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Nurses' perceptions of performance management development system implementation in Mafikeng sub-district clinics

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Dissertation submitted in partial fulfilment of the requirements for the degree *Master of Nursing Science* at the North-West University

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Graduation ceremony April 2019

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ACKNOWLEDGEMENTS

I sincerely thank the following people and institutions for making this study a success:

The Holy Trinity, God, the father, the son, Jesus Christ and Holy Spirit, had it not because of Him, I would not be where I am, and I would not have what I have. He planned my life before I was born and His plans prosper me and give me peace and this is what I found in studying for my Master's in Nursing Science.

I thank my parents Mr and Mrs Seane for their support, prayers and encouragement, especially understanding my unavailability for them because of school work.

I thank my late paternal and maternal grandmothers who always believed in education and encouraged me to study further.

I am grateful to my siblings, Lebogang Seane, and Morekolodi and Tsaone Seane for believing in me and all the support.

I thank my spiritual parents, Pastor Bothepa and Prophet David Morgets who always believed in me, that I could always be better than I was in terms of education.

I thank my supervisor, Professor Hunadi Rakhudu for her consistent support, for being available and accessible to me whenever I needed her. From the motivational messages and research support, I learnt a lot.

I also thank my co-supervisor, Dr Leepile Sehularo, for support and always encouraging me to do this study, especially when I felt like I could not do it.

I am eternally thankful to my language editor, Dr Muchativugwa Liberty Hove who made this a coherent submission.

I thank all the registered nurses who participated and shared their perceptions regarding PMDS implementation and the Mafikeng sub-district management for the permission to conduct this study

I acknowledge DENOSA and NWU for funding this study.

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ABSTRACT

Background: PMDS has been adopted and implemented in Mafikeng sub-district clinics since 2003 to evaluate performance of nurses for improved quality patient care. However, the current researchers five years' experience in this sub-district is that nurses are dissatisfied with the outcome of PMDS. There is lack of knowledge, participation or involvement and less interest of nurses regarding PMDS implementation. Nurses are dissatisfied, demotivated and discouraged as they are not well informed, not appreciated and their performance is not appropriately evaluated.

Purpose: The purpose of the study was to explore and describe registered nurses' perceptions on a performance management development system (PMDS) in Mafikeng Sub-district clinics.

Methodology: A qualitative, exploratory, descriptive and contextual research design was followed in order to give "voice" to perceptions of registered nurses regarding PMDS implementation. Purposive sampling technique was utilised to identify participants who met the inclusion criteria in this study. Sample size was determined by data saturation, which was reached after eight individual semi-structured interviews with registered nurses in Mafikeng Sub-district clinics. Semi-structured individual interviews were used to gather data after approval from the research ethics committee of the North-West University, Mafikeng Sub-district, facility managers for the clinics where data was collected, as well as from registered nurses who participated. The researcher and co-coder analysed data independently and met to reach agreement on themes and sub-themes that emerged from data.

Results: Findings of this study confirmed the following themes from perceptions of registered nurses on PMDS implementation: structure, process and outcomes for PMDS implementation. From the results, registered nurses further added that there is insufficient knowledge and training on PMDS, unfamiliarity with PMDS policy and lack of resources under the theme structure. Under process theme, registered nurses outlined inadequate orientation, erratic reporting periods, paucity of information on job description and work plans, inadequate mentoring and support and unfair, fragmented reporting lines. Under the outcomes theme, they outlined job dissatisfaction and demotivation, subjective PMDS scoring, low staff morale, manager-subordinate conflict, concerns on performance bonus and disruption of service delivery.

Conclusions: PMDS is a legislated policy for all public servants in South Africa and the researcher established that in all the interviews conducted the participants did not have a positive outlook of the PMDS.

Recommendations: Nursing education needs to aim at improving competence of nurses in implementing PMDS to facilitate good performance. All policies related to performance evaluation needs to be addressed. From findings of this study, it is clear that there is a need for further research which should be conducted across all categories where PMDS is used to evaluate performance. With reference to practice: structure of PMDS, the following recommendations was made: policy review and revision, staff training and workshops on the PMDS, and resources allocation. With regard to the process for PMDS implementation: staff orientation on the policy, staff mentoring, and support and job descriptions and work plans need to be addressed. The outcomes recommendation included: oral reporting, feedback, remedial action, and staff morale.

Key words: perceptions, registered nurses, performance management development system, implementation

ACRONYMS

MEC	Member of the Executive Committee
NMMD	Ngaka Modiri Molema District
NWP	North West Province
OM	Operational Manager
PAS	Performance Appraisal System
PMDS	Performance Management Development System
RN	Registered Nurses
SA	South Africa
SANC	South African Nursing Council
WHO	World Health Organization

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CHAPTER 1: OVERVIEW OF THE STUDY

1. 1 INTRODUCTION

Performance management is a critical component of human resource management that ensures the achievement of positive health outcomes, yet it is one of the most contested and poorly understood at operational health care service level. This chapter provides an overview of the study which includes the background and rationale, problem statement, research questions, purpose, objectives, significance of the study, conceptual framework as well as a brief description of the research methodology, ethical considerations, trustworthiness and chapter outline for this study.

1.2 BACKGROUND AND RATIONALE

Globally, performance evaluation of registered nurses (RNs) is done using a performance appraisal system (PAS) that has the potential of increasing productivity significantly (Nikpeyma, 2014:15). PAS improves knowledge and skills, changing attitudes and ensuring that nurses feel appropriately recognized as valued members of the wider health system and this conceptualisation justifies the exploration of the nurses' perceptions regarding Performance Management Development System (PMDS) implementation (Nikpeyma, 2014:15). The challenges associated with the proper use of PMDS have been recognised by the WHO (World Health Organization, 2012:89). Improper implementation of PMDS has been identified as a main cause of poor patient care worldwide (WHO, 2012:88). Such improper use leads to dissatisfied nurses, confusion and demotivation and these affect nurses' performance negatively leading to poor patient care (WHO, 2012:88). The above observations necessitate the exploration of nurses' perceptions on PMDS in this setting.

Human resources for health, consisting mainly of nurses who are the most significant assets of health care systems, need to be appropriately appraised as the entire productivity lies within their ambit. As such, it is therefore important for employers to provide suitable working conditions and support the satisfaction expectations of the health care professionals (Nikpeyma, 2014:15). To avoid burnout, the employer needs to appreciate health care professional appropriately through proper PMDS, thereby ensuring good performance so as to meet the desired standards (Elarabi & Johari, 2014:14). When this appraisal system is improperly implemented, performance of nurses cannot be professionally evaluated and consequently the developmental needs of the individual in relation to an organizational goal may not be adequately identified (Elarabi & Johari, 2014:14;

Nikpeyma, 2014:15). The main purpose of evaluating performance is to enhance quality patient care, reduce costs, achieve goals and respond to challenges in an organization (Department of Health, 2010:33). This indicates that proper performance evaluation of nurses is part of good human resource management and the information above justifies the exploration of nurses' perceptions on PMDS as a part of human resources management in this context.

A study conducted in Saurashtra region of India on PAS of nurses in hospitals using a quantitative questionnaire found that nurses emphasised the need to improve this instrument's implementation so as to get sound outcomes such as good and quality performance. The study ultimately recommended that nurses ought to be involved throughout the process as this facilitates gaining their understanding and cooperation (Dave, 2014:366). Furthermore, in Asia, particularly Pakistan, nurses reported that the mismatch of nursing performance with the PAS caused conflicts and complications in the performance evaluation process and this has been a problem in the HR department that cumulatively affects their work negatively(Dave, 2014:366).This implies that nurses' perceptions have been identified as an important component for good implementation of PAS that culminates in improved performance, leading to quality patient care and enhancement of satisfaction among nurses. The study cited above used a quantitative approach whilst the current study adopts a qualitative approach to understand the meanings and interpretations that participants attach to the rules, challenges and behaviours of performance management.

In Korea, it was found that nurses confirmed that PAS was based on opinions, preferences and inaccurate information leading to bias, poor communication and this created unfavourable feelings among nurses. Again, nurses emphasised that they need to be involved in the whole evaluation process (Nikpeyma, 2014:15). In a different setting, research established that employees in a corporate firm know the process of performance management system partially and employees recommended it be done twice a year with the full involvement of both managers and employees as employees were unhappy about non transparency, bias and non-delegation of power (Makhubela *et al.,* 2016:5). This indicates that PMDS implementation is not only a concern in health care settings but also in other organisations outside health where the concerns are identical. This indicates that there is a problem with regards to PMDS implementation even in different contexts, hence this study's exploration of the perceptions of nurses in this regard.

In Japan, a quantitative study found that management of HR is essential in engendering efficient service delivery, achieving patient satisfaction and identifying the developmental needs of nurses and quality of healthcare service (Elarabi & Johari, 2014:21). In France, a quantitative study found that the application of PAS is neither always smooth nor necessarily productive. It is believed that PAS is prone to bias which shows high levels of inaccuracy and this has been consistently discredited by nurses who attribute their dissatisfaction, lack of motivation, resistance and refusal to the procedures enacted in its administration (Giangreco *et al.*, 2010:161). These concerns about the efficacy of PAS have been outlined globally and this says internationally PMDS has not been received well in health sectors, including other broader organisations globally.

In Africa, particularly Namibia, a qualitative study found that one of the factors affecting nurses' performance is improper implementation of PAS which leads to growing concerns regarding poor patient care (Soilkki *et al.*, 2014:53). Therefore, this supports the concerns identified about PMDS implementation and literature on this area. In the same setting, Awases *et al.* (2013) investigated factors affecting performance of nurses and found that lack of recognition of employees who perform well and good and the absence of formal participation by nurses in the process of AP, lack of knowledge and expertise, lack of leadership expansion are major factors (Awases *et al.*, 2013). Furthermore, Puoane (2013:62) conducted a study in Rwanda -East Africa on factors influencing job performance of nurses using mixed methods and reported that lack of performance feedback, unfair incentives and employer recognition, unclear job expectations, unfavorable work environments contribute significantly to nurses' underperformance and dissatisfaction on the job (Puoane, 2013:62). This indicates that there is a salient problem with regards PMDS implementation hence this study explores the perceptions of nurses in this regard.

In South Africa, employees working in the public sector used to receive automatic notch increment based on the number of years each one had been employed. It was assumed that if the employee has been in the specific public for the duration, they were deemed to have been performing since there was no specific policy of measuring performance (Department of Health, 2010:33). But after 1994, there was no policy because the old procedure of automatic notch increment was no longer practised as it was phased out by the new administration. Since there was no new policy in place

to replace the old policy, there was a very serious problem among public sector employees who received no performance appreciation that cumulatively generated confusion and dissatisfaction (Department of Health, 2010:33).

Therefore, health care organizations in SA have justified the need to implement PMDS since 2003 to develop and utilize their human resources for maximum quality performance and subsequent patient satisfaction (WHO, 2012:88). This reinforces the need for the exploration of the perceptions of the nurses as the backbone of health care services on performance management in the North West province. Despite the introduction of this system, quality performance has not been noted and this is identified as a health concern that has a negative impact on the kind of care rendered, patient speedy recovery, department budget and dissatisfied community members and even nurses themselves over past 10 years now (WHO, 2012:89; Achar & Nayak, 2014:9).

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In South Africa, a study by Seyama and Smith (2015:5) in a selected university revealed inadequacy in financial rewards and disparities in implementation of performance reward as well as nebulous criteria for assessment of performance. Similarly, the controversial findings were also revealed in the study by Makamu (2016:xi) which indicated ineffective PMDS of five national departments. The author also revealed lack of competencies and biasness on the part of managers and demotivation, loss of trust in the system by the employees. Performance management has been identified as a neglected imperative of accountability in South Africa (Mosoge & Pilane, 2014:3). The authors further highlighted the weaknesses in the integration of staff development in performance appraisal, and inadequate processes such as mentoring, coaching of staff for performance improvement (Mosoge & Pilane, 2014:3). The given scenario necessitated the need to explore and describe the views and perceptions of nurses at a regional level.

A study conducted in Limpopo province on factors motivating nurses to provide quality patient care using a qualitative design reported that nurses revealed non-financial and financial factors. Financial factors referred to monetary incentives and study leave as an outcome of proper PMDS implementation and non-financial incentives referred to acknowledgement and appreciation of performing employees by managers (Luhalima *et al.*, 2014:478). This study is of importance to

the current study as it emphasises non-financial and financial factors which motivate nurses in the performance of their duties.

Ochurub *et al.* (2012:6) conducted a study in Johannesburg which investigated organisational readiness for PMS implementation using a quantitative design and found out that employees were unclear about the communication of PMDS, its purpose, vision and policy framework. As a result, employees worked under unfavourable conditions such as high work load. Overall, the workers exhibited an unwillingness to take part in PMDS as this led to frustration of managers and confusion of employees since the PMDS implementation was problematic from the onset (Ochurub *et al.*, 2012:6-7). Paile (2012:64) conducted a study on PMDS in the Department of Public Service and Administration in Gauteng Province and also reported that participants regard the PMDS as a confusing, non-beneficial undertaking that does not drive the performance system because there is always bias (Paile, 2012:64). Therefore, these studies indicate employees' general view on PMDS implementation in health sectors and in other contexts. This reinforces the need to conduct the study in the North West province to explore and describe the perceptions of the registered nurses on PMDS, so that a comparative estimation could be developed with other findings.

In Pretoria, a study of perceived effectiveness of PMS was done in 2015 by Ramulumisi *et al.*(2015:517) using a quantitative design and the study reported that good management support, personal development, good personal performance, knowledge of employees regarding PMDS implementation all significantly assist in implementing the system more effectively (Ramulumisi *et al.*, 2015:517). In the same setting, du Plessis (2015:4) determined nurses' knowledge on PMDS using quantitative design and reported that respondents had limited knowledge about implementation of PMDS due to lack of training (du Plessis, 2015:4). These studies are of importance to the current study as they emphasise the importance of nurses' perceptions in PMDS implementation and what needs to be addressed and improved.

In the Free State province, it was found that rewards and the attitudes of nurses regarding PMDS play an important role towards the success of its implementation. It was reported that negative attitudes of nurses and unfair rewards ultimately lead to improper PMDS practices (Samakula-

katende *et al.*, 2013:7). This study helps in identifying contributing factors towards the success of PMDS implementation.

In NWP, where this study was conducted, Provincial Health Administration is committed to improving the lives of its communities and this mission can only be achieved through good performance reviews of nurses such that they strive to provide quality patient care which is a world health priority that has not been achieved as yet (Bezuidenhout, 2011:9). This is supported by the South African Nursing Council (SANC) statistics (2014) which show that nurse misconduct cases reported in NWP for the period July 2008 to May 2012 were high and poor nursing care is a second leading indicator in this instance (South African Nursing Council Statistics, 2014:2). This indicates that performance has significantly gone down gradually yet there is a system to evaluate performance and some undeserving nurses have been rewarded for non-performance and their kinship or closeness to those who administer the evaluation PMDS instrument.

A study conducted by Bezuidenhout (2011:102) in Dr Kenneth Kaunda District within NWP regarding guidelines on the implementation of PMDS highlighted that these have to be followed when implementing PMDS. This study outlined the guidelines to be followed when implementing PMDS that are hardly adhered to in most instances. The fact that most guidelines are flouted spurs this study so that should similar conclusions be reached, then there is a case that would need more urgent attention from decision makers and policy makers regarding implementing PMDS.

In Mafikeng, Molefe and Sehularo (2015:478) investigated nurses' perceptions on factors contributing to job dissatisfaction in public hospitals using a qualitative design and found that financial factors play a major role in the satisfaction scale of nurses and PMDS was identified as one system used to arrive at the financial incentives awarded. It was found that PMDS is not implemented fairly and therefore contributes significantly to nurses' dissatisfaction with financial incentives as these are incorrectly calibrated (Molefe & Sehularo, 2015:478). To the best of the researcher's knowledge, there is dearth of literature on studies conducted in Mafikeng sub-district clinics around PMDS implementation. The present study addresses this gap. This is the significant strength of the present study as it specifically addresses this serious concern. From the above

background, the researcher deemed it necessary to conduct this present study to give "voice" to the nurses' perceptions on PMDS implementation in Mafikeng sub-district clinics.

1.3. PROBLEM STATEMENT

PMDS has been adopted and implemented in Mafikeng sub-district clinics for the past 15 years to evaluate the performance of nurses for improved quality patient care. However, the researcher's five years' experience in this sub-district is that nurses are dissatisfied with the outcome of PMDS. There is lack of knowledge of proper implementation of PMDS, lack of participation or involvement and less interest of nurses regarding PMDS in general. These unconfirmed results suggest that nurses are dissatisfied, demotivated, confused and discouraged as they are not well informed, not well appreciated and performance is not appropriately evaluated. The researcher has anecdotal evidence that PMDS implementation is always done under pressure when reports are due for submission, in some instances overnight. In most instances, social relations of operational managers and nurses determine the PMDS results of assessment leading to nurses whose performance is underrated becoming demotivated. This is clearly evidenced by poor completion of records in the facility where the researcher noticed that previous records of other nurses are copied on the current evaluation on 3 occasions while others are justified and supported. Such unethical and unfair practices sound the alarm bell with regards the appropriate use of PMDS. Often, most nurses have a feeling that they are overburdened by their work and that their contributions are not fully appreciated, not supported by relevant skills development because PMDS failed to identify appropriate skills development. All these ultimately lead to poor nursing care.

Furthermore, at the end of every PMDS cycle, there is mounting dissatisfaction among nurses as non-performing nurses are rewarded and well appreciated while those who actually perform are left behind. Unacceptable attitudes of nurses surface as a consequence, and a high rate of unplanned leave days increases, complains of patient-waiting time increases during this time because hard working nurses are discouraged and feel that their good performance is not recognized. Frustration of operational managers due to over work during the evaluation of a high number of nurses within a short period of time is factors that cumulatively taint the PMDS implementation. Due to that improper implementation of PMDS, there is poor identification of the professional and developmental needs of nurses. Hence PMDS has been identified as confusing,

non-beneficial and not driving performance in other contexts (Nikpeyma, 2014:15). In view of the above concerns, there is a need to conduct this study with the aim of exploring and describing nurses' perceptions on PMDS implementation in Mafikeng sub-district clinics.

1.4. RESEARCH QUESTIONS

According to Creswell (2014:129), research questions frame the specific queries that ask for an exploration of the central phenomenon and these questions guide the method and data type sought to address the research problem. This study is directed by the following three research questions:

- What are nurses' perceptions on structure regarding PMDS implementation in Mafikeng sub-district clinics?
- What are nurses' perceptions on process regarding PMDS implementation in Mafikeng sub-district clinics?
- What are nurses' perceptions on outcomes regarding PMDS implementation in Mafikeng sub-district clinics?

1.5. RESEARCH PURPOSE

Creswell (2014:112) states that research purpose is a summary of an overall goal containing information about the central phenomenon explored in a study.

The purpose of this study was to explore and describe nurses' perceptions on structure, process and outcome regarding PMDS implementation in order to make recommendations that are aimed at improving PMDS implementation and enhancing quality and good performance in Mafikeng sub-district clinics.

1.6 RESEARCH OBJECTIVES

The objectives of this study were to:

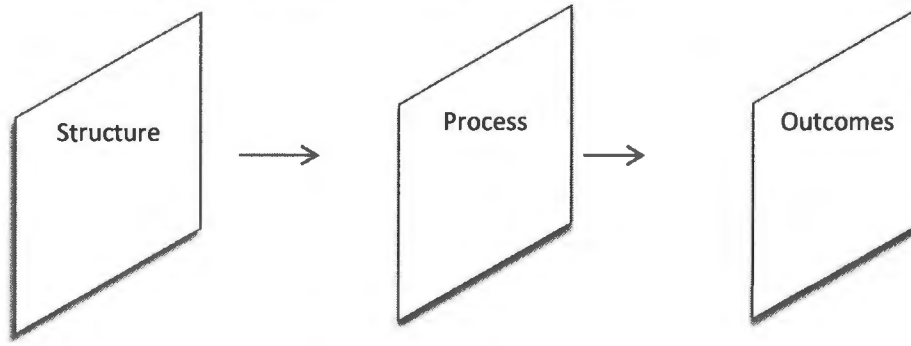
- Explore and describe nurses' perceptions on structure regarding PMDS implementation in Mafikeng sub-district clinics
- Explore and describe nurses' perceptions on process regarding PMDS implementation in Mafikeng sub-district clinics
- Explore and describe nurses' perceptions on outcomes regarding PMDS implementation in Mafikeng sub-district clinics

1.7. STUDY SIGNIFICANCE

Findings from this study could contribute positively to the new body of knowledge, practice and research. For nursing practice, the findings and recommendations of the study could strengthen the training of nurses on how best PMDS could be implemented and that might improve good implementation leading to good performance and improving satisfaction of nurses at the end of PMDS cycle. The image of the nursing and evaluation profession could be enhanced as there may be no costs out of the department budget to pay for cases of poor nursing care where these are rewarded on the unfair administration of PMDS. The recommendations could contribute to further research aiming at improving the current system and developing evidence-based practices and influence policy makers in refining a system that is currently misused in South Africa.

1.8. CONCEPTUAL FRAMEWORK

Brink *et al.* (2012:25) explain a conceptual framework as a way at which one looks at natural phenomena based on a set of study assumptions which guide one's approach to research by organizing a researcher's thinking, frames the way disciplines are viewed, structures questions that need to be posed, suggesting the criteria which the researcher could use to judge the appropriateness of a research tool to evaluate quality. In order to comprehend the phenomenon under research which aims to improve PMDS implementation in Mafikeng sub-district clinics, the researcher explored, described and contextualized nurses' perceptions on PMDS implementation in Mafikeng sub-district clinics. Therefore, the conceptual framework of nursing in this study is based on the Donabedian Model which is widely accepted as a method in designing the main dimensions of health care quality (Donabedian, 2005:651). Donabedian (2005:692) defined this conceptual framework as a measure of health care quality based on three components, namely: Structure, Process and Outcomes. These components are explained below:



1. **Structure:** The Component "Structure" is defined as the characteristics of the personnel who provide care and the settings where care is rendered. The characteristics above include:

- Personnel (nurse): level of education, training, relevant experience and applicable certification in terms of PMDS implementation.
- Policy: availability and latest or reviewed policy, staff knowledge regarding policy and their ability to apply it.
- Settings: are places where care is rendered and the constructs measured include the adequacy of the facility's staffing for proper PMDS implementation, equipment, safety devices, and overall organization in relation to PMDS implementation.

2. **Process**: Component "Process" refers to all activities happening during service delivery of care to patients. It concerns how care is rendered according to two aspects, named below:

- Technical aspect: is the relevant application of current medical science and advanced technology in an attempt to maximize equal balance between the benefits and the risks in terms of PMDS. It includes the timeliness and appropriate diagnosis of performance problems, the relevance of therapy to manage such, complications and incidents which may occur at treatment time. In this study the process refers to the activities taking place during PMDS implementation such as orientation, work plans, PMDS implementation and empowerment.
- The interpersonal aspect is linked to clinician-patient relationship and entails the rules and standards which regulate all the human interactions, to ethical standards which are specific to the health profession and to patients' expectations

3. **Outcome:** Component "Outcome" refers to the end product of care which is the quality patient care.

- Quality of patient care is evaluated in terms of outcome measurements, which seek to identify whether or not the aims of care were met. In this study it means quality and impact of PMDS as measured by improved performance in relation to the goals of the health care system.
- Indicators of final outcomes in this study include incentives, career development, emotional state of nurses and the work environment.

1.9. THEORETICAL FRAMEWORK

The focus of this study is on the nurses' perceptions on PMDS implementation in Mafikeng sub-district clinics. Therefore, the exploration and description of the nurses' perceptions on structure, process and outcome regarding PMDS implementation assisted the researcher to make recommendations aimed at improving PMDS implementation and enhancing quality and good performance in Mafikeng sub-district clinics. The findings and recommendations of the study are envisaged to assist all RN's involved in PMDS implementation to evaluate and improve their practice when evaluating performance and quality patient care in Mafikeng sub-district clinics.

1.10. CONCEPTUAL DEFINITIONS

The concepts defined in this study are Nurses, Perceptions and Performance Management Development System.

Nurse, from the Nursing Act 33 of (2005:84), means one who has a higher nursing programme qualification regulated by a professional body and has passed a national licensing exam to obtain a nursing license to practice. In this study, nurse is personnel who has a diploma or degree in a nursing programme qualification and is licensed by the SANC to practice as a registered nurse in Mafikeng sub-district clinics.

Perception is defined by Weller (2008:297) as our sensory awareness of the world which surrounds us and involves both recognition of the environmental stimuli, understanding of impression presented and actions responsive to such stimuli. Through the perceptual process, we gain knowledge on properties and elements of the environment which are critical to our survival. Thus, perceptions held by a person are the basis of how a person sees and understands a concept. In this study, perception refers to how nurses regard, understand or interpret PMDS implementation in Mafikeng sub-district clinics.

Performance Management Development System (PMDS) refers to a standardised framework for managing an employee's performance, including the policy framework and elements in a performance cycle. These include performance planning and performance agreement, monitoring of nurses, review and control, performance appraisals, moderating and management of outcomes of the appraisal (Paile, 2012: 105). In this study PMDS is a system in Mafikeng sub-district clinics

used to evaluate performance of nurses to enhance quality patient care, reduce costs, achieve goals and respond to challenges in an organization as stipulated by policy.

1.11. RESEARCH METHODOLOGY

Research methodology entails ways of obtaining, organizing, analysing data and structuring of data gathered to answer a research question (Burns & Groove, 2009:112). The research methodology of this study is briefly described below and a detailed description is given in Chapter 2.

1.11. 1 RESEARCH DESIGN

A qualitative, explorative, descriptive and contextual research design was used in this study.

Qualitative research

Qualitative research approach was utilized in this study because the researcher was concerned about gaining insight about nurses' perceptions regarding PMDS implementation in Mafikeng sub-district clinics.

Exploratory

This study is exploratory because the researcher sought to gain insight into and an understanding of nurses' perceptions on PMDS implementation in Mafikeng sub-district clinics. Information was obtained directly from the nurses in Mafikeng sub-district clinics. There were no predetermined or contrived responses as the researcher engaged practically with the nurses in order to identify and describe their perceptions.

Descriptive

A descriptive study provides intensive, accurate and relevant characteristics of a particular individual and situation where phenomenon were explored, described accurately and precisely (De Vos *et al.*, 2014:96). Therefore this study was descriptive because an element in life like perceptions of RN's are accurately described in words and narrative rather than in numbers.

Contextual

According to De Vos *et al.* (2014:96) qualitative study seeks not to generalize findings but to find new ideas in a specific setting. Therefore once registered nurses' perceptions on PMDS implementation in Mafikeng sub-district clinics have been described, it was important to contextualize the findings to Mafikeng sub-district clinics because perceptions differ from one person to another in a different context and setting.

1.11.2 STUDY SETTING

The setting for this study is Mafikeng sub-district clinics located in Ngaka-Modiri Molema district in the North West Province of South Africa. Mafikeng sub district has 18 clinics in total and only those operating 24 hours a day and 7 days a week were included because they have high number of nurses taking part in the implementation of PMDS. These clinics are 9 in total and each clinic has at least 12 registered nurses.

1.11.3 POPULATION AND SAMPLING

Population and sampling are given in the following sections.

Population

Population for this study are all nurses working in Mafikeng sub-district clinics, operating for 24 hours a day and 7 days a week, and who are registered with the South African Nursing Council to practice as such because they are deemed to have insight into the area of interest for this study.

Sampling

Sampling is a process where participants are selected as representative of the study population (Burns & Groove, 2009:129; Creswell, 2014:189). In this study sampling of participants was done by following non-probability purposive sampling technique because this study seeks to maximize the range of specific information to understand the problem. In this study participants were purposefully selected by the researcher from the knowledge that rich and quality data emerged from the chosen participants.

Sampling criteria of participants

The participants met the following sampling criteria for inclusion in this study:

- Nurses registered with South African Nursing Council (SANC)
- Nurses working in Mafikeng sub-district in 24 hours a day and 7 days a week working clinics.
- Experience on participation of PMDS implementation.
- Participants who signed consent form.
- All other nurses not meeting stated inclusion criteria were excluded

Sample size

As for the sample size of the study, data was collected until data saturation is reached to avoid repetition of information (Brink *et al.*, 2012:143).

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1.11.4 DATA COLLECTION

Data was collected using semi-structured individual interviews because they are effective and appropriate in understanding people's perceptions and these assisted the researcher to get clarification and depth in the responses (Creswell, 2014:191). An audio tape was used to record the interviews for data transcription and analysis. Field notes were also taken during and after interviews.

1.11.5 DATA ANALYSIS

Data analysis was done concurrently with data collection and Tesch's eight steps of qualitative data analysis were followed in line with the recommendations of Creswell (2014:198). Detailed descriptions of Tesch's eight steps of qualitative data analysis are explained in detail in Chapter 2.

1.11.6 ETHICAL CONSIDERATIONS

The researcher committed to ethical research in terms of research mission of North-West University (NWU). The ethical clearance and approval were received from NWU ethics committee with Reference no: NWU-0078-15-A9. Written permission from Mafikeng sub-district (Appendix C) and verbal permission was obtained from specific health clinics.

The following aspects of ethics have been considered: Interview details were not disclosed to anyone to ensure confidentiality. Names of participants remained unknown throughout data

collection and analysis to ensure anonymity. The interviews were held in a closed room to make sure that details of interviews were not heard by anyone not involved in the study and equally to ensure privacy. The researcher explained to the participants that they had a right to discontinue with the study to ensure right to withdraw from the study if any of the procedures highlighted was violated. To disseminate information, information obtained in this study, it will published in accredited journal and presented in seminars and conferences. There was a standardized consent form for all participants (Appendix D). Copy of the study research report was handed to the health care facility where the study was conducted to inform participants about research outcomes.

1.11.7 TRUSTWORTHINESS OF THE STUDY

The following four strategies were observed to ensure trustworthiness of this study: credibility, transferability, dependability and conformability. These strategies are explained in detail in Chapter 2 with support of literature and table 1.1 briefly explains their applicability in this study.

Table 1.1 Strategies to ensure trustworthiness

Strategies	Applicability
Credibility	By use of prolonged engagement before data collection and even after. The researcher made three (3) contacts with participants. Firstly to explain the project, build rapport with participants and recruit them for participation. Secondly to collect data through individual interviews and lastly to verify the information provided after transcribing the data. All participants were taken through the same question. Interviews continued until data saturation. Interviews were tape recorded and verified with participants after verbatim transcription Experts in qualitative research were consulted e.g. supervisor and co-supervisor Peer evaluation was done through the Faculty of Health Sciences and the School of Nursing Sciences compulsory post graduate seminars where the research process was presented and critiqued by other students and staff members. During these seminars students presented the research process from proposal stage to data collection and analysis. Audit trailing was used to establish the rigor of a study by providing the details of data analysis and some of the decisions that led to the findings (De Vos *et al.*, 2014:305)
Transferability	Selection of sample was purposefully Participants background was thoroughly explained Dense description of research methodology and results to provide thorough explanation for possible use by other researchers. Literature control acted as a source for making comparison in data collected (De Vos *et al.*, 2014:305)
Dependability	Dense description of research methodology and data was done. Interviews were tape recorded and transcripts made available to supervisors for audit. All the transcription, findings, interpretation and recommendations were made available for supervisors and other researchers. The document with data collected and results was given to peers for reviewing and recommendations were implemented
Conformability	Tape recorded data and field notes were used for results. Research process was carefully followed Audit trail was done in the transcribed interviews to attest to the interpretations of the researcher (Brink *et al.*, 2012:1725) Findings are products of raw data to avoid bias, this means findings explained in chapter 3 report what was shared by participants.

1.11.8. DIVISION OF CHAPTERS

This study is divided as follows:

Chapter 1: Study overview

Chapter 2: Research methodology

Chapter 3: Data analysis, results and literature control

Chapter 4: Conclusion, limitations and recommendations

1.12. CONCLUSION

This chapter offered an overview of the study which included introduction, background and rationale, problem statement, research questions, research purpose, research objectives, significance of the study, conceptual framework as well as a brief description of the research methodology followed to answer the research question of this research study. Ethical considerations, trustworthiness and division of chapters were also outlined in this chapter. Chapter 2 provides a detailed description of study research methodology.

CHAPTER 2: RESEARCH METHODOLOGY

2.1 INTRODUCTION

The previous chapter provided an overview which outlines the background and rationale of the research study, including a brief description of the research methodology. This chapter comprises detailed description of the research methodology which includes research design, study setting, population of the study, sampling, data collection, data analysis, literature control, and the detailed measures adopted to ensure trustworthiness of the study.

2.2 RESEARCH METHODOLOGY

Methodology consists of the methods used to carry out research, explaining the process and describing it comprehensively. The scope of methodology includes the context in which data collection occurs, particularly the connections and relationship between the research question and data collected (De Vos *et al.*, 2014:252). In this study, methodology points to how the research was conducted and the logical sequence followed. The main aim of this study is an exploration and description of nurses' perceptions on PMDS implementation in Mafikeng sub-district clinics.

2.2.1 RESEARCH DESIGN

Research design entails a framework which is structured to organise components of a research study in a way which is likely to give valid answers to the research questions. The design in this study indicates ways that the researcher developed to collate data that is accurate and interpretable (Creswell, 2009:85). A qualitative, exploratory, descriptive and contextual research design was used in this research study to answer research questions stated in Chapter 1.

Qualitative

Qualitative research refers to a method of research aimed at obtaining specific and even additional information about certain phenomenon studied within a particular field in a natural setting. The researcher was as a key instrument, through examining documents, observing behaviours and interviewing participants (Creswell, 2014:185). Burns and Grove (2011:356) further define qualitative research as systematic, narrative and subjective research approach used to describe lived experiences, perspectives and ascribing meanings to those experiences while trying to understand them. Often qualitative research is associated with stories, narrative information and descriptive experiences rather than statistical measurements and numerical information (Burns &

Grove 2011:356). A qualitative approach was utilized in this study because the researcher is concerned with gaining the insight and ideas of nurses' perceptions on PMDS implementation in Mafikeng sub-district clinics.

Exploratory

Exploratory design is used when the researcher explores and describes experiences and new ideas of participants that are then subsequently interpreted to enhance the understanding of these experiences and not allowing predetermined views to direct the study research (Higgs *et al*, 2009: 10). This study is exploratory in nature because the researcher sought to gain insight, in-depth understandings of perceptions of RNs on implementation of PMDS in Mafikeng sub-district clinics. Data was obtained directly in a natural setting from the nurses in Mafikeng sub-district clinics.

Descriptive

The phenomenon was explored and examined to represent the views and perspectives of participants. Each submission was configured into a theme that ultimately contributed in explaining each view accurately and precisely because views are best described in words rather than using numbers (Yin, 2011:7-8). Therefore descriptive design was used in this study to provide relevant and accurate account of the characteristics of participants as individual perceptions.

Contextual

Contextual research strategy is studied for its intrinsic and immediate contextual significance (Burns and Grove, 2011:332). Additionally, the focus is more specific to events in naturalistic settings. The naturalistic study settings are real-life situations which are uncontrolled and constitute the field study settings. The research conducted in a natural setting is enquiry in a setting free from any kind of manipulation (Burns & Grove, 2011:332). In this study, this means that once nurses' perceptions on PMDS implementation in Mafikeng sub-district clinics are explored and described, there was need to contextualize the findings to Mafikeng sub-district clinics because perceptions differ from one person to another in different contexts and settings such that the findings cannot be generalised.

2.2.2 STUDY SETTING

The study setting for this study was Mafikeng sub-district clinics. This study was conducted in Mafikeng sub-districts because it is the largest sub-district in Ngaka-Modiri Molema district and most densely populated sub-district. Again, there are no similar studies neither recorded nor conducted on nurses' perceptions on implementation of PMDS in Mafikeng sub-district clinics. Mafikeng sub district has 18 clinics in total and only those operating 24 hours and working over 7 days were included because they have high number of Registered Nurses participating in PMDS implementation. These clinics are 9 in total.

2.2.3 POPULATION AND SAMPLING

Population is defined by Burns and Groove (2009:313) as the entire group of interest for the study, which qualifies for the criteria that the researcher in interested in. Population of this study was all registered nurses working in Mafikeng sub district clinics that operate for twenty four hours a day and 7 days a week and who are registered with SANC to practice as such.

Sampling of the study

A sample is a subset of population of the study which takes part in a study (Polit & Beck, 2012:294). In this study sampling was divided into sample approach, technique, criteria and size.

Sampling approach and technique

Non-probability purposive sampling was used to maximize the range of specific information as the researcher selected participants who knew more and better about the field of interest (Brink *et al.*, 2012:139). Participants were purposefully selected by the researcher to elicit rich and quality data.

Sampling criteria

Sampling criteria are the characteristics which are essential to membership in a population (Burns & Grove 2011:313). The study sample criteria are characteristics which delimit the study population of interest and the researcher used her own judgment to choose participants who are knowledgeable of the question at hand (Burns & Grove 2011:313). The participants met the following sampling criteria for inclusion in this qualitative study:

- Nurses registered with SANC

- Permanent nurses working in Mafikeng sub-district in 24 hours a day and 7 days a week working clinics.
- Experience on participation of PMDS implementation.
- Nurses who signed voluntary consent forms
- All other nurses not meeting stated inclusion criteria were excluded

Recruitment process

This process started when the researcher requested a permission to conduct study from Mafikeng sub-district (Health) to the facility managers in the clinics included in study setting and then purposefully identified nurses meeting inclusion criteria and requested their participation in the study after explaining what is the topic of the study, why is it done, benefits/importance of the study, objectives of the study. The process was then explained to those interested to participate, prolonged contact or meeting more often was then established to build trust and provided them with interview guide (appendix E) as well as consent form (Appendix D) to make an informed decision. Their rights were clearly explained as outlined under ethical consideration 2.2.7.

Sampling size

The sample size of the study was determined by saturation of data. Data saturation means the time at which additional sampling yields no new information pertaining to the research questions (LoBiondo-Wood & Haber, 2010:236). De Vos *et al.* (2014:391) further say sample size depends on what needs to be known and whether the purpose of inquiry has been met. Thus, in this study the sampling method depended upon the quality of information obtained from the study sample. In each clinic, one registered nurse was interviewed and data saturation was reached on the eighth clinic and eighth nurse.

2.2.4 DATA COLLECTION

Data collection is a precise, systematic gathering of information that is relevant to the study question, using procedures such as interviews, participant observation, focus group discussion, and narrative stories and finding cases of history (Polit & Beck, 2012:294). Semi-structured individual interviews were used to gather data because they allow free flow of information sharing. Data is

not limited by strictly focused questions but the interviews were kept focused. Interviews were conducted as normal conversations but with a purpose of clarifying the research questions.

Furthermore, Creswell (2014:191) states that interviews are important in gathering data where participants can be directly observed. Participants are able to narrate previous incidents and experiences and allow the researcher to control the line of questioning. In this study, semi-structured individual interviews were used because they are effective in exploring nurses' perceptions and allowed the researcher to get clearer information on responses. Field notes were taken during the semi-structured individual interviews. The interviews were tape recorded to ascertain accuracy and then transcribed for data analysis. Verbatim transcription and this was coded and categorised under themes in the data analysis.

Preparation for interviews and instrumentation

The researcher had a semi-structured interview tool to gather data after careful consideration of alternatives. A tape recorder was used as a reliable instrument in capturing raw and reliable data for transcription and data analysis purposes. The data was collected in the same manner using one semi-structured interview tool. Interviews were conducted in a separate room that was quiet and conducive for data collection purposes. The researcher clarified the topic and purpose of the research study was discussed to establish good relationship, understanding, obtain consent to participate in a study and permission to record interviews. Field notes were taken during and immediately after data collection.

Role of the researcher

Before data was collected, the researcher obtained written ethical approval from the research ethics committee of North-West University (Reference no: NWU-0078-15-A9) (Appendix B) and from sub-district manager (Appendix C).

All the participants signed a written informed consent voluntarily after topic, study purpose, objectives, study questions and process of data collection were explained to them (proof of informed consent in Appendix D).

The interviews was conducted in each clinic and the chosen room was organised a day before as agreed with participants and the time was convenient for both the researcher and participants (Brink *et al.*, 2012:159). The participants' right to withdraw from the research study at any time was clearly explained to participant.

Interview process

All the participants in the study signed the consent forms and they were asked three main research questions as they are also interview schedule which are:

- What are your perceptions on structure regarding PMDS implementation in Mafikeng sub-district clinics?
- What are your perceptions on process regarding PMDS implementation in Mafikeng sub-district clinics?
- What are your perceptions on outcomes regarding PMDS implementation in Mafikeng sub-district clinics?

The researcher used the following communication skills to get more information as explained by De Vos *et al.* (2014:345 & 349):

- Probe: when response lacked sufficient detail or clarity the researcher offered further explanation and examples so as to make meaning clear;
- Reflection: the researcher availed the shared perceptions on PMDS implementation throughout the interviews to confirm;
- Nodding: the researcher confirmed with the head to reflect on the shared perceptions during data collection;
- Paraphrasing: the researcher restated texts of perceptions just shared by giving the meaning in another form to ensure that there was common understanding between researcher and participant;
- Questioning: the researcher indicated intellectual curiosity by extending to related issues in the process of sharing perception on PMDS implementation;
- Interpreting: the researcher extrapolated thematic meanings out of shared perceptions;
- Clarification: the researcher repeated what the participant shared just to confirm perceptions shared;

- Eye contact was maintained to ensure and encourage participants to talk more and respond further, until no new themes emerged;
- Informing: the researcher clarified vague questions and offered conducive pointers to guide the response; and
- Summarizing: the researcher summed up the main facts of every interview concisely just to confirm facts.

2.2.5 DATA ANALYSIS METHOD

Data collection and data analysis were conducted concurrently. Data collection and analysis are processes that mutually depend on one another therefore they are interdependent processes (Creswell, 2014:195). In this study, the data analysis was carried out after verbatim transcription of the interviews which were audio taped. Tesch's 8 steps of qualitative data analysis were followed to analyse data (Creswell, 2014:198). These 8 steps of qualitative data analysis are as follows:

1. The researcher made sense of the whole transcripts by reading it all.
2. The researcher identified the shortest and the most interesting transcript with the most apt information to get an understanding of the underlying meanings.
3. In completing this task for several study participants, the researcher listed all topics down. Similar topics were clustered together and columns were drawn for the most unique topics. This list was compared with codes documented next to the segment of each text. The researcher then cited the preliminary organization to identify any new categories and themes.
4. The themes were turned into categories.
5. More familiar topics were grouped together, the themes were reduced and lines drawn between sub-themes to show interrelationships.
6. A finalised decision was taken on the abbreviation for each theme.
7. The data material belonging to each theme were grouped together to allow for preliminary analysis and to arrange themes in order of priority and not by alphabetical order, for logical coherence.
8. The themes were referred back to the original raw data to check whether any information was left out that should be part of the themes.

2.2.6. TRUSTWORTHINESS

Trustworthiness is the establishment of truthfulness in qualitative research. Brink *et al.* (2012:171) describe trustworthiness as the measure of confidence in data. This study is trustworthy because it accurately presents perceptions of the nurses on implementation of PMDS in Mafikeng sub-district clinics. The following four strategies of trustworthiness as explained by Polit and Beck (2012:769) and De Vos *et al.* (2014:405) were observed, namely credibility, transferability, dependability and conformability. These qualities are explained below.

Credibility

Credibility is defined as the confidence in the truth of data and its interpretation (Pilot & Beck, 2012:539). To ensure that the study is carried out in a way that enhances truthfulness and believability, the researcher spent time with study participants to explain the purpose of the study as well as to build rapport. All participants who voluntarily took part were taken through the same research questions. The participants were interviewed by this researcher until data saturation was reached. To keep original raw data, interviews were tape-recorded and then transcribed. The researcher took effort of going back to participants to ensure that the transcribed data was truthful information of their perceptions.

Dependability

Dependability is explained as the consistency and stability of study data and findings (Jooste, 2013:322). In this study, a dense description of the research methodology was followed to carry out the study, including the study data. Data was organized into themes and sub-themes (Chapter 3). All interview instruments, transcribed interviews, interview documents, study findings, research interpretations and recommendations were made available and accessible to the supervisors and other researchers, for the aim of carrying out an audit trail should a need arise. The supervisor and the co-supervisor participated in debriefing and peer review.

Confirmability

Confirmability is a criterion where data quality is evaluated and implies objectivity of the data, confirmed by two or more different individuals (Polit & Beck, 2012:539). This criterion has been

ensured by raw data from tape records and field notes compiled. The researcher carefully followed research processes of design, sampling, data collection and analysis. The supervisor and co-supervisor conducted an audit trail of verbatim scripts, themes and sub-themes. An independent qualitative co-coder was appointed to help in analysis of data. After the researcher and the co-coder were done with data analysis independently, a meeting was scheduled to confirm themes and sub-themes. The themes and sub-themes were referred back to the participants to check accuracy and a correction reflection of their perceptions was done in order to ensure credibility of findings. The consensus was then reached that themes and sub-themes described were their perceptions and these are fully described in Chapter 3 of this study.

Transferability

Transferability is explained as the extent at which the findings can be used in other contexts with different participants (Creswell, 2009:190). This report provides a dense description of the research methodology, the participants' background, detailed description of data in a specified context and reported the findings with sufficient details to allow researchers interested in a transfer of findings to make a conclusion about whether such transfer can be done or not. A literature control was done to identify both convergent and divergent findings in different sites.

2.2.7. ETHICAL CONSIDERATIONS

Ethical considerations observed in the study are given in the following sections:

Ethical clearance

The researcher was committed to ethical research in terms of the research mission of the North-West University (NWU). Codes of conduct and ethics that are supported by North-West University were adhered to and ethical clearance has been received from NWU ethics committee (Reference no: NWU-0078-15-A9; Appendix B). Written permission from Mafikeng sub-district (Appendix C) and verbal permission was obtained from specific health clinics.

- **Participant's rights**

The following participant's rights were considered in this study on nurses' perceptions regarding implementation of PMDS in Mafikeng sub-district clinics:

Informed Consent

Voluntary informed consent is a prerequisite for a subject's participation in research. Participation that is voluntary and based on sufficient information requires an adequate understanding of the purpose, methods, demands, risks and potential benefits of the research. The process of communicating information to participants and seeking their consent was not merely a matter of satisfying a formal requirement (Polit & Beck, 2012:297).The aim was mutual understanding between researchers and participants. This created an opportunity for participants to ask questions and discuss the information and their decisions with others.

There was a standardized consent form for all participants and this was signed before collection of data (Appendix D).

Confidentiality and anonymity

De Vos *et al.* (2014:423) explain that confidentiality indicates that no information that the study participants share is in the public domain. The anonymity of participants was protected by making it difficult to link information in data to a specific individual or institution by not using their names and not stating clinic by names. Confidentiality and anonymity were ensured by using pseudonyms and alphabetic letter codes instead of actual names in the final report (Polit & Beck, 2012:297).In this study no participants' names attached to the information gathered are used. The co-coder understood that this information is not allowed to be shared with anyone else not consent in this study like supervisors and the researcher as transcriber made sure that was clearly understood by co-coder.

Privacy

According to De Vos *et al* (2014:423), privacy defines the agreements between individuals who limit access to secretive data and information is not divulged unless the participants give permission to that in writing. In this study, privacy has been maintained by not stating participants' real names during the interviews. Interviews were held in a private area to ensure that details of interviews were strictly confidential. Participants were informed that findings of this research study would be published in article form and in the form of a dissertation and presented at local, national and international conferences but without disclosing their real names.

Justice

Justice is explained by Jooste (2013:24) as the ability of the researcher to avoid discrimination and treat all participants equally. In this study, justice was ensured by not discriminating participants according to their perceptions. The researcher treated all participants equally irrespective of their gender, qualifications and perceptions.

Principle of beneficence and non-maleficence

This is the act of the researcher being helpful, supporting and protecting participants against harm as they voiced out their perceptions (Jooste, 2013:24). The researcher avoided all harm to the participants and gave them a platform to voice out their perceptions. Respect of human dignity was ensured by not making fun out of their perception. The researcher did not include the clinic where she is working to prevent influence from researcher to subordinates.

Principle of liberty

Principle of liberty means freedom to take participants' own decisions in a manner they wish (Jooste, 2013:23). It was made clear to the participants that they could withdraw from the study at any stage if they wished to do so. This right was clearly explained to all the participants.

Dissemination of information

The results of this study are disseminated in the form of a research report, article and at local, national and international conferences. It is the researcher's belief that the report should urge readers who study it to determine the feasibility for implementation. Participants were told that a copy of the findings was deposited at the sub-district office as well as to the health care clinic where the study was carried out.

2.2.8. CONCLUSION

A detailed description of research methodology undertaken in this study was provided. The next chapter deals with data analysis, results and literature control on the perceptions of nurses regarding PMDS implementation in Mafikeng sub-district clinics.

CHAPTER 3: DATA ANALYSIS, RESULTS AND LITERATURE CONTROL

3.1 INTRODUCTION

The previous chapter provided a detailed description of the research methodology followed in this study. This chapter provides demographic data of participants, data collection procedures, analysis, results and literature control. The principal objective of the study was to explore and describe nurses' perceptions concerning PMDS implementation in Mafikeng sub-district clinics. Four main themes which emerged from the data collected are annotated.

3.2 OBJECTIVES

The objectives of this chapter are to:

3.2.1 Present results of the study;

3.2.2 Categorise the results into themes and sub-themes;

3.2.3 Control the results with literature.

3.3 DEMOGRAPHIC DATA

Participant A- interview 1

Participant A was a 44 year-old black female registered nurse who has been working in this clinic for 9 years. She started working as a community service nurse and then was absorbed into the system thereafter. She worked in another clinic before joining the current clinic as an auxiliary nurse for 2 years. She is qualified as a nursing assistant, auxiliary nurse and she has a diploma in nursing science. She has 9 years of experience in PMDS implementation.

Participant B- interview 2

Participant B was a 49 year-old black female registered nurse who has been working in this clinic for 12 years. She started working as a community service nurse and then was absorbed into the system thereafter. She has a degree in Nursing Science, a diploma in nursing administration, and a diploma in primary health care. She has 9 years of experience in PMDS implementation.

Participant C- interview 3

Participant C was a 33 year-old black female registered nurse who has been working in this clinic for 13 years. She started working in this clinic as a transfer another district. Her qualifications

include a degree in Nursing Science, a diploma in primary health care. She has 15 years of experience in PMDS implementation.

Participant D- interview 4

Participant D was a 47 year-old black male registered nurse who has been working in this clinic for 14 years. He started working as an auxiliary nurse for one year and was sent to study for a diploma in nursing and then got absorbed into the system on completion as a registered nurse. His qualifications include a diploma in nursing science and primary health care. He has 10 years of experience in PMDS implementation.

Participant E- interview 5

Participant E was a 42 year-old black female registered nurse who has been working in this clinic for 14 years. She started working as a community service nurse and then was absorbed into the system thereafter. Her qualifications include a diploma in nursing science, primary health care and nursing management. She has 14 years of experience in PMDS implementation.

Participant F- interview 6

Participant F was a 39 year-old black female registered nurse who has been working in this clinic for 15 years. She started working in this clinic as a transfer from another clinic where she worked for 4 years. She is a qualified nursing assistant and auxiliary nurse. She currently holds a diploma in nursing science. She has 9 years of experience in PMDS implementation.

Participant G-interview 7

Participant G was a 33 year-old black female registered nurse who has been working in this clinic for 9 years. She started working as a community service nurse and then was absorbed into the system thereafter. She worked in another clinic before coming to this clinic as an auxiliary nurse for 2 years. Participant G is a qualified nursing assistant and auxiliary nurse. She also has a diploma in nursing science. She has 9 years of experience in PMDS implementation.

Participant H-participant 8

Participant H was a 35 year-old black male registered nurse who has been working in this clinic for 11 years. He started working as a community service nurse and then was absorbed into the system thereafter. He has a diploma in nursing science. He has 11 years of experience in PMDS implementation.

3.4 DATA COLLECTION AND ANALYSIS

As discussed in Chapter 1 and 2, semi-structured individual interviews were used to collect data on perceptions of nurses regarding PMDS implementation in Mafikeng sub-district clinics. When data was collected through semi-structured individual interviews, an audiotape recorder was also used to record the perceptions of nurses regarding PMDS implementation in Mafikeng sub-district clinics. The recordings were then transcribed verbatim for data analysis. These transcribed interviews are provided in Appendix G and field notes were annotated in each interview. All the participants signed a written informed consent as proof of voluntary permission to participate in the research interview.

The interviews were conducted in a clinic office to avoid disturbance and the room was conducive enough for the interviews. All the staff members were informed about these interviews where the study topic and purpose were explained again to the participants.

Data saturation was reached after interviewing eight (8) participants from 8 clinics so there was no need to further interviews to the 9th participant. Of the eight participants, five were female and three were male. The participants' ages ranged from 33 to 49. Their experience concerning the implementation of PMDS varied between 9 and 16 years. Relating to their experience with the implementation of the PMDS two had 9 years, one had 10 years, two had 12 years, and the remaining two had 14 and 15 years' experience respectively. All the participants at the time of the interviews were registered nurses.

Data analysis was done concurrently with collection and Tesch's eight steps of qualitative data analysis were followed according to Creswell (2014:198). Detailed description of Tesch's eight steps of qualitative data analysis was given in Chapter 2. After the researcher collected and

analysed data independently there was a meeting with a co-coder after doing his analysis to confirm the themes and sub-themes that arose from the data collected. Detailed description of these themes and sub-themes is provided in 3.5.1.

3.5 RESEARCH FINDINGS AND LITERATURE CONTROL

The following themes emerged from the data collected:

- Perceptions on structure,
- Perceptions on process,
- Perceptions of outcomes.

Table 3.1.The table below depicts the themes and sub-themes that emerged from the interviews

Theme	Subthemes
• Theme 1:Perceptions nurses on structure of PMDS implementation	1. Insufficient knowledge and training on PMDS 2. Unfamiliar with PMDS policy 3. Lack of resources
• Theme 2: Perceptions of nurses on process of PMDS implementation	1. Minimal orientation on PMDS 2. Erratic reporting periods 3. Job description and work plans 4. Mentoring and support 5. Unfair, fragmented reporting lines
• Theme 3: Perceptions of nurses on outcomes of PMDS implementation	1. Job dissatisfaction and demotivation 2. Subjective scoring 3. Low staff morale 4. Manager-subordinate conflicts 5. Concerns on performance bonus 6. Disruption of service delivery

3.5.1 MAIN THEMES AND THE SUB-THEMES FROM THE INTERVIEWS

3.5.1.1 THEME 1: PERCEPTIONS OF NURSES ON STRUCTURE OF PMDS IMPLEMENTATION

The first theme sets the tone for participants' understanding of the structure of PMDS. The participants were asked to share their perspectives regarding the structure of the PMDS. Across all the eight interviews, the participants expressed similar views regarding the structure of the PMDS. The following sub-themes emerged: Insufficient knowledge and training on PMDS of personnel regarding implementation of PMDS, unfamiliar with PMDS policy and lack of resources. These sub-themes are explained below.

Sub-theme 1: Insufficient knowledge and training on PMDS

The participants in the study linked insufficient knowledge and training as one of the structural problems impeding the successful implementation of the PMDS. Participants further reported insufficient understanding and knowledge of the PMDS as a structural problem. Most participants expressed that they have not been thoroughly engaged on how to properly implement PMDS. They further expressed that they often find that they are tasked with evaluating nurses or being evaluated by their superiors without any proper training on what is expected of them regarding PMDS.

They have further articulated that as staff they rely on what fellow colleagues tell them about what is expected of them during the PMDS reporting period. They indicated that most of the staff do not understand how the PMDS works and what is expected from them. They also expressed that in some instances, both the assessed and the assessors are not informed about what is expected of them during the PMDS. They raised concerns that when workshops on PMDS are held, only a selected few get the opportunity to attend, leaving many of them in the dark in terms of expectations since feedback from workshops is never done. They further articulated that it would be beneficial if all staff were trained on PMDS. Some of the participants said:

"My view is that staff needs to have enough knowledge regarding PMDS. But what I'm witnessing is that staff doesn't have enough knowledge about PMDS. (Participant C).
"When you are employed or when you are being assessed, they don't explain in full anything regarding what is in it. You will only see by the time when they give you all the documents that you have to do this and that" (Participant B).
Nurses get to hear about PMDS by the date when submissions are to be made. We are not told in time what PMDS is, and what is expected of us. We are just told to write and submit but we are not trained on PMDS (participant E).

These results are compatible with the findings from Soilkki *et al.* (2014:61) whose mixed-methods study confirmed that one of factors causing nurses not be involved or not taking part in performance appraisals is because of insufficient training on performance appraisal and in such instances the nurses end up with low motivation to participate (Soilkki *et al.*, 2014:61). Additionally Nagah and El-Shanawany (2016:132) explored hospital management support on performance appraisal and found that participants indicated that the nurse manager`s knowledge of the performance appraisal instrument was limited and therefore they are not trained; managers neglect the development in PA and cumulatively these lead to demotivation in knowing more (Nagah& El-Shanawany, 2016:132).

Sub-theme 2: Unfamiliar with the PMDS Policy

All the participants have shared that although the policy is being implemented in the facilities, they do not have comprehensive understanding of what it entails. Most expressed that they have not seen the actual policy document on PMDS. They hear that it exists, with some managers reporting that they "have it or have seen it". Some indicated that at their facility they have adopted and copied the PMDS policy document from another facility. The participants cited that some managers do not know anything about the policy and yet they are expected to implement it. Overall, the participants view it as problematic because there is often a lack of decisiveness and direction on its implementation. They indicated that currently a lot of systems are set in place and policy documents and legislature supporting and advocating for its implementation have been approved. This is often not filtered at the clinic level where it is being directly implemented. The participants

reported that they have not physically seen or witnessed a copy of the policy document. Participants submitted the following verbatim perceptions:

I've never seen any policy in my facility. But I think somewhere by the offices there is one policy, we can't just be forced to do this without policy (Participant C).
"I have heard that there is a PMDS policy but I haven't seen it (Participant G).
We have policies but the managers don't mentor personnel, we don't know how to go about it because policy and our managers must be directing us but it's not the case (Participant E).

These perceptions are similar to the findings from the quantitative study by du Plessis (2015:7) which found that participants have limited knowledge about the legislative framework governing the implementation of the PMDS. Participants articulated that they only heard of policy but never trained on its use (du Plessis, 2015:7). This is in contrast with what Yadav and Dabhade (2013:67) established about participants having complete understanding about performance appraisal policy but totally not impressed about its financial ramifications which remain non-transparent to employees (Yadav & Dabhade, 2013:67).

Sub-theme 3: Lack of resources

The participants also pointed out the lack and at times inadequacy of resources. In particular insufficient resources came out strongly as one of the impediments in the structure of the PMDS. With regards the lack of resources, across all the interviews conducted the participants isolated four resources specifically: computers, printers, time and stationery. They expressed that once the PMDS assessment has been conducted they are expected to compile a report. They do not have sufficient resources to enable them to produce the required reports such as computers for typing the reports and paper for printing. They have also submitted that they do not have efficient printing facilities, that in some cases the PIN for the computer and printer is with the clerk and they are unable to access such enabling facilities as a consequence.

The lack of computers and working stations also makes it difficult for them to compile the reports on time. As a result, they sometimes have to work on the reports after hours at home where some do not have personal computer access, forcing them to pay for such services at internet cafés. They further articulated that lack of these resources is a huge challenge, particularly during the reporting period and impacts on their focus to attend to serious matters such as patient care. They find themselves preoccupied with compiling the report and paying less attention to the patients. The issue of computer literacy came out strongly as most of the participants are computer illiterate. As a result they sometimes request the clerk(s) to type the report for them. This is a concern as they regard PMDS as a confidential document and feel that some clerks do not maintain the privacy and instead discuss the contents of the report with fellow colleagues. Participants hinted at the following salient points:

There is no space to sit and time to write the reports at work (Participant A).
"There are not enough computers, we use only one to do all the PMDS reports or internet café" (Participant C).
Nurses are not computer literate, yet expected to use it in writing their reports (Participant A).

In contrast, a study by Soilkki *et al.* (2014:63) found that the lack of equipment and resources impacted on the nurses in caring out their duties rather than on PMDS implementation. Nurses further expressed lack of some critical medical equipment and resources impacting upon them doing their work efficiently and as result, patient care is compromised. In disagreement to this study, Luhalima *et al.* (2014:483) talked about factors motivating nurses using mixed methods and reported that adequate technical support to nurses affects how they write their performance reports thus the higher management are unable to recognise the good work if the immediate supervisor failed to do so (Luhalima *et al.*, 2014:483).

3.5.1.2 THEME 2: PERCEPTION OF NURSES ON THE PROCESS OF PMDS IMPLEMENTATION

Across all the interviews, participants reported process challenges on the implementation of the PMDS. They specifically cited the following reasons; minimal orientation on PMDS, erratic reporting periods, job descriptions and work plans, mentoring and support , unfair, fragmented reporting lines. These sub-themes are explained below:

Sub-theme 1: Minimal orientation on PMDS

The participants expressed that they are not oriented on the process of PMDS. Even the new nursing personnel is not informed, they get to only learn about it when they have to compile a report. Respondents also indicated that there was no proper explanation regarding expected outcomes and necessary procedures projected. The absence of formal orientation and explanation on PMDS impacts on the performance of the nurses because the appraisal instrument clearly states the key performance areas of each individual and they will understand what average performance, under performance and over performance convey. This is a reason why they end up becoming less interested in the process and just submitting the report as a necessity. Participants said:

"Nurses that are new in the facility are not orientated concerning PMDS" (Participant E).
"Orientation on PMDS is not fully implemented upon the staff" (Participant B).
"In terms of process, we are not oriented and there are no explanations on many things. We are given PMDS reports to compile and there are no proper explanations regarding what is expected" (Participant H).

These submissions from the participants all confirm what Ramulumisi *et al.* (2015:539) found, specifically the fact that personal development before actual employment commences is essential to inform new employees of policies which will be used to evaluate their performance. Additionally Du-Plessis (2015:6) used qualitative study descriptively and stated that educational initiative before employment is important as it plays a major role in the productivity of employees and when signing any contract they know exactly what are they contracting themselves to perform (du Plessis, 2015:6).

Sub-theme 2: Erratic reporting periods

The participants described the process of PMDS implementation as distorted and flawed. They indicated that they do not have sufficient time to complete the PA during working hours and have to complete the process at home. They feel that PA is an added burden extending beyond normal working times and that they do not get paid for undertaking this chore. There is no consistent and specific reporting format and period. Although it has to be conducted on a quarterly basis, in most cases it is conducted on an annual basis. This places a lot of pressure on staff as at the end of the year they are expected to compile all four reports. The participants also expressed that when the reporting period commences, hardly sufficient time is allocated to compile and complete the report. This leads them to sometimes provide compromised responses engendered by reporting false outputs. Participants said:

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"We are expected to do PMDS after hours, which mean that it is overtime but we are not paid for it" (Participant G).
There is not enough time to write the report; some people omit some things they should have written (Participant E).
"We have four quarters in a year, and all four are done all at once in a year. That is why the person doing the reports will do them for a long time, spend the whole night; because all the work is done once a year" (Participant A).

These findings are different from what Tesfaye *et al.* (2015:7) found in their study. They reported that most of the nurses in their study confirmed that the process of performance review was done informally. However, they reported consistent discussions with their manager concerning past performance and agreed on the future action that needs to be taken in rectifying issues identified during the PA (Tesfaye *et al.*, 2015:8). In addition, they found that a quarter of participants in their study felt that the feedback from performance appraisal was not used because always there is not enough time to reflexively look back (Tesfaye *et al.*, 2015:8). In contrast Nikpeyma (2014:21) qualitatively described that there are long intervals between evaluation which leads to weaknesses or under performance becoming routine chores instead of these getting intercepted and rectified on time (Nikpeyma, 2014:21).

Sub-theme 3: Job descriptions and work plans

The participants reported that they do not have comprehensive job descriptions and work plans. As a result, they often do not know what is actually expected of them. In some facilities, they have to be all-rounder's do administrative and dispensary duties when there is no clerical and pharmacy staff delegated to execute these responsibilities. This frustrates the PMDS reporting process as without the aforementioned they cannot do their review. Moreover, they cannot report on other duties such as administration work because this is specifically not in line with their job specifications. The participants also shared their frustrations concerning their work plans: they only get their work plans when the reporting period approaches. Those who received work plans expressed their discomfort concerning the limited period they are given to engage the work plan. It is made available for them just to sign and return to their manager, as a result, they do not know what it contains as they just briefly browse through it. The submissions below sum up their frustrations:

"Job description ...they appear by the time of PMDS submission" (Participant H).
"Job descriptions should be given in the beginning so that we know where to go and what is expected of us" (Participant F).
"There are many non-nursing duties that we are expected to do and if we don't it becomes a problem. When we add those duties on our PMDS reports we are told we can't add them because it's not part of our duties. No orientation, there are work plans and job descriptions" (Participant E).

Similarly, Vasset *et al.* (2011:10) found the association between performance management and job description and work plan to be weak since nurses who are clueless of such will never perform as expected. Their findings suggest that when the process is efficiently conducted, disclosing what is expected of them and feedback is used to improve the performance of the workers and this ultimately leads to motivation for staff to carry out their duties efficiently (Vasset *et al.*, 2011:10).

Sub-theme 4: Mentoring and support

Some of the participants reported that there is no mentorship available to support them when they implement the PMDS. There is no one to guide staff in the process of self-evaluation, and as a result nursing staff do not know what to do and what is expected of them in the self-evaluation. They also reported that there is no continuous supervision to support subordinates during the evaluation process. They feel less empowered because the manager is only available during the reporting period, and there is less engagement between the supervisor and their subordinate during the year. Report writing of the PMDS in some facilities is compiled once by the manager because the staff are not empowered and equipped to compile the report. Findings from the study revealed lack of support and mentorship on the PMDS implementation process as a major concern. Managers who are sometimes well-versed in the process do not support the junior staff members in preparing them for the PMDS reports. As a result, nurses are not aware of the monitoring periods for the PMDS. Participants mentioned the following:

"The supervisor mentoring doesn't happen and I think that is the reason why most personnel can't do a self-evaluation and there is no continuous evaluation by supervisor" (Participant E).
"In my view, the process is not done properly because the facility manager doesn't empower us regarding PMDS" (Participant C).
"I believe that if our supervisor does not mentor us, it would be better. Mentoring would allow us to know our weaknesses and offer us an opportunity to make corrections" (Participant F).

du Plessis (2015:9), in her study, found that the majority of the participants were not clear about the monitoring process and how often it should be happening. She also found that participants did not have sufficient knowledge concerning the purpose of monitoring. Ramulumisi *et al.* (2015:540) confirms that management support is not good as expected hence the unpalatable situation of having less motivated health professionals (Ramulumisi *et al.*, 2015:540).

Sub-theme 5: Unfair, Fragmented reporting lines

The participants indicated that distorted reporting lines frustrate the process implementation of the PMDS. Often the evaluation is conducted by a supervisor who is working in another shift, who is incapable of reporting on the performance of that particular staff member. These results affect rating scores in a very bad way and make it difficult to complete fair and truthful performance evaluation. Participants verbalised that the following:

"The other challenge is that we are allocated to present staff that we don't work with in the same shift, since this is a 24 hour facility. This means that I will forge the scores because I haven't worked with the person (Participant C).
"I feel that the PMDS is unfair. When the assessment presentations are done, you discover that a supervisor who is not in the same shift as you will present your report. Sometimes that person is not even in good terms with you and will definitely score you low" (Participant E).
"I feel...that a person who is not in the same shift as you should not evaluate you" (Participant D).

These observations resonate with Rubel and Kee (2015:192) who found out when they carried a cross sectional study that fairness in human resources management practices play a more positive influence on nurses' attitudes, their commitment and reduces their intent for quitting. They further stated that fair PMDS practices increase career advancement, promotional opportunity and higher job satisfaction and participants stated that they never saw fair PMDS being practised. Additionally Nikpeyma (2014:22) found that there are unfair PMDS practices as the reports are based on personal opinion, the evaluator's judgement is mostly not fair as they would give equal scores to avoid defending cases when presenting performance (Nikpeyma, 2014:22).

3.5.1.3 THEME 3: PERCEPTIONS OF NURSES ON OUTCOME OF PMDS IMPLEMENTATION

The participants expressed the following concerning the outcomes of the PMDS: job dissatisfaction and demotivation, subjective scoring, low staff morale, manager-subordinate

conflicts, concerns on performance bonus and disruption in service delivery. These sub-themes are discussed below.

Sub-theme 1: Job dissatisfaction and demotivation

The participants submitted that the process often results in dissatisfaction with one's job. This is pre-empted by an assessment conducted that was perceived to be unfair and not a true reflection of the level of individual effort. The participants expressed their discontent with the PMDS. They articulated that the unfair practices and favouritism by supervisors results in conflict and often contributes to staff not working effectively and efficiently which recursively affects patient care. Some participants expressed that they often get negative attitudes from their managers when doing the presentations during the reporting period. The findings suggest that nurses feel demotivated and dissatisfied to carry out their duties due to how PMDS is implemented. They reported not getting any feedback on the outcomes of the evaluation process but they were still expected to perform magic without any sufficient support from their senior nurse manager. This is succinctly captured in what the participants hinted:

"It's because in some cases the supervisor would be giving you lots of work to do and when the evaluation comes, the person who was not working as hard will get PMDS incentives and you don't. That causes a conflict because I won't get along with the person who got PMDS incentive bonus" (Participant H).
"This causes a lot of discouragement when some people you work with get higher scores, and you know that they have not done anything extraordinary to get a reward, and you do the same work (Participant F).

Similarly Vasset *et al.* (2011:11) found the association between performance management and motivation. Their findings suggest that when the process is efficiently conducted, feedback is used to improve the performance of the workers and it leads to motivation for staff in carrying out their duties efficiently (Vasset *et al.*, 2011:11). It is also supported by a study on the outcomes of performance management which found that the majority of nurses are demotivated and dissatisfied with their jobs because they are never appreciated correctly (Luhalima *et al.*, 2014:484).

Sub-theme 2: Subjective Scoring

The participants in this study conveyed concerns regarding the scoring process, where they felt that the scoring is unfair and at the manager's discretion and is not a true reflection of the work conducted. They recalled that sometimes they get scored less and do not dispute that but just accept scores for the sake of maintaining peace between themselves and their managers. Prior to the performance management system, the participants are expected to evaluate themselves and allocate a score that they believe reflects their performance. Scoring was perceived as one of the instigators of conflict in the relationship between the manager and the nurses. Once they have self-allocated their scores they sometimes get questioned as to why they gave themselves a high score, and the nurse manager would then deliberately score them lower with no justification for the lowered scoring. Participants mentioned that the following observations:

"I think more than 50% of what we do in PMDS is forgery. There is no true reflection of what is happening in the facility or individual performance" (Participant C).
"After the presentations by all the clinics, you will hear them (panel-managers) saying that everyone across the board has performed as a norm. The norm is a score of 3 and a very small percentage will get bonuses" (Participant G).
"The one shift will do its work, be punctual and do everything they are supposed to; the other shift wouldn't be working as hard but they get bonuses. It just means that people that don't do the work are the ones who get PMDS incentives" (Participant H).

These findings confirm those of Nikpeyma (2014:22) who reported that there is always subjective scoring when preparing reports, and there is always lack of objectivity and therefore the evaluation becomes biased (Nikpeyma, 2014:22). Additionally Tesfaye *et al.* (2015:7) found that the majority of participants were not certain of the performance management scoring just because managers cannot justify their subjective scoring. In addition, findings in this study suggest that the participants perceive the scoring system as subjective, and not reflecting their day-by-day performance (Tesfaye *et al.*, 2015:7).

Sub-theme 3: Low staff morale

The participants also expressed that during the appraisal period certain expectations are raised and when those are not met there is a significant onset of low morale. Incentive allocation is not evenly allocated, and this created conflict among staff and other members become demoralized, they drag their feet, are drained physically and emotionally, others abstain from work. They feel that people who work hard do not the recognition they deserve and only those who idle get all the credit for the work they did not do. Participants said:

"There is no morale boost and as a result I continue doing my work. I drag myself to do my work even though the morale is low, I would be discouraged for some time but at the end I recover all by myself, drained physically and emotionally. Sometimes I end up deciding to take leave, stay at home and maybe I will feel better afterwards (Participant E).
The feeling will be that those who get PMDS must do the work" (Participant C).
"The one who has been performing would get demoralized, feel that no one recognizes their hard work" (Participant G).

These findings are similar to those by Dawson *et al.* (2014:16) which established that performance review was critical and significantly associated with high performance and staff retention, when nurses morale is supported which was not the case in this study (Dawson *et al.*, 2014:16). The results imply that if PMDS is implemented effectively, the performance management system has the potential of increasing staff motivation and performance, resulting in staff retention and high morale. Rubel and Kee (2015:193) further support this in identifying that participants reported a negative perception of PA on fairness and promotion opportunity. The study shows a link between fairness of the performance appraisal, promotion, staff morale and retention of nurses (Rubel & Kee, 2015:193). This suggests that if the performance appraisal system is conducted in a fair and consistent manner and affords staff with opportunities for promotion, then it has a potential of ensuring staff morale is high and retention is guaranteed.

Sub-theme 4: Manager - subordinate conflicts

Some participants reported that they have personal clashes and confrontations with their immediate supervisors and managers because of explicit unfairness in the implementation of the PMDS. They

expressed that the staff who work hard do not get the credit for work done. They felt overworked as they get assigned to a lot of tasks and during the evaluation nurses who do not work as hard are given incentives. Participants said:

"I and the supervisor might end up not seeing eye to eye. The conflict will affect staff as well, and there will be no teamwork in our unit all because of unfair PMDS reports (Participant E).
"When you get to the facility, there will be questions among personnel on how others got the bonuses, how did they get them, etc.; this causes lack of peace. It causes conflict (Participant G).
"It's because in some cases the supervisor would be giving you lots of work to do and when the evaluation comes; the person who was not working as hard will get PMDS incentives and you don't. That causes[s] a conflict because I won't get along with the person who got PMDS incentives" (Participant H).

Nikpeyma (2014:20) revealed that participants in her study were not clear on how the scoring system is measured leading to unfair incentives allocation and most felt that the scoring system was biased and at the discretion of the manager. Such an observation often results in the conflict between the evaluator and the nurses (Nikpeyma, 2014:20). Additionally Nagah and El-Shanawany (2016:134) found out that lack of motivation brought in disharmony between nurses as sub-ordinates as well as to the nursing managers because the dominant perception was that PMDS reports are based on favouritism (Nagah & El-Shanawany, 2016:134).

Sub-theme 5: Concerns on performance bonus

The participants conveyed concerns regarding the incentives allocations. The felt that it is unfair and at the manager's discretion and in most instances the reports written are not a true reflection of the work conducted. They sometimes get scored less and do not complain about that, because no one listens to the complaints. Participants stated that they just accept that they were betrayed and let it go with time. Prior to the performance management system, the participants are expected to evaluate themselves and allocate a score that they believe reflects their performance. Once they

have self-allocated their scores they sometimes get questioned as to why they gave themselves a high score, and the nurse manager would then deliberately score them lower with little if any justification for the scoring. Hence the incentives are unfairly distributed. Despite this information, a few participants expressed positive perceptions about PMDS where bonuses were perceived as an encouraging incentive for those who have worked hard but only when manager is in good mood. Participants said:

"Everyone across the board has performed as a norm. The norm is a score of 3 and a very small percentage will get bonuses" (Participant G).
"I feel that the PMDS is unfair. When the assessment presentations are done, [our] manager unfairly scores us less and we end up not getting incentives (Participant E).
"At least as employees we sometimes get performance bonuses. That encourages us to work hard and enjoy coming to work. Even though we don't come to work only for PMDS, it encourages us to do our work with love" (Participant H).
"Due to PMDS, nurses work very hard. They go the extra mile because they know they will get bonuses" (Participant C).

Sub-theme 6: Disruption in service delivery

The participants expressed that PMDS often impacts negatively on service delivery. Nurses indicated that they are expected to complete their reports and their job suffers because of that. Concerning training, the manager does not check the staff member who critically requires the training and at the end of PMDS cycle when employees are demotivated they tend not to carry their own duties as expected since reports are unfair and there is no supportive or meaningful feedback. Participants mentioned that the following:

"Service delivery suffers because the person will not be doing their work but only focusing on writing the PMDS report. The other staff will be overworked" (Participant A).
The queues become longer because we are fighting amongst ourselves; the issue becomes that those who got bonuses should do the work" (Participant H).
"We don't have space where we can use to prepare these reports, no time, no knowledge, and no nothing. We do it when we are on duty or even on our day off and no one pay us. When we do this on duty patients suffer long waiting period" (Participant F).

Similar to what Aly and El-Shanawany (2016:132) found when evaluating specialized critical care and toxicology nurses' satisfaction with performance appraisal and their findings suggest that nurses were unsatisfied with the performance appraisal process and less motivated in carrying out their duties and service delivery gets disrupted. One of the attributes to dissatisfaction in the PA process was the lack of involvement and poor discussion with head nurses (Aly & El-Shanawany, 2016:132).

3.6 CONCLUSION

The findings of this study on exploring and describing perceptions of nurses regarding PMDS implementation, data analysis as well as literature control were presented in this chapter. These findings were enriched with direct quotations from the transcripts as verbalised by the nurses. In the next chapter the researcher discuses conclusions, limitations and recommendations of the study with specific reference to nursing education, nursing research and nursing practice.

CHAPTER 4: CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

The previous chapter comprised findings of this study on exploring and describing the perceptions of nurses regarding PMDS implementation in Mafikeng sub-district clinics, data analysis as well as literature control. These findings were enriched with direct quotations from the transcripts as verbalised by registered nurses. In this final chapter, pertinent conclusions and recommendations are drawn from the findings, literature and field notes. Limitations and recommendations with specific reference to nursing education, nursing research and nursing practice are generated and presented.

4.2 SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

This section outlines the summarised themes and sub-themes of the findings that emerged and selected according to their connectedness to the initial research questions. Conclusions are drawn accordingly and recommendations thereof given.

4.2.1 Summary of theme 1: structure

- **Sub-theme 1: Insufficient knowledge and training on PMDS**

Findings: Participants reported insufficient understanding and knowledge of the PMDS as a structural problem since they have not been properly involved in implementing PMDS because they hardly know the protocols and procedures involved.

Conclusion: Staff members do not understand how the PMDS works and what is expected from them. Both the assessed and the assessors are not adequately informed about what is expected of them during the PMDS.

Recommendation: Participants articulated the need to have more training and workshops on the PMDS implementation. They emphasized that training should not be left until the last notice on submission.

- **Sub-theme 2: Unfamiliar with the PMDS Policy**

Findings: Participants shared that although the evaluation policy is being implemented in the facilities, they do not have a comprehensive understating of what it entails. Participants expressed that they have not seen the actual policy document on the PMDS.

Conclusion: PMDS is implemented without sufficient knowledge of the policy by both managers and employees. There is no support for PMDS implementation as the participants have not physically been inducted appropriately into the implications of the policy document.

Recommendation: Review of the policy is essential in order to assess its efficacy thus far, to ascertain if the workers are satisfied with how it has been implemented.

- **Sub-theme 3: Lack of resources**

Findings: With regards the lack of resources, it emerged across all the interviews conducted that the participants do not have access to adequate resources, specifically computers, printers, time and stationery.

Conclusion: Nurses do not have sufficient resources to enable them to produce the required reports such as computers for typing the reports and paper for printing.

Recommendation: Resources should be allocated to every health care facility to enable the implementation of the PMDS. Time for such tasks should be allocated to staff to work on their PMDS reports. Even if there are computers in the facility, personnel should be trained on computer literacy.

4.2.2 Summary of theme 2: process

- **Sub-theme 1: Minimal and inadequate Orientation**

Findings: The participants expressed that they are not oriented on the process of the PMDS. Even the new nursing staff is not informed; they get to only learn about it when they have to compile a performance report.

Conclusion: No proper explanation regarding expected outcomes and necessary procedures has been projected. The absence of formal orientation and explanation of PMDS impacts negatively on the performance of nurses because it clearly states the key performance areas of each individual and they would understand what average performance, under performance and over performance imply.

Recommendation: There is a need for transparency in the all the PMDS processes. Job description and work plans should be explained to staff before they can commit and sign the PMDS document.

- **Sub-theme 2: Erratic reporting periods**

Findings: The participants reported that insufficient time to complete reports during working hours and that they have to complete the process at home. They feel that this task is an added burden and over the time that they get paid for. There is no consistent and specific reporting format and period.

Conclusion: Reports are done yearly instead of quarterly and time is always not enough, leading to compromised positions such as reporting false outputs.

Recommendation: Participants should be given sufficient time to prepare for presentations of their targeted and achieved performance agreements. The work of PMDS should not be done outside working hours but within the facility to shorten patients' long waiting time

- **Sub-theme 3: Job descriptions and work plans**

Findings: Participants reported that they do not have their job descriptions and work plans at the onset of the reporting year. As a result, they often do not know what is actually expected of them. In some facilities, they have to be all-rounder's do administrative and dispensary duties when there is no clerical and pharmacy staff respectively.

Conclusion: Work plans ought not to be received when the performance appraisal report period approaches. These ought not to be made available for them just to sign and return to their manager because then the nurses do not know the significant content as they briefly browse through it.

Recommendation: Job descriptions and work plans should be explained before employees can commit and sign the PMDS document. These documents and processes need to be transparent about all PMDS formulations.

Sub-theme 4: Mentoring and support

Findings: Participants reported that there is no mentorship available to support them when they implement PMDS. There is no one to guide staff in the process of self-evaluation, and as a result nursing staff do not know what to do and what is expected of them in the self-evaluation.

Conclusion: There was evidently no continuous supervision to support subordinates during the evaluation process. They feel less empowered because the manager is only available during the reporting period, and then there is less engagement between the supervisor and their subordinate

during the year. Report writing of the PMDS in some facilities is compiled once by the manager because the staff are not empowered and equipped to compile the reports.

Recommendation: On-going support and mentoring by the supervisor to monitor progress is strongly recommended. Supervisors should monitor the work of subordinates. There should be no negative attitudes among staff. Supervisors have to lead the process effectively and share information on protocols and expectations.

- **Sub-theme 5: Unfair and fragmented reporting lines**

Findings: The participants expressed that distorted reporting lines frustrate the process of implementing PMDS.

Conclusion: Evaluation is currently conducted by a supervisor who works in another shift, and is therefore incapable of accurately and judiciously reporting on the performance of that particular staff member. These results affect scores in a very bad way and make it difficult to complete fair and truthful performance evaluation.

Recommendation: Managers should ensure that supervisors are allocated staff that they are working with to assess during PMDS; especially in the 24 hour facilities.

4.2.3Summary of theme 3: outcomes

- **Sub-theme 1: Job dissatisfaction and demotivation**

Findings: Participants articulated that the unfair practices and favouritism by supervisors result in conflict and often contribute to staff not working effectively and efficiently which jeopardises patient care. They reported not getting any feedback on the outcomes of the evaluation process yet they are expected to perform miracles without any sufficient support from their senior nurse manager.

Conclusion: Nurses feel demotivated and dissatisfied to carry out their duties due to how PMDS is currently being implemented.

Recommendation: If the manager notices that nurses are de-motivated, take many unplanned leave days off then they should sit you down and establish the problem. They ought to then find ways to help and maybe send the affected nurses to debriefing sessions to resolve issues.

- **Sub-theme 2: Subjective Scoring**

Findings: The participants conveyed concerns regarding the scoring process where they feel the scoring is unfair and at the manager's discretion and is not a true reflection of the work conducted. They reported getting scored less and do not dispute that; they just accept scores for the sake of maintaining peace between themselves and their managers.

Conclusion: Scoring was perceived as one of the instigators of conflict in the relationship between the manager and the nurse. Once they have self-allocated their scores they sometimes get questioned as to why they gave themselves a high score and it was established that the nurse manager would then deliberately score them lower with no justification for the lowered scoring.

Recommendation: The relationship nurses have with the person who has to represent them at the PMDS presentation should not affect how reports are done. There should be no underscoring or over scoring: strictly, scores should be allocated as one deserves. Incentives should be linked to facility indicators to avoid the current practice on subjective scoring by managers which often perpetuates favouritism.

- **Sub-theme 3: Low staff morale**

Findings: The participants expressed incentive allocation is not evenly distributed and this created conflict among staff where members become demoralized, drag their feet, are drained physically and emotionally while others abstain from work. They felt that nurses who work hard do not get the recognition they deserve and only those who idle get all the credit for work they did not do.

Conclusion: During the appraisal period certain expectations are raised and when those are not met they generate low morale.

Recommendation: Managers should take the initiative in addressing low staff morale. They should be proactive in identifying staff with low morale and work on improving such by acknowledging work done exceptionally well.

- **Sub-theme 4: Manager-subordinate Conflict**

Findings: Participants reported that they had personal clashes and confrontation with their immediate supervisor and managers because of unfairness in the implementation of the PMDS. They are of the view that the people who work hard do not get credit for all the work done.

Conclusions: Nurses feel overworked as they get assigned to a lot of tasks and during the evaluation people who do not work hard are given incentives at the expense of those who do.
Recommendations: Managers should avoid favouritism as it causes conflict in the relationship between the manager and the nurse. Nurse Managers should not deliberately lower scores of nurses without clear justification.

- **Sub-theme 5: Concerns on Performance bonus**

Findings: The participants raised concerns regarding the incentives allocations and most felt that it is unfair and at the manager's discretion and in most instances the reports written are not a true reflection of the work conducted.
Conclusion: There is evidence of unfairness and betrayal which induces unfair distribution of rewards and thereby generates more fights.
Recommendation: Managers should fairly evaluate nurses to avoid unfavourable working environment.

- **Sub-theme 6: Disruption in service delivery**

Findings: The participants expressed that PMDS often impacts negatively on service delivery. In that regard, they are expected to complete their reports and their job suffers because of that.
Conclusions: Concerning training, the manager does not check the staff member that critically requires training and at the end of PMDS cycle when employees are demotivated they tend not to carry their duties as expected since reports are unfair and there is no feedback.
Recommendation: A positive word could make nurses work harder; managers should be there for their staff, give them a word of encouragement and enough time to prepare PMDS reports to avoid service delivery disturbance.

4.3 CONCLUSIONS

The study aimed at exploring and describing nurses' perceptions on the implementation of the PMDS in Mafikeng sub-district clinics. Eight in-depth individual semi-structured interviews with the nurses were conducted in order to explore and describe their perceptions on the implementation of the PMDS. PMDS was established to be a legislated policy for all public servants in South Africa, and as public servant employees, nurses are compelled to implement the policy. The

researcher identified that in all the interviews conducted the participants did not have positive perceptions of the PMDS. The participants shared their perceptions regarding structure, process, and the outcome of the PMDS implementation which are described in details below.

4.3.1 Conclusion on structure

From the findings, firstly the nurses feel ill-equipped to implement the PMDS as they do not have sufficient resources to aid them in facilitating the process such as computers and printers. Nurses submitted that their core role is to attend to patients and paperwork is not a priority. Thus not having a computer and printer makes it difficult for them to write the report. Under the current structure of the implementation of PMDS, they also cited lack of understanding and training on the policy itself, which makes it difficult for them to engage with it thoroughly.

4.3.2 Conclusion on process

The process of PMDS implementation has a lot of challenges. Participants indicated that they were not informed of job descriptions and work plans, that there were inconsistent reporting periods which often results in them having to take work home or in some instances request the administrative staff to assist with the compilation of the report. This anomaly was cited as one that seriously comprises the confidentiality of the process.

4.3.3 Conclusion on outcomes

Regarding the outcome of the PMDS, it is evident that the participants are dissatisfied with the process as it does not yield attractive benefits such as support or intervention in cases where a staff member scored low or performance bonuses in cases of employees with outstanding performance. Findings from the study revealed a lot of uncertainties concerning participants' perceptions on the outcomes of the PMDS. These suggest that the participants are not clear on what should be an ideal outcome of the PMDS. The findings also revealed a lot of frustration by the participants concerning the outcome of the PMDS implementation.

4.4 LIMITATIONS

The researcher's subjective position in the research as a professional nurse could have influenced the findings obtained. The researcher conducted the interviews and was actively involved in the

recruitment, transcription and analysis process. This might have affected the manner in which the participants responded to the questions during the interviews and contributed to their level of empathy.

Due to the nature of the qualitative research method, it was not feasible and plausible to have a large study sample. The qualitative research method is concerned with an in-depth understanding of the phenomena, and individual lived experiences. Qualitative research employs the use of a small and manageable sample size in order to thoroughly study the phenomenon. Hence only eight in-depth interviews were conducted with registered nurses with experience in the implementation of the PMDS. More research needs to be conducted with a larger sample size following a quantitative or mixed methods approach.

4.5 RECOMMENDATIONS

From the findings, literature and conclusion of this study as discussed above, recommendations for nursing education, nursing research and nursing practice are outlined below.

4.5.1 Recommendations for nursing education

Nursing education needs to aim at improving the competence of nurses in implementing PMDS to facilitate good performance as well as all the policies related to performance evaluation to assess performance needs to be addressed. Nursing education should further aim to increase nurses' insight about how to use PMDS in order to render quality patient care and reduce the cases of job dissatisfaction. This includes the example that nurses find it difficult to practise proper implementation of PMDS and this highlights the need for guidance and support.

The findings of this study thus add significant insights into existing guidelines for PMDS implementation for nursing management students and nursing managers as well as other practitioners who rely on PMDS to evaluate their performance.

4.5.2 Recommendations for nursing research

From the findings of this study on exploring and describing perceptions of nurses regarding PMDS implementation, it is clear that there is a need for further research. This research should be

conducted across all the categories where PMDS is used to evaluate performance. Such research is recommended in the following areas:

- Effective use of the PMDS policy for professional implementation.
- Preventative programmes to allay unfair implementation of PMDS.
- Further research should be conducted on investigating strategies to enhance collaboration between PMDS implementation and other legislative instruments such as Batho Pele Policy to facilitate good performance.
- More research on guidelines to assist nurses involved in PMDS implementation as it was found that almost all the nurses interviewed indicated that they wanted to learn more of PMDS and its applications.
- More research needs to be done on the relationship between PMDS reports and PMDS incentives.
- More research needs to be done on relationship between PMDS reports and job satisfaction.
- Finally, the scope of the study could be further broadened and used in the development of quantitative tools for assessing nurses' attitudes and perceptions on PMDS using a larger and representative sample size so as to get a bigger and broader picture on nurses' views regarding the PMDS implementation in the South African context.

NWU LIBRARY

4.5.3 Recommendations for nursing practices

From the findings of this study on exploring and describing nurses' perceptions regarding PMDS implementation, recommendations for nursing practice are given in order to facilitate proper PMDS implementation.

4.5.3.1 Recommendations on Structure

With reference to the structure of the PMDS, the participants made the following recommendations: policy review and revision, staff training and workshops on the PMDS and resources allocation.

- **Policy review and revision**

Participants recommended the review of the policy in order to assess if it has been working thus far, to ascertain if the workers are satisfied with how it has been implemented. Nurses should be able to use those policies in implementing PMDS. The PMDS policy reviews should be done from time to time and every staff member should be informed about it.

- **Staff Training and workshops on the PMDS**

Participants articulated the need to have more training and workshops on PMDS implementation. They emphasized that the training should not be left until the last notice. The participants also expressed the need for staff to attend computer training lessons to prepare them for report writing of the review as they are expected to submit a report. Supervisors and evaluators should make sure that every registered nurse is computer literate. There should be on-going workshops where all staff members in every category are sufficiently trained on PMDS. Training should be given; training needs identification is important and staff needs to be developed. Favouritism must stop.

- **Resources allocation**

The participants suggested that resources be allocated to every health care facility to enable the implementation level of PMDS. Time should be allocated to staff to work on their PMDS reports. Even if there are computers in the facility, personnel should be trained on computer literacy. Computer literacy is not something that requires a formal qualification but it needs practice so that personnel know what to do when writing their reports. The time within which they require the reports should be adequate. Nurses should be given enough time to submit the reports. Separate budgets for all the stationery and all the other resources need to be appropriately allocated. There should be a budget that ensures that paper supplies and other resources are available.

4.5.3.2 Recommendations on process

The participants made the following recommendations regarding the process for PMDS implementation: staff orientation on the policy, staff mentoring and support and job descriptions and work plans.

- **Staff orientation on the policy**

The participants are of the view that there needs to be transparency in the all the PMDS processes. Job description and work plans should be elucidated to them before they can commit and sign the PMDS document. They need to be transparent about all the processes of PMDS. Nurses need to be given work plans that they understand. The work plans should clearly outline duties and how these should be executed. Before signing, nurses should get proper explanations on these job descriptions. People should not just sign without a proper explanation of the job and what is expected of them. There should be transparency concerning PMDS, which is currently not the case. Since the human resources managers are the ones dealing with such issues; they should always come to explain what PMDS is all about. PMDS are frustrating at times because nurses know nothing about it. The work of PMDS should not be done outside working hours but within the facility to reduce patients' long waiting time. Managers should ensure that supervisors are allocated staff that they are working with to assess during PMDS; especially 24 hour facilities.

- **Staff mentoring and support**

On-going support and mentoring of work by the supervisors to monitor progress. Supervisors should monitor the work of subordinates. There should be no negative attitudes among staff. Nurses need to be trained and attend workshops that deal with PMDS because some of the workshops that nurses attend do not have anything to do with PMDS. Essentially, nurses also need to get equal opportunity to train and attend workshops. Supervisors have to be able to lead the process effectively, share information.

- **Job descriptions and work plans**

Participants should be given sufficient time to prepare for presentations, performance agreements, work plans and job descriptions should be given in advance not a time of presentation. Performance agreements, work plans and job descriptions should not be done on the 11th hour, they should be

done at the beginning of the financial year and be revised quarterly is it is supposed to. These should be signed on time to avoid the forgery that is currently happening. In terms of work plans, they should check the training needs a nurse had identified and attend to them that will improve performance because when you know that something is your duty, you will not neglect it. You will do it and also go an extra mile where necessary

4.5.3.3 Recommendations on outcomes

The following recommendations on the outcomes of the PMDS have emerged: oral reporting, feedback, remedial action, and staff morale.

- **Feedback**

There is a need to receive constructive feedback after the PMDS presentations. Feedback should include the all steps, their breakdown, and interpretation of the assessment findings and its meaning. The need for oral feedback during the review process is of importance. Feedback meetings with concerned staff allow constructive review of the process. Quarterly performance should be conducted in order to measure and track performance progress. They should do quarterly performance reviews in order to know where nurses perform well and where they are underperforming. That will enable them to do proper planning. In terms of process, the bad relationship one has with the person who has to represent the nurse at the PMDS should not affect how they do individual reports. Nurses should not be underscored but ought to get the scores that they rightly deserve.

Participants have expressed the need to receive constructive feedback after the PMDS. We need to have a discussion concerning the results and know what needs to happen moving forward. That will help staff to know the areas they need to improve on. Therefore RN and all the other staff need to get feedback so that they can work on their development. When the outcomes are not favourable, they need to come back and discuss how to improve things. In such cases, a moral will be boosted. Nurses get encouraged to work better after the PMDS is done, not being discouraged. Meetings need to be organized where staff will be told how the process went. It would allow the participants to openly share their frustrations, may limit the odds of staff taking leave erratically and improve in the next financial year to ensure that they achieve something. Such meetings will allow nurses to share views and relax. Such meetings could also help minimize unplanned leave

since staff is likely to talk about their issues and address their anger without having to go on leave because they are angry.

The panel should also allow supervisors to motivate staff orally, because they know their nurses better and what they have omitted in the report could be said verbally. And when they ask questions during the PMDS presentation they should also accept verbal motivations which are not part of the reports if there are any that do not appear this will give confidence to the manager to give us feedback knowing very well that they did their work.

- **Remedial action and incentives**

The final performance management report should also include remedial action to be taken, when that need has been identified during the implementation or meeting with the supervisor then it will be done effectively. Incentives should be linked to facility indicators to avoid the current practice on subjective scoring by managers which often perpetuates favouritism If all the indicators of the facility are improved, let all the personnel be assessed in accordance with the indicators of the facility. Leave of absence as an incentive for the staff that is feeling low and discouraged may help in encouraging them. The report should reflect the overall performance of the clinic in the PMDS, and where there are weaknesses, the facility manager should take remedial action. Such a report will allow staff to know what and what not to do but this is not done, you are discouraged by managers at the panel and you do not even know what to tell the subordinates and even you were presented and no one will say a small feedback to you.

- **Staff morale**

Managers should take the initiative in addressing low staff morale. They should be proactive in identifying staff with low morale and work on improving by acknowledging work done exceptionally well. The manager should have debriefing sessions to address staff issues that may impact on work performance negatively and organise them to debriefing in case she fails to solve the problem. If the manager notices that you are de-motivated, you take many unplanned leave days; he should sit you down and find out what the problem entails. He should then find ways to help you and maybe send you to debriefing so that you can deal with your feelings. A positive word can make you work harder, managers should be there for staff, give them a word of encouragement which appreciates them. Where you have not performed well, and your morale is low; your manager should

have a way of approaching you, encourage you as well as boost your work performance. The manager has to come up with suggestions on how one could improve on the weak areas of your KPAs so that they can get better results in the future.

4.6 CONCLUSION

The purpose of this study was reached, which was to explore and describe the nurses' perceptions on structure, process and outcome regarding PMDS implementation in order to make recommendations that are aimed at improving PMDS implementation and enhance quality and good performance in Mafikeng sub-district clinics. The exploration and description of these perceptions provided insight into performance evaluation in order to reduce improper PMDS implementation.

The findings of this study indicated that nurse' perceptions on structure, process and outcome regarding PMDS implementation is unsatisfactory due to the fact that it causes confusion, frustration and uncertainty at the time of reports leading to them losing interest. Although some nurses verbalised that if they were involved fully from the beginning that may increase their interest and somehow make implementation simpler and more beneficial to employees and employer. Recommendations for nursing education, nursing research and nursing practice were made. These recommendations have the potential to improve PMDS implementation and improve performance of nurses through a fair assessment instrument.

REFERENCES

Achar, A.P. & Nayak, D. 2014. An evaluation of performance management system in health care organization- a case study. *International Journal of Human Resource Management and Research,* 4(3): 9-18.

Aly, N.A.E.F.M. & El-Shanawany, S.M. 2016. The Influence of Performance Appraisal Satisfaction on Nurses' Motivation and their work outcomes in Critical Care and Toxicology Units. *European Scientific Journal, ESJ*, 12(20): 132-140.

Awases, M.H., Bezuidenhout, M.C. & Roos, J.H. 2013. Factors affecting the performance of professional nurses in Namibia. *Curationis*, 36(1):1-8.

Bezuidenhout, S.S. 2011. Guidelines for the implementation of performance appraisal in clinics in the Dr Kenneth Kaunda District (Doctoral dissertation, North-West University).

Brink, H., Van der Walt, C. & Van Rensburg, G. 2012. Fundamentals of research methodology for health care professionals. 3rd edition. Cape Town: Juta.

Burns, N. & Groove, S.K. 2009. Understanding nursing research. 4th ed. Philadelphia: Saunders.

Burns, N. & Groove, S.K. 2011. Understanding nursing research. 4th ed. Philadelphia: Saunders.

Creswell, W. 2009. Research design: A qualitative, quantitative and mixed method approaches. Sage Publications. Thousand Oaks: USA.

Creswell, W. 2014. Research design. 4th ed. International Student Edition. Sage Publications. Thousand Oaks: USA.

Dave, K.S. 2014. Research Paper on Performance Appraisal of Nurses in Hospitals with Specific Reference to Saurashtra Region, India: University of India. (Dissertation -MSM).

Dawson, A.J., Stasa, H., Roche, M.A., Homer, C.S. & Duffield, C. 2014. Nursing churn and turnover in Australian hospitals: nurses perceptions and suggestions for supportive strategies. *BMC nursing*, 13(1):11.

De Vos, A.S., Strydom, H., Fouche, C.B & Delport, C.S.L. 2014. Research at grass roots for the social and human service professions. Pretoria: Van Schaik.

Donabedian, A.2005. Evaluating the quality of medical care. *European management review*, 83(4): 691-729.

du Plessis, M.A. 2015. Determining professional nurses' knowledge on the performance management and development system in Tshwane. *Curationis*, 38(1):1-7.

Elarabi, H.M., & Johari, F.2014. The impact of human resources management on healthcare quality. *Asian journal of management sciences & education*, 3(1): 14-22.

Giangreco, A., Carugati, A., Pilati, M. & Sebastiano, A. 2010. Performance appraisal systems in the Middle East: Moving beyond Western logics. *European management review*, 7(3): 155-168.

Higgs, J., Horsfall, D., & Grace, S. 2009. Writing qualitative research in practice. Rotterdam: Sense Publishers.

Jooste, K. 2013. The principles and practice of nursing and health care: Ethos and professional practice, management, staff development, and research. Pretoria: van Schaik.

LoBiondo-Wood, G & Habber, J. 2010. Nursing research: Methods and critical appraisal for evidence-based practice. St Louis: Mosby.

Luhalima, T.R., F.M. & Phetlhu, D.R. 2014. Factors that motivate nurses to provide quality patient care in a rural hospital in Vhembe district, Limpopo Province, South Africa: rural health and

indigenous knowledge system. *African Journal for Physical Health Education, Recreation and Dance*, 20(1):473-484.

Makamu, N.I. 2016. Assessment of performance management and development system in selected South African national government departments (Doctoral dissertation, North-West University (South Africa) Mafikeng Campus).

Makhubela, M., Botha, P.A., & Swanepoel, S. 2016. Employees' perceptions of the effectiveness and fairness of performance management in a South African public sector institution. *SA Journal of Human Resource Management,* 14(1): 1-11.

Molefe, J. & Sehularo, L.A. 2015. Nurses' perceptions on factors contributing to job dissatisfaction in a public psychiatric hospital in North West Province, South Africa. *African Journal for Physical Health Education, Recreation and Dance*, 21(2):472-482.

Mosoge, M.J. & Pilane, M.W. 2014. Performance management: the neglected imperative of accountability systems in education. *South African Journal of Education,* 34(1):1-18.

Nagah Abd El-Fattah Mohamed Aly & Safaa Moustafa El-Shanawany. 2016. The Influence of Performance Appraisal Satisfaction on Nurses' Motivation and Their Work Outcomes in Critical Care and Toxicology Units. *European Scientific Journal*, 12(20):119.

Nikpeyma, N., Abed-Saeedi, Z., Azargashb, E. & Alavi-Majd, H. 2014. Problems of clinical nurse performance appraisal system: A qualitative study. *Asian Nursing Research*, 8(1):15-22.

Ochurub, M., Bussin, M. & Goosen, X. 2012. Organisational readiness for introducing a performance management system. *SA Journal of Human Resource Management*, 10(1): 1-11.

Paile, N.J. 2012. Staff perceptions of the implementation of a performance management and development systems: Father Smangaliso Mkhatswa case study (Doctoral dissertation).

Polit, D.F. & Beck, C.T. 2012. Generating and Assessing Evidence for Nursing Practice. 9th ed. Philadelphia: Lippincott Williams & Wilkins.

Puoane, T. 2013. Factors influencing the job performance of nurses and midwives in postpartum units in two district hospitals in Rwanda. *Africa Journal of Nursing and Midwifery*, 15(2): 59-69.

Ramulumisi, T.V., Schultz, C.M. & Jordaan, C.J. 2015. Perceived effectiveness of a performance management system. *Journal of Contemporary Management*, 12(1): 517-543.

Rubel, M.R.B. & Kee, D.M.H. 2015. Perceived fairness of performance appraisal, promotion opportunity and nurses' turnover intention: The role of organizational commitment. *Asian Social Science*, 11(9):183.

Samakula-katende, S.M., Pelser, T.G. & Schmikl, E.D. 2013. Reward and attitudes: The unintended outcomes of an effective performance appraisal. *SA Journal of Human Resource Management*, 11(1):1-11.

Seyama, S. M & Smith, C. 2015. "Not worth the sweat": Performance rewards at a South African university. *Indo-Pacific Journal of Phenomenology*, 15(2): 1-1.

Soilkki, K.K., Cassim, N. and Karodia, A.M. 2014. An evaluation of the factors influencing the performance of registered nurses at the national referral hospital in Namibia. *Australian Journal of Business and Management Research*, 4(2):47.

South Africa. 2005. Nursing Act 33 of 2005. Government Printers: Pretoria.

South Africa. 2012. World Health Organization: National Healthcare Quality Report Government Printers: Pretoria.

South Africa. Department of Health. 2010. Performance management and development system policy 01/2010. Government Printers: Pretoria.

South African Nursing Council. 2013. Statistics on professional misconduct cases from June-December 2013.http://www.sanc.co.za/pdf/Disciplinary. Pretoria. Date of accessed 15 May 2014.

Tesfaye, T., Abera, A., Hailu, F.B., Nemera, G. & Belina, S. 2015. Assessment of factors affecting performance of nurses working at Jimma University Specialized Hospital in Jimma Town, Oromia Region, South-West Ethiopia. *J Nurs Care*, 4(6):312.

Vasset, F., Marnburg, E. & Furunes, T. 2011. The effects of performance appraisal in the Norwegian municipal health services: a case study. *Human resources for health*, 9(1):22.

Weller, D. 2008. Organisational performance management system. *SA Journal of Human Resource Management,* 10(3): 297.

Yadav, R.K. & Dabhade, N. 2013. Performance management system in Maharatna Companies (a leading public sector undertaking) of India–a case study of BHEL, Bhopal (MP). *International Letters of Social and Humanistic Sciences*, 4(49): 49-69.

Yin, R.K. 2011. Qualitative research from start to finish. New York London: The Guilford press.

Appendix A: Request for permission to various authorities to conduct research

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

Request for permission to conduct research

I, Doreen Onkarabile Seane, hereby request permission to conduct a research study entitled nurses' perceptions regarding performance management development system (PMDS) implementation in Mafikeng sub-district clinics. The purpose of this study is to identify, explore and describe nurses' perceptions regarding PMDS implementation in order to make recommendations that are aiming at improving PMDS implementation and enhance good performance of nurses in Mafikeng sub-district.

In order to achieve the above purpose, semi-structured individual interviews will be conducted and tape recorded with nurses in Mafikeng sub-district clinics.

The interviews for those who voluntarily consent to participate in the research will be conducted between forty five minutes and one hour.

Your consideration of this request is sincerely appreciated.

Yours faithfully

Doreen Onkarabile Seane - MNSc student
078 7646 400
doseane@gmail.com

Supervisor: Prof. M.A Rakhudu
0183892466
Hunadi.Rakhudu@nwu.ac.za
Co-supervisor: Prof. L.A. Sehularo
0183892642
Leepile.Sehularo@nwu.ac.za

Appendix B: Ethics certificate from North West University ethics committee

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

Private Bag X6001, Potchefstroom
South Africa 2520

Tel: (018) 299-4900
Faks: (018) 299-4910
Web: http://www.nwu.ac.za

Ethics Committee
Tel +27 18 299 4849
Email Ethics@nwu.ac.za

ETHICS APPROVAL OF PROJECT

The North-West University Research Ethics Regulatory Committee (NWU-RERC) hereby approves your project as indicated below. This implies that the NWU-RERC grants its permission that provided the special conditions specified below are met and pending any other authorisation that may be necessary, the project may be initiated, using the ethics number below.

Project title: Registered nurses' perceptions regarding performance management development system implementation in Mafikeng sub-district clinics.

Project Leader: MA Rakhudu & Seana

Ethics number: NWU-00078-15-A9
(Institution – Project Number – Year – Status)
Status: S = Submission, R = Re-Submission, P = Provisional Authorisation, A = Authorisation

Approval date: 2015-05-22 **Expiry date:** 2020-05-21

Special conditions of the approval (if any): None.

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- *The project leader (principle investigator) must report in the prescribed format to the NWU-RERC:*
  - *annually (or as otherwise requested) on the progress of the project,*
  - *without any delay in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.*
- *The approval applies strictly to the protocol as stipulated in the application form. Would any changes to the protocol be deemed necessary during the course of the project, the project leader must apply for approval of these changes at the NWU-RERC. Would there be deviated from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.*
- *The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date, a new application must be made to the NWU-RERC and new approval received before or on the expiry date.*
- *In the interest of ethical responsibility the NWU-RERC retains the right to:*
  - *request access to any information or data at any time during the course or after completion of the project;*
  - *withdraw or postpone approval if:*
    - *any unethical principles or practices of the project are revealed or suspected,*
    - *it becomes apparent that any relevant information was withheld from the NWU-RERC or that information has been false or misrepresented,*
    - *the required annual report and reporting of adverse events was not done timely and accurately,*
    - *new institutional rules, national legislation or international conventions deem it necessary.*

The Ethics Committee would like to remain at your service as scientist and researcher, and wishes you well with your project. Please do not hesitate to contact the Ethics Committee for any further enquiries or requests for assistance.

Yours sincerely

Linda du Plessis

Prof Linda du Plessis
Chair NWU Research Ethics Regulatory Committee (RERC)

Appendix C: Mafikeng sub-district permission letter

health
Department of
Health
North West Province
REPUBLIC OF SOUTH AFRICA

1st Floor, NW Dolil New
Office Park
Cnr Setlame & Fire Str
Industrial Site
MAHIKENG, 2745
Private Bag X127
MMABATHO, 2735

Tel: (018) 381 4000
Fax:
Email:
www.

MAHIKENG SUB DISTRICT

TO : **LEEPILE SEHULARO**

FROM : **MS. S J MTSHENGU**
PHC MANAGER

DATE : **04 AUGUST 2015**

RE : **REQUEST PERMISSION TO CONDUCT RESEARCH IN MAHIKENG SUB DISTRICT**

This communiqué serves to inform you that your request has been approved.

Please note that relevant managers will be informed

Thanking you in advance for your usual support and cooperation

Regards

Ms. S J Mtshengu
PHC Manager

Healthy Living for All

Appendix D: Written informed consent

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

North-West University
Mafikeng Campus
Corner of Albert Luthuli
and University Drive
Mmabatho
2745

I ----------hereby consent to voluntarily participate in the research project entitled: **Nurses' perceptions regarding performance management development system (PMDS) implementation in Mafikeng sub-district clinics**. The purpose of this study is to explore and describe the nurses' perceptions regarding PMDS implementation in order to make recommendations that are aiming at improving PMDS implementation and enhance quality performance of nurses in Mafikeng sub-district.

I give permission that an interview will be conducted with me as personally arranged and that it will be audio-taped.

I also understand that my participation is voluntarily and that I have the right to decide whether to or not to participate in a study, without the risk of penalty or prejudicial treatment.

The results will be included in a research report and a scientific article. Confidentiality will be upheld at all times.

Signature of participant: ---------- Date: ----------

Signature of researcher: ---------- Date: ----------

Appendix E: Interview guide

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

Word of welcome and appreciation to participate in the study

Descriptive data of participants:

Age

Gender

Qualification

Years of experience in PMDS implementation

Position level at work

Recap on the study topic

Recap on study purpose

Questions:

What are your perceptions on structure regarding PMDS implementation in Mafikeng sub-district clinics?

What are your perceptions on process regarding PMDS implementation in Mafikeng sub-district clinics?

What are your perceptions on outcomes regarding PMDS implementation in Mafikeng sub-district clinics?

Appendix F: Request to act as co-coder in research

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

North-West University
Mafikeng Campus
Corner of Albert Luthuli
and University Drive
Mmabatho
2745

I, Doreen Onkarabile Seane, MNSc student at the Mafikeng Campus of the NWU working on a research project for completion of her study. The research study is entitled: Nurses' perceptions regarding performance management development system (PMDS) implementation in Mafikeng sub-district clinics. The purpose of this study is to explore and describe the nurses' perceptions regarding PMDS implementation in order to make recommendations that are aiming at improving PMDS implementation and enhance quality performance of nurses in Mafikeng sub-district.

In order to achieve the above purpose, I hereby request your assistance as co-coder. Semi-structured individual interviews will be conducted with nurses in Mafikeng sub-district clinics knowledgeable about PMDS implementation.
Please find enclosed research proposal that gives an outline of what the research entails.
Your favourable consideration of the above matter and a response at your earliest convenience will be appreciated.

Yours faithfully

Doreen Onkarabile Seane- MNSc student
078 7646 400
doseane@gmail.com

Supervisor: Prof M.A Rakhudu
0183892466
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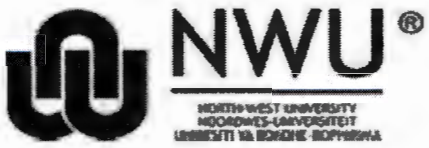
Co-supervisor: Prof. L.A. Sehularo

: 0183892642

: Leepile.Sehularo@nwu.ac.za

Appendix G: Language editor certificate



Office: 0183892451

FACULTY OF EDUCATION

Cell: 0729116688

Date: 12th May, 2018

TO WHOM IT MAY CONCERN

CERTIFICATE OF EDITING

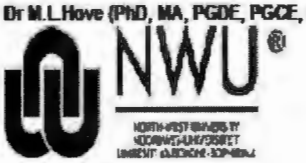
I, Muchafivugwa Liberty Hove, confirm that I have read and edited the entire dissertation, Nurses' perceptions of performance management development system implementation in Mafikeng sub-district clinics by Doreen Onkarabile Seane, Student number: 21988366, Orcid.org/0000-0002-5603-2920 submitted in partial fulfilment of the requirements for the degree *Master of Nursing Science* at the North-West University

Doreen Onkarabile was supervised by Professor MA Rakhudu and Dr LA Sehularo of the North-West University.

I hold a PhD in English Language and Literature in English and am qualified to edit such work for cohesion and coherence. The views expressed herein, however, remain those of the researcher/s.

Yours sincerely

Dr M.L Hove (PhD, MA, PGDE, PGCE, BA Honours – English)



Appendix H: One of interviews conducted

Interview	Themes and sub theme
Description data Age: 44 year Gender: female Qualifications: assistance nurse certificate, auxiliary nursing certificate, diploma in nursing science Years of experience in PMDS implementation: 9 years Position level: middle position (registered nurse) **Participant A** **TIME: 44:02** **Interviewer**: How are you madam? **Participant A**: I'm ok and you **Interviewer**: I am ok. I have come to see you as we have made this appointment to meet concerning my study on PMDS. By the way, do you still remember what the topic of my research is? **Participant A**: Yes, we are supposed to discuss the views of nurses concerning the implementation of PMDS. **Interviewer**: Yes, you are right I want to know how nurses perceive PMDS implementation in the Mafikeng Sub-district. Do you still remember what the main purpose of this study is? **Participant A**: Yes we want to improve PMDS and that people must be satisfied with it **Interviewer**: You are right, we want to improve PMDS implementation if there is any need. We want to come up with the	

recommendations that aim at improving PMDS implementation. Since you understand the purpose of this study, my first question for this interview is what is your view about structure concerning PMDS implementation?	
Participant A: My view is that I know that there are policies, but I have not seen any of those policies, I have not seen any reviews done. We think our seniors understand them but we, as nurses don't know much about them. I have not seen any of the policies practiced anywhere.	Structure-Unfamiliar with PMDS policy
Interviewer: When you say that policies are there, where do you mean, is it in the clinic or where?	
Participant A: We know that PMDS cannot be implemented without any policy but we have never seen the actual policy. We have never seen the policy in the clinics.	Structure-Unfamiliar with PMDS policy
Interviewer: Ok, does it mean that the managers haven't mentioned the policy to you, or haven't you asked the managers where the policy is or anything like that?	
Participant A: When the PMDS assessments are done, it is said that the policy says this and that but we have never seen such a policy. When we ask the whereabouts of the policy, we are told it's not there at the clinic. It's there somewhere but not in the clinic	Structure-Unfamiliar with PMDS policy
Interviewer: What does the manager do about the issue that you want the policy, it's there but you can't see it? Does he make means to get hold of the policy or what?	
Participant A: Not at all, they always promise to invite personnel from HR to come and explain to us what the PMDS policy says, but that hasn't materialized either.	Structure- Unfamiliar with PMDS policy

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Interviewer: You mean that hasn't been done till to date? **Participant A**: No **Interviewer**: So, in other words you no information about PMDS policy? **Participant A**: Yes. The other concern is with regards to training. We as personnel have not done any training on PMDS. We also don't have resources to do the PMDS.	Structure- Insufficient knowledge and training on PMDS
When the time to do it comes, you find that the managers will have to borrow a fellow nurses' computer so that they can write the reports. That person will spend the whole night typing and printing. There is no space to sit and write the reports at work, you find that we just have to squeeze ourselves in a corner somewhere in order to do the report. There are no printing resources either.	Structure- Lack of resources
Interviewer: I heard you talk about the fact that you haven't received any training. You mean that personnel were never been trained on PMDS? **Participant A**: I have never seen or attended any training. That is why I said that a manager would promise to invite someone from HR to come and explain the PMDS. This means that the manager has not attended training either; hence the issue of having to invite someone from HR to come and explain it.	Structure-Insufficient knowledge and training on PMDS
Interviewer: So, how do you compile your PMDS report if you were never trained on it? **Participant A**: When the time of assessments comes, we have to write everything that was done in all the previous months. That's why you find that we spend a lot of time trying to write the report.	

Interviewer: So how do you do the reports; do you just write anyhow because you said you don't have the knowledge? **Participant A**: Yes we just write anyhow so that we can fulfill the requirement.	Outcome- subjective scoring
Interviewer: So you just do anyhow as a procedure that you have to do? **Participant A**: Yes so that it's done	
Interviewer: I'm hearing you talk about the issue of computers. Explain further? **Participant A**: Yes we are expected to type the PMDS reports.	
Interviewer: Who types the reports? **Participant A**: They just invite a nurse who is computer literate or a data capture. They are the ones who type the reports for us.	
Interviewer: You mean that someone else types your work for you? **Participant A**: Yes	
Interviewer: How does this work? What causes the nurses not to type their own reports? **Participant A**: The reason is that most nurses are not computer literate. But it's not a good thing that a fellow nurse will type your work. You find that in some instances that nurse is your subordinate, so it's really not nice.	Structure-Lack of resources
Interviewer: When you say it's not nice when someone else compiles your report, how do you mean? **Participant A**: I mean that the person who compiles all our reports will now have access and information on our performance. The	Outcome: Manager-subordinates conflict

person will know how colleagues perform, their weaknesses and all that. It's not a good thing at all, and it causes conflict at work. **Interviewer**: Explain more about conflicts happen at work that you talking about? **Participant A**: An individual might be dissatisfied because of the scores they were given and secondly we fight because the person typing your PMDS might make your report a gossip and I fight with manager because she will not do anything about it **Interviewer**: I heard you talk about the issue that a subordinate will know people's scores. You said it causes conflicts. How does that happen? **Participant A**: Some people can't keep information to themselves. You find that they will be going around discussing people's performances with others. There will gossip and some will be discouraged. It's not a nice thing at all **Interviewer**: You mean there's no confidentiality? **Participant A**: Yes there's no confidentiality **Interviewer**: I heard you talk about the time when PMDS is done. You mentioned something about doing reports at night. Explain please? **Participant A**: Since we have not seen the policy, we have been hearing that it should be done quarterly but the way it's done is not like that. We have four quarters in a year, and all four are done all at once in a year. That is why the person doing the reports will do them for a long time, spend the whole night; because all the work is done once a year.	Outcome: Job dissatisfaction and demotivation Outcome-Manager-subordinates conflict Outcomes: low staff morale, job dissatisfaction and manager-subordinates conflict Structure-Lack of resources

Interviewer: When the person does the PMDS reports, where do they do it?	
Participant A: Yes they do them when they are on duty. But they don't do their work, they only focus on writing the PMDS report.	Outcome-disruption of service delivery
Interviewer: So what happens to service delivery?	
Participant A: Service delivery suffers because the person will not be doing their work but only focusing on writing the PMDS report. The other staff will be overworked since there will be a shortage of staff during that time.	Outcome-disruption of service delivery
Interviewer: So how does that affect service delivery?	
Participant A: Others will feel bad because the others will be focusing on PMDS. You now find that there is a negative attitude towards PMDS at work because it causes a lot of discomfort. Many will not even understand why some people are sitting and others work. Sometimes, they would not even realize that the person who is sitting is doing PMDS. Some may even decide to bank work, and not come as they feel overworked. This in turn affects the patients' waiting time, it becomes longer. When they take breaks, they go long periods, and patients suffer in the process. This affects the quality of the service given to patients.	Outcome-disruption of service delivery Outcome-disruption of service delivery
Interviewer: I hear you. Is there any other thing you want to add under structure?	
Participant A: There's nothing I want to add	
Interviewer: The other question I want to ask you is what is your view on the process of the implementation of PMDS?	
Participant A:: My view is that it is not done properly because there are no explanations given. There are no explanations given on what	

PMDS is, why is it done, when it should be done and how it should be done. We are just told that now is the time for PMDS, there is no transparency. **Interviewer**: In that situation, what do you do as a subordinate when the time to do PMDS comes? **Participant A**: Just because they say it's something that needs to be done, we don't have a choice. I once asked if I can refuse to be assessed in this PMDS process, and I was told that it's a must; everyone should do it and it's compulsory. So we just do it because it's supposed to be done. If it all depends on me, I wouldn't do it. **Interviewer**: What makes you not to want to do PMDS? **Participant A**: I feel that the PMDS is unfair. When the assessment presentations are done, you discover that a supervisor who is not in the same shift as you will present your report. How does that person know how you work? How can they defend you since they don't know your work? I think it's unfair because that person doesn't even know how you perform. Sometimes that person is not even in good terms with you, you know that you don't work well together. That person will definitely score you low. **Interviewer**: I heard you say that the one person will be in this shift and the other one in another. How does that work out? **Participant A**: The person doing your report and representation will come to your house. **Interviewer:** I want to know how that person will assess your work in that case.	Process-minimal or inadequate orientation on PMDS Process-job description and work plans Process-unfair, fragmented reporting lines Erratic reporting periods

Participant A: That's the reason I'm saying that the assessments are not fair because the person will write your report without having seen your performance. **Interviewer**: So, in your view, how should the report be? **Participant A**: I think that someone who works with you should do the report. Someone that knows your performance will be able to write your report properly. If you don't do your work, she will write that you don't do your work and if you work hard she will also be able to say so. I think the whole process of PMDS is unfair because how can a person who does not work with you know how you perform. **Interviewer**: I understand you, what else do you want to add under the process? **Participant A**: There are no trainings for us as subordinates, and the managers also don't have the necessary training. That is why you find that they don't have information, or they get it but they don't share with us. The other issue is that of skills development. Managers do not identify the kinds of skills we lack, and choose the types of training or development that we need to undergo so that we can improve. Those are the requirements of PMDS but it's not done. The other reason is that such assessments are done by people that don't know how we work, and in such instances, the identification of skills development will not be done. **Facilitator**: So, which criteria do they use to send people for development programs? **Participant A**: I cases where there are workshops, they just select maybe one person to attend. There is no proper procedure that is used to select people. An example would be in a case where someone needs	Process-unfair, fragmented reporting lines Structure-insufficient knowledge and training on PMDS

to attend a workshop on breast cancer, they don't choose someone who works with that or has the need to know more about it; they just select anyone who can attend. If the person chosen says they can't attend, they choose the next person. There is also no report that will be presented by the person after they have attended the in-service training. **Interviewer**: How does that impact on the knowledge of personnel? **Participant A**: Personnel are supposed to go for training; but if they just send people anyhow, that would cause some people to be stagnant since they don't receive the training they deserve. An example is a case where a nurse only knows how to take patients vitals, but there are areas where she needs training, if they don't send them for that particular training, they will remain only knowing the same thing. There won't be any growth for them, hence I'm saying that some people will remain stagnant while other is given opportunities to grow. **Interviewer**: I heard you say that they choose people to go for training anyhow, what do you mean? **Participant A**: I mean that when there is training, the communiqué will come out with all the details about the type of training; the high class hotel where it's going to be held; the type of food etc. Based on that information they will then choose a certain category of personnel to attend. When the training is held at a low class venue, they will choose just anybody to attend. **Interviewer**: By category, what do you mean? **Participant A**: I mean that when the standard of the venue and other things is high (5 star treatment) people who are in control or leadership choose themselves to attend even thou the training would	Structure-Insufficient knowledge and training

have benefited personnel at the lower levels. Personnel that are in need of the training will be deprived an opportunity to get skills they need just because of the standard of the venue etc.

Interviewer: What are these categories?

Participant A: In most cases, if I am a staff nurse I won't get an opportunity to attend the training but a professional nurse will be favored. A professional nurse can sleep at a hotel, while a staff nurse is not supposed to. You understand what I mean? They do those things sometimes

Interviewer: Ok, you mean that professional nurses are given preference over staff nurses?

Participant A: Yes

Interviewer: I hear you. Is there anything you want to add on the PMDS process?

Participant A: Concerning trainings and workshops, they send people through favoritism. They don't check if the person has the information for what she is sent, or if she will benefit from such. This means that the person won't get the necessary development and can't also share the knowledge with others in the work place because the training was not relevant for them.

Interviewer: What happens after the trainings?

Participant A: There is nothing-different happening after the training. We will just know that a person attended a workshop.

Interviewer: In other words, you mean that the workshop doesn't have any impact on your work?

Participant A: No it doesn't have any impact, it was just a leisure time for the person who attended. They would just go there to enjoy the hotel stay, and pile up the papers. Nothing more, and reason for that they sent someone who doesn't even have interest on the subject. **Interviewer**: Ok, interest also counts? **Participant A**: Yes it does. **Interviewer**: Is there anything else you want to add on the process? **Participant A**: No **Interviewer**: My second last question, what is your view on the outcomes of PMDS? What happens at the end of PMDS implementation? **Participant A**: The outcomes of PMDS are not nice. A lot happens in some cases some people get performance bonus and others don't. The one that gets performance bonus will have their moral boosted, work hard because they got money. Usually, those that didn't get any performance bonus or steps are demoralized. They become bitter; absenteeism increases, because of unnecessary and unplanned leave. Some people get discouraged and they no longer do their work as expected, they come to work with a bad attitude. The patients suffer the most during this time. An example is when I work with someone, we are on the same category, maybe I got the incentive and she didn't; when I ask that we do something together to help a patient, the person can say that "you continue working, I won't do that because you got money and I didn't". The patient is the one to suffer and the workload increases for some staff members. The impact of this is not good at all	Outcomes-Job dissatisfaction and demotivation Low staff morale

Interviewer: So what does the manager do to control the situation in such instances?	
Participant A: I notice that managers don't want to involve themselves in such cases because they also don't want to be accountable for PMDS. I don't know where PMDS is coming from and managers don't have any conflict resolution mechanisms in place to deal with problems that arise from PMDS. They also don't give us feedback after the assessments were done. Sometimes we even forget that assessments were done.	Process-mentoring and support
Interviewer: So, as a subordinate what do you do when you are not given any feedback?	
Participant A: There is nothing we can do	
Interviewer: You don't ask any questions?	
Participant A: We don't, or even if we do we won't get any useful information. In some cases, as I have explained you find that you were presented by someone who works on the other side, you won't even get the chance or time to there and ask questions. There is never a time where we get feedback about the results or anything that has to do with the assessments. In my view, PMDS is done for the sake of doing it, not in accordance with the provisions of the policy.	Process-Unfair, fragmented reporting lines
Interviewer: How do you think it should be done?	
Participant A: I think it should be done quarterly and it should be a process where a supervisor will sit with his/her subordinate and do a thorough assessment; identify areas of training or development as well as improve the manner in which the worker does her work. I believe that it should be a process whereby the employee will get a chance to work through her development needs and also get advice on how to improve. That will ensure that people don't only do PMDS	Outcomes-Concerns on performance bonus Process-mentoring and support

for incentives or bonus but for them to improve their work standard and improve service delivery. They will also be able to identify their training needs, thereby increasing the number of staff that can do many services. Unlike a situation where someone will just sit and do nothing when patients are waiting because e/she doesn't have the skill required to serve that patient.	
Interviewer: I understand what you are saying and would like to hear from you what do you recommend should be done under structure, process and outcomes of PMDS?	
Participant A: Under structure I recommend that time is made for the policy to be seen, read to people and they be checked if they do understand the PMDS policy. The main issue is that people should understand and know how PMDS is implemented. Managers should also receive training on PMDS, and train the staff so that the required skill will be developed.	Recommendation-structure-policy
Interviewer: You mean training for PMDS?	
Participant A: Yes and staff should be trained on computer literacy, even though we don't have computers but at least we will have the knowledge.	Recommendation-structure-training
Interviewer: yes I hear you…	
Participant A: When people have access to computers, they can be able to write their own reports.	Recommendation-structure-resources
Interviewer: So, what do you mean? Are you saying that managers should advice you to buy computers or what?	
Participant A: I mean that they should at least encourage personnel to be computer literate. Obviously when you are computer literate, you would want to own a computer.	Recommendation-structure-resources

Interviewer: All right, you mean you have to go for computer lessons, then you will buy your own computers? **Participant A**: Yes	
Interviewer: Ok, I understand you. So under structure, what can you add as a recommendation? **Participant A**: Honestly speaking there is no time to do PMDS. You find that the facility is full early in the morning; there is no time to sit and do PMDS. The process is exhausting because one has to sit the whole night and do PMDS. I think there should be time set aside quarterly to do the process. The issue of space is another challenge that needs to be looked at because the facility is small and there is no space to do the PMDS. You find people writing their reports in the kitchen.	Recommendation-process-erratic reporting periods
Interviewer: I heard you say that PMDS is done overnight; how does that impact on the PMDS report? **Participant A**: I think a lot of what is written on the report is not accurate because the person will be under pressure to finish. They will write anything just to finish, and in the process leave out some vital information regarding the person's performance.	Recommendation – outcome-subjective scoring
Interviewer: So what you are saying is that it does not reflect actual performance? **Participant A**: Yes it does not reflect the actual performance of the personnel; and that puts the personnel at a position of disadvantage because they won't get a step or performance bonus. That's why in some instances you become amazed when you discover that a person who doesn't perform their duties well get performance bonuses, while those who work hard don't get anything. I think that because the reports are done at night and the person will be exhausted you find	Recommendation – outcomes-concerns on bonus

that they will write well for the first person and later write anyhow. I think that is another issue. **Interviewer**: Ok, is there anything you want to add under recommendations for structure? **Participant A**: No **Interviewer**: What do you recommend under the process of PMDS implementation? **Participant A**: I recommend that people should be orientated, more especially during induction. They should be taught about PMDS, what it is all about; what is expected of them. This should be done before a person even starts working. This will help them know what is expected, when and how. I believe that if that can be done, the process of implementing PMDS can be quite easy and interesting; unlike now that we do it with a negative attitude. People should also know their job descriptions, because in most cases we just work randomly. Supervisors will just tell you to do something even though it's not part of your job description. When there is a job description, a person will not overlook what she's supposed to do because they would know it's their duty. Presently there are things that we overlook when we are not supposed to, and do those that are above our scope. The reason being that we don't know that it's part of our duties. **Interviewer**: How do you think being given job descriptions will affect performance? **Participant A**: I think it will improve performance because when you know that something is your duty, you will not neglect it. You will do it and also go an extra mile where necessary. **Interviewer**: What more do you want to add under process?	Recommendation-process-orientation on PMDS Recommendation-process- job description and work plans

Participant A: I recommend that training should be given; training needs identified and people be developed. Favoritism must stop; people must not attend training just because it's done at a nice hotel. It should be based on the training needs of individuals. The needs assessment can be done through having a meeting with staff and discussions happen on what the development needs of individuals are. The other way would be to use the development needs as identified during the PMDS, if the process was done properly. **Interviewer**: Is there anything you want to add under process? **Participant A**: I would like to recommend a person be evaluated after attending training. That evaluation will enable managers to discover if that training was relevant and if it improved anything on the person. This will help in the process of selecting staff for future training, because only those that will benefit or develop because of that training will be chosen. People won't just go for training randomly, without even having an interest on the subject. **Interviewer**: You mean interest must be checked? **Participant A**: Yes, only those interested and will benefit **Interviewer**: Is there any other recommendation you want to add under the process of PMDS implementation? **Participant A**: No there's nothing **Interviewer**: What do you want to add under outcomes? What do you recommend should be done to improve the whole situation? **Participant A:** I recommend that supervisors should give us feedback when they come back from the presentation of the assessments. They should tell us everything that was said about us and the scores that were awarded. Managers should be able to come back and share	Recommendation-outcomes-unfair, fragmented reporting lines Recommendation-outcomes-subjective scoring

information with staff members about the whole process of PMDS. This will help people to understand why they underperformed, and help them know how to improve their performance in future. Talking to staff about the outcomes of PMDS will also minimize the issue of conflict that arises because some got performance bonuses and some did not. There should be a conflict resolution mechanism in place. I also strongly recommend that nurses should speak out about their feelings and views concerning PMDS. There should be briefing sessions before and after the process. **Interviewer**: How do you think that briefings will help? **Participant A:** Briefings will help a lot because in such settings nurses will be able to share their views, fears and frustrations about the PMDS. I believe that such will improve relationships and the manner in which we view PMDS, because it will be known that people want this and they don't want that. Briefings are a good process to help improve the manner in which things are done currently. **Interviewer**: I hear you, you have said quite a lot. In all this, what do you like about PMDS? You have said much about what you don't like, now tell me what you like about PMDS, positive things about PMDS. **Participant A**: The positive thing about PMDS is that when it comes we get paid performance bonuses or you get a step or two. It's nice, you get another notch and money comes into your account. That is what is nice about PMDS. The bonuses are good. **Interviewer**: You only like it when it comes to money only? **Participant A**: Not at all; the other thing I like is the study leave because I believe it's one of the incentives of PMDS. The study leave	Recommendation-outcomes-low staff morale, job dissatisfied and demotivation

gives us an opportunity to improve so that we can grow from one level to the next. **Interviewer**: Is there anything else you want to add on everything we have spoken about? **Participant A**: What I can add is that PMDS would be a very good process if everything was done properly. If the person, who works directly with you, knows how you do your work was the same person to represent you at the assessments. It would work very well if every quarter, the supervisor would remind you of areas of concern; where you need to improve and also encourage you to develop necessary skills. It would make the process more relevant and beneficial to everyone since there would be proper communication prior to the assessments. It would work very well if there was proper communication and everyone understands the policies and what needs to happen. **Interviewer**: Ok, thanks very much for your time and the information you have given. I strongly believe that it will help me in this study and if there is anything more I need from you, I will contact you. I will also give you feedback about the results of the study. I appreciate and thank you very much. **Participant A**: Thanks very much. I would really appreciate if you can give me feedback.	Recommendation-process-mentoring and unfair, fragmented reporting lines