THE MAINTENANCE OF QUALITY IN HEALTH CARE ORGANISATIONS: A MANAGERIAL PERSPECTIVE (NORTH-WEST PROVINCE, KLERKSDORP/ TSHEPONG/POTCHEFSTROOM/WITRAND HOSPITAL COMPLEX)

BY

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DECLARATION

I, SELLOANE SARAH MANAMELA declare that the dissertation for the degree of Masters of Business Administration at the University of North West hereby submitted, has not previously been submitted by me for a degree at this or any other university. That is, it is my own work in design and execution and that, all material contained herein, has been acknowledged.

Selloane Sarah Manamela

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ABSTRACT

The purpose of the study was to explore and investigate ways and means of attaining quality services production as well as maintaining the status quo, within the health care organisations (North West Province, Klerksdorp/Tshepong/Potchefstroom/ Witrand hospital complex).

The survey method was used for this study, and the respondents to this study consisted of the Klerksdorp/Tshepong/Potchefstroom/Witrand hospital complex, employees and managers as well as the Southern region of the North West Province community members who were patients/clients during the period of survey. The primary tools for data collection were questionnaires for employees and patients/clients, as well as a structured interview for managers. The questionnaires respondents were 21, that is, 9 employees and 12 patients/clients respondents. All 21 useable questionnaires were returned. The interview respondents were 9 and none withdrew his/her participation from the interview. For the analysis and interpretation of data, tools such as frequency distribution tables and summation methods were used.

The findings revealed the general satisfactory responses from the three categories of samples, however, aspects such as high morale of employees, motivation, reward systems and security, on the side of employees, and waiting time for both treatment and services, progress and treatment discussion and security services on the patient/client's side, were of major concern which warrants further investigation.

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1. CHAPTER ONE

ORIENTATION OF THE STUDY

1.2 INTRODUCTION

According to Tappen(1995: 367), Health Care Organisations vary widely in the type of services they offer, the people they serve and the way in which they are financed. Some are highly specialised e.g. offering only renal dialysis while others, such as general hospitals, offer a wide range of services from prenatal classes to day surgery and intensive care. Most of these health care organisations include: hospital, clinics, public health agencies and community mental health care centres.

This study will focus on hospital type health-care services and will explore ways which organisations should follow in order to enable them to maintain quality standards once achieved, or serve as guidelines towards quality productivity. The study will further investigate problems encountered by managers within their health-care organisations which hamper organisational goal achievement. For health care organisations to be effective, some of the following aspects have to be considered: Employer factors, employee factors as well as the organisational culture. These factors may have a positive or negative impact on the effectiveness of the organisation. It is therefore of prime importance that the organisational strategies are as effective as possible.

The terms of reference of each health care organisation is embedded in its vision, mission values and objectives.

1.1. BACKGROUND OF THE STUDY

Quality is an integral part of health care, part of its professional standards, guidelines and codes. For various reasons, however, all health care organisations should pay special attention to quality issues, today (Booyens 1999:595). The world is becoming more quality conscious and companies that resist implementing total quality principles may not survive (Evans & Dean 2000:9). Health care organisations therefore, to gain a competitive advantage, need to pursue efficiency and effectiveness in setting organisational goals which are appropriate. Apps (1994:28) defines effectiveness as a balancing term for efficiency which is a measure of how well or

how productively resources are used to achieve a goal, as asserted by Jones et al (2000: 6). They cite an example of the Ford Motor Company Manufacturing Plant in Avon Lake whose managers work hard and long hours to make the Ford Company Plant the highest performing plant.

Managerial functions are the basis of achieving effectiveness in an organisation e.g. planning, organising, leading and controlling (Jones, 2000: 8), whilst Tappen (1995: 60) states that planning involves the following:
Priorities, i.e. beginning with the most important and urgent tasks, followed by allocation of scarce resources, which is the greatest challenge faced by the managers. Furthermore, timing and sequence is also important and denotes that some tasks must be prioritised. These are followed by deadlines that must be met. Organisational rules, such as emphasis on risk management should also be considered. Skills mix of the staff i.e. the ability and experience of staff members is also important. Some tasks require technical skills and precise timing therefore, characteristics of work are also important.

1.2. STATEMENT OF THE PROBLEM

The Health Care System is publicly criticised and challenged and productivity and quality are major problems which have become the focus of attention. A person's health is one of his/her most important assets, therefore, health care delivery should be of the highest quality (Booyens,1999: 595). To ensure that quality care is everybody's business, a formal Council for Health Service Accreditation of South Africa (COHSASA), was registered in 1995. Its aim being to assist health care facilities with the process of continuous quality improvement (Booyens, 1998:623) This is an indication that even if an organisation is known to be a highly effective one, there is still a need for continuous quality improvement programs to maintain the status quo. In this manner, the collapse or deterioration of quality services in any health care organisation can be avoided, which unfortunately seems to be the main problem that health care organisations are encountering.

The other situation is that much planning for health sector reform on expanding the coverage and efficiency of services (in South Africa) is taking place. Public health

services are morally obliged to render the best possible care to patients within the prevailing resource constraints, regardless of race, income or geographical location. To ensure this, explicit decisions and processes are required to prioritise resource use, develop treatment protocols, train personnel and monitor many aspects of patient care on continuous basis (Dept of community Health: Oliver Tambo fellowship programme 1997:50). The effort to prioritise resource use might also be a complicated aspect due to migration of key health professionals which impact negatively on human resource as well as quality service delivery. The OECD study on migration of health professionals reflected that in 2001, already 23407 were working in selected overseas countries (Department of Health, A National Human Resource plan for Health 2006: 27). Another study by World Health Organisation was regarding migration in six African countries. It was found that while financial incentives featured prominently, working and living conditions at home were named by the majority of respondents as key reasons for their departure. Deteriorating working conditions within the public sector, lead to the health professionals seeking better working conditions (Department of health, A national Human Resource Plan for Health, 2006:27)

1.3. THE PURPOSE OF THE STUDY

The purpose of this study is to explore and investigate ways and means of attaining quality services production as well as maintaining the status quo within health care organisations, once attained. The outcome of this study, therefore, will serve as one of the guidelines and motivation to managers and employees in health care organisations to strive for quality productivity within their health care organisations.

1.4. RESEARCH QUESTIONS

1. Where will health care organisations be in three years time (as far as quality productivity is concerned)?
2. Is quality maintenance a possible aspect to achieve in the organisation?
3. What motivates employees to achieve the organisational objectives?
4. What are the obstacles in attaining the organisational objectives (quality productivity)?
5. How is employees' wellness ensured in health care organisation?

1.5. OBJECTIVES OF THESTUDY

The specific objectives of the study are to:

- ❖ Clarify roles of employers and employees within the health care organisation.
- ❖ Clarify activities to be carried out in maintaining organisational quality.
- ❖ Understand organisational culture leading to its efficiency and effectiveness.
- ❖ Describe behaviours of employees and employers in health care organisations.
- ❖ Understand the needs of other stakeholders within the health care context.

1.6 SIGNIFICANCE OF THE STUDY

In order effectively to improve, monitor and maintain quality standards within the organisation, it is important to identify ways and means of achieving this goal and also identify obstacles, and deal with them accordingly.

Theoretically, this study will assist managers to expand their managerial perspective and body of knowledge as far as quality improvement and maintenance within their organisations is concerned. It will also enable them to revisit their administrative activities and thus contribute to their practical context.

Le Compte, Preissle and Tesch (1993:26) cite Smith (1987) which state that experiences of individuals, whether powerful or powerless, must be represented in the theories of the society. That is why it is necessary, even in this study, also to explore the perceptions and experiences of other health care stakeholders e.g. health care customers, with regard to health care services rendered. The study should therefore provide the researcher with an understanding of such stakeholders' experiences and perceptions, and to improve, manage and maintain quality health care services.

1.7 ASSUMPTIONS OF THE STUDY

According to Kuhn (in Mouton & Marais, 1992:147) any research undertaking has three areas of commitment, i.e. theoretical- conceptual, methodological- technical and ontological. Accordingly, the researcher formulated the following assumptions for the study with reference to Kuhn's area of commitment.

1.7.1 Assumptions regarding theoretical- conceptual commitment

- Trained, motivated, informed and satisfied, individuals or employees are capable of peak performance thus, quality productivity.
- If participated in organisational decision making, employees display shared ownership of such decisions and on aligned commitment towards goal achievement.

1.7.2 Assumptions regarding methodological- technical commitments

These assumptions pertain to the criteria regarded as scientific and to the method as well as instrumentation by means of which a given view of what is scientifically valid, may be realised (Mouton & Marais, 1992:147). In this study it is assumed that:

- The qualitative method also applies to the maintenance of quality in health care organisations.
- Qualitative research can also lead to the ability to identify ways of improving, monitoring and maintaining quality care service in health care organisations.

1.7.3 Assumptions regarding ontological commitments

According to Mouton & Marais (1992:147) ontological dimensions of research examines the nature of the research object and addresses the "what is" of the phenomenon. In this study it is assumed that:

- ❖ The maintenance of quality services upholds the reputation of health care organizations in question.
- ❖ Ways and means of improving, monitoring and maintaining quality can be clarified.

1.8 OUTLINING THE RESEARCH DESIGN AND METHODOLOGY

1.8.1 Research design

The researcher will adopt a descriptive and contextual qualitative approach using a non-experimental research design.

1.8.2 Target population

A population consists of all cases that meet the designated criteria. In this study the target population will consist of managers, employees as well as health care customers from three health care organisations within the Southern region of North West Province.

1.8.3 Sample design.

Purposive sampling, a non-probability method of sample selection will be used to identify respondents of the study.

1.8.4 Sample size

Three from each category within three organisations and twelve heath care customers will be interviewed and thus the total subjects will be thirty. This means the researcher will interview thirty subjects (nine managers, nine employees, from three health care organisations as well as twelve health care customers) and eligibility criteria will be used. The study will be conducted at different organisations within which all the respondents work.

1.8.5 Data collection

The data will be collected during focus group interview sessions lasting between fifteen and twenty minutes each. This will apply to all respondents. The researcher will facilitate sessions and listen actively to the respondents in order to obtain clues to

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what questions to ask next (with guideline questions as part of the structure). Opportunities will be used as they arise for probing relevant responses.

1.8.6 Data analysis

The four phases of data analysis and process will be guided by the process cited by Van der

Waldt (2000: 331-362).

A thorough review of all recorded and written information that the researcher obtained during data collection will be done. All interviews will be conducted in the relevant language, depending on the group interviewed e.g. English, Afrikaans or Tswana. Data will thereafter, be analysed.

The focus on the data analysis will be on the speech or sentence, not just single words in isolation. Data will also be coded by identifying recurring themes and organized according to the themes (Brink,1999:192, Morse & Field,1996:21,Pilot & Hungler,1991:500-505).

The data collection method, namely focus group interviews, will guarantee the quality of the data collected because probing will be done and the researcher's availability will make it possible to check the completeness of the data (Wilson,1993:160).

1.8.7 Ethical Issues

Ethical issues will be taken into consideration to protect the respondents of this study. The following ethical considerations will ensure that the informants' right are not violated (Polit & Hugler, 1995: 134-142):

- The informants' self determination will be ensured by the provision of verbal and written information about the study.
- The informants will be given an opportunity to give voluntary written consent to participate in the study.
- The informants will be free to withdraw from the study if and when they so wish.

- ❖ Ensuring anonymity and confidentiality of the information provided will enhance the informants' right to privacy. This means that the responses will not be labelled. Informants will remain anonymous in reports and publication of the study.

1.8.8 Trustworthiness.

The researcher develops the models in order to ensure rigour without sacrificing the relevance of qualitative research. According to Lincoln and Guba (1985:218) trustworthiness endeavours to establish confidence in the truth of the findings and determine the degree to which the findings or the inquiry may have applicability in other contexts as well as whether the findings would be consistently repeated on replication of the research in a similar context. The researcher will use Guba's model to assess the credibility, applicability, consistency and neutrality. These four aspects of trustworthiness will be fully discussed later in Chapter 5.

1.9 LIMITATIONS OF THE STUDY

The researcher recognises restrictions in the study that may limit the credibility of findings and restrict the population to which the findings can be transferable.

- ❖ Being an exploratory study in this area, the instrument used for data collection may have limited credibility because it has not been tested before.
- ❖ Another limitation inherent in the study is that the researcher knows that the quality standard of certain organisations tend to deteriorate after such an organisation has been known to be a highly effective one. This has a positive side, however, as the researcher can better understand the respondents' perceptions.

The researcher will apply second level bracketing by not allowing previously conducted interviews to contaminate following interviews.

1.10 CLARIFICATION OF CONCEPTS

1.10.1 Management: The process of designing and maintaining an environment in which individuals working together in groups, efficiently accomplish selected aims (Weihrich,& Koontz,2005: 4).

1.10.2 Quality: Refers to the characteristics or features associated with excellence, and these characteristics form the criteria for evaluating the quality of a specific service (Kreitner,& Kinicki, 2001:416).

1.10.3 Effectiveness: Is a measure of the appropriateness of the goals that managers have selected for the organisations to pursue and the degree to which such an organization achieve these goals(Joans ,George & Hill,2000:6).

1.10.4 Efficiency: Is a measure of how well or how productively resources are used to achieve a goal (Apps,1994:28).

1.10.5 Organisation: Means a system of consciously coordinated activities or forces of two or more persons.(Kreitner,& Kinicki, 2001:21).

1.10.6 Vision: A vision is a statement that describes the mental picture held by an organisation or business unit of what it will be like in some years' time. It is what an organisation or business stand for (Kenny, 2005: 72).

1.10.7 Mission: A mission is a statement which expresses the fundamental purpose of an organisation or business. It answers the question, "What business are we in? (Kenny, 2005: 244).

1.10.8 Values: Values are beliefs about what is right or wrong, good or bad. Values of an organisation or business unit guide its culture, e.g. respect for staff or technical excellence (Kenny, 2005: 245)

1.10.9 Objectives: Objectives are the end towards which activity is aimed (Weihrich, & Koontz, 2005: 100).

1.10.10 Performance: Performance means realising goals and meeting expectations (Coetzee, 2002:139).

1.10.11Peak performance: Peak performance means realisation and utilisation of the potential of team members and realisation of goals and expectations (Coetzee, 2002139).

1.10.12 Aligned commitment: Aligned commitment is when team members are focused, energetic and ready to unleash their potential to achieve their goals (Coetzee, 2002; 141).

1.10.13 Organisational Culture: Organisational culture means shared values and beliefs that underlie a company's identity (Kreitner,& Kinicki,. 2001:66).

1.10.14 Strategy: It is a statement that describes how competitive advantage is to be achieved on strategic factors (Kenny, 2005:245).

1.11 ORGANISATION OF THE STUDY

Chapter one will provide the research problem, the aim of the research and methodology to be used. It also clarifies some key concepts of the dissertation.

Chapter two outlines the theoretical foundation of the study and linked with chapter three which reviews the literature, will give a clear guideline of which relevant information to be included in the focus group interviews. For example, managerial aspects, important in maintaining quality productivity, are being clarified.

Chapter three reviews the literature and reveals the nature of the concepts, quality and health care organisations, by applying it to the maintenance of quality in health care organisations.

Chapter four defines the problem and clarifies the objectives of the study.

Chapter five deals with the design of the research instrument and a discussion of the questions formulated in respect of maintenance of quality in health care organisations

and ways to make employees within these organisations aware of quality maintenance are also indicated

In chapter six reflection of the validity and reliability of the research findings are ensured through thorough analysis of the study results. These results are interpreted in a brief discussion.

Chapter seven deals with the recommendations of research and provides conclusions

1.12 CONCLUSION

In recent years, most health care organisations, public or private, acknowledge that quality health care service delivery is a major concern to the extent that most of them have already been accredited as highly efficient organisations as far as quality care is concerned, by different bodies committed to ensuring that quality productivity and services are delivered (Council for Health Service accreditation of South Africa). The process is still continuing to accredit more health institutions. Even though quality care has been attached to health care since its existence, there is still a need to ensure that, once quality care has been improved, where it was poor and fully attained after some efforts to do so, it is maintained within the organisation.

The fact that most organisations have managed to be accredited as highly efficient, indicates that people within such organisations have an enormous potential. It is thus encouraging and promising that in the same way that quality productivity has been managed to be achieved, so is the possibility and ability to maintain the status quo, once ways and means, are clarified.

This chapter provided the problem statement and dealt with the objectives of the study as well as the methodology. Chapter two will be devoted to the theoretical foundation of the study.

CHAPTER 2

THEORETICAL FOUNDATION

2.1 INTRODUCTION

Quality maintenance and other aspects involved in it, are clarified by means of the literature study and include management as a concept. The concepts quality, human resource management and related issues as well as organisational behaviour and culture will be discussed. To ensure the clarity of this study, all concepts will be defined and briefly outlined where the need arises.

2.2 THE CONCEPT "MANAGEMENT"

Among many definitions of management, by different cultures, the following are given:-

Management means the planning, organising, leading and the controlling of resources to achieve organisational goals effectively and efficiently (Jones, George & Hill, 2000: 5). Smit & De J. Gronje (2001:9) also define management as combining, allocating, coordinating and deploying resources or inputs in such a way that the organisations' goals are achieved as productively as possible. To emphasise these authors' definition of management, Van der Waldt & Du Toit (1999:11) define management as a process whereby people in leading positions utilise human and other resources as efficiently as possible in order to provide certain products or services, with the aim of fulfilling particular needs and achieving the stated goals of the institution.

Management thus, ensures the attainment of what is stipulated in its definition, by following a specific process which entails four fundamental management functions: i.e. planning, organising, leading and controlling. According to Weihrich &Koonts (2005: 64) however, there is also a fifth fundamental management function, namely, staffing: These fundamental management functions will be outlined later in this chapter. In order for management as a concept, to take place, there has to be an organisation and managers in place. According to Hellriegel & Slocum (1991:7- 8) an organisation is defined as any structured group of people brought together to achieve

certain goals that individuals alone could not achieve. The manager on the other hand, is a person who allocates human, financial and material resources and directs the operations of a department or an entire organisation. They further outline the levels of management as follows: First-line managers, who are directly responsible for the production of goods or services and most of their time is spent side by side with the people they supervise. Van der Waldt & Du Toit (1999:159) refer to first line managers as assistant directors and supervisors and further explain their responsibilities as operational management of smaller divisions, departments or units in the organisation. They are also responsible for the implementation of objectives set by middle management and to do this, they need to draw up operational plans and programmes to be executed by employees of the institution. Aspects such as leading, motivation and communication play a significant role in developing a positive relationship that should exist between management and employees between whom this level of management serves as a link. Hellriegel & Slocum (1991:8) further explains the other level of management as middle management. Middle managers receive broad overall strategies and policies from top managers and translate them into specific objectives and plans for the first line managers to implement. Van der Waldt & Du Toit (1999:159) further explain middle managers as directors and deputy directors within the organisation and are responsible for tactical management of the organisation. These managers need to compile divisional objectives and programmes to ensure that the organisational policies are implemented and the aims of the institution are achieved.

Another management level is top management. Top managers are responsible for overall direction and operations of an organisation. They often represent their organization in community affairs, business deals and government negotiations (Helreigel & Slocum,1991: 8)

Top management in government organisations usually consists of director general, deputy director general and chief directors (Van Der Waldt & Du Toit 1999:159). They further explain top managers' responsibility as strategic management which entails among other things, a mission, strategy and aims, the compiling of strategic plans and organisational structures, control and decision making. Other tasks involved are: Developing and reviewing organisational policy, reviewing labour practices,

maintaining and improving community relations and monitoring product and or service quality.

Having been enlightened with management as a concept, its levels and their responsibilities, top management seem to be playing a major role through its strategic management so as to achieve the rewarding outcomes for the organisation. Kenny (2005:68-74) emphasises the point that an organisation needs a sound strategic planning for it to achieve its expected outcomes. The strategy development thus, involves mission, vision, values and objectives of the organisation. According to Kenny (2005:69) mission is concerned with the question of "what business are we in". The mission statement expresses the fundamental purpose of an organisation or business unit. A vision statement is one that describes the mental picture held by an organisation or business unit, of what it will be like in future years. Values are what an organisation or business unit stands for and they guide culture. Value statements are often concerned with how an organisation treats its employees or the attitude expected within the organisation regarding, say, technical excellence or quality. Objectives describe what an organisation or business unit wants to achieve via its key stakeholders: For example, to increase revenue from customers. The point of departure on objectives setting is that they be led by key stakeholders. This means there must be objectives for customers, employees, suppliers, owners and objectives for any other relevant stakeholders.

Over and above Kenny's views on aspects involved in strategic, development, Booyens (1999:438) describes a vision as a picture of a further state of affairs that is attainable, realistic, credible and infinitely better than what exists at present. It energises people to act in order to bring about change, and this change leads to the achievement of success and excellence. A vision also has two essential purposes, namely : to create an attractive future and this motivates people to find their own roles in an organisation and to work purposefully towards defined goals. Secondly, it serves to focus people's attention on where the organization is going. These allow the leader and followers to choose those activities which will lead to envisioned goals and to avoid wasting time on actions which are not relevant.

2.3 FUNCTIONS AND ROLES OF MANAGERS

Before proceeding to the quality concepts of this study, functions and roles of managers will be briefly discussed. Generally, different authors identified fundamental functions of management as planning, organising , leading and controlling. Planning is a process that managers use to identify and select appropriate goals and course of action (Jones et al, 2000:8).

2.3.1 Planning

Jones (et al, 2000:8) identify three steps in the planning process:

- Deciding which goals the organisation will pursue;
- Deciding what course of action to adopt to attain those goals; and
- Deciding how to allocate organisational resources to attain those goals.

How well managers plan, determines how effective and efficient their organisation is i.e. its performance level. Either success or failure is a possible outcome of the planning. Hellriegel & Slocum (1991:11) explain planning as defining goals and objectives for future performance and deciding on ways to reach them. They also identify three reasons for planning, namely, to establish objectives for the organisation, such as increased profit, expanded market share, and social responsibility. Secondly, to identify and commit the organisation's resources to achieve those objectives and decide which activities are necessary to achieve them.

2.3.2 Organising

The second managerial function is organising. According to Hellriegel & Slocum(1999:11) this is the managerial function of creating a structure of relationships among employees that will enable them to carry out management's plans and meet overall objectives. By organising effectively, managers can better co-ordinate human and material resources. An organisation's success depends largely on management's ability to utilise those resources effectively and efficiently. The organising process involves creating departments and development of job descriptions. In this sense, staffing proceeds directly from the planning and organising functions. Jones et al (2000:9) also view organising as a process that managers use to establish a structure of working relationships that allow organisational members to work together to achieve organisational goals. Organising involves grouping people

into departments according to the kinds of job specific tasks they perform. In organising, managers also lay out the line of authority and responsibility between different individuals and groups, and they decide how best to co-ordinate organisational resources, particularly, human resources. The outcome of organisation is the creation of an organisational culture, a formal system of task and reporting relationships that co-ordinates and motivates organisational members to work together to achieve organisational goals.

2.3.3 Leading

Leading is the other managerial function and Jones et al (2000:10) define leading as articulating a clear vision and energising and enabling organisational members so that they understand the part they play in achieving organisational goals. Leadership depends on the use of power, influence, vision, persuasion and communication skills to coordinate the behaviours of individuals and groups so that their activities and efforts are in harmony and to encourage employees to perform at high levels. The outcome of leadership is a high level of motivation and commitment among organisational members. Hellriegel & Slocum (1999:11) view leading as a managerial function of communicating with and motivating others to perform the tasks necessary to achieve the organisation's objectives. After management has made plans, created a structure and hired the right personnel, some one must lead the organisation. Some managers call this process, directing or influencing. Leading is not done only after planning and organising end but it is crucial to those functions, too.

2.3.4 Controlling

Controlling is the process by which a person, a group or organisation consciously monitors performance and takes corrective action. Performance is expected to justify expenditure and if it does not, corrective action is taken. Thus, the process of controlling is self regulating and often cyclical (Hellriegel & Slocum:1999:12). Managers set standards of performance, they take action to correct any deviations and they may adjust the standards if necessary. Just as a thermostat sends signals to the heating system that room temperature is too high or too low, so a control system sends signals to managers that things are not working as planned and corrective action is needed. Jones et al (2000:10) define controlling as evaluating how well an organisation is achieving its goals and taking action to maintain or improve

performance. For example, managers monitor the performance of individuals, departments and the organisation as a whole to see whether they are meeting the desired performance standards. The outcome of the control process is the ability to measure performance accurately and regulate organisational efficiency and effectiveness. In order to exercise control, managers must decide which goals to measure, perhaps goals pertaining to productivity, quality or responsiveness to customers and then they must design information and control systems that will provide the data they need to assess performance. The controlling function also allows managers to evaluate how well they, themselves, are performing the other three functions of management namely: planning, organising and leading, and to take corrective action.

The four managerial functions discussed above are generally considered, by many authors as the four principal functions of management. However, some authors, in addition, to these four also add other managerial functions. Tappen (1995:59-71) considers planning, organising, leading and controlling as the traditional type of managerial functions. On top of these she added the functions of recognition and rewards which effective managers use to encourage desired behaviours and retain good employees. Managers must however, ensure that rewards are being given in a fair and objective manner. They can be an effective motivator, but if rewards seem to be subjective, staff can be destructively competitive, apathetic or confused about what is really expected of them. Another function is staff development, however, there seems to be two schools of thought about staff development (Tappen, 1995: 60-68). The first view is that staff members are valuable resources of the organisation and should be developed to their fullest potential. Staff development is considered a wise investment in the future growth and development of an organisation. The second opposing point of view is that as little as possible should be spent on staff development. If a particular expertise is needed, a manager must look for someone who already has that expertise. Staff members are kept as long as they are useful. When they are no longer useful, they are discarded. The first approach to staff development indicates that employees are expected and encouraged to work cooperatively and to remain with the organisation for a long time. The result is a far more loyal staff with a higher degree of security and a much higher level of commitment to the organisation. Employees feel valued and function accordingly.

The second approach encourages competition and fosters a climate of insecurity. "The use and discard" approach threatens staff members and they are far more concerned about their own future than about the future of the organisation.

Another management function according to Tappen (1995: 69) is representation. A manager can spend a great deal of time representing his or her staff members. How their manager represents them, is of vital interest to most employees. It can also be a source of conflict for the manager who finds her/himself in the middle- between staff and upper management. Another important role in representing one's department is to act as a coordinator, ensuring adequate communication and smooth operations between different departments within the organisation and with outside agencies. For example, when a new policy is put into practice, staff members need to be informed of the change, the policy be explained and then the implementation thereof, be ensured. Smit & De J Gronje (2001: 15&16) apart from planning , organising, leading and controlling as managerial functions, add the following functions of management:

Financial function which includes the acquisition, utilisation and control of the money that the organisation needs to finance its activities and to buy materials and equipment. The purchasing function entails the acquisition of all products and materials required by business to function profitably. The purchasing manager who has to be in contact with suppliers must be aware of new products and know prices at which goods can be bought. He or she also has to keep the inventory up to date, to ensure continuity of functioning. The public relations function of a manager is to create a favourable image of the organisation and to establish good relations with those directly or indirectly concerned with the organisational service. Over and above these functions, Van der Waldt & Du Toit (1999: 9) have the coordinating function which coordinates activities of all other managerial functions. Various functions of management will therefore be given in table 2.1.

TABLE 2.1 VARIOUS FUNCTIONS OF MANAGEMENT

Authors	Functions
1. Jones, G.R.,George, J.M. & Hill, C.W.L 2000, Hellriegel, D & Slocum, J.W. 1992.	Planning, organising,leading and controlling
2. Tappen, R.M. 1995	Regarded a traditional classification of planning, organising, leading and controlling as not sufficient and added recognition and rewards as well as representation as other managerial functions.
3. Smit, P.J. & De J Gronje, G.L. 2001	Also added financial function to the traditional managerial functions
4. Van der Waldt, G. & Du Toit, D.F.P. 199	Added coordinating function to the traditional managerial functions

There are, therefore, some quality related aspects which among others, needs to be considered and include the following: Quality Assurance, Quality improvement, Quality control, Quality management and Total Quality management.

Quality Assurance is generally defined as designing a product or service and controlling its production so well that quality is inevitable. On the other hand, especially to health care, it is defined as the activities and programmes intended to guarantee or ensure quality of patient care (Katz, & Green,1993:9).

Quality control is defined as the activities and techniques employed to achieve and maintain the quality of a product, process or a service. It includes a monitoring activity but is also concerned with finding and eliminating causes of quality problems so that the requirements of the customer are continually met (Oakland,1993 :15-16).

Quality improvement is defined as a process of continuously setting and achieving higher standards and implies identification of areas of poor quality and solution of quality problems (Ellis,& Whittington,1993:250).

Quality Management is defined as an approach to quality management that stresses the establishment of company wide structure, systems and procedures and involves all personnel and encourages the development of quality culture. Emphasises quality improvement as well as quality appraisal (Ellis, & Whittington,1993:250).

These quality aspects will be briefly outlined. Dale, & Bunney (1999:29&30) however differentiate these aspects by prevention versus detection. According to Dale and Bunney,(1999:29-30) quality control and inspection are basically detection type activities while quality assurance and Total Quality Management are prevention based. They further indicate that detection will not improve product or service quality but only highlight it when it is not present and sometimes it does not even achieve this. Problems in the process are not removed but contained. An environment in which the emphasis is on making good the non-comformance rather than preventing it arising in the first place, is not ideal for engendering team spirit, co-operation and effective climate for work. The focus tends to be on "switching" the blame to others, and people making themselves "fireproofs" not prepared to accept responsibility and ownership as well as taking disciplinary action against people who make mistakes. A direct organisational effort towards planning and preventing problems occurring at the source is therefore, needed i.e. the prevention approach.

2.4 HUMAN RESOURCE MANAGEMENT AND RELATED ISSUES

Human Resource Management is defined as managing all aspects related to and flowing from the employment relationships between the organisation as employing entity (the employer) and those persons employed to do the work (employees). All these aspects relating to the interaction between the employees and the organisation have to be managed in such way that organisational success is enhanced and all stake holders satisfied (employees, customers, owners or shareholders and the public at large) are involved (Erasmus, Van Wyk,& Schenk 2000:15).

While more about employer, employee factors as well as other stakeholders (e.g. customers) will be discussed later, the scope of human resource management will be outlined as follows and is according to Erasmus et al (2000:18).

2.4.1 Planning and organising for work, people and human resource management (HRM)

- Strategic planning for HRM- formulating strategy, structuring the work and the organisation through work analysis, job design/ redesign and designing appropriate organisational structures to facilitate optimal flows of work;
- Workforce planning through the participation of job descriptions and specification and matching projected supply and labour demand.

2.4.2 Staffing the organisation with the necessary employees

- Recruiting job candidates;
- Selecting the most suitable persons;
- Appointing employees (including new appointment, transfers promotions);
- Socialising newly appointed employees (induction or orientation).

2.4.3 Utilising and maintaining human resources

- Appraising and managing the work performance of employees;
- Leading/ directing all employees in the performance of their tasks and duties (including the application of motivation and leadership principles);
- Training and developing all levels of employees;
- Maintaining employee well-being (including health and safety, sport and recreation, canteen facilities and accommodation, welfare services and transportation);
- Compensating and rewarding employees (including remuneration structures, job evaluation, fringe benefits and incentive schemes;
- Ensuring compliance with labour related legislation;
- Negotiating with employees representatives and engaging in other collective bargaining process (including dispute settlement and strike handling);
- Maintaining discipline and dealing with employee grievances;

- ❖ Ensuring that employees agree with proposed changes and are prepared to help the organisation constantly to change in order to cope with an ever changing external environment;
- ❖ Maintaining and using all employee and human resource management related information and statistics, including maintaining HR information systems; undertaking variety of HR related research and evaluating or measuring the quality and nature of the human resources management system of the organisation.

2.5. ORGANISATIONAL BEHAVIOUR AND CULTURE

Organisational behaviour is defined as an interdisciplinary field dedicated to better understanding and managing people at work (Kreitner, & Kinicki, 2001: 10). Organisational culture on the other hand, includes the climate of an organisation and is based on the shared values, norms, beliefs and traditions that have been established over time in an organisation. It dictates what is acceptable, unacceptable or right and wrong in an organisation and the values and norms, people live by in an organisation (Coetsee, 2002: 200). There are also three basic levels of analysis in organisational behaviour; namely individual, group and the organisation itself. Organisational behaviour also draws upon a diverse array of disciplines, including psychology, management, sociology, organisational theory, social psychology, general system theory, economics, information technology and ethics (Kreitner, & Kinicki, 2001: 1).

2.5.1 ORGANISATIONAL BEHAVIOUR

According to Robbins (2005: 15-25) the following are among others, challenges and opportunities for organisational behaviour:-

(a) Responding to globalisation

Organisations are no longer constrained by national borders. There are increased foreign assignments, working with people from different cultures, e.g. bosses, peers, and other employees who were born and raised in different cultures.

(b) Managing work-force diversity

Work-force diversity means that organisations are becoming a more heterogenous mix of people in adapting to people in terms of gender, race, ethnicity and sexual orientation. A diverse work –force for instance, includes women, people of colour, the physically disabled, senior citizens and gays and lesbians.

(c) Improving quality and productivity

Quality management is driven by constant attainment of customer satisfaction through the continuous improvement of all organisational processes. It has implications for Organisational Behaviour because it requires employees to rethink what they do and become more involved in work place decisions. Today's managers understand that the success of any effort to improve quality and productivity must include their employees. These employees will not only be a major force in carrying out changes but will increasingly participate actively in planning those changes.

(d) Stimulating innovation and change

Today's successful organiSations must foster innovation and master the art of change or they'll become candidates for extinction. Victory will go to organisations that maintain their flexibility, continually improve their quality and beat their competition to the market place with a constant stream of innovative products and services.

(e) Helping employees balance work/ life conflicts

Employees are increasingly recognising that work is squeezing out personal lives and they are not happy about it. For an example, recent studies (Robbins 2005:23) suggest that employees want jobs that give them flexibility in their work schedules so they can better manage work/ life conflicts. In fact, evidence indicates that balancing work and life demands now, surpasses job security as an employee priority. The next generation of employees is likely to show similar concerns. They want a "life as well as a job". Organisations that do not help their people achieve work/ life balance will find it increasingly hard to attract and retain the most capable and motivated employees.

The following are the major personality attributes influencing Organisational Behaviour (Robbins, 2005: 105-109):-

Locus of control, where by some people believe that they are masters of their own fate. The first type believes that they control their destinies and are called internals while others see their lives as being controlled by outside forces and are called externals. A person's perception of the source of his or her fate is termed locus of control. The other personality attribute is self-esteem. This is the degree to which people like or dislike them-selves. In managerial positions, low self-esteem will tend to be concerned with pleasing others and therefore are less likely to take unpopular stands than are those with high self- esteems. Self-monitoring is the other attribute and refers to an individual's ability to adjust his or her behaviour to external, situational factors. Proactive personality refers to people who are actively taking the initiative to improve their current circumstances or create new ones. They identify opportunities, show initiative, take action and persevere until meaningful change occurs. They create positive change in their environment, regardless or even in spite of constraints or obstacles. Pro-actives have many desirable behaviours that organiSations covet. For instance, pro-actives are more likely to be seen as leaders and more likely to act as change agents within the organisations. Other actions of pro-actives can be positive or negative. For example, they are more likely to challenge the status quo or voice their displeasure when situations are not to their liking.

2.5.2 ORGANISATIONAL CULTURE

Kreitner & Kinicki (2001: 75) indicate the following types of organisational culture:

(a) Constructive culture

This is one in which employees are encouraged to interact with others and to work on tasks and projects in ways that will assist them in satisfying their needs to grow and develop. This type of culture endorses normative beliefs associated with achievement, self- actaulising, humanistic encouraging and affiliation.

(b) Passive- defensive culture

This culture is characterised by an overriding belief that employees must interact with others in ways that do not threaten their own job security. This culture reinforces the normative beliefs associated with approval, convention, dependence and avoidance.

(c) Aggressive- defensive culture

This type of culture encourages employees to approach tasks in forceful ways in order to protect their status and job security. This culture type is more characteristic of normative beliefs reflecting oppositional, power, competition and perfectionist. Normative beliefs represent an individual's thoughts and beliefs about how members of a particular group or organisation are expected to approach their work and interact with others.

Kreitner & Kinicki (2001: 73& 74) further mention the following as functions of organisational culture:-

- Give members an organisational identity;
- Facilitate collective commitment;
- Promote social system stability;
- Shape behaviour by helping members to make sense of their surroundings. This function helps employees to understand why the organisation does what it does and how it intends to accomplish its long term goals.

Organisational culture is transmitted to employees in a number of forms, the most potent being stories, rituals, material symbols and language (Robbins, 2005: 498). Stories contain narrative events about the organisation's founders, rule breaking, reaction to past mistakes etc. Rituals are repetitive sequences of activities that express and reinforce the key values of the organisation. Material symbols convey to employees who is important, the degree of egalitarianism desired by top management, and the kinds of behaviour that are appropriate. For example, participation or socialisation . Language is used as a way to identify members of culture or sub-culture.

2.6 ORGANISATION (AS AN EMPLOYER)

For the health care organisation's purpose of effectively maintaining quality services at all times, management-leadership is needed at all levels. Coetsee (2002: 55) indicates that management- leadership is focused on the enhancement of performance, satisfaction and aligned commitment. These are the three outputs of a motivating climate. Kreitner & Kinicki (2001: 6 & 551) define management and leadership as follows: Management is a process of working with and through others to achieve organisational objectives efficiently and ethically. On the other hand, leadership is defined as a social influence process in which the leader seeks the voluntary participation of sub-ordinates in an effort to reach organisational goals.

Coetsee (2002:69) also indicates that effective manager-leadership needs a combination of competency and emotional intelligence. Competencies include knowledge, intelligence, abilities, skills, values and personality traits such as drive, internal commitment, self- confidence and integrity. Emotional intelligence on the other hand implies a strong self- monitoring personality because the manager- leader must be very sensitive to situational and emotional cues from other people as well as his or her own. He or she needs to readily adopt his or her own behaviour appropriately, to these cues. Coetsee (2002:69) further indicates that according to Daniel Goleman, the best known scholar of emotional intelligence, the hallmarks of high emotional intelligence include five characteristics and are as follows:

(a) Self-Awareness

A manager-leader who has a high degree of self-awareness and self-insight recognises how his or her feelings affect him or her self, other people and their job performance. Manager-leaders with self-awareness and self-insight are aware of their own limitations and strengths, are able to openly admit and discuss them and are open to criticism.

(b) Self-regulation

A self-regulated person feels bad moods and emotional impulses, similar to other people, but they find ways to control them and even channel them in useful ways.

Incorporated in this is also a propensity to suspend judgement – to think before acting, to be comfortable with ambiguity and open change.

(c) Motivation to achieve

These manager-leaders are optimistic, have a strong achievement drive, a passion for work for reasons that go beyond money or status (external factors), are restless with the status quo, look for creative challenges and pursue goals with energy and persistence.

(d) Empathy

This refers to the ability to understand the emotional make up of other people and treat others according to their emotional reactions. They are attuned to the subtleties of body language and hear the message beneath the words being spoken. These characteristics find expression in things such as expertise in building and retaining talent, cross-cultural sensitivity and service to clients and customers.

(e) Social skills (managing interpersonal relationships)

Manager-leaders who have these skills are friendly people by nature, have the ability to move people in the desired direction are able to find common ground and to build rapport. They are good at managing teams, and are expert persuaders. They know how to make an emotional plea, or when to appeal to reason. These are also emphasised by Robbins (2005: 368) and who indicates that the recent evidence makes a strong case for concluding that emotional intelligence is an essential element in leadership effectiveness.

Apart from competencies and emotional intelligence, however, there are some aspects important for good management-leadership as well. Von Stamm (2004: 1) indicates innovation, creativity and design as most important aspects of good management and leadership. He refers to this threesome, as having to do with curiosity, taste for experimentation, dissatisfaction with the status quo and the desire continuously to improve things. She also emphasizes facts raised earlier by other authors, concerning management and leadership by indicating that management is about directing people, about efficiency, structuring and organising while leadership is about motivating

people and about inspiring them to go an extra mile, something that is often required in innovative projects (Von Stamm, 2004:381)

Swanepoel et al. (2000: 692) encourage manager-leaders to communicate with employees in order to establish sound employee relations. Different methods of communicating among others, include formal letters or memoranda, notice boards, in-house news papers or journals, special publications, briefing groups, committees, diverse face-to-face methods, diverse written communication methods and mass media. Communications are however, critical for the functioning of an organisation. Nurses need to be familiar with the communication process, communication systems and directions communication can take. There are also numerous barriers to communication and managers need to know them as well as ways to overcome them (Marriner-Tonmey, 1996: 354).

Another important aspect that manager-leaders must consider is empowering people. An increasing number of organisations are using self-managed teams, in which workers largely operate without bosses. Managers, by so doing, are empowering employees, putting employees in charge of what they normally do. In so doing, managers must learn how to give up control, and employees must learn how to take responsibility for their work and make appropriate decisions (Robbins, 2005: 22).

Motivation of employees also plays an imperative role in achieving organisational goals which in this study, are quality improvement and maintenance. Coetsee(2002: 13), divides motivation into two categories. The older content theory which focuses on the factors which cause motivation as well as the more modern process theories that endeavour to explain how motivation and behaviour, relate. According to Coetsee(2002:13) in the older content theories, motivation is caused by needs and motives. A need is an internal force (such as the mother instinct, thirst or hunger), all the result of the more fundamental survival need. A motive on the other hand, is something one learns when one observes that it leads to certain results or outcomes (reward or punishment). One learns that hard work leads to reward such as promotion or recognition. The most important difference between needs and motives is that needs are seen as mostly subconscious and therefore, beyond one's control, while motives are seen as largely within one's control.

Modern process theories of motivation are concerned with answering the question of how individual behaviour is energised, directed, maintained and stopped. These theories focus on the relationship between elements which produce or block motivation. According to these theories, each individual's behaviour is a result of her or his own assumptions, premises, expectations, values and other psychological processes (Coetsee, 2002: 15). He further states that in these modern processes of motivation, motivated behaviour is seen as the result of conscious, rational decisions between alternative choices which each individual makes. Examples of these theories are expectancy theory, which is based on the assumption that one is motivated by the attractiveness of consequences of one's efforts. The equity theory explains how people develop perceptions of fairness about the distribution of rewards in exchange for their inputs or efforts. Based on this theory, one can predict what employees are motivated to do when they feel inequitably (unfairly) treated. The goal setting theory is one of the most effective and widely practiced motivational techniques. Goal setting is the process of motivating employees and clarifying their role perceptions by establishing performance objectives. Lastly, job characteristics theory, is the most recent addition to motivational theories. The characteristics of the job which an individual needs to perform, are the key to motivation. Monotonous, repetitive jobs with few challenges inhibit the motivation of employees to perform well. On the other hand, jobs that involve a variety of activities and are challenging, enhance motivation.

Another important and last aspect that the manager-leader must consider is employee wellness. Employee wellness refers to the employees' state of optimised social, physical and mental health and well being (Swanepoel et al. 2000: 586). These authors further explain that apart from common law and the Bill of Rights (in the Constitution), there are two pieces of legislation with refined legal requirements regarding employee health and safety, namely, the Occupational Health and Safety Act (OHSA) 85 OF 1993 and the Mine Health and Safety Act (29 of 1996). Specific issues in pro-active, holistic health and safety management among others, include the following:

- Health screening and safety auditing, sensitisation and education, whereby awareness is being created in the form of posters, talks, leaflets and demonstrations;
- Fitness programmes and recreation facilities, for example, sports events, outdoor activities like fishing and cultural activities like going to art and music festivals;
- Work and family life interaction, for example, providing child and elder (parent) care facilities and involvement of spouses and children in other social activities and facilities of the organisation.
- Nutrition programmes, to inform employees about potential disadvantages and risks associated with poor nutritional habits;
- Being prepared for emergencies. The emergency infrastructure should include the necessary first aid facilities such as first aid room and first aid equipment and material.

Generally, according to Swanepoel et al. (2000: 132) employer's duties are as follows:

- To receive the workers into the service and to retain them;
- To pay the workers' wages;
- To provide safe working conditions;
- Not to expect the worker to do the work inconsistent with his or her status;
- To provide work for the worker.

Employees will be discussed in chapter 3.

2.7 CONLUSION

Having discussed different managerial aspects, it was evident that the employer, the organisation itself, managers and employees, need to maintain balance within the organisation. That is, the employers offer the job to employees and always treat them fairly, the organisational environment is conducive for employees to work in, managers fulfill their duties and responsibilities as expected and employees also perform their tasks, loyally. This balance of expectations from each category, will eventually lead to continuous quality improvement and maintenance of quality in health care organisations.

In chapter three, the literature of health care organisations will be specifically addressed.

CHAPTER 3
LITERATURE REVIEW

3.1 INTRODUCTION

Much about the quality concepts have already been discussed in the previous chapter, however, some information, which is specific to health care organisations, will be discussed in this chapter. One of the quality management gurus, Joseph M Juran, who is an advocate for Total Quality Management identified a quality trilogy which includes three activities- quality planning, control and improvement (Marriner-Tomey,1996:467).

3.2. THE CONCEPT OF QUALITY

The concept of quality that initially brought about a restructuring of health care was grounded in the works of industrial experts such as Fiegenbaum, Crosby, Juran and Deming (Katz,& Green,1992:4). These experts revealed the importance of quality in business. In the 1940s and 1950s, Edwin Schefer states that achieving quality performance requires a clear sense of what quality is. He continued by defining quality according to the following characteristics:

- Conformance meeting or exceeding the minimum standards;
- Fitness for use: Performing the task as advertised;
- Reliability: Performing the intended function in the specified environment for the prescribed period of time;
- Yield: The percent of the product or service that conforms to the specifications at each evaluation point;
- Customer satisfaction: meeting customer's expectations (Katz, & Green,1992:6).

Other authors such as Booyens (1999:596) also associate quality with an element of excellence whereby it is defined as features associated with excellence which in health care can be viewed from various perspectives by patient, health care managers, professional practitioners or funders of health care. Such features include appropriativeness, equality, accessibility, effectiveness, acceptability and efficiency. In simpler terms, quality means meeting customer's expectations (Oakland,1993:5)

Eight dimensions of quality have been identified by Garvin (in Tenner & Detoro, 1992:63) and are as follows:

3.2.1 Performance

The product's primary operating characteristic. For example, performance of an automobile includes traits such as acceleration, handling, cruising speed, and comfort while performance of an airline includes on-time arrival.

3.2.2 Features

Secondary aspects of performance. These are the "bells and whistles" that supplement the basic functions. Examples include free drinks on planes and sunroofs on cars while in health care it can be free monitoring of blood glucose, cholesterol or haemoglobin levels.

3.2.3 Reliability

Probability of successfully performing a specified function for a specified period of time under specified conditions.

3.2.4 Conformance

Degree to which a product's design and operating characteristics meet established standards. Although this is sometimes defined as "conformance to requirements" a sounder analysis will be obtained by examining each characteristics divergence from its target value.

3.2.5 Durability

Durability can be defined as the amount of use obtained from a product before it deteriorates to the point that replacement is preferred rather than repair and is closely linked to both reliability and serviceability.

3.2.6 Serviceability

The speed, courtesy, competence and ease of repair. The cost of repairs includes more than the simple out of pocket costs. Serviceability covers this full dimension by recognising the loss and inconvenience due to downtime of equipment, the nature of

dealings with service personnel and frequency with which repairs fail to correct the outstanding problems.

3.2.7 Aesthetics

How a product looks, feels, sounds, tastes or smells. Aesthetics is largely a matter of personal judgment and a reflection of individual preference and it is a highly subjective dimension.

3.2.8 Perceived Quality

Consumers do not always have complete information about a product or service's attributes, indirect measures or perceived quality may be their only basis for comparing brands.

Tenner, & DeRoto (1992:64) further provide the following ten determinants of Service Quality, i.e. from 3.2.9 to 3.2.18:

3.2.9 Reliability

Consistency of performance and dependability, performing the right service correctly the first time, honouring promises, accuracy.

3.2.10 Responsiveness

Willingness or readiness of employees to provide service, timeously.

3.2.11 Competence

Possession of the skills and knowledge required to perform the service.

3.2.12 Access

Approachability and ease of access, waiting time, hours of operation.

3.2.13 Courtesy

Politeness, respect, consideration and friendliness of contact person.

3.2.14 Communication

Keeping customers informed in a language they can understand listening to customers, adjusting language to different needs of different customers, explaining the service itself, how much it will cost and how problems will be handled.

3.2.15 Credibility

Trustworthiness, believability, honestly, company reputation and personal characteristics of personnel.

3.2.16 Security

Freedom from danger, risk or doubt, physical safety, financial security and confidentiality.

3.2.17 Understanding the customer

Making the effort to understand the customer's needs learning the customer's specific requirements, providing individualised attention and recognising regular customers.

3.2.18 Tangibles

Physical evidence of the service, physical facilities appearance of personnel, tools or requirements used to provide service, physical representation of the service such as information fliers concerning the particular health care facility.

On the other hand, Deming's principles of quality improvement were also identified by authors like Booyens (1999:601) as well as Flood (1995:15) and are as follows:

3.2.19 Introduction of a long term goal for service improvement

This first principle centres on management's leadership role in quality improvement. The manager cannot simply delegate this responsibility to a committee. Top management should demonstrate dynamic management for continuous improvement of the quality of service. Long- term goals are a prerequisite and should be made known to all employees (professional and non-professionals). Institutions that fail to conform will not survive in the business world.

3.2.20 Adopt a new philosophy

Everyone should adopt a new philosophy, namely, doing things right the first time (Gillem 1998:72) cited in Booyens (1999:601). Professional practitioners and non professional workers should develop a positive attitude towards their work, and doing things right the first time should become a matter of routine. Costs should be considered from a long -term investment viewpoint, which would encourage quality of service and lower costs over the long term.

3.2.21 Inspection

Regular inspection, in the form of a formal evaluation, is inclined to focus on negative performance and tend to demoralize health practitioners.

Performance evaluation should be aimed at improvement of skills and effective application of new technology for the improvement of productivity and quality. The health service should develop information and evaluation systems to improve the quality of service rather than concentrating on past mistakes.

3.2.22 Purchasing of equipment and supplies

When equipment and supplies are purchased, health services should not just consider the purchase price but should consider all the costs involved, and involve sellers as part owners or as share-holders in the organisation. Aspects such as installation costs, durability, and service by the seller, all contribute towards total costs. Deming maintains that inspection costs are lowered if sellers are involved as shareholders in the organisation and all those concerned are committed to providing quality service. Long term planning of health manpower, should include efforts to retain personnel. Hospital Managers should consider the total costs of training and personnel development as an asset which has a positive influence on productivity and quality of service.

3.2.23 Constantly improve each activity which is inherent in the planning and provision of a high quality service

To bring about good quality service in a hospital, each employee should know how to make these improvements and should obtain the necessary authority to do so. Each employee should therefore, know the hospital's mission and definition of good quality service. A decentralised approach to management is thus advocated where every

employee is given the authority constantly to strive to bring about the necessary changes in their every day activities in order to improve the service they render.

3.2.24 Training and personnel development

Deming points out that continuous education and personnel development are the first areas to suffer when there is a need to economise because of budgeting problems (Booyens, 1999:601). The value of training and personnel development should not be under estimated. A formal personnel development system should be in place to determine personnel needs in a scientific manner and to meet these needs appropriately. The focus should not be on how the work ought to be done, but on how it can be improved. Personnel should be regarded as the organisation's most valuable asset.

3.2.25 The establishment of leadership for the improvement of top-level management

According to Deming organisational management greatly contributes towards poor performance (Booyens 1999:601) quality improvement depends on improvement of the top-level management. When leadership behaviour at the top is improved, it inevitably leads to improved managerial behaviour lower down the hierarchy, with the result that employees are put in a better position to improve the quality of the service they rendered.

3.2.26 Eliminate Fear

Deming maintains that the hierarchical post structure in a hospital makes sub-ordinates fearful of making suggestions for improvement. Professional role guarding fear and rob the professional, the institution, and ultimately the patient, of better quality (Gillem, 1988:75) cited in Booyens (1999:602). It is advocated that the traditional, hierarchical structure should be changed to a flatter one in order to provide a leadership that understands the purpose and methods of quality improvement.

3.2.27 Break down barriers between departments

It is also indicated that hospital departmens often function in isolation from each other and teamwork is replaced by competition, which is detrimental to the quality of service. When competition is emphasised at the expense of teamwork, resources are not used or shared as they should be. A concerted effort to break down these barriers requires leadership and a participative management approach (Booyens, 1999:602)

3.2.28 Eliminate slogans, warning and targets for personnel

Deming rejects slogans and general warnings such as "improve quality" or "provide better care" and believes that slogans like these and indirect warnings result in counter productive behaviour. These slogans imply that the employee's performance is not up to standard and impact on management's ability to improve quality by creating formal systems.

3.2.29 Eliminate work standards that prescribe numerical quotas for the day

If the achievement of short term quantifiable objectives is always the aim, it is easy for the employees to lose sight of the need continuously to improve the overall level of quality. Deming (in Booyens, 1999:602), points out the danger of the exclusive use of short- term quantification of objectives for achieving a long- term goal. It is particularly important in health service organisations to focus on quality. When the management sends out a message for instance, that figures are important, employees will provide figures; but if the message is perceived as a concern about quality service, employees will react accordingly, and productivity will automatically follow.

3.2.30 Pride in doing the job

Deming believes that evaluation of performance occurs in too isolated a manner and that individual job performance receives too much attention (Booyens, 1999:602) Team -work and the achievement of the group's mutual goals are much more effective for quality improvement. Management behaviour should not focus on individual motivation only, but it should also promote group motivation to improve the service as a whole.

3.2.31 The introduction of powerful training and self- development programme

It is also believed that good service begins and ends with adequate training and that it requires management to concentrate on the training needs of personnel. Intellectual stimulation will lead to resourcefulness, which is a positive influence on service. The value of motivated personnel in an organisation, as well, is often underestimated but motivation leads to higher productivity and high quality service.

3.2.32 Everybody in the institution should participate to accomplish a transformation from traditional management to modern management

Employees at the bottom of the hierarchy are given sufficient authority to make and implement decisions regarding their work activities in order to deliver improved services. This also involves a change from viewing quality as something which must be improved only when problems crop up, instead of something which must be improved continuously.

In summary, the determinants of service quality and quality dimensions given by Tenner & Detoro (1992:63) coupled with Booyens (1999:601) and Flood (1995:15) quality improvement principles of Deming, indicate how complementary quality aspects are to one another. Together they contribute to peak performance and quality productivity or service which will ensure continuous quality improvement process in organisations.

3.3. QUALITY ASSURANCE

This is a prevention based system which improves product and service quality, and increases productivity by placing the emphasis on product, service and process design (Dale & Bunney, 1999:31). Ellis & Whittinghton (1993:10-14) identify quality assurance in health care as having three stages i.e. embryonic, emergent and mandatory stage. In the embryonic stage, it is reflected that concern for health care quality, is as old as care itself. From the earliest times providers of health care have articulated guidelines for both education and practice. Such guidelines reflect concern for the quality care and in embryo at least, for its assurance. In the emergent health care quality assurance stage, quality assurance gains currency, concepts are explicity

discussed and procedures are self consciously implemented and evaluated. The pattern of development remains haphazard however, depending on the enthusiasm and commitment of individual professionals and managers and professional associations. In recent years the rate of change in health care practice and technology has led to colleges and professional bodies taking an interest in standards for continuing education and there has even been the discussion of systems of regular relicencing. All these activities reflect considerable confidence in the effectiveness of professional education as a guarantee for quality care. Finally, in mandatory health care quality assurance stage, government, professionals and patients are in broad agreement that quality assurance for health care is essential. The health care system should be managed so that the quality of care is guaranteed and the best possible care is provided for the greatest possible number in the most economical way. The debate is about systems of quality assurance and about the degree of participation and control to be afforded to government, professionals and patients. According to Ellis & Whittington (1993:34-35) the essence of health care quality assurance includes the following essential parameters:

3.3.1 Concern for excellence and standards

All quality assurance initiatives, whether implicit or explicit focusing on individual care or population service, undertaken by professionals, managers or consumers, must reflect an abiding interest in the provision of the highest possible quality care. If such concern is not given primacy quality assurance cannot take place. It should extend to all aspects of care including the technical, the interpersonal and the moral.

3.3.2 Specificity and explicitness

Despite the many difficulties health care quality assurance is, in aspiration at least a rational explicit and practically based exercise. Standards are specified and operationalised and measurement tools are developed for their appraisal. Respect for professional judgement and careful analysis of social and ethical dilemmas provide the essential context but the operation itself remains an attempt at developing empirically rigorous procedures for the observation, analysis and review of care and indeed, reflexively, that of techniques for appraisal and improving quality.

3.3.3 Adoption of cyclical model

All quality assurance systems involve appraisal of quality standards followed by action for quality improvement. The cycle is what is known as an "open" system that is one in which direction is determined but actual destination may not be. This openness is necessary to allow for the idea of continual quality improvement. At each stage of the quality assurance cycle, the observations and events of the previous stage influence the decisions to be made and action to be undertaken in the next. If any one stage is missed or inadequately carried out, the others will suffer and the ultimate aim of quality maintenance or improvement will not be achieved. Today's highest possible standards may not satisfy the consumers and professionals of tomorrow.

3.3.4 Commitment

Finally, both individuals and organisations must be positively motivated to implement quality assurance. Concern for quality and even compliance in the implementation of quality assurance procedures are necessary but not sufficient. At the individual level, time and energy must be devoted to the exercise and persistence displayed in the face of opposition. At the organisational level there must be recognition that quality assurance does not just happen but it must be managed. That implies commitment of time, energy and resources not just to the quality assurance system itself, but to designing and modifying it to match and complement the organisational climate in which it operates. Ellis & Whittington (1993:216-219) further indicate future developments in Health Care Quality Assurance which include, future growth and desirable developments.

Concerning future growth, according to these authors, health care quality assurance has growth at an exponential rate over the past years. It is now a formal requirement in public funded health systems throughout the developed world and is regarded as both useful and marketable in the private sector. The economic, social, political and professional pressure which were identified, show no sign of losing their force. It can thus be predicted that future years will see growth continue. More people will be involved in health and quality assurance, more approaches and techniques will evolve, the literature will become more extensive, and public awareness and expectations will increase. It seems likely, that quality assurance in some guise will continue to flourish in health care. How effective it will be in actually improving or even sustaining the

quality of care may, however, depend on how systematically it is used and developed. Desirable developments include the following;

(a) Standards.

The fundamental problem in all quality assurance is the establishment of clear, appropriate and acceptable standards. Process standards have been more extensively developed in nursing than in any other professional area and almost all instruments for the measuring of quality are designed for use in nursing. Other professions could profitably learn from the nursing experience. Even in nursing the technical processes of care have received far more attention than the interpersonal. So far, neither the growing literature on interpersonal communication in health care nor the better established literature on the analysis of teaching behaviour has been exploited in developing detailed standards for the interpersonal processes of care. Such exploitation would assist both standards setting and the development of related measurement and appraisal techniques.

(b) Measurement.

Measurement is of central importance in quality appraisal. Better measurement tools are highly in need. Improved techniques for both outcome and process measurement and appraisal would in turn improve the prospects of detailed mapping of relationships between them.

(c) Inter-professionalism.

Health care is basically inter-professional, yet, its quality assurance is most frequently carried out by mono-professional groups. There is an obvious need for techniques and measures designed for inter-professional activities and for quality management systems which encourage their development and use. It would also be sensible to foster techniques which facilitate dialoque between professionals and other groups such as managers, support workers and consumers. Health service organisations are themselves relatively compartmentalised and there is a danger that current quality systems will consolidate divisions rather than break them down.

(d) Consumerism.

Quality assurance is often defined as "meeting customer requirements and consumer concern for maintenance of high standards". It is one of the factors creating current interest in health care quality. Despite this consumer involvement in health care, quality assurance is very limited. Patient satisfaction measures could be much improved and a wider range of techniques for involving patients in the appraisal and improvement of quality could be considered.

(e) Costs and Benefits.

Relationships between costs and quality were discussed at several points. In industry, quality assurance is often said to pay for itself by cutting down waste and increasing profitability or market share. In health care the relationship between quality costs and benefits are less certain. The costs of care are difficult to establish, relationships between supply and demand are complex and quantification of the benefits extended lifespan or improved health and quality of life, remain exclusive. More sophisticated economic analysis in each of these areas would be a highly desirable advance.

(f) Management

Several approaches and systems for quality assurance management has been mostly transferred directly from their industrial origins with little regard for the special conditions of health care organisations. There is a need for careful monitoring of their implementation and modification in their new setting.

3.4 TOTAL QUALITY MANAGEMENT (TQM)

As another preventive approach, quality management requires a comprehensive approach that must first be recognised and then implemented if the rewards are to be realized. TQM is an approach to improving the competitiveness, effectiveness and flexibility of a whole organization (Oakland, 1993: 23). He further states that TQM is concerned with moving the focus of control from outside the individual to within, the objective being to make everyone accountable for their own performance and to get the committment attaining quality in a highly motivated fashion. TQM is concerned chiefly with changing attitudes and skills so that the culture of the organisation becomes one of preventing failure doing the right things first time every time.

According to Dale and Bunney(1999:32-36) TQM has the following key elements:

3.4.1 Commitment and leadership of senior management.

Without commitment of the organisations top management team, nothing will happen and anything that does will not be permanent. They have to take charge, provide direction and exercise forceful leadership.

3.4.2 Planning and Organisation.

This features in a number of facts of a continuous improvement process including among others:

(a) Developing a clear long-term approach for TQM.

This is intergrated with other strategies such as information technology, production/ operations, human resource and the business plans of the organisation. Secondly, pursuing standardisation,systematisation and simplification of work instructions, procedures and systems.

(b) Using quality management tools and techniques

The use of tools and techniques helps to get the process of improvement started: Employees using them feel that they are involved and making a contribution, quality awareness is enhanced, behaviour and attitude change starts to happen and projects are brought to a successful conclusion.

(c) Education and training

The training program should be viewed as an investment in developing the ability and knowledge of the people and helping them realise their potential. Without training it is difficult to solve problems and without education, people's behaviour and attitude will not change. Training programmes must also focus on helping managers think through what improvements are achievable in their areas of responsibility. The structure of a training programme must also incorporate some updating of basic education skills in numeracy and literacy, but it must promote continuing education and self-development.

3.4.3 Involvement

There must be a commitment to the development of employees, with the recognition that they are an asset which will appreciate over time. Management must therefore be prepared to share some of their powers and responsibilities. This also involves seeking and listening carefully to the views of employees and acting upon their suggestions. The more people understand the business and what is going on around them, the greater the role they play in continuous improvement. People must be encouraged to control, manage and improve the processes which are within their sphere of responsibility.

3.4.4 Team-work

Team-work needs to be practiced in a number of forms. Consideration needs to be given to the operating characteristics of the teams employed, and how they fit into the organisational structure. Team -work is one of the key features of involvement and without it, it will be difficult to gain the commitment and participation of people throughout the organisation.

3.4.5 Measurement and Feedback

Measurement needs to be made continually against series of results or performance indicators internal and external, which are the most important as it relates to customer perceptions of product or service improvement. The indicators should be developed from existing business measures, external and internal benchmarking, and customer surveys and other means of external input. From these measurements, action plans must be developed to meet objectives and bridge gaps.

3.4.6 Working Together

It is necessary to create an organisational environment which is conducive to continuous improvement in which everyone can participate and work together. Quality assurance also needs to be intergrated into all of an organisation's processes and functions. This requires changing people's behaviour, attitude and working practices in a number of ways, for example: everyone in an organisation must be involved "improving" the processes under their control on a continuous basis and take personal responsibility for their own quality assurance. Employees must also inspect

their own work and honesty, sincerity and care must be an integral part of daily business life.

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3.5 QUALITY PLANNING

Tenner & De Toro (1992:20) define quality planning as a process that identifies the customers, their requirements, the product and service features the customers expect; the processes that will deliver those products and services with the current attributes and then facilitates the transfer of this knowledge to the producing arm of the organisation

According to Ellis & Whittington (1993:49&50) the quality planning depends on the nature of the company's activities but is likely to include clear guidelines for the following:

- Specifications for raw materials, equipment and services to be brought in
- Quality control for such goods and services at the point of purchase
- Flow charts and systems for stock control and purchase scheduling
- Process control systems
- Sampling and inspection procedures
- Equipment maintenance schedules
- Packing specifications and control
- Procedure for delivery control and customer service

Ellis & Whittington (1993:198-201) further refer to the following as part of quality planning:

(a) Develop quality mission and commitment

In health care, concern for quality of service and commitment to high standards is wide spread but recognition that the establishment of quality assurance procedures and systems can help to improve quality, is less so. The primary management task at this stage is the articulation and dissemination of mission and policy statements which link the two in ways which are believable and acceptable. Credibility is improved if the statements reflect knowledge of a range of possible approaches and of ways in which they might be employed in the organisation concerned. It is also assisted by clear a commitment of resources to setting up quality systems and procedures and to

implementing such improvement as may eventually be proposed. Acceptability is improved if the mission statement recognises existing quality expertise, acknowledges the particular role of professional judgement in identifying and maintaining standards and emphasizes the organisation-wide benefits of improved quality.

(b) Develop quality strategy

Quality mission statements are designed to answer the question why quality systems should be developed. Quality strategy should answer the question "how". It is a broad plan setting out priorities, targets and schedules for the entire organisation. The most commonly cited technique for quality prioritisation in both health care and industry is cost benefit analysis. Priority areas are those where the maximum improvement can be obtained for the least expenditure of human and material resources. In health care, the estimation of both costs and benefits is less straight-forward but the general principle holds good. Motivational considerations can also contribute to prioritisation as strategic planning. Thus initial quality activities should be likely to achieve their objectives. At a more basic level, consideration should be given to individual incentives for involvement in quality activities. Many quality strategies include prize schemes with and opportunities for staff development, promotion and increased financial reward. However, once priorities are established, they should be enshrined in a clear and explicit strategy document. It should identify target areas, specify objectives and determine a schedule for their achievement, since it will eventually be widely available, it should be written with its readership in mind. (Ellis & Whittington 1993: 200).

(c) Structures

The process of strategic planning is likely to have generated ideas for project teams, individual responsibilities and ideas for project teams, individual responsibilities and communication channels. One issue, which is regularly debated, is the extent to which the quality management structures and responsibilities are separated. Separation can mean marginalisation and failure to take quality issues seriously but intergration can mean that quality issues are regularly at the bottom of agendas and never given due attention. The problem is resolved in different ways; however, it is done in such a way that the structures must allow sufficient time and attention for quality to be regularly discussed. Responsibilities may be differently shared in different structures but it must

be possible to identify people who are, in the end, both responsible and accountable (Ellis & Whittington 1993: 201).

3.6. QUALITY IMPROVEMENT

The concept of quality improvement has already been defined earlier. Booyens (1999:599) indicates the following as motives in formalising quality improvement in health care:

(a) Professional accountability

One of the characteristics of professionalism is the pursuit of excellence and the desire to regulate one's own performance. The professional health practitioner is personally, professionally-ethically accountable for his or her practice. Practitioners are, therefore, eager to become formally involved in quality improvement. The public has become increasingly informed about what constitutes good, as well as poor health care, therefore health care professionals have to account for their actions (or omissions).

(b) Financial consideration

Purchasers and consumers of health care services are beginning to state explicitly the kind of quality of health care delivery they expect from health professionals and health care organisations. The incidence of court cases and related claims has increased significantly in addition to the increased perception of what constitutes good health care. It is the rapid escalation in health care costs which is placing health care out of the reach of significant numbers of people in many countries. Since the concept of quality is associated with the efficient utilisation of resources, quality systems in health care are becoming essential components of health care environment. The funders of health care want proof of quality of care delivered (Booyens, 1999:599).

(c) Quest for excellence

For professional-ethical reasons, health professional themselves are realising that they need to have a method for defining and showing that they are providing quality of services. Quality improvement activities stimulate resourcefulness, and staff should

be afforded the opportunity to initiate and implement innovations which address the key components of quality improvement in the organisation.

(d) Marketing in health services

Quality is not an entity, but varies according to the circumstances under which it is to be judged. It is often easier to know when quality is not present, because in most circumstances in which health care is delivered quality service provision is expected and regarded as normal. Consequently, it is possible to set standards for the delivery of quality health care, based on what is expected and feasible given the present level of medical technical, managerial and economic resources. The proven evidence of quality health care delivery could serve as a marketing principle to be utilised in a professional manner, by the health care organisation.

(e) Internal desire to position oneself

The last reason for formalised quality is man's desire to position him or herself to compare his or her performance with that of another. In this regard, the health care practitioner and organisations could become competitive.

Booyens, (1999:624) further indicates the following as internal mechanisms in formalising quality in health care:

(i) Developing a health-service based quality improvement programme.

Any health care institution should have an internal quality improvement programme which focuses on those dimensions which have an impact on quality in that specific institution or service. The setting of standards, monitoring and evaluation of performance and implementation of remedial actions resulting in organisational transformation, are initiated and implanted by the staff of the health care institution or service itself in a formalised and structured manner, complying with all the principles of trustworthiness. Each department in the health service should have a structured quality improvement programme in the health service, with necessary infrastructure and support systems.

(ii) Total quality management

This implies that quality is incorporated in the management process. Total quality management demands an organisational culture that empowers quality improvement

of health care services in all settings. Quality is thus seen as an element of the service delivery, but intergrated within the management process of the health care organisation.

(iii) Community ownership.

Community ownership is also a control mechanism whereby pressure can be put on health services and professional practitioners in the pursuit of excellence. The national media can be used as an example, regular television and newspaper programme, but the focus will obviously be more on the complaints of the community. The establishment of community development committees on all levels of health care delivery in South Africa should contribute towards community participation in the maintenance of health care standards-initially, in an informal manner, but later, when the committees are functioning, in a formal manner.

Tappen (1995:461-462) identified three quality improvement programme approaches: they are retrospective (evaluating past performance) concurrent (evaluating current performance) and prospective (future orientated). These quality improvement programs are not only addressing whether the appropriate interventions took place and the desired outcomes occurred, but also how long it took and how much it cost. One of the primary reasons that quality `improvement programs are becoming integral parts of health care institution's functions is that they can be used to identify areas in which cost savings can occur without adversely affecting the processes and outcomes of care. To ensure that quality improvement is a never ending endeavour, the continuous quality improvement is followed. Continuous quality improvement consists of four basic elements.

The first element is teamwork, which is essential for effective continuous quality improvement, especially, the ability to function as part of an interdisciplinary team in which each discipline is accorded recognition for its contribution to patient care.

The second element is the patient perspective. In the past, the patient's point of view was often omitted from evaluation of the health care service, an omission that would surprise an expert in marketing and that should have dismayed any nurse who claimed

to provide patient-centered care. Both patient care outcome and patient satisfaction should be considered in evaluating health care services.

The third and perhaps, most essential element is measurement of the work process. This includes both baseline measures and measures after changes have been instituted. Both process and outcome measures should be included. For example, the patient receives food and the satisfaction with his or her ability to feed him or herself.

The last element is the adequacy of resources available for implementation of any improvements. For example: administrative support, adequate staff, equipment and sufficient information and consultation which are needed.

Another important aspect of quality improvement according to Apps (1995: 461) is benchmarking, whereby a health care organisation may compare its functions to those of another of similar size and scope known for its high quality of care. Katz & Green (1997: 97&98) define benchmarking as the search for industry best practices, which lead to superior performance. They further refer to benchmarking as a tool that assists in developing more realistic goals and objectives. A goal setting process and a means by which the practices needed to achieve new goals are identified. Benchmarking legitimises goals and targets by base-lining them on an external orientation. It challenges in a productive, planned fashion, those individuals and organisations to concentrate on what will make operations more successful in the market place and eventually attain superior performance. App & Green (1995: 461) further identify the following as chief benefits of benchmarking:

- More adequately meeting end user customer requirements;
- Establishing goals based on a concerted view of external conditions;
- Determining true measure of productivity;
- Attaining a competitive position;
- Becoming aware of and searching for industry best practices;

The benchmarks may indicate the direction that must be pursued rather than specific operational quantifiable matrix that is immediately achievable. There are four types of benchmarking which are as follows:

Internal; A comparison of an internal process, Secondly; competitive; which is competitor to competitor comparison of specific process; Thirdly; functional, which is comparisons of processes to similar processes within the same industry and lastly, generic, which is comparison of processes regardless of industry.

Similarly to other authors, Weihrich & Koontz (2005:485), define benchmarking as an approach for setting goals and productivity measures based on best industry practices. They however, identify three types of benchmarking which are: strategic, operational and management. Strategic benchmarking compares various strategies and identifies the key strategic elements' success. Operational benchmarking compares relative costs or possibilities for product differentiation. Management benchmarking focuses on support functions such as market planning and information systems, logistics and human resource management. The benchmarking procedure according to Weihrich and Koontz (2005:485) begins with identification of what is to be benchmarked. Then superior performers have to be selected, data collected and analysed, which becomes the basis for performance goals. During the implementation of the new approach, performance is periodically measured and corrective actions are taken at that time.

Dale & Bunney (1999: 132-133) share a similar perspective with Katz & Green (1997:98) as far as the definition and types of benchmarking are concerned. They however, identify a number of steps in a formal benchmarking which are as follows:

- Identify what is the subject to be benchmarked and reach agreement on the measures to be used;
- Identify which companies will be benchmarked;
- Agree with the most appropriate means of collecting data, who will be involved and the plan of action;
- Determine the reasons for the current gap in performance between the company and the best amongst the companies involved in the benchmarking exercise;
- Estimate over an agreed time frame, the change in performance of the company and the benchmark company in order to assess if the gap is going to grow or decrease;

- ❖ Define and establish the goals to close the gap in performance. This step requires effective communication of the benchmarking findings;
- ❖ Develop action plans to achieve the goals set out. This step involves gaining acceptance of the plans by all employees likely to be affected by the changes;
- ❖ Implement the actions, plans and strategies. This involves good project planning and management;
- ❖ Assess and report the results of the action plans;
- ❖ Reassessment or recalibration of the benchmark. This should be conducted on a regular and systematic basis and involves maintaining good links with benchmark partners.

Evans, & Dean,(2000: 121) and Boddy, & Paton(1998: 371) share the idea that benchmarking helps an organisation to learn its strengths and weaknesses and those of the other industrial leaders, at the end, incorporate the best practices into its own. Almost all the authors about benchmarking acknowledge that benchmarking was founded by Rank Xeror, in Japan.

(f) Work-life quality improvement

Work-life quality improvement also plays an important role in the quality improvement process. (Booyens,1999: 697-700) identified the following strategies:

(i) Participative management

This is a system of management in which employees participate in the making of management decisions that affect them and their jobs. Typically, it involves a departmental supervisor conducting meetings with his or her immediate subordinates to make plans and decisions regarding such matters as the staffing of units, the distribution of tasks, the handling of problems and working conditions. This process increases employees' motivation, generates ideas and reduces resistance to new methods and processes. It helps meet the human needs for autonomy, achievement and self expression.

(ii) Management by objectives (MBO)

MBO involves three psychological foundations, namely, goal- setting, feedback and participation. It is known that employees who have clear goals usually perform better than those who do not. Clear, attainable goals help channel energies in specific directions and let subordinates know the basis on which they will be appraised and rewarded. Employees who receive frequent feedback concerning their performance, are usually more highly motivated than those who do not. Feedback that is specific, relevant and timely helps satisfy the need most people have for knowing where they stand and exactly what is expected of them. Allowing subordinates to genuinely participate in setting their own goals can increase their commitment to those goals and improve their performance. It also makes them feel more involved, and this appeals to their high-level needs, resulting in a feeling of self worth and a positive contribution.

(iii) Effective leadership and supervisory behaviour

Administrative justice ensures that disciplinary and grievance- handling procedures are carried out according to recognised principles. Employees like to work for supervisors who show consideration for them, who are supportive and who are fair and just in their treatment of others. Supervisors should create an atmosphere of approval in interpersonal relationships with their subordinates, as the latter's perception of the quality of their working life is heavily affected by the treatment they receive from their supervisors. The supervisor must be able to organize and direct people in order to enable them to reach the organisational goal of quality patient care, and she should possess a technical knowledge and other skills needed in order to diagnose difficulties or problems within the service units. She should set challenging but attainable performance standards, be available when needed but also leave enough room for independent thought and the use of initiative when subordinates have the potential to be creative and independent. The supervisor must be able to develop teamwork among employees. He or she should generate an appropriate degree of participation in day-to-day decisions, so that employees care about their work because they are highly involved.

(iv) Quality circles

In recent years the emphasis has shifted from controlling quality of health care, to assuring high quality health care. Health agencies have thus used quality circles to motivate employees to improve the quality of nursing care that is delivered to patients.

(v) Job enrichment programmes

Job enrichment can be defined as the purposeful restructuring of a job to make it more challenging, meaningful and interesting for an employee. This process assumes that the employee is able to do the job at a higher level, carry more responsibility and that she/he will react positively for being given the opportunity to function at higher level. Job enrichment may be achieved in various ways. Firstly, work groups may be formed where each employee is allocated a specific responsibility for the total number of tasks that need to be done. When a task becomes this employee's own responsibility, he or she is allowed to plan and make decisions with respect to that task, resulting in a sense of achievement and authority. An employee can then identify with that section of work. Secondly, tasks may be combined so that one employee will be responsible for different aspects of a process. Thirdly, vertical loading may be instituted. This means an employee will plan and control his or her own work. Fourthly, channels need to be introduced so that faster and better work methods can be communicated to the employee without delay (Booyens,1999:698)

(vi) Career development

To fully utilise people's potential, to help employees realise their career ambition and to enhance their feeling of achievement and recognition, management needs to implement a systematic career planning and development programme aimed at guiding and developing subordinates. The principal components of a comprehensive career programme within an institution are as follows:

- Human resource planning;
- Communication of job opportunities and career path information to employees;
- Career counseling, both by the supervisor as part of performance appraisal and by the personnel development;

- ❖ Provision for the education and training of employees both within and out side the organisation; and
- ❖ Special broadening and stimulating job assignments and job rotation; (Booyens, 1999:699)

Some institutions also have formal assessment centers to analyse and evaluate the capabilities and potential of the personnel.

(vii) Alternative work schedules

Employers are continually trying to introduce more flexible work arrangements which will give employees more freedom of choice in their working hours. Such schedules presently appear in three different forms, namely, flexi-time, part-time or job sharing as well as shorter work weeks. Flexi-time divides workday into core time and choice time. Within limits, the worker is able to begin and end his or her workday as it suits him or her. Part-time suits people who have other commitments and do not wish to work a full eight hour day, every day of the week. Shorter working weeks involve accomplishing a full week's work in less than five days.

3.7. QUALITY CONTROL

In order to sustain high levels of commitment towards quality maintenance in health care organisations, by all stakeholders, quality control measures should be employed.

A number of quality control measures in health care organisations include programmes inculcating values, extensive training and tight evaluation and control systems. In the presence of widely shared values and beliefs within the organisation, clan controls dominate (Klein, 1990: 53). In health care organisations specifically, there are also four analysis criteria and are as follows:

High risk, high volume, problem prone and high costs processes which are most critical to the service, practice and governance offered by health care organisations.

- ❖ High-risk processes include those in which harm or lack of significant benefit may occur if the activity is either performed or not performed i.e. acts of commission and acts of omission. A process is a high risk if its performance

or omission could result in trauma, death, litigation, or loss of accreditation or license.

- ❖ High-volume processes are those that occur frequently or involve a large number of customers, employees, or organisational systems. They however, do not always indicate a critical process.
- ❖ Problem-prone processes in the service domain include those processes that produce problems for the customer. In the practice domain, these include processes that produce problems for employees, and in the governance domain, those processes that produce problems for the system.
- ❖ High-cost processes of health care delivery systems are not always obvious and might include those processes or items not covered by insurance, such as invasive procedures and the costs of consultants. These processes in the practice domain include the basic life support certification and mandatory in-services.

3.8 CONCLUSION

Through discussions about quality as a concept as well as other related aspects, it is evident that quality maintenance is a continuous process whereby quality improvement will take place on a continuous basis. Aspects such as Total Quality Management are therefore playing a major role in ensuring that quality service standards are maintained. This information about quality aspects also plays an important role in this dissertation. For example, some of the research questions are based on the information about the concept "quality". The quality concepts already discussed also anchors this study as health workers might learn more about quality and thus achieve their goals which revolve around quality maintenance.

Having discussed quality concepts, chapter four will address the problem statement and objectives of this study.

CHAPTER 4

PROBLEM STATEMENT AND OBJECTIVES

4.1 INTRODUCTION

In this chapter the problem will be defined and objectives briefly outlined. Health care services are for the public to utilise and accessibility needs are to be ensured by health care officials. Failure to meet the public needs will lead to a problem of the health care system being publicly criticised and challenged. It will also indicate that productivity and quality services are major problems.

4.2 PROBLEM DEFINITION

Some factors within health care organisations induced public criticism and challenging of the health care system. For example, in recent years, most people or the public at large, know their rights as prescribed by the Human Rights Charter in the Constitution of the Republic of South Africa. When a person realises that his/her rights are being infringed, action is immediately taken. Such violation of rights might be publicised through the media, like press or television.

Another factor which is closely related to the first one is when health care workers' actions by (ommiting some of their obligations) within their work place directly violate the rights of health care customers. For example, when an individual has to undergo an operation of any kind but the site to be operated is misindentified, which might lead to the performance of an operation on the wrong site. It might also happen that the correct site is used but some negligence takes place in such a way that the swabs which were used to wipe the blood during the operation, are left in the abdomen of the operated patients.

There are also instances in health care organisations where new-born babies are being incorrectly identified and mothers get the wrong babies, relatives get wrong corpses to be buried or patients disappear from hospitals when their relatives have entrusted their safety and security to the health care organisation concerned.

These factors lead to a major problem for the health care system which are subject to criticism and challenged by the public. It also predisposes health care organisations to litigations and mistrust by the public.

4.2.1 Primary problem definition

Poor productivity and poor quality services emerge from certain factors within the health care system. There is therefore an urgent need to attend to such factors effectively so that they do not subject the health care system to the secondary problem which is public criticism and challenges or even major litigations.

(a) Questions which must be addressed are:

- What measures are taken within the health care organisation to ensure commitment of personnel to quality productivity?
- How are the employees delegated to their duties, randomly or within their scope of knowledge?
- Is the working environment within the health care organisation conducive to work?
- Does the organisation have a reward system in place for the employees?

4.2.2 Secondary problem definition

Bad publicity and criticism of the health care system also emanates from certain factors. Examples of such factors include poor communication between the health care organisation and the public where eventually members of the public are misinformed about the health care system.

There is also low morale and motivation within health care organisations which lead to employees committing errors or omitting obligations.

(a) Relevant questions are:

- Are the lines of communication opened for all in the health care organisation.
- How is the high morale and motivation of the employees ensured in the health care organisation?
- Is public inputs considered when planning health care services in the organisation?

- How does the health care organisation identify whether the public is satisfied or not, with the services rendered?

4.3. CLARIFICATION OF OBJECTIVES

4.3.1. Objectives of the study

The objectives of this study are to:

(a) Clarify roles of employers and employees within the organisation.

This clarity will bring about the balance within the organisatoin whereby each party will fulfill its role as expected and thus ensure quality.

(b) Clarify activities to be carried out in maintaining high quality.

This clarity will lead to proper delegation of personnel within the organisation where the right people will be placed at the right place within their working place.

(c) Understand the organisational culture leading to an effective organisation.

Understanding the organisational culture will lead to proper planning of activities within the organisation.

(d) Describe behaviours of employers and employees within highly effective organisations

This will encourage other employers and employees to adopt such behaviour for their organisations also to be highly effective.

(e) Understand the needs of other stake holders within the health care context.

Proper services will be rendered according to the expectations of other health care Stakeholders.

4.4. CONCLUSION

The above questions will be verified in the questionnaire where health care managers, employees and health care customers will be involved and their views recorded. The problems and sub questions have been identified and objectives have been formulated to address the problem. The following chapter will explain the research methodology and design.

CHAPTER 5

RESEARCH DESIGN AND METHODOLOGY

5.1 INTRODUCTION

Chapter 2 and 3 which were theoretical foundation and literature review of this study provided a stepping stone for the researcher, to further describe the research design, research methodology comprising the selection of sample and population as well as data collection. All these are outlined in this chapter. The researcher's role during interviews is also outlined.

5.2 THE RESEARCH DESIGN

The research design is a blueprint for the conduct of a study that maximises control over factors that could interfere with the study's desired outcome (Burns & Grove, 1997:49-50). Polit & Hungler (1993:36) further describe a research design as an over all plan for obtaining answers to questions under study and handling difficulties encountered during the study.

In this study, the main focus is on the maintenance of quality in heath care organisations. The researcher adopted a quantitative approach as it was regarded as the most suitable for this study.

5.2.1 Quantitative research method

Quantitative research method is defined as a formal, objective, systematic process to describe test relationships and examine cause and effect interactions among variables. Burns & Grove (1997:38) provide an over view of a quantitative research by (1) discussing concepts relevant to quantitative research; (2) identifying steps of quantitative research process and (3) providing examples of different types of quantitative studies.

(a)Concepts relevant to quantitative research

(i) Basic or pure research

Basic or pure research is a scientific investigation that involves the pursuit of "knowledge for knowledge's sake" or for the pleasure of learning and finding the truth (Nagel, in Burns & Grove 1997: 39). The purpose of basic research is to generate and refine theory and build constructs, thus, the findings are frequently not directly useful in practice.

(ii) Applied research

Applied or practical research is a scientific investigation conducted to generate knowledge that will directly influence or improve clinical practice (Burns& Grove 1997: 40). The purpose of applied research is to solve problems, make decisions or predict or control outcomes in real life practice, situation.

(iii) Rigour in quantitative research

Rigour is the striving for excellence in research and it involves discipline, scrupulous adherence to detail and strict accuracy. The researcher constantly strives for more precise measurement methods, representative samples and tightly controlled designs. The researcher continually searches for new and more elements and events of the world (Burns & Grove 1993: 41).

(iv) Control in quantitative research

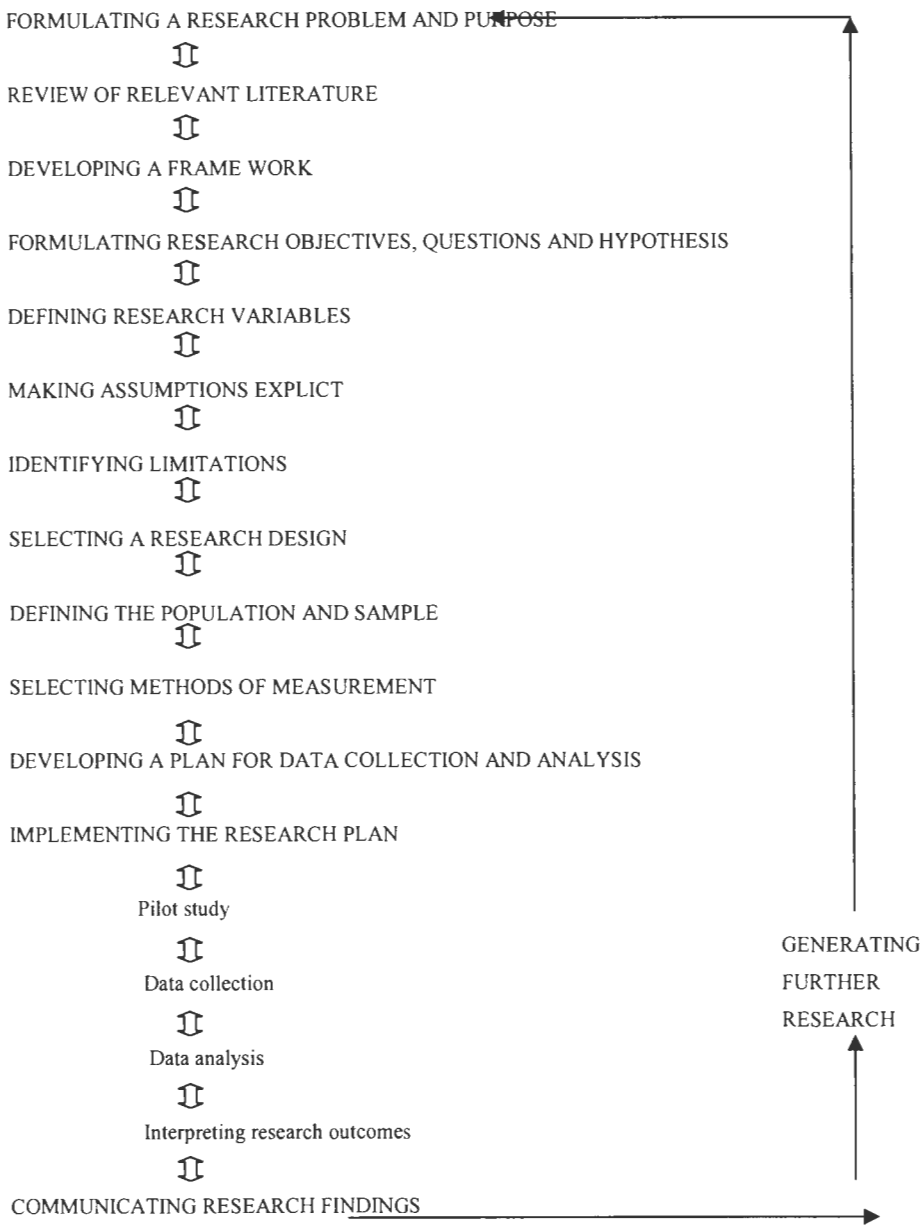
Control involves the imposing of rules by the researcher to decrease the possibility of error and thus increase the probability that the study's findings are an accurate reflection of reality. Quantitative research requires the varying degree of control, ranging from uncontrolled to highly controlled, depending on the type of the study (Burns & Grove 1997:).

(b) Steps of the quantitative research process

The quantitative research process involves conceptualising a research project, planning and implementation thereof, and communicating findings (Burns & Grove 1997: 44). Figure 5.1 identifies the steps of the quantitative research process and

indicates the logical flow of this process as one step progressively builds upon another.

Figure 5.1 STEPS OF THE QUANTITATIVE RESEARCH PROCESS



Source: Burns & Grove (1999: 44)

(c) Types of quantitative research

Among four types of quantitative research included in this text, (descriptive, co relational, quasi-experimental and experimental research) two which according to the researcher's own perspective, are regarded as relevant to this study and will be outlined as follows:

(i)Descriptive research

The descriptive research provides an accurate portrayal or account of characteristics of a particular individual, event or group in real life situations for the purpose of discovering new meaning, describing what exists, determining the frequency with which something occurs, and categorising information (Burns & Grove 1997: 779). The purpose of descriptive research is the exploration and description of the phenomenon in real life situations. This approach is used to generate new knowledge about concepts or topics that have limited or no research (Burns & Grove 1997: 55).

(ii) Quasi- Experimental research

Quasi- experimental research is defined as a type of quantitative research conducted to explain relationships, clarify why certain events happen, and examine causality between selected independent and dependent variables. Quasi-experimental studies in health care are conducted to determine the effects of health care interventions (independent variables), on patient outcomes (dependent variables) (Coock & Campbell 1997: 171).

5.2.2 The reason for choosing the quantitative method

Based on the information furnished in 5.2.1 concerning quantitative research method, the researcher found it relevant to employ this method in investigating and exploring the topic under study: namely, maintenance of quality in health care organisations.

Adherence to quantitative research concepts such as applied, rigour and control would assist the researcher to achieve positive results of this study. The descriptive type of the quantitative research method, with its ability to explore and describe phenomenon in real life situation, would enable the researcher to generate new knowledge about quality maintenance in health care organisations as topic under study.

(a) Descriptive

In this design, accurate information was collected through the use of questionnaires and interviews whereby respondents responded to formulated questions in such a way that the researcher acquired a better understanding of some aspects pertaining to quality maintenance in health care settings.

(b) Exploratory

An exploratory study begins with the phenomenon interest with the aim of exploring the dimensions of the phenomenon, about which little information has been found. Exploratory research focuses on the "what" and every thing about the phenomenon is important. Facts related to the phenomenon are identified (Brink, 1999: 11; Polit & Hungler, 1995: 11). Exploratory studies are designed to increase the knowledge of the field of the study (Burns & Grove 1997: 302).

5.2.3 Sampling

Sampling is defined as scientific a research in which a few people are studied to determine something about a large number of people (Frey, Bothan and Friedman 1991:44).

The researcher used the non-probability sampling method. In this method, not every element of the population has an opportunity for being included in the sample (Burns & Grove, 1997: 302). Non-probability sampling methods have, however, five different designs and of those, the purposive sampling was regarded as the most relevant, by the researcher. It is also used in qualitative research method.

Holloway and Wheeler (1996:74) describe purposive sampling as a sampling where individuals or groups with specialties or groups can also be referred to as useful informants.

5.2.4 Criteria for selection of respondents

Three categories of informants were chosen which are health care organisations managers, health care organisations employees and health care clients. The researcher adhered to the inclusion and exclusion criteria in the study whereby, not all other health care stakeholders were involved. Thirty potential respondents were selected and this will be further outlined later in this chapter.

5.2.5 Target population

In this study the target population consists of health care managers, employees and clients (De Vos 1998:190 in Polit & Hungler 1993:173; Thomson 1997:227).

5.2.6. Sample

A sample is defined by Mouton,Muller, Franks and Sono (1998:132) as a process of selecting a small group of people from a defined population. The sample in this study comprised thirty respondents who were categorised as follows: nine health care managers, nine health care employees, within health care organisations as well as twelve health care consumers within health care organisations as patients.

Three health care organisations within Southern region of North West province were identified, namely, Klerksdorp/Tshepong Hospital Complex, Witrand Hospital as well as Potchefstroom Hospital. All these hospitals form the greater Klerksdorp/Tshepong/Potchefstroom/Witrand Hospital Comlex.Three health care managers from each hospital were identified i.e.Klerksdorp/Tshepong Hospital Complex, Potchefstroom and Witrand Hospital. The same was done with health care employees, namely, three from each hospital. Health care consumers were in-patients, four from each hospital within the greater hospital complex.

5.3 RESEARCH METHODOLOGY

5.3.1 Research tools

Structured interviews and questionnaires were primary measuring tools of this study. Borg & Gall (1989: 418) identified questionnaires and interviews as the most common instruments for data collection in research. In this study, the researcher regarded this as the main instrument for obtaining knowledge and had to understand the ethical guidelines for decision-making with regard to sampling criteria.

(a) Interviews

The interview is a purposeful inter-action between two or more people who are in the process of communication, conversation and negotiation for specific purposes associated with some agreed subject matter (Cormack, 2000: 294). Through interviews, the respondents were able to discuss, answer and pose questions related to the phenomenon under discussion. The interviewer was able to identify what respondents' thoughts were and generated data that might be collected (Patton, 1990: 278).

Structured interviews were conducted with the managerial category of this study, meaning that, questions were formulated for nine managers to answer although different approaches in answering them, was used. Some were open ended questions while others were decisive questions (See annexure A). The consequences of these interviews were that the researcher took the principle of beneficence into account in the sense that the study should benefit the respondents and the target population (Kvale 1996: 116-117). This was true in the case of this study for understanding the ways and means of maintaining quality in health care organizations which might lead to continuous quality improvement and peak performance within health care organisations.

(b) Questionnaire

A questionnaire is a device which enables respondents to answer questions (Burns & Grove 1997: 779). In this study, data was collected by means of handing questionnaires to health care employees and the customers categories to complete (See annexure A & C). Both categories had questionnaires specifically formulated for them.

(c) Questions

Annexure A contains the questionnaire regarding, measuring employees' effective performance. There are twenty five questions, categorised into seven criteria, randomly distributed on the questionnaire (see annexure B).

Annexure C contains the questionnaire regarding patients/clients services rendered within health care organisations. This questionnaire also consists of twenty five questions. These questions are based on aspects assumed to be important indicators of quality services within health care organisations (see annexure D).

Annexure E consists of the interview questions for the management category of samples. There are also aspects assumed to be important indicators of good management and quality performance (see annexure F). Managers were expected to

mention at least two aspects responding to each question. Such question would thus be considered as fully answered.

5.3.2 Ethical issues in collecting data

Cornmarck (1991: 30) states that the first duty of the researcher is to ensure that the researcher shall do the respondents no harm. Human rights in health care services should be protected as in any other circumstances. The participants' right to privacy, self determination and freedom to withdraw at any time from the study were considered in this study (Cornmarck 1991: 31-34). The researcher observed the following ethical issues:

(a) Principle of beneficence

With this principle, the researcher kept the principle of no harm in mind. This is the most fundamental principle in any research.

(i) Freedom from harm

Although physical harm was not considered, psychological harm was a possibility, as some of the respondents had never been interviewed before. The researcher advised them to withdraw at any time should they feel unable to continue with the interview (Polit & Hungler 1995: 120).

(ii) Freedom from exploitation

All the respondents were purposefully selected because of their knowledge of health care organisations and not because of their vulnerability. Freedom from exploitation in this study is equated with the principle of justice, in the sense that the researcher considered the fact that the respondents were selected fairly.

(b) Principle of respect for human dignity

Respect for human dignity included observing the right to self determination in the sense that the respondents were made aware that they had freedom of choice to participate or to withdraw from the study at any time if they so wished. The researcher would respect their person and their wishes.

(i) The right to self determination

The respondents had the right to choose to participate or not. The researcher approached the respondents purposefully and no remuneration was offered. The respondents volunteered to participate in the study after being approached by the researcher. Written consent and an agreement,as well as the declaration by the researcher was signed prior to the interviews (See annexure D & E). Participants, who withdrew from the study, were not threatened or intimidated, but just replaced as there was a specific required number of respondents. Permission was requested to record the interview (Polit & Hungler 1995: 122).

(ii) The right to full disclosure

Full disclosure means that the nature of the study was fully explained to the respondents. Self determination depended on full disclosure. The research questions, aim and purpose were discussed with the respondents. The nature of the study, time and commitment as well as the involvement of participants was explained.

(c)The principle of justice

Justice includes the right of fair treatment and privacy of the respondents as well as their freedom to withdraw whenever they so wish.

(i) The right to fair treatment

Fair treatment entails that the participants were selected on the basis of the requirements of the research questions. It entails non-prejudicial treatment of individuals who decline to participate or withdraw from the study (Polit & Hungler 1995: 124).

(ii) The right to privacy

The promise of confidentiality was guaranteed and information was not publicly reported in a way that the respondent's identity was exposed. Confidentiality was verbally and in the informed consent, ensured.

(d) Informed consent

The researcher informed the respondents about the overall purpose of investigating the ways in which the quality services are achieved and maintained (See annexure C).

The main features of the design were discussed including freedom of choice, the use of technical devices during interviews. Voluntary participation of respondents with their right to withdraw from the study at any time, was emphasised (Kvale 1996: 112). Respondents themselves gave consent (See annexure D).

(e) Honesty and integrity

Honesty ensured that the respondents saw all the draft versions of the report during data analysis (De Raeve 1996: 38-40). Kvale (1996: 117) states that the researcher's moral behaviour is more than ethical knowledge and cognitive choice. It involves the researcher as a person as well as the sensitivity and commitment to the moral issues and action which makes for integrity.

5.3.3 The role of the researcher

The researcher is the instrument and the main source of data collection. As already indicated, the researcher's moral behaviour involves the researcher as a person who has to be sensitive and committed to honesty and integrity. Data collection and recording was done as honestly as possible. As an active participant, the researcher was aware that her presence might trigger a variety of reactions from respondents, such as psychological factors including, responding according to what they thought the researcher expected and not for the sake of the truth. This was however, counteracted by explaining to the respondents that they should say what they know the way they know it (Bulmer & Warwick 1993: 208-213).

During the interview, the researcher is the main facilitator of obtaining knowledge and has to understand the ethical guidelines for the decision-making with regard to sampling criteria. Respondents should not just be chosen because of their vulnerability. They have to be selected because of their knowledge of the health care organisation set up. In this study, the researcher was therefore, fair and honest during sampling (Kvale 1996: 117).

5.4. CONCLUSION

In this chapter, research methodology and design were outlined whereby a quantitative research method was employed. The reason for choosing this method is that it helps to find answers and acquires new knowledge about phenomena which is very relevant to the topic under study and searching for the ways and means of maintaining quality. In collecting a data, the rights of respondents as participants was highlighted, through discussion about ethical issues. Data collected was not reported in a raw form but was summarised and subjected to analysis, which will be reflected in chapter six.

CHAPTER 6

RESULTS

6.1 INTRODUCTION

This chapter outlines the results of the survey conducted whereby the questionnaires, as well, as the constructive interview was conducted. As three categories of samples were used, findings will be given, analysed and interpreted according to each sample category, which is employees, patients and managers.

A questionnaire, pertaining to employees, was classified according to different criteria and findings analysed and interpreted as such. The results of the questionnaire, concerning patients, given per question and analysis and interpretation of each question was done per question. The managers' interview results will also be given, analysed and interpreted separately.

6.1.1. Measuring the health care employees' effective performance

A questionnaire was formulated based on the following criteria: Performance focus, co-operation, motivating employees, trust, member contribution, and cohesion and job satisfaction. Performance focus criterion is also divided into three sub- criteria, which are goals, norms and roles, while cohesion has aligned commitment as a sub-criterion.

After nine candidates completed the questionnaires, the scoring was conducted. Simplistic scoring involved the summation of the different ratings of respondents for every statement. Summation of the totals of different statements pertaining to each criterion was then conducted. The average was calculated and translated into percentages (See Annexure B). The findings were also displayed in tabular form at the end of each criterion finding, analysis and interpretation.

According to the scale presented, it is assumed that any percentage range between 0%-20% portrayed a strong disagreement by employees, 21%-40% portrayed a disagreement, 41%-60% portrayed uncertainty amongst the employees, 61%-80% portrayed an agreement by the employees while 81%-100% portrayed a strong agreement by the employees.

A further assumption is made that the strong disagreement relates to the criterion not being met at all; disagreement relates to the criterion not met; uncertainty relates to ignorance of the criterion by employees; agreement relates to the criterion being met; while strong agreement relates to the criterion fully met, on which the following results were found, see table 6.1 below.

Table 6.1 THE RESULTS FOR MEASURING THE EMPLOYEES PERFORMANCE QUESTIONNAIRE

Criteria	**Score**	**Results**
Performance focus	**69%**	**Criterion met**
Goals	71%	Criterion met
Norms	68%	Criterion met
Roles	58%	Uncertainty
Cooperation	**79%**	**Criterion met**
Motivating employees	**65%**	**Criterion met**
Trust	**58%**	**Uncertainty**
Member contributions	**69%**	**Criterion met**
Cohesion	**73%**	**Criterion met**
Aligned commitment	74%	Criterion met
Job satisfaction	**74%**	**Criterion met**

Table 6.1.1 Performance focus results

Statement	Strongly Agree		Agree		Uncertain		Disagree		Strongly Disagree	
	n	%	n	%	n	%	n	%	n	%
10.Every employee knows exactly why certain activities are carried out or not to be carried out.	0	0%	6	66.7%	1	11.1%	2	22.2 %	0	0%
11.Every employee knows and understands the health care organisation's priorities	0	0%	6	66.7%	1	11.1%	2	22.2 %	0	0%

6.1.1Performance Focus results, discussed

A score of 69% was calculated, relating to the criterion having been met (see table 6.2). From performance focus statements, 66, 7% of candidates agreed. Those statements being, every employee knows exactly why certain activities are carried out or not, while the other is about every employee understanding the health care priorities. It is however, interesting to observe that even though many agreed to these statements, none strongly felt the statements were true. According to the literature, employees portray performance focus as if they have cognisance of the purpose of their roles within the organisation.

6.1.1.1 Goals results

Statement	Strongly Agree		Agree		Uncertain		Disagree		Strongly Disagree	
	n	%	n	%	n	%	n	%	n	%
2. Every employee knows what to achieve and how to measure success	0	0%	4	44,4%	3	33,3%	2	22,2 %	0	0%
12.Employees understand management expectations and are clear about organisational goals.	0	0%	8	88,9%	1	11,1%	0	0%	0	0%

6.1.1.1 Goals results, discussed

This sub-criterion of performance focus, scored 71% (see table 6.1) was thus, met. Statement 2, which concerned the full knowledge of how employees achieve their goals, 33,3% of employees were uncertain, 22,2% did not agree while 44,4% agreed. See table 6.3. Statement 12, which was concerned with employees being aware of management expectations and organisational goals, 88, 9% of employees agreed, while11,1% were uncertain. These results also reflect an interesting image, whereby most employees seem to be aware of organisational goals, but, lacking knowledge and the skills of how to accomplish them. This thus, reflects a great imbalance between activities versus knowledge and skills.

Table 6.1.1.2 Norms results

Statement	Strongly Agree		Agree		Uncertain		Disagree		Strongly Disagree	
	n	%	n	%	n	%	n	%	n	%
13.Employees understand unwritten rules about behaviour within the organisation	0	0%	6	66,7%	3	33,3%	0	0%	0	0%
17.Every employee agrees about his/her "speaking your mind".	0	0%	3	33,3%	4	44,4%	2	22,2%	0	0%

6.1.1.2 Norms results, discussed

This performance focus sub-criterion, scored 68% (see table 6.1) was thus, met. Concerning statement 13 on the questionnaire, which was about employees understanding unwritten rules and how to behave within the organisation, 66, 7% agreed while 33, 3% were uncertain. On statement 17, which was about employees speaking their minds and understanding disagreement, as not personally orientated, 33, 3% agreed, 44, 4% were uncertain and 22,2% disagreed. Results reflected a greater percentage of uncertainty as far as organisational norms are concerned. The literature of this study indicates ways in which organisational norms and values can be reinforced to employees.

Table 6.1.1.3 Roles results

Statement	Strongly Agree		Agree		Uncertain		Disagree		Strongly Disagree	
	n	%	n	%	n	%	n	%	n	%
3. Employees have the skills they need to accomplish their activities	0	0%	3	33,3%	3	33,3%	3	33,3%	0	0%
21. There is a good match between capabilities and responsibilities of employees.	0	0%	2	22,2%	5	55,6%	2	22,2%	0	0%

6.1.1.3 Roles results, discussed

This performance sub-criterion scored 58% (see table 6.1) which reflected employees' uncertainty as far as their roles are concerned and also rated the lowest of all the criteria in this section. Statement 3 on the questionnaire concerns employees having necessary skills to accomplish their activities and roles. The following results were obtained from the candidates: 33, 3% agreed, 33,3% were uncertain and 33,3% disagreed. Statement 21concerned the match between capabilities and responsibilities, 22, 2% agreed, 55,6% were uncertain while 22,2% disagreed. These findings reflect a serious concern as far as role clarification, knowledge, skills and capabilities of employees are concerned. An interesting part in this criterion outcome is that, even though candidates were from three different hospitals within the complex, their responses, in this regard were more or less, similar. This is an indication of a generalised concern as far as knowledge, skills and role clarification is concerned. Table 6.5, reflects the respondents' responses to this performance focus, sub-criterion.

Table 6.1.2 Cooperation results

Statement	Strongly Agree		Agree		Uncertain		Disagree		Strongly Disagree	
	n	%	n	%	n	%	n	%	n	%
5. As employees, we work together to set clear, achievable goals.	1	11,1%	7	77,8%	1	11,1%	0	0%	0	0%
14. Every employee contributes towards organisations' success, not own.	0	0%	7	77,8%	1	11,1%	1	11,1%	0	0%

6.1.2. Cooperation results, discussed

This criterion scored 79%, (see table 6.1) thus, was met, and was also of the highest score as compared to other criteria in this section.

Statement 5 on the questionnaire (see table 6.6) which is about employees working together to set clear achievable goals scored as follows: 11, 1 % strongly agreed, 77,8% agreed while 11,9% were uncertain. As for statement 14 (see table 6.6) which is about employees wanting to contribute towards organisational and not own goals, the results were as follows: 77, 8% agreed, 11, 1% uncertain while 11, 9% disagreed. An interesting finding is that, while in their previous responses employees did not reflect their extreme feelings about statements, in this regard, there was 11,1% strongly agreeing to the team spirit prevailing and still a large number of 77, 8% also agreeing. These results depict a general reflection of cooperation in the health care organisations.

Table 6.1.3 Motivating employees results

Statement	Strongly Agree		Agree		Uncertain		Disagree		Strongly Disagree	
	n	%	n	%	n	%	n	%	n	%
4. Our management gives constant feedback on our performance.	0	0%	4	44,4%	2	22,2%	3	33,3%	0	0%
15. The management assures employees that their success will be measured against their performance.	0	0%	4	44,4%	4	44,4%	1	11,1%	0	0%

6.1.3 Motivating employees results, discussed

This criterion scored 65% (see table 6.7) and thus, met the requirement. Statements on the questionnaire were number 4 which was about constant feedback on employee performance by management and the results were as follows: 44, 4% agreed, 22, 2% were uncertain while 33, 3% disagreed. The second statement was number 15 and concerned the management measuring employee's success against his/her performance. Findings were as follows: 44, 4% agreed, 44, 4% were uncertain while 11, 1% disagreed. The results in both statements in this criterion depict that there is a great uncertainly among employees as far as motivation is concerned.

Table 6.1.4 Trust results

Statement	Strongly Agree		Agree		Uncertain		Disagree		Strongly Disagree	
	n	%	n	%	n	%	n	%	n	%
6. Our communication can be described as "open", "honest", "timely" and "two way"	0	0%	0	0%	5	55%	4	44,4%	0	0%
16. As employees, we are able to work together to solve destructive conflicts.	0	0%	4	44,4%	2	22,2%	3	33,3%	0	0%
22. Every employee believes that the other employees' actions are for the good of the organization and will guard against harming each other with their actions.	1	11,1%	2	22,2%	4	44,4%	2	22,2%	0	0%

6.1.4. Trust

This criterion, like roles criterion, scored the lowest of all criteria which is 58% (see table 6.1). This score reflects the uncertainty of employees as trust relationship in the health care organisation is concerned. The first statement on the questionnaire is number 6, which is about communication which is "open", "honest" "timely" and "two-way"(see table 6.8) The response was as follows: 55, 6% were uncertain and 44,4% disagreed with the statement. The second statement was number 16, which concerned employees working together to solve destructive conflicts rather than ignoring them (see table 6.8) and the response was as follows: 44, 4% agreed, 22, 2% were uncertain while 33,3% disagreed. The last statement was number 22, pertained to employees guarding against harming each other. The findings were as follows: 11, 1% strongly agreed, 22, 2% agreed, 44, 4% were uncertain while 22, 2% disagreed. The interesting part in this criterion is that employees from all three hospitals, within the complex, reflected a great concern as far as communication is concerned. None of

the respondents were satisfied with communication channels. 44, 4% disagreed and 55, 6% were uncertain. Another interesting outcome was concerning the statement of employee's actions being for their or good of the organisation, guarding against not harming one another. A small percentage of employees agreed to its extreme, i.e. 11, 1% and still smaller percentage agreed to the statement which is that 22,2% of an average of 66,7% were uncertain and some disagreed with the statement. Results on the last statement may indicate that one of the three hospital within the complex, fully meet the criterion of trust, but the results influenced by other hospitals which reflect uncertainty as far as this criterion is concerned.

Table 6.1.5 Member contribution results

Statement	Strongly Agree		Agree		Uncertain		Disagree		Strongly Disagree	
	n	%	n	%	n	%	n	%	n	%
1. Our management believes that every employee has something to contribute, such as knowledge, abilities etc.	2	22,2%	5	55,5%	2	22,2%	0	0%	0	0%
18. Every employee is given enough opportunity to gain knowledge and skills necessary to complete the work.	1	11,1%	2	22,2%	4	44,4%	2	22,2%	0	0%

6.1.5. Member Contribution.

This criterion scored 69% which indicates that it was met. The first statement on the questionnaire was number 1, which was about management believing that every employee has something to contribute such as knowledge, skills, abilities and information. The response was as follows: 22, 2% strongly agreed, 55, 6% agreed and 22, 2% were uncertain. The second statement was number 18, which was about every employee being given enough opportunity to gain knowledge, skills and experience

necessary to complete their work. The response for this statement was as follows: 11,1% strongly agree, 22,2% agree, 44,4% uncertain and 22,2% disagreed.

The results in this criterion reflected a great imbalance between the outcomes of both statements. The most interesting part however, is an indication of extreme agreement reflected in both statements. This depicts the possibility of easily correcting management's belief of employees being knowledgeable, skilful and informed, while in fact, employees feel that they are not granted enough opportunity to acquire the necessary knowledge, skills and information. If it were not because of this imbalance, this criterion could have scored a higher percentage.

The results of this criterion, further confirms the problem of communication in the hospitals because 77, 8% of employee respondents confirmed that management believes that they are knowledgeable, skilful and informed. At the same time, 66, 6% of employees are uncertain and disagreed about being knowledgeable, skillful and informed.

Table 6.10 Cohesion results

Statement	Strongly agree		Agree		Uncertain		Disagree		Strongly Disagree	
	n	%	n	%	n	%	n	%	n	%
8. As an employee, I am proud to be part of this health care organization.	0	0%	7	77,7%	2	22,2%	0	0%	0	0%
23. Every employee is committed to achieve common objectives.	0	0%	6	66,7%	1	11,1%	2	22,2%	0	0%

6.1.6. Cohesion.

This criterion scored 73% (see table 6.1) which indicates it having been met. Statement number 8 on the questionnaire is about employees being proud of their health care organisations (see table 6.10) and the response was as follows: 77, 8% agreed and 22, 2% were uncertain. The second statement, (number 23) was about

every employee being committed to common goal achievement (see table 6.10) and the outcome was as follows: 66, 7% agreed, 11,1% uncertain while 22, 2% disagreed.

The outcome of this criterion reflects a great cohesion between employees and it confirms the results on co-operation criterion discovered to be 79%, earlier in this study. Both statements had a positive response from employees (see table 6.10). This cohesion criterion also has a sub-criterion which is aligned commitment and will follow.

Table 6.1.6.1 Aligned commitment results

Statement	Strongly Agree		Agree		Uncertain		Disagree		Strongly Disagree	
	n	%	n	%	n	%	n	%	n	%
9. Every employee in the health care organisation is working towards accomplishing the same organisational goals.	2	22,2%	4	44,4%	2	22,2%	1	11,1%	0	0%
20. Every employee has equal ownership of the success of the organisation.	0	0%	6	66,7%	2	22,2%	1	11,1%	0	0%

6.1.6.1 Aligned commitment.

This sub- criterion which scored 74% (see table 6.1), was met. Statement 9 on the questionnaire, which was about every employee working towards accomplishing the common organisational goals (see table 6.11) was responded to in the following way: 22, 2% strongly agreed, 44, 4% agreed, 22, 2% uncertain while 11, 1% disagreed. Statement 20, which was about every employee having ownership of the success of the organisation (see table 6.11) obtained the following score: 66, 7% agreed, 22, 2% uncertain and 11, 1% disagreed.

The general responses of the candidates, portrayed employees' aligned commitment and also confirmed co-operation and cohesion prevailing in their health care organisations.

Table 6.1.7 Job satisfaction results

Statement	Strongly Agree		Table 6.12Agree		Uncertain		Disagree		Strongly Disagree	
	n	%	n	%	n	%	n	%	n	%
7. As an employee, I am satisfied with the kind of job I am doing in this organisation.	2	22,2%	6	66,6%	3	33,3%	0	0%	0	0%
19. My working environment is safe and secured.	5	55,6%	3	33,3%	1	11,1%	0	0%	0	0%
24.As an employee, I get recognition for the good performance of my tasks	1	11,1%	5	55,6%	2	22,2%	1	11,1%		0%
25. If I perform above expectation I am financially rewarded.	0	0%	1	11,1%	3	33,3%	5	55,6%	0	0%

6.1.7. Job satisfaction

This criterion scored 74% (see table 6.1) thus, was met. Statement 7, which was about employees satisfied with the kind of job they are doing (see table 6.12), reflected that 33, 3% were uncertain, 66, 7% agreed while 22, 2%, strongly agreed. Statement 19, which was about safe and secured environment (see table 6.12), 11, 1% was uncertain, 33, 3% agreed while 55, 6% strongly agreed. Statement 24, which was about employees getting recognition for the good performance of his/her tasks, 11,1% disagreed, 22,2% was uncertain, 55,6%, agreed while 11,1% strongly agreed. Concerning statement 25, which was about employees, financially rewarded when performed above expectations, 55,6% disagreed, 33,3% was uncertain while 11,1% agreed.

Generally, respondents' results revealed a great job satisfaction however, the aspect of financial rewards for above expectation performance reflected a grave concern. An

over all 89% of respondents reflected that there is a problem in this regard. Table 6.12 reflects how respondents responded.

SUMMARY

The results on measuring the employee performance focus revealed the satisfying responses by employees. Most criteria were met and those which were not met do not reflect any complications in order to achieve them. The most promising criteria were concerning cooperation, cohesion and job satisfaction which indicate the possibility of rectifying identified problems without much difficulty. The clients' responses on rating their services are following this session.

QUESTIONS, RESPONSES AND INTERPRETATIONS

6.1.2. Rating of clients/patient service

In this part of the study, a questionnaire was formulated based on questions about clients and or patients. After 12 respondents completed their questionnaires, scoring was conducted. Score in each statement of the questionnaire was translated into percentage and the findings were listed as per each statement, analysed and interpreted as such.

According to the scale presented, it is assumed that any percentage range between 0% - 40%, portrayed poor client/patient service rendering. 41% - 60%, portrayed an average service rendering, 61% - 80% portrayed good service rendering while 81% - 100% portrayed an excellent client/patient service rendering.

QUESTION 1 TO QUESTION 25

6.1.2.1. How do you rate your waiting time for your appointment?

The responses to this question was as follows: 66, 7% reflected the waiting period for the appointment was average while 33,3% considered it good.

Considering the respondents' responses to this question, an urgent need to review the waiting period for appointments is evident. The score indicated, reflects a poor service rendering as far as this matter (appointment waiting period) is concerned.

6.1.2.2. How do you rate the helpfulness of the reception clerk?

The findings were as follows: 8, 3% rated it as poor, 25%, as average while 66, 7% rated it as good.

This score reflects a good helpfulness of the reception clerk as per assumed ratings given in this section.

6.1.2.3 How do you rate the waiting time?

The responses were as follows: 25% referred to it as poor, which means, patients and clients wait for a long period before receiving health care services, 41%, as average, meaning that the service rendering is not to their satisfaction while 33,3% referred to it as good.

These responses however, generally portrayed poor service as far as waiting period is concerned. Similar to the statement concerning the helpfulness of the reception clerk, this aspect needs urgent attention as it also reflects a poor image of clients/patients service rendering within organisations under study.

6.1.2.4. How do you rate the quality of time the health care worker spent with you?

The findings pertaining to this question were as follows: 16, 6% rated this question as average, 33, 3% as good and 50% as excellent. Generally, an overall score of 83, 3% reflects an excellent service rendering as far as quality time spent with clients and patients is concerned.

6.1.2.5. How do you rate accessibility of the dispensary?

The responses were as follows: 25% rated this question as average while 75% rated it good, meaning that the service is accessible.

6.1.2.6. How do you rate the waiting period at the chemist?

The responses were as follows: 8, 3% rated it as poor, indicating that patients and clients wait for a long period before medication or treatment before it is dispensed to them. Thirty three percent rated it as average while 58,3% rated it as good.

Generally, this waiting period is rated as average, meaning that it is not according to the clients/patients' expectation. It is therefore recommended that the source of this problem be identified and rectified. For example, if it is due to shortage of personnel, human resource manager intervene by recruiting more personnel as indicated in the literature review of this study.

6.1.2.7. How do you rate instructions given to you at the dispensary?

Respondents replied in the following way: 16, 6% rated it as average, 16, 6% as good while 66, 7%, rated it as excellent. The over all score of 83, 3% is reflected by the respondents who confirm that instructions given by the pharmacy as excellent.

6.1.2.8. How do you rate racial relations in the hospital?

Respondents replied in the following way: 16, 6% rated it as poor, indicating that there are still racial issues prevailing in the process of rendering service to patients and clients. Over 30% rated this question as average while 50% rated it as good.

Generally, the score in this question reflects an average service rendered. There is however an encouraging reflection of diversity management in the health care organisation under study. The fact that an average score of 50% was attained indicates that there is a great attempt to manage diversity completely.

6.1.2.9. How do you rate security service at the hospital?

Results of this question are as follows: 33, 3% rated security service as poor, 41,6% as average while 25%, as good.

Generally, the score in this question reflects a poor security services in the health care organisations under study.

6.1.2.10. How was your reception in the ward?

Findings were as follows: 8,3% rated the reception in the ward as average, 33,3%, as good while 66,7%, as excellent. The overall percentage of 91% reflected the reception in the ward, as excellent.

6.1.2.11. How was the attitude of staff?

Respondents replied to this question in the following manner: 8,3% rated the attitude of the staff as average, 25% as good while 66,7%, as excellent. The over all score of 91% rated the staff attitude as excellent, which confirms a positive staff attitude.

6.1.2.12. Were you informed about hospital routine and was the ward layout shown to you?

The following responses were reflected by the respondents: 8, 3% rated it as poor, meaning that they were not informed about the hospital routine nor shown the ward layout. More than 30% rated it as average, 25%, as good while 33,3% rated it as excellent. The overall percentage of 58% for good service was scored and thus reflected an average service delivery as far as this question is concerned.

6.1.2.13. Were you kept informed about the nature and progress of your treatment?

The following responses were received: 41, 6% rated it as poor, 41, 6%, as average while 16,6% rated it as good. Generally the out come reflected poor service.

6.1.2.14. How long did it take for nursing staff to react to your request?

Respondents replied as follows: 8, 3% rated it as poor, 33,3% rated it as average and 58,3% rated it as good. These results reflected an average satisfaction by respondents concerning nursing staff reaction to their requests.

6.1.2.15.Did you receive your telephone messages?

Respondents responded as follows: 16,6% rated this service as poor,58,3% was uncertain while 25% rated it as good. The outcome of this service turned out to be generally poor however, a large percentage of respondents was uncertain. This may be due to increased technology access whereby, almost every patient has a cellphone. This however does not isolate the health care employee's responsibility to give telephone messages to patients or clients.

6.1.2.16. Was enough attention given to any complaints you had?

The responses to this question were as follows: 33, 3% was uncertain, 50% rated it as good while 16,6% rated the service as excellent. This generally indicated a good service as far as handling patients/clients complaints is concerned.

6.1.2.17. Were you visited by a doctor daily?

Respondents replied as follows: 25% rated it as good, 75%, as excellent. Doctors' services were 100% acceptable, and excellent.

6.1.2.18. Did the doctor discuss your condition with you?

The responses as follows:16, 6% rated it as uncertain, 25%, good while 58,3% as excellent. These services rated an overall 83, 3% and were thus generally, rated excellent.

6.1.2.19. How is the overall impression of the ward with regard to hygiene?

Respondents answered as follows: 33, 3 rated the ward hygiene as good, while 66,7% rated it as excellent. The overall rating of ward hygiene is 100%.

6.1.2.20. Was your food placed within reach?

The responses were as follows: 16, 6% rated it good while 83, 3% as excellent. The overall rating of food services was 100%, thus, perceived as excellent.

6.1.2.21. Was there assistance available during meal time?

The findings were as follows: 16, 6% rated it as good, 83,3% rated it as excellent, thus an over all 100% excellent service during mealtime was confirmed.

6.1.2.22. Were your visitors allowed enough time for their visits?

The respondents responded in as follows: 8, 3% rated it as good while

91, 6%, rated it as excellent. The overall 100% excellence in visitors' time allowance was rated.

6.1.2.23. What the noise level and disruptions during visiting hour is?

The findings were as follows: 8, 3% rated it poor, 41,6% as average while 50% said it was good. The overall response was average, indicating that the noise level during visiting time is a cause for concern.

6.1.2.24. How was the information given to you when you were discharged regarding usage of medicine?

Respondents replied as follows: 33, 3% rated this service as good while 66,7% rated it excellent. The general feeling therefore, was that the service is 100% satisfactory.

6.1.2.25.How was your follow-up arrangements?

The results on this question were as follows: 16, 6% rated it as good while 83, 3% rated it as excellent. An overall 100% score was obtained, which also indicated an excellent service as far as arrangements for follow up is concerned.

SUMMARY OF QUESTIONNAIRE IN ANNEXURE C

Patient/clients services are generally, good and to a certain extent, excellent. There are however, areas which need urgent attention and they include waiting time for both appointments and services, security services, progress and treatment discussions with the patients, noise level as well as attendance to patients complaints. The recommendations concerning all these problem areas will be discussed in chapter 7.

6.1.3 Interview for managers

In this part of the study, nine managers were interviewed individually, visiting each, at their working areas (within the three health care organisation under study). Their responses to the interview questions were carefully noted (written) to simplify and analysis and interpretation. Assumed aspects considered to be important indicators of good management and quality performance were used to rate their responses. At least two indicators within one question were expected in order to rate such a response positive.

QUESTIONS, RESPONSES, ANALYSES AND INTEPRETATION

6.1.3.1 Are the lines of communication opened for all in the health care organisation?

HEALTH CARE ORGANISATION A

Manager 1: Yes, they are opened because management always gives feedback to subordinates through notices, meetings and through their input during management decision making.

Manager 2: Yes, there are notices and also the workers' forum where some issues are communicated by employees and managers

Manager 3: Yes they are, because in our organisation there is always consultation before action is taken, for example, before employees going on leave, they are encouraged to choose periods which are suitable for them. Their choices are respected as far as possible.

HEALTH CARE ORGANISATION B

Manager 1: We do have open communication lines as there is always feedback given to subordinates, and our offices are always opened for them to present their problems or what ever needs to be communicated.

Manager 2: Lines of communication are opened as communication is two way and there are always available means to take it up or down the line, depending on the situation.

Manager 3: Yes, they are, there are always circulating notices and meetings.

HEALTH CARE ORGANISATION C

Manager 1: Yes, there are always meetings held to give subordinates reports and feedback on matters concerning our organisation.

Manager 2: Yes, there are open lines of communication as there is even the labour relation officer to intervene where communication between employer and employee or employee and employee seem to be a problem.

Manager 3: Yes, there are notices circulating, and regular meetings attended.

ANALYSIS AND INTERPRETATION

Generally, this question had a positive response as all managers confirmed opened lines of communication with engagement of most available means such as media, circulars, labour relations officer and others.

6.1.3.2 How is the morale and motivation of employees ensured in the health care organisation?

HEALTH CARE ORGANISATION A

Manager 1: There are extramural activities for employees e.g. choir practices and different sports activities.

Manager 2: There are awards given to employees and they also get financial rewards, depending on their performance (PMDS).

Manager 3: They get PMDS and also rotate from time to time to new environments and new adventures.

HEALTH CARE ORGANISATION B

Manager 1: Employees get PMDS and are sent for further training and development.

Manager 2: Employees get rewards financially and also awards e.g. MEC'S or CEO's, for good performance.

Manager 3: Employees are getting PMDS, depending on their performance.

HEALTH CARE ORGANISATION C

Manager 1: Employees morale and motivation are ensured through inviting motivational speaker to come and talk to them and they also get financial rewards like PMDS bonus or steps.

Manager 2: Employees are praised for the work well done by management addressing them or writing letters of appreciation to them, when they are ill, get well soon cards, are sent, during their birthdays, birthday cards.

Manager 3: Employees are getting PMDS and are also getting home subsidies from the employer.

ANALYSIS AND INTERPRETATION

Managers mostly indicated monitory rewards in this aspect, there were however, also some interesting aspects brought into picture, such as birthdays as well as get well cards given to employees, depending on the situation.

6.1.3.3 Are public inputs considered when planning health care service in the organisation?

HEALTH CARE ORGANISATION A

Manager 1: Yes, they are, there is a public relation officer who co-ordinates the hospital and the public and there are also suggestion boxes for the public to make suggestions on health care matters.

Manager 2: Yes, they do, through the media and suggestion boxes.

Manager 3: Yes they are, although the public is still reluctant to participate in decisions taken but quick to point fingers when things are or seen to be wrong.

HEALTH CARE ORGANISATION B

Manager 1: Yes they are, there is a Hospital Board which consists of community members and they represent community in matter of its concern.

Manager 2: Yes, the inputs are invited through the media and questionnaires which their responds give guidance in planning the health care services.

Manager 3: Yes there are always suggestion boxes and visitors' books for either positive or negative comments.

HEALTH CARE ORGANISATION C

Manager 1: Yes there are suggestion boxes and patient questionnaires.

Manager 2: Yes through the media where relevant telephone numbers for different services enquiries are published and there are also suggestion boxes.

Manager 3: Yes, sometimes they come as suggestions but sometimes, criticism by the public is turned into inputs and aspects which are, genuinely criticised, are attended to positively.

ANALYSIS AND INTERPRETATION

This question was also responded to, in a more common responses, for example, suggestion boxes. There was however, one manager who reflected his/her perspective by indicating the community's reluctance in participating in matters concerning their health care services, however, quick to judge the health care organisation whenever things are or seem to be wrong

6.1.3.4 How does the health care organisation identify whether the public is satisfied or not, about the services rendered?

HEALTH CARE ORGANISATION A

Manager 1: Through the media and books in which the public make comments.

Manager 2: Through positive or negative comments in the suggestion box.

Manager 3: By commenting negatively or positively through the press.

HEALTH CARE ORGANISATION B

Manager 1: By sending messages through hospital board members and suggestion boxes.

Manager 2: Through word of mouth and the media, for example, some clients complain of prolonged waiting time or reporting matters to the media (pleasant or unpleasant ones.

Manager 3: Through comments which are positive or negative.

HEALTH CARE ORGANISATION C

Manager 1: Through suggestion boxes and word of mouth as some community members sometimes demand to see the hospital manager and report matters personally, to him/her.

Manager 2: Through the media or writing comments in the book.

Manager 3: By engaging the press and placing suggestions in the suggestion box.

ANALYSIS AND INTERPRETATION

The responses to question 4 were more or less similar to those of question 3 as the former was actually a follow up on the latter. The interesting part however, was the mentioning of Public Relation Officer as part of information disseminator.

6.1.3.5 What measures are taken within the health care organisation to ensure commitment of personnel to quality productivirty?

HEALTH CARE ORGANISATION A

Manager 1: Through in- service training, workshops and peer review evaluation.

Manager 2: By managers doing inspections and employees attending workshops.

Manager 3: Through proper delegation and supervision by supervisors and managers.

HEALTH CARE ORGANISATION B

Manager 1: Through workshops and in-service training.

Manager 2: Through workshops and in-service training.

Manager 3: Through engaging employees in quality improvement programmes and in-service training concerning quality related matters.

HEALTH CARE ORGANISATION C

Manager 1: Through in-service training.

Manager 2: By delegating duties within employees' abilities and further training and further training and development.

Manager 3: Through quality improvement programmes and workshops.

ANALYSIS AND INTERPRETATION

Most managers indicated workshops and in-service as important measures to ensure commitment of personnel to quality productivity. The interesting responses which were further indicated were peer review evaluation and quality improvement programmes. Although the inspection was not much encouraged by the literature review of this study, it is, to a certain extent, regarded by some managers as another measure to emphasise quality productivity..

6.1.3.6 How employees are delegated to their duties, randomly or within their knowledge, skills and capabilities?

HEALTH CARE ORGANISATIONS A, B & C

All nine managers responded to this question by saying employees are delegated within their knowledge, skills and capabilities.

ANALYSIS AND INTERPRETATION

All managers responded to this question by indicating employees as being delegated according to their knowledge, skills and abilities.

6.1.3.7 Is the working environment within the health care organisation conducive to work in?

HEALTH CARE ORGANISATION A

Manager 1: Yes, it is conducive because surroundings are clean and there is security in place.

Manager 2: Yes, because employees are provided with protective clothing where necessary as encouraged by Occupational Health and safety department.

Manager 3: Yes, because there is safe security and employees are also immunised against infectious diseases, there are also risk management processes in place thus risky areas can easily be identified and dealt with accordingly.

HEALTH CARE ORGANISATION B

Manager 1: Yes, employees are positive and conflicts are limited, however, shortage of personnel compromises the conduciveness of the environment.

Manager 2: Yes, environment is clean, safety measures in place, for example, disaster plan and protective clothing available.

Manager 3: Yes, the environment is clean, security and health and safety officers present.

HEALTH CARE ORGANISATION C

Manager 1: Yes, the buildings are safe and surroundings clean.

Manager 2: "Yes, health and safety measures are practiced and equipments are also safe and of good quality.

Manager 3: Yes, the security is tight, buildings safe and environment clean inside and outside.

ANALYSIS AND INTERPRETATION

In this questions most managers seemed to be satisfied about security services as well as health and safety measures in place. Some however, also mentioned infection control and clean surroundings as indications of safe and secured environment. Managers' perception about safe and secure environment seem to differ vastly as some viewed from their perspective of absence of conflicts and enough personnel, while others, from a health, cleanliness and safe structures' perspective.

6.1.3.8 Does the organisation have a reward system in place?

HEALTH CARE ORGANISATIONS A,B & C

Six managers responded by mentioning PMDS (Performance Management Development System) as the prevalent reward system in place, however, three other managers coupled it with other systems as follows:

Manager 7: Yes, although your question is not specific because rewards may either be negative or positive. For example, our organisation has PMDS as a positive financial reward system but also has a disciplinary procedures as a negative reward system for employees who transgress and act contrarily to organisational norms.

Manager 8: In our organisation, rewards are coupled with recognition whereby PMDS is given as a reward for an outstanding performance and a job well done also recognised through awards, for example, the best performer in the unit, or just saying well done.

Manager 9: Yes, other employees are rewarded by PMDS while others are rewarded by being given study leave to develop themselves further.

ANALYSIS AND INTERPRETATION

This question about reward systems, generally reflected a less interest by managers as far as rewards are concerned. All managers referred to PMDS as the means to reward

employees, at least, one of those nine managers indicated some other means, such as study leave as a form of reward.

SUMMARY

The literature review of this study indicates that employees are the assets of the organisation. Matters concerning employees' needs therefore, need to be treated cautiously and genuinely. Managers' responses generally reflected the positive results. Three aspects however, which in practical situation also, are closely related, i.e. High morale, motivation as well as reward systems for employees reflected a need for urgent attention to enhance good management practices and peak performance. Recommendations as how to ensure that the aspects reflecting shortcomings as well as the conclusion of this study in general, will be discussed in chapter 7.

CHAPTER 7

CONCLUSIONS AND RECOMMENDATIONS

7.1 INTRODUCTION

In this chapter, the whole research study will be summarised and concluded. The most essential findings and interpretations of the results, after responses to questionnaires and interviews, are indicated. The chapter concludes with recommendations and suggestions for further research regarding the maintenance of quality in health care organisations.

This chapter focuses on the recommendations in line with literature review, the findings on questionnaires and the interviews results. These recommendations are categorised into three, following the nature of findings in survey samples, categories.

7.2 SUMMARY

Chapter I provided the orientation of the study whereby the problem statement and the objectives of the study were outlined.

Chapter 2 focused on the theoretical foundation of the study whereby the following aspects were dealt with:

- Management;
- Human resource management;
- Organisational behaviour;
- Organisational culture.

Chapter 3 reviewed the literature where the concept of quality was discussed according to the following aspects:

- Quality assurance;
- Total quality management (TQM);
- Quality planning;
- Quality improvement and;
- Quality control.

Chapter 4 defined the problem statement and clarified the objectives of this study.

Chapter 5 dealt with the design of the research instrument and questions formulated, displayed.

Chapter 6 reflected the validity and reliability of the findings through analysis of the study results which are also interpreted.

7.3 RESEARCH FINDINGS

7.3.1 Measuring the health care employees effective performance

In this section, finding were classified into criteria, therefore, recommendations were also done following each criterion. These findings were also recorded in average percentages, emanating from two or more statements within different criteria.

7.3.1.1 Performance focus

This criterion scored 69%, however, none of all candidates strongly agreed to performance focus as a criterion. This criterion also, has three sub-criteria and are as follows:

(a) Goals

This sub criterion scored 71%.

(b) Norms

This sub criterion scored 68%.

(c) Roles

This sub criterion scored 58% which was the lowest of all the criteria in this section of the study.

7.3.1.2 Co-operation

This criterion scored 79% which was the highest of them all.

7.3.1.3 Motivating employees

This criterion scored 65%.

7.3.1.4 Trust

This criterion scored 58% which was the lowest score of all criteria.

7.3.1.5 Member contribution

This criterion scored 69%.

7.3.1.6 Cohesion

This criterion scored 73% which was the second highest with positive results and it also has a sub criterion, which is aligned commitment.

(a) Aligned commitment

This sub criterion scored 74%.

7.4 Conclusions and recommendations

Based on the findings, criteria 7.3.1.1 to 7.3.1.6, some areas of concern were identified, thus, the following recommendations are made:

7.4.1 Measuring the health care employees' effective performance

7.4.1.1 Performance focus

According to literature, employees portray a performance focus if they have cognisance of the purpose of their roles within the organisation. It is thus recommended that health care organisations under study, put more emphasis on employees' role s clarification through job descriptions and the proper delegation of tasks. Employees must be informed about their key performance areas and indicators, which is the task of the health care organisations' human resource manager to fulfill.

(a) Goals

This is the performance focus sub criterion and the findings have reflected that employees know organisational goals. There is however, a need for training and skills development programmes to be conducted, in order to achieve a balance between employees' knowledge and skills, as well as their performance. The literature review has indicated that the value of personnel development and training must not to be underestimated, that a formal personnel development system must be in place to determine personnel needs in a scientific way and those needs be appropriately, met. The literature further indicated that personnel be regarded as the organisations' most valuable assets.

(b) Norms

In this performance sub criterion, it is recommended that an organisational culture, as it is stated in the literature review, is inculcated among all employees. They must be conversant with organisational values and beliefs such as, valuing quality performance and productivity.

(c) Roles

This performance focus sub criterion, scored the lowest of all criteria in this study section, 58%. It is therefore recommended that urgent attention be given through reviewing employees' placement in their different working environments within the health care organiations under study. The literature review of this study indicated some facts regarding job enrichment, rotation and alternative work schedules for employees.

7.4.1.2 Co-operation

This criterion scored the highest of all, 79%. It is therefore recommended that the health care organisations under study, continue to pursue the highest level of excellence as it is indicated in the literature review that concerns it. It must be every body's business, be it individuals or populations.

7.1.4.3 Motivating employees

According to the literature review of this study, motivation of employees plays an imperative role towards attaining peak performance. It is therefore recommended that in- service training concerning motivational lectures, be conducted. Employees' motivation in the form of incentives and performance monitory rewards must also be considered. The motivating working environment must be ensured whereby buildings and other structures are safe and secure in, resources are adequate and always available in order for employees to carry out their activities.

7.4.1.4 Trust

This criterion scored the lowest of all the criteria in this section, 58%. This might however indicate the unfortunate situation for the health care organisations under study as trust is among the most important and the basis of achieving peak performance. It is therefore recommended that managers with-in the health organisations under study, ensure open, honest, two way and timely communication. The literature review of this study also emphasised the importance of good communication in order to achieve and maintain peak performance and quality productivity.

7.4.1.5 Member contribution

This criterion's findings reflected a great discrepancy in equilibrium between management's belief concerning employees' knowledge and skills and the reality

as far as the latter is concerned. The findings further confirm the problem in the communication channels, revealed by the results of trust, as a criterion. It is therefore recommended and reinforced that employees be empowered, educated and trained to acquire necessary knowledge and skills. The literature review in this study, has reflected different ways in which some employers handle their employees as far as their empowerment is concerned. Some empower their own employees while others want the readily empowered and discard them when they are no longer required. The general findings of this section of the study however, portray health care organisations under study as positive ones towards handling their employees. The issue of this imbalance between knowledge and skills as well as employees' activities can be easily resolved.

7.4.1.6 Cohesion

This criterion was the second best as compared to the rest of the criteria. It also reflected a realistic view when compared to co-operation criterion, which scored the highest in this section. It is therefore recommended that standards concerning employee cohesion be continually improved, which is likely to happen especially if all other recommendations mentioned earlier, will be considered and implemented.

(a) Aligned commitment

This is a cohesion sub criterion and also scored higher with comparison to other criteria. The outcome of this sub criterion confirmed the positive results in cooperation and cohesion within health care organisations under study. The recommendations for cohesion criterion are thus, also applicable in this sub criterion.

7.4.1.7 Job satisfaction

This criterion scored an average 74% and generally, employees revealed a great job satisfaction. It is however, important that the health care organizations under study, urgently review their Performance Management Development systems (PMDS), as the smallest 11,1%, confirmed their financial rewards while the rest denied it.

7.4.2 Rating of patient/client service

7.4.2.1 Findings

Twenty five questions were asked based on different aspects assumed to have an impact on patient/client service within health care organisations. Thirteen of them were responded to, as excellent services, which is 52% of excellence. The following questions fall within this category: 6.1.2.4; 6.1.2.5; 6.1.2.7; 6.1.2.10; 6.1.2.11; 6.1.2.17; 6.1.2.18; 6.1.1.19; 6.1.2.20; 6.1.2.21; 6.1.2.22; 6.1.2.24 and 6.1.2.25 (see annexure C). Five questions were responded to, as average services, which is 20%. The following questions fall within this category: 6.1.2.6; 6.1.2.12; 6.1.2.14; 6.1.2.16 and 6.1.2.22 (see annexure C). Seven questions were responded to, as poor service delivery and it constitutes 28%. The following questions fall within this category: 6.1.1.2; 6.1.2.3; 6.1.2.8; 6.1.2.9; 6.1.2.13; 6.1.2.15 and 6.1.2.23.

7.4.2.2 Recommendations

Recommendations will be based on the average and poor patient/client service delivery, responses.

(a) Questions and their recommendations

6.1.2.1 How do you rate your waiting time for appointment?

The responses here indicated a serious concern about poor service delivery, thus, urgent attention is needed. The problem may however, be due to shortage of staff on one hand, and on the other hand, an increased patient/client turn over. The actual cause needs to be identified and corrective measures taken.

6.1.2.3 How do you rate the waiting time? & 6.1.2.6 How do you rate the waiting period at the clinic?

These two questions both regard waiting time. A number of factors might influence this aspect and these include, patient turn-over, shortage of staff and/or employees' lack of motivation towards peak performance. Depending on the cause, human resource manager or management, through its motivational strategies, must act promptly to rectify the situation, where it is possible. The process might be hampered by an increased number of patients with infectious

diseases for example: HIV pandemic, which is beyond any one's control at the present moment.

6.1.2.8 How do you rate racial relations within the health care organisation?

Racial relations scored marginally, at 50%. This indicates that there still is a need for transformation to be emphasised within the health care organisations under study. Experts in transformation need to be involved and emplooyees' as well, participate in transformation programmes within their health care organisation.

6.1.2.9 How do you rate security service in the health care organisation?

The security services are also cause for serious concern. These services need to be reviewed, errors corrected and where the need arises, new security contracts bemade.

6.1.2.12 Were you informed about hospital routine and the ward lay out shown to you?

This service scored 58% which reflects an average service delivery. Showing patients the ward lay-out and informing them about the ward routine is imperative. It needs to be done concurrently with other duties in the ward if patients are fully conscious and in due time, if the patient was unconscious on admission.

6.1.2.13 Were you kept informed about the nature and progress of your treatment?

This aspect is also important and the patients need to participate in their care. Informing them about the progress and nature of treatment will reduce their length of stay in the health care organisation and enhance their healing process.

6.1.2.14 How long did it take the nurising staff to react to your request?

This aspect reflected an average performance and might be influenced by shortage of staff which is a generalised problem within health care organisations. It however, needs serious attention considering the patients' right charter.

6.1.2.15 Did you receive your telephone messages?

Telephone messages received a large number of average responses. This might be due to the fact that most patients/clients use their own cellular phones. This therefore might not reflect a serious concern, however, patients/clients must be given their telephone messages when they are received

6.1.2.16 Was enough attention given to any complaints you had?

This question also rated an over all 67% which portrays an average service delivery. There were however, no responses reflecting this service as poor. 33%

rated it as average which might be due to lack of complaints because people were not certain about what to say concerning this aspect. It might therefore, also be considered as a good service rather than average

6.1.2.23 How is the noise level and disruption during visiting hour?

A large percentage of respondents rated the noise level as average, 41 % and 50% accept the noise level. This might also indicate an acceptable noise level and disruptions within health care Organisations under study. An overall of 91% is accepting it as average and good, thus have no alarming effects.

7.4.3. Managers' Interview.

7.4.3.1 Findings

Most managers answered interview questions according to the interview expectations. That is, in line with the given aspects considered to be indicators of good management. There were however, two questions, which were generally not answered satisfactorily by most managers. Those questions are 2 and questions 8. which are bout high morale and motivation as well as the reward system for employees. Recommendations are therefore, going to be based on those two questions.

7.4.3.2 Recommendations

(a) Questions and their recommendations

6.1.3.2 How is the high morale and motivation of employees ensured in the health care organisation?

Managers need to be innovative, creative and reflect the ability of craftsmanship and need to understand the organisational culture and behaviour within their organisations as indicated in the literature review of this study. This will enable them to initiate motivating ideas and activities relevant to the needs of their subordinates. Other than responding to this question by mostly mentioning workshops and in service training, a large number of motivating ideas could have been created and employed.

6.1.3.8 Does the organisation have a reward system in place for employees?

Most managers responded to this question by mentioning PMDS as a reward system. One would wonder whether managers themselves understand what this PMDS entails. Performance Management Development System may be used as one of reward systems in the organisation provided that there are other systems in place. For example, PMDS applies to a small percentage of employees, i.e. ranging between 1 and 5%, whose performance is considered outstanding. This monitory is therefore, reward on its own, can not fulfill the organisation's entire reward system. 95% of employees still need to be rewarded, which made it in urgent need of review.

Managers therefore, need more information on PMDS to ensure that rewards are being received by relevant candidates. As employees are the organisation's assets, other reward systems must be identified and employed so that eventually, a large number of employees are rewarded.

7.5 RECOMMENDATION FOR FURTHER RESEARCH

As managers within health care organisations are faced with the challenge of maintaining positive outcomes as far as quality service production is concerned, this study might be of assistance effectively to improve, monitor and maintain quality standards within their organisations.

A further research is however, recommended as "quality" concept is very broad. Some aspects within this study reflected a need to be redressed and quality improvement is also a continuous phenomenon therefore, a further research will address such aspects.

7.6 CONCLUSION

Considering the findings of this study, it is evident that quality maintenance is not an easy task which also, to a certain extent, justifies the need for the study being conducted. The promising aspect of this study is that its outcome reveals a link between the responses of three categories of respondents. For example, co-operation within this hospital complex was a common feeling. Knowledge, skills and development as well as reward systems reflected a common concern from both employees and managers' responses.

Recommendations were made for redressing areas which, according to the researcher, reflected a concern. Some information provided by respondents has reflected some excellence as far as quality related matters are concerned, within the health care organisations under study which indicates that redressing of identified aspects might not be such a huge problem.

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The Hospital Manager
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Re-request to conduct a mini-dissertation in the K/T Hospital Complex

Dear Madam

I hereby request a permission to conduct a research in the complex. The research topic is: Maintenance of quality in health care organisations: A managerial perspective (North-West , Klerksdorp/Tshepong/Potchefstroom/Witrand Hospital Complex)

This mini dissertation is part of the requirements in my studies with North-West University, so, being granted that opportunity will be highly appreciated. The reseach purpose and objectives are reflected in the proposal attached here in.

Yours faithfully
Manamela S.S.

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ANNEXURE A

MEASURING THE HEALTH CARE EMPLOYEES EFFECTIVE PERFORMANCE

It is required of you to complete the following questionnaire as truthfully and honestly as possible. Your anonymity is guaranteed. The objective of this questionnaire is to measure the effective functioning of the team of which you are a member. When you evaluate the following statements, think about similar circumstances in which you have found yourself, previously and mark the appropriate scale you feel corresponds with your assessment of your team. The results of this study will be disclosed to the team after analysis where your inputs to address certain aspects which need to be refined, are also welcome. Your effort to participate in this research is much appreciated. Enjoy and good luck!

Scale

5= strongly agree, 4= agree, 3=uncertain, 2= disagree, 1= strongly disagree

Statement	Scale				
1.Our management believes that every employee has something to contribute- such as knowledge, skills, abilities and information.	5	4	3	2	1
2. Every employee in my organisation knows exactly how to achieve our organisational goals	5	4	3	2	1
3. Employees have the skills they need to accomplish their activities and roles within the organisation	5	4	3	2	1
4. Our management constantly give feedback on our performance in meeting our customers' expectations	5	4	3	2	1
5. As employees, we work together to set clear, achievable and appropriate goals	5	4	3	2	1
6. If outsiders were to describe the way we communicate within our organisation, they would use such words as "open", "honest", "timely" and "two way"	5	4	3	2	1
7. As an employee, I am satisfied with the kind of job I am doing in this organisation.	5	4	3	2	1

8. As an employee, I am proud to be part of this health care organisation	5	4	3	2	1
9.Every employee is working towards accomplishing the same organisational goals	5	4	3	2	1
10. Every employee knows exactly why certain activities are carried out or not carried out	5	4	3	2	1
11.Every employee knows and understands the health care organisation's priorities	5	4	3	2	1
12.Employees understand what management expects of them as they are clear about the organisational goals	5	4	3	2	1
13.Employees clearly understand unwritten rules of how to behave within the health care organisation	5	4	3	2	1
14.Every employee in this organisation wants to contribute towards the organisation's success, not only to his/her own	5	4	3	2	1
15. The management assures employees consistently that every employee's success will be measured against his/her performance	5	4	3	2	1
16. As employees, we are able to work together to solve destructive conflicts rather than ignoring them	5	4	3	2	1
17. Every employee agrees on "speaking your mind" and understands that disagreement is not personally orientated	5	4	3	2	1
18. Every employee is given enough opportunity to gain knowledge, skills and experience necessary to complete the work	5	4	3	2	1
19. My working environment is safe and secured	5	4	3	2	1
20. Every employee has equal ownership of the success of the organisation	5	4	3	2	1
21. There is a good match between capabilities and responsibilities of each employee within the organisation	5	4	3	2	1
22. Every employee believes that the other employees' actions are for the good of the organisation and will guard against harming one another with their actions	5	4	3	2	1
23. Every employee is committed to achieve common objectives	5	4	3	2	1
24. As an employee, I get recognition for the good performance of my tasks	5	4	3	2	1
25. If I perform above expectation I am financially rewarded	5	4	3	2	1

ANNEXURE B

1.Performance focus

10. Every employee knows exactly why certain activities are carried out 31
11. Every employee knows and understands the health care organisation's priorities 31

Total 62

(62/2)/45*100 = 69%

(a)Goals

2.Every employee knows exactly how to achieve our organisational goal 29
12.Employees understand what management expects of them as they are clear about the Organisational goals 35

Total 64

(64/2)/45*100 = 71%

(b)Norms

13. Employees clearly understand unwritten rules of how to behave within the health care organisations 33
17. Every employee agrees on "speaking your mind" and understands that disagreement is not personally orientated 28

Total 61

(61/2)/45*100 = 68%

(c)Roles

3.Employees have the skills they need to accomplish their activities and roles within the organisations 27
21.There is a good match between capabilities and responsibilities of each employee 25

Total 52

(52/2)/45*100 = 58%

2.Cooperation

5. As employees, we work together to set clear, achievable goals 38
14.Every employee in this organisation wants to contribute towards the organisation's success not only his/her own. 33

Total 71

(71/2)/45*100 = 79%

3.Motivating employees

4.Our management constantly gives feedback on our performance in meeting our customers' needs.

28

15.The management assures employees consistently that every employee's reward will be measured against his/her performance. 30

Total 58

(58/2)/45*100 = 65%

4.Trust

6.If outsiders were to describe the way we communicate within our organisation, they would use such words as "open", "honest", "timely" and "two way" 23

16.As employees, we are able to work together to solve destructive conflicts rather than ignoring them 28

22.Every employee believes that other employees' actions are for the good of the organisation and will guard against harming one another with their actions 27

Total 78

(78/3)/45*100 = 58%

5.Member contribution

1.Our management believes that every employee in our health care organisation, has something to contribute such as, knowledge, skills, abilities and information 36

18.Every employee is given enough opportunity to gain knowledge, skills and experience necessary to complete the work 26

Total 62

(62/2)/45*100 = 69%

6.Cohesion

8.As an employee, I am proud to be part of this health care organisation 34

23.Every employee is committed to achieve common objectives 31

Total 65

(65/2)/45*100 = 73%

(a) Aligned commitment

20.Every employee has equal ownership of the success of the organisation 32

9.Every employee is working towards accomplishing organisational goals 34

Total 66

(66/2)/45*100 = 74%

7.Job Satisfaction

7.As an employee, I am satisfied with the kind of job I am doing in this organization 37

19.My working environment is safe and secured 40

24.As an employee, I get recognition for the good performance of my tasks 33

25.Every employee is committed to achieve common objective 23

Total 133

(133/4)/45*100 = 74%

ANNEXURE C

In order to help us to improve our service we would like you to complete the following questionnaire.

Mark the relevant answer with X.

1.Gender

Male		**Female**	

2.

0-14	**15-20**	**21-30**	**31-60**	**>60**

3.Home Language

Afrikaans		Tswana		Xhosa	
English		Tsonga		Zulu	
Ndebele		Pedi		Other	
North Sotho		Venda		Specify	

4.Rating of Patients/clients Service

	0	1	2	3
	Poor	Average	Good	Excellent
1.How do you rate waiting period for an appointment?				
2.How do you rate the helpfulness of the reception clerk?				
3.How do you rate your waiting time?				
4.How do you rate the quality of time the health care worker spent with you?				
5.How do you rate accessibility if dispensary?				
6.How do you rate waiting time at the dispensary?				
7.How do you rate instructions given to you at the dispensary?				
8.How do you rate racial relations in the health care organisation?				
9.How do you rate security service in the health care organisation?				

10.How was your reception in the ward?				
11.How was the attitude of staff?				
12.Were you informed about the hospital routine and were you shown the lay out of the ward?				
13.Were you kept informed about the nature and progress of your treatment?				
14.How long did it take nursing staff to react to yourrequest?				
15.Did youreceive your telephone message?				
16.Was enough attention given to any complaints you had?				
17.Were you visited by the doctor, daily?				
18.Does he discuss your condition with you?				
19.How is the over all impression of the ward with regard to hygiene?				
20.Was your food placed within reach?				
21.Was there assistance available during meal time?				
22.Were your visitors allowed enough time?				
23.How is the noise level and disruption during visiting hour?				
24.How was the information given to you when you were discharged regarding how to use your medicine?				
25. How were your follow up arrangements?				

ANNEXURE D

Aspects assumed to be important indicators of quality patients/clients services

1. Waiting time for appointment.
2. Helpfulness of the reception clerk
3. Waiting time to receive relevant services.
4. Quality time spent with the patient/client.
5. Accessibility of the dispensary.
6. Waiting period at the chemist.
7. Instructions given at the dispensary (how to take medication)
8. Racial relations.
9. Security services.
10. Reception in the ward.
11. Attitude of the staff.
12. Hospital routine and lay out of the ward.
13. Nature and progress of the treatment.
14. Reaction of the staff to requests.
15. Telephone messages.
16. Attention to raised complaints.
17. Doctors' visits in the ward.
18. Discussion of patients' conditions (with them) by the doctors.
19. Ward hygiene.
20. Accessibility of food to patients.
21. Assistance during meal time.
22. Visiting time.
23. Noise level and disruptions.
24. Information during discharge (diet, use of medication).
25. Follow up arrangements

ANNEXRE E

INTERVIEW QUESTIONS FOR MANAGERS

1. Are the lines of communication open for all, in the health care organisation?

2. How is the high morale and motivation of employees ensured in the health
   care organisation?

3. Is the public input considered when planning health care services in the organisation?

4. How does the health care organisation identify whether the public is satisfied or not, with the service rendered?

5. What measures are taken within the health care organisation to ensure
   personnel commitment to quality productivity?

6. How are the employees delegated to their duties, randomly or within their scope of knowledge?

7. Is the working environment within the health care organisation conducive in
   which to work?

8. Does the organisation have a reward system in place for employees?

ANNEXURE F

Management interview questions and aspects which, based on literature review, are assumed to influence managerial actions and performance

Questions	Assumed aspects influencing managerial actions and performance
1. Are the lines of communication opened for all in the health care organisation?	• Two way communication • Participative management/shared governance (consultation) • Feed back • Notices (circulating)
2. How is the high morale and motivation of employees ensured in the health care organisation?	• Training and development • Job enrichment • Empowerment • Reward systems in place
3. Is public inputs considered when planning health care services in the organisation?	• Through board members (who are part of the community) • The media • Suggestion boxes • Questionnaires • Visitors' books for comments
4. How does the health care organisation identify whether the public is satisfied or not, about the services rendered?	• Suggestion boxes • Books for comments • Media • Word of mouth
5. What measures are taken within the health care organisation to ensure commitment of personnel to quality productivity?	• Training and development • Organisational culture reinforcement • Performance Management Development System (PMDS) • In-service training and workshops
6. How are the employees delegated to their duties, randomly or within their knowledge, skills and capabilities?	• Within their knowledge, skills and capabilities.
7. Is the working environment within the health care organisation conducive to work in?	• Safe buildings, structures and equipments • Resources available • Wellness program for employees • Occupational health and safety measures taken (OHS officers available)

	safety measures taken (OHS officers available)
8.Does the organisation have a reward system in place for employees?	• Performance Management Development system • Financial rewards and rank promotions • Recognition by word of mouth (thank you) and tokens of appreciation such as service certificates, cards and just a pad on a shoulder

ANNEXURE G

VOLUNTARY CONSENT TO PARTICIPATE IN THE RESEARCH

Attached is a form for obtaining written consent from participants

I..... consent to participate in the research study on maintenance of quality in health care organisations (Klerksdorp/Tshepong/Potchefstroom/Witrand hopital complex, North West Province)

I understand that participation is voluntary and I am free to withdraw at any time I may need to.

Nna..... ke dumela ho nka karolo phuputsong ya ho baballa maemo a phahameng a boleng ba ditshebeletso. Maokelong/ dipetleleng tsa karolo e ka Borwa ya Profensi ya Bokone/Bophirima

Ke utlwisisa hore ho nka karolo ho etsahala ntle le qobello hape ke na le hona ho itokolla nako e nngwe le ennwe ha ke batla.

Signature of participant.....

Date.....

ANNEXURE H

INTERVIEW DECLARATION

I, Selloane Sarah Manamela, the MBA student at Univesity of North West (Mafikeng campus), promise to adhere to the freedom of choice with regard to your(participation). To withdraw at any time from the study if you so wish.

Your voluntary participation in this study is appreciated. You are expected to answer your questions as freely as possible. Your names will not be published upon publications of interview information.

Your honesty in this regard is very important though there are no right or wrong answers. All the answers will be taken as the true reflection of your views and perceptions, regarding maintenance of quality in health care organizations.

Thank you for participating

Signature of the researcher:

Student number: 10691677

Date: 19 April 2006