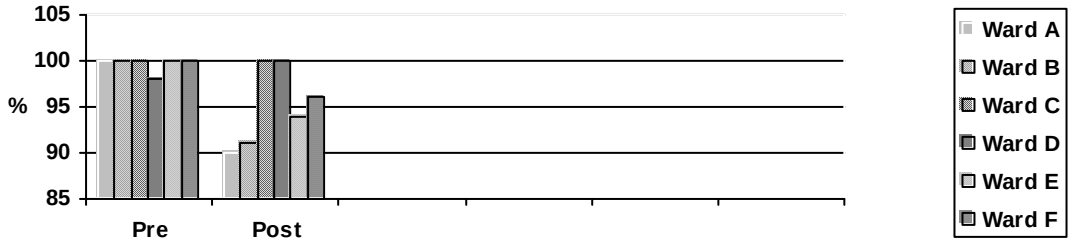


**Figure 4.8: The record complies with legal requirements of record keeping such as no abbreviations, legible signatures. N =372**

VARIABLE 4.9: THE EXPECTED OUTCOMES ARE REALISTIC

Figure 4.9 shows that the majority of the wards were most likely not to have realistic expected outcomes pre-implementation. Only Wards C (100%) and D (100%) were most likely to have set realistic expected outcomes post-implementation.

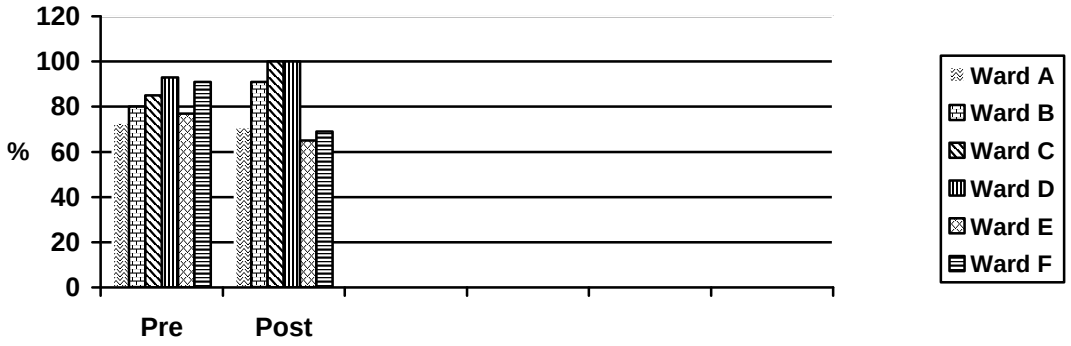


**Figure 4.9: The expected outcomes are realistic. N = 372.**

VARIABLE 4.10: ONLY ACCEPTED ABBREVIATIONS ARE USED

All the files audited had no abbreviations. N = 372.

VARIABLE 4.11: SIGNATURES ARE LEGIBLE AND NAMES PRINTED, DESIGNATION SHOWN

All files audited had legible signatures and designation, but 100% of the files had no name printed below the signature. N = 372.

**Section 4: Planning**

VARIABLE 12: NURSING ORDERS ARE PRESCRIPTIVE (STARTING WITH A VERB)

Figure 4.10 shows that all wards were most likely not to have prescriptive nursing orders starting with a verb pre-implementation. Only Wards C (100%) and D (100%) were most likely to have prescriptive nursing orders starting with a verb post-implementation. However, some improvement in documentation is shown in all wards except Ward F, where the audit results decreased from 91 before to 76 after implementation.

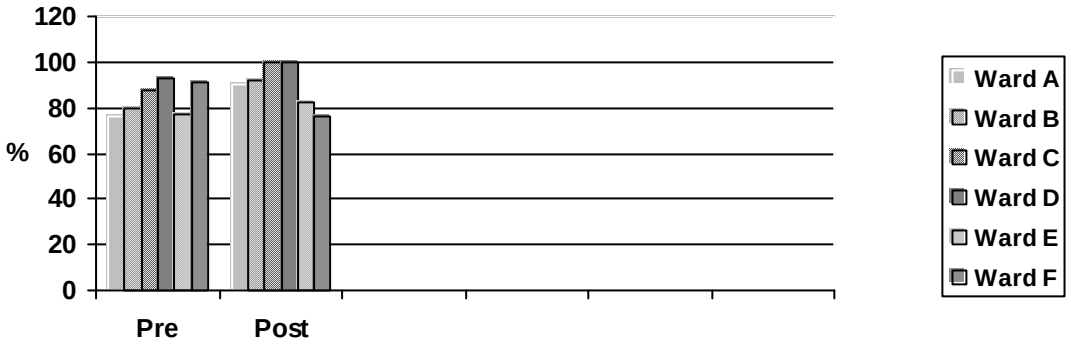


**Figure 4.10: Nursing orders are prescriptive (starting with a verb) N = 372.**

VARIABLE 13: THERE IS NO REPETITION ON THE NURSING CARE PLAN

Figure 4.11 shows that all wards were most likely to have repetition on the nursing care plans pre-implementation. Only Ward C (100%) and D (100%) were most likely not to have repetition on the nursing care plans post-implementation. However, some improvement in documentation is shown in all wards except Ward F, where the audit results decreased from 83 before to 75 after implementation.

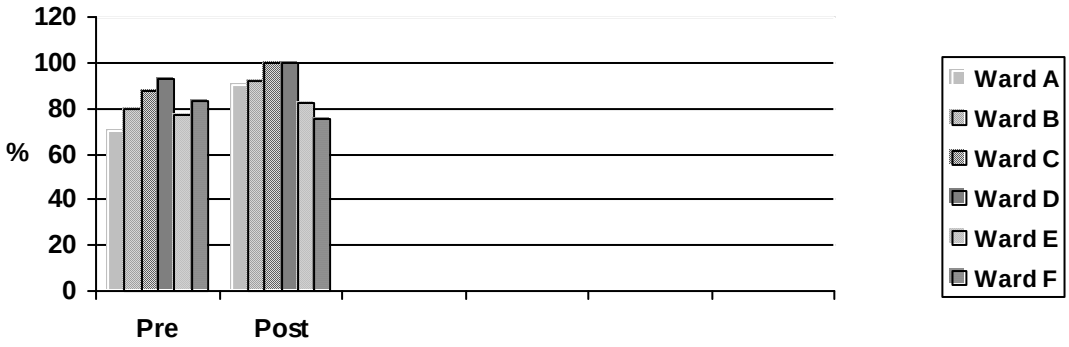


**Figure 4.11: There is no repetition on the nursing care plan. N = 372.**

VARIABLE 14: DOCTORS' PRESCRIPTIONS ARE RELEVANT TO THE PROBLEMS IN ORDER TO BRING ABOUT THE EXPECTED OUTCOMES

Figure 4.12 shows that doctors' prescriptions were relevant to the problems in order to bring about expected patient outcomes pre-implementation. Ward A shows deterioration post-implementation.

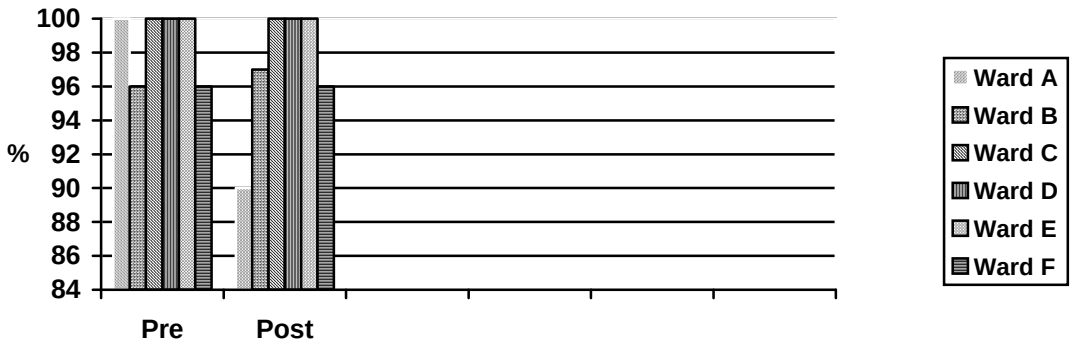


**Figure 4.12: Doctors' prescriptions are relevant to the problems in order to bring about the expected outcomes. N = 372.**

VARIABLE 15: NURSING PRESCRIPTIONS SPECIFY THE INITIATION AND RESOLUTION OF THE RELATED PROBLEM

Figure 4.13 shows that the wards were most likely not to have had nursing prescriptions specifying the initiation and resolution of the problem pre- and post-implementation. These results show unsafe nursing practice.

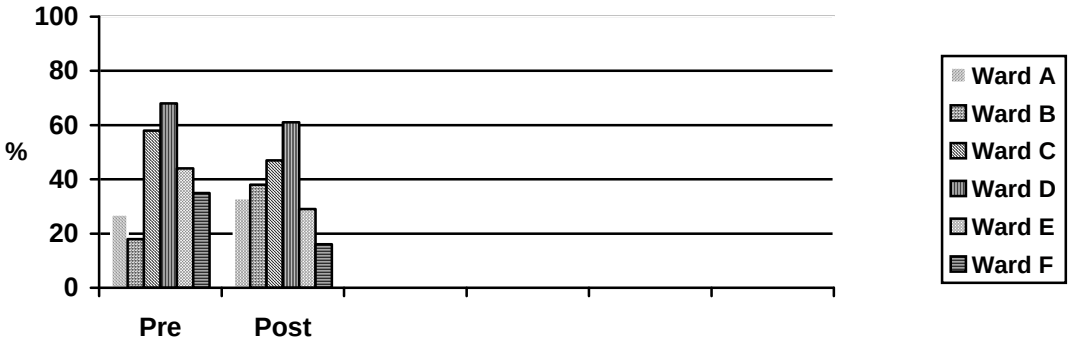


**Figure 4.13: Nursing prescriptions specify the initiation and resolution of the related problem. N = 372.**

VARIABLE 16: NURSING PRESCRIPTIONS ARE RELEVANT TO ACCEPTED POLICIES

Figure 4.14 shows that the wards were most likely not to have had nursing prescriptions relevant to accepted policies pre- and post-implementation.

**FIGURE 4.14: NURSING PRESCRIPTIONS ARE RELEVANT TO ACCEPTED POLICIES**

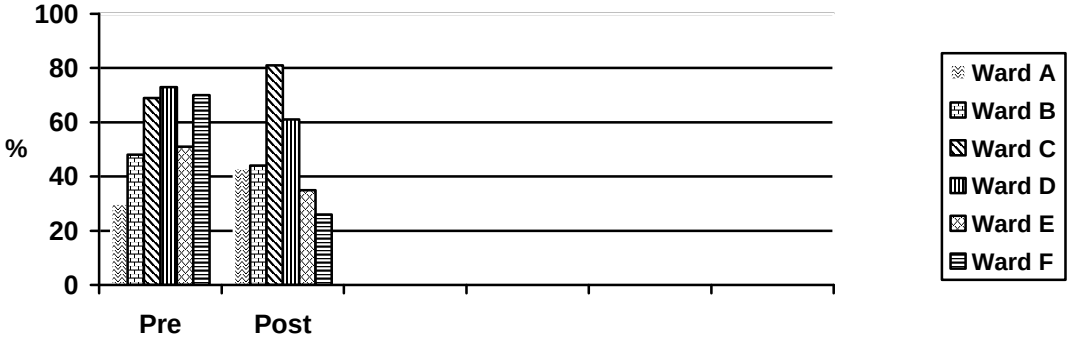


**Figure 4.14: Nursing prescriptions are relevant to accepted policies. N = 372.**

VARIABLE 17: NURSING PRESCRIPTIONS ARE RELEVANT TO THE PROBLEMS IDENTIFIED ON INITIAL AND DAILY ASSESSMENT

Figure 4.15 shows that the wards were most likely not to have had nursing prescriptions relevant to the problems identified on initial and daily assessment pre- and post-implementation.

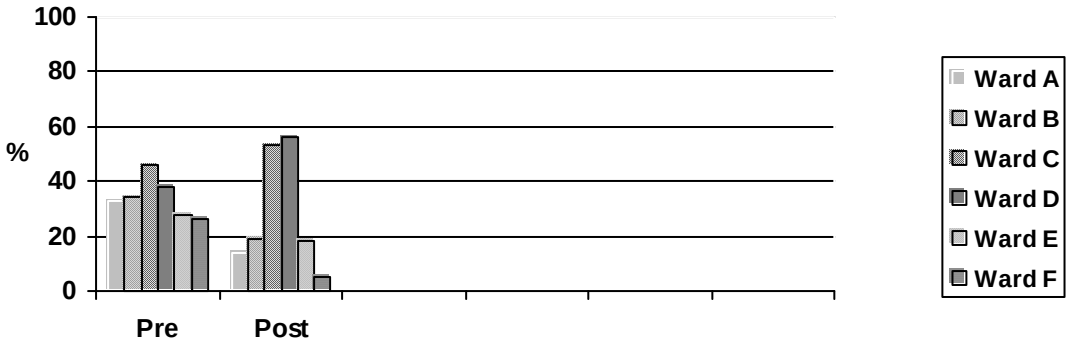


**Figure 4.15: Nursing prescriptions are relevant to the problems identified on initial and daily assessment. N = 372.**

VARIABLE 18: NURSING PRESCRIPTIONS SPECIFY THE NURSING PROCEDURES REQUIRED TO BRING ABOUT THE EXPECTED NURSING OUTCOMES

Figure 4.16 shows that nursing prescriptions were most likely not to have specified the nursing procedures to bring about the expected nursing outcomes pre- and post-implementation. This is legally unaccepted nursing care.

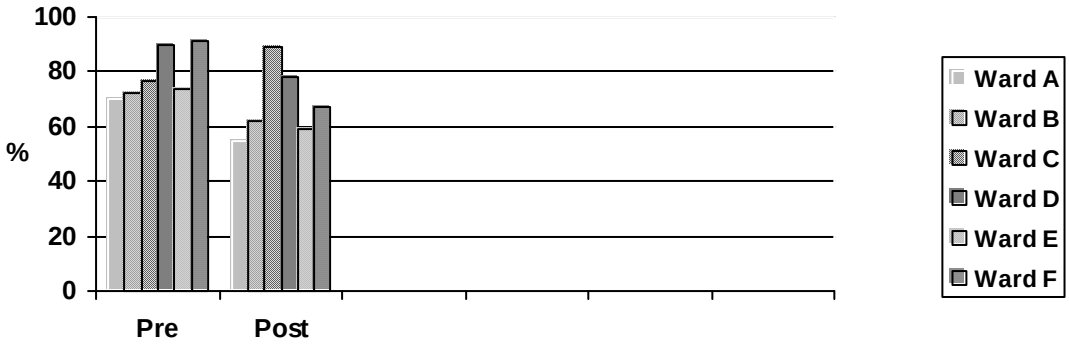


**Figure 4.16: Nursing prescriptions specify the nursing procedures required to bring about the expected nursing outcomes. N = 372.**

VARIABLE 4.19: ALL NURSING ACTIONS AIM TO BRING ABOUT THE EXPECTED NURSING OUTCOMES

Figure 4.17 shows that most wards were most likely to perform nursing actions to bring about expected outcomes without a prescription.

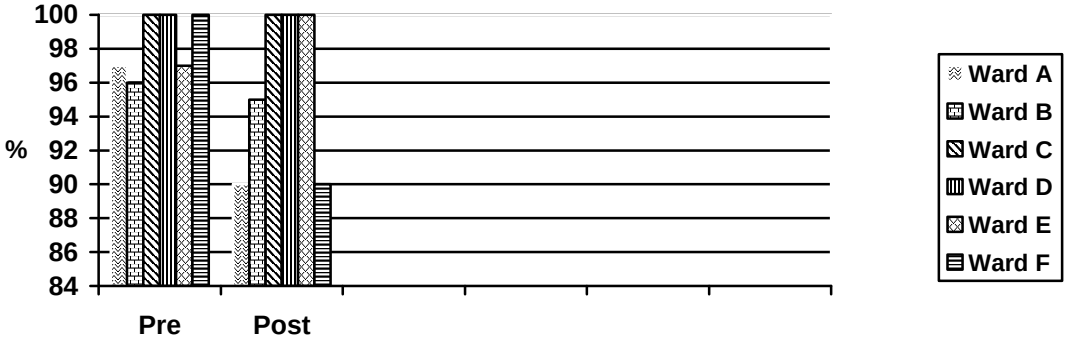


**Figure 4.17: All nursing actions aim to bring about the expected nursing outcomes.**

**N = 372.**

VARIABLE 4.20: TERMINATION OF A NURSING PRESCRIPTION IS COUNTER-SIGNED BY A PROFESSIONAL REGISTERED NURSE

Figure 4.18 shows that professional registered nurses were not likely to counter-sign termination of a nursing prescription pre- and post-implementation. The results indicated a deterioration post-implementation. These results show illegal nursing practice.

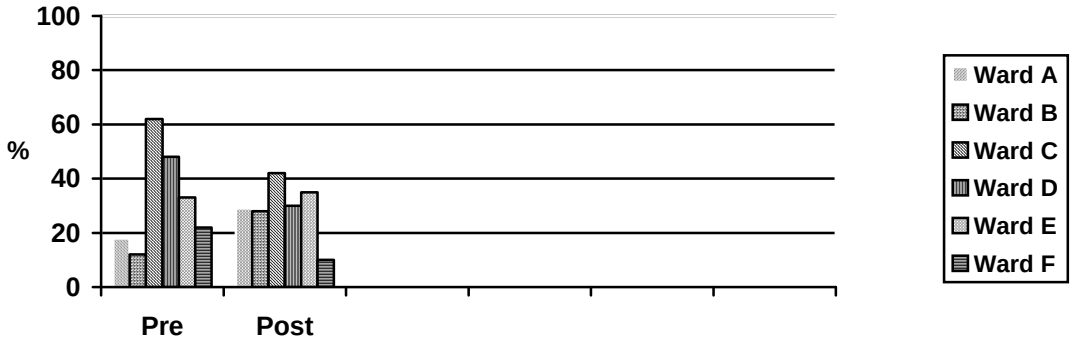


**Figure 4.18: Termination of a nursing prescription is counter-signed by a professional registered nurse. N = 372**

**Section 5: Implementation**

Patients' records are utilised to enhance individualised patient care and to ensure responsibility and accountability for patient care.

VARIABLE 4.21: ALL RECORDED NURSING ACTIONS CAN BE COMPARED WITH THE NURSING ACTIONS AS PRESCRIBED IN THE NURSING CARE PLAN

Figure 4.19 shows that in all wards the recorded nursing actions cannot be compared with the nursing actions as prescribed in the nursing care plan. These are unacceptable nursing care results.

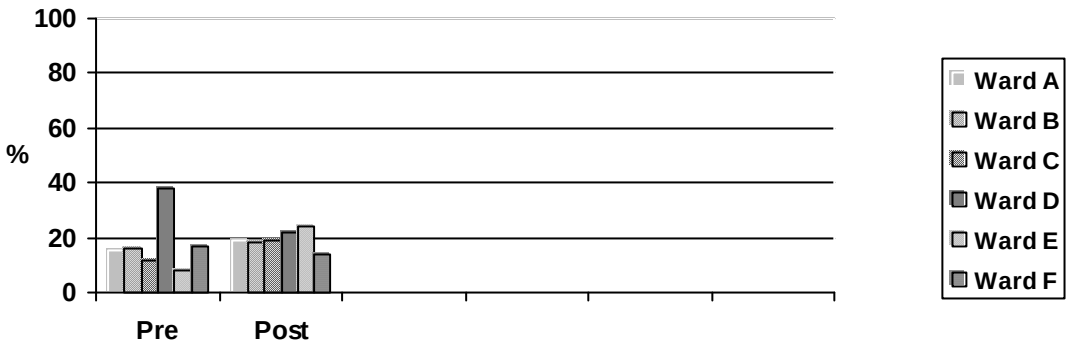


**Figure 4.19: All recorded nursing actions can be compared with the nursing actions as prescribed in the nursing care plan. N = 372.**

VARIABLE 4.22: NURSING INTERVENTIONS ARE FOLLOWED UP AND COUNTER-SIGNED BY THE PROFESSIONAL REGISTERED NURSE

Figure 4.20 shows that professional nurses were most likely not to follow up and counter-sign nursing interventions. This is an illegal practice.

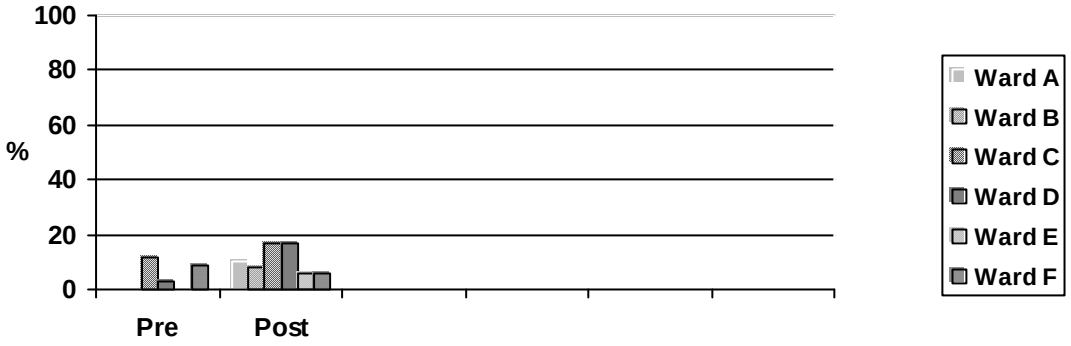


**Figure 4.20: Nursing interventions are followed up and counter-signed by the professional registered nurse. N = 372.**

VARIABLE 4.23: AS PROBLEMS ARE RESOLVED THE NURSING CARE PLAN CHANGES AND NEW PROBLEMS ARE IDENTIFIED, INDICATING THE EFFECTIVENESS OF THE CARE PROVIDED

Fgure 4.21 shows that the nursing care plans were most likely not to change as problems were resolved and new problems were identified pre- and post-implementation. There is a statistically significant result between pre- and post-implementation (p = 0.02).

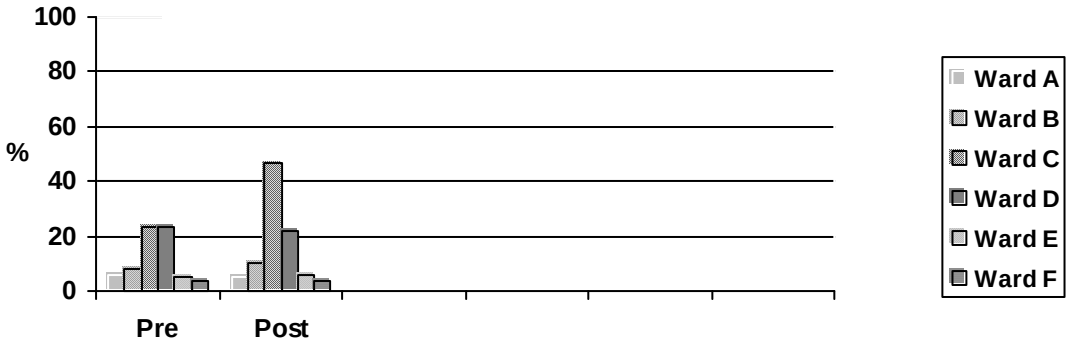


**Figure 4.21: As problems are resolved the nursing care plan changes and new problems are identified, indicating the effectiveness of the care provided. N = 372.**

VARIABLE 4.24: EVERY PRESCRIPTION IS CARRIED OUT AT THE CORRECT TIME AND DOCUMENTED BY THE NURSE WHO CARRIED OUT THE PRESCRIPTION

Figure 4.22 shows that all wards were most likely to implement and document all nursing interventions at the correct time by the nurse who carried out the prescription, except Ward F pre-implementation. Post-implementation, Ward A and F were most likely not to implement and document all nursing interventions at the correct time.

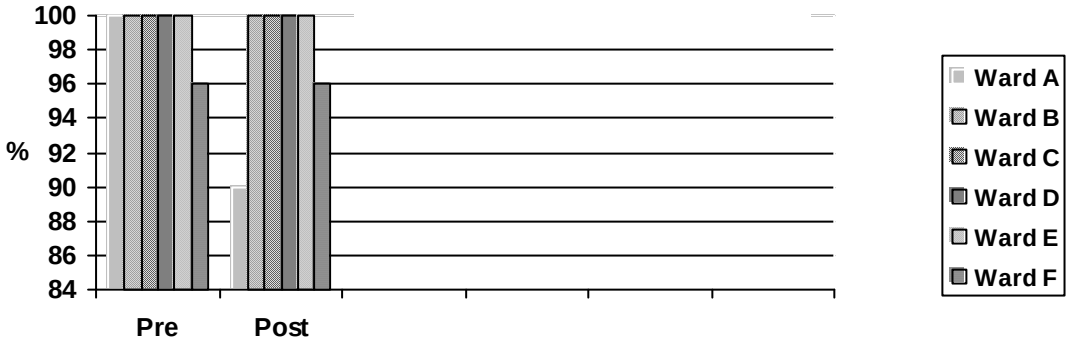


**Figure 4.22: Every prescription is carried out at the correct time and documented by the nurse who carried out the prescription. N = 372.**

VARIABLE 4.25: APPROPRIATE PERSONNEL ARE KEPT INFORMED OF ANY CHANGE IN THE PATIENT'S CONDITION OR CRISES

Figure 4.23 shows that the majority of wards were most likely to keep appropriate personnel informed of any change in the patient's condition or crises pre- and post-implementation.

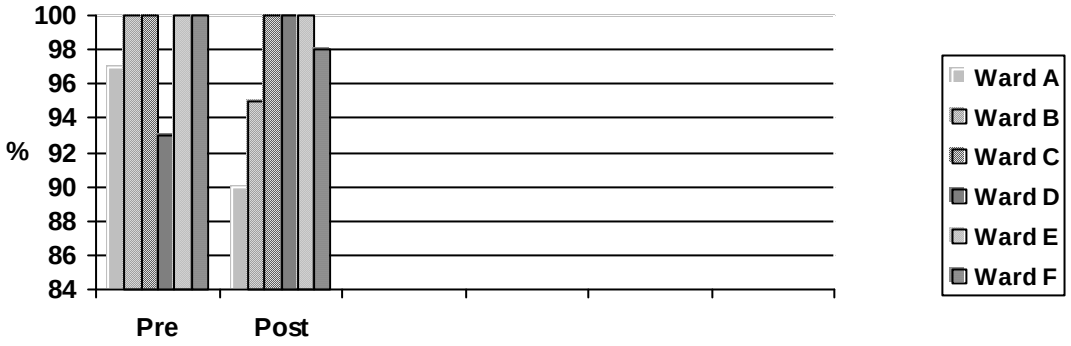


**Figure 4.23: Appropriate personnel are kept informed of any change in the patient's condition or crises. N = 372.**

**Section 6: Evaluation**

Evaluation of patient progress is done according to the different prescriptions and interventions at least twice in 24 hours.

VARIABLE 4.26: PROBLEM-ORIENTATED PROGRESS NURSING NOTES REFLECT THAT THE PATIENT'S PROGRESS IS EVALUATED AT LEAST TWICE IN THE 24 HOUR PERIOD

Figure 4.24 shows that the wards were most likely to evaluate nurse records at least twice in 24 hours pre- and post-implementation. Ward A is the only ward that deteriorated post-implementation.

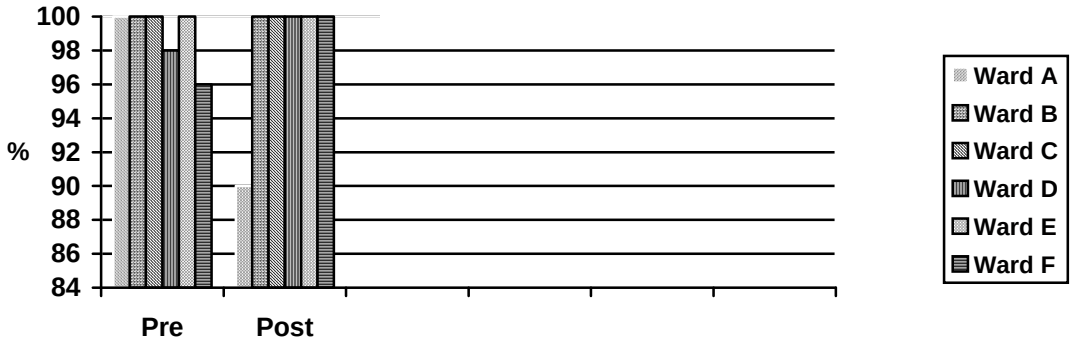


**Figure 4.24: Problem-orientated progress nursing notes reflect that the patient's progress is evaluated at least twice in the 24 hour period. N = 372.**

VARIABLE 4.27: PATIENT'S PROGRESS REPORT IS CONCISE AND CLEAR REGARDING:

- Change in the condition of the patient;
- Date and time the doctor was called;
- Date and time patient was attended by both the doctor and the nurse;
- Date and time the orders were carried out; and
- Both the attending doctor and the nurse document interventions.

The results obtained for this variable was 100% for all the wards, both pre- and post-implementation.

VARIABLE 4.28: ANY ADAPTATIONS TO THE NURSING CARE PLAN IS RECORDED

Figure 4.25 shows that in all the wards adaptations to the nursing care plan were unlikely to be recorded pre- and post-implementation. On average, the total number of wards pre-implementation was 8.6% and post-implementation 19%. This is unsafe nursing practice.

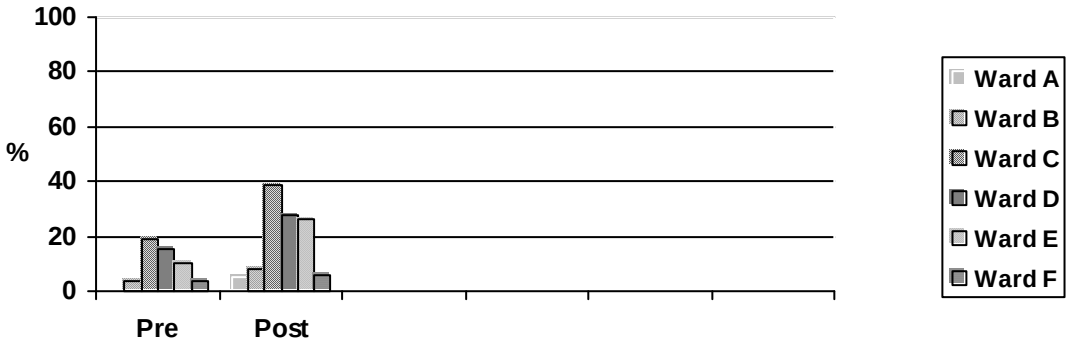


**Figure 4.25: Any adaptations to the nursing care plan is recorded. N = 372.**

VARIABLE 4.29: PRESCRIBED NURSING CARE ACTIVITIES ARE CARRIED OUT AND RECORDED, AS WELL AS THEIR EFFECTS

Figure 4.26 shows that prescribed nursing activities were most likely to be carried out and recorded, as well as their effects, pre- and post-implementation. Ward A (76%) and E (88%) show a deterioration post-implementation.

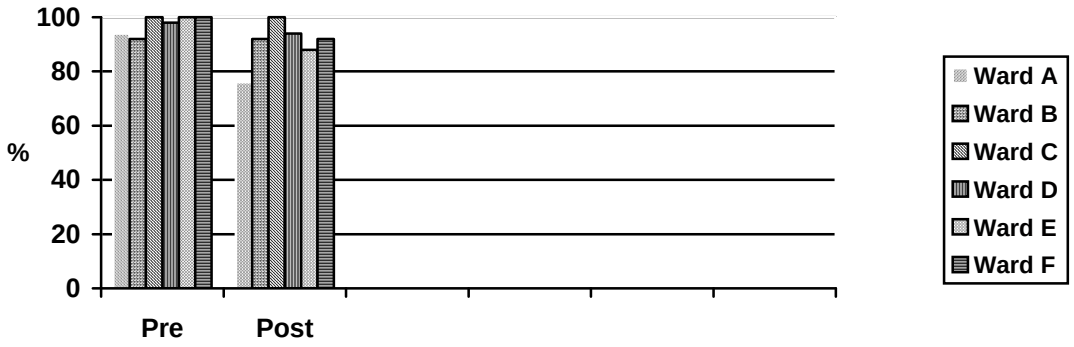


**Figure 4.26: Prescribed nursing care activities are carried out and recorded, as well as their effects. N = 372**

**Section 7: Discharge, transfer or death**

A written final report is essential for discharge criteria and health education provided.

VARIABLE 4.30: DATE AND TIME OF DISCHARGE, TRANSFER OR DEATH ARE DOCUMENTED

Figure 4.27 shows that all the wards were most likely not to record the date and time of discharge, transfer or death pre- and post-implementation.

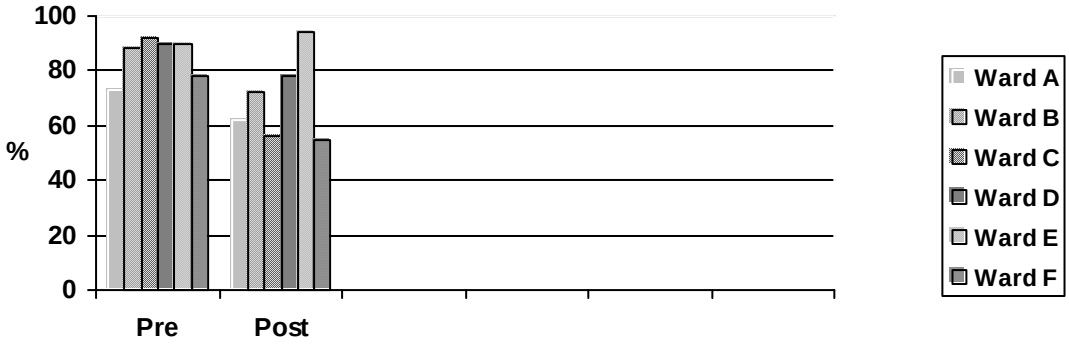


**Figure 4.27: Date and time of discharge, transfer or death are documented. N = 372.**

VARIABLE 4.31: FINAL DIAGNOSIS RECORDED

Figure 4.28 shows that all the wards are most likely not to record the final diagnosis post-implementation.

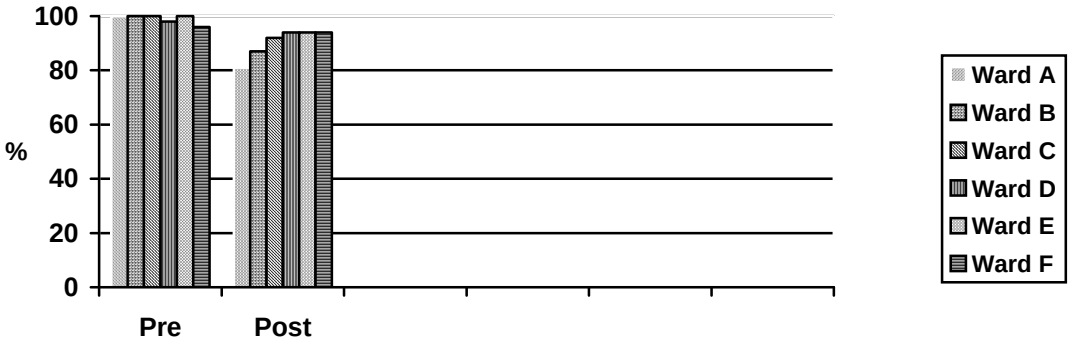


**Figure 4.28: Final diagnosis recorded. N = 372.**

VARIABLE 4.32: DOCUMENTATION OF FINAL PATIENT ASSESSMENT BY THE NURSE INDICATING SKIN CONDITION, VITAL SIGNS, MOBILITY AND RESOLUTION OF INITIAL PROBLEMS IDENTIFIED

Figure 4.29 shows that all the wards were most likely not to document the final assessment pre- and post-implementation. While there was minimal improvement in some wards, Ward C demonstrated a marked decline post-implementation to 19%.

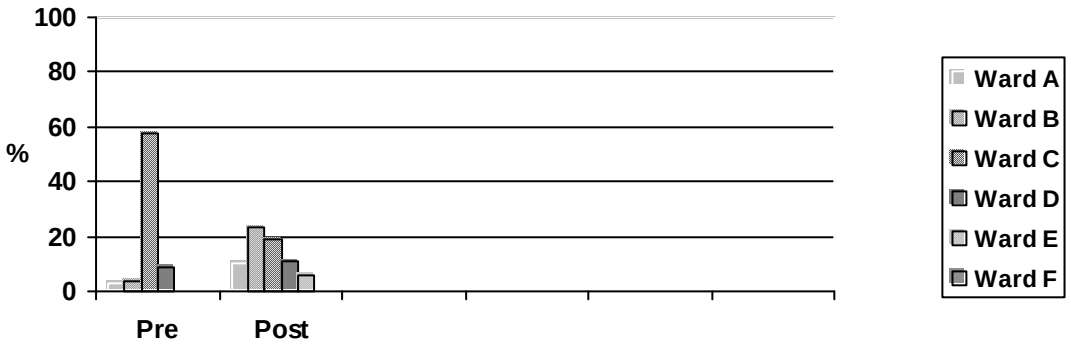


**FIGURE 4.29: Documentation of final patient assessment by the nurse indicating skin condition, vital signs, mobility and resolution of initial problems identified. N = 372**

VARIABLE 4.33: HEALTH EDUCATION, E.G. DIET AND MEDICATION

Figure 4.30 shows that all the wards were most likely not to give health education pre- and post-implementation.

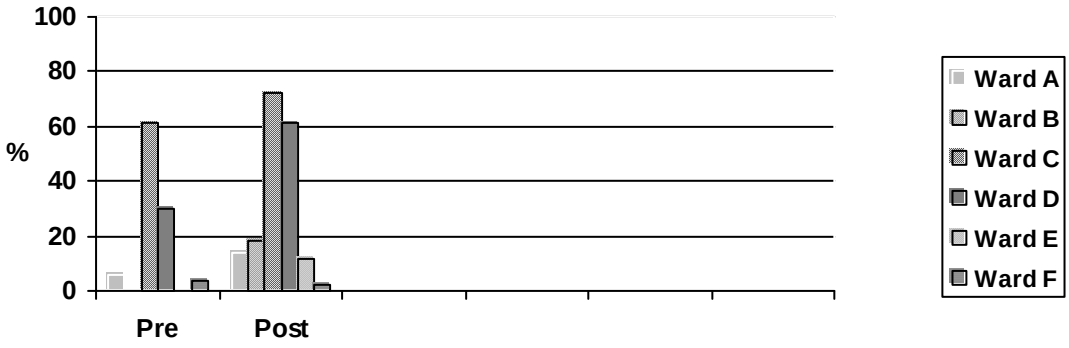


**Figure 4.30: Health education, e.g. diet and medication. N = 372.**

VARIABLE 4.34: DOCUMENTATION REGARDING DRESSINGS OR MEDICATION HANDED TO THE PATIENT OR RELATIVES

Figure 4.31 shows that the wards are most likely not to document the receipt of dressings and medication to patients or relatives pre- and post-implementation. Ward D (63% and 67% respectively) was the only ward that was likely to document some information about dressings and medication taken home.

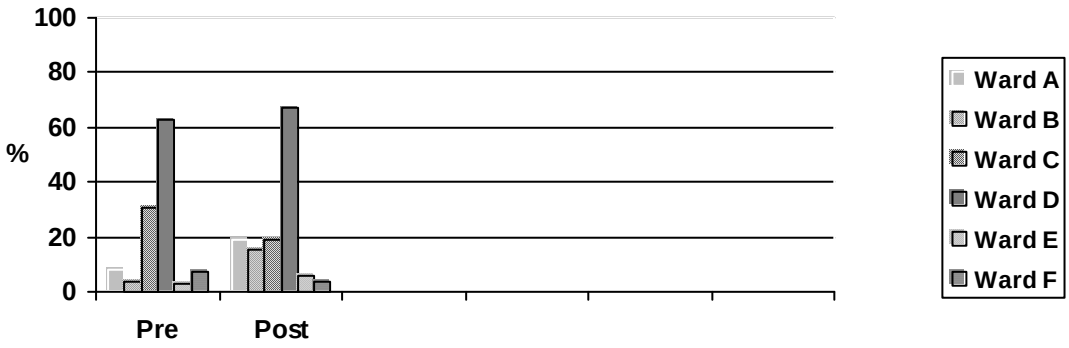


**Figure 4.31: Documentation regarding dressings or medication handed to the patient or relatives. N = 372**

VARIABLE 4.35: COPIES OF DISCHARGE OR TRANSFER RECORD COMPLETED BY THE DOCTOR ARE IN THE ARCHIVED FILE

Figure 4.32 shows all the wards were most likely to have copies of the discharge or transfer record completed by the doctor in the archived file pre-implementation. Post-implementation the wards show a decline.

**FIGURE 4.32: COPIES OF DISCHARGE OR TRANSFER RECORD COMPLETED BY THE DOCTOR ARE IN THE ARCHIVED FILE**

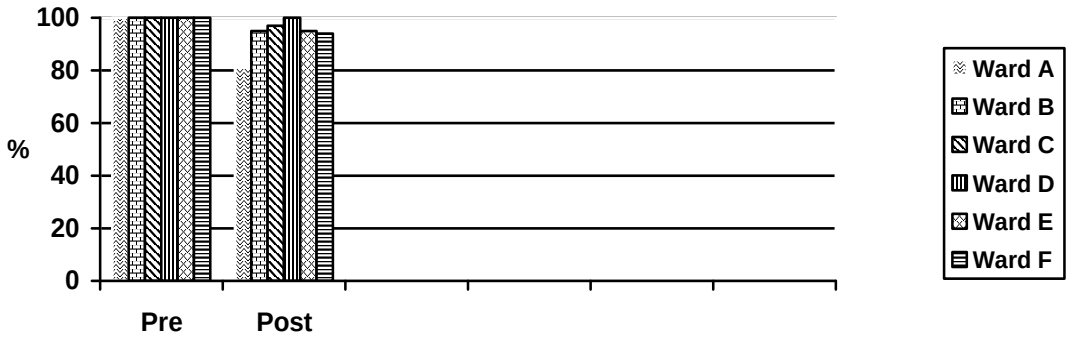


**Figure 4.32: Copies of discharge or transfer record completed by the doctor are in the archived file. N = 372**

VARIABLE 4.36: DOCUMENTATION OF PATIENT OR RELATIVES RECEIVING PERSONAL BELONGINGS KEPT FOR SAFEKEEPING

Figure 4.33 shows that all the wards were most likely not have documented patient or relatives receiving personal belongings pre- and post-implementation.

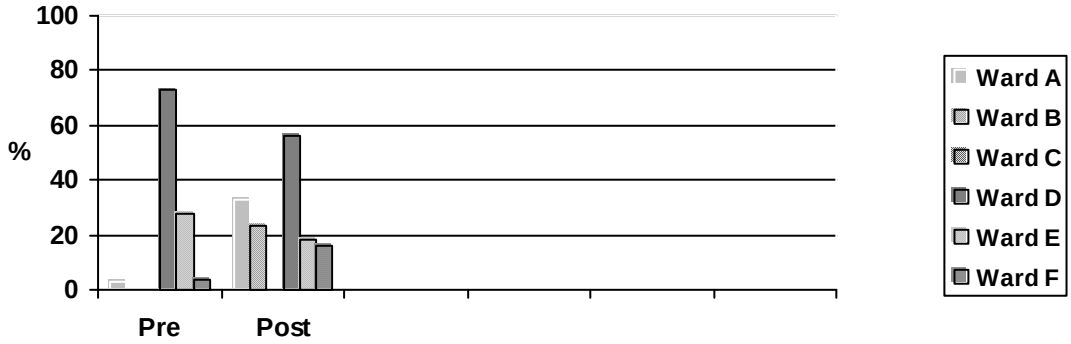


**Figure 4.33: Documentation of patient or relatives receiving personal belongings kept for safekeeping. N = 372**

VARIABLE 4.37: RELATIVES INFORMED ABOUT DEATH, TRANSFER OR DISCHARGE

Figure 4.34 shows that all the wards were most likely not to inform relatives about death, transfer or discharge.

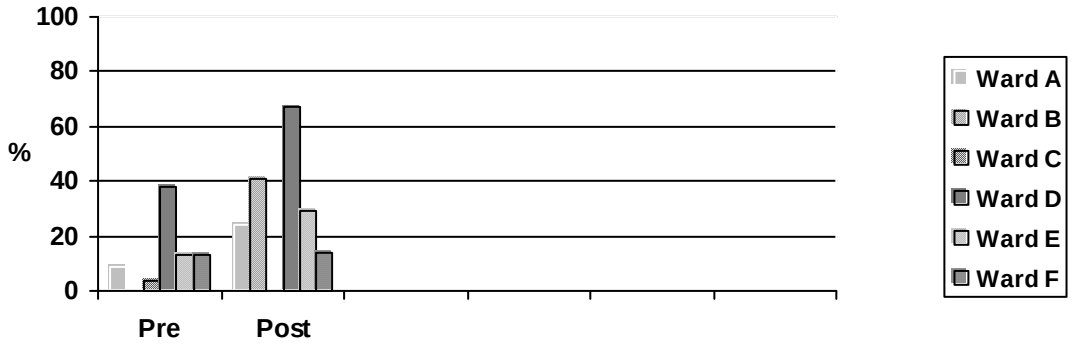


**Figure 4.34: Relatives informed about death, transfer or discharge. N = 372.**

VARIABLE 4.38: RECORD IS COMPLETED AND ARCHIVED FOR SAFEKEEPING

Figure 4.35 shows that the clerical staff of the wards were most likely to complete and archive the records for safekeeping pre-implementation, but the results show decline post-implementation.

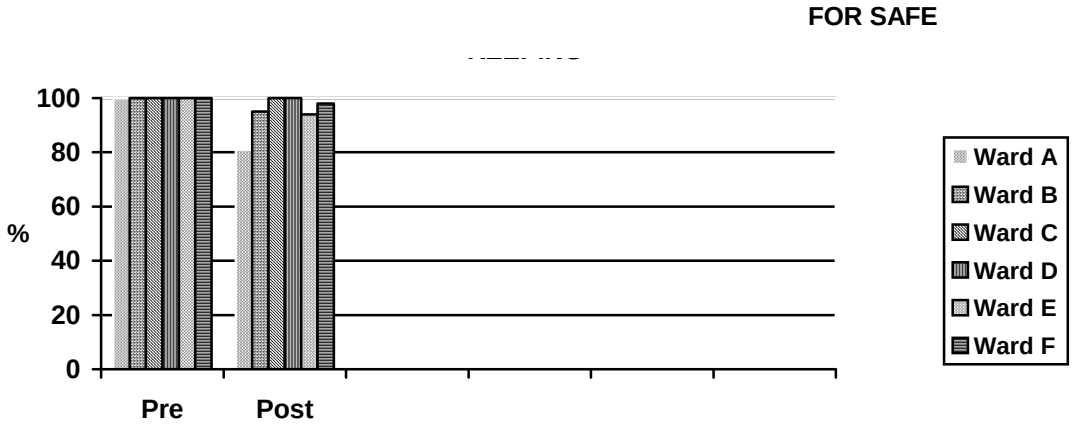


**Figure 4.35: Record is completed and archived for safekeeping. N = 372.**

## 4.4 DISCUSSION

The goal and objectives set for the study (Sections 1.3 and 1.4) were reached. The results of the study indicate that the audit instrument measured the variables as was intended by the researcher. No statistical significance was found for the variables tested. The audit instrument measured the phases of the nursing process accurately and showed the measure of quality in the structure, process and outcome standards in the nursing care delivered in the hospital.

The results show that the professional registered nurses are not ethically competent (Section 2.2). They are negligent (Section 2.2), as are the nursing managers (Section 2.2). Despite the hospital management providing the structure standards, by implementing the strategy, deterioration was noted in all phases of the nursing process in all wards post-implementation of the staffing strategy.

The process standards of assessment, diagnosis, planning and evaluation all deteriorated post-implementation, which led to a consequent deterioration of the outcome standards. From the results, it is evident that the nurses were able to implement nursing activities that are automatically performed. Evidence of their making educated decisions and solving problems does not exist.

The results show that the structure standards of the quality assurance programme put in place by the employer are compliant with expected standards. It is the process standards that are lacking. The lack of process standards has a detrimental effect on the outcome standards, which is evident from the results of the study.

## 4.5 CONCLUSION

In this chapter, the data was analysed and interpreted, using the phases of the nursing process, i.e. assessment, nursing diagnosis, planning, implementation evaluation and discharge, transfer or death. The results show that the structure standards of the quality assurance programme put in place by the employer are compliant with expected standards. It is the process standards that are lacking. The lack of process standards has a detrimental effect on the outcome standards, which is evident from the results of the study.

# 5. CHAPTER 5

# RECOMMENDATIONS

## 5.1 INTRODUCTION

Claims are often instigated months or years after an incident. If the law courts are satisfied that the patient records are mostly accurate and complete, circumstances are simplified for the nurse and her/his employer (Verschoor et al, 2005:45) the converse applies as well.

## 5.2 ASSESSMENT

The assessment phase of the nursing process relates to the nursing assessment of the patient or client. In this phase, data relating to the extent to which each identified need is or is not met is collected, as described in Section 2.4.1. Although the assessments were completed within 24 hours of admission in the files audited before and after implementation of the strategy, the documentation was found to be incomplete (Figure 4.3). It was established that the information required about the discharge of the patient was not done. Ward C and D used standardised documentation and this consequently resulted in better results than in the rest of the wards. There was a deterioration of assessments post-implementation.

## 5.3 NURSING DIAGNOSIS

The nursing diagnosis is made based on the subjective and objective information obtained during the assessment phase (Section 2.4.2). The study shows that the nursing diagnoses were not made according to the subjective and objective data identified in the assessment (Figure 4.5). In addition, the nursing care plans do not have realistic expected outcomes (Figure 4.9). There is deterioration in making a nursing diagnosis post-implementation (Figure 4.4 to Figure 4.10).

The results indicate that the professional registered nurses are not supervising the patient care. It is in the scope of practice of the professional registered nurse to make a nursing diagnosis, formulate a nursing prescription and ensure that the prescription is implemented, evaluated and reassessed (Section 2.2; 2.5.1). There is a lack of accountability (Section 2.3; 2.7).

## 5.4 PLANNING

The results show that the nursing care plan was not congruent with the assessment and problems identified, as shown in Figure 4.12 to Figure 4.16. These findings show the lack of critical analytical skills in understanding the association between assessment, nursing diagnosis and the planning phase. The nursing care plan is designed to meet the patient's needs based on the assessment and diagnosis (Section 2.4.3). The plan can only be formulated once the nursing diagnosis is made.

The results further show that there is deterioration in planning of nursing care post-implementation. Ward C and D have shown better planning of nursing care than Ward A, B, E and F. The researcher believes that this is due to the use of standard care plans by professional registered nurses in the two wards. This result indicates that the professional registered nurses in Ward A, B, E and F are not practicing within the norms of their scope of practice due to poor supervision of care plans and the failure to co-sign the plans. The quality standard is unacceptable (Sections 2.2. and 2.5.1). Due to the 'domino effect', planning cannot be done without a nursing diagnosis, as these findings corroborate.

## 5.5 IMPLEMENTATION

In the implementation phase, the nursing care plan is put into action (Section 2.4.4). Figure 4.19 shows that the recorded nursing actions do not form an integral association with the nursing actions as prescribed in the nursing care plan (Section 2.4.2). Actions are carried out without a plan. In addition, the professional nurses are not counter-signing any nursing intervention (Figure 4.20), which is a legal requirement as supported by the literature (Sections 2.6 and 2.7).

There is a deterioration in the implementation of nursing care post-implementation. Due to the 'domino effect', implementation cannot take place without planning, as supported by these findings.

## 5.6 EVALUATION

Evaluation requires nurses to continually reassess the degree to which the patient's needs have been met, to determine if there are any new needs, as expressed by the patient, and to observe how the patient is responding to the care given (Section 2.4.5). Figure 4.24 shows that nursing records are evaluated at least twice in 24 hours. Ward A is the only ward that deteriorated post-implementation.

The results show that patient progress reports are concise and clear in respect of change in condition and the date and time the doctor was called. However, the adaptations to nursing care plans were not recorded (Figure 4.25) and therefore not done. A slight improvement was obtained, but the results overall were poor. Due to the 'domino effect', evaluation cannot be done without implementation, as the findings support.

## 5.7 DISCHARGE, TRANSFER OR DEATH

A written final report is essential for discharge criteria and health education provided**.** The results show that the records are illegal (Figure 4.27 to Figure 4.29; Figure 4.33), as described by the literature in(Sections 2.5.1 and 2.6). It was established that education about dressings and medication was not given to the patients (Figure 4.30). Results also show that relatives are not informed about the death, transfer or discharge of their loved ones (Figure 4.34.). After implementation, the majority of the wards showed a slight improvement, but the overall results were poor. On average, the wards improved from 12.8% to 29%.

During the study, Ward C and D consistently delivered better quality care than ward A, B, E and F. Professional registered nurses staff these wards. Safety and quality care are directly related to the number of registered nurses and the skills mix of direct care nursing staff (Zondagh, 2004:20).

The findings of the study show that the following two issues were repeatedly evident: quality assurance, and record keeping. The researcher recommends the following, which can be applied to every phase of the nursing process as each phase deteriorated post-implementation or indicated a slight improvement.

## 5.8 RECOMMENDATIONS

### 5.8.1 Quality assurance

The study shows that the quality of nursing care in most wards deteriorated after implementation. The staffing strategy failed to improve or maintain the quality of nursing care.

The researcher recommends that the hospital applies this staffing strategy with discretion. A recruitment strategy should be implemented to alleviate the need for nurses to work the extra ten hours to compensate for the lack of professional registered nurses.

On the basis of the research results, the following are recommended:

- Provide leadership to improve performance;
- Identify customer expectations to ensure satisfied customers;
- Conduct strategic planning with quality care as the focus;
- Develop and manage human resources, i.e. professional registered nurses;
- Empower and involve employees in a quality assurance programme;
- Use valid statistical procedures for evidence-based strategic decision making; and
- Use benchmarking, improved relationships and input from stakeholders.

### 5.8.2 Implement and sustain a quality assurance programme

A quality assurance committee with a purpose of monitoring the quality of patient care in the hospital should be implemented. The functions of this committee should include identifying indicators against which patient care will be measured, such as auditing of documentation, infection control, patient satisfaction surveys and negative incidents, and should measure whether the objectives set for the hospital are achieved.

Develop and use set process and outcome criteria (Section 2.5). These criteria must be clear and concise, and specific statements should be worded in terms of actions and behaviour required for the intended outcomes.

Maintain and set technical excellence as a standard.

Ensure that structure criteria are in place, e.g. that the physical setting meets acceptable standards. In addition, ensure that nursing philosophies, unit objectives, organograms, financial resources, equipment and accreditation of the institution are in place.

### 5.8.3 Human Resource Management

Development and up-skilling of staff are crucial factors in developing critical analytical thinking skills to improve patient care and therefore the following are recommended:

- Introduce teamwork by encouraging participation at all levels of decision making.
- Nurse managers should be supportive and trusting and act as mentors, as described in the literature (Section 2.5.3). Introduce a mentorship programme to support the nursing staff with nursing practice.
- Reach consensus on the formulation of a nursing philosophy, unit objectives and organogram and put these in place after consultation with the nursing staff.

- Include ability, responsibility and authority in orientation and induction programmes and job descriptions, and evaluate the implementation of these in professional registered nurses' performance appraisals. Evaluate skills, knowledge, attitudes and values in performance appraisals and daily ward rounds.
- Formulate a policy for in-service education where record keeping and nursing practice (Section 2.6) are primary topics and include it in the orientation and induction programme for newly recruited staff. Evaluate the record keeping knowledge of practicing nurses on employment interview and during the performance appraisal and hold them to account after quality audits through disciplinary action (Section 2.6).

### 5.8.4 The nursing process

Introduce standardised nursing process documentation, especially nursing care plans, which through repetition will encourage decision-making and problem-solving skills. Nurse educators should emphasise the nursing process and the skills of decision making and problem solving (Section 2.5). As described in Sections 5.2 to 5.7, deficits have been identified in all the phases of the nursing process, and aggressive measures should therefore be implemented to ensure that nursing staff develop the required knowledge and skills to manage the nursing process, for example, workshops and a mentoring programme.

The nurses should be taught to put their knowledge and skills into practice to determine what care to give and how to care for the patient. Holistic, individualised care for each patient must become a standard. The nursing process should be used as a practical teaching tool when teaching all disease processes and professional practice. Supervision should be included in the curriculum of enrolled nurses, professional nurse training and professional midwife nurse training.

### 5.8.5 Record keeping

Professional nurses are held accountable for their acts and omissions (R 387) as promulgated by the Nursing Act No 50 of 1978 and the Nursing Act no. 33 of 2005. The records are legal documents and must show accurate and honest nursing activities performed, reflect accountability and provide proof that the nursing care was in fact carried out. Any negligence regarding record keeping should be acted upon.

## 5.9 CONCLUSION

In this chapter, the recommendations were made based on the analysis and evaluation of the study. The recommendations include quality assurance and its implementation and sustenance, human resource management, the nursing process and record keeping. The patient has the right to safe and competent nursing practice.

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## ADDENDUM A
## QUALITY ASSURANCE AUDIT INSTRUMENT: NURSING CARE

**RATING**

Each YES answer is denoted a score of 1 point.

Each NO answer is denoted 0 points.

Total the points allocated to the criteria for each standard.

Subtract the total number of Not Applicable criteria for each standard from the total YES answers.

Multiply the number obtained of Total Criteria used by 100 to calculate the percentage score of this set of standards.

Percentage score that meets the accepted standard is 95% and above.

Below 95% is an unacceptable score for each standard as well as the entire document audited.

**STANDARD 1**

**ASSESSMENT**

The patient is assessed according to her/his activities of daily living and psychosocial data.

**CRITERIA**

| | **YES** | **NO** | **Not applicable** |
|---|---|---|---|
| The nursing admission assessment format is completed within 24 hours of admission | | | |
| Information entered is relevant to the questions asked | | | |
| All sections of the assessment form have been completed | | | |
| **TOTAL 3** | | | |

**GENERAL REMARKS**

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**STANDARD 2**

**NURSING DIAGNOSIS**

The patient's nursing problems are identified, itemised and recorded together with the expected outcome.

**CRITERIA**

| | **Yes** | **No** | **Not applicable** |
|---|---|---|---|
| The care plan has been written within 24 hrs of admission and is neat, tidy, legible and with no erasure. | | | |
| Nursing problems are based on the admission assessment findings. | | | |
| Identified problems are prioritised. | | | |
| An expected outcome is listed for each problem. | | | |
| The record complies with the legal requirements of record keeping. | | | |
| The expected outcomes are realistic. | | | |
| **TOTAL = 7** | | | |

**GENERAL REMARKS**

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**STANDARD 3**

**PLANNING**

Nursing interventions are prescribed for each problem identified.

**CRITERIA**

| | **Yes** | **No** | **Not applicable** |
|---|---|---|---|
| Nursing orders are prescriptive (starting with a verb). | | | |
| There is no repetition on the nursing care plan. | | | |
| Doctors' prescriptions are relevant to the problems in order to bring about the expected outcome. | | | |
| Nursing prescriptions specify the initiation and resolution of the related problem. | | | |
| Nursing prescriptions are relevant to accepted policies. | | | |
| Nursing prescriptions are relevant to the problems identified on initial and daily assessment. | | | |
| Nursing prescriptions specify the nursing procedures required to bring about the expected nursing outcomes. | | | |
| All nursing actions aim to bring about the expected nursing outcomes. | | | |
| Termination of a nursing prescription is counter-signed by a professional registered nurse. | | | |
| **TOTAL=9** | | | |

**GENERAL REMARKS**

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**STANDARD 4**

**IMPLEMENTATION**

Patients' records are utilised to enhance individualised patient care and to ensure responsibility and accountability for patient care.

**CRITERIA**

| | **Yes** | **No** | **Not applicable** |
|---|---|---|---|
| All recorded nursing actions can be compared with the nursing actions as prescribed in the nursing care plan. | | | |
| Nursing interventions are followed up and counter-signed by the professional registered nurse. | | | |
| The nursing care plan changes as problems are resolved and new problems are identified, indicating the effectiveness of the care provided. | | | |
| Every prescription is carried out at the correct time and documented by the nurse who carried out the prescription. | | | |
| Appropriate personnel are kept informed of patient's sudden change or crises. | | | |
| **TOTAL = 6** | | | |

**GENERAL REMARKS**

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**STANDARD 5**

**EVALUATION**

Evaluation of patient progress is done according to the different prescriptions and interventions at least twice in 24 hours.

**CRITERIA**

| | **Yes** | **No** | **Not applicable** |
|---|---|---|---|
| Problem-orientated patient progress notes reflect that the patient's progress is evaluated at least twice in a 24-hour period. | | | |
| Any adaptation to the nursing care plan is recorded. | | | |
| Nursing activities prescribed are carried out and recorded, as well as their effects. | | | |
| **TOTAL = 3** | | | |

**GENERAL REMARKS**

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**STANDARD 6**

**DISCHARGE, TRANSFER OR DEATH**

A written final report is essential for discharge criteria and health education provided.

**CRITERIA**

| | Yes | No | Not applicable |
|---|---|---|---|
| Date and time of discharge, transfer or death are documented. | | | |
| Final diagnosis recorded? | | | |
| Final patient assessment by the nurse. | | | |
| Health education, e.g. diet, medication and life style changes. | | | |
| Dressings or medication handed to the patient or relatives are documented. | | | |
| Copies of discharge or transfer record completed by the doctor are in the archived file. | | | |
| Documentation of patient or relatives receiving personal belongings kept for safekeeping. | | | |
| Relatives notified of death/ transfer/ discharge. | | | |
| Record completed and archived for safekeeping. | | | |
| **TOTAL = 9** | | | |

**GENERAL REMARKS**

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| | |
|---|---|
| SCORING PERCENTAGE | |
| DEPARTMENT | |
| MONTH YEAR | |

SIGNED: _____

BY: _____

Designation: _____

Date: _____

**GENERAL REMARKS**

_____

_____

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Medical Superintendent : Dr Helga Holst
Financial Director : J E Carroll
Senior Nursing Service Manager : Mrs Z E Mageba

## RESEARCH ETHICS COMMITTEE

17th October 2005

Mrs J McIntosh
c/o McCord Hospital
28 McCord Road
OVERPORT
4001

Dear Mrs McIntosh

RESEARCH THESIS FOR 'M Cur' DEGREE

The Research Ethics Committee finds that your proposal has met all the stipulated requirements and have pleasure in informing you that it has been accepted.

It must be emphasized, however, that it must not be made known, in any way, that it is your thesis and there should be no signing of respondents' names as the anonymity of the nurses must be stressed.

Yours sincerely

Dr H Holst
VICE CHAIR
RESEARCH ETHICS COMMITTEE

P.O.Box 42065
Zinkwazi Beach
Darnall
4460

14 June 2005

Dr. H. Holst
The Medical Superintendent
McCord Hospital
P.O.Box 37587
Overport
Durban.

Dear Dr. Holst,

RESEARCH THESIS FOR MASTER OF NURSING DEGREE

I, Jane McIntosh, a student of the university of Stellenbosch, currently completing a Master of Nursing degree, respectfully request permission to undertake the following research at McCord Hospital. The research title is "An investigation of the effect of a management on the quality of patient care in a selected Kwa Zulu Natal hospital" as per the attached research proposal.

I undertake to ensure both the anonymity of the hospital and the principles of research ethics, throughout the research.

I request permission to, through the Senior Nursing Services Manager, access a sample of patient records, for a retrospective audit of the quality of nursing care delivered at the hospital.

I would appreciate you presenting my request at the next ethics committee meeting, following which, I would appreciate the permission being granted to be in writing to myself.

Yours faithfully

J McIntosh

Mrs. J McIntosh
Nursing Services Manager
McCord Hospital