Investigating the challenges of delivering basic quality patient care in selected Gauteng government hospitals

MJ du Toit

orcid.org 0000-0001-8343-7301

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Supervisor: Ms K Nell

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Student number: 12624578

ABSTRACT

The South African Nursing profession is experiencing a crisis – this is the opinion of various academics as well as politicians. Addressing the crisis is not necessarily always within the ability of nursing personnel, but rather various stakeholders on provincial and national level.

Guided by the research question "What currently prevents basic quality nursing care in Government hospital institutions?" a scientific investigation was undertaken. The main goal was to investigate obstacles that hinder nursing personnel to deliver basic quality patient care in these institutions. Two district hospitals were identified in the eastern parts of Gauteng.

The objectives set out for this study were:

- to determine whether adequate staffing is available to render nursing care;
- to evaluate whether current nurses experience job satisfaction at the institution;
- to determine whether nursing staff have access to necessary resources to deliver quality nursing care; and
- to evaluate whether nursing staff receive the necessary support and supervision from relevant superiors while performing nursing duties.

A quantitative approach was applied with a descriptive non-experimental design. The population comprised all the nursing staff available at the time of data collection working in five different units, as selected by the researcher, in the two district hospitals.

Data collection was done using a structured questionnaire. Ethical clearance was obtained from the North-West University and informed consent from the participants was also obtained. From a population of 115, the final sample of nursing staff was N=50; all members were initially invited to participate. The questionnaires were collected by the researcher personally and it was analysed with the support of a statistician from the North-West University. The data was expressed in tables and frequencies. Comparisons between variables were made using cross-tabulations with a Cramer's V and phi coefficient. The reliability of the Likert scale questionnaire was determined through the

calculation of a Cronbach alpha for sections of the instrument and an average of 0.7 was achieved. This indicated a high reliability of the data.

The following recommendations were made according to the four research questions after an in-depth study was undertaken to identify key issues regarding obstacles that hinder the quality of basic nursing care. When these key issues are addressed, it might be the start of a positive change in the way nursing staff perceive the quality of nursing care they have to render in terms of adequate staff provision, increasing job satisfaction that nurses are experiencing currently in these institutions, which has a direct effect on their ability to deliver quality nursing care. Furthermore, the role that nursing management plays in nurses' ability to deliver quality care was investigated, as well as, lastly, the availability of equipment and consumables that nurses need to render proper patient care.

Keywords:

Keywords: Quality nursing care, job satisfaction, staff provision, equipment and consumables, nursing crises, nursing management, supervision

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CHAPTER 1 OVERVIEW OF THE RESEARCH

1.1 INTRODUCTION

1.1.1 BACKGROUND

The nursing profession is delivered in various settings and remains an integral part of patient care. According to Tourangue *et al.* (2005:220), a growing body of evidence demonstrates a nurse's vital impact on the provision of care that is safe, effective, patient-centred, efficient and timely. The adequacy and proportion of registered nursing staff can be directly linked to death rates in acute medical patients within 30 days of hospital admission. It is therefore evident that desired patient outcomes rely heavily on the quality of nursing care in various institutions.

1.1.2 PROBLEM STATEMENT AND CORE RESEARCH QUESTION

Nursing is in crisis. According to Bruce and Rispel (2015), there seems to be a declining interest in the profession with huge shortages, a lack of ethos and a gap between nurses' needs and that of the communities and patients they serve. A general description of the services a nursing professional is qualified to perform can be found in the scope of nursing and midwifery practice (Nursing Act, 2005). It also provides guidelines on how duties should be performed, which are regulated by relevant legislation and the regulatory body, the South African Nursing Council. It describes standards of professional nursing practice that identify the responsibilities of the nurse to perform safe, competent and ethical care. According to the Department of Health Government Gazette (2012), in the financial year of 2011/2012 alone, disciplinary action was taken against 50 nursing professionals in terms of the Nursing Act 33 of 2005. Of these 50 cases, nine case types were related to poor basic care, 11 were maternity related, one was a forgery and fraud case, two were education related, two cases were assault on a patient and four of these 50 cases related to medication errors; the rest of the case types are unknown. Most of these cases resulted in suspensions and varied between 12 months and three years. For the less serious cases that were not described in detail, fines were given,

resulting in R2 000 each. From this evidence, it is clear that there are nursing professionals whose basic delivery of quality patient care is impaired and there could be several reasons why.

These 50 cases may not initially sound like many nursing professionals being taken from the practice for a short period of time; what we do, however, need to consider is, how many nurses are currently practising in South Africa and what is the ratio of patients to nurses in SA? This might shed more light on the issue that nursing staff might experience an overload of work. According to the South African Nursing Council (2012), there was a total of 248 736 registered nurses in South Africa in 2012 (which does not necessarily mean that they were all actively practising nursing) who served a population of 51 770 600. The average ratio of nurse practitioners to patients was 208:1 (SANC, 2012). A First-world country such as Switzerland had 17.4 nurses for every 1 000 patients, which resulted in a nurse:patient ratio of 57:1 (Ratio, 2013). From these statistics, it is clear that South African registered nurses have a greater patient workload in comparison to some nursing counterparts in some countries. It is evident that when 50 registered nurses are taken out of the practice in one year due to offences, it might have left 14 000 people of the population without a nurse to care for them and increasing the workload on existing nursing practitioners, which might, in turn, result in an undeliberate delivery of poorer quality nursing care. According to Weisman (2007), a 10% increase in the number of patients a nurse practitioner has to care for can lead to a 28% increase in adverse events, such as medication errors, poor infection control, injuries to patients and in general, poor basic patient care. The understaffing of registered nurses in hospital intensive care units increases risks of serious infections for patients with pneumonia (Hugonnet *et al.*, 2007).

The Health Department estimated in 2010 that the country was short of over 44 000 nurses; however, only approximately 3 155, on average, who had completed the four-year qualification programme at both universities and colleges, from 2010 to 2015, are being registered each year (SANC, 2015). This evident shortage has led to nursing agencies providing temporary nurses, which, according to Bruce and Rispel (2015), has resulted in a ‘casualisation’ of the workforce. Between 2005 and 2010, the provincial governments spent over R1.5 billion on agency nurses to supplement shortages. However, hospital managers reported that agency nurses often provided sub-optimal basic nursing care, had inadequate relationships with doctors, were often uncooperative and were reluctant to perform certain nursing interventions according to their scope of

practice. Having good relationships with the rest of a patient's medical team is vital to a patient's recovery and care. If a good professional understanding between medical team members does not occur, a patient's quality care might be jeopardised.

During his address to the parliamentary health portfolio committee in August 2015, Health Minister Dr Aaron Motsoaledi said the department was doing all it could to stop doctors and nurses from leaving South Africa, which is also a major contributing factor in nurse practitioner shortages, resulting in an increased workload of remaining staff. According to Storesund and McMurray (2009:121), the improvement of the overall quality of patient care had a direct link with better recruitment and retention of nursing staff members. Aitken *et al.* (2002:1992) investigated that if nurses had a lesser workload, i.e. decreased nurse-patient ratios, then better patient outcomes will be observed in terms of timely discovery interventions, which can save lives. From the literature, it seems to be critical to implement strategies to retain, recruit or motivate nursing staff in a more effective way, which would be sustainable.

A lack of proper resources could be another form of obstacle to quality basic nursing care. James (2002) found, in her interviews with nurses, that they experience a lack of resources or inadequate amounts of resources. This lack of resources leaves the nurses with a feeling of dissatisfaction because they cannot do their work as expected of them. The resources include items such as medication, linen, food and equipment. Better resource allocation seems to be one of the obstacles that might be in the hands of hospital management and might also include unit managers' operational decisions.

Not only is there a shortage of nurses, but it also seems to resonate to nurse leaders, managers and the pressing matter of public opinion, revealing poor standards of nursing care. Headlines in the media bring our focus to a growing perception that the quality of nursing in South Africa is a big concern. Given the number of press reports that nursing may have lost its way in delivering quality, compassionate, person-centred care, there might be an urgent need to consider how to address and effectively manage this issue. The core of these challenges seems to be the disengagement of nurses from their work and workplace cultures (Duffield *et al.*, 2007). Addressing the obstacles may lead to an enhancement of the total well-being of nurses; it might have a positive impact on nurses' internal motivation, productivity and performance and, in turn, have a positive effect on quality patient care (South African Department of Health, 2012:21).

The purpose of this study is to fill a gap in the literature by adding to the existing body of knowledge on this relevant and dire issue, in light of the occurrence of poor quality basic

nursing care and identifying the obstacles that lead to this occurrence. This will be accomplished, firstly, by investigating obstacles that result in poor quality basic nursing care, and secondly, by facilitating the development of effective interventions that could assist hospital management and nursing professionals to identify and manage these obstacles more effectively, as these are not obstacles that could easily be eradicated, but all efforts should rather be on the effective management of given and available resources, better work environment, motivation and interventions to retain the country's trained nurses.

1.1.3 RESEARCH OBJECTIVES / SPECIFIC RESEARCH QUESTION

What currently prevents basic quality nursing care in Government hospital institutions?

The following objectives are set for the research study:

- Determine whether adequate staffing is available to render nursing care;
- Evaluate whether current nurses experience job satisfaction at the institution;
- Determine whether nursing staff have access to necessary resources to deliver quality nursing care; and
- Evaluate whether nursing staff receive the necessary support and supervision from relevant superiors while performing nursing duties.

1.1.4 IMPORTANCE AND BENEFITS OF THE PROPOSED STUDY

According to Stone *et al.* (2007), increasing nursing staff and allocating resources better can reduce costs and improve basic patient care. Therefore, it can be said that all parties will benefit from this investigation, namely hospital management, nursing staff and members of society in need of nursing care. Nurses are the primary caregivers in all healthcare institutions, and therefore they are critical to the provision of quality patient care. Gaining a deeper understanding of the role a typical nurse has to fulfil each day in quality improvements as well as the challenges she faces every day in this set-up, might provide hospitals with a better understanding of how to optimise resources and improve basic nursing care to ensure quality patient care (Draper *et al.,* 2008). The benefits of firstly identifying these obstacles by engaging nursing staff might give nurses a sense of mutual respect between themselves and hospital management, government and stakeholders, because of the fact that their concerns and insights with regard to these

obstacles can be raised. Hospital management might be equipped with better knowledge on what the actual obstacles and underlying causes are, and attempt to address them in a more efficient manner. Society would gain the lost respect for the nursing profession and nursing staff can gain lost dignity again, and a renewal of professional trust in the nursing profession might also be experienced by doctors and other members of the medical teams.

1.1.5 PROPOSED CHAPTER LAYOUT

Chapter 1: This chapter describes the background, the focus and rationale of the study. A brief outline of the goals, objectives, research model and methodology is described.

Chapter 2: This chapter concentrates on the literature study concerning research completed on the quality of basic patient care in hospital institutions and possible barriers leading to declines in quality nursing care delivery.

Chapter 3: In this chapter, the research methodology that will be applied in the study will be described, which will include the research design, population, sampling and data analysis. The results are discussed, interpreted, and analysed based on the data collected. The results are presented in the format of simple graphs and tables.

Chapter 4: In this chapter, the conclusions and recommendations are described based on the scientific evidence obtained in this study over the specific time period.

1.1.6 RESEARCH ETHICS

The protocol for this study was presented to the North-West University Ethics Committee in the prescribed format and written consent was received to proceed with the study. Informed consent was also obtained from each participant.

As discussed previously, an information session was held with the relevant unit managers/matrons and staff of the various hospital institutions to explain the purpose of the study.

Participation was voluntary, and anonymity and confidentiality were maintained. No risks were foreseen in this study.

1.2 DELIMITATIONS AND ASSUMPTIONS

1.2.1 DELIMITATIONS (SCOPE)

According to Burns and Grove (2003:491), a population includes all the individuals that meet the sample criteria for inclusion in a study; it is also sometimes referred to as the target population. A probability sample is one in which each person in the population has the same known probability of being selected (De Vos *et al*., 2005:198).

The population for the purpose of this study was all the nursing staff (nursing assistants, staff nurses, registered nurses, excluding unit managers and nursing managers) working in the clinical areas of government hospitals in the greater suburbs of Johannesburg, Gauteng.

1.2.2 ASSUMPTIONS

As mentioned earlier, various assumptions have been made that nursing as a profession is in crisis in terms of staffing shortages as well as the quality of nursing care being delivered in hospital institutions. The aim of this study is to investigate these assumptions and attempt to clarify a few of these assumptions.

1.3 LIST OF ABBREVIATIONS

Abbreviation	Meaning
SANC	The South African Nursing Council
NDoH	National Department of Health
HIV	Human Immunodeficiency Virus infection
AIDS	Acquired Immune Deficiency Syndrome
TB	Tuberculosis
OCS	Office of Standards Compliance
NCS	National Core Standards

Table 1: Abbreviations used in this document

1.4 SUMMARY

In this chapter, the researcher described the study to be undertaken. A brief background, focus and rationale are explained. The objectives of the study are discussed as well as the specific research question. Finally, the importance of the research is also mentioned.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

One of the fundamental requirements for the delivery of quality nursing care in South Africa is the image of nurses and nursing in particular (Waters, 2005:22). In South Africa, the health services have to rely on great numbers of nursing staff to provide these services. One of the challenges in the South African health services nowadays is the increase in birth rate and the growth in the number of people with Human Immunodeficiency Virus infection and Acquired Immune Deficiency Syndrome (HIV/AIDS) as well as Tuberculosis (TB); this challenge in particular puts a greater amount of pressure on the current healthcare resources (Matsuvama, 2007:33). It is a known fact that healthcare quality is directly related to available resources; in other words, the availability of a decent number of nursing staff. According to Kahn (2008), an enormous shortage of nurses is experienced in the public healthcare sector at this stage.

The values of quality health and nursing care are emphasised in the White Paper on the Transformation of Public Services (South Africa, 1997). *Batho Pele* (People First) is the philosophy that has been adopted in this legal framework. It basically implies that the receiver of health- or nursing care should be at the centre of service delivery and that they should be satisfied with the service.

2.1.1 SOUTH AFRICAN NURSING CARE CONTEXT

The South African National Department of Health (NDoH) has in recent years shown a devoted commitment to improve the quality of healthcare; this has been emphasised through the publication of the ten-point plan in July 2010. According to the NDoH Strategic Plan (2010), its vision is to ensure “an accessible, caring and high-quality health system”. Its mission is “to improve health status through the prevention of illnesses and the promotion of healthy lifestyles and to consistently improve the healthcare delivery system by focusing on access, equity, efficiency, quality and sustainability.”

It is a well-known fact that, in South Africa, nurses make up the largest group of healthcare providers. The quality of care afforded by nurses directly impacts the performance of the healthcare system. In a study conducted by WITS University (2015), it revealed that in excess of 60% of nurses in South Africa felt too tired to work while on duty, and 70% admitted to working overtime due to the massive shortage in this under-

resourced sector. Another challenge is an ageing nursing workforce. Currently, more than 43% of professional nurses are aged 50 and above. According to WITS (2015), these statistics reveal that nursing is a profession in crisis at this stage and that this might have detrimental implications for quality patient care.

The South African government could be considered to be the main source of producing trained health practitioners for both private and public healthcare sectors. According to WITS (2015), the main objective of the government should be to achieve universal healthcare; in order to do so, government needs to address the skills shortage and resulting casualisation of nurses. He also added that both the private and public sectors are facing major challenges to recruit and retain skilled nurses. The national health budget for nursing, according to WITS (2015), has not been adjusted for two consecutive years and these budget constraints directly lead to skills shortages, because the lack of investment in clinical specialisation in both private and public healthcare systems places additional pressure on an already decreased pool of expertise.

According to Chabikuli and Ibeziako (2013), the changes in status of South African healthcare facilities during the early 1990s have affected critical aspects such as budgets, work environments, equipment and staff motivation indirectly. Factors such as quality care, availability of motivated and skilled personnel and healthcare outcomes have been shown in many studies to have a close correlation with one another. Low morale and unmotivated personnel can burden a healthcare system further by directly encouraging the migration of nurses from the nursing profession or, even worse, from the country, thereby leaving the profession debilitated and unskilled.

2.1.2 QUALITY DEFINED

2.1.2.1 Introduction

The Office of Standards Compliance (OSC) within the NDoH piloted and developed a set of National Core Standards (NCS) in 2008, which is supposed to form the basic requirements for safe care and quality. The NCS's main purposes are:

- To develop a comprehensive definition of quality of care that shall guide the public, managers and staff at public health institutions in South Africa;
- To develop a benchmark where public health institutions can measure themselves against and therefore identify gaps and strengths;

The NCS aids in identifying health areas in a public institution where the quality and safety of patient care might be at risk, with the structure of the seven cross-cutting domains. The first three domains relate to the core business of the health system and the last four act as a support for the first three to ensure that they are being delivered. The domains are further categorised into sub-domains, which consist of a set of standards with associated measurement criteria.

Table 2: Domains and sub-domains of the NCS

Domain 1: Patient rights The domain of patient rights sets out what a hospital or clinic must do to make sure that patients are respected and their rights upheld, including getting access to needed care and to respectful, informed and dignified attention in an acceptable and hygienic environment, seen from the point of view of the patient, in accordance with Batho Pele principles and the Patient Rights Charter.	1. Respect and dignity 2. Information to patients 3. Physical access 4. Continuity of care 5. Reducing delays in care 6. Emergency care 7. Access to package of services 8. Complaints management
Domain 2: Patient safety, clinical governance and care The patient safety, clinical governance and clinical care domain covers how to ensure quality nursing and clinical care and ethical practice; reduce unintended harm to healthcare users or patients in identified cases of greater clinical risk; prevent or manage problems or adverse events, including healthcare-associated infections; and support any affected patients or staff.	1. Patient care 2. Clinical management for improved health outcomes 3. Clinical leadership 4. Clinical risk 5. Adverse events Infection prevention and control
Domain 3: Clinical support services The Clinical Support Services domain covers specific services essential in the provision of clinical care and includes the timely availability of medicines and efficient provision of diagnostic, therapeutic and other clinical support services and necessary medical technology, as well as systems to monitor the efficiency of the care provided to patients.	1. Pharmaceutical services 2. Diagnostic services 3. Therapeutic and support services 4. Health technology services 5. Sterilisation services 6. Mortuary services 7. Efficiency management
Domain 4: Public health The public health domain covers how health facilities should	1. Population-based service planning and delivery

work with NGOs and other healthcare providers along with local communities and relevant sectors, to promote health, prevent illness and reduce further complications; and ensure that integrated and quality care is provided for their whole community, including during disasters.	2. Health promotion and disease prevention 3. Disaster preparedness 4. Environment control
Domain 5: Leadership and corporate governance The leadership and corporate governance domain covers the strategic direction provided by senior management, through proactive leadership, planning and risk management, supported by the hospital board, clinic committee as well as the relevant supervisory support structures and includes the strategic functions of communication and quality improvement.	1. Oversight and accountability 2. Strategic management 3. Risk management 4. Quality management 5. Effective leadership 6. Communications and public relations
Domain 6: Operational management The operational management domain covers the day-to-day responsibilities involved in supporting and ensuring the delivery of safe and effective patient care, including the management of human resources, finances, assets and consumables, and of information and records.	1. Human resource management and development 2. Employee wellness 3. Financial resource management 4. Supply chain management 5. Transport and fleet management 6. Information management 7. Medical records
Domain 7: Facilities and infrastructure The facilities and infrastructure domain covers the requirements for clean, safe and secure physical infrastructure (buildings, plant and machinery, equipment) and effective waste disposal.	1. Buildings and grounds 2. Machinery and utilities 3. Safety and security 4. Hygiene and cleanliness 5. Linen and laundry 6. Food services

Source: National Department of Health, 2011

2.1.2.2 Definition of quality

According to Donabedian (1990), a definition of quality should be adapted according to the specific industry it is situated in. This particular definition could also depend on the organisation's purpose, customer base and other contextual factors. According to the Macmillan English Dictionary (Rundell, 2002:1153), quality means the following: how good or bad something is or a high standard. Quality, as described by Muller *et al.*

(2008:534), is the degree of excellence, or the extent to which an organisation can meet clients' needs and exceed their expectations. Seven attributes of healthcare according to Donabedian (1990:1115), can define its quality:

- Acceptability: The effects of care, cost of care, conformity to patient preferences regarding accessibility and the patient practitioner relation.
- Effectiveness: The improvement of health that is achieved, or can be expected to be achieved under normal circumstances of everyday practice.
- Efficacy: Ability of science and art of healthcare to bring about improvement in overall well-being and health.
- Efficiency: Ability to obtain the highest level of health improvement at the lowest cost.
- Equity: Fairness in the distribution of care and its direct effect on health
- Legitimacy: Conformity to social preferences concerning all seven mentioned attributes
- Optimality: The most advantageous balancing of benefits and costs.

According to Lancaster (1999:462), quality includes a service that meets customers' needs and is free from deficiencies. It is difficult to define because of differences in values and individual perceptions regarding quality, and therefore quality can be defined and measured on the basis of expectations and specifications.

2.1.2.3 Fast track to a quality initiative

The NDoH has used information from patient surveys to develop an initiative called *Fast Track to Quality – The six most critical areas for patient centred care.* The initiative is based on four pillars, namely the Constitution of SA, the Batho Pele principles, the Patients' Rights Charter and the NCS. Six priority areas were identified that needed immediate attention and were also reflected in the first three domains:

- **Values and attitudes** of staff members who ensure that patients are treated with the necessary respect in terms of privacy (Domain: Patients' Rights).
- **Reducing waiting times and queues** for various purposes such as administration, diagnostic evaluations, surgeries, pharmacy queues as well as transfer times (Domain: Patients' Rights).
- **Cleanliness of hospitals and clinics** including staff, buildings, equipment and amenities (Domain: Patients' Rights).

- **Keeping patients safe and providing reliable care** by reducing adverse events resulting from care given, including operations and failures of the systems and workers through ignorance, inadequate skills or negligence (Domain: Patient Safety, Clinical Governance and Care).
- **Preventing infections from being passed on,** more specifically hospital-acquired infections (Domain: Patient Safety, Clinical Governance and Care).
- **Ensuring that medication and supplies are available** and that patients get their prescribed medications on the same day (Clinical Support Services).

2.1.2.3 Outcomes of quality

Quality improvement, according to Muller *et al.* (2008:535), is a formal process where quality standards are developed and set, work performance is then measured against these standards and, if need be, remedial steps are then taken to solve problems and improve performance outcomes.

Figure 1: Process of quality improvement (Muller *et al.,* 2008:535).

The most frequently cited examples in the literature of evidence of quality outcomes are the following, according to Gelinas and Manthey (1997:11):

- Decreased mortality rates
- Fewer patient complaints and falls
- Higher patient volumes over a reduced length of stay
- Increased staff member satisfaction
- Increased physician satisfaction
- Increased patient satisfaction
- Lower infection rates
- More staff members available for individual patient care

2.1.2.5 Value of quality

According to Burhans and Alligood (2010), intense criticism and debate always evolve around healthcare and the quality thereof. Meaningful improvements have been very low to improve nursing quality, which is at the forefront when it comes to patient outcomes and safety. Literature has shown that nurses very rarely are involved in developing improvement programmes for quality nursing care, and therefore it is important to emphasise that quality nursing care programmes must be meaningful and relevant and aim for more effective improvement approaches. Patient safety remains the cornerstone of high-quality healthcare, as well as minimising patient harm. A root cause analysis of errors resulting in patient harm includes:

- Failure to follow standard operating procedures
- Poor leadership
- Breakdown in communication and teamwork
- Losing track of objectives

2.1.3 BARRIERS

According to Guralnik (2004), barriers refer to anything that is a hindrance to progress. In previous studies, it has been recorded that nurses experience barriers in delivering quality healthcare (Aiken *et al,* 2002).

2.1.3.1 Increased workloads and burnout

According to Sochalski (2004:11-67), the intertwined relationship of adequate nursing staff and resulting quality of nursing care in hospitals is of great significance, as well as workload that has a great effect on the quality of nursing care. Staff shortage is an aspect very relevant to poor quality nursing care, because of the resulting stress levels it causes among nurses due to increased workload.

A study done by the University of Pennsylvania (source of the study) concluded that when there is a lack of teamwork and support from the top, and an inability to act independently, stress builds up, until the giver of care just detaches; then, nurses are doing work, but they are not cognisant of what they are doing, because of the increased stress levels, so they may even forget to wash their hands.

The study is believed to be the first to examine why staffing matters. It is also among the

first to measure the potential harm – both injuries to patients and costs for hospitals – using detailed infection data available only in Pennsylvania, where reporting is mandatory.

If hospitals could reduce their proportion of burned-out nurses to 10% from the 30% that is typical, according to the study, they would prevent 4 160 cases a year of the two most-common hospital-acquired infections state-wide and save a staggering $41 million.

The researchers examined the 2006 infection data from 161 acute-care hospitals reported to the Pennsylvania Health Care Cost Containment Council. They then linked the data to responses of two surveys: staffing information that hospitals supply to their national association and nurse-burnout levels based on a standard measure applied to answers to a questionnaire returned by 7 076 registered nurses in direct patient care, at those particular hospitals.

Each nurse cared for an average of 5.7 patients. There were 8.6 catheter-related urinary tract infections for every 1 000 patients state wide. Adding one patient to a nurse's workload was associated with an increase of nearly one infection per 1 000 – a total of 1 351 additional infections if the nurse-to-patient ratio was applied state wide. Surgical site infections, which are half as common, but which cost far more, went up at a similar rate.

When the researchers considered burnout instead of staffing levels, they found that a 10% increase in a hospital's proportion of burned-out nurses raised urinary tract infections by approximately the same amount, but surgical site infections by more than 50%, from 4.2 per 1 000 patients to more than six.

Neither finding was a surprise. The researchers discovered that burnout appeared to be responsible for nearly all the harm caused by greater workloads.

2.1.3.2 Skills shortage

During his address to the parliamentary health portfolio committee in August 2015, Health Minister Dr Aaron Motsoaledi said the department was doing all it could to stop doctors and nurses from leaving South Africa. He said it was a struggle as countries such as the United States and the United Arab Emirates offered "greener pastures" for local medical professionals. South Africa could not afford to compete with that.

A survey was conducted at a South African public healthcare institution among nurses, and some of the reason nurses leave the profession were as follows:

- Long queues in hospitals and clinics and a compromised healthcare system.
- The loss of life due to the lack of equipment to save patients.
- Unqualified staff being produced by the many unregistered nursing schools.
- Exploitation of workers.
- Inadequate training, which exposes patients to danger.
- Unqualified doctors who put nurses' jobs under threat.
- Infrastructural issues, shortages of water, electricity and resources.
- Lack of ambulances and paramedics and failure by provincial and national health departments to step in and make changes.

According to WITS (2015), bright young nursing professionals are often fast tracked into senior positions by management, which often deprives capable nurses of clinical expertise and the opportunity to specialise. He also reiterates that South Africa is running the risk of producing nurses with mediocre competency inevitably resulting in sub-optimal patient care.

Beal, Riley and Lancaster (2008:488) mentioned elements for an optimal clinical practice environment; they added that the best care can be provided to patients and their families by developing clinical nurses as bedside scholars across their careers.

2.1.3.3 Organisation

When nurses are fully and adequately supported by their organisation, they deliver quality services, enjoy high levels of job satisfaction and take advantage of career developmental opportunities (Kingma, 2009:880).

2.1.3.4 Difficulty in time management

When people experience that they are understaffed, they feel a great deal of guilt because they cannot render quality care. The amount of time a nurse has available to properly care for her patients depends on the number of staff and the resources available.

Williams (1998:36-44) discovered that time is one of the most important elements for the adequate development of a therapeutic relationship between a nurse and a patient. When time is limited, it was discovered that low levels of intimacy were prevalent.

Bowers, Lauring and Jacobson (2001:484-491) found that nurses prioritise their time into ‘must do’ and ‘should do’ activities. They also emphasise time as a scarce commodity. When time ran short, nurses tried to work faster by combining tasks, they leave the ‘should do’ tasks, they become inaccessible to outside needs, they convert ‘downtime’ to task completion, skip or shorten breaks and lunch times and reassign work to the next shift.

In South African clinics, crucial services such as preventative care are sacrificed for more urgent, curative ones. Dennill *et al.* (1999) argue that the need for preventative care is dismissed. Nurses currently spend so much time treating the hordes of patients with medicine for symptoms of acute conditions that preventative care is totally scaled down. The number of patients to be seen during a day is so overwhelming that it causes a nurse to not spend a reasonable amount of time on each individual patient (Sochalski, 2004).

2.1.3 SUMMARY

Quality can be defined as a cyclic process, which will result in standards being revised or adapted on a continual basis in order to correct problems. It is evident, from the literature, that there can be many barriers creating these problems and affect basic quality nursing care outcomes.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

The purpose of this chapter is to define the research methodology that was applied to investigate the obstacles of basic quality patient care in selected Gauteng government hospital institutions. According to Bryman *et al.* (2014), research methodology is the systematic, theoretical analysis of the methods applied to a field of study. It is about the theoretical analysis of the body of methods and principles.

3.1.1 DESCRIPTION OF OVERALL RESEARCH DESIGN

According to Bryman *et al.* (2014), quantitative methods emphasise objective measurements and the statistical, mathematical or numerical analysis of data collected through polls, questionnaires and surveys. The researcher had a clearly defined research question to which objective answers were sought.

According to Bryman *et al.* (2014), patterns of association can be distinguished with a cross-sectional design. In this study, the researcher wants to examine the relationship between variables/obstacles and the researcher cannot manipulate any of the variables. If there were to be indications of casual relationships it can be said that these variables are related.

3.1.2 POPULATION/SAMPLING

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

A probability sample is one in which each person in the population has the same known probability of being selected (De Vos *et al*., 2011:198).

The population for the purpose of this study was all the nursing staff (nursing assistants, staff nurses, registered nurses, excluding unit managers and nursing managers) working in the clinical areas of hospitals in the eastern suburbs of Johannesburg, Gauteng.

Sampling is the process of selecting a group of people who are representative of the

population being studied (Burns & Grove, 2003:496). It also refers to the process of selecting a portion of the population to represent the entire population (Polit & Beck, 2008:339; De Vos *et al*., 2011:224).

Purposive sampling, a non-probability sampling method, might be the method of choice for this study. In purposive sampling, also referred to as judgemental sampling, participants are selected because they are able to give the researcher access to a specific perspective or experience that the researcher wishes to understand (De Vos *et al.,* 2011:232). The researcher is interested in investigating what the obstacles are that prevent nursing staff from delivering quality patient care. Nursing staff will be selected because they are first-line caregivers having direct, every-day contact with patients in the hospitals.

The advantage of purposive sampling is that it allows the researcher to hand-pick the sample. The disadvantages include potential sampling bias, not representative of the population and generalisation difficulties and limitations (Brink, 2006:134).

3.1.2.1 Sampling strategy would be as follows

The eligibility criteria will comprise inclusion and exclusion criteria.

Participants have to meet the following inclusion criteria:

- They must be professional nurses registered with SANC.
- They must be permanently employed by the hospital institution, and should not be a temporary/casual employee.

The exclusion criteria were as follows:

- Categories of care givers, other than registered by SANC.
- Professional nurses not permanently employed by the hospital institution

3.1.2.2 The geographic unit analysis

The setting of a research study, as defined by Polit and Beck (2008:766), is a physical location in which data collection will take place. In this study, the setting will be government hospitals in the greater eastern suburbs of Johannesburg, Gauteng.

All the hospitals render services at a general specialist level. It also serves as a platform for the training of health workers (Department of Health Government Gazette, 2012).

3.1.2.3 Ease of access to the units of analysis

The nature of the researcher's day-time job is within several of these hospitals every day, assisting specialists with endoscopic equipment in theatres; she is also a registered nurse and has daily access to these facilities.

3.1.2.4 The suitability of the particular unit of analysis to answer the primary research question

Every patient comes to a hospital with the expectancy of receiving quality healthcare. A person's health is one of his or her most important rights; therefore, healthcare delivery should be of the highest quality. Every nursing practitioner is personally, professionally, ethically and legally accountable for the provision of quality nursing care. This accountability is towards the patient, as well as the employer and the professional council.

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

3.1.3 DATA COLLECTION AND QUESTIONNAIRE DESIGN

An existing questionnaire was used to determine the factors influencing the quality of nursing care.

The questionnaire was designed by a previous researcher and based on her clinical experience and appropriate literature. The questionnaire was again validated by an ethics committee and was available in English. The questionnaire was adapted for the purpose of the researcher's investigation.

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

Gender: Male or Female.

Age in years: older than 20 and younger than 30 years, older than 30 and

younger than 40 years, older than 40 and younger than 50 years, older than 50 and younger than 60 years and above 65 years of age.

Categories of staff: Chief professional nurse, senior professional nurse, professional nurse, enrolled nurse, enrolled nurse assistant.

Qualifications: General, midwifery, psychiatry, community health, primary healthcare, staff nurse and enrolled nurse assistant.

Total number of years working at this institution: Less than five years, between five and ten years and more than ten years.

Personnel have to identify the current department in which they are working. The following departments were identified: Paediatrics, maternity, casualty, general, surgery and theatre.

Duration of current employment in current department in months could be indicated as: less than six months, between six and 12 months, between 12 and 18 months, between 18 and 24 months and more than 24 months. Personnel indicated appropriate answers.

Section B of the questionnaire referred to the factors influencing nursing care. This part of the questionnaire is based on a Likert scale. The Likert section has four options to choose from, namely: strongly disagree, disagree, agree and strongly agree. Numerical values of 1, 2, 3 and 4 were accordingly provided, which were used to capture data on an Excel spreadsheet. Space was left for comments. The following divisions are included:

- Staff provision (nursing): To determine whether there are adequate personnel in terms of numbers and skills. Furthermore, to establish whether personnel provision is adequate during the day, at night, on weekends and on public holidays.

- Management of wards or departments: To evaluate the availability of unit managers and whether all duties delegated to subordinates were adequately supervised.

- Job satisfaction: Whether respondents are satisfied with their salaries, allowances and staff evaluation. Aspects such as job satisfaction of the current work situation, acknowledgement of good performance and enough time for sound nurse-patient relationships are included.

- Professional development: These numbers deal with aspects such as continuing education, career development and whether there are adequately skilled personnel.

- Patient documentation: It is the aim of the researcher to evaluate how the respondents experience the present documentation system in the form of the nursing process.

- Patient care: To identify whether patients receive nursing care as required. The researcher differentiated between the categories of emergency care, labour, debilitated, paediatric, as well as pre- and post-operative patients.

- Nursing staff: Included in this part, the researcher wanted to identify whether it was necessary for registered nurses, staff nurses and nursing assistants to work beyond their scope of practice. The researcher included the registered nurse without the qualification of primary healthcare.

- Equipment and consumables: To evaluate whether consumables and equipment are adequate and in a good working condition.

- Work conditions: Referring to tea breaks, lunches, relaxation facilities and scheduled leave.

- Shifts: Dealing with requests according to the needs of personnel regarding duty rosters and whether staff are able to leave the hospital on time at the end of shifts.

- Doctors: The researcher wants to evaluate the availability of the doctors to deal with trauma, medical and maternity emergencies. The aim was to determine whether doctors are available in the hospital full time, and whether patients must wait a long time before being evaluated and treated by a doctor.

These questions were explained to respondents in an information session and an

information leaflet was also handed out on how to complete the questionnaire.

Information sessions were held with the nursing staff in each ward or department at each of these hospitals. At these sessions, the details of this project were discussed and personnel were invited to participate.

The researcher discussed the questionnaire and explained how it should be completed. Each hospital was given a week in which to complete it. Staff handed in the completed questionnaire in a sealed envelope at the nurse manager's office where a sealed container was made available for them. The researcher collected the questionnaires at an agreed time.

3.1.4 RESULTS AND DATA ANALYSIS

Data analysis is "the process of bringing order, structure and meaning to the mass of collected data" (De Vos *et al*., 2011:397).

The data was analysed with the support of a statistician. It was presented in frequencies and tables.

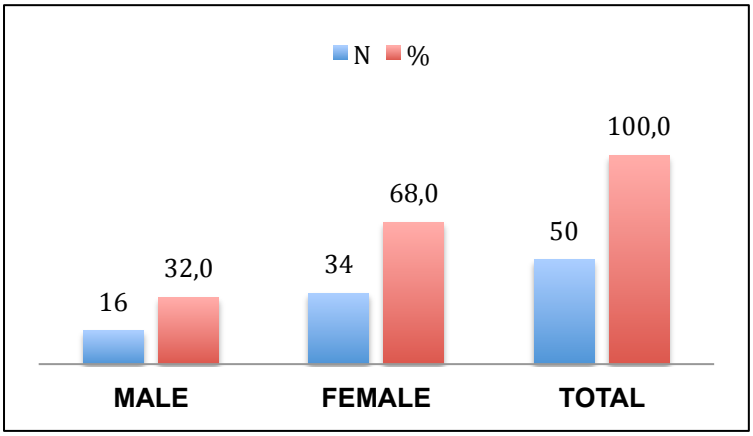
Quantitative data was captured in an Excel spreadsheet, which was developed by the statistician. A total 115 questionnaires were sent out, and 50 were received back.

3.1.4.1 SECTION A: BIOGRAPHICAL INFORMATION

Section A refers to the personal information of the participants

3.1.4.1 a Variable 1: Gender

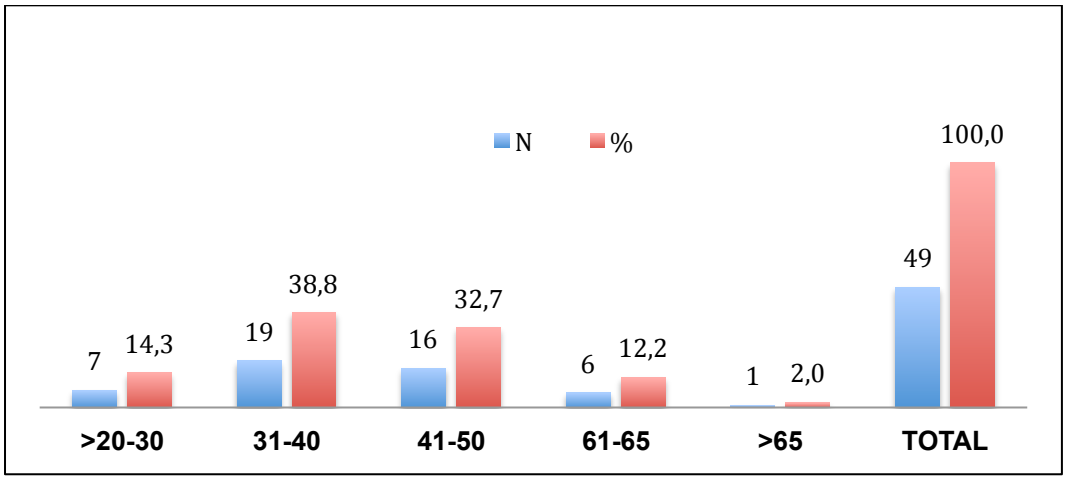
Graph 1: Gender



As shown in Graph 1, the participants in this study were both male and female; 68% were females, as it is a known fact that the nursing profession is dominated by females.

3.1.4.1 b Variable 2: Age (in years)

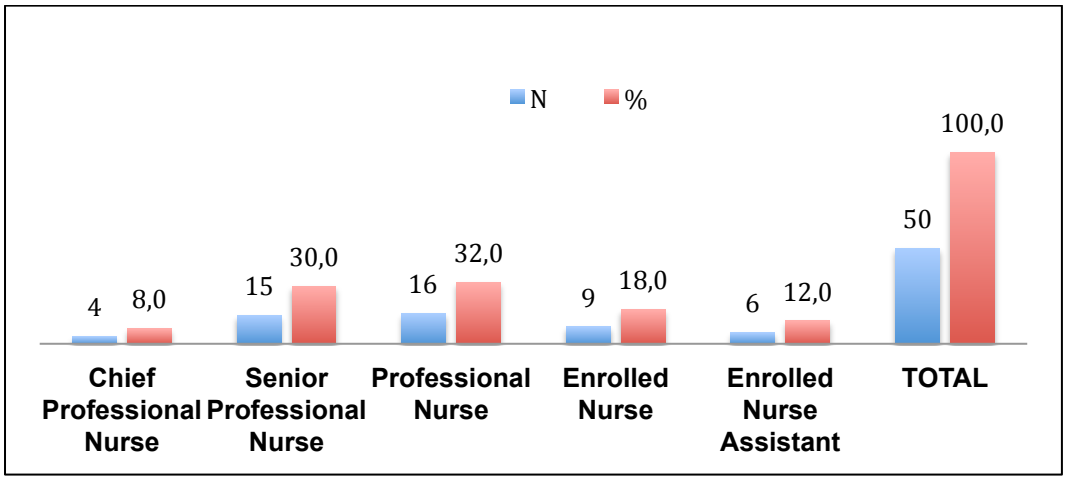
Graph 2: Age



Graph 2 shows that the majority of participants are between the ages of 31 and 50 years, with a total percentage contribution of 71.5%. What is noticeable is that the younger age group, between 20 and 30 years of age, contributed only 14.3% of the participants, which could be a good sign in terms of experience of the participants.

3.1.4.1 c Variable 3: Categories of staff

Graph 3: Categories of staff



In Graph 3, it is evident that the categories of staff included are chief professional nurses (N=4), senior professional nurses (N=15), professional nurses (N=16), enrolled nurses (N=9), and enrolled nursing assistants (N=6), 50 participants in total.

A two-way frequency table (Table 3) between the two variables age and category of staff was drawn and the following conclusions were reached:

Age group 20-30 years

Seven participants fell in the age category 20 to 30; these participants represented 14.3% of the total participants. Within this age category, enrolled nurses represented 57.1% and 44.4% represent the total of enrolled nurses within the population group. Within this age category, enrolled nurse assistants represented 42.9%, and 60% represent the total of enrolled nurse assistants within the population group.

Age group 30-41 years

The next age group was between 30 and 41 of age and 19 participants made up this age group. This age group represents a total of 38.8%. The categories were slightly more spread out, with senior professional nurses (SPN) 10.5%, professional nurses (PN) 68.4%, enrolled nurses (EN) 15.8% and enrolled nurse assistants (ENA) 5.3% within the age group. Category participation for the total population in the age group was as follows: SPN (13.3%), PN (81.3%), EN (33.3%) and ENA (20%).

Age group 41-50 years

The next age group was between 41 and 50 years of age and 16 participants made up this age group. This age group represents a total of 32.7%. The categories were slightly more spread out, with senior professional nurses (SPN) 68.8%, professional nurses (PN) 18.8%, enrolled nurses (EN) 6.3% and enrolled nurse assistants (ENA) 6.3% within the age group. Category participation for the total population in the age group was as follows: SPN (73.3%), PN (18.8%), EN (11.1%) and ENA (20%).

Age group 51-60 years

The next age group was between 51 and 60 years of age and six participants made up this age group. This age group represents a total of 12.2%. The categories were slightly more spread out, with chief professional nurse (CPN) 50%, senior professional nurses

(SPN) 33.3% and enrolled nurses (EN) 16.7% within the age group. Category participation for the total population in the age group was as follows: CPN (75%), SPN (13.3%) and EN (11.1%).

Age group 61-65 years

The next age group was between 61 and 65 years of age and one participant made up this age group. This age group represents a total of 2%. The only category represented was chief professional nurse (CPN) 100%. Category participation for the total population in the age group was as follows: CPN (25%).

From the above data, it is evident that the majority participants are middle aged, and there are therefore not sufficient young individuals to be trained and mentored for future professional development in the various categories. The majority workload remains with the age categories 31 to 50 years of age, which results in the most qualified nurses, enough mentors for age category 20 to 30, but not enough mentees. From the chief professional nurse category, representing 8.2%, being in age categories 51 to 65 who remain to mentor the “bottleneck” majority age group 31 to 50, it is evident that there are not enough mentors to train the mentees in this case. (Limitation of the study might be that the final sample from the population group was quite small).

Age * Category Crosstabulation

			Category					
			1	2	3	4	5	Total
Age	1	Count	0	0	0	4	3	7
		% within Age	0,0%	0,0%	0,0%	57,1%	42,9%	100,0%
		% within Category	0,0%	0,0%	0,0%	44,4%	60,0%	14,3%
		% of Total	0,0%	0,0%	0,0%	8,2%	6,1%	14,3%
	2	Count	0	2	13	3	1	19
		% within Age	0,0%	10,5%	68,4%	15,8%	5,3%	100,0%
		% within Category	0,0%	13,3%	81,3%	33,3%	20,0%	38,8%
		% of Total	0,0%	4,1%	26,5%	6,1%	2,0%	38,8%
	3	Count	0	11	3	1	1	16
		% within Age	0,0%	68,8%	18,8%	6,3%	6,3%	100,0%
		% within Category	0,0%	73,3%	18,8%	11,1%	20,0%	32,7%
		% of Total	0,0%	22,4%	6,1%	2,0%	2,0%	32,7%
	4	Count	3	2	0	1	0	6
		% within Age	50,0%	33,3%	0,0%	16,7%	0,0%	100,0%
		% within Category	75,0%	13,3%	0,0%	11,1%	0,0%	12,2%
		% of Total	6,1%	4,1%	0,0%	2,0%	0,0%	12,2%
	5	Count	1	0	0	0	0	1
		% within Age	100,0%	0,0%	0,0%	0,0%	0,0%	100,0%
		% within Category	25,0%	0,0%	0,0%	0,0%	0,0%	2,0%
		% of Total	2,0%	0,0%	0,0%	0,0%	0,0%	2,0%
Total		Count	4	15	16	9	5	49
		% within Age	8,2%	30,6%	32,7%	18,4%	10,2%	100,0%
		% within Category	100,0%	100,0%	100,0%	100,0%	100,0%	100,0%
		% of Total	8,2%	30,6%	32,7%	18,4%	10,2%	100,0%

Table 3: Two-way frequency table: Age vs category of staff

Nominal by Nominal	Phi	1,179
	Cramer's V	0,590
N of Valid Cases		49

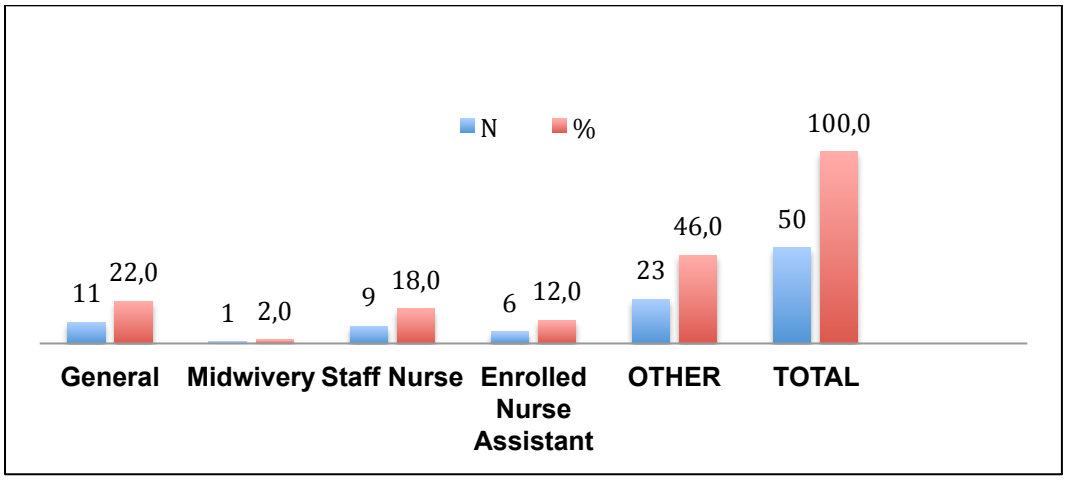
Table 4: Phi and Cramer's V values

According to Bryman *et al.* (2014), the phi and Cramer's V are two closely related statistics. The *phi* coefficient is normally used for the analysis of the relationship between two dichotomous variables, in this case age and categories of staff. The coefficient will lie between 0 (no relationship) and 1 (a perfect relationship). The closer the coefficient is to 1, the stronger the linear relationship between the two variables, the closer to 0, the weaker the relationship will be. A positive or negative coefficient indicates the direction of the relationship – a value of +1 indicates a perfect positive relationship and a -1 indicates a perfect negative relationship. As can be seen in Table 4, the *phi* value represents a perfect positive relationship between age and categories of staff with 1.179. Cramer's V uses a similar formula to *phi,* and can be employed with nominal variables; it can, however, only have a positive value that can only indicate the strength of the

relationship between the variables and not the direction. The value of Cramer's V in Table 4 is 0.590, which suggests a moderate relationship between the two variables.

3.1.4.1 d Variable 4: Qualifications

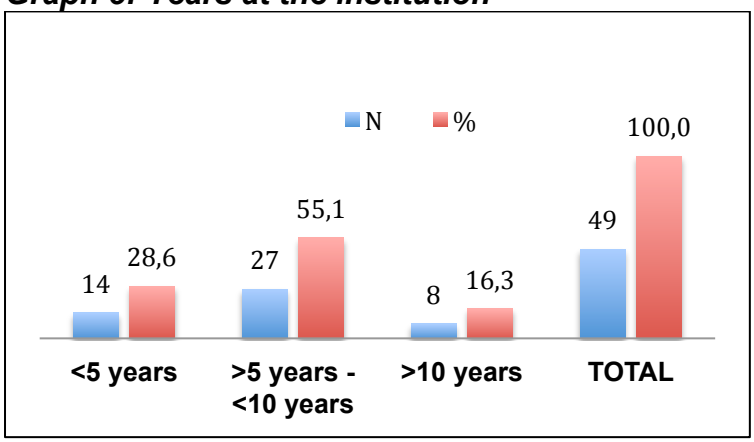
Graph 4: Qualifications



According to Graph 4, N=11 of the participants are registered nurses who have only a general nursing qualification, N=23 of the participants have both a general nursing and either a midwifery or theatre technique combined qualification with the general nursing component. The combined qualification contributes 46% of the study group. There is only one participant who is a registered nurse and has only a midwifery qualification.

3.1.4.1 e Variable 5: Number of years working at the institution

Graph 5: Years at the institution

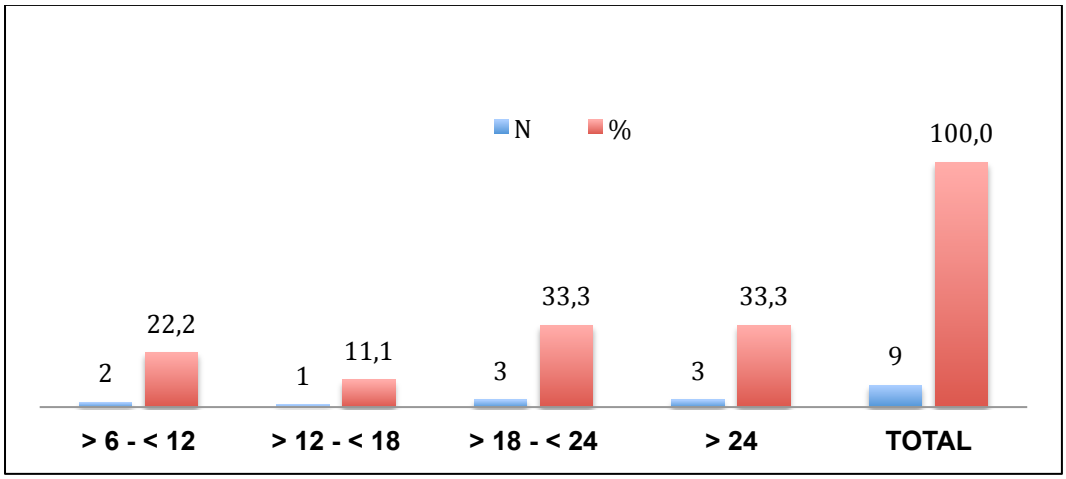


Graph 5 shows that the majority, 55.1%, of the participants have been with the institution between five and 10 years, which is a relatively good sign of a smaller staff turnover rate

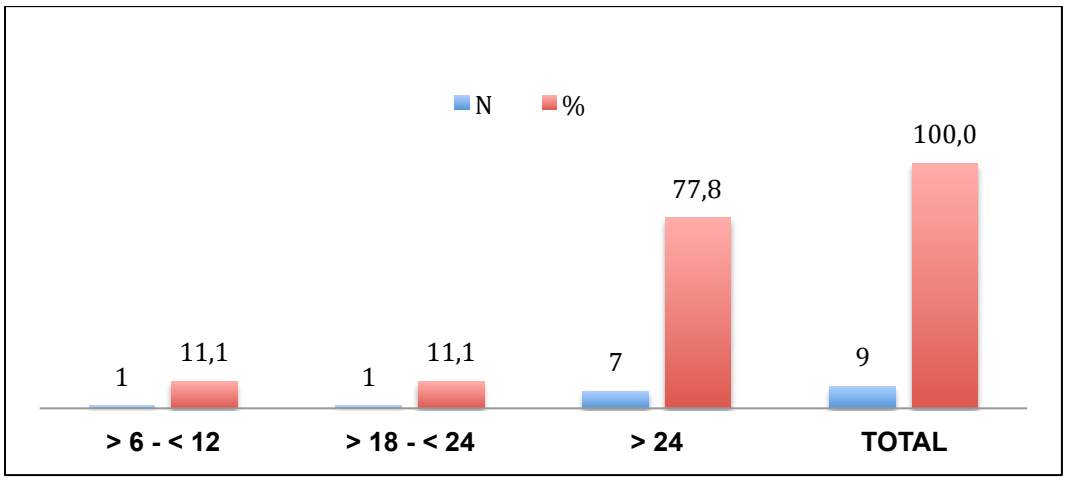
in this sample size of the participants. One participant, however, did not state the number of years at the institution.

3.1.4.1 f Variable 6: Years working in a department (in months)

Graph 6.1: Paediatrics

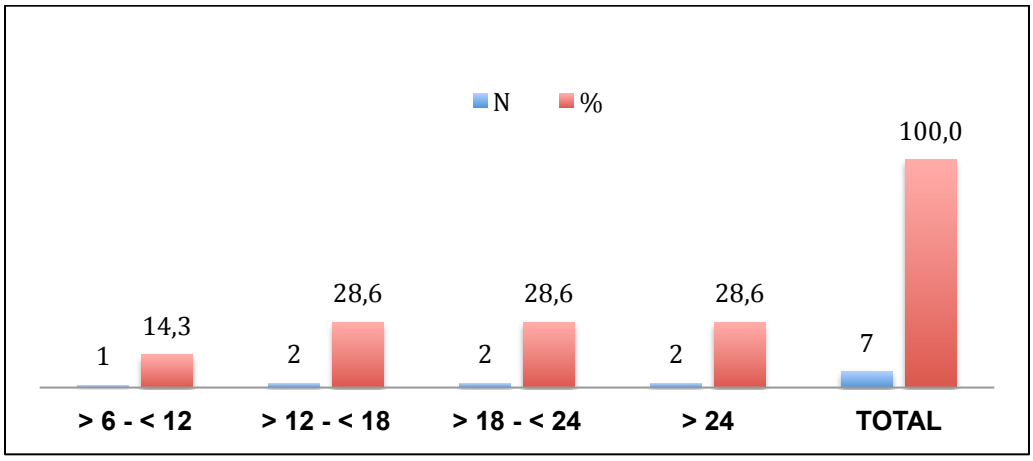


Graph 6.2: Maternity

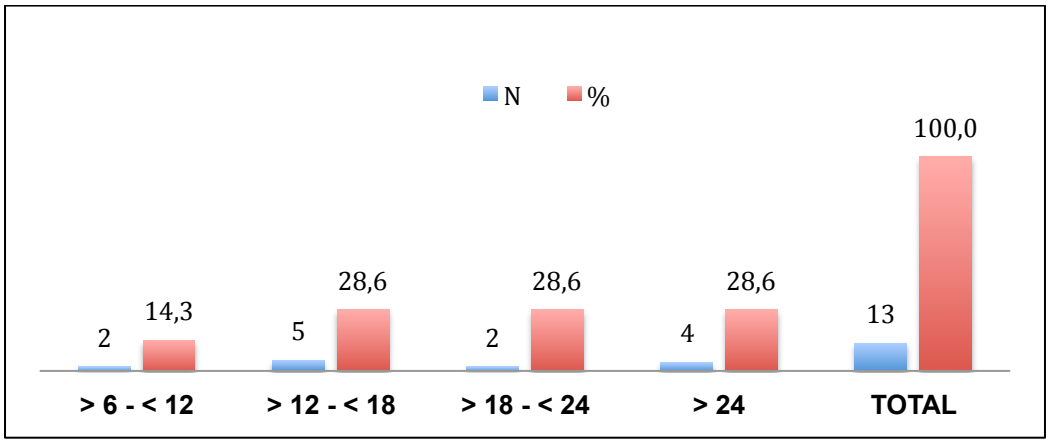


From Graph 6.2, it is shown that the majority of participants N=7 have been working in this unit, maternity, for more than 24 months, which could indicate that a majority of the participants should have a sound knowledge of the unit's rules and routines.

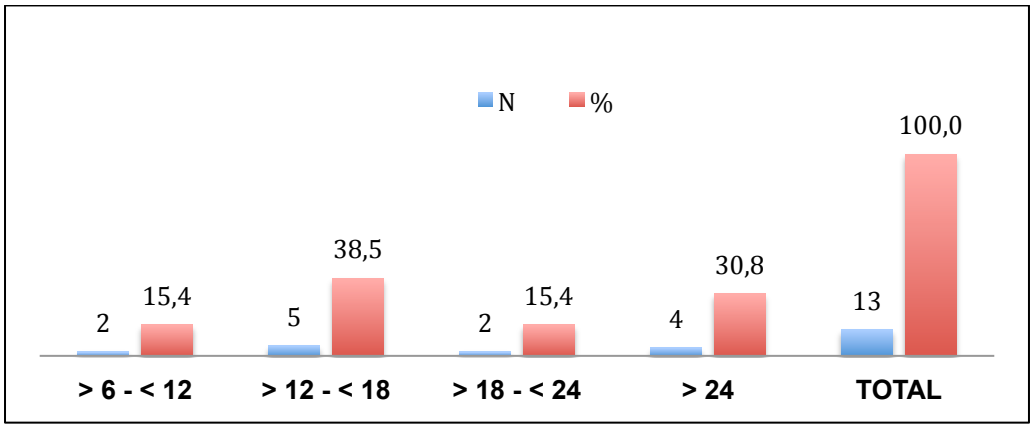
Graph 6.3: Casualty



Graph 6.4: Medical/surgical



Graph 6.5: Theatre



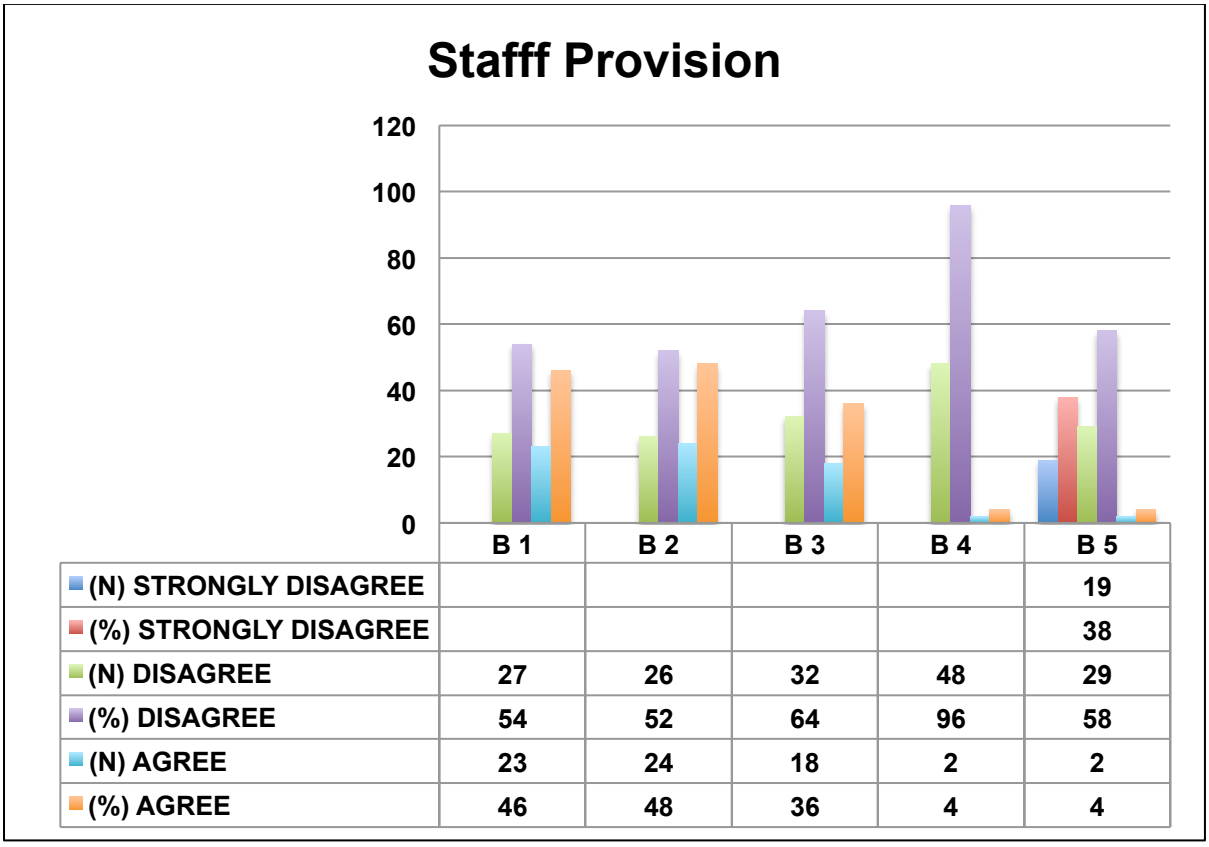
3.1.4.2 SECTION B: FACTORS INFLUENCING NURSING CARE

3.1.4.2 a **Staff provision**: Variables B1, B2, B3, B4 and B5.

Table 5: Staff provision variables

Staff provision: Nursing	Variable
There is adequate staff during weekends and public holidays	B 1
There is enough staff during a day shift for all the nursing duties	B 2
There is enough staff during a night shift for all the nursing duties	B 3
There is enough skilled staff in all the departments of the hospital	B 4
There is sufficient staff per patient ratio	B 5

Graph 7: Staff provision data



	B 1	B 2	B 3	B 4	B 5
(N) STRONGLY DISAGREE					19
(%) STRONGLY DISAGREE					38
(N) DISAGREE	27	26	32	48	29
(%) DISAGREE	54	52	64	96	58
(N) AGREE	23	24	18	2	2
(%) AGREE	46	48	36	4	4

Graph 7 shows that the majority of participants ***disagree*** that staff allocation is adequate, according to staff provision data:

- B 1: There is no real significance between staff feeling that there are or are not enough staff allocated over weekend shifts, where N=27 disagreed and N=23 agreed. It could be that in some of the units, staff allocation is better than in others and that there is no norm in the institution of inefficiently allocating staff.

- B 2: The same is true of staff allocation during day shifts; N=26 disagreed and N=24 agreed that there is adequate staff on a day shift.

- B 3: With nightshift, there are more participants feeling that staff allocation is not accurate, with N=32 who feel that there is not enough staff on night shift and only N=18 who feel there is enough.

- B 4: Overall, in all the units/departments of the hospital, therefore the hospital in its entirety does not have sufficient staff, N=48 of participants felt this way.

- B 5: N=19 strongly disagreed and N=29 disagreed that there is enough staff per patient ratio.

According to Bryman *et al.* (2014), Cronbach alpha is used to determine the internal reliability. It calculates the average of all possible split-half reliability coefficients. The calculation of the alpha correlation coefficient varies between 0 – no correlation and therefore no internal consistency, and 1 – perfect correlation and therefore complete internal consistency. A result of >0.7 implies an acceptable level of internal reliability.

According to the above data, the Cronbach alpha result for staff provision was calculated as 0.765, which would result in an acceptable level of internal reliability. From Graph 7.2, it is also visible that the majority of participants were of the opinion that staff provision is not adequate.

In the DENOSA Memorandum of Demands (2017), issued to Health Minister A Motsoaledi late February 2017, DENOSA expressed their concerns relating to

inadequate staff allocations in various government hospitals across South Africa, all with the view of implementing the National Health Insurance by Government. They added that it creates a real problem in health service provision, not only through under- or over-provision of health service staff, but also with regard to the allocation of different cadres of staff. The workloads become more substantial and the numbers of nurses per patient decrease, which not only puts patients at risk but also healthcare workers around the country (DENOSA, 2017).

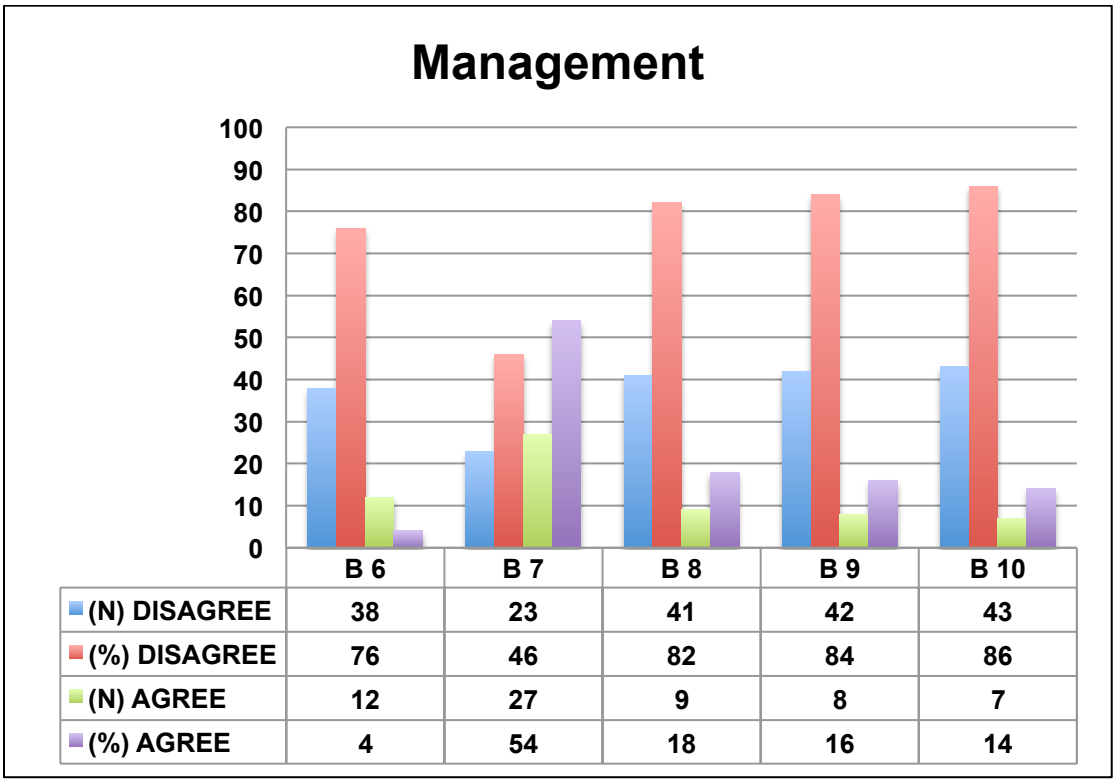
According to the Strategic Plan for Nursing Education, Training and Practice (2012), safe patient care and healthcare planning depend greatly on the number of nurses employed in a healthcare institution and the communities and it should be done according to relative guidelines. Traditionally, population-based norms were used to determine this spread of workforce, but recently, the WHO recognised activity-based norms, as they account for numbers of patients and location of services, which might determine the number and certain skills sets of particular nurses. It was proposed in this strategic plan that a combination of these two norms be used in South Africa.

3.1.4.2 b **Management of departments and wards**: Variables B6, B7, B8, B9 and B10.

Table 6: Management of department and wards

Management of departments and wards	**Variable**
All duties that are allocated are being supervised accordingly	B 6
Department managers are not part of the production team and do not get allocated duties	B 7
Department managers are always available	B 8
Department managers act as mentors for young professionals	B 9
Department managers are eager to teach young nurses	B 10

Graph 8 – Management of departments and wards data



	B 6	B 7	B 8	B 9	B 10
(N) DISAGREE	38	23	41	42	43
(%) DISAGREE	76	46	82	84	86
(N) AGREE	12	27	9	8	7
(%) AGREE	4	54	18	16	14

Graph 8 shows that the majority of participants ***disagree*** that the management of wards is adequate, according to the management of departments and wards data:

- B 6: N=38 said that duties are not being supervised accordingly.

- B 9: N=42 are of the opinion that department managers do not act like mentors to younger nurses who are starting out their careers in the nursing profession; this is also in accordance with the following variable at B 10.

- B 10: N=43, which is 86% of the participants, feel that department managers are not as eager to teach young professionals or carry out in-service training duties.

The following Cohen's D was calculated for B 6, B 9 and B 10:

Male: B 6's mean was 2.25 and the standard deviation was 0.447
Female: B 6's mean was 2.24 and the standard deviation was 0.431

It resulted in a Cohen's D of 0.022, which means that there was no significant difference in opinion between males and females in the population group regarding duties that are allocated that are not being supervised accordingly at the institution as the majority (76% of the participants) stated that in Graph 7.4.

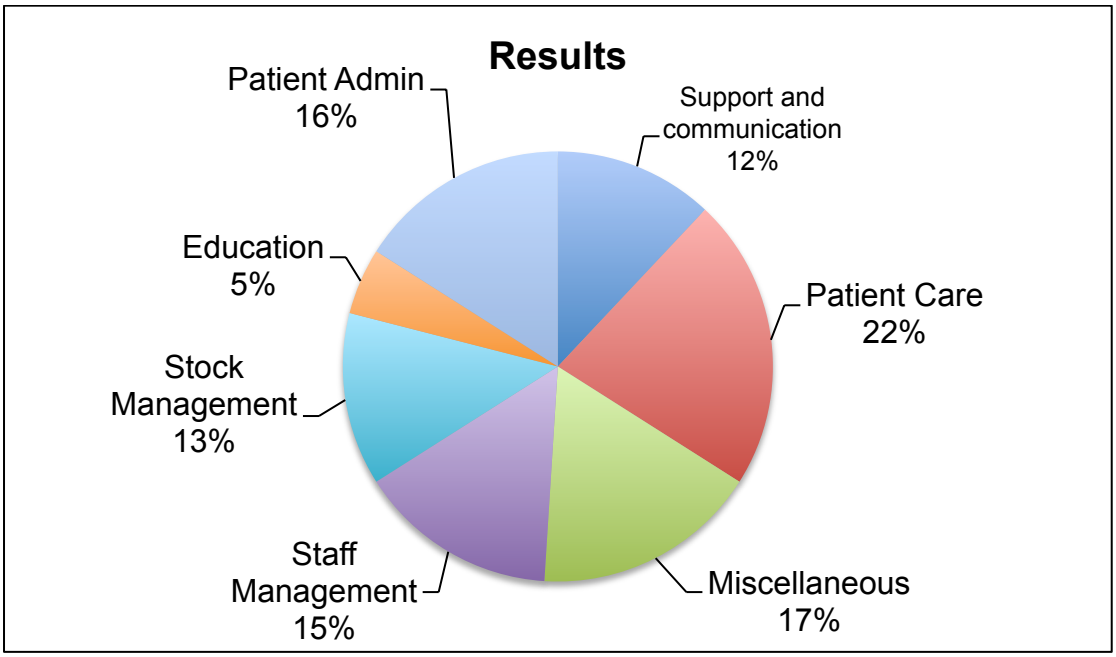
Male: B 9's mean was 2.31 and the standard deviation was 0.479
Female: B 9's mean was 2.09 and the standard deviation was 0.288
It resulted in a Cohen's D of 0.46, which means that there was a medium effect size in opinion between males and females in the population group regarding department managers who do not act as mentors to teach young nurses at the institution as the majority (84% of the participants) stated that in Graph 7.4.

Male: B 10's mean was 2.25 and the standard deviation was 0.447
Female: B 10's mean was 2.09 and the standard deviation was 0.288
It resulted in a Cohen's D of 0.36, which means that there was a medium effect size in opinion between males and females in the population group, regarding department managers who are not eager to teach young nurses at the institution, as the majority (86% of the participants) stated that in Graph 7.4.

A reliability test was also performed on the data once again using Cronbach alpha. According to the above data, the Cronbach alpha result for staff provision was calculated as 0.711, which would result in an acceptable level of internal reliability. From Graph 7.4, it is also visible that the majority of participants were of the opinion that all duties were not being supervised adequately and that department managers were not eager to act as mentors or teach young nurses.

In a study conducted by Rispel *et al,* (2012), the focus was placed on the relationship between the quality of nursing in unit management and quality of care. The study was conducted in two provinces, nine hospitals and four units per hospital. Data was collected in 40 nursing units, between March 2011 and November 2011. The methods of data collection were a mixture of observations, unit manager, doctor and patient interviews as well as record reviews. The results were as follows:

Graph 9: Unit management and quality of care



Source: Rispel *et al.* (2011)

From the results in Graph 9, it is evident that only 15% of a unit manager's time was spent on actually managing and guiding her staff members, and only 5% dedicated to training; furthermore, only 12% were dedicated to support and communication with staff members. Aspects that required more of their time, according to the study, were aspects such as too many meetings they had to attend, problems with equipment, concerns about quality of care in their units mainly because there were staff shortages and they had to make sure there were enough staff for the following shift, by phoning and enquiring about who would be able to assist.

In conclusion, according to Graph 4.7.4, the results reflected that department managers do not spend a great deal of time being mentors to young professionals or show interest in teaching them.

3.1.4.2 c **Job satisfaction**: Variables B11, B12, B13, B14, B15 and B16.

Table 7: Job satisfaction

Job satisfaction	**Variable**
High standards are maintained because of good working conditions	B 11

Your workload is not that much, so you have time to build up a relationship with your patients	B 12
Good staff performance is always acknowledged	B 13
Nurses experience job satisfaction at the hospital	B 14
The type of salaries will retain staff and recruit them as well	B 15
Staff are happy with the method of evaluation	B 16

Graph 10: Job satisfaction data

	B 11	B 12	B 13	B 14	B 15	B 16
(N) DISAGREE	34	49	33	45	36	45
(%) DISAGREE	68	98	66	90	72	91
(N) AGREE	16	1	17	5	14	4
(%) AGREE	32	2	34	10	28	8

(*Note: one of the participants did not answer B 16).

Graph 10 shows that the majority of participants ***disagree*** that they are completely satisfied with their job and the factors leading to job satisfaction:

- B 12: N=49 (98%) disagreed that their workload is manageable in such a way that they can build a good caring relationship with their patients.
- B 14: N=45 (90%) are of the opinion that nurses at the institution do not experience job satisfaction.

- B 15: N=36 (72%) feel that they are not remunerated enough in order to justify staff retention.

According to Bryman *et al.* (2014), Cohen's D is determined when comparing two means. This is simply the difference in the two groups' means divided by the average of their standard deviations. If a d=1, the two groups' means differ by one standard deviation. If d=0.2, Cohen suggests that that the effect size is "small", a d=0.5 represents a "medium" effect size and d=0.8 a "large" effect size. This means that if two groups' means do not differ by 0.2 standard deviations or more, the difference is trivial, even if it is statistically significant.

The following Cohen's D was calculated for B 14:

Male: B 14's mean was 2.06 and the standard deviation was 0.250
Female: B 14's mean was 2.12 and the standard deviation was 0.327
This resulted in a Cohen's D of 0.18, which means that there was no significant difference in opinion between males and females in the population group regarding nurses experiencing job satisfaction at the institution, as the majority (90% of the participants) stated that in Graph 7.7.

According to Selebi (2007), the high level of dissatisfied nurses in South Africa should be brought under the attention of the Health Services of South Africa. In her research, she recommended that her findings indicated some of the very important aspects that have to be taken into consideration in various human resource planning strategies in order to make the nursing profession and environment a desirable one in order to retain nurses in our hospitals. She suggested that hospital and nursing management should re-think nurses' salaries, supervision methods and relationships and also how the Department of Health policies are being implemented.

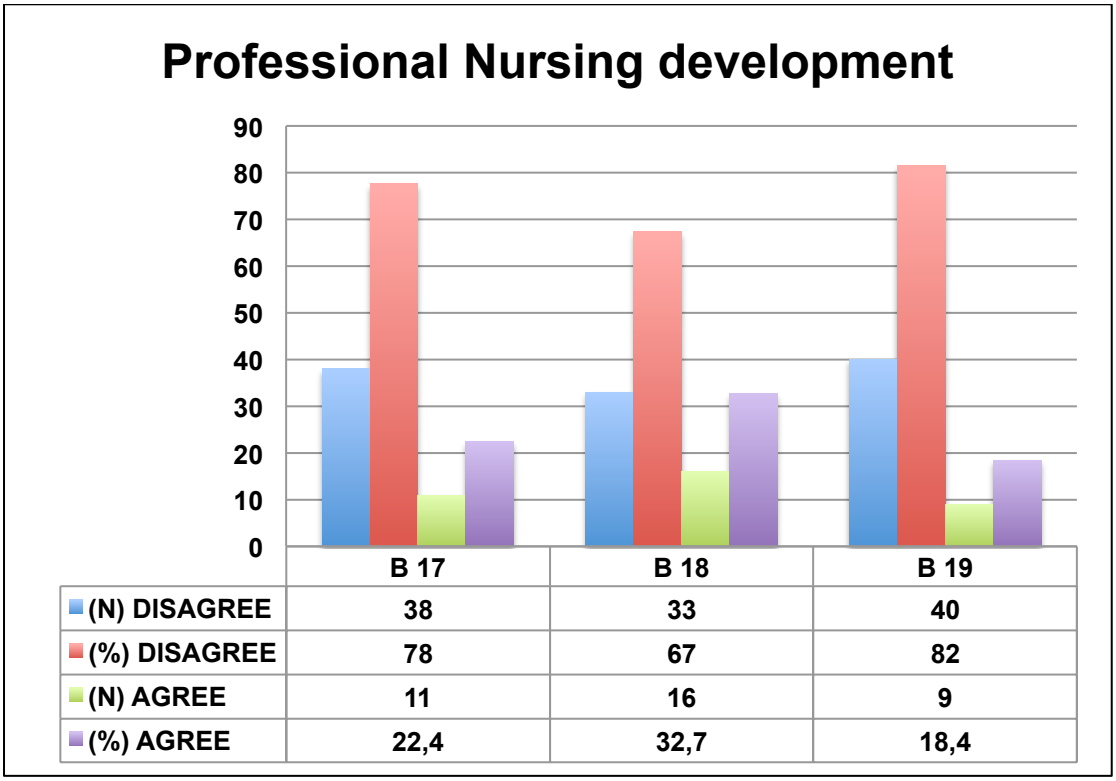
To conclude, the data showed that participants at this institution do not experience job satisfaction and this could be due to various reasons.

3.1.4.2 d **Professional nursing development**: Variables B17, B18 and B19.

Table 8: Professional nursing development

Professional nursing development	Variable
There is continued education to enable you to advance professionally	B 17
There are adequate opportunities for career development	B 18
There are enough staff members to cope in all the departments, e.g. theatre, maternity etc.	B 19

Graph 11: Professional nursing development data



(*Note: one of the participants did not answer this section, i.e. B 17-B 19).

Graph 11 shows that the majority of participants ***disagree*** that their nursing development is satisfactory:

- B 17: N=38 (78%) disagreed that there is continued education to advance their careers professionally

- B 18: N=33 (67%) are of the opinion that there is no career development.

According to the DENOSA Memorandum of Demands (2017), issued to Health Minister A Motsoaledi late February 2017, DENOSA demands that more nurses be trained on advanced nursing care courses to be able to refer and treat high-risk patients. In this view, they requested that nursing education be the sole competency of government and that nursing education and training be regarded as a national competency to eliminate issues such as provincial inequalities, fragmentation, lack of clinical training and social accountability.

To conclude, the majority of participants are of the opinion that they do not believe there are enough career and professional development opportunities at the institution.

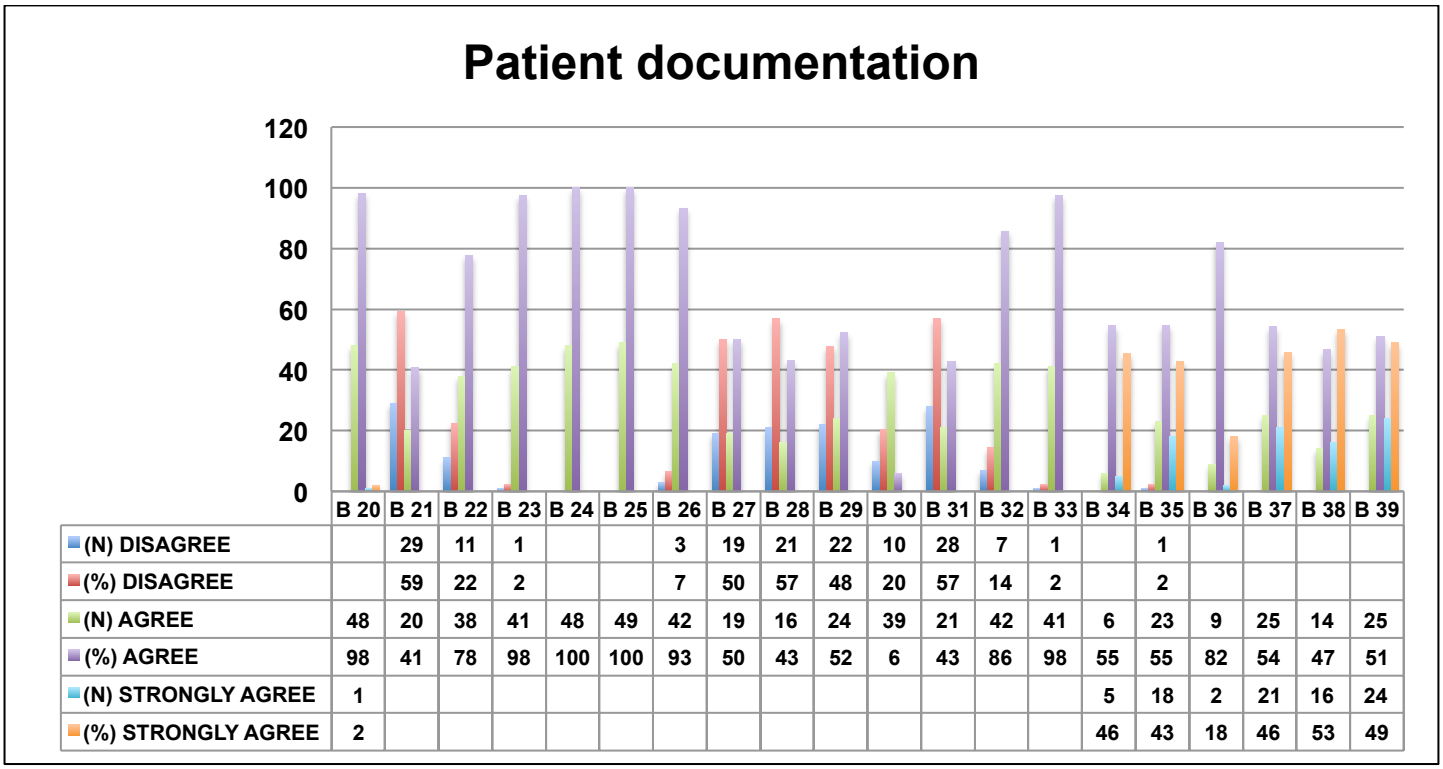
3.1.4.2 e **Patient documentation**: Variables B 20-B 39

Table 9: Patient documentation

Patient documentation	**Variable**
Patients always receive nursing care as required	B 20
There is enough time to record all information about a patient's treatment that is given	B 21
Notes on the patient's files are eligible, accurate and complete	B 22
Doctors rounds and notes are always documented	B 23
With admission, every patient is assessed and all problems are identified	B 24
Each patient has a checklist to cater for his/her basic needs	B 25
Nursing care diagnoses are always made	B 26
Nursing care plan is always drawn up by a registered nurse	B 27
Nursing care plan is always implemented by a registered nurse	B 28
Nursing care plans are not updated continuously	B 29

Discharge criteria are always set	B 30
Documentation audits are not done continuously	B 31
Patients are nursed in a healthy, safe environment	B 32
Emergency care is always available	B 33
Patients in labour receive necessary care as required	B 34
Debilitated patients receive care as required	B 35
Paediatric patients receive care as required	B 36
Care for patients during death and dying is with dignity	B 37
Pre/post-operative care is rendered as required in surgical wards	B 38
Patients are treated by an identified health worker	B 39

Graph 12: Patient documentation data



	B 20	B 21	B 22	B 23	B 24	B 25	B 26	B 27	B 28	B 29	B 30	B 31	B 32	B 33	B 34	B 35	B 36	B 37	B 38	B 39
(N) DISAGREE		29	11	1			3	19	21	22	10	28	7	1		1				
(%) DISAGREE		59	22	2			7	50	57	48	20	57	14	2		2				
(N) AGREE	48	20	38	41	48	49	42	19	16	24	39	21	42	41	6	23	9	25	14	25
(%) AGREE	98	41	78	98	100	100	93	50	43	52	6	43	86	98	55	55	82	54	47	51
(N) STRONGLY AGREE	1														5	18	2	21	16	24
(%) STRONGLY AGREE	2														46	43	18	46	53	49

(*Note: There are a few variables that were not answered by all participants because some of the questions did not relate to their job description in their units)

- B 20: The majority (N=48) agreed that patients received relevant nursing care as required.
- B 22-B 26: The majority agreed that documentation relating to diagnosis and problems of patients are identified and documented.
- B 33-B 39: The majority of the participants agreed that patients receive specific nursing care as required.

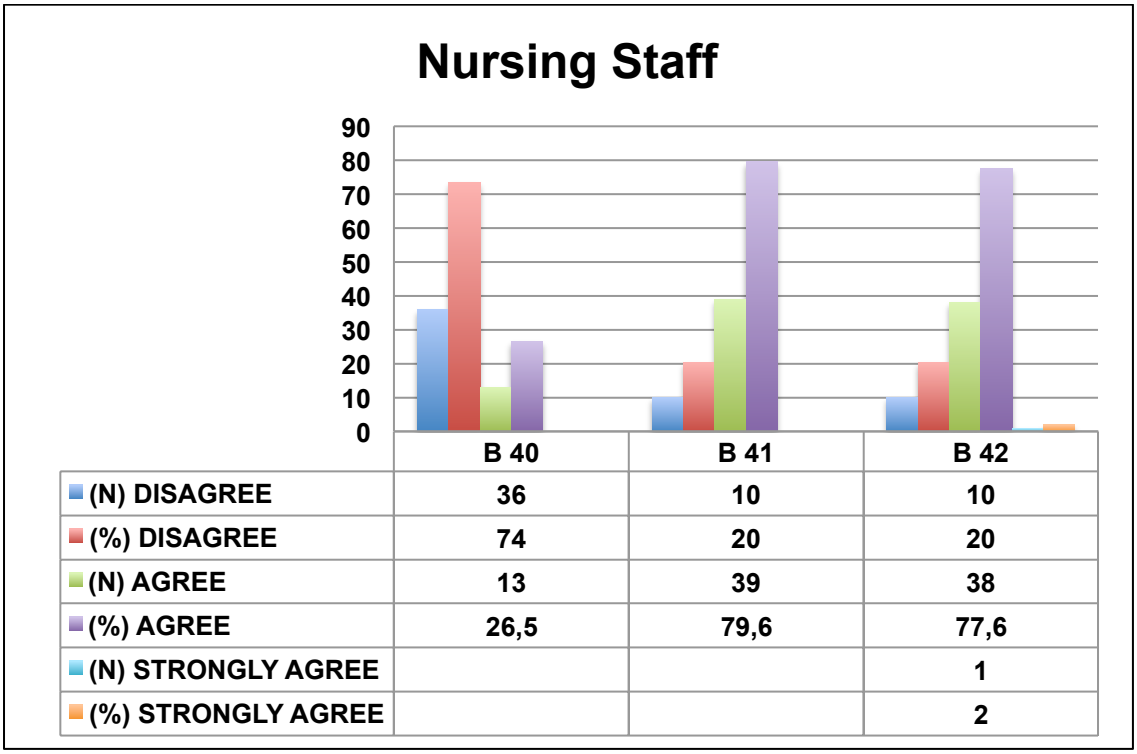
According to Booysens (2008:135), nursing record-keeping has to be done according to a patient care plan; these records are kept to ensure safe and high-quality care to patients. Therefore, it can be said that quality healthcare depends on accurate and chronological evidence of the relevant care provided. Inadequate record-keeping can lead to medico-legal risks, and Vlok (2007:200) states that record-keeping is the one tool through which nurses take responsibility for their scientific actions within a legal framework.

3.1.4.2 f **Nursing staff**: Variables B 40-B 42

Table 10: Nursing staff

Nursing staff	**Variable**
It is sometimes necessary for nurses to practise beyond their scope of practice	B 40
Nurses' primary responsibility is to treat uncomplicated health conditions where patients are stable	B 41
Auxiliary nurses' responsibilities are to care for patients in an assisted way for activities of daily living and self-care	B 42

Graph 13: Nursing staff data



	B 40	B 41	B 42
(N) DISAGREE	36	10	10
(%) DISAGREE	74	20	20
(N) AGREE	13	39	38
(%) AGREE	26,5	79,6	77,6
(N) STRONGLY AGREE			1
(%) STRONGLY AGREE			2

(*Note: One participant did not fill out this section B 40-B 42).

Graph 13 shows that the majority of participants ***agree*** that their nursing responsibilities are towards patient-centred care and they should not practise beyond their scope as set out by SANC:

- B 40: N=36 (74%) disagreed that they are expected to practise beyond their scope of practise
- B 41: N=39 (79.6%) are of the opinion that they as nurses should treat uncomplicated conditions with stable patients.
- B 42: N=38 (77.6%) agreed that auxiliary nurses should assist patients in daily living activities.

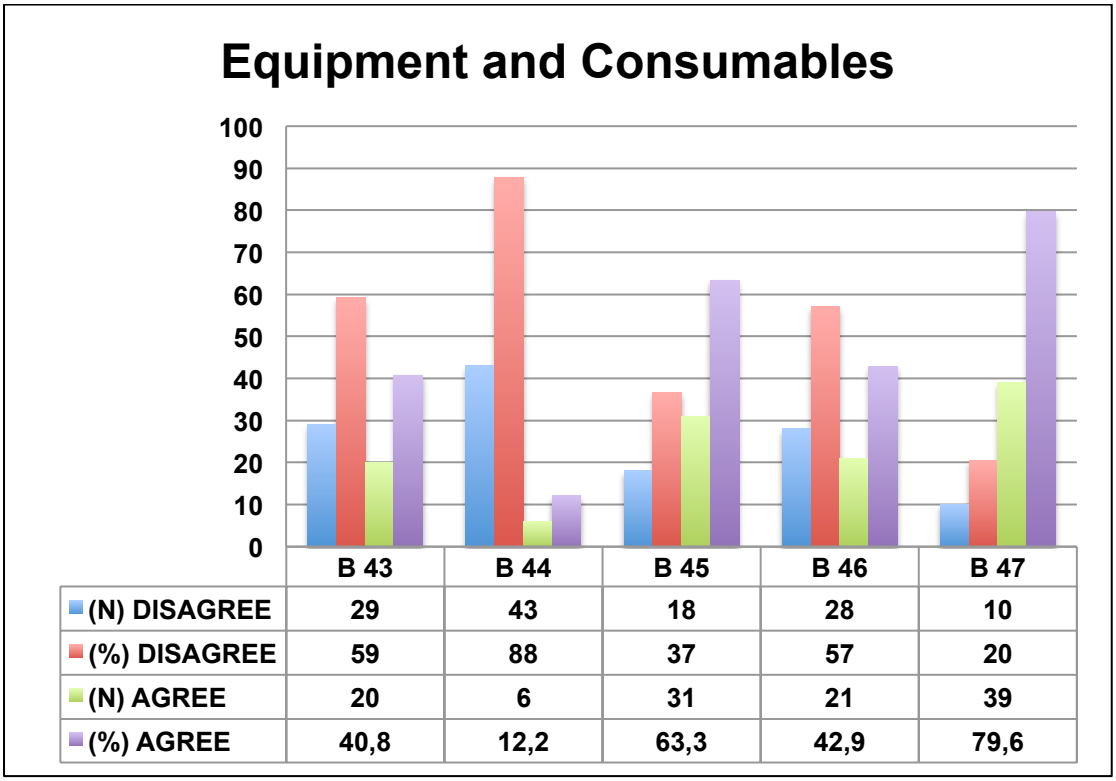
According to the World Health Organization (2006), nurses bring people-centred care closer to the communities where it is in dire need of it; by doing this, nurses help improve the outcomes and overall cost effectiveness of these services according to their scope of practise. Nursing care is about autonomous and collaborative care of individuals of all ages, families, groups and communities, sick or well. It includes the promotion of health, the prevention of illness, and the care of ill, disabled and dying people.

3.1.4.2 g **Equipment and consumables**: Variables B 43-B 47

Table 11: Equipment and consumables

Equipment and consumables	Variable
Equipment and consumables are always enough	B 43
Equipment are always in working condition	B 44
Maintenance on equipment is being done on a regular basis	B 45
Consumables that prevent cross infection are always adequate	B 46
Training on equipment is always done and you are equipped to work it	B 47

Graph 14: Equipment and consumables data



	B 43	B 44	B 45	B 46	B 47
(N) DISAGREE	29	43	18	28	10
(%) DISAGREE	59	88	37	57	20
(N) AGREE	20	6	31	21	39
(%) AGREE	40,8	12,2	63,3	42,9	79,6

(*Note: One participant did not fill out this section).

Graph 14 shows that the majority of participants ***disagree*** that the equipment and consumables they need to work with are in a correct working condition.

- B 43: N=29 (59%) disagreed that equipment and consumables are always enough to fulfil their daily responsibilities with.
- B 44: N=43 (88%) are of the opinion that the equipment is not always in working condition.
- B 45: N=31 (63,3%) agreed that maintenance is regularly done on equipment, which, from the above data, could have one of two explanations, either equipment is being broken on such a regular basis that it is not always in a working condition, or it is not repaired up to standard.
- B 46: There are mixed feelings about the availability of consumables that prevent cross-infection, such as soap, gloves etc., and this might be that in certain departments it might be deemed more important to supply them with it.
- B 47: N=39 (79.6%) are of the opinion that they are adequately trained on equipment.

According to the above data, the Cronbach alpha result for equipment and consumables was calculated as 0.654, which would result in an uncertain reliability. From Graph 7.15, it is also visible that at B 46, participants had mixed feelings regarding the availability of consumables needed to prevent cross-infection.

According to the DENOSA Memorandum of Demands (2017), issued to Health Minister A Motsoaledi late February 2017, many government healthcare facilities lack the most basic equipment because the end-user is not involved in the procurement process, they argue that the red-tape is too long, and that healthcare staff get frustrated with the system. They demand the sufficient allocation of the healthcare budget to be able to fund equipment as needed by the institutions as well as the development of a standard equipment list that all facilities must have.

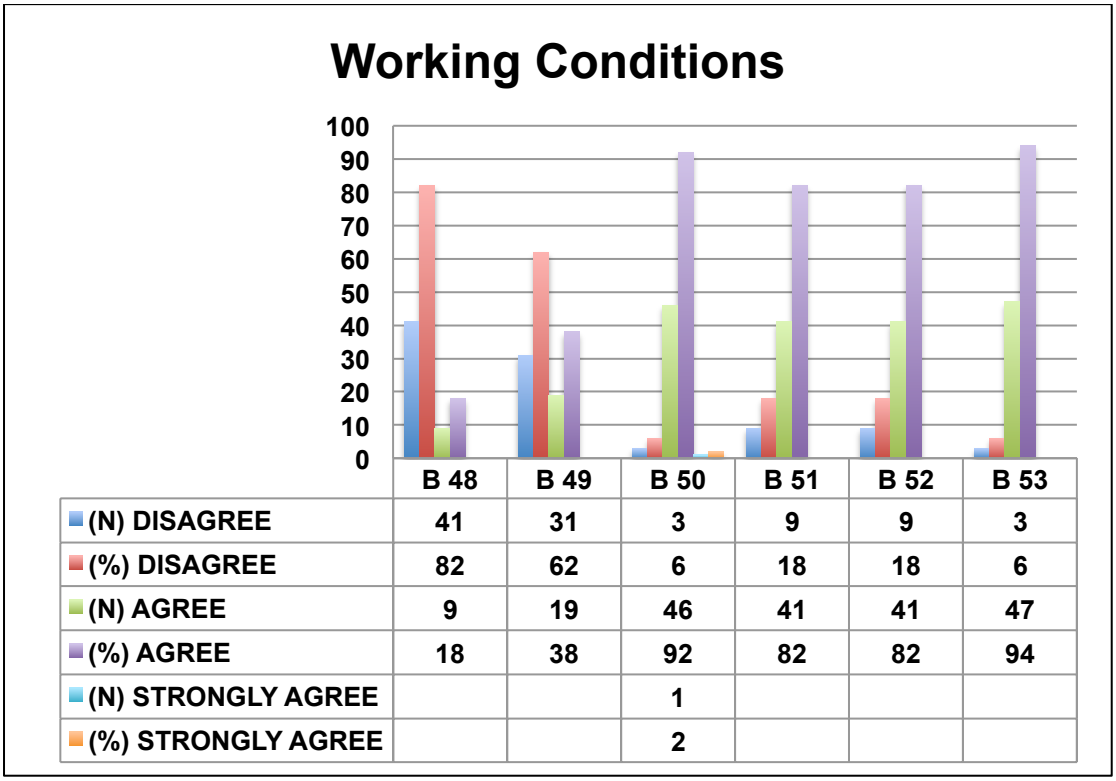
3.1.4.2 g **Working conditions**: Variables B 48-B 53

Table 12: Working conditions

Working conditions	**Variable**
It is not necessary to work overtime	B 48

There is always time for tea breaks and lunch breaks	B 49
Relaxation facilities for staff are adequate	B 50
Staff are always able to work within a legal and ethical framework	B 51
Nurses are able to schedule their leave according to their needs	B 52
Nurses are able to take leave as scheduled	B 53

Graph 15: Working conditions data



	B 48	B 49	B 50	B 51	B 52	B 53
(N) DISAGREE	41	31	3	9	9	3
(%) DISAGREE	82	62	6	18	18	6
(N) AGREE	9	19	46	41	41	47
(%) AGREE	18	38	92	82	82	94
(N) STRONGLY AGREE			1			
(%) STRONGLY AGREE			2			

Graph 15 shows that the majority of participants ***agree*** that they are able to schedule their leave as per their needs as well as work within an ethical framework.

- B 48: N=41 (82%) disagreed that it is ***not*** necessary to work overtime, which means that they are required sometimes to work overtime.
- B 49: N=31 (62%) are of the opinion that they do get their lunch and tea breaks.
- B 50: N=46 (92%) agreed that their relaxation facilities, such as a tearoom, are adequate.
- B 51: N=41 (82%) agree that they can work within a legal framework

- B 52: N=41 (82%) are of the opinion that they can schedule their leave according to their needs, and
- B 53: N=47 (94%) agreed that they are actually allowed to take their leave as scheduled.

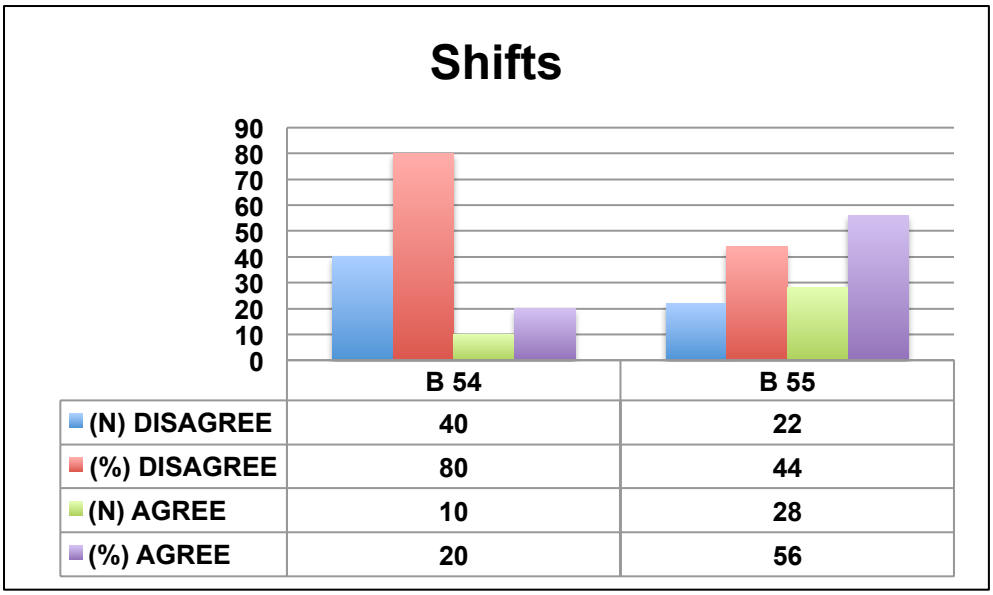
A recent study conducted by the North-West University's Dr S Coetzee and Prof H Klopper showed that 71% of nurses in the public sector rated their work environment as poor or fair. This is disconcerting, since research shows that improving the work environment of nurses holds the most promise for retaining a qualified and committed nurse workforce, which has obvious benefits for patients in terms of better quality care.

3.1.4.2 h **Shifts**: Variables B 54 & B 55

Table 13: Shifts

Shifts	Variable
At the end of a shift, staff are able to leave the hospital on time	B 54
When rosters are planned, staff are taken into account	B 55

Graph 16: Shifts data



Graph 16 shows that the majority of participants ***agree*** that they are able to schedule their leave as per their needs as well as work within an ethical framework.

- B 54: N=40 (80%) disagreed that they are not able to leave the hospital on time, therefore correlating to the findings of B 48, where participants disagreed that it is not always necessary to work overtime, which is now evident that it is that way.
- B 55: The data is almost in accordance for both agree and disagree categories, that some participants experience contribution towards off-duty rosters with unit managers.

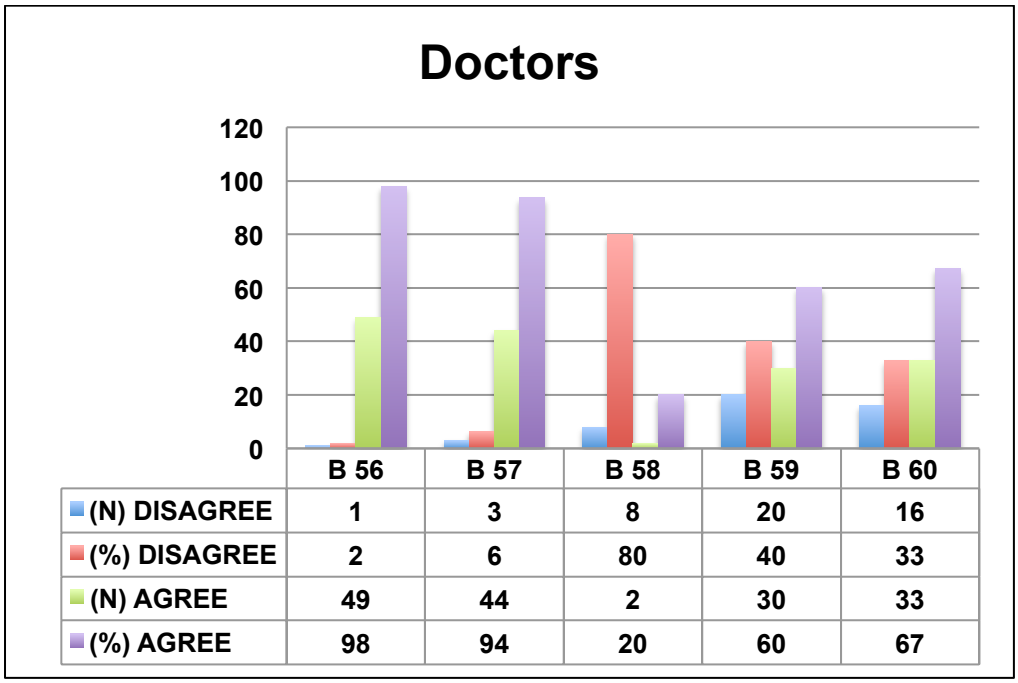
According to Mokoka *et al.* (2010), there are various factors that cause nurses to either look for other jobs or go on early retirement, and some of these factors include work schedules, inflexible hours, long shifts and mandatory overtime. Older nurses go on early retirement because they feel the strain of the long hours, whereas younger nurses were reportedly unhappy with the shifts as these impacted negatively on their family and social lives.

3.1.4.2 i **Doctors**: Variables B 56-B 60

Table 14: Doctors

Doctors	**Variable**
Medical officers are available full time in the hospital	B 56
Due to availability of doctors, the staff can cope with emergencies better	B 57
Staff can handle maternity emergencies better because there are ample doctors available	B 58
In case of emergencies, doctors are immediately available	B 59
Patients do not have to wait long before a doctor evaluates and treats them	B 60

Graph 17: Doctors data



	B 56	B 57	B 58	B 59	B 60
(N) DISAGREE	1	3	8	20	16
(%) DISAGREE	2	6	80	40	33
(N) AGREE	49	44	2	30	33
(%) AGREE	98	94	20	60	67

(*Note: Some participants did not answer all the questions as maternity does not relate to all participants in their units).

Graph 17 shows that the medical doctors are available in the hospital and perform their duties as expected.

- B 56: N=49 (98%) agreed that medical officers are available in the institution.
- B 60: N=33 (67.3%) are of the opinion that patients do not have to wait long before doctors treat them.

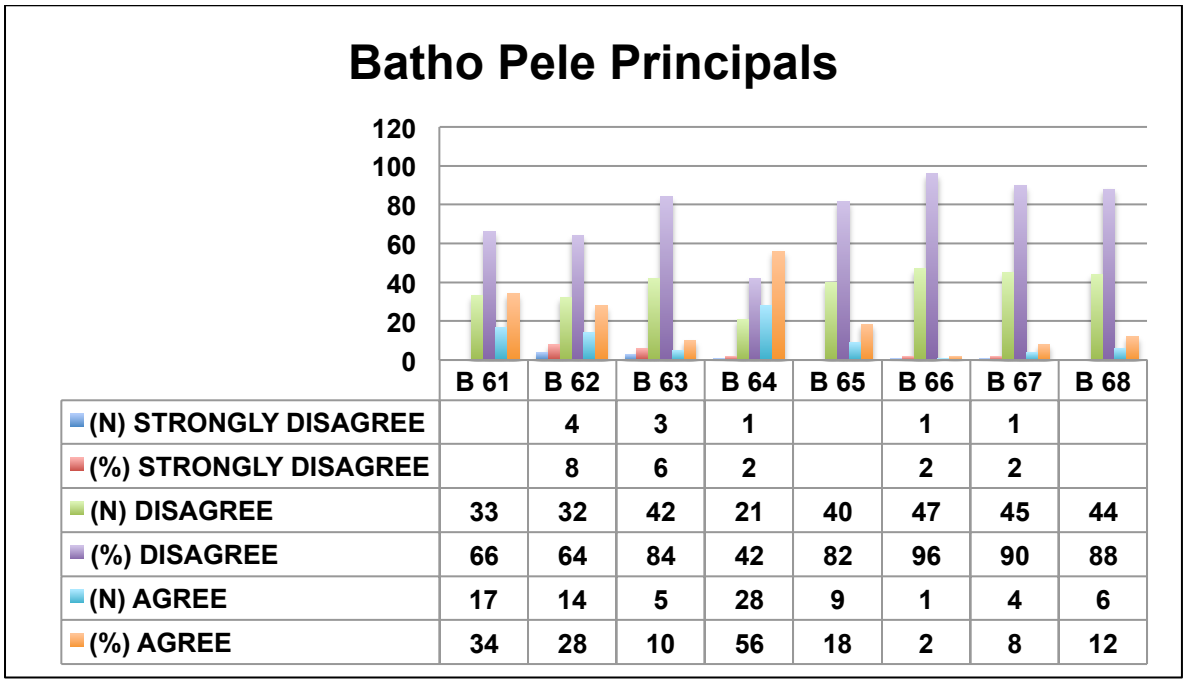
3.1.4.2 j **Batho Pele principles**: Variables B 61-B 68

Table 15: Batho Pele principles

Batho Pele principles	**Variable**
If possible, patients are given a choice of the services on offer to them	B 61
Patients are consulted about the level and quality of service they receive	B 62

Patients are told about the level of service and quality so they know what to expect	B 63
All patients have equal access to all services	B 64
Patients are given full, accurate information about the services available to them	B 65
Patients are told how the institution is run, how much services cost and who is in charge	B 66
When complaints are made, patients receive sympathy and a positive response	B 67
Services are provided economically and efficiently, to give patients the best value	B 68

Graph 18: Batho Pele principles data



	B 61	B 62	B 63	B 64	B 65	B 66	B 67	B 68
(N) STRONGLY DISAGREE		4	3	1		1	1	
(%) STRONGLY DISAGREE		8	6	2		2	2	
(N) DISAGREE	33	32	42	21	40	47	45	44
(%) DISAGREE	66	64	84	42	82	96	90	88
(N) AGREE	17	14	5	28	9	1	4	6
(%) AGREE	34	28	10	56	18	2	8	12

Graph 18 shows overall that Batho Pele principles are not adhered to as stipulated by the White Paper, published in 1997.

The Batho Pele principles are also known as the White Paper on the transformation of the public services in October 1997 (South Africa, 1997). It sets out eight national priorities, among which transformation of service delivery is the key criterion on which a transformed South African Health service will be judged.

3.1.5 ASSESSING AND DEMONSTRATING THE QUALITY AND RIGOUR OF THE PROPOSED RESEARCH DESIGN

The quantitative paradigm was chosen for the purpose of understanding and interpreting what nursing staff are experiencing as barriers to delivering quality nursing care within the current dynamic and changing healthcare environment of today.

According to Stone *et al.* (2007), increasing nursing staff and allocating resources better can reduce costs and improve basic patient care. Therefore, it can be said that all parties will benefit from this investigation, i.e. hospital management, nursing staff and society in need of nursing care. Nurses are the primary caregivers in all healthcare institutions, and therefore they are critical to the provision of quality patient care. Gaining a deeper understanding of the role a typical nurse has to fulfil each day in quality improvements as well as the challenges she faces every day in this set-up, might provide hospitals with a better understanding of how to optimise resources and improve basic nursing care to ensure quality patient care (Draper *et al.,* 2008). The benefits of firstly identifying these obstacles by engaging nursing staff might give nurses a sense of mutual respect between themselves and hospital management, government and stakeholders, because of the fact that their concerns and insights with regard to these obstacles can be raised. Hospital management might be equipped with better knowledge on what the actual obstacles and underlying causes are, and attempt to address them in a more efficient manner. Society would gain the lost respect for the nursing profession and nursing staff can gain lost dignity again as well as a renewal of professional trust in the nursing profession might be experienced by doctors and other members of the medical teams.

The researcher has collected the data herself to improve the reliability of the study.

3.1.6 CONCLUSION

The researcher has successfully addressed the research question. “What currently prevents basic quality nursing care in government hospital institutions?” Through a scientific investigation, a few obstacles were identified that affect the quality of basic nursing care at two district hospitals that were identified in the eastern parts of Gauteng.

The following objectives that were set out for this study were all met by determining:

- whether adequate staffing is available to render nursing care

- whether current nurses experience job satisfaction at the institution
- whether nursing staff have access to necessary resources to deliver quality nursing care
- whether nursing staff receive the necessary support and supervision from relevant superiors while performing nursing duties.

CHAPTER 4: RECOMMENDATIONS

4.1 INTRODUCTION

In the past, the nurses' responsibility in patient safety and quality care was viewed in narrow aspects of patient care, for example avoiding medication errors and preventing patient falls. While these very important aspects remain vital within the scope of practice, the depth of patient safety and quality improvement are far greater. The most critical contribution of nursing to patient safety, in any setting, is the ability to coordinate and integrate the multiple aspects of quality within the care such as all the factors that have an influence on nurses' ability to render this care. Many view quality healthcare as the overarching umbrella under which patient safety resides. Patient safety is believed to be the cornerstone of high-quality healthcare. Much of the work defining patient safety and practices that prevent harm has focused on the negative outcomes of care, such as mortality and morbidity. Nurses are critical to the surveillance and coordination that reduce such outcomes.

The four objectives set out for the research study were researched and the data analysis and interpretations are described in Chapter 3. The recommendations based on the findings as described in Chapter 3 are discussed in this chapter.

The following objectives that were set out for this study were all met by determining:

- **Whether adequate staffing is available to render nursing care:** According to the above data, the Cronbach alpha result for staff provision was calculated as 0.765, which would result in an acceptable level of internal reliability. From Graph 7.2, it is also visible that the majority of participants were of the opinion that staff provision is not adequate.
- **Whether current nurses experience job satisfaction at the institution:** Male: B 14's mean was 2.06 and the standard deviation was 0.250. Female: B 14's mean was 2.12 and the standard deviation was 0.327. It resulted in a Cohen's D of 0.18, which means that there was no significant difference in opinion between males and females in the population group regarding nurses experiencing job satisfaction at the institution as the majority (90% of the participants) stated that in Graph 7.7.

- **Whether nursing staff have access to necessary resources to deliver quality nursing care:** According to the above data, the Cronbach alpha result for equipment and consumables was calculated as 0.654, which would result in an uncertain reliability. From Graph 7.15, it is also visible that at B 46, participants had mixed feelings regarding the availability of consumables needed to prevent cross-infection.
- **Whether nursing staff receive the necessary support and supervision from relevant superiors while performing nursing duties:** According to the above data, the Cronbach alpha result for staff provision was calculated as 0.711, which would result in an acceptable level of internal reliability. From Graph 7.4, it is also visible that the majority of participants were of the opinion that all duties were not being supervised adequately and that department managers were not eager to act as mentors or teach young nurses.

4.1.1 RECOMMENDATIONS

4.1.1.1 Staff provision

The analysis in Graph 7 shows that the majority of participants disagree that staff allocation is adequate. From the data, it is evident that most participants agree that there is adequate staff during weekends and public holidays to handle the wards and patients; it seems, however, that the night duty allocations might be a problem, as the majority of participants agreed that there is not enough staff available on night duty. The staff-per-patient ratio also seems to be a problem as most participants disagreed with the statement that there are adequate staff per patient. Overall, it seemed that staff are an agreement when disagreeing with the statement that there are not sufficient skilled staff in the hospital.

4.1.1.2 Recommendation

Adequate staff in terms of numbers

Urgent attention needs to be given to staff numbers, especially in critical departments such as casualty, maternity and theatre to ensure proper quality patient care. As the majority of participants stated that there are sufficient staff on night duty, the day staff allocations should also be reflecting this majority opinion. It is noticed that during the day there is much more activity in the hospital and wards overall, and separate staff have to be provided for the more critical

departments, even if the management should employ agency nurses from a reliable agency with sufficient skills.

Adequate staff in terms of skill

Having skilled staff is vitally important, not only for the sake of the patients by rendering quality basic nursing care, but also for the reputation of the Department of Health, as in recent years the department has seen an increase in medico-legal cases brought against them, which result in a major financial output for the Department and Government at the end of the day. These are funds that could have been utilised in a better way, such as upgrading the facility or equipment, or creating more jobs for community service nurses or doctors.

4.1.1.3 Job satisfaction

Graph 11 shows that the majority of participants disagree that they are completely satisfied with their job and the factors leading to job satisfaction at their institution. 98% of the participants disagreed that their workload is manageable in such a way that they can build a good caring relationship with their patients, and 90% of them are of the opinion that nurses at the institution do not experience job satisfaction. Another important fact to recognise is that 72% of the participants feel that they are not remunerated sufficiently in order to justify the retention of staff.

4.1.1.4 Recommendation

Superior communication

Superior-subordinate communication plays an important role in job satisfaction in the workplace. The way in which subordinates perceive a supervisor's behaviour, verbally or non-verbally, can positively or negatively influence job satisfaction. Non-verbal communication, such as facial expressions, eye contact and body movement, is crucial to the superior-subordinate relationship – all of these actions demonstrate respect, and everybody has the need to be respected by somebody. A supervisor who uses nonverbal cues such as friendliness, as well as open communication lines is more likely to receive positive feedback and high job satisfaction from a subordinate. Conversely, a supervisor who is antisocial, unfriendly, and unwilling to communicate with subordinates will naturally receive

negative feedback and this will result in low job satisfaction in their subordinates in the workplace.

Employee recognition

Employee recognition is not only about gifts, points and money; it is about changing the culture of the institution in order to meet goals and initiatives and most importantly to connect employees to the institution's core values and beliefs. Everybody working in the hospital is working towards a common goal – to serve patients and ensure top quality patient care.

Practical implications and working hours

One common research finding is that job satisfaction is correlated with life satisfaction. This correlation is reciprocal, meaning people who are satisfied with life tend to be satisfied with their job and people who are satisfied with their job tend to be satisfied with life. In fact, a 2016 FlexJobs survey revealed that 97% of respondents believe a job that offered flexibility would positively impact their lives, 87% think it would help lower stress and 79% think the flexibility would help them live healthier (Weiler, 2016). The working hours of a nurse have always been considered difficult; management can consider more flexible shifts such as three eight-hour shifts instead of two 12-hour shifts to give staff more flexibility in working an eight-hour workday and still also have a quality personal life. They can keep the same number of staff per roster; they just need to allocate them differently in three shifts so they could then add students to their rosters to alleviate professional nurses from doing chores such as patient feedings and linen cleansing. In this way, professional nurses get to have time doing their chores according to their scope of practice and the student nurses get to familiarise themselves with the wards and hospital, at the same time being exposed to many in-service learning opportunities and mentorship from seniors.

4.1.1.5 Equipment and consumables

Graph 15 shows that the majority of participants disagree that the equipment and consumables they need to work with are in a correct working condition. The majority (88%) of the participants were of the opinion that the equipment is not always in working condition and 63.3% agreed that maintenance is regularly done

on equipment, which, from the above data, could have one of two explanations: either equipment is being broken on such a regular basis that it is not always in a working condition or it is not repaired up to standard. There were mixed feelings about the availability of consumables that prevent cross-infection, such as soap, gloves etc., and this might be that in certain departments it might be deemed more important to supply them with it.

4.1.1.6 Recommendations

Equipment

Although 79.6% are of the opinion that they are adequately trained on equipment, there has to be a reasonable explanation as to why so much equipment is broken so often. Could it be the quality of the equipment? In which case the supplier of the equipment should be reconsidered. In the case where sufficient training, although staff might think they received adequate training, was not provided, the company's representatives need to be informed and a series of proper in-service trainings need to be given on a monthly basis. Many companies render this service as part of their after sales service, free of charge. They also include the clinical engineers and technical personnel of the hospital in these types of trainings to equip them with sufficient knowledge on how to take ownership and proper care of their capital equipment. There should be proper record-keeping of what is broken in the ward or theatre, it might be on a big white board next to the wards notice board, to monitor which instruments/equipment are out of circulation and not working, when has it been sent in to technical and upon receipt the technical personnel should give a brief 10-minute training at the morning handover to discuss possible reasons why it was broken and how to prevent it. Cost of ownership of this type of equipment is extremely high, and it should be handled and cared for with the utmost respect, as this could easily drain a department's repair budget.

4.1.1.7 Management of departments and wards

In Graph 9, it shows that the majority of participants disagree that management of wards is adequate. 38 of the participants said that duties are not being supervised accordingly and 42 are of the opinion that department managers do not act like mentors to younger nurses who are starting out their careers in the nursing

profession. 86% of the participants feel that department managers are not as eager to teach young professionals or carry out in-service training duties.

4.1.1.8 Recommendations

It is indeed a great concern that the analysis shows that unit managers do not supervise tasks accordingly; it should be the norm that tasks that are delegated be inspected and supervised or followed up properly in order to ensure correct performance of the given task. From the above-mentioned studies, it is evident that unit managers are being occupied with much more administrative duties these days than actually performing supervisory or mentorship roles for younger nurses. It is unclear if it is just the administrative duties that are very overwhelming or an inability of these managers to be mentors. In the instance of managers not having enough knowledge or experience in performing these important managerial tasks, then the recommendation is that hospital management should invest in empowering these managers by making them take management developmental and up-skilling courses, designed specifically for mentorship and proper time management. If managers are able to properly supervise staff, then they might be able to delegate more of their tasks in order to have a little more time for mentorship. It is a balancing act for sure, but one worth exploring.

4.2 SUMMARY

Four research questions were identified, and an in-depth study was undertaken to identify key issues regarding obstacles that hinder the quality of basic nursing care. When these key issues are addressed, it might be the start of a positive change in the way nursing staff perceive the quality of nursing care they have to render.

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APPENDIX A

Data collection instrument(-s) -

QUESTIONARE
SECTION A – BIOGRAPHICAL DATA

1. Gender

	MALE		FEMALE

2. Age (in years)

>20 -30	31-40	41-50	51-60	61-65	>65

3. Categories of Staff

	Chief Professional Nurse		Senior Professional Nurse		Professional Nurse

	Enrolled Nurse		Enrolled Nurse Assistant

4. Qualifications

	General		Midwifery		Psychiatry

	Staff Nurse		Enrolled Nurse Assistant		Other

5. Total number of years working at this institution

	< 5 years		>5 years - <10 years		> 10 years

6. Identify the department you are currently working in and duration of your employment (in months)

Department	<6	> 6- <12	>12 - <18	>18 - <24	>24
Paediatrics					
Maternity					
Casualty					
Medical/Surgical					
Theatre					

SECTION B – FACTORS INFLUENCING NURSING CARE

Staff Provision - Nursing	Strongly disagree	Disagree	Agree	Strongly agree
There are adequate staff during weekends and public holidays				
There are enough staff during a day shift for all the nursing duties				
There are enough staff during a night shift for all the nursing duties				
There are enough skilled staff in all the departments of the hospital				
There are sufficient staff per patient ratio				

Management of departments and wards	Strongly disagree	Disagree	Agree	Strongly agree
All duties that are allocated are being supervised accordingly				
Department managers are not part of the production team and do not get allocated duties				
Department managers are always available				
Department managers act as mentors for young professionals				
Department managers are eager to teach young nurses				

Job satisfaction	Strongly disagree	Disagree	Agree	Strongly agree
High standards are maintained because of good working conditions				
Your workload is not that much, so you have time to build up a relationship with your patients				
Good staff performance is always acknowledged				
Nurses experience job satisfaction at the hospital				
The type of salaries will retain staff and recruit them as well				

Staff are happy with the method of evaluation				

Professional nursing development	Strongly disagree	Disagree	Agree	Strongly agree
There is continued education to enable you to advance professionally				
There is adequate opportunities for career development				
There are enough staff members to cope in all the departments e.g.: theatre, maternity etc.				

Patient documentation	Strongly disagree	Disagree	Agree	Strongly agree
Patients always receive nursing care as required				
There is enough time to record all information about a patients treatment that is given				
Notes on the patient files are eligible, accurate and complete				
Doctors' rounds and notes are always documented				
With admission, every patient is assessed and all problems are identified				
Each patient has a checklist to cater for his/her basic needs				
Nursing care diagnosis is always made				
Nursing care plan is always drawn up by a registered nurse				
Nursing care plan is always implemented by a registered nurse				
Nursing care plans are not updated continuously				
Discharge criteria are always set				
Documentation audits are not done continuously				
Patients are nursed in a healthy, safe environment				

	Strongly disagree	Disagree	Agree	Strongly agree
Emergency care is always available				
Patients in labour receive necessary care as required				
Debilitated patients receive care as required				
Paediatric patients receive care as required				
Care for patients during death and dying is with dignity				
Pre/post-operative care is rendered as required in surgical wards				
Patients are treated by an identified health worker				

Nursing staff	Strongly disagree	Disagree	Agree	Strongly agree
It is sometimes necessary for nurses to practise beyond their scope of practice				
Nurses' primary responsibility is to treat uncomplicated health conditions where patients are stable				
Auxiliary nurses' responsibilities are to care for patients in an assisted way for activities of daily living and self-care				

Equipment & consumables	Strongly disagree	Disagree	Agree	Strongly agree
Equipment and consumables are always enough				
Equipment is always in working condition				
Maintenance on equipment is being done on a regular basis				
Consumables that prevent cross infection are always adequate				
Training on equipment is always done and you are equipped to work it				

Working conditions	Strongly disagree	Disagree	Agree	Strongly agree
It is not necessary to work overtime				
There is always time for tea breaks and lunch breaks				
Relaxation facilities for staff are adequate				
Staff are always able to work within a legal and ethical framework				
Nurses are able to schedule their leave according to their needs				
Nurses are able to take leave as scheduled				

Shifts	Strongly disagree	Disagree	Agree	Strongly agree
At the end of a shift staff are able to leave the hospital on time				
When rosters are planned, staff are taken into account				

Doctors	Strongly disagree	Disagree	Agree	Strongly agree
Medical officers are available full time in the hospital				
Due to availability of doctors, the staff can cope with emergencies better				
Staff can handle maternity emergencies better because there are ample doctors available				
In case of emergencies, doctors are immediately available				
Patients do not have to wait long before a doctor evaluates and treats them				

Batho Pele principles	Strongly disagree	Disagree	Agree	Strongly agree
If possible, patients are given a choice of the services on offer to them				
Patients are consulted about the level and quality of service they receive				

Patients are told about the level of service and quality so they know what to expect				
All patients have equal access to all services				
Patients are given full, accurate information about the services available to them				
Patients are told how the institution is run, how much services cost and who is in charge				
When complaints are made, patients receive sympathy and a positive response				
Services are provided economically and efficiently, to give patients the best value				

Source: Eygelaar (2009)

APPENDIX B
- Informed consent form -

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TITLE OF THE RESEARCH PROJECT: AN INVESTIGATION INTO THE OBSTACLES OF BASIC QUALITY PATIENT CARE IN SELECTED GAUTENG GOVERNMENT HOSPITAL INSTITUTIONS

PRINCIPAL INVESTIGATOR: Mrs MJ du Toit

ADDRESS: 4 Grace Road, Bryanston, Johannesburg

CONTACT NUMBER: 083 468 1569

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

(This study has been approved by the Faculty of Commerce and Administration Research Ethics Committee **of the North-West University** and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.)

What is this research study all about?

- *Where will the study be conducted?*

- ***The study will be done at Government Hospitals in the Gauteng region.***

- *What is the aim of the project and why it's being conducted?*

- ***Nursing personnel are increasingly complaining that they cannot manage their workload; they are feeling stressed and tired quite a lot. The media***

and other parties are also constantly complaining about the level of quality nursing care that nursing professionals are rendering. The researcher wants to investigate the barriers influencing the quality of nursing care to establish a plan of action

- *All procedures explained.*

- ***A questionnaire is compiled to determine the factors influencing the quality of nursing care. The questionnaire is divided into a biographical section and the second part is based on a Likert scale. The Likert scale section has questions with four options to choose from, namely "strongly disagree, disagree, agree and strongly agree". Numerical values of 1, 2, 3 and 4 will be awarded. The researcher will hand out this questionnaire to each member of the nursing staff working in these hospitals. Space is available after each question to give comments.***

Why have you been invited to participate?

You are working in the hospitals where the research is undertaken.

What will your responsibilities be?

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

Will you benefit from taking part in this research?

Deficiencies in nursing practices will be identified to establish a plan of action, which would enable nursing staff to assure patients of quality nursing care.

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

No risks are foreseen.

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

You have the right to withdraw without any disadvantage.

Who will have access to your medical records?

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

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

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

You will receive a copy of this information and consent form for your own records.

Declaration by participant

By signing below, I ..... agree to take part in a research study entitled: **Investigating the challenges of delivering basic quality patient care in selected Gauteng government hospitals.**

I declare that:

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

Signed at (*place*) ..... on (*date*) ..... 2017.

Signature of participant:_____

Signature of witness:_____

Declaration by investigator I ***Mrs Michelle du Toit*** declare that:

· I explained the information in this document to .....

· I encouraged him/her to ask questions and took adequate time to answer them.

· I am satisfied that he/she adequately understands all aspects of the research, as discussed above

· I did/did not use an interpreter. (*If an interpreter is used then the interpreter must sign the declaration below.*

Signed at (*place*) ..... On (*date*) .....2017.

Signature of investigator:_____

Signature of witness:_____

Declaration by interpreter

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

· I assisted the investigator (*name*) ..... to explain the information in this document to (*name of participant*) ..... Using the language medium of Afrikaans/English.

· We encouraged him/her to ask questions and took adequate time to answer them.

· I conveyed a factually correct version of what was related to me.

· I am satisfied that the participant fully understands the content of this informed consent document and has had all his/her question satisfactorily answered.

Signed at (*place*) ..... On (*date*) ..... 2017.

Signature of interpreter:_____

Signature of witness:_____

Source: Eygelaar (2009)

APPENDIX C

- Application for ethical clearance –

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT

Governance
North-West University
Private Bag X6001, Potchefstroom
South Africa 2520
Prof CJ Botha
Tel: (018) 299 1672
Email: christoff.botha@nwu.ac.za

25 April 2017

12624578
DU TOIT MJ MS

ETHICAL CLEARANCE

This letter serves to confirm that the research project of **DU TOIT MJ** has undergone ethical review. The proposal was presented at a Faculty Research Meeting and accepted. The Faculty Research Meeting assigned the project number **EMSPBS16/06/03-01/19.** This acceptance deems the proposed research as being of minimal risk, granted that all requirements of anonymity, confidentiality and informed consent are met. This letter should form part or your dissertation manuscript submitted for examination purposes.

Yours sincerely

Prof CJ Botha

Manager: Research - NWU Potchefstroom Business School

Original details: Wilma Pretorius(12090298) C:\Documents and Settings\Administrator\My Documents\Briewe MBA\2017\