EVALUATION OF QUALITY MANAGEMENT PRACTICES IN THE EKURHULENI PUBLIC HOSPITALS

By

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DEDICATION

This dissertation is dedicated to all staff members

of public hospitals

who have offered quality of health care

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ABSTRACT

This study has demonstrated that continuous quality improvement and total quality management are the names for a philosophy of management that aims to help outcomes in both the individual and organizations of all kinds, eliminating quality waste during health care delivery service. In an effort to make a contribution to addressing the current challenges, areas of poor patient and lack of quality health care are explored in this study. Patients and healthcare professionals' views on Quality Management (QM) practices are also explored. Therefore, for the purposes of this dissertation, the researcher has expanded the QM definition. The poor patient care and shortage of skilled nursing practitioners' in nursing has indicated the need for top management commitment to measure, improve and provide high-quality health care for all its citizens. This is mainly due to lack of quality knowledge and skills, patients' education, and communication skills. In addition, no formalised framework exists on how quality of care in the context of nursing should occur, despite policy on quality health care being a legal requirement (National Department of Health, 2007:11).

The purpose of this dissertation was to evaluate quality management practices in the Ekurhuleni Metropolitan Municipality public hospitals. Quality management for health care delivery in public hospitals in Gauteng Department of Health was determined and conceptualised and a framework developed on which the improvement of a quality strategy could be based. Altogether three (3) public hospitals throughout Gauteng Ekurhuleni region participated in this dissertation.

A triangulation approach was adopted to collect data, analyse and answer the research questions. In this dissertation both quantitative and qualitative methods of data analysis were employed to analyse data derived from self-administered (open and closed) questionnaires, whilst semi-structured interviews were also conducted with the hospital unit manager (see Annexure 1 & 5).This, in turn, increased the validity of the empirical study part of this dissertation and enhanced the rigorous use of both quantitative and qualitative data.

The literature review was conducted to ascertain the current knowledge and information present on quality management practices in a public hospital service environment. Various sources such as books, journals and other relevant materials were used to analyse and discuss as well as identifying concepts. In this study, the researcher used a purposive sample of a unit manager (n=1), patients admitted (n=29) and hospital nurses (n=185) who were highly involved on service delivery in the hospital wards.

The researcher used a non-probability sampling method for this study and selected the most representative elements and characteristics as part of the population (De Vos, 1998; Babbie, 1992). This assisted the researcher to gain insight of the situation. In this regard, purposive sampling techniques represent the procedure of this study (Lincoln & Guba, 1985; Burns & Grove, 1993:246). It is important to note that this sampling technique was also used to achieve saturation data. Lincoln & Guba (1985) add by saying that this ensures trustworthiness. In this dissertation, data was analysed using the Statistical Package for the Social Sciences version 17.0 (SPSS), and a statistician at the University of Johannesburg was consulted.

Approval for conducting the research was obtained from the Head of Department: Quality and Operations Management at the University of Johannesburg before any data were collected in the 2012 academic year. The study was also limited to the eastern-region of Gauteng Department of Health hospitals due to the fact that the researcher could not afford to conduct more surveys because of insufficient financial background.

The study recommends that management should ensure that health quality programs are established, as well as enhancing customer satisfaction. The main contribution of this study is that quality improvement activities in the public hospitals especially the Ekurhuleni region of Gauteng province should be implemented and monitored. The skills considered necessary for an effective quality management practice and personnel development support services, coordination, training and human rights aspects of patient caring for the patients are also revealed.

Based on all of these factors, the study has been evaluated and sets a way forward for further exploration of this subject. It is also hoped that this dissertation will make a worthwhile contribution to the patients and healthcare professional's public hospital environment. In addition, it proposed a nursing framework for improved quality assurance programmes at the Ekurhuleni public hospitals.

KEY TERMS

Public hospitals, quality dimensions, nursing profession, patient care, quality control and assurance, quality improvement tools, public hospitals, quality improvement strategies

TABLE OF CONTENTS

CHAPTER TWO:

LITERATURE STUDY: PERSPECTIVES ON NURSING PROFESSION IN SOUTH AFRICA

CHAPTER THREE:

LITERATURE REVIEW: A CRITICAL DISCUSSION OF QUALITY HEALTHCARE

CHAPTER FOUR:

RESEARCH METHODOLOGY AND ITS IMPLEMENTATION

CHAPTER FIVE:

PRESENTATION AND DISCUSSION OF FINDINGS:

CHAPTER SIX

GUIDELINES AND OPERATIONALISATION:

CHAPTER SEVEN

SYNTHESIS, CONCLUSIONS AND RECOMMENDATIONS:

LIST OF TABLES

LIST OF FIGURES

LIST OF ACRONYMS

AQA-	Australian Quality Award
BSC-	Balance Scorecard
CEO-	Chief Executive Officer
COQ-	Cost of Quality
DOH-	Department of Health
EMM-	Ekurhuleni Metropolitan Municipality
EQA-	European Quality Award
GDOH-	Gauteng Department of Health
ISO-	International Standards Organisation
PHC-	Primary Health Care.
QA-	Quality Assurance
SABS-	South African Bureau of Standards
SANC-	South African Nursing Council
SPC-	Statistical Process Control
TQC-	Total Quality Control
TQM-	Total Quality Management
WHO-	World Health Organisation
WTO-	World Trade Organisation

CHAPTER ONE

ORIENTATION OF THE STUDY

"The public is protected and the provider of care knows exactly how she has to conduct herself legally and ethically, how to obtain registration or enrolment, remain on the register, remove her name from the register and cope with disciplinary issues"

*(*Charlotte Searle, 2008:48)

1.1 INTRODUCTION

In this section, a broad overview of the study is provided. The background and the poor patient care quality and the shortage of nurses within Ekurhuleni region and abroad are discussed. It is important for the nurses to provide quality care to patients, whilst working conditions therefore need to satisfy the nursing staff.

On the eve of the 21st Century, Nursing in South Africa is facing serious challenges. They are many factors that contribute to the non-existence of quality service delivery in some areas especially the Ekurhuleni communities; it is grossly understaffed and is running at 30-40 % normal capacity (Ekurhuleni Metropolitan Municipality Integrated Development Planning (IDP) Budget Document, 2010/11:127).This problem was also highlighted by the medium of the radio, television or by word of mouth that there are increasing problems relating to lack of patient care, malpractice, and uncommitted nurses in the Ekurhuleni-based state hospitals. According to Cullinan (2006), there are insufficient senior doctors at many Gauteng public hospitals due to the fact that more student doctors also leave once they finish their community service. He further that there is strong evidence of an increased staff shortage in terms of doctors and qualified professional nurses in the public hospitals in South Africa.

It seems clear, on the basis of the above mentioned information that many patients at many public hospitals within the EMM region are not receiving adequate health care services which include quality patient care and community nursing care. A shift

in the emphasis of quality health care is necessary in order to deliver health services efficiently and effectively through an infrastructure that provides the needs of communities at ground or district levels, with necessary support at referral services at provincial or central or national level (Dennill, King and Swanepoel, 2011:7). The primary purpose of the study was to explore and describe perceptions of registered nurses and patients to evaluate the quality of health care strategy implemented in the public hospitals. Thus, the researcher was able to assess the causes of this failure, and discuss the potential changes. Factors that could possibly be attributed to the difficulties experienced by patients admitted include a lack of resources, insufficient use of resources and inadequate diagnosis and treatment, which leads to valuable human potential (National Department of Health, 2007:3). Public hospitals in South Africa could face a bleak future should the nursing practitioners not perform at adequate levels. This situation places public hospitals under further pressure in their quest to improve quality patient's care and health service delivery system (Von Holdt & Murphy, 2006). The challenge is how this should be achieved (Von Holdt, 2005).The specific influence of these factors, with respect to the public health sector will be discussed in the next section.

The success of health organizations is measured largely in terms of quality nursing management services. The National Health Act in the South African health sector has been implemented to play an active role in the patients' expectations in the hospitals (Jooste, 2010:69). However, there is evidence of a growing patient concern about poor quality care, shortage of nurses and treatment negligence. This is also true for Gauteng Department of Health (GDoH), where the process of public health services in the EMM is often experienced as a lack of specific assets, lack of training and support skills to staff nurses and insufficient performance recognition and reward (Ekurhuleni Metropolitan Municipality Integrated Development Planning Budget Document , 2010/11).

1.2 BACKGROUND TO THE STUDY

The conditions in public hospitals have been characterized by a shortage of nurses and lack of patient care which includes negligence and inability of nursing practitioners to use resources by the nursing practitioners (Van Rensburg, 2011:111; Jooste, 2010:64-66). A challenge for the South African government was to develop and implement a new constitution and various policies and pieces of legislation (Van Rensburg, 2011:117). The Constitution of the Republic of South Africa, Act 108 of 1996, Chapter 2, No 27 (1) states that "....everyone has the right to have access to health care services, including reproductive health"(Republic of South Africa, 1996). In addition to this, Department of Health (DoH) (1994:3, 1999), has published a Patients' Rights Charter as a common standard for achieving this right as well as to ensure effective access for all patients to health care as provided for in the Constitution of the Republic of South Africa, so that both patients and health care providers have a clear understanding of the standards of service that patients should receive

In an attempt to transform the health system in South Africa, the Department of Health has developed and implemented legislation and policies that impact directly or indirectly on the delivery of health services (Department of Health, 2000). In a speech the Minister of Health, Dr. Aaron Motsoaledi announced the need to improve quality of health care in an efficient and caring environment has also necessitated the promulgation of applicable pieces of legislation and policies (National Department of Health Strategic Plan, 2010/11-2012/13). The White Paper is seen as the Transformation of the Health System in South Africa and elucidates the aim to present to the people of South Africa with a set of policy objectives and principles upon which the Unified National Health System of South Africa will be based on (Department of Health, 1997:1 & Dennill, King and Swanepoel, 2011:125). The purpose behind this set of policy and objectives is to facilitate various implemented strategies designed to meet the basic needs for all people, given the limited resources available (Department of Health, 1997:1)

Mashaba and Brink (1994:48) mention that there is rapid growth of reports from patients who have criticised the standard of care that is, given to patients who access health care in the hospitals. Searle (2005:92) contends that nursing is the major caring profession in the world. Therefore, it is important for the nurse and midwife practitioners to know and understand the purpose of a Nursing Act. The context for quality management practice in a nursing profession is the focal point of this study, as discussed in this study (see Section 2.7.3, 3.10, 3.15; Chapter 5).

The success of nursing practitioners requires them to be formally trained and supported to acquire the knowledge of policy developments (Searle, 2005:53). The development of healthcare practitioners requires professional commitment by nurses and hospital managers, while at the same time the healthcare sector has grown more complex with greater demands being placed on its management capability (Kemp & Richardson,1994:8). Public hospitals can improve the quality of healthcare through patient teaching during day-to-day care, throughout hospitalisation, upon discharge, and post-hospitalisation (Mashaba and Brink, 1994:115).

According to Dennill *et al*. (2011:176), policy makers have noted the right of access to health care services as guaranteed in the Constitution of the Republic of South Africa (Act No.108 of 1996), to commit itself to upholding, promoting and protecting this right.

The specific objectives of the policy are as follows (Van Rensburg, 2011:118; Jooste, 2010:25):

i. To ensure promulgation of applicable pieces of legislations and policies to improve functionality of hospitals;
ii. To ensure appointment of competent and skilled managers;
iii. To provide for decentralization of management;
iv. To provide for the development of accountability frameworks;
v. To ensure training of managers in leadership, management and governance.

Kemp & Richardson (1994:8) argue that Patients' Rights Charter has been introduced as the policy in the healthcare sector to ensure that sufficient qualified nurses are available to take the responsibility of providing the best way to care for patients. In the South African context, in a Department of Health (1997:14-16) report Batho Pele was introduced as a fresh approach to service delivery: "....an approach which puts pressure on systems, procedures, attitudes and behaviours within the public service and reorients them in the customer's favour, an approach which puts people first,....it enable citizens to hold public servants to account for the service they receive".

The Department of Health (1997) reiterates that developing Batho Pele makes crucial demands on the training and support services to improve the skills of unit managers, supervisors, and nurses. It is therefore clear that various principles exist explaining the concept of quality of healthcare and based on the strategies and applicability to the healthcare industry. The next section discusses the key principles DoH has placed on the service delivery process.

Good nursing is planned and systematic, which focuses on goals mutually agreed with patients (Kemp & Richardson, 1994:83). The unit manager is responsible for setting and maintaining standards of care in the unit. Therefore, it is clearly important that productivity and development needs of employees, and the work flow processes are planned accordingly. This should include a supportive role for nurses and patients. Through this planning process, the nurses should become sources of information. The unit managers are provided with content-related problems by the nursing practitioner, which serves as the focal point for their learning activities.

According to Mashaba & Brink (1994:78), different people learn from different ways. In this regard, it is clearly important to understand that employees tend to learn what they want to know and remember what they understand. The Republic of South Africa (1997:16) cited in Dennill *et al*. (2011:83) indicate the key principles of policy development as follows:

i. *"Involve communities in various aspects of the planning and provision of health services*

ii. *Establish mechanisms to improve public accountability and promote discipline and feedback between the public and health providers, and*

iii. *Encourage communities to take greater responsibility for their own health promotion and care"*

The previous section emphasizes that, the key principle of policy development is to change the nature of management to democratic participative. The concept of quality management requires extensive training and support from the top management levels. This involves hospital and unit managers' budget responsibility and knowledge skills to support the nursing personnel to further their studies and attend workshops, but also the ability to communicate with subordinates about the training programme (Kemp & Richardson, 1994:13).

Factors that could possibly be attributed to the difficulties experienced by the nursing practitioners include ineffective leadership, limited resources and lack of knowledge and skills within the organizations (Mashaba and Brink, 1994; Draper, 1997:36; Kemp & Richardson, 1994:45). According to Chinn & Kramer (1999:152), nursing is a profession that requires ethical knowledge to guide practice. Kemp & Richardson (1994:69) claim that this kind of situation places healthcare institutions under further pressure in their quest to develop a quality assurance programme to their employees. The challenge is how this should be achieved. It can thus be argued that the move towards quality care for the patients and nursing profession has been motivated by certain factors outlined by the International Council of Nurses (Van Rensburg, 2011:335; Jooste, 2010:6).

Through education and training, nurses need to acquire communication and effective educational skills in order for them to adapt to the demands of quality life (Van Rensburg, 2011:17; Jooste, 2010:10; Feigenbaum, 1991:217; Juran & Gryna, 1993:119). Muller (2000:7) also purport that the intended change should be relevant and essential to improve the functioning of the organization and knowledge skills. In other words, this means that nurses must be educated and trained to perform well in the quality of patients' service.

1.3 RATIONALE FOR THE STUDY

It has been reported that the Gauteng Department of Health (GDoH) is experiencing a shortage of nurses and doctors, negligence, and malpractice particularly in the Ekurhuleni region (The Times, 2010). Understandably, there is little effort placed on how to sustain quality standards through appropriate transformational strategy in the hospitals. Health management and staff of the health departments need to respond to patients while creating and managing the organizational change process correctly

Ekurhuleni Metropolitan Municipality forms the local government of the East Rand region of Gauteng, South Africa. Ekurhuleni is one of the 5 districts of Gauteng province of South Africa and one of the 8 metropolitan municipalities of South Africa. Ekurhuleni covers the eastern part of Gauteng from Germiston in the west to Springs in the east (Ekurhuleni Metropolitan Municipality Integrated Development Plan, 2008-2012:2). In addition, it has a total land area of +-2000 km and accommodates +-2.5 million people. The Ekurhuleni Metropolitan economy is larger and more diverse than that of many of the smaller countries in Africa, including all the countries in Southern Africa. It accounts for nearly a quarter of the Gauteng economy, which in turn contributes over a third of the national GDP (Ekurhuleni Metropolitan Municipality IDP, 2008-2012:2).

The EMM's annual budget is in the region of R13.5 billion, of which R2 billion is being budgeted for capital projects in line with the priorities set in the Integrated Development Plan (IDP) (Ekurhuleni Metropolitan Municipality IDP, 2008-2012). The bulk of this expenditure is dedicated to upgrading facilities and infrastructure backlogs that were caused by apartheid (Ekurhuleni Municipality Integrated Development Plan, 2008-2012:2).The crisis around the number of health workers remains severe, with the World Health Organization (WHO) estimating in 2006 that 57 countries in the world (36 are in Africa) have a critical shortage of doctors, nurses and mid-wives (Jooste, 2010:4). WHO (2006), indicates a shortage of 4.3 million health workers globally with 1.5 million in the African region.

Against this background, in the context of the health sector, many health organizations across the world are already implementing Total Quality Management

(TQM) in their healthcare service delivery (Goetsch & Davis, 2006:774). This strategy offers various ways of improving quality of products and service in every organization. A well implemented Total Quality Management (TQM) in healthcare sector has grown significantly since the 1980s when a wealth of information on successful implementation and the techniques was introduced in organizations (Goetsch & Davis, 2006:774).The strategic plan is an integrated system of management for achieving satisfaction that involves managers and employees. Ovretveit (2000:74) states that TQM ideas have been currently applied in some European hospitals in which they also found incredible success given certain conditions.

Today, customers know what is on offer elsewhere, and it is expected that their expectations have been raised to expect an appropriate competency of service quality. These competency profiles are in place on the organization‘s focus towards a continuous improvement of service, and techniques for any effective and efficient programmes are implemented through TQM techniques (Basu, 2004:39).

1.4 RESEARCH PROBLEMS AND RESEARCH QUESTIONS

The background of the study and contextualization provided in the previous section highlighted challenges facing Ekurhuleni public hospitals as well as the roles and responsibilities of the nursing practitioners’. In essence, the Government Department of Health has implemented the quality management system (QMS) for all nursing practitioners and health care providers in their public hospitals, with the requirement that the nursing staff should improve the quality of care in these public hospitals. This, in turn, might provide a basis for the formulation of a sound quality management system for best sustainable practice.

Alharbi & Yusoff (2012:61) shared a sentiment that total quality management systems have been implemented in order to improve service across the world. It is also intended to ensure that it is possible for nursing professionals and their managers to understand and sustain these continuous improvement processes. However, health systems have become more complex. Consumers expect quality health care, and that all nurses should possess the necessary skills to perform any

nursing interaction effectively. Muller (2000:53) also points out that every health practitioner therefore has a public as well as an ethical, professional and legal obligation to act in the interest of the patients.

The public hospitals need to decide whether to adopt effective strategic plans from the recent advances about having a quality management health care environment that will ensure nurses are committed to deliver the expected delivery of health service. Furthermore, this is compounded by the current situation where educated and skilled qualified professionals leave the country for better jobs in developed countries (Morfaw, 2009:9).

The researcher sought to investigate the following research questions which guided the study:

i. What system is being used?
ii. How is this system supposed to work?
iii. Why is this system used?
iv. What are the attitudes of staff to the management at the system?
v. How do the attitudes influence the implementation of the system

1.5 AIM AND OBJECTIVES OF THE STUDY

Mouton (1996:101) states that research gives a broad indication of what researchers wish to achieve in their project research. The study objective is the research's version of the business problem (Zikmund, 2003:99). The main objective of this study is to evaluate quality management practice in public hospitals within the Ekurhuleni Metropolitan Municipality region.
The study is further intended:

i. To describe the nurses' and patients' perceptions on the specific quality management practices in terms of improving quality care
ii. To investigate the nurses' and patients' views on general systems in relation to patient care

iii. To provide an overview on what nurses understand regarding quality management practices as a strategy for managing a healthcare system.

The study could serve as a guide for the health ministries, public and private hospitals as well as all interested individuals on quality and standards within the South African health system, as acknowledged by government since 1994 (African National Congress, 1994b).

1.6 THE SIGNIFICANCE OF THE RESEARCH

In recent years, many studies have shown increasing interest in the concept of quality of health care being conducted, but most of them focus on hospital care. The significance of this study is that it should create a much greater awareness relating to quality care practice specifically to the public hospitals within the Ekurhuleni Metropolitan Municipality, Gauteng Province of South Africa in which this study was undertaken. In this regard, an increased awareness of the quality management practice could be used to improve the methods employed when delivering quality care to patients. Thus, this study could create a body of knowledge (that is, knowledge quality improvement activities) on health systems in a South African context, especially in the public hospitals.

According to Draper (1997:43), many of the researchers failed to link their quality of life scale to an explicit statement of the meaning of quality of life in justification of the scale items. Bunge (in Draper 1997:43) suggested that a valid quality of life scale will possess three characteristics:

i. An adequate definition of quality of life
ii. A range of indicators which are sensitive to and reflect variations in quality of life
iii. A theory that explains how changes in quality of life produce changes in the indicator.

First, critical thinking skills are crucial for hospital managers and nursing professionals. The pace of consumer awareness has increased and they are aware

of their right to quality care (Kemp & Richardson, 1994:11; Chinn & Kramer, 1999:11). Second, the body of health system knowledge has become so large that it is difficult to convey health system's growing numbers of facts and concepts, let alone to teach families and relatives how to effectively treat their patients in terms of medication. The selected EMM hospitals include Tembisa Hospital, Germiston Hospital and Natalspruit Hospital

The study findings in the research could also be utilized for the following aims:

i. The results of this study may contribute to the improvement of the patient care management of public hospitals by nurses
ii. It can serve to outline the awareness of quality of patient care to the nursing practitioners' and to empower them to manage such patients effectively.
iii. This study will provide additional data about the processes of the appropriate training and developmental programmes.
iv. This research project may, furthermore, serve to stimulate other hospital managers to conduct further research on the other tasks of managers as hospital managers.

1.7 ASSUMPTIONS: PARADIGMATIC PERSPECTIVE OF THE STUDY

The theoretical assumptions of this research project are based on the following perceptions:

i. Quality Management System
ii. Nursing profession in South Africa (Searle, 2005:101)
iii. The Patient's (Client's) Rights Charter
iv. Health policy and policy reforms
v. Ethical-legal framework
vi. Labour Act No 66 of 1995(Government Gazette no 17427)

1.8 RESEARCHMETHODOLOGY AND ITS IMPLEMENTATION

1.8.1 Literature review

The literature review was done to ascertain the present knowledge and information available on quality management practice in the health care sector and service delivery. Leedy & Ormrod (2005:77) defined the literature review as the process in which the researcher conceives the study topic in a way that permits a clear formulation of the problem and ability to evaluate and organize the ideas that might be encountered during the study review. The purpose of a literature review is to emphasize the importance of the research problem, offer the basics for the research questions and help in explaining the findings of the research (Creswell, 2003:87). In this regard, the information obtained from the literature was used to formulate questions relating to the study topic selected.

1.8.2 Methodological approaches

A mixed method research is used in this study. Houser (2012:38) asserted that mixed methods combine quantitative and qualitative elements; it involves the description of the measurable state of a phenomenon and the individual's subjective response to it. Houser (2012:38) further stated that mixed methods is becoming an important tool in nursing research, particularly in evaluation research. The most effective use of mixed methods, however, is when they are used in a systematic way.

In the context of this study, mixed-methods are used to describe both the measureable state of a phenomenon and the individual responses to it. The next section explains how the research approach is employed:

i. Describe the nurses' (quantitative) and patients' perceptions on the specific quality management practices in terms of improving quality care (qualitative)
ii. Measure the nurses' (quantitative) and patients' views on general systems in relation to patient care (qualitative)

iii. Provide an overview on what nurses understand regarding quality management practices as a strategy for managing healthcare system (qualitative)

A more detailed and in-depth description of the research methodology that the researcher used is provided in chapter 4.

1.8.3 Research design

Zikmund & Babin (2010:56) define research design as a master plan which specifies the methods, approaches and procedures used to collect and analyse the information needed. They further state that an advantage of the research design is the framework of the action plan for the study. Houser (2012:38) noted that the research design's "primary importance to the selection of an approach is the nature of the research question". The research design of this study is a combination of both qualitative and quantitative approaches.

In this research project, the researcher used contextual, descriptive and exploratory approaches. A full description of the research design is provided (see Sections 4.3.1, 4.3.2, 4.3.4; Chapter 5).

1.8.3.1 Arguments regarding quantitative and qualitative approaches

Houser (2012:35) notes that qualitative research is a naturalistic approach to research in which the focus is on understanding the meaning of an experience from the individual's perspective. Mouton (1996:130) and Creswell (1994:1-2) assert that the purpose of qualitative research is to probe more deeply on words and observations. Bless, Higson-Smith and Kagree (2006:44) agree with Houser (2012) when they pointed out that qualitative research is aimed at deeper understanding of how specific populations are impacted, and accessing the results of a representative sample of that universe. Zikmund (2003:110) asserted that qualitative research is also called exploratory; it is often conducted as a preliminary step to future research on this topic.

According to Burns & Grove (2005:23-24), quantitative research is a formal, objective, systematic process in which numerical data are used to obtain information about the research topic. Quantitative research involves identifying the variables that represent characteristics of interest and then measuring them in a reliable, valid way (Houser, 2012:35). In addition to this, Davis (2000:265) states that both the qualitative and quantitative research designs are more helping approaches in classifying the primary data studies. The data that will be used is both numerical (simulation) and textual (semi-interviews).

1.8.3.2 Contextual design

According to Burns & Grove (2005:732), a contextual design denotes the environment and the circumstances in which the research project takes place. Babbie & Mouton (2001:272) believe that a skilled researcher should aim at describing and understanding all the elements or events that are relevant to a study with a view of the natural context in which they occur. In order to meet the objectives of this study, the researcher selected hospitals within the Ekurhuleni region in the Gauteng province in which nursing practitioners of various staff positions were employed as well as patients who were admitted to these hospitals.

1.8.3.3 Descriptive design

Zikmund& Babin (2010:45) assert that descriptive research addresses who, what, when, where, why, and how questions. They further explain that the research method means the result of the main section of the investigation conducted can be described. Parahoo (1997:143) says that descriptive research can be quantitative or qualitative or a combination of the two. A descriptive design is therefore used to identify or describe theories and events that involve participants who resemble the population in which the researcher is interested (Woods, 1988:121).Creswell (2009:217) suggests that the descriptive research is based on both open (qualitative) and closed questions (quantitative) that must be collected with the purpose of portraying characteristics of a situation and the frequency of which the central phenomena occur.

1.8.3.4 Exploratory design

Zikmund& Babin (2010:44) assert that an exploratory study refers to exploring phenomena and necessarily seeks explanations or relationships between variables. This approach of exploratory research can be useful in assisting the researcher to better define and narrow the observed problem or issue requiring investigation (Zikmund & Babin, 2010:44). In addition to this, the researcher needs to understand the disadvantages of using an exploratory design as it is limiting due to the fact that it does not make provision for description of phenomena although it discovers relevant connections or differences (Wood, 1998:150).

1.8.4 RESEARCH METHOD

In this study, multiple data collection methods were used. Mixed methods which combine qualitative and quantitative data collection is an appropriate method for studying the responses of individuals and small groups related to interventions, nurses behaviours and perceptions of patients (Houser, 2012:429). The qualitative research method may involve conducting interviews with the unit nurse manager, whilst quantitative research is aimed at measuring responses from nurses and patients. In this kind of research method, credibility can be enhanced by cross-checking information and conclusions, using multiple data sources and perspectives to assist interpreting the data (Houser, 2012:427).

1.8.5 THEDEMARCATION OF THE FIELD OF STUDY

It is important to note that the focus of this study is the registered nurse professionals and their assistant nurses including a sizeable sample of patients/consumers admitted to these public hospitals.

1.8.5.1 Study population and sampling

Zikmund & Babin (2010:412) state that the population can be defined as any complete group of people or communities where they are able to share a common set of characteristics. Creswell (1994:1-2) argues that population refers to an

identifiable group of elements (people, organizations) of interest to the study and pertinent to the problem statement. The target population for this study are registered professional nurses working at public hospitals in the Ekurhuleni Metropolitan Municipality. The population also includes unit managers, sisters, nurses and assistant nurses as well as patients admitted at these hospitals. The researcher decided to obtain both nurses and patients' perspectives in order to evaluate quality of care. Thus, patients and nursing staff formed part of the target population for this research project.

From the statements above, the researcher used a purposive sample of unit manager (n=1), patients admitted in the hospitals (n=29) and hospital nurses (n=185) who were highly involved on service delivery in the hospital wards. In this regard, purposive or judgement sampling represented the procedure of this study (Lincoln & Guba, 1985; Burns & Grove, 1993:246). According to Houser (2012:424), "purposeful sampling is a characteristic of qualitative research in which the researcher identifies criteria for the type of informant most likely to illuminate the research question and actively seeks out these individuals, and personally invites their participation". It is important to note that this sampling technique was also used to achieve saturation data. Purposive sampling is an increasingly common strategy in which the researcher's knowledge of the population and its elements is employed to handpick the cases to be included in the sample (LoBiondo-Wood & Haber 2006:268). Lincoln & Guba (1985) add by saying that this ensures trustworthiness. Burns and Grove (1993:246) further state that the purpose of using a purposive sampling technique is to discover, understand gain insight and choose a sample from which the most can be learned.

1.8.5.2 Pilot study

Leedy & Ormrod (2005:110) state that the purpose of a pilot study is to determine the feasibility of the project study. Zikmund & Babin (2010:61) contended that conducting a pilot study helps the researcher to solve the overall research problem and to assess specific aspects of the study to find out if the chosen procedures will actually work as intended.

The researcher selected staff and patients who volunteered on the basis of convenience, following initial invitation and explanation. It was also agreed by the researcher and his supervisor to exclude enrolled and nursing students, and pay special attention to the role of the registered nurse and admitted patients. The comments received from participants following the piloting of the structured questionnaire were most favourable. In addition, the pilot questionnaires did not form part of the empirical analysis of this study. The average time taken for completing the questionnaires with nurses and patients was 15 minutes.

1.9 DATA COLLECTION

The major source of data collection for this study was obtained by a means of a scheduled semi-structured interview and self-administered questionnaires (Bless & Higson-Smith,1995:105). Babbie (2004:256) reveals that self-administered questionnaires are given to the participant to complete the answers themselves.

1.9.1 Interviews

Interviews are a data collection technique in which an interviewer interacts directly with respondents one-on-one via telephone or in person (Houser, 2012:239; Cooper & Schindler, 2001:292). In this study, data was collected by means of a scheduled semi-structured interview and self-administered questionnaire. Interviews are more personal than questionnaires (Houser, 2012:239).

1.9.2 Questionnaires

Respondents are made aware of the purpose of the study by an enclosed covering letter attached to the questionnaire, which will be hand delivered by the researcher himself. The closed and open-ended-questionnaires, personal structured interviews which are fully explained in Chapter 4, sought to obtain information from nurses, patients and the unit manager. Each group of results are divided into three sections of methods used to obtain information as follows:

i. Main survey results
ii. Data collected
iii. Results from semi-structured interview

1.9.3 Data analysis

In this study, the researcher analyses the transcribed data from the interviews. Zikmund & Babin (2010:66) states that raw data analysis can be defined as the application of reasoning to understand data that have been gathered. Furthermore, graphs and tables are used in an effort to draw relevant conclusions from the data gathered. Thus, the data collected, procedures and analysis of documents drawn are based on the findings. The questionnaire is administered to a sample that is representative and sufficient in size. The statistical software package SPSS version 17.0 is used for data analysis and support from STATKON is secured at the University of Johannesburg.

In the context of this study, two sets of data are obtained (i.e. qualitative data through open-ended questions and quantitative data through closed-ended questions).

1.9.3.1 Qualitative data analysis

Boeije (2010:5) states that during qualitative data analysis the textual accounts of interviews or observations are searched for common themes and regularities. In the qualitative mode of this study, the researcher collects information with regard to implemented quality management systems and practices by means of structured interviews. In this study, the researcher uses the content method of analysing data. Merriam (1998:12) states that qualitative research is grounded theory in the real world. Thus, data analysis will be based on how the respondents view their world by what they say.

1.9.3.2 Quantitative data analysis

The quantitative data from patients' are obtained by means of self-administered questionnaires (both closed and open-book questions) and entered into separate databases of registered nurse' perceptions in the Ekurhuleni public hospitals quality of health care.

1.10. RELIABILITY AND VALIDITY

Reliability of an instrument means, according to LoBiondo-Wood & Haber (2006:345), the extent to which the instrument yields the same results on repeated measures. A reliable measure is one that can produce the same results if the behaviour is measured again by the same scale (LoBiondo-Wood& Haber, 2006:345).

According to Houser (2012:427), triangulation is a useful strategy for the enhancement of credibility. The study is located within a triangulation approach research design (qualitative and quantitative paradigms). The validity and reliability of Phase One is ensured by the result of data analysis. Theoretical validity can be defined as a statement of meaning that conveys essential features of a concept in a manner that fits meaningfully within a theory (Chinn & Kramer, 1999:94). Validity refers to whether or not a method measures what it sets out to measure (LoBiondo-Wood & Haber, 2006:338). They further state that the validity of the measurement of a procedure should be valid in terms of measuring the concept.

In the context of this study, validity would refer to the information from the sources to be verified and considered valid. Thus, it is important to consider measuring the concept in question to obtain accuracy. Therefore, in the case of this study, the concept needed therefore to be measured, if measured correctly; the study will be valid. This is supported by Woods (1988:237) saying that being valid and reliable, the instrument should be sensitive in order to suit the purpose of the measure.

On the other hand, Terre Blanche & Durrheim (1999) describe triangulation as critical in facilitating interpretive validity and establishing data trustworthiness

(McMillan & Schumacher, 2001). Additionally, this could require a researcher to check the extent to which conclusions based on qualitative sources are supported by a quantitative perspective, and vice versa.

Furthermore, Padget (1998:97) and Creswell (2009:178-9) are of the opinion that triangulation requires the research inquiry be addressed from multiple perspectives. They further outlined the possible kinds of triangulation as:

i. Multiple methods of data collection and analysis
ii. Multiple data sets
iii. Multiple researchers analysing the data depending on different research perspectives
iv. Data collection in multiple time periods
v. Providing selective breadth in informants in order to reach the research perspectives

The researcher aimed to achieve a situation where the combination of both qualitative and quantitative approaches would be applied to gain a single final product that would be verified. It is also essential, for the purpose of this study, to note that the researcher endeavoured to ensure reliability of the dissertation by applying the following triangulation processes:

i. theoretical triangulation –an assessment of the utility and power of health theories
ii. methodological triangulation – the use of two or more research projects in one study

The researcher maintained confidential information collected. The choice of research method demanded that the researcher adhered to certain ethical requirements, whereby attention will now be focused.

1.11 ETHICAL CONSIDERATIONS

Ethical standards can be defined as the best set of moral principles governing a society (Mulaudzi, Mokoena & Troskie, 2001). The ethical requirements were applied in accordance with the position of the Democratic Nursing Organization of South Africa (DENOSA, 1997). The following ethical standards are being considered in this study.

1.11.1 Participant information

In this research study, the researcher, with the watchful eye of his supervisor, will adhere to the highest possible standards of research planning, implementing and reporting. Information about participants is privileged and is not shared with others. Ethically the researcher will maintain confidentiality and will only give information to third parties when the participant consents to this. All the findings are reported fully, without the omission of significant data and include details regarding methods, and research designs which might influence the interpretation of the data. The inputs of all the respondents are acknowledged.

1.11.2 Confidentiality and anonymity

In this study, confidentiality means that any information from the registered nurses or patients (respondents) divulged will not be made public or available to others. When an informant agrees to take part in a research project his or her right is waived since information has to be made public in the research report. However, respondents are ensured that their participation of the information they provide will not be used against them in any way.

With reference to the above statements, the researcher respects participants' right to privacy guarantee confidentiality and anonymity.

1.11.3 Informed consent

Approval for conducting the research is obtained from the Head of Department: Quality and Operations Management at the University of Johannesburg before any data is collected in the 2012 academic year. In addition to this, the necessary permission to conduct research in sampled hospitals under the jurisdiction of the Gauteng Department of Health is made. A cover page is attached to ensure that important points were outlined (See Annexure A), which also highlights human basic rights and in all aspects respondents could also expect the highest degree of professionalism by the researcher.

Therefore, the results of the study will be published and the benefits of the study will be communicated to all participants. The respondents will be informed of the research results on request, and they will be made aware of their right to withdraw their consent if they wish to, despite their initial consent to participate.

1.11.4 Privacy

Participating in the study is voluntary and those who do not respond to the questionnaire were not questioned.

1.11.5 Termination

Termination of respondents is permitted in case of:

i. An registered nurse or patient wanting to withdraw despite initially consenting to participation; and
ii. The project no longer adhering to the standards set in planning

A full detailed description of the methodology for the empirical part of this study is provided in Chapter 4. When these discussed ethical requirements are taken into account pertaining to the study, certain concepts used in study will now be clarified.

1.12 DEFINITION OF CENTRAL CONCEPTS

The following concepts are clarified in order to ensure clarity and to provide a better understanding of their contextual use:

Caring in nursing refers to a process whereby the nursing profession instils confidence in helping in supporting and in a forming relationship with the patient by determining how the patient will receive support in his or her struggle for improved health (Searle, 2008:92).

Co-ordination means bringing together the acts of members of the health team to meet the spectrum of identified health needs of the individual, family, group or community (Searle, 2008:121)

Healthcare system can be defined as" the organization by which an individual or group's health is being managed for an effective and efficient service delivery" (Morfaw, 2009:118)

Hospital refers to the large organization where people who are ill/sick or injured are given medical treatment and care (Oxford Advanced Learner's Dictionary, 2004:579).

Management means getting results, building and maintaining a specific team, and developing individual team members with regard to their skills, and attributes.

Nursing means a service to humankind to prevent illness through support for those in need, and give care to others (Jooste, 2010:5).Nursing involves the nurse knowledge self as a caring person, coming to know the other as caring and treats a patient to achieve or maintain better health(George, 2002:545)

Registered Nurse, with regard to health care, *"is a person who is registered with the South African Nursing Council Regulation 425 (as amended). Nursing Act No 50 of 1978*". The registered nurse practitioner is able to take up a wide range of posts in the managerial, educational, clinical and research fields (Searle, 2008:63)

Patient is defined as a person who is receiving medical treatment from a particular clinic, hospital, any medical or surgery sector which might be conducted by doctor, nurse, dentists etc. Searle (2008:122) defines patient as a person who is sick or well- who needs help to complement his or her specific ability to accept optimal responsibility for his or her own health.

Professional Nurse refers to a professionally and qualified person whose job is to take care of sick or ill people, and who practices his or her profession in any capacity that prescribes registration as a nurse as a pre-employment requirement (Searle, 2005:5). The South African Nursing Council (2008) defines the professional nurse as a person who is qualified and competent to independently practise comprehensive nursing in a manner that shows the capability of assuming responsibility and accountability for such practice.

Public Health can be defined as understanding and improving the health of populations rather than the health of individuals.

Quality control in health care can be defined as the process of ensuring that patients get the best quality care that is affordable, within the framework and constraints of the health care institution, as well as the continuous improvement of health care (Jooste, 2010:234).

Quality assurance in health care with regard to healthcare sector, “is a dynamic process through which health care practitioners assume accountability for the quality of the care they provide (Jooste, 2010:235)

Practice is a meaning to put knowledge into practice to work of a profession (Searle, 2008:134).

1.13 LIMITATIONS AND TRUSTWORTHINESS OF THE STUDY

The study is delimited to three public hospitals within the Ekurhuleni Metropolitan Municipality region, namely Tembisa, Germiston and Natalspruit Hospitals.

Furthermore, this study is focused on the role and responsibilities of the nursing practitioners and hospital management in the quality improvement of the primary health care in the public hospitals. Quality of patient care is the most crucial task in health management. Management commitment and employee involvement is required by the Gauteng Department of Health in all Gauteng hospitals.

The researcher therefore employed the following strategies in order to accomplish the objectives of the research:

i. Literature review on the involvement of nursing practitioners in the quality management practice of the hospital in the South African context and health policy and legislation
ii. A self-administered questionnaire is to be distributed to nurses and patients to complete and return to the researcher
iii. Semi-structured interviews with the hospital managers to understand the benefits of quality management practices.

This study is based on the perceptions of the nurses and patients working and who are admitted within Ekurhuleni Public Hospitals respectively. The study is also limited to the eastern-region of the Gauteng Department of Health hospitals due to the fact that the researcher could not afford to conduct more surveys due to insufficient funding. Thus the researcher did not cover data it would have if the study had been conducted in other places.

1.14 STRUCTURE OF THE STUDY

The study consists of six chapters which are structured as follows:

In Chapter One the background and an introduction to the study has been provided. It has highlighted the contextual and theoretical framework guiding the study and has provided the objectives to address the research problem and value of the research study.

In Chapter Two the researcher discusses the health care industry in a South African context, with possible guidelines to develop public hospitals as effective quality management practitioners in South Africa (A review of the literature)

Chapter Three consists of a review related to literature on the concept of quality management. It is in this chapter that literature pertaining to quality management is explored and related to the South African public hospitals' roles and responsibilities. It is expected that the researcher will be able to conceptualise the problem regarding the topic under investigation.

Chapter Four provides the details of the research methodology of this study. It depicts the research design to be employed to gather empirical information and the data of the inquiry. It entails how the data is to be analysed and what the intended purpose of the data will be, including sources and statistical data.

In chapter five, the researcher discusses the findings of the completed study and makes recommendations based of the findings of the study.

Chapter Six will discuss the guidelines and operationalization. Based on the findings presented after completion of the study, Chapter seven will be a discussion on the full recommendations.

1.15 SUMMARY AND CONLUDING REMARKS

It is clear that effective management is essential for a well-functioning district-based hospital to achieve the wide range of objectives; these objectives are set by the Ministry of Health. This is one of the key challenges of a well-functioning district based hospital as well as the South African hospitals and, at the same time, one of the core requirements of the Primary Health Care (PHC) approach in responding to new policies and legislation in the contents of the health care system. This alludes to the concept of the public sector, and points toward hospitals running an effective, efficient, equitable and accessible health service. At the same time, the extent of this depends largely on the nature and quality of internal health managers. Thus, there needs to be strong leadership around this and a strong bottom-up approach to

planning, policy development and management (Van Rensburg, 2011:135). All this contributes to higher standards of the quality of healthcare to the patients and community- which is the bottom line for the public hospital, a basic service delivery sector.

The fact is that a district or metropolitan hospital also has problems that need to be borne in mind in the development and implementation of quality management systems related to the health care sector as shown by international experience. Once research and investigation have been conducted, perhaps the development and implementation of total quality management (TQM) may be the solution to the problems many hospital management teams experience with respect to the quality healthcare management of their hospitals as well as the provision for their patients. Further to this, the role of the hospitals in communities and necessity for the research project is established in this chapter. The next chapter will focus on the review of the literature in order to provide a basis for this investigation.

CHAPTER TWO

"Nursing is a profession that has its own code of conduct, its own philosophic views, and its own place in the health care team....Nurses work under their own license. That means that nurses are completely responsible for their work"

Janie R. Katz

LITERATURE REVIEW: PERSPECTIVES ON NURSING PROFESSION IN SOUTH AFRICA

2.1 INTRODUCTION

This chapter reviews the literature on the concept of the South African nursing profession and the public hospital context, focusing on the nursing process and patient care quality as well as relevant legislation, policies and guidelines. Searle's nursing model will be used as the theoretical framework for this study. The concept of professional practice, its code of conduct and the scope of practice relating to the Nursing Act and its consequences on the nursing practitioner's experience are also discussed. Problems encountered by nurses and patients during health care service delivery are also described

According to George (2002:5), the purpose of nursing theory is to describe, explain predict or prescribe nursing care. In this way theory will cover broad areas of concern within a discipline. In this study, concepts will be used to generate theories. The main emphasis is the patient care quality and health transformation developmental processes, which were implemented through state legislation. As the study focuses on the development of a health framework towards the wide range of roles and functions in modern nursing influenced by ever-widening scope of nursing practice, it is also important to explore the role of the South African Nursing Council (SANC) in public health institutions.

This study was conducted using comprehensive concepts of some aspects of reality to fit the study topic. In addition to this, if the study could be linked to the other

studies, then it would assist in combination with the information previously achieved. As explained in the previous chapter (see Section 1.8.1), journal articles, books, SANC regulations, presentation of papers as well as the internet was used as sources of information for this study.

It is important to understand that the literature review conducted will determine whether any previous studies have been conducted on the quality management practice in patient care within the public health care sector, to identify the difficulties, if any, and make recommendations on how these could be improved.

Currently, most literature focuses on the role of hospital management; no studies could be retrieved on the role played by the nursing profession in practising quality care management from the Gauteng Department of Health at the Ekurhuleni Metropolitan Municipality region or from any Nursing Science department. Many nursing researchers have, however, focused on the four year diploma course for student nurse support as well as the aspects of ethical behaviours. It is important to understand the history of the health care environment in the South African context, which is discussed in the next section.

2.2 HISTORICAL OVERVIEW OF THE DEVELOPMENT IN SOUTH AFRICA

According to Booysen, Erasmus & Van Zyl (2008:2), the profession of nursing has not always been treated with respect; nurses originally had no formal training, they worked under difficult circumstances, and were treated as little more than domestic workers. Searle (2008:9) remarks that the development of professional practice concepts and ethical codes for South African nursing has a long history which can be highlighted by a series of events.

Searle (2008:10) further states that a professional nurses association known as the South African Trained Nurses Association, was established on 1 October 1914 and continued until 7 November 1944, when it was replaced by a statutory nursing association, the South African Nursing Association (SANC). According to Booysen *et al*. (2008:2), Florence Nightingale is acknowledged as the founder of modern nursing. As early as 1859, Nightingale‘s role in nursing the sick and wounded during

the Crimean War gave nursing a social standing and a much-improved image in society (Mulaudzi *et al*., 2001:2). She began the first planned training programme for nurses at St Thomas's Hospital in London. From this time, nursing became a respected and professional occupation (Mulaudzi *et al*., 2001:2; George, 2002:43).Professor C. Searle was the first Professor of Nursing in South Africa and was the first to appoint black nurses to senior positions in Gauteng hospitals (Booysen *et al*., 2008:3).

In Southern Africa, it is in the interests of the health of the public to expect competent, high quality, ethically based nursing, and a relationship of trust to exist between itself, the individual served and the practitioner (Searle 2005:7). From an operational nursing practice perspective, it is important that senior nurse managers and nurses of hospitals understand the involvement of patients in their care programme. Understanding this will help the professional nurses and unit managers to interact with patients, especially in the form of communication (George, 2002:198).

The nursing profession of South Africa is influenced by this movement, moreover, a historical overview of the development in South Africa provides direction in which the interpretation and nursing practitioners should be maintained and undertaken (Searle, 2005:6). Professional behaviour refers to a set of standards of behaviour that professionals are expected to adhere to when and as they offer their specific knowledge and skills to those who seek or need their counsel or help.

Mashaba & Brink (1994:29) stated that "promoting the profession and its goals and achievements to the wider community is the responsibility of all nurse professionals". They add that working through a professional organization is often a way of maximizing the efforts and influence of nurses. It is for this reason that this chapter seeks to provide a number of perspectives on the concept of professional practitioner of nursing within the South African context. Draper (1997:20) argues that the financial resources to pay for health services are limited. Campbell's (in George, 2002:33) states that few nurses have undertaken education and training on their own initiative and in their own time. Furthermore, it is important to note that both public and private hospitals are affected by legislation in terms of nursing practice. This will be discussed in this chapter.

A philosophy of nursing usually involves advancing human understanding about that which is fundamentally true and good about the act of nursing (Mashaba & Brink, 1994:5). Philosophy is defined to mean the concepts, beliefs, or assumptions one holds about life, human behaviour and education (Riehl-Sisca, 1989:3-5). Jooste (2010:4) postulate that the philosophy of nursing has several purposes such as delivering services to patients, strong moral principles and motivating and rewarding staff. Searle (2005:9) notes that access to knowledgeable and experienced health professionals is essential to improve access to quality health care. Therefore, there is a need to:

i. statutorily recognized education and training centres
ii. statutorily recognized curricula
iii. statutory nursing examinations
iv. statutory certification of nurses.

In the South African context, a nurse practitioner is a registered nurse who practices the profession of nursing (Searle, 2005:70). Everyone who is registered as a nurse is a practitioner. In this regard, the patient receives nursing care at the hands of nurses assisted by other categories of nursing personnel which include enrolled nurses, enrolled nursing auxiliaries, student and pupil nurses and pupil auxiliaries (Searle, 2005:71; Mashaba & Brink, 1994:45). Jooste (2010:5) describe nursing as “a science that calls for certain personal attributes, for the development of professional values and attitudes, as well as a firm foundation of knowledge and understanding of humankind”. World Health Organisation (2006:9) reveals that quality improvement is not a new concept for hospitals. This view is also supported by Searle (2005:11) who stated that the concept of nursing has not changed in the last century; only the range and extent has grown a great deal.

The researcher regards an effective learning method at nursing institutions and relevant structures as a priority in the South African health system arena. The researcher is currently employed at the School for Quality and Operations Management of a South African university of technology situated within the Ekurhuleni Metropolitan Municipality, and has been lecturing quality and

management sciences related subjects for the past three years. The researcher has witnessed and experienced the consequences and frustration of nurses' negative attitudes from the EMM public hospitals. The researcher is of the opinion that the health system and quality care of nursing practitioners can be improved by suitably structured frameworks. It is also necessary to explore the role of the South African Nursing Council (SANC) in public hospital institutions.

2.3 EKURHULENI METROPOLITANMUNICIAPLITYAS A CONTEXT

This section looks at the introduction and description of the context in which this study took place. This description will highlight the statement of the problem that follows and will describe conceptualisation for nursing practice as both the clarification and analysis of the key terms in a study (Mashaba& Brink, 1994:247). This will also include various ethical issues and responsibility of professional practice to which registered nurses are exposed or to which they themselves might contribute during their nursing process and quality care in the public or private healthcare setting.

The issue of professionalism in South African nursing practice context remains unclear relating to registered nurses caring for the patient from the public hospitals. It is crucially important to empower the nursing staff in order for them to provide a quality human caring process. Riehl-Sisca (1989:223) emphasizes that human care is placed upon helping a person gain more self-knowledge, self-control, and readiness for self-healing, regardless of the external health condition.

There have been interesting developments in the nursing profession field work in the Ekurhuleni department of health, with matric qualification or less, whilst the South African Nursing Council indicates that nursing practitioner has to possess either a degree or a diploma in nursing work in order to be employed (South African Nursing Council, 2008; Jooste, 2010:47). Later in this chapter there will be a discussion in greater depth on the ethical and legal framework in relation to registered/midwife, enrolled nurses.

Figure 2.1: Ekurhuleni district map where the hospitals are situated

Source: Gauteng Map Search (2008:1)

The researcher conducted this study in the following areas: Tembisa, Germiston and Natalspruit Hospitals situated in the greater Ekurhuleni area of the Gauteng Province, South Africa. Figure 2.1 shows more detailed and in depth description of the area in which the three selected hospitals are situated.

2.4 PRIMARY HEALTHCARE SYSTEM IN SOUTH AFRICA

The South African health system has evolved from different origins; the main contributions being Western medicine and the various African cultures with their traditional tribal medicine (Dennill *et al*., 2011:34). They further state that the main reason for the health department's existence is to ensure access to good-quality

health care for everyone. To achieve this, the government must (Dennill *et al*., 2011:43):

i. create, monitor and change when necessary, the framework or system in which health is promoted and health care is delivered
ii. be a major provider of services

The Department of Health and a few other accredited organizations such as SANC, DENOSA also use the community/public hospitals for nursing staff to apply theory and practice in complex and dynamic situations. Furthermore, the purpose of this department is to provide quality health services and ensure caring for service users (National Department of Health, 2007:6). It also aims to implement best-practice healthcare strategies with a positive work environment for employees, and provide top-quality training for health workers. The researcher believes that it is fact that public hospitals in South Africa do provide high quality inpatient and outpatient care for everyone at all times, and its existence is defined through its vision and mission as stated in (Department of Health-Gauteng, 2012)
http://www.healthandsocdev.gpg.gov.za/doctors-hospitals-medical-cape-town-south-africa.blaauwberg.net/details.php?id=1098

Vision: "To be the best provider of quality health and social services to the people in Gauteng".

Mission: "Provide excellent, integrated health and social development services in partnerships with stakeholders to contribute towards the reduction of poverty, vulnerability and the burden of disease in all communities in Gauteng".
Values:

i. Batho Pele principles
ii. Excellence
iii. Integrity
iv. Humanity
v. Selflessness
vi. Respect
vii. Social justice

“We care, we serve, we belong” (Department of Public Service & Administration, 1997:15-22).

As noted previously, regulation and legislation of nursing is designed to protect the interests of nursing practitioners’ welfare with specific emphasis on community care. In 1994, the African National Congress (ANC) adopted a Primary Health Care (PHC) philosophy (African National Congress, 1994 (b):44-50) and Dennill *et al*. (2011:42). According to Dennill *et al*. (2011:37-8) and Jooste (2010:36), objectives for primary health care in South Africa are to:

i. Promote safe pregnancies
ii. Promote safe contraception and provide counselling related to child spacing and fertility , and
iii. Provided with information about the availability of health services and how best to use such services
iv. Promote the development and training of personnel for mother and child health care
v. Social security, including, if they are unable to support themselves and their dependants, appropriate social support”
vi. Promote school health services

The transformation in the health sector has been hindered by the lack of a legislative framework to guide the process (Dennill *et al*., 2011:105). This view is also supported by Department of Health (1997:1) who states that the White Paper was only signed into law in 2004, aimed at providing guidance on how a national health system should be managed and operated. Department of Public Service and Administration (1997) postulates that the White Paper on Transforming Public Service Delivery- also known as the Batho Pele document- aims to provide a policy and a practical implementation strategy for the transformation of health human resources.

The latter accords with and builds on the health objectives spelled out in the *Reconstruction and Development Programme* and the *National Health Plan for South Africa* (African National Congress, 1994b). In the main, the White Paper

advanced a wide range of policy measures that would fundamentally transform health care delivery in South Africa. According to Van Rensburg (2011:118-119), these include:

i. Unifying the fragmented health services into a comprehensive and integrated NHS to address the legacy and impact of apartheid on health
ii. Decentralizing health service management with emphasis on the DHS
iii. Promoting equity, accessibility and utilization of health services by rendering PHC available to all South Africans
iv. Establishing health service units that offer essential PHC service packages within an effective referral system linking primary, secondary and tertiary levels of care.

2.4.1 The National Health System

The post-apartheid government that came to power in 1994 in South Africa was faced with many challenges (African National Congress, 1994b).One of these was to transform a highly fragmented health system, in terms of design and legislation, into a comprehensive, equitable, non-racial and integrated National Health System (NHS) that would, in collaboration with the other social systems, redress social and economic injustices, eradicate poverty , reduce waste and duplication/fragmentation of services, increase efficiency and promote greater control by communities and individuals over all aspects of healthcare delivery (public and private) at national , provincial , district and local levels (Geyer, Mogotlane & Young, 2009:24).

According to the ANC's National Health Plan, the national health system is organized on four levels: community level, district level, provincial level and national level (Booysen *et al.,* 2008:327). The public or government sector, in the name of Department/Ministry of National Health, is the biggest employer of nurses, and owns the majority of nurse-training hospitals (Geyer *et al*., 2009:26).Booysen *et al.* (2008:327) and Hattingh *et al.* (2006:64-66) indicate that the characteristics of an ideal primary health care service should include the following:

i. *Accessible:* Primary health care should be accessible to all people in the country with special attention offered to disadvantaged regions of the country. Thus, patients should not be refused health services if they are unable to pay for the services.

ii. *Geographically**:*** Primary health care services should not be situated more than 5-10 kilometres from where the patient stays

iii. *Functionality:* If the majority of patients, especially mothers, are employed during the day, services must be rendered after hours and over weekends so that the patient can attend.

2.4.2 District level

The district health authority (DHA) is responsible for providing primary health care services to all members of the community (Dennill *et al*., 2011:48; ANC, 1994). These include:

i. Promotion of primary healthcare, planning, monitoring and evaluation of services
ii. Management and co-ordination of health-promotion activities
iii. Collaboration with governmental sectors and NGOs
iv. Engagement of communities in their healthcare matters
v. Provision of PHC and other relevant services within the community, in clinics, community health centres, district hospitals and other facilities
vi. Provision of primary environmental health services, essential medico-legal services and services to persons arrested and charged (Geyer *et al*., 2009:25).

2.5 SEARLE'S NURSING MODEL

The registered nurses have to be educated and supported for them to render quality health care service to patients in the public hospitals. According to Searle (2005:64), the nursing model can be described as a process of an intervention in the patient's

health and helping the patient's illness in order to ensure that each patient receives the personal care necessary for attaining the high-quality level of health. The purpose of the nursing process is to create a plan from which all nursing staff can work, and establish interaction with a patient on a scientific basis (Booysen et al., 008:102)

Nursing theory involves guiding the assessment of patients by describing the characteristics to be assessed (Bouwer, Dreyer, Herselman, Lock & Zeelie, 2003:15). The characteristics of assessments involve learning about the patient and his/her present and past medical and social history (Booysen *et al.,* 2008:103). It is imperative that the process of scientific nursing diagnosis and management process conceptual framework are explained in a clear manner (refer to Figure 2.2).

It is important that the professional nurse at all the levels of health care service delivery, including the planners of health care, work together to provide high-quality patient care. Working together involves health promotion, encouraging community development and involvement which should be co-ordinated by the quality assurance team members as well as the hospital ward managers. A registered nurse is taught to understand the needs and expectations of the clients/patients. These involve educating patients/clients to take responsibility for their own health care.

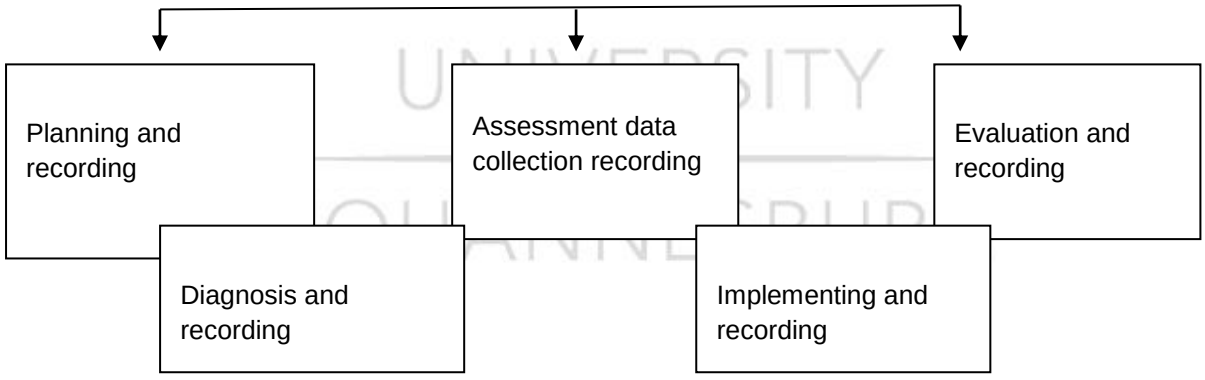

Figure 2.2: A Summary of the nursing process

Source: Adapted from Searle (2005:64)

There are many theories of nursing. For the purpose of this study, Searle's nursing process is taken as the basis of practice, namely that 'Nursing is the core of nursing practice (Searle, 2008:92).

2.5.1 IMPORTANT CONCEPTS USED IN SEARLE'S MODEL

Theory in quality health promotion can, according to Dennill et al. (2011:128), be applied to help in guiding and understanding what to study (and what not to study). It is further stated that theory in the field of health promotion assists to understand how various pieces fit together and why some combinations of variables would be valued more than others (Dennill et al., 2011:128). Searle's model have been selected for discussion in this study because they are compatible with multi-units such as patients, families, nurses, comprehensive strategy to quality health care delivery.

It is noteworthy to understand that Searle's model evolves from the way she conceptualises the nursing process, particularly from her view, nursing is about meeting the needs of patients (Searle 2005:64). Important concepts utilized in this model include: assessment, planning and recording, implementing and recording, evaluation, and record keeping(Searle, 2005:64).This is also in line with the strategy of the World Health Organisation (WHO), and is seen as vitally important part of primary health care (Bouwer *et al*.,2003:16)

2.5.1.1 Assessment

Assessment is the core of Searle's model. Assessment relates to systematic collection of data in order to establish how to treat the patient at hand. It also involves identifying patients' needs in general and in a particular nursing process that can be best used during nurse's observation (Searle, 2005:64).

Assessment is the means of identifying and recording the specific needs of a patient and making observations, interactions, interviews, self-reactions, and physical, physiological, or psychological measurements (Searle, 2005:122).

George (2002:25) argues that assessment is the systematic and orderly collection and analysis of data about the past and present health status of the patient for the purpose of making the nursing diagnosis. Assessments are based on nurse's self-awareness skills so that they may reduce some of the barriers to communication (Kemp & Richardson, 1994:27). Thus the registered nurse should be aware of what is required of him or her in order to achieve setting standards for nursing care.

In a study by Bowman (1995:32), it was found that many ward sisters and staff nurses said they had little if any time teaching due to staff shortages and they were overloaded with administrative tasks and caring for their patients. Examples of assessments in nursing are 'training and skills programmes that help the nursing staff and patient in ascertaining the learning process' (Riehl-Sisca, 1989:288-289). In the same manner assessment is the way in which information is gathered and recorded to determine whether nursing care has been practised properly.

2.5.1.2 Diagnosis

Diagnosis is the identification of a health problem in an individual or in the context of groups such as family, work or social groups and the community (Searle, 2005:122). This will reflect the importance of the environment to the health and well-being of the patient (Mashaba & Brink, 1994:66).

The primary purpose of patient assessment should be responding to patient health conditions, this can result in a diagnosis process (Searle, 2005:122). Any health care institutions, Houser (2012:304) notes, have to develop unit managers and registered nurses to educate patients regarding the various illness or injuries as well as diagnoses of particular illness or diseases. Mashaba & Brink (1994:66) argue that teaching is goal-oriented aimed at assisting other people to develop so that their behaviours change as they are influenced by what they have been taught.

It is important for the nurses to use a variety of tools and appropriate forms of assessment. In short, an assessment method is a procedure that assists the nurse in understanding how individual patients may respond to treatment, and clarify the unique aspects of individuals that may affect their response to an intervention

(Houser, 2012:304). Furthermore, George (2002:27) suggests that data analysis should be performed to identify the client's behaviour patterns that either promote health or place the client at risk for poor health. In this way, the information is then organized and sorted and a nursing diagnosis is made (Booysen *et al*., 2008:103).

2.5.1.3 Planning and recording

Planning can be described as the determination of what can be done to help the patient/client, and reflects nursing actions (George, 2002:31). The nursing actions include determining outcomes and nursing interventions, and decisions on equipment (Geyer *et al.,* 2009:2002). Nurses should be able to work with the patient, the family, or both to choose appropriate actions in order to achieve the identified outcomes (George, 2002:32). Planning and recording will be possible only if the nurses can first meet those needs that the client feels are most important.

2.5.1.4 Implementing and recording

Implementing refers to the care plan in the patient ill health situation. Searle (2005:64) defines the implementing and recording as the process of putting the plan into action which should be checked and validated before they are implemented. According to George (2002:32), implementation is an on-going process through which the nurse reassesses, reviews, and modifies the plan of care. This should take place between the nurse and the patient. Through Searle's implementation model, the nurse refers to the written plan for particular information about nursing actions. These actions are counselling, teaching, coordinated resources, therapeutic communication (verbal and nonverbal), and serving as a patient advocate (George, 2002:32). When nursing actions are finished, the results should be recorded against each diagnosis.

2.5.1.5 Evaluation

Evaluation refers to determining the value of something (Oxford Advanced Learner's Dictionary, 2004:396). Evaluation is an essential component of any patient education programme (Mashaba & Brink, 1994:120). Searle's goal of nursing is to meet the

patient's behavioural changes that are a result of the nursing practice. Evaluation is based on the reassessment, which may turn the whole nursing process all over again (Searle, 2005:65). During this study Searle's evaluation refers to the nurse observing that patients are educated about medication. This should involve emotional support provided by the professional nurse.

Wilkinson (in George, 2002:35-36) identified two types of evaluation based on the behavioural changes of a patient, namely:

i. *Structure evaluation:* focuses on the equipment to assess the patient or to carry out the plan and to record evaluation conclusions (see Section 3.2)

ii. *Process evaluation:* relates to the activities of the nurse which may be carried out at the end of the process (see Section 3.3.3)

Searle's theory thus serves to define the process of nursing by the registered nurse. The experienced nurse can be perceived as carrying all the nursing processes. Thus, it can be noted that the nursing process means the tool of the professional nurse that helps nurses to achieve quality decisions and assists them in predicting and evaluating results. In order for the nursing profession to provide quality patient care, the nurse needs to apply concepts and theories from nursing: biological, physical, and behavioural sciences and from the humanities to give a rationale for decision making and interpersonal relationships and actions (George 2002:37)

Searle's theory of the nursing process which includes: assessment, nursing diagnosis, planning and recording, implementing and recording, and evaluation are considered as a point of departure for this study (Searle, 2005:64). As new challenges evolve in modern health care, selected theory of nursing can be used as a tool to provide rational, knowledgeable reason for actions based on organised written descriptions of the reality of nursing (Geyer et al., 2009:11). This view is also supported by George (2002:37), who states that today quality is based on expected outcomes. Case management models quality circles have been implemented to improve the proficiency of nursing care through meeting the expected outcome criteria.

2.6 THE KEY CONCEPTS SUPPORT AND RELATED ASPECTS

A concept can be described as a complex mental formulation of experience (Chinn & Kramer, 1999:54).In this section, various definitions of the key concept of support are explored and described. Literature is utilized to identify related aspects in order to support Searle's theoretical framework which include ethics, values, care, nursing, standards of care, motivation, mentoring and accountability. The concepts are clarified in the following way:

2.6.1 Ethics

Ethics refers to a type of philosophy that studies right and wrong of individuals, based on moral judgement (Houser, 2012:50; Chinn & Kramer, 1999:5). Geyer *et al*. (2009:61) describe ethics as a science of morals, because it relates to human behaviour, norms and values. In the context of nursing practice, ethical codes of practice involve respecting individual patients and co-workers as well as the working conditions for any particular task to be performed.

Ethics are a set of moral principles that control or influence a person's behaviour (Oxford Advanced Learner's Dictionary, 2004:395). In this study, ethics are an important aspect of nursing practitioners as they reflect on matters of obligation or what ought to be done (Chinn & Kramer, 1999:5) and a system of moral rules of behaviour (LoBiondo-Wood & Haber, 2006:292).

It is important that registered nurses or enrolled persons consider the ethical guidelines and practices in almost every step of the nursing process in order to provide quality care in the health care setting. These practices remind each nurse of their accountability as health professionals (Kemp & Richardson, 1994:3). It is, therefore, important for the nursing profession to conform to the standards of conduct and good based on moral judgements.

2.6.2 Values

Values are beliefs about what is right and wrong and what is important in life (Oxford Advanced Learner's Dictionary, 2004:1323). Values are organized into a system that has meaning for an individual (Geyer *et al*., 2009:72). Values then refer to a way of life and they give direction to life. Among the nursing professions, values are those things which make a difference to patients' attitudes in life. They are essentially personal beliefs and attitudes, the truth or worth of any thought, object or behaviour according to Steele and Harmon (in Hattingh *et al*., 2006:2).

Values are beliefs that are based on a personal's life experiences, and which guide behaviour (Bouwer *et al*., 2003:64). Our value systems are usually shaped and affected by gender, religion, culture, tradition and socialising within the family (Mulaudzi *et al*., 2001:13). According to Geyer, *et al*. (2009:11), the value of a nursing theory is as follows:

i. It provides rational, knowledgeable reasons for actions based on organized written descriptions of the reality between concepts
ii. It provides a knowledge base for acting and responding appropriately in nursing care situations
iii. It provides a base for discussion
iv. It provides a resolution on current nursing issues
v. It promotes problem-solving skills of the knowledgeable nursing practitioner to provide organized and purposeful nursing action
vi. It prepares the nurse to question assumptions and values, thus leading to other definitions of nursing and an increased knowledge base

In the context of the public hospitals, the values of the public hospitals must be reflected by registered nurses and unit managers. When the registered nurse and unit manager is delivering a service to patients, their values and principles should provide guidance about what is right.

2.6.3 Morals

Morals refer to a ‘must’ and ‘ought to’ based on principle. In nursing practice, for example, morals can be seen as what the nurse must and ought to do (Geyer *et al*., 2009:72). A nursing pledge includes the statement of moral principles which are collectively upheld by the nursing profession (Jooste, 2010:21).

2.7 CARE, NURSING AND STANDARDS OF CARE IN PUBLIC HOSPITALS FOR THE PATIENTS

Giving care for a patient at the basic needs level provides the nurse and patient with an opportunity for interactions. In this way, the patient perceives the nurse as a potential comforter, one who provides ideas and comfort through professional practice. The professional nurse acts as a mirror for the patients, where clients are able to look at and explore feelings regarding his or her present health status (George, 2002:114).

2.7.1 Caring

Caring is a process during which the nurse learns to know himself or herself as well as the patient. Mulaudzi *et al*. (2001:98) indicates that caring refers to a process based on the moral ideal of restoring the patient to a state of well-being. Jooste (2010:18) argues that caring means an action or activity directed towards providing care. Caring in a generic sense that refers to both the registered nurse and the patient being cared for while receiving opportunities for personal growth. Mayeroff (in Mulaudzi *et al*., 2001:98) argues that caring consists of knowledge, learning from experience, patience, honesty, trust, humility, hope and courage. Thus, caring can be regarded as the core value of the nursing profession.

2.7.2 Nursing

Nursing is a process of looking after a patient’s physical, mental and spiritual well-being (Mulaudzi, *et al*., 2001:1). Nursing can be described as a learned profession with a disciplined focus on care phenomena (Jooste, 2010:18). Jooste (2010:51)

goes on to say that nursing is a regulated profession that forms an integral part of a comprehensive health care system, practised by persons registered under a nursing act. Geyer *et al*. (2009:10-11) states that the South African Nursing Council defines nursing science as:

"...A human clinical health science that constitutes the body of knowledge for the practice of persons, registered or enrolled under the Nursing Act as nurses or midwives. Within the parameters of nursing philosophy and ethics it is concerned with the development of knowledge for the nursing diagnosis, treatment and personalised health care of persons exposed to, suffering, or recovering from physical or mental ill health. It encompasses the knowledge of preventative, promotive, curative and rehabilitative health care for individuals, families, groups and communities and covers man's lifespan from before birth".

The aim of caring is to enhance the relationship aimed at the individual, at families and at the community, promoting their physical, mental and spiritual health through teaching and example (Mulaudzi *et al.,* 2001:1). According to Jooste (2010:51), nurses should be competent to make practice-related decisions quickly enough to affect the outcomes for the patients in a positive way.

Geyer *et al*. (2009:11) argue that nursing has the following characteristics:

i. It is a system comprising a specific, unique body of knowledge
ii. It uses existing and new knowledge to solve problems
iii. It requires study and practice separate from other disciplines.

In the context of caring, the nurses need to know about the patient he or she is nursing. According to Mulaudzi *et al*. (2001:100), the nurses need an effective knowledge base if the credibility of nursing is to be proved. They further state that this knowledge is acquired by conducting research and using the findings in real situations while generating new theories and testing them. Nursing care is needed to promote the quality of a person's health and to prevent ill health for him or her during periods of ill health (Geyer *et al*., 2009:16).

2.7.3 Standards of care

A standard of care is a difficult concept to define simply because there are many ways to measure standards. In nursing practice, care standards refer to the way the unit manager/professional nurse is able to provide a level of care that, as professionals, they know the patient needs (Bowman, 1995:35). According to Geyer *et al.* (2009:205), standards care plans should be individualized before being applied on patients. Jooste (2010:54) contend that a nursing regulatory body sets standards for nursing practice. In line with these standards, professional nurses should:

i. Provide nursing based on a scientific approach to promote comprehensive health care to patients of all ages
ii. Provide efficient , effective and relevant care
iii. Place the primary health care approach at the centre of their practice
iv. Ensure that nursing includes the promotion and creation of a safe and caring environment
v. Adhere to accurate recording, efficient management of information and teamwork
vi. At all times promote and improve the health status of patients
vii. Maintain excellence, credibility and competence through education
viii. Be guided by legal frameworks, ethical standards, a code and a scope of practice
ix. Maintain the highest standards and quality of health care with the available resources
x. Improve their practice through research and the use of research findings (Jooste, 2010:54-55)

2.7.4 Accountability

The nurses' accountability can be defined as central to the integrity of the professional nurse (Bowman, 1995:65; Geyer *et al*., 2009:78). Thus it is important for the registered nurse to give an account of a task that has been delegated. In this study, nursing accountability will be defined as the responsibility to practise ethically and competently by the registered nurse in public hospitals. In South Africa, the

South African Nursing Council (SANC) is empowered to control and regulate the ethical and professional behaviour of nurses and expects a high degree of accountability for all actions to patients, the employing body and other members of the profession (Mulaudzi *et al*., 2001:15).

The nurse should be able to explain how he or she did or did not fulfil his or her responsibility. If a nurse harms or injuries patients negligently, through incompetence or intentionally, according to Geyer *et al*. (2009:78), three things can happen:

i. Firstly, the nurse may be disciplined by the employer in terms of the code of conduct of the employer
ii. Secondly, a criminal or civil case, depending of the offence, can be brought against her or him in the courts
iii. Thirdly, the SA Nursing Council may take disciplinary action against the nurse.

2.7.5 Professionalism

Professionalism and professionalization of nurses refers to a growth process that can be measured in a specific working condition and is never an end in itself. In nursing practice, Geyer *et al*. (2009:34) describes professionalism of a nurse as a process that takes place within a practitioner her-or himself which influences other practitioners in the health sector with whom they work throughout their careers.

Searle (2008:86) identified five criteria that form the conceptual framework of professionalism for nursing in Southern Africa, namely:

i. The existence of a body of specialized knowledge and skill per-training to the profession of nursing and social sciences
ii. The legal and ethical foundations on which professional practice rests
iii. The social role and function the profession fills in society
iv. The development of a specialized body of knowledge obtained through research and empirical experience

v. The preparation of the professional neophyte within a specialized form of education and training

2.7.6 Negligence

Negligence means to fail to do what should have been done. A hospital is public i.e.it is governed by the state. In the context of professional nursing, negligence refers to knowing or unknowing failure to act appropriately regarding the patient and the nursing care of the patient (Geyer *et al*., 2009:50-51). Furthermore, negligence whether deliberates or not, renders a nurse liable to professional conduct action. In this case, negligence may relate to nursing care, prescribed treatment, and diagnosis of needs.

2.7.7 Acceptability

Acceptability is from the term accept, which means the foundation on which all health services should be rendered (Hattingh *et al*.,2006:65). A health service should be accessible, affordable, available, equal, effectively and efficiently, continuous, comprehensive and comfortable to the patients.

2.7.8 Communication skills

Communication is defined as a process in which information is transmitted between people (Geyer *et al*., 2009:261). The quality of nursing practice is dependent on a variety of ways such as communication taking place between the nurse and the patient (Searle, 2005:253). The above statements, emphasize that a registered nurse should eliminate all the indirect aspects of communication that undermine patient trust. The registered nurses are, for example among the lowest paid group of public employees.

Aspects of the communication context should be taken into consideration in order for the registered nurse to be more effective (Geyer *et al*., 2009:262-263). Communication in nursing practice takes the following forms:

i. Giving health information to a patient, and being conducive to listening
ii. The nurse should also be aware of the social context of communication
iii. Communication that takes place in an atmosphere of anxiety is unlikely to be effective, and it is necessary to reassure the patient
iv. It is not a good idea to start communication on matters requiring a great deal of time and attention on the part of the patient at a time when a lot of other activities involving the patient are taking place
v. Culture should always be treated with respect, and it is necessary for the nurse to be aware of the patient's cultural beliefs when engaging in communication with the patient.

2.8 HUMAN RIGHTS

Searle (2008:179) sees rights as fundamental powers possessed by a person unless revoked by law. The professional nurse should be empowered, motivated and trained. Nurses are trained to understand the human rights and charter. They are motivated because they are regulated by the SA Nursing Council. Through advanced training and empowerment, nursing practitioners will be motivated to work hard to improve the quality of patient care and health. The professional nurse has to take the leading understanding and implementing human rights. The nursing practitioners who lack the knowledge to implement the patient charter should receive further training that aims at improving patient care.

2.8.1 Nursing Charter

The purpose of a charter is to set parameters that guide the practice of members of the nursing profession and, that nurses are responsible and accountable for the provision of a professional service to the public to respond to the needs of the community (South African Nursing Council, 2003a). In public hospitals, for instance, according to the proposed Charter for Nursing, the people of South Africa could mandate the profession to take responsibility for nursing care that is provided by committed nurses who :

i. do not discriminate on the grounds of race, colour, gender, religion, culture, politics, personal attributes or the nature of the health problem
ii. promote, maintain and restore health and alleviate suffering
iii. recognize the health needs and vulnerability of the community and individual health care users
iv. create and maintain an environment that fosters safety, compassion and caring for nursing practice
v. provide care that is accessible to the community, free of negligence and malpractice and free of harassment and intimidation
vi. promote the continuity of health care
vii. continuously develop their professional knowledge and skills
viii. respect and maintain the nationally accepted Patient's (Client's) Rights Charter
ix. respect and promote the principles of an accessible, acceptable, affordable, equitable and efficient health care service for the health care user
x. take appropriate action to safeguard health care users when their care and safety are endangered by any person or circumstance (Jooste, 2010: 48)

2.8.2 The Patients' RightsCharter-1999

The Constitution of the Republic of South Africa (Act No.108 of 1996) commits itself to upholding, promoting, and protecting the Patient's (Client) Rights Charter in order to ensure the realization of the right of access to health care services (Department of Health, 1999). It is therefore important that the nurse practitioner understands the quality of care practice, as well as the concepts of responsibility and accountability. A quality of life is achieved by an individual through independent performance of the components of nursing care in order to work effectively. To attain health, an individual must have the necessary strength, will or knowledge (Geyer *et al.,* 2009:13). Mulaudzi *et al*. (2001:49) emphasize that the Health Minister Tshabalala-Msimang, launched the National Awareness Campaign of Patients on 2 November 1999. The Charter is referred to as the National *Patients' Rights Charter*. Department of Health (2000:33) state the aims of the Charter as *"to provide a clear description to both patients and health workers of what standards of service standards should receive".* On the one hand, Mulaudzi *et al*.(2001:49) describe the purpose and

expected outcome of the Patients' Rights Charter and complaints procedure is to deal effectively with complaints, rectify service delivery problems, improve the quality of care, raise awareness of rights and responsibilities, raise expectations and change attitude by strengthening the relationship between nursing staff and patients, improve the use of services and develop a mechanism for enforcing and measuring the quality of health care.

The Department of Health has shown its commitment to upholding patients' rights by formulating a National Patients' Rights Charter (Jooste, 2010:35).The aims of this charter are:

i. to ensure that improved quality health care is provided
ii. to enhance the relationship between health care providers and health consumers
iii. to inform consumers about the services available and their freedom to choose the service of their choice
iv. to encourage consumers to report anything that is wrong with the provision of health care so that this can be adhered to
v. to make sure that patients' rights are upheld by health care providers
vi. to give consumers the opportunity to participate in policy making, thereby building a trusting relationship and confidence in the health care service
vii. to make available the necessary counselling and specialized services for certain categories of patients (Department of Health, 2000)

According to the Charter, patients (particularly those who make use of public services) have certain rights. These are the right to:

i. a healthy and safe environment
ii. access to health care
iii. confidentiality and privacy
iv. informed consent
v. be referred for a second opinion
vi. exercise choice in health care
vii. continuity of care

viii. participation in decision making that affect his /her health
ix. be treated by a named health care provider
x. refuse treatment and
xi. knowledge of their health insurance/medical aid scheme policies
xii. complain about health service delivery they receive (Booysen *et al*., 2008:7-8)

This charter is subject to the provisions of any law operating within the Republic of South Africa and to the financial means of the country. According to Geyer *et al.* (2009:13), a person is an independent, whole and complete being with 14 basic needs, which include:

i. To breathe normally
ii. To eat and drink adequately
iii. To eliminate
iv. To move and maintain posture
v. To sleep and rest
vi. To dress and undress
vii. To maintain body temperature
viii. To keep clean and well groomed
ix. To avoid danger and injury to self and to others
x. To communicate to express emotion, needs, fears and opinions
xi. To worship according to the particular person's faith
xii. To work and experience a sense of accomplishment
xiii. To relax through recreation and play
xiv. To promote development and health

In the South African context, the South African Nursing Council (SANC) is empowered by the Nursing Act, Act 50 of 1978, as amended, to regulate the nursing profession (Mulaudzi *et al.,* 2001:42). Broadly, the SANC in its role has embraced the following principles in its function:

i. Maintenance of public welfare
ii. Registration of practitioners (professional qualifications)

iii. Determination of minimal standards of education and practice (professional practice)
iv. Exercise of control of practitioners (professional discipline)

2.9 PERSONNEL CHARACTERISTICS OF THE REGISTERED/MIDWIFERY PROFESSION

2.9.1 Honesty

Honesty appears to include a great deal of recording and reporting the correct information about the patient's medical condition. No one can render a quality of patient care if he or she is not truthful. The registered nurse must be honest when caring for a patient's belongings (Booysen *et al*., 2008:14).

2.9.2 Emotions

The essential issue for the registered nurse is to control his/her emotions in all interactions (Booysen *et al*., 2008:14). This demands that the nurse remains stable even though the patient is very sick or ill.

2.9.3 Obedience

To give orders, the nursing practitioner first needs to learn to obey orders. A registered nurse must carry out orders obediently (Booysen *et al*., 2008:14).

2.9.4 Punctuality

Punctuality is vital for every professional nurse registered nurse (Booysen *et al*., 2008:14).

2.9.5 Awareness

To understand what occurs for the patient in the caring situation, it is necessary to be aware of, and observe, the patient at all times (Booysen *et al*., 2008:14).

2.9.6 Avoid ignorance

Nursing is a scientific discipline that encompasses diverse beliefs and practice. Therefore, it is very important that the registered nurse maintain high standards and be eager to learn (Booysen *et al*., 2008:14).

2.9.7 Promote trust

This means creating a peaceful attitude that allows the patient to relax and promotes trust (Booysen *et al*., 2008:14).

2.9.8 Commitment

To be committed, means to be dedicated to the task at hand. Avoid misunderstanding and promoting good teamwork in the nursing care unit (Booysen *et al*., 2008:14).

2.9.9 Loyalty

Loyalty is essential for the registered nurse and unit manager. Viewed in this manner, loyalty is no longer just employee retention, but part of patients' and nurse relationship. In everyday interaction with clients/patients, relationships are often aroused (Booysen *et al*., 2008:14).

2.9.10 Humility

Without humility the professional nurse cannot proceed to obtain better knowledge in the nursing practice, or acknowledge the contributions of others, whether they are members of the health team or household staff (Booysen *et al*., 2008:14).

2.9.11 Tolerance

To be tolerant means to behave appropriately towards others. It is important because everyone would wish to be respected towards their own life (Booysen *et al*., 2008:14).

2.10 ETHICAL AND LEGAL PRINCIPLES

2.10.1 South African Nursing Council- Registered nurses

The SANC is responsible for setting and maintaining the standards of nursing and midwifery in South Africa (Booysen *et al*., 2008:16). The council also investigates any complaints about nursing conduct which violates their set standards of care. The acts which are regarded as misconduct include giving a patient incorrect treatment, neglecting to give medical assistance to a patient and failure to keep accurate records of all nursing care provided to a patient (Booysen *et al*., 2008:16).

Ethical standards are established to provide a guideline to what is right and reasonable to the nursing profession in South Africa (Searle, 2005:97). The registered nurse is expected to preserve human life and respect each person's uniqueness, personal values, beliefs and traditions (Booysen *et al*., 2008:29).

National Department of Health (2007) regards quality of health care systems as the best results possible within the available resources. It is the responsibility of every nurse to know the essential quality dimensions relating to their nursing profession. Searle (2005:39) remarks that nurses need to learn how to study a Nurse Practice Act. In this regard, an updated copy of the Nursing Acts of all the relevant regulations will assist the nursing staff in nursing practice.

According to a report published in Government Notice R2598 of 30 November 1984 (Government Gazette 9513), the Minister of Health is empowered by the act to make regulations regarding the scope of practice of persons registered in terms of the act 545 (1) (9). Searle (2008:158) maintains that, the nurse should provide nursing care

in terms of human need and with respect for the dignity of the human being irrespective of race, nationality or social standing.

Thus there is a need for the nurse to establish and maintain professional standards. It is the responsibility of the unit manager to support the registered nurse in developing his or her professional competence. It should be noted that the nurse has a duty to warn those he or she works with from performing functions that may harm a patient (Searle, 2008:159). The registered nurse is enrolled the Nursing Act as a registered nurse.

2.10.2 Scope of practice of registered nurse

The scope of practice is defined as the activities that a professional nurse performs in the delivery of patient care (Jooste, 2010:52).The author further goes on by stating that the scope of practice reflects the types of client for whom the professional nurse can care and what procedures and activities the nurse can perform. These are the legal limits that professionals practise within. Mulaudzi *et al*. (2001:45), however, suggest that a scope of practice enhances the profession to expand and to extend the role of its members.

According to Booysen *et al*. (2008:19-20) and Searle (2008:123-129), the scope of practice of a registered nurse, as highlighted by the South African Nursing Council shall entail the following acts or procedures, which may be performed by scientifically based physical, chemical psychological, social, educational and technological means applicable to health care practice:

a) the diagnosing of a health need and the prescribing, provision and execution of a nursing regimen to meet the need of a patient or group of patients;
b) the execution of a program of treatment or medication prescribed by a registered person for a patient;
c) the treatment and care of and the administration of medicine to a patient, including the monitoring of the patient's vital signs and of his reaction to disease conditions, trauma, stress, anxiety, medication and treatment;

d) the prevention of disease and promotion of health and family planning by teaching and counselling with individuals and groups of persons;
e) the prescribing, promotion or maintenance of hygiene, physical comfort and reassurance of the patient;
f) the promotion of exercise, rest and sleep with a view to healing and rehabilitation of a patient;
g) the facilitation of body mechanics and the prevention of bodily deformities in a patient in the execution of the nursing regimen;
h) the supervision over and maintenance of a supply of oxygen to a patient;
i) the supervision over and maintenance of fluid, electrolyte and acid base balance of a patient;
j) the facilitation of the healing of wounds and fractures, the protection of the skin and the maintenance of sensory functions in a patient;
k) the facilitation of the maintenance of bodily regulatory mechanisms and functions in a patient;
l) the facilitation of the maintenance of nutrition of a patient;
m) the supervision over and maintenance of elimination by a patient;
n) the facilitation of communication by and with a patient in the execution of the nursing regimen;
o) the facilitation of the attainment of optimum health for the individual, the family, groups and the community in the execution of the nursing regimen;
p) the establishment and maintenance, in the execution of the nursing regimen, of an environment in which the physical and mental health of a patient is promoted;
q) preparation for and assistance with operative, diagnostic and therapeutic acts for the patient;
r) the co-ordination of the health care regimes provided for the patient by other categories of health personnel;
s) the provision of effective patient advocacy to enable the patient to obtain the health care he needs;
t) care of dying patient and the care of a recently deceased patient within the execution of the nursing regimen (Booysen *et al*., 2008:19-20).

Thus, all nurses play a key role in the success of their organization. It is important for the registered nurse to understand the scope of practice and actions associated with the practice because the patient is unable to do it for him or her. Searle (2008:129) argue that the scope of practice shows that the role and function of the registered nurse in South Africa is a vital professional one that provides registered nurses and meets every aspect of the human being's need for health care (Searle, 2008:129).

On the other hand, Jooste (2010:52-53) indicates that the scope of quality of practice can be described as:

i. actively engaging in the development of standards, criteria and indicators for quality care
ii. participating in the development and maintenance of a plan to improve quality care
iii. implementing and managing a quality improvement plan for one's own area of practice
iv. participating in the auditing of quality care
v. assisting with the development of nursing practice and the improvement of standards of care through research
vi. creating an environment and learning opportunities that foster professional growth and improvement in nursing practice
vii. committing to the development, maintenance and facilitation of lifelong learning for oneself and others
viii. engaging in the education and training of learners in the health care system
ix. identifying one's own learning needs, and maintaining the knowledge and skills required for competent and independent nursing practice (Jooste, 2010:52-53).

2.10.3 The Nursing Acts

It is important for every nurse to understand and know the essentials of the law relating to the exercise of the profession of nursing. The purpose of a Nursing Act is to ensure that the nursing profession has a statutory relationship with other health professions, and provides for the aspirations of the profession by providing for peer group control by means of a prescribed statutory body (Searle 2008:37)

2.10.3.1 The Nursing Act, 1978 (Act 50 of 1978)

This Act extends the scope of the functions of the SA Nursing Council, provided for representation on the Council by whites, blacks, coloureds and Indians *and for the abolition of the Advisory Committees for Blacks, Coloureds and Indians* (Searle, 2008:19).

2.10.3.2The Nursing Amendment Act, 1995 (Act 5 of 1996)

Searle (2008:22) remarks that this Act amends the Nursing Act 50 of 1978 in certain definitions. In addition to this, it provides for the constitution and for the filling of the vacancies on the Council, as well as for the abolition of the various nursing councils in the Republic arising from the re-incorporation of the independent states into the Republic of South Africa (Searle, 2008:22).

2.10.3.3 The Nursing Amendment Act, 1997 (Act 19 of 1997)

According to Searle (2008:23), the Act has provided for the abolition of the SA Interim Nursing Council and a new South African Nursing Council was established.

2.10.4 LABOUR RELATIONS ACT AND LABOUR LAWS

In the context of South Africa, the Labour Act No 66 of 1995 guides the labour laws of the country. This Act looks after the interests of all employees within the country, which includes nursing practice and professional nurses.

The registered nurse is regulated by the Nursing Act No 50 of 1978, and is also enrolled by the SA Nursing Council as a registered nurse after passing the prescribed examination. The professional nurse and all other staff such as the unit manager fall under the Labour Relations Act which makes provision for the unions, which include the public hospital management, to abide by the labour laws. In this case, if the public hospital transgresses any of these laws, the nursing practitioner has a right to consult the labour court for assistance with his or her grievance. This Act also provides guidelines for the public hospitals to protect the patient from poor health care delivery service.

2.10.5 CODES AND CONDUCT

The Nurses' Codes of Ethics was originally adopted in 1953 to guide nurses' actions, based on social values and needs (Mulaudzi *et al*., 2001:34). It is essential for any profession to understand that codes and professional ethics or conduct is a social instrument developed by members of a profession to control and guide the practitioner. In this regard, the same code of conduct must be reflected in the public hospitals for patient care. Furthermore, if code and conduct is implemented, one of the functions of the code and professional will involve serving as a framework in solving ethical problems.

According to Mulaudzi *et al*. (2001:34) and Jooste (2010:574), this code makes it clear that human rights, including the right to life, dignity and to be treated with respect are inherent in nursing. The profession nurse is guided to refuse to take part in acts come into conflict with healing and caring. Professional conduct is defined as behaviour, attitudes and actions of the person registered or enrolled with the SA Nursing Council (Geyer *et al*., 2009:36).

A code means a system of moral rules and principles. Within a professional setting, code can be described as the values and norms of the majority of members of a professional. A professional code is a set of moral principles or rules that regulate the professional conduct of a profession (Geyer *et al*., 2009:88).

The nurses become more responsible. Responsibility for human action will be evident to the patient care. Mulaudzi *et al*. (2001:35) emphasize that the nurses' pledge always puts the patient first, and they are obliged to act in the best interests of their patient. They further indicate that, as a tribute to Florence Nightingale, an American nurse published The Florence Nightingale Oath, which is recognized as the nurses' pledge of service, and it was taken by nurses at nurses' graduation ceremonies in South Africa until Ernst van Heerden prepared the MER National Laboratories' Creed for Nurses. Thus, it can be concluded that both the oath and the creed indicate that nurses should put the patient's health first.

A code of ethics in nursing can be defined as a statement related to nursing and the nursing objectives. In nursing practice, nurses are to follow a specific moral guideline that takes patients' interests and rights into account (Geyer *et al.,* 2009:88). It also assists the professional nurse in being responsible for acceptable standards of nursing care. Geyer *et al*. (2009:88) remark that the benefits of a professional code of ethics are that it reassures the public, provides guidelines for the regulation of the profession and affords a framework within which nurses can formulate their decisions.

In the public hospital context, ethical codes of conduct must be in place to ensure that competent nurses are available to the communities they serve (Geyer *et al*., 2009:36).In the South African context, the South African Nursing Council (SANC) is empowered by the Nursing Act, Act 50 of 1978, as amended, to regulate the nursing profession (Mulaudzi *et al*., 2001:42). Broadly, the SANC in its role has embraced the following principles in its function:

i. Maintenance of public welfare
ii. Registration of practitioners (professional qualifications)
iii. Determination of minimal standards of education and practice (professional practice)
iv. Exercise of control of practitioners (professional discipline)
v. Implementation of ethical standards considered as part of practice standards

It should be noted that ethical codes guide everyone in nursing, advising the nursing practitioners what they would like to do, than with what they ought to do. A discussion of the International Council for Nurses (ICN) Code of Ethics for Nurses about codes of conduct related to nursing life of the professional nurse in the public hospitals setting, and in so doing, guide the registered nurse and unit manager(Geyer *et al*., 2009:88).

2.10.6 CODE FOR NURSES

2.10.6.1 Ethical terms applied in nursing

The Code of Ethics for Nurses stresses four basic responsibilities of nurses in caring for people (Muller, 2002:3; Dennill et al., 2011:148). These are to:

i. Promote health
ii. Prevent illness
iii. Restore health
iv. Alleviate suffering (Nursing Update 2000:14 in Mulaudzi *et al*., 2001:35).

2.10.6.2 Nurses and people

The nurse's primary professional responsibility is to provide people requiring nursing care. In providing care, the nurse promotes an environment in which the human rights, values, customs and spiritual beliefs of the individual, family and community are respected. The nurse holds in confidence personal information and uses judgement in sharing this information (Geyer *et al.,* 2009:89).

2.10.6.3 Nurses and practice

The nurse carries personal responsibility and accountability for nursing practice, and for maintaining competence by continual learning. The nurse maintains a standard of personal health such that the ability to provide care is not compromised**.** The nurse uses judgement regarding individual competence when accepting and delegating responsibility**.** The nurse at all times maintains standards of personal conduct which

reflect well on the profession and enhance public confidence**.** The nurse, in providing care, ensures that use of technology and scientific advances are compatible with the safety, dignity and rights of people (Geyer *et al*., 2009:89).

2.10.6.4 Nurses and the profession

The nurse assumes the major role in determining and implementing acceptable standards of clinical nursing practice, management, research and education. The nurse is active in developing a core of research-based professional knowledge**.** The nurse, acting through professional organization, participates in creating and maintaining safe, equitable social and economic working conditions in nursing (Geyer *et al*., 2009:89).

2.10.6.5 Nurses and co-workers

The nurse sustains a co-operative relationship with co-workers in nursing and other fields. The nurse takes appropriate action to safeguard individuals, families and communities when their health is endangered by a co-worker or any other person (Geyer *et al*., 2009:89).

2.11 THE FLORENCE NIGHTINGALE PLEDGE

I solemnly pledge myself before God and in the presence of this assembly: To pass my life in purity and to practise my professional faithfully; I will abstain from whatever is deleterious and mischievous and will not take or knowingly administer any harmful drug.

I will do all in my power to maintain and elevate the standard of my profession, and will hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in the practice of my calling.

With loyalty will I endeavour to aid the physician in his work, and devote myself to the welfare of those committed to my care (Geyer *et al*., 2009:88).

According to International Council of Nurses (1997), the International Council of Nurses (ICN) first developed and adopted an ethical code for a nurse in 1953.The code was revised in 1965 and 1973 and again at the ICN Congress in 2005(International Council of Nurses 1997). The elements of the 2005 revision of the ICN Code are given here (Geyer *et al*., 2009:88-89).

A registered nurse and unit manager should be assisted to understand some aspects most frequently in terms of patient care conditions. In the public health setting, it is important for the patient to have trust and faith in the registered nurse and unit manager. As Geyer *et al* (2009:12) indicate, the concept of environment in this theory embraces the physical environmental aspects, which include warmth, diet, cleanliness, ventilation, light and the absence of noise.

An analysis of Florence Nightingale's, writings indicates that she considered the person to be an individual who desires health and who deals with disease through vital reparative processes yet does not strive to influence the nurse (Geyer *et al*., 2009:12).Attention was given to the poor sanitation, working conditions, and the low quality of nurses in the hospitals of her day. This means that nursing should provide optimal environmental situations to promote and maintain the individual's own recuperative processes.

Geyer *et al*. (2009:90) states the South African Code has been amended by many of the nursing education institutions and basically consists of the following:

i. I solemnly pledge myself to the service of humanity and will endeavour to practise my profession with conscience and with dignity
ii. I will maintain by all the means in my power the honour and the noble traditions of my profession
iii. The total health of my patients will be my first consideration
iv. I will hold in confidence all personal matters coming to my knowledge
v. I will not permit considerations of religion, nationality, race or social standing to intervene between my duty and my patient
vi. I will maintain the utmost respect for human life
vii. I make these promises solemnly, freely and upon my honour

2.12 MANAGEMENT IN PUBLIC HOSPITALS FOR THE PATIENT CARE QUALITY

2.12.1 The role of management in public hospitals

The hospital CEO and ward managers should plan, direct, coordinate and manage nurses and support services effectively and efficiently as an integral part of the health service delivery in the area served by the hospital (Dennill *et al*., 2011:42; Jooste, 2010:135-6). The sister or nurse manager should be able to lead his or her nursing staff and make decisions based on day-to-day activities. On the one hand, Kemp & Richardson (1994:21) suggest that key ingredients to successful hospital management in terms of patient care include the following:

i. The patient is involved in planning his care
ii. Continuity of care is assured
iii. Communication between relatives or guardians is enhanced
iv. Communication between the caring disciplines and outside agencies should improve
v. Interpersonal relationships between disciplines are improved
vi. The patient has an advocate
vii. Collaborative care is planned and evaluated systematically
viii. The patient knows who his or her unit manager is
ix. Coordinated performance by all involved agencies is assured
x. Coordinated and individualized care is a reality
xi. Resources are used effectively and fairly
xii. Resources of the hospital are used more efficiently

Commitment to good management ensures the success of health care; the nurse unit manager implements and evaluates quality management processes. It is important for the hospital ward manager to communicate effectively by demonstrating knowledge of communication skills, which include both verbal and non-verbal.

According to Searle (2005:77), LoBiondo-Wood & Haber (2006:15), there are several basic requirements to ensure quality patient care which include the following:

i. The determination and observance of standards of patient care
ii. Ensuring personnel satisfaction, appropriate organization, decision making at the various levels of service
iii. Ensuring cost control and cost effective management which are inseparable from commitment to quality patient care
iv. Being a concerned change agent in order to meet changing social, organizational, economic and political circumstances.
v. Focus on health promotion and risk reduction
vi. Emphasis on community-based care

2.12.2 Competencies of nursing

Competencies are the keeping correct records, information management, attitudes and personality traits of nurses (Jooste, 2010:56). Searle (2005:5) defines competencies as the standards set and related to certain levels of knowledge, skills and beliefs that describe the work behaviours of nurses that account for good or bad performance in their work environment. According to Jooste (2010:55), the outcome of nursing care delivery is the "what" of a nurse's performance, whereas competencies are the "how". Professional nurses should be able to demonstrate technical skills, conceptual and knowledge, taking into consideration the legal framework in which nursing care is delivered, as well as ethical practice and public hospital (Chinn & Kramer, 1999:7; Kemp & Richardson, 1994:85).Learning means a process in which knowledge and skills are gained (Geyer *et al*., 2009:264).

In other words the unit manager should be able to place mechanisms in order to ensure that the professional nurse maintains the best competency levels. To do this, the regulatory body offers opportunities for further education after the basic level of training. These include various post-registration diploma and degree courses to prepare the nurse for specialized areas, for example theatre, intensive care, orthopaedics, primary health care, nursing administration and nursing education (Mulaudzi *et al*., 2001:40).

Chinn & Kramer (1999:7) further disclose that the nurses should be responsible and accountable for all duties required to be carried out in the wards. Nurses should be trained to meet the patient's concerns and requirements. It is important that every nurse acquire skills that motivate performances and incorporates the standards set. This in turn should improve practice and decrease the number of complaints, thereby reducing the stress of those who complain and staff whose work is subject to investigation (Kemp & Richardson, 1994:85). This point was acknowledged by the report (National Department of Health, 2007:3) which reflected concern on the lack of strategic support, and the lack of capacity to deal with small operational issues. It is important to note that the competencies should reflect the requirements of the specific job.

The hospital CEO and ward managers should plan, direct, coordinate and manage nurses and support services effectively and efficiently as an integral part of the health service delivery in the area served by the hospital (Dennill *et al*., 2011:151; Juran & Gryna, 1993:142). The sister or nurse manager should be able to lead his or her nursing staff and make decisions based on day-to-day activities. On the one hand, Kemp & Richardson (1994:21) suggest the key ingredients to successful hospital management in terms of patient care include the following:

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Commitment to good management ensures the success of health care. The nurse unit manager implements and evaluates quality management processes. It is important for the hospital ward manager to communicate effectively by demonstrating knowledge of communication skills, which include both verbal and non-verbal. According to Searle (2005:77), LoBiondo-Wood &Haber (2006:15), there are several basic requirements to ensure quality patient care which include the following:

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iv. Being a concerned change agent in order to meet changing social, organizational, economic and political circumstances.
v. Focus on health promotion and risk reduction
vi. Emphasis on community-based care

Teaching involves helping the individual to learn. To help the individual relate what she or he has learnt through knowledge that cannot be used in everyday life is perceived as useless, especially by adults. The professional nurse and patients must accept that medicine is not always necessary in the management of a health problem. For example, health guidance is the most efficient way of managing day-to-day health problems (Hattingh et *al*., 2006:65).

2.13 CONCLUSION

The care, nursing and ethics in public hospitals for the patients necessitated this study. Searle's model which has been discussed could help the registered nurse to provide patient care quality in a public hospital. The aim of the study was to develop a strategy on the quality health care activities of registered nurses and unit managers in the public hospitals. Key concepts have clarified; the scope of registered nurse, competencies, a nursing model, and the characteristics of the registered nurse could assist in delivering quality nursing care, and also sustain the business of public hospitals.

CHAPTER THREE

LITERATURE REVIEW

A CRITICAL DISCUSSION OF QUALITY HEALTH CARE

"Nature ensures that such defective human beings do not live long. It is the duty of the nurse to provide them with comfort, warmth, fluids, sedation and human contact until death, for in nursing terms they are human beings needing her care"

(Charlotte Searle, 2008:105)

3.1 INTRODUCTION

The literature review in this chapter assists in addressing the research problem. The focus of this study is to evaluate quality management practices in the Ekurhuleni public hospitals. Many organizations including South African government departments have tried to introduce Quality Management (QM) but with little progress. Many organizations including Department of Health have implemented quality care in their health system. The ultimate objective for improving the quality of health care in South Africa should seek more appropriate use of health services through the practice of evidence-based health care (National Department of Health, 1997:6).

The main provider of health care services in South Africa is the National Department of Health (NDoH), the public and private CEOs and managers need to understand the importance of quality through modernizing health care delivery systems (Department of Health, 1997:8; Draper, Felland, Liebhaber and Melichar, 2008:1). This will assist managers to focus on quality of health care and innovation.

Today's global health care environment is extremely competitive and highly turbulent. Consequently, public hospitals in South Africa, including the Tembisa Hospital, and Natalspruit Hospital face considerable pressure to improve the quality

of health care (Ekurhuleni Metropolitan Municipality Integrated Development Planning (IDP) Budget Document, 2008-2012). Therefore, it is important for hospital CEOs and managers to know and understand how patients and the community that surround those hospitals perceive the quality of the health care systems, including the service element. The definition of quality will be briefly discussed first.

3.2 QUALITY MANAGEMENT IN HEALTH CARE

The term ‘quality’ needs to be defined. There are several definitions of quality or quality dimensions (Basu, 2004:5; Dale, Cooper & Wilkinson, 1997:2; Foster, 2001:5; Oakland, 2003:4). They add, however, the concept of quality offers a wide range of comprehensive approaches committed to organization development, and encourages strong relationship-building skills in keeping customer satisfaction as a primary focus. There is increased knowledge of health issues on the side of patients (Jooste, 2010:223). In the context of South African nursing practice, Batho Pele principles have been introduced and emphasis placed on patients’ rights.

Basu (2004:5) described the examples of the meanings of main quality dimensions as presented below:

i. Characteristics such as: reliability, maintainability, availability
ii. Drivers of quality, such as standards
iii. Quality of design versus quality performance
iv. Quality planning, control, and improvement
v. Product quality versus improvement of all organizational processes (Basu 2004:5)

Quality is defined by Deming as a predictable degree of uniformity and dependability at low costs both in manufacturing and service industries (Besterfield, D.H. Besterfield-Michna, Besterfield, G.H. and Besterfield-Sacre, 2003:4).The greater emphasis on quality management should be aimed at meeting the needs of the customer, present and future (Charantimath, 2004:1).Oakland (2003:137) states that self-assessment should demonstrate the organisation’s success in satisfying the needs and expectations of its external customers.

Searle (2005:392) postulated that every nurse practitioner makes a contribution to the development of health services and should be knowledgeable regarding the provision of health care. The unit manager creates value by offering products or services quality to cope with change to meet the patient expectations. This makes the point that it is also important to recognize all nursing practitioners in the government hospitals; this fact is forcing both the unit manager and the nurse to have the same goal in mind.

Oakland (2003:35) further suggests that the quality of total service is user-driven, it cannot be imposed from outside the organisation; perhaps a quality management standards. On the other hand, Dale *et al*. (1997:12) identified five factors that customers consider important when they evaluate quality of service or products, namely:

i. Performance
ii. Durability
iii. Responsiveness
iv. Empathy
v. Tangibles

It is therefore important that quality management is both a comprehensive hospital managerial philosophy including a collection of tools and approaches for its implementation. Against this definition, the next section focuses on the historical background of the quality management concept.

3.3 HISTORICAL BACKGROUND ON QUALITY MANAGEMENT (QM)

The origins of formal quality theory can be traced as far back as the 1800s and the early 1900s respectively (Gavin, 1984). Dale *et al*. (1997:188) and Charantimath (2004:25) state that employees used to operating in a complicated manner and complex situation due to the shared perception of the change should be reached in order to be an effective and efficient organization. Thus, the managers of any organization need to learn to operate a range of skills at the same time. The focus

would seem to be on presenting a scientific explanation for human performance in the organization. He further stated that employees were considered as machines doing routine and tightly controlled works. In this regard, the so-called standard productions were totally used. The following strategic management of quality should apply to processes relating to quality management (Zairi, 1994:32):

i. Inspection: all work has to be checked
ii. Quality Control (QC): certain activities only subjected to quality
iii. Quality Assurance (QA): uniformity, standards and company-wide awareness on quality
iv. Continuous improvement: quality management as a way of life look continuously for areas to improve
v. Continuous learning: using quality for learning and creativity using quality for building competitive strengths.

The healthcare industry increasingly has to deal with systems for improvement and managing quality over the past two decades which resulted in changing in the way they operate in the business environment. This enables both the public and private health institutions to replace the first stage of inspection by quality control, and quality assurance focusing on issues such as continuous process and improvement leading to quality management systems (Dale, 2003:21).

According to Dale (2003:21), major influences on quality development can be identified: inspection, quality control and quality assurance will be discussed next.

3.3.1 Inspection

At this stage one employs inspection as a means of ensuring quality, identifying sources of non-conformance and taking corrective action (Basu, 2004:9). The key to a successful simple inspection-based system, includes one or more characteristics of a product, service or activity being examined, measured, tested, or assessed and compared with requirements in order to assess conformity with a specification standard (Dale, 2003:22). As stated earlier, Rao, Carr, Dambolena, Kopp, Martin, Rafii & Schlesinger (1996:48) believed that jobs of the quality inspectors should be

redefined and allow them to act as internal consultants promoting new methods and techniques.

In the context of organizational publicness, inspection is carried out by dedicated staff employed and more specifically, components, paperwork, products and goods which do not conform to specifications to be reworked, re-evaluated or passed on concession (Rao *et al*., 1996:543; Dale, 2003:22). The emphasis should be on prevention rather than detection, thus the cost of inspection and supervision will go down (Basu, 2004:10). This, in turn, will reduce the external costs that can be associated with expensive consultations if not properly implemented within the organisation.

3.3.2 Quality Control (QC)

The concept of specialization was introduced during the Industrial Revolution (Besterfield *et al.,* 2003:9).They further explained that in the 1900s products were manufactured in small units and quality was not greatly affected. The control aspects of total quality control are appropriate to stable, routine environments where repetitive operations such as high-volume service delivery (Evans & Lindsay, 2005:454). Quality Control is a process that measures output relative to a standard (Stevenson, 2002:418). He further describes the purpose of quality control as processes that are performed in an acceptable manner. Besterfield *et al.* (2003:9) is of the opinion that the history of quality control activities was performed by artisans and skilled craftsmen.

Basu (2004:9) state that the process of control is based on the statistical method which includes the phases of analysis, relation and generalization. According to Evans & Lindsay (2005:454), quality controls exploit existing skills resources, increase control and reliability, and respond to customer needs. Gitlow (2001:7) agrees with Evans & Lindsay by stating that variation control should be monitored and controlled to successfully implement a quality management system in order to satisfy the needs and objectives of the organization. These findings are supported by other attempts to control quality and document systems in addressing all of the new requirements (Dale *et al*., 1997:114-115).

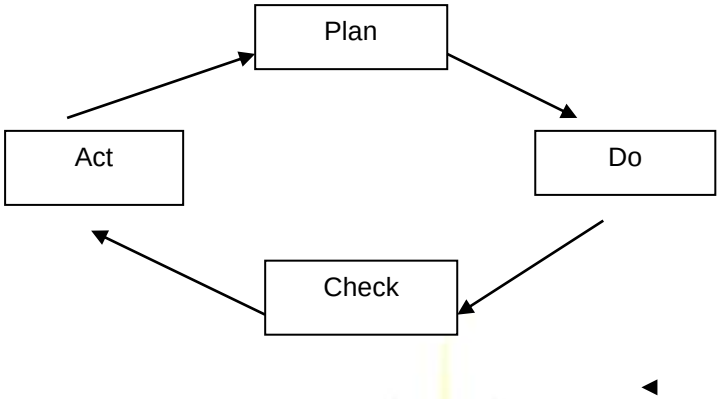
Dale (2003:25) produced similar comments to Rao *et al*. (1996:40). He further indicated development from the basic activity in terms of sophistication of methods and systems, self-inspection by approved operators, use of information and the tools and techniques which are employed. The process of managing the inspection of quality control plays an important role in the health industry today. Control of quality records as stated by Oakland (2003:213) "*are needed to demonstrate conformance to requirements and effective operation of the quality management system".* Thus, best quality control records can be regarded as all the processes being measured, monitored and controlled in order to meet the standards required higher levels of quality.

The inspection of quality control includes a series of activities such as measuring, testing, gauging one or more characteristics of a service and comparing these specified requirements to determine conformity (Fox, 1994:15).Wadsworth, Stephens & Godfrey (2002:32) identified several benefits from Quality Control and Total Strategic Quality as the following:

i. Improving the quality of products and services to meet customer needs
ii. Increasing the productivity of manufacturing processes and commercial businesses
iii. Reducing manufacturing and service costs
iv. Determining and improving the marketability of products and services
v. Reducing consumer prices of products and services

As described in the above statement, leading a successful quality control inspection is not easy. The most critical role in quality control is the principle of inspection concerned with finding and eliminating possible causes of quality problems to faulty items (Oakland, 2003; Fox, 1994:37). In addition, effective human interaction and automated tools tend to provide a great combination to enhance quality control exercises at all levels (Feigenbaum, 1991:6).

The Deming PDCA Control is shown in the diagram (Fig.3.1) below.



Source: Adapted by the author from Zairi (1994:112); Summers (2009:35)

Figure 3.1: The Deming PDCA Control

It is evident from Figure 3.1that the PDCA Cycle is a never-ending process of improvement. This implies that there are number of increasing organizational improvement opportunities.

3.3.3 Quality Assurance (QA)

Draper *et al.* (2008:2) are of the view that many hospitals organisations have applied the idea of quality assurance to improve patient care through planned and systematic activities. Feigenbaum (1991:1) state the purpose of quality assurance is to provide assurance to a customer that the standard of workmanship within the organization is of the highest level. He goes on further to say that overall quality control is being done effectively.

An appropriate way of eliminating the root cause of a problem is to prevent the problem from occurring at the source, which is quality assurance (Dale, 2003:24). It may be useful to provide high-quality products and services for the organization in today's competitive markets in order to be accepted globally. Evans & Lindsay (2005:63; Draper *et al*., 2008:3) state that one of the most important quality requirements in the healthcare industry to be taken towards positive workplace

includes patient safety, health wellness and performance measurement. They further noted several types of quality problems in health care, namely:

i. Avoidable errors.
ii. Underutilisation of services
iii. Overuse of services
iv. Variation in services

Evans & Lindsay (2005:65) state that a substantial amount of quality in education represents one of the most interesting and challenging areas for quality improvement. The significance of quality assurance methods in the health care sector is clearly due to the importance of quality care. In general terms, all other various quality improvement efforts such as internal audits, performance measurement and highly effective top management play a pivotal role in achieving efficient and effective quality care.

There are a number of factors affecting quality assurance in the healthcare sector in South Africa. These factors are however controllable and manageable. Various factors include lack of resources, personnel problems, improper maintenance, lack of review procedures, and lack of good and information (Dennill *et al.,* 2011:87; Juran & Gryna, 1993:135-6; Draper *et al*., 2008:1). The healthcare industry across the world indicates signs of continuous improvement of quality in public hospitals. However, in practice, sustaining this philosophy has proved to be the biggest challenge for many of these organizations. The next section looks at QM as a strategic objective for organizations.

3.4 QUALITY MANAGEMENT AS A STRATEGIC OBJECTIVE OF ORGANIZATIONS

Wadsworth *et al*. (2002:31); Oakland (2003:102); Zairi (1994:37-38); Rao *et al*. (1996:19) explain the effectiveness of quality management as a strategy that focuses on delivering excellent service to consumers or users. These can be achieved by creating an organizational culture and a set of values of that foster performance excellence and provide opportunities for all health employees to develop and reach

their full potential. Successful organizations understand the partnerships of their employees and suppliers in designing new and improved products and services (Evans & Lindsay, 2005:9; Feigenbaum, 1991:20; Oakland, 2003:3 & Basu, 2004:28).

Furthermore, Deming stresses the importance of understanding that assessment criteria can lead to increased credibility within an organization. Oakland (2003:12) acknowledges that it is best practice that all employees should be trained and empowered to problem-solve and identify and eliminate waste.

To summarize, the concept of quality and the management thereof is by no means modern, and quality consultants, in particular Deming, Juran, Crosby, Feigenbaum, Taguchi and Ishikawa have had a significant influence in the development of the quality improvement throughout the world (Basu, 2004:1), and their contributions are examined in the next section:

3.5 QUALITY MANAGEMENT CONSULTANTS

3.5.1 W. Edwards Deming

W. Edwards Deming, one of the early contributors of quality standards, was instrumental in developing Statistical Quality Control (SQC) and Statistical Process Control (SPC) together with other co-workers of this time, namely: Shepherd and Joseph Juran during the 1930s and 1940s (Besterfield *et al*., 2003:4; Rao *et al*., 1996:37).The Deming prize for quality was established in 1951 by the Japanese Union of Scientists & Engineers (Kruger & Ramphal, 2009:132). They further state that this prize is awarded to individuals and groups that make a significant contribution to the field of quality control. In the late 1970s, when it became apparent that many Japanese products were of better quality than U.S products, U.S. managers were surprised to learn that the Japanese had learned quality management from W.E. Deming, an American (Foster, 2001:35).

Basu (2004:18-19) and Foster (2001:37) outlined Deming's 14 points that provide a theory for organizational management in order to improve quality, productivity, and competitive advantage for constancy of purpose and continual improvement as follows:

i. Create constancy of purpose toward improvement of product and service.
ii. The new philosophy :adopt the new philosophy
iii. Cease dependence on mass inspection: prevent defects rather than detect defects
iv. End the practice of awarding business solely on the basis of price tag.
v. Find problems: it is management's job to work continually on the system.
vi. Institute modern methods of training on the job
vii. Institute leadership: adopt responsibility of foreman aimed at helping people and machines to do a better job
viii. Drive out fear: encourage everyone to work more efficiently for the organization.
ix. Break down barriers between department and staff areas to foresee various materials and specifications
x. Eliminate numerical goals: eliminate the use of slogans, posters and exhortations
xi. Eliminate work standards that prescribe numerical slogans
xii. Remove barriers that stand between hourly workers and the right to pride of workmanship
xiii. Encourage education: institute a vigorous program of education and retraining
xiv. Create a structure in top management so that every day focuses on the above 13 points.

3.5.2 Joseph M. Juran

Like Deming, Juran was an American statistician and there are similarities between his work and that of Deming (Basu, 2004:19). According to Kruger & Ramphal (2009:121), Juran was the first guru to emphasize quality as achieved by communication, and identified three basic processes essential for managing and improving quality: planning, control, and improvement. The teachings of Juran

introduced the managerial dimensions of planning, organizing, controlling, and goal setting as well as the importance of achieving quality (Rao *et al*., 1996:40). Quality according to Juran is fitness for use which stresses the totality of quality considerations which together satisfy all needs (Fox, 1994:5)

Juran's 10 steps to quality improvement are (Oakland, 2003:19):

i. Build awareness of need and opportunity for improvement
ii. Set goals for improvement
iii. Organize to reach goals
iv. Provide training
v. Carry out projects to solve problems
vi. Report progress
vii. Give recognition
viii. Communicate results
ix. Keep score
x. Maintain momentum by making annual improvement part of the regular systems and processes of the organization

3.5.3 Philip Crosby

Philip B. Crosby, quality guru of the late 1970s was the populist who 'sold' the concept of total quality management and 'zero defects' to the United States (Basu, 2004:20). Quality according to Crosby is suitability for use meaning that the product conforms to design and other specifications (Charantimath, 2004:1).

According to Kruger &Ramphal (2009: 122); Suganthi & Samuel (2004:41-42) and Ross (1994:6), Crosby proposed a quality improvement programme consisting of 14 steps, as follows:

i. Management commitment
ii. The quality improvement team
iii. Determine how to measure where current and potential quality problems lie
iv. Evaluate the cost of quality and explain its use as a management tool

v. Raise quality awareness as people need to know about the costs of doing things wrong
vi. Take actions to correct problems identified and eliminate problems forever
vii. Establish a committee for the zero defects programme
viii. Train all employees to carry out their part of the quality improvement programme
ix. Encourage individuals to establish improvement goals for themselves and their groups
x. Encourage employees to communicate to management the obstacles they face in attaining their improvement goals
xi. Recognize and appreciate those who participate
xii. Establish quality councils to communicate on a regular basis
xiii. Do it all over again.

Crosby believed that if staff have the right attitude, know what the standards are and do things right first time every time, the cost of conformance will be free (Basu, 2004:21). His view is that 85 per cent of quality problems are within management's control. Deming put this figure at 90 per cent. As such, employees should not be blamed for errors, but rather that management should take the lead and the employees will follow.

3.5.4 Armand Feigenbaum

Feigenbaum's primary contribution to quality thinking in America was his assertion that the entire organization should be involved in improving quality (Foster, 2001:7; Feigenbaum, 1991:4; Evans & Lindsay, 2005:17). Further, Armand V. Feigenbaum was General Electric's world-wide chief of manufacturing operations. He was the originator of the concept 'total quality control' defined in 1961 in his first edition of *Total Quality Control* (Dale, 2003:55):

"...an effective system for integrating the quality-development, quality-maintenance, and quality-improvement efforts of the various groups in an organization so as to enable engineering, production and service at the most economical levels which allow for full customer satisfaction"

Feigenbaum believed that the absence of the development and use of a system of (TQC) would result in inspection and control of quality after the happening rather than incorporating it at an earlier stage of the process (Fox, 1994:5; Evans & Lindsay, 2005:18). Feigenbaum also says that quality begins when the organization identifies the customer's requirements and ends with a service or product in which the customer expresses wholehearted satisfaction (Besterfield *et al*., 2003:4). In referring to customer satisfaction, Feigenbaum claimed that his quality principles are genuine management. This includes regular quality control and quality assurance (Foster, 2001:22). Quality has been defined more differently by the top managers of the organizations in the health care sectors, and practitioners as a management philosophy mainly due to their experiences, beliefs and values in their own disciplines (Basu, 2004:4; Gitlow 2001:2; Oakland, 2003:4)

Charantimath (2004:1) supports these statements when he puts forward that quality management refers to "the totality of features and characteristics of a product or service quality that bear on its ability stated or implied needs".

To summarize, Dale (2003:56) identified Feigenbaum's ten benchmarks for total quality success as follows:

i. Quality is a company-wide process
ii. Quality is what the customer says it is
iii. Quality and cost are a sum, not a difference
iv. Quality requires both individual and team participation
v. Quality is a way of managing
vi. Quality and innovation are mutually dependent
vii. Quality is an ethic
viii. Quality is the most cost-effective, least capital-intensive route to productivity
ix. Quality is implemented with a total system connected with customers and suppliers

3.5.5 Kaoru Ishikawa

Ishikawa was known for his contributions to use visual tools for the communication and understanding of statistical concepts (Kruger & Ramphal, 2009:122). A literature review was conducted to ascertain Ishikawa's success in quality achievement' studies show that Ishikawa produced the seven tools for quality improvement. Many have reviewed continuous improvement, and an aspect of quality by Ishikawa's philosophy was based on the following 11 points:

i. Quality begins with education and ends with education
ii. The first step in quality is to know the requirements of the customer
iii. The ideal state of quality control is when inspection is no longer necessary
iv. Remove the root causes and not the symptoms
v. Quality control is the responsibility of all employees in all divisions
vi. Do not confuse the means with the objectives
vii. Put quality first and set your sights on long-term objectives
viii. Marketing is the entrance and exit of quality
ix. Top management must not show anger when facts are presented by subordinates
x. Ninety-five percent of problems can be solved with the normal tools of quality control
xi. Data without dispersion information is false data

As the above discussion of these quality gurus makes clear, even with all the differences, all the gurus have in common the notion that quality is largely important (Kruger & Ramphal, 2009:122). According to this view, it is the responsibility of everyone in an organization. It is important to know that different approaches to quality improvement exist. Whatever the contribution situation, according to Suganthi & Samuel (2004:42), similarities and a common message from quality gurus are:

i. There are no shortcuts to quality-prescribed procedures to be followed
ii. No quick fixes- it takes time to establish quality.
iii. Improvement requires full commitment and support from top management
iv. Extensive training needed

v. Participation of all employees is a must

Dale (2003:58) concludes that the teachings of Crosby, Deming, Feigenbaum and Juran can be characterised by main the focus of their approach, as follows:

i. Crosby: Company-wide motivation
ii. Deming: Statistical process control
iii. Feigenbaum: Systems management
iv. Juran : Project management

Figure 3.2: Consultants on Quality's key elements in competing with ISO

	Crosby	**Deming**	**Feigenbaum**	**Ishikawa**	**Juran**	**ISO 9000**
Quality definition	Conformance to requirements	Three corners of quality	What the customer wants	Satisfaction to the customer	Fitness for use	Conformance to procedures and specifications
Philosophy	Defect free	Constancy of purpose; statistical analysis	Full customer satisfaction at economical cost	Company-wide quality of control (CWQC)	Project approach; in order of importance	Documentation defines and reflects practise
Approach	Motivate the people	Statistical techniques	Systems approach to total quality control	Talk with data	Quality trilogy; planning; control and improvement	Self-audit with independent review
Mechanics	Fourteen steps	Fourteen obligations of management	The nine "M"s	Seven Statistical tools	Diagnostic and remedial journeys	Three ISO 9000 standards and two guidelines

Source: Adapted by the author from Richardson (1997)

Figure 3.2: Consultants of Quality's key elements in comparing with ISO

Understanding quality code of practice is of great benefit to organizations. The next section discusses the quality management and quality assurance standards thereof.

3.6 THE ISO 9001CODE OF PRACTICE FOR QUALITY MANAGEMENT AND QUALITY ASSURANCE STANDARDS

3.6.1 ISO 9001

ISO 9000 is a series of International Standards (ISO) and the more recent 14000 environmental series have been developed over a long period of time (Evans & Lindsay, 2005:128-129; Oakland, 2003:209; Basu, 2004: 29). ISO 9001 is therefore concerned with the standards, and ISO helps determine what is needed to maintain an efficient quality management system (Foster, 2001:111). These documented processes should be measured and tested regularly in order to maintain an adequate record-keeping system as well many other elements of a competitive quality management system as a means of continually improving the organizational processes (Charantimath, 2004: 184).

The ISO 9001 Series of Standards can be tailored to fit any organization's needs, large or small, healthcare, a manufacturer or a service organization (Besterfield *et al*., 2003:255). They further make the following statement regarding ISO 9000: "its purpose is to unify quality terms and to demonstrate a supplier's capability of controlling its processes. In very simple terms the elements of a quality assurance system include the organizational culture and structure, policies, procedures, processes, and resources required an organization to say what it is doing to ensure quality control, inspection, quality assurance and process of quality improvement" (Goetsch& Davis, 2006:475; Besterfield *et al*., 2003:255).

ISO 9001 is a series of standards of 19 International Standards for quality management systems. Oakland (2003:209) contends that a quality management system should be applied in an organization to identify the customer requirements. Wadsworth *et al*. (2002:60) and Basu (2004:31) indicate that the ISO 9001 series of standards are designed to meet the requirements of a good international standard.

Table 3.1: A summary of Translating Manufacturing Language to Service Language

ISO 9001	Translation
Design	Think in terms of inventing or originating your services or processes (some firms do provide design services for these, no translation is necessary)
Development	Think in terms of improving or maturing your services.
Confirming product	Services that conform to customer requirements.
Requirements	May be something ISO 9001 requires you to do, or something customers have specified as needed in your services.
Product	The service(s) you provide, or knowledge you impact to customers for remuneration.
Production	Everything you do in providing your services to your customers. The result of your processes.
Processes	Various kinds of processes include: the means by which you determine which services to provide, the means by which you design or develop them.
Procedures	Documented instructions of operating your processes, and for complying with the requirements of ISO 9001

Table 3.1: Translating Manufacturing Language to Service Language

Source: Adapted from Goetsch & Davis (2006:19)

Table 3.1 indicates the comparison of the service Sector and ISO 9001. According to Goetsch & Davis (2006:475), both ISO 9000 and TQM organizations find it necessary to seek ISO 9000 registration to indicate to customers that its quality assurance systems are appropriate, by registering with ISO 9000 to demonstrate compliance for quality system elements (Basu, 2004:31). This is done to ensure the organization is focusing on customer requirements and satisfaction from an individual's point of view. ISO 9001 compliance creates a way of improving the organization's products, service and culture.

Foster (2001:113) states that in many organizations people use the ISO standard effectively to plan their processes that are effective, and should be chosen if there is design work. Stevenson (2005:409) is of the opinion that the key requirement for registration is that an organization must view, refine, and map functions such as

process control, inspection, purchasing, training, packaging, and delivery. Because of the benefits of ISO 9001, certification and registration is more helpful for organizations. It also provides effective guidelines for establishing the system (Stevenson, 2005:409).

The basic requirements of the ISO 9001 help organizations maintain standards that meet acceptable quality assurance processes. This enables the organization to gain competitive advantage. Considering the above, Wadsworth *et al*. (2002:55) admits that the establishment of ISO 9001 reflects the commitment of continual improvement within all organization units. They also stated the following as the benefits that some organizations enjoy:

i. Improved quality with less variation
ii. Reduced costs
iii. Greater investment and satisfaction of employees
iv. Greater productivity
v. Enhanced customer satisfaction
vi. Better supplier relations
vii. Improved leadership from top management

Evans & Lindsay (2005:408-9) state that the document and data control requirements of ISO 9001 require organisations to define a process for ensuring that any critical information that is required for the performance of a company is up-to-date, accurate, and effective for its intended purpose. In addition, most ISO 9001registered firms in North America and the number of registered companies is approaching 50,000 as this written (Goetsch& Davis, 2006:285).They further reveal that customer pressure is one of the principal factors driving registration. It is further stated that this may be seen as an approach to becoming and remaining competitive in the marketplace.

A quality management system may from the business point of view be seen as an “admission ticket” to doing business (Goetsch& Davis, 2006:285).The same view is held by Evans & Lindsay (2005:409) that ISO 9001emphasis on processes that,

involves establishing measurement and monitors information about customer satisfaction as a performance metric.

By making use of ISO 9001, Goetsch & Davis (2006:225) believe that the organization is confident; there is a need to require a documented procedure. In this instance, the organization should apply a dedicated, disciplined approach to consistently maintain requirements and carry out the measurement procedures at its best. One of the major pitfalls is that organizations do not entirely understand the part of the written documentation for policies, procedures, and work instructions (Goetsch & Davis, 2006:233).

3.6.2 Quality Management System (QMS) audit

According to Fox (1994:70), quality audit is defined as "periodic in that the entire system is reviewed at planned time intervals which are established by management taking into account the effectiveness over a given time". The objective is to ensure that the requirements for quality have been met (Fox, 1994:71). Oakland (2003:146) agrees with Fox (1994), and state that the aims of the quality audit is to ensure that procedures are effective, are understood and that they are functioning satisfactorily. Moreover, quality audit is a comprehensive and fundamental rule or belief for addressing issues that are a potential source of customer complaints in the organization (Zairi, 1994:240).

According to Goetsch & Davis (2006), policies and procedures are developed by the organization. They go on to maintain that if an organization so wishes, the QMS audit will verify whether the firm is doing what is said it would do. The results will confirm whether the organization's QMS is effective. Two important elements of quality systems that are specifically related to the ISO 9000 series are those of documentation and auditing (Wadsworth *et al*., 2002:65)

From the above content, it is clear that a quality management system audit has the following characteristics (Goetsch & Davis, 2006:248-249). These include:

i. They are systematic, not improvised and not casual

ii. The audit process is documented and will be performed accordingly
iii. The audit team will objectively seek and evaluate information, events, conditions management systems, and related information
iv. The objective is to determine whether these events, conditions and management systems conform with the audit criteria

It can thus be stated here that due to the above, issues such as internal and external auditors become important to any organization that wishes to increase their market share. The process can be considered out of control when there is lack of understanding procedures and policies set to be followed. Organizations seek to eliminate waste and rework in their operations, processes and management activities to gather data affecting the quality problem (Summers, 2009:245). Use of a Quality audit enables the organization to realize the negative side, and take action accordingly (Ahire, Golhar & Waller, 1996). According to Goetsch & Davis (2006) and Ahire *et al*. (1996), conducting quality audit steps involves the following:

i. Initiation and preparation including defining the audit scope and objectives, assigning the resources
ii. Performance of the audit which includes briefing and conducting the collection, evaluation, verification and recording of information
iii. Reporting including developing an audit report and briefing concerned personnel about the audit results
iv. Completion which includes evaluating any corrective action to be taken, and closing out the audit process.

Quality audit ensures that management understand the cost of quality as a waste, and they are discussed next.

3.7 COST OF QUALITY AS A WASTE

Most of the studies on quality costs conclude that it is important to remember that the cost of quality is at best, an educated estimate of the costs and not a precise measure (Rao *et al*., 1996:124; Dale, 2003:157). In this regard, Dale (2003:165) also

suggests that there is need for a set of specific definitions and elements to help determine the costs associated with these types.

Oakland (2003:106) agrees with the above points that analysis of quality-related costs provides a significant management tool as the following:

i. a method of assuring the effectiveness of the management of quality
ii. a method of determining problem areas, opportunities, savings and action priorities.

Cost of quality should be conducted to know the current cost of quality, whereas there is need to reduce the cost of quality and identify the key targets for quality improvement (Goetsch & Davis, 2006:47; Stevenson, 2002:401), summary of quality costs involves the following:

Table3.2: Summary of Quality Costs

Category	Description	Examples
Internal failure costs	Costs related to defective products or services before they are delivered to customers	Rework costs, problem-solving, material and product losses, scrap and downtime
External failure costs	Costs related to delivering substandard products or services to customers	Returned goods, reworking costs, warranty costs, loss of goodwill, liability claims, and penalties
Appraisal costs	Costs related to measuring, evaluating and auditing materials	Inspection equipment, testing, labs,
Prevention costs	Costs related to reducing the potential for quality problems	Quality improvement programs, training, monitoring and analysis, and design costs

Table 3.2: A summary of quality costs

Source: Adapted from Stevenson (2002:401)

Table 3.2 shows the quality costs in four categories: internal, external, appraisal and these are typically four views in cost of quality figures.

Stevenson's (2002:401) stance on quality costs includes all the costs incurred associated with quality. It is crucial to understand and apply effective activities of quality costs in any service industry in order to determine the competitive advantage

for the organization through cost management. Therefore, knowledge of cost can be identified as the key ingredient of quality.

The next section focuses on arguments for and against QM.

3.8 ARGUMENTS FOR AND AGAINST QUALITY MANAGEMENT

3.8.1 Arguments in favour of Quality Management

For the product or service to be more competitive, the organization must have a quality manual. It is believed that a quality manual is the cornerstone of the quality system (Wadsworth *et al*., 2002:65). Summers (2004:187-189) agree that the quality system document is crucial to the human resource development and planning. Based on this view, organizations have a choice about whether to seek information and then make decisions. According to this view, clear communication about QM should always take place in order to motivate employees (Summers, 2009:189).

Suganthi & Samuel (2004:267) also contend that in terms of documented procedures, an activity should be implemented and performed procedurally by well-trained quality assessors. They believe that the role of certified qualified leaders is to ensure that the organization receives the certification as they also check whether all the relevant clauses and processes are followed.

Wadsworth *et al*. (2002:65) share the same sentiments regarding the concept of the quality manual. They base their argument on the fact that the quality manual involves informing the employees at all divisions about the company's quality policies and procedures that must be adhered to at all level (Oakland, 2003:212). Oakland (2003:212) elaborates further on the quality manual that it should include but not necessarily be limited to:

i. the quality policy
ii. definition of the quality management system-scope, exclusions, etc.
iii. description of the interaction between the processes of the quality management system,

iv. documented procedures required by the QMS, or reference to them

Oakland (2003) maintains that a quality manual should indicate the existence and contain the detailed procedures and practices in operation within the specific areas of the system. Based on these premises, quality assessors are trained to encourage teamwork and self-discipline among their employees. The successful quality leader sets a good example by providing all the relevant work instructions and procedures to be followed. Therefore it is important for the organization to provide training for all employees that expand the foundation of quality system documentation (Suganthi & Samuel, 2004:268; Wadsworth *et al*., 2002:49).

It is, therefore, of great importance to provide all employees with training and to bear in mind that customers are informed about quality procedures and policies. Therefore it is clearly important to coordinate and maintain communication at all levels of the organization (Oakland, 2003:212). Thus, top management must intensify their commitment and involvement for the organization to succeed (Wadsworth *et al*., 2002:106; Suganthi & Samuel, 2004:220).

There is no question that without comprehensive training and skills development, employees will fail to understand the procedures and work instructions. This, in turn, will result in a negative impact on the quality product or service and its development processes within the organization.

It is important to manage quality records and reports to determine the expected change in a controlled and effective way (Wadsworth *et al.,* 2002:65; Goetsch & Davis, 2002). Knowing where the standards sets of the organization are and which policies are established, records and reports should be coordinated and managed regularly. Therefore, a lot of positive attitudes can be seen from the employees in the workplace because all the assessment will be in the form of written and verbal discussions. Where necessary the questions might be asked in writing or during the programme sessions. It will be encouraging to see that all employees within the organization work together to achieve the goals and objectives of the company.

3.8.2 Arguments against Quality Management

Quality Management concept is not just one individual concept, but numerous studies refer to the concepts pulled together as a comprehensive approach to doing business (Goetsch & Davis, 2006:17). This concept has received a great deal of attention by researchers such as J.M. Juran –the Chairman Emeritus Juran Institute, Inc. and F.M. Gryna- Director, Centre for Quality at the University of Tampa, these quality management researchers investigated the obstacles to the success of the total quality approach to organizations in a countrywide survey of quality managers (Juran & Gryna, 1993:134).

In a study conducted by Juran & Gryna (1993:135-136), the following obstacles were found as inhibiting the success of organizations' attempting to adopt quality management principles:

i. Lack of leadership by upper management
ii. Lack of an infrastructure for quality
iii. Failure to understand the scepticism about the "new quality program"
iv. An assumption by management that the exhortation approach will work
v. Failure to "start small" and learn from pilot activities.
vi. Reliance on specific techniques as the primary means of achieving quality goals
vii. Understanding the time and resources required

In the service delivery at large, establishing quality management principles means more danger than expected mainly because customers form part of the delivery process. Goetsch & Davis (2006:34) mention the following quality management critical factors of provider-perceived total quality management in hospitals for the future:

i. Total commitment to continually increasing value for the customers, investors and employees
ii. Commitment to leading people with a bias for continuous improvement and communication.

It is important to obtain an understanding of the process for determining quality improvement at this stage. This requires a disciplined continuous system in terms of trust and teamwork with everyone in the organization willing to improve the system (Goetsch & Davis, 2006:27). This fact is reflected in the Deming 14 points (see section 2.5.1).

The next section discusses QM organizations as one of the companies responsible for improving and measuring service quality in South Africa.

3.9 QUALITY MANAGEMENT IN SOUTH AFRICAN ORGANIZATIONS

The South African Bureau of Standards is a statutory body that was established in terms of the Standards Act, 1945 (Act No.24 of 1945) and operates as the national institution for the promotion and maintenance of standardization and quality with regard to commodities and the rendering of service (South African Bureau of Standards, 2008:1)

The SABS, furthermore, represents national quality assurance and standards as the fundamental development of international standards required in terms of the International Organization for Standardization (ISO) as well as the International Electro technical Commission (IEC). Generally, they provide standardization services that improve the competitiveness of South Africa by understanding and developing the standardization products and services in South Africa at the international standard.

SABS is well known for their certification, testing, consignment inspection and other services in the industry. According to SABS (2008), the functions of this organization on behalf of South Africa are to keep the best international practice. Some of the new Vision and Mission laid out by SABS Group are listed below:

Vision: “To be the trusted third party who offers uncompromised value-added standardization services”

Mission:

i. To protect the integrity of the South African market and the end consumer.
ii. To create a competitive advantage for South African industry.
iii. To improve market access locally and internationally.

Standards criteria used by any member body of ISO should be a national body that is the most representative standardization body in that particular country. It is not the purpose of the researcher to choose a member body of ISO which organizations could apply in the working environment. However, it is one of the objectives of this study to explore the standards documented aimed at ensuring that resources, processes, products or service are those that may be established at many various levels in an organization.

Recent changes in the business world forced SABS improve its service offerings and responsiveness to customer needs; as a result the SABS also restructured its commercial services into seven industry clusters:

i. Chemicals
ii. Electro-technical
iii. Food & Health
iv. Mechanical & Materials
v. Mining & Minerals
vi. Services
vii. Transportation

In South Africa, the ISO member body is located at the following address (South African Bureau of Standards, 2008:1)

South African Bureau of Standards
1 Dr Lategan Rd, Groenkloof
Private Bag X 191
ZA-Pretoria 0001
Tel: +27124287911
Fax: +27123441568
E-mail:info@sabs.co.za
Web: www.sabs.co.za/

3.10 DEPARTMENT OF HEALTH

In the healthcare context, the hospital senior managers can influence positive change in a number of ways which are required for the success of the quality initiative (Duggirala, Rajendran & Anatharaman, 2008:695). They view the crucial process management in health-care quality as dimensions to analyse patient and hospital activities. They further stated that hospitals should support the process management strategy in the following ways:

i. Management of patients' records
ii. Ease of access to the hospital and admission process and procedures
iii. Processes: clinical and administrative
iv. Clinical outcomes of medical care
v. Patient focus
vi. Employee focus
vii. Measurement of hospital performance
viii. Hospital information system
ix. Errors, safety and risk management
x. Service culture
xi. Continuous improvement
xii. Benchmarking, Union intervention, and
xiii. Governance and social responsibility

3.11 ORGANIZATIONAL CULTURE

Organizational culture is a system of shared values and beliefs that shape a firm's people, organizational structures, and control systems to produce behavioural norms (Dess, Lumpkin & Eisner, 2008:309).Leaders and managers need to have great leadership skills to ensure that they manage their organization effectively.

The practices to effect large-scale paradigm-shifting organizational change usually end in totally new paradigms for organizing and performing work (Dale *et al*., 1997: 183; Juran & Gryna, 1993:161). In this regard, there is a need to identify and develop more leaders, and to create an organizational culture. This will lead to the employees sharing their cultural values and norms as a means to understand each other as well as do things right. In this respect, Ross (1994:48) says that organizations could play a key role in how careers should be managed. This may itself reduce negative attitudes among staff members with regard to respect to each other in terms of language proficiency.

The above statements suggest that culture plays a major role on the shaping of personality. Thus, culture influences the person through a process of socialization during which certain behaviour patterns, values, attitudes, and views of humanity are acquired. It has been shown that cultural differences play a role in the shaping of personality. Feigenbaum (1993:196) stress the importance of creating strong cultures or simply change culture in order to bring more positive attitudes. Oakland (2003:212) and Zairi (1994:14) note that managing a changing organization requires effective training, which leads to enabling the top management to plan and control measure activities, and ensure a selective method of fitting employees in accordance with their specific task based on the requirements set by the model.

In the following section attention is given to QM awards in international organizations and emerging markets

3.12 QM AWARDS IN INTERNATIONAL ORGANIZATIONS AND EMERGING MARKETS

Oakland (2003:24-25) states QM awards are the most useful criteria of the total quality audit process of the self-assessment of any organization in pursuit of quality and performance objectives, broad culture change and quality assurance. They are the Malcolm Baldrige National Quality Award, the Deming Prize and the European Foundation for Quality Management Excellence Model (EFQM), these include setting guidelines for total quality (Wadsworth, *et al*., 2002:102).They view the quality award core values as focusing on the customer. For this reason the company's quality planning, control, process improvement and the system should be considered as the critical processes for quality management. In some cases it is important for a hospital manager to keep quality in place to control the quality standard.

To ensure that the total quality audit process is effective, TQM must be implemented properly to achieve organization objectives. This strategy must include positioning of people in management, organizational structure, policy management, education and training. Coulter (2010:45) suggests, in addition to the criteria, three models are aimed at encouraging employers and its employees to provide quality product or service in the workplace. As a result of the increasing interest in quality frameworks, world class organizations have been placing greater emphasis on exceeding wants and needs as part of an organizations continuous improvement.

3.12.1 Malcolm Baldrige National Quality Award (MBNQA)

Besterfield *et al*. (2003:191) indicate that the United States became aware of the quality awards, where they had the Malcolm Baldrige National Quality Award (MBNQA), named after the late U.S. Secretary for Trade (Charantimath, 2004:152). This management approach has been used successfully in the education and health organizations in the USA. The following are criteria are given as the Baldrige National Quality Program Criteria for Performance Excellence by (Oakland, 2003:23):

i. help improve organizational performance practices, capabilities and results,
ii. facilitate communication and sharing of best practices information,
iii. serve as a working tool for understanding and managing performance and for guiding, planning and opportunities for learning.

Due to an increasing number of national quality awards, according to Wadsworth *et al.* (2002:102), many leaders in the United States began to be interested in this model, similar to the JUSE's Deming Application Prize. This would help to stimulate the quality efforts of U.S. healthcare institutions.

In terms of its criteria, the MBNQA (Oakland, 2003:23; Wadsworth *et al*., 2002:106) identified the following award criteria built upon a set of interrelated core values and concepts:

i. visionary leadership
ii. customer-driven excellence
iii. organizational and personal learning
iv. valuing employees and partners
v. agility
vi. focus on the future
vii. managing for innovation
viii. management by fact
ix. public responsibility and citizenship
x. focus on results and creating value
xi. systems developments

One of the primary purposes of the award is to promote understanding of the requirements for performance excellence, and share information on successful performance strategies (Rao *et al.,* 1996:45).In this regard, Zairi (1994:26) indicates that, in addition to the above factors, quality models can be used in many ways including framework, working and audits.

3.12.2 The Deming Prize

The Deming Prize is another model that can be used by organizations to perform self-assessment (Zairi, 1994:26; Rao *et al*., 1996:66 &Wadsworth *et al*., 2002:78). With consideration of these quality models, it appears from the Deming Prize that these approaches help to ensure that all improvements contribute to the organization's overall objectives (Rao *et al*., 1996:70). Essentially, a crucial factor to the success of the award criteria is customer focus. The idea behind the customer focus should lead to better customer satisfaction and organization performance requirements.

Besterfield *et al.* (2003:113-114) argue that explaining the forms of recognition and reward program among employees promotes desirable behaviour. Stevenson (2005:383) has emphasised the introduction of Deming Awards in Japan as one of the famous quality management standards set up by this quality guru. Zairi (1994:75) is of the opinion that applying for the Deming Prize is accepted only when the applicant company has already been rewarded the medal more than five years ago. He says that the examination is carried out based on the implementation of CWQC subsequent to the winning of Deming Application Prize recipients.

Various criteria still remain in use for assessment of Deming Prize applications. According to Zairi (1994:75), ten criteria which are used for assessing Deming Prize applications with a huge interest across the world are as follows:

i. Company policy and planning
ii. Organization and its management
iii. QC education and dissemination
iv. Collection, transmission and utilization of information on quality
v. Analysis
vi. Standardization
vii. Control (Kanri)
viii. Quality assurance (QA)
ix. Effects
x. Future plans

According to Oakland (2003:133) good assessment results are used by the management team to help focus on quality management opportunities within the areas of the organization. This means that, top management must be consistent and be able to lead by example. A clear understanding of the need to manage performance from the systems view is also necessary. As stated, for self-assessment to be measurable, any continual process improvement should provide answers on how an organization's value meets the needs and wants of their customers

3.12.3 Australia Quality Award (AQA)

The Australian Quality Award (AQA), according to Zairi (1994:88) was introduced in 1988 for similar reasons linked to MBNQA and EQA. He further states that this award is based on the level of education and awareness of working on the quality in raising competitive standards and its impact on the community. The award, in turn, recognizes efforts of outstanding companies. The following are the three sections of potential award (Zairi, 1994:88):

i. large organization section
ii. subsidiaries and divisions section, and
iii. small enterprise section

3.12.4 European Quality Award (EQA)

The form of measures used to indicate performance should, according to Oakland (2003:137) be concerned with what an organization has achieved and what it is planning to achieve. Their criteria are to focus on those areas needing improvement in order to be best class' organization. Charantimath (2004:154) writes that the European Commission has developed EQA. He further states that this award was instituted in a meeting held in Paris, where it is also called the European Foundation of Quality Management (EFQM).

In Europe, they recognize EQA as the technique of self-assessment, which is very useful for any organization wishing to monitor and improve its performance (Oakland, 2003:131). As such it is a systematic model; its criteria include leadership, policy and strategy, people, resources and partnerships (Oakland, 2003:132; Nel, 2007:121).

With this discussion in mind, it is widely accepted that employee recognition plays a major role to the success and growth of the organization (Nel, 2007:121). It is a common occurrence that failure to implement reward systems within organization may result in unsatisfied employees and poor customer service, while at the same time contributing to company bad image when measuring its quality standards in the organisations (Oakland, 2003:121)

3.12.5 Balanced Scorecard

The Balanced Scorecard (BSC) is an integrative approach to performance evaluation which enables an organization to keep a track record of its strategy through a set of focused, strategic objectives and measures (Oakland, 2003:121). According to George (2002:133), the concept embodied in the balanced scorecard promotes organizational governance based on a set of diverse and representative metrics. George further recognizes that the Balanced Business Scoreboard has four focus areas that guide to examine the organization as follows:

i. Strategy
ii. Financial
iii. Customer
iv. Process

Additionally, George (2002) points out that each focus area reveals a different set of potential projects with the allowance to compile an exhaustive list of project ideas. He maintains that many common themes help converge the problems that are consistently impacting performance.

3.12.6 Scotland

The Scottish Quality Management System is a comprehensive auditing system that can be used by organizations to evaluate themselves against requirements and help to guide and support quality developments (Nel, 2007:122).The eight quality features are: strategic management, quality management, marketing staffing, staff development, equal opportunities, health and safety, premises and equipment, communication and administration, and financial management.

3.12.7 The Revised International Health Care System

In the healthcare context, the hospital senior managers can influence the positive change in a number of ways which are required for the success of the quality initiative (Duggirala *et al*., 2008:695). The key bases of this process of management in health care system are dimensions to analyse patient and hospital activities. The hospital should support the process management strategy in the following ways (Duggirala *et al*., 2008:695):

i. Management of patients' records
ii. Ease of access to the hospital and admission process and procedures
iii. Processes: clinical and administrative
iv. Clinical outcomes of medical care
v. Patient focus
vi. Employee focus
vii. Measurement of hospital performance
viii. Hospital information systems
ix. Errors, safety and risk management
x. Service culture
xi. Continuous improvement
xii. Benchmarking, Union intervention, and
xiii. Governance and social responsibility

The next section discusses the quality management tools and techniques

3.13 QUALITY MANAGEMENT TOOLS AND TECHNIQUES

3.13.1 Quality Function Deployment (QFD)

Oakland (2003:81) discussed the ‘house of quality ’as the most common framework approach also known as quality function deployment (QFD). In addition, this framework originated from Mitsubishi’s Kobe shipyard in 1972 where numerous ways have been developed by Toyota and its suppliers, and many other organizations. Ford and General Motors applied the house of quality (HOQ) as integration into successfully manufacturing and implementing a quality improvement process (Oakland, 2003:35; Draper *et al*., 2008:6).

A framework of QFD is usually both a philosophy and a set of planning and communication tools (Dale *et al*., 1997:231). Dess *et al*. (2008:418) provide an excellent description of what a framework should focus on: aspects of customer needs, coordinating the design, manufacturing and marketing of goods. A major benefit of QFD is of course to increase in customer satisfaction and loyalty, which may be measured in terms of reductions in warranty claims (Oakland, 2003:86).

As Oakland (2003:35) points out, Quality Function Deployment (QFD) is often seen as a ‘system’ for designing a product or service, based on customer demands. However, while the literature suggests participation of members of all functions of the supplier organization, Dale (2003:364) seems to imply effective implementation of QFD is based on the management issues, project issues, QFD team and methods of working. Oakland (2003:87) argues that there are various matrices used in QFD to ensure that customers’ requirements are met throughout the product design process and in the design and operation of production systems.

Quality function deployment describes a method for translating customer requirements into functional design. The quality function deployment approach was developed by Dr.S.Mizano; a former professor of the Tokyo Institute of Technology (Foster, 2001:220).It is envisaged that the main benefits of QFD will also increase the market share. This will ensure that loyalty and customer satisfaction adds value in terms of reductions and warranty claims in the workplace (Oakland, 2003:85).

There are various other reasons why QFD can be considered as a unique tool. Firstly, it is about building partnerships between customers and suppliers and encouraging a spirit of shared aspirations. Secondly, QFD is essentially a quality technique. Quality is about what a customer wants. Thirdly, there is a strong relationship between business performance and the quality of goods and services a company is able to provide (Zairi, 1994:58).

3.13.2 Statistical Process Control

Statistical Process Control (SPC) is a methodology for monitoring a process to identify special causes of variation and signalling the need to take corrective action when it is appropriate (Oakland, 2003:81). Moreover, Fox (1994:148) describes statistical process control as the periodic sampling and analysis of units, items or activity, to determine if the system is performing as expected, according to some pre-determined target design limits.

In addition, the primary purpose of SPC is to analyse the process to verify that it is operating correctly. Oakland (2003) argues that SPC is not only a toolkit; it is a strategy for reducing variability, part of never ending improvement. Quality improvement tools and techniques play an important role that organizations need to take into consideration and are discussed next.

3.14 QUALITY IMPROVEMENT TOOLS AND TECHNIQUES

This section describes some better known tools and techniques to quality that an organization should possess. Some of these quality improvement tools have been identified (Charantimath, 2004:67). These are discussed below:

3.14.1 Check-Sheet

The check-sheet intends to ensure that data is collected by operating personnel (Besterfield *et al*., 2003:466). Check-sheet is the process of collecting data and determines measurements (Charantimath, 2004:78). Stevenson (2005:407) is of the

view that a check-sheet aims to present information in an efficient, graphical format. It actually identifies causes of problems which are recorded and solved. This tool includes providing people with adequate work methods and performance outcomes in order to improve customer service. Check sheets, as the data gathering tools in forming histograms, is a tabular or schematic (Foster, 2001:289; Oakland, 2003:228). This gives managers the ability to make joint decision making with employees by having different levels of employees in a transparent approach, where everyone can be seen as a win-win employee. This according to George (2002:197), in most industries, checklists are computerised. In this respect they are able to keep records of errors.

3.14.2 Histogram

According to Summers (2009:404), a histogram is a graphical summary of the frequency distribution of the data. Oakland (2003:228) suggests this can be used to display both attribute and variable data effectively and in fact emphasises collective effort from everyone in the organization. It is therefore crucial among employees to understand charts of the frequency of occurrence (Basu, 2004:303). The very facts that organizations are faced with competitive demands for quality products or services should encourage the involvement of employee participation which leads to more quality decision-making by these employees.

3.14.3 Pareto Charts and Analysis

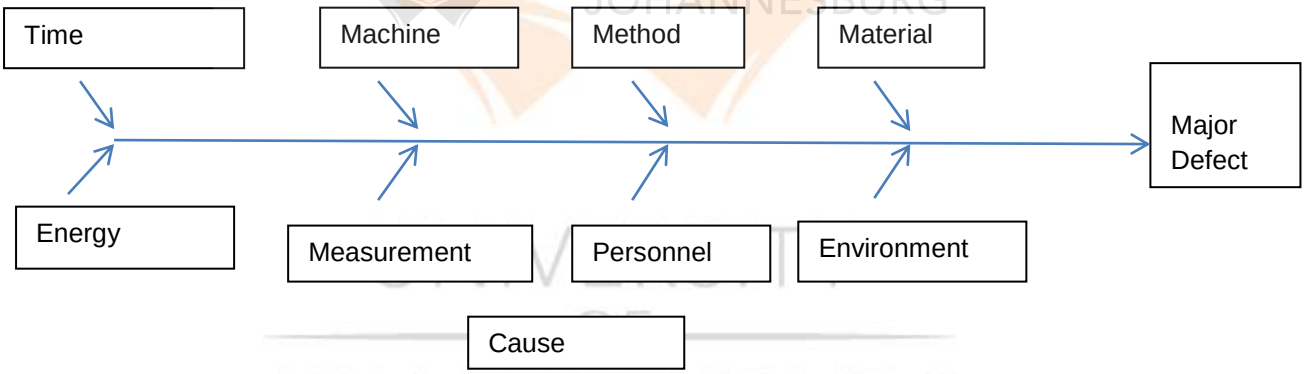
Pareto analysis is a technique which pays attention to the most important areas (Stevenson, 2002:680). This view is supported by Charantimath (2004:71) who defines the Pareto concept as the 80:20 rule, which states that 80% of failures come from 20% of all faults. Recognition of the importance of this diagram is a powerful quality improvement tool. Failure data are analysed, and having analysed the overall failures, important items could be identified and listed by means of descending order (Summers, 2009:397).

According to Besterfield *et al*. (2003:463), the five steps of the Pareto Diagram are as follows:

i. Determine the method of classifying the data
ii. Decide: frequency or both are to be used to rank the characteristics
iii. Collect data for an appropriate time interval or use historical data
iv. Summarize the data and rank order categories from largest to smallest
v. Construct the diagram and find the vital few

3.14.4 Cause-and –Effect Diagrams

According to Summers (2009:400), the cause-and-effect diagram was invented by Kaoru Ishikawa as a structured approach to be used as problem solvers and increase process improvement efforts (Stevenson, 2005:481). Moreover, Stevenson (2005:481) further states that this diagram is also known as a Fishbone or Ishikawa diagram. An example of a one format of a cause-and–effect diagram is shown in Figure 3.3



Source: Adapted from Duncan (1996:86)

Figure 3.3 illustrates one format of a cause-and- effect diagram, and possible causes are shown as a branch, which also indicates some sub-branches. It also needs to be noted that in most cases, the use of cause-and-effect diagrams includes methods, materials, people, equipment, environment, and measurement, where its categories may not exceed 6 whilst there is no limit for the causes.

3.15 BENEFITS OF DELIVERING SERVICE QUALITY

According to Besterfield *et al*. (2003:13), benefits such as improved products or service, employee participation, teamwork, work relationships, customer and employee satisfaction, communication skills and profitability can be achieved from the type of service provided by a particular organization. It is important for organizations to ensure that customer needs are met. Furthermore, this is good evidence that a clear customer focus and delivering quality service is pivotal to drive satisfaction (Besterfield *et al*., 2003:55).Morfaw (2009:124) adds that some of the benefits of service quality include:

i. Opportunities for increased program impact
ii. Sequence and continuity in educational programs
iii. Clarification of actions and resources needed to implement a program
iv. Improved education and accountability
v. Improving the quality of products and services to meet customer needs
vi. Reducing manufacturing and service costs

On the other hand, Ovretveit (2000:75) stated that the benefits of service quality to a patient satisfaction and healthcare organization can be summarized by three dimensions below:

i. *Patient quality*: service quality builds strong consumer relationships, resulting in increased word-of-mouth communication.
ii. *Professional quality*: professionals are confident to meets patients' needs and carry out procedures which are believed to be necessary to meet patients' needs.
iii. *Management quality*: the most efficient and productive use of resources to meet client needs, without waste and within limits and directives set by higher authorities (Ovretveit, 2000).

The next section focuses on discussing total quality management (TQM).

3.16 TOTAL QUALITY MANAGEMENT (TQM)

TQM is an approach to management of an organization which ensures that long-term objectives of the firm are achieved. However, the success of TQM fosters the involvement of employee and feedback, exceeding customer expectations and needs. Oakland (2003:30) asserts that TQM is a comprehensive organizational approach utilized to improve the quality of each of the activities involved in the organization's products or services and processes. In this approach, the aim should be continued quality improvement and, as such, this is a useful approach in today's business environment where the winning strategy is to gain customer loyalty (Omachonou & Ross, 1994:5; Juran & Gryna, 1993:12).

Total Quality Management (TQM) involves the understanding and implementation of quality management principles and ensures that management adopts a strategic overview of quality (Oakland, 2003:30). In a recent study, Ovretveit (2000) suggested that TQM in health care refers to quality leadership, resistance and opposition, variety of experiences, involvement of doctors, special training for doctors, training facilitators and selecting strategically significant quality projects. Thus it can be seen that TQM aims to bring all aspects of quality together. In the healthcare context, this can be done through the ability of organizations to support the nursing staff with educational facilities to enable them to cope with innovations and to grow professionally (Kemp &Richardson, 1994:68; Oakland, 2003:337).

TQM programme stresses systematic, integrated, consistent and reducing defects. It focuses primarily on totally customer satisfaction in any organization. According to Besterfield *et al*. (2003:1), there are certain basic principles of TQM which can implement in order to secure increase profits, better market share and reduce cost. These are as follows:

i. management leadership and commitment
ii. continuous improvement
iii. total customer satisfaction
iv. employee involvement
v. training and education

vi. reward and recognition

Since this study focuses on the evaluation of quality management practices in public hospitals, it is very important at this initial stage to have a clear understanding of total quality management advantages. Besterfield *et al*. (2003:03) identified the following advantages:

i. *Top management commitment and involvement:* The role of the top management and leadership commitment has the critical success factors in any organization that have implemented TQM programmes. Senior managers should be able to provide the necessary direction (Hansen, Nohria &Tierney, 1999).

ii. *Focus on the customer, both internally and externally:* patients in the hospitals are customers externally, and employees are assumed to be internal ones. Employees should be provided with opportunity to participate in the process of improving the health product or service to be rendered because they make physical and emotional contact with the end-users (Rao *et al*., 1996:84-85).

iii. *TQM and effective employees' involvement and their utilization processes:* For an effective TQM programme, employees should be empowered to make decisions and solve problems in their own activities.

iv. *Continuous improvement:* Organizations must be able to assess how consistent the organizational culture is with the basic principles of TQM.

v. *Treating suppliers as partners:* It is important for organizations to understand that both the customer and the supplier are fully responsible for the control of quality.

vi. *Establish performance measures for the processes:* TQM organizations should be able to examine employee performance and customer satisfaction.

The next section discusses quality benchmarking as one of the management techniques for improving and measuring service quality.

3.17 QUALITY BENCHMARKING

According to Besterfield *et al*. (2003:207), benchmarking refers to the systematic search for best practices innovative, ideas, and highly effective operating procedures. It is a strategic tool that can be used by organizations to identify existing assets within the business environment, learn new skills, understanding and adopting the best suitable practices as well as the systems leading to an effective way to attain the organization's long term goals and objectives (Summers, 2009:293).

In order for an organization to realize their opportunities and capabilities, it is imperative for strategic managers to strongly search for most suitable practices inside or outside an organization (Oakland, 2003:162). Effective performance measurement is vital in all organization processes. Too often many managers compare their organizational performance with those of their major competitors in the industry. By so doing, organizations are able to identify areas lacking in terms of improving products or service standards. The purpose of benchmarking is much significant investment in knowledge gained about where the organization stands compared to standards set by its customers, or by national certification (Summers, 2009:293).

Table 3.3: Reasons for Benchmarking

Objectives	Without benchmarking	With benchmarking
Becoming competitive	• Internally focused • Evolutionary change	• Understanding of competitiveness. • Ideas from proven practices
Industry best practices	• Few solutions • Frantic catch-up activity	• Many options • Superior performance
Defining customer requirements Establishing effective goals and objectives	• Based on history or gut feeling • Perception • Lacking external focus • Reactive	• Market reality • Superior performance • Credible, unarguable • Proactive
Developing true measures of productivity	• Pursuing pet projects • Strength and weaknesses not understood • Route of least resistance	• Solving real problems • Understanding outputs • Based on industry best practices

Source: Adapted from Oakland (2003)

It is evident from Table 3.3 that many activities and tasks must be performed to attain best benchmarking practices within an organisation. Benchmarking is an important strategic tool of organizational performance and opportunities for improvement. This may lead to an effective way to attain the company's long term goals and objectives.

As such, measuring service is of great importance an in QM organization which is discussed next.

3.18 MEASURING SERVICE QUALITY IN GENERAL

According to Rao *et al*. (1996:544), measurement instruments should be used to improve effectiveness and efficiency in terms of service quality, empathy, responsiveness, assurance, and tangibles. An organization wishing to implement TQM system must consider the frameworks for quality assurance. Oakland (2003:103) argues that for many organizations where value added activities took place several common questions should be answered as follows:

i. Why measure?
ii. What to measure?
iii. Where to measure?
iv. How to measure?

To assess the levels of business performance, Oakland also stresses the need to meet the customer needs in all areas of business operations. To be a truly quality-driven, never-ending improvement organization, the following main reasons were proposed by Oakland as why measurements are needed. Quality and productivity involves the following:

i. ensure customer requirements have been met
ii. be able to set sensible objectives and comply with them
iii. provide standards for establishing comparisons
iv. provide visibility and scoreboard for people to monitor their own performance levels
v. quality problems and areas of determination are highlighted
vi. give an indication of the costs of poor quality
vii. justify the use of resources
viii. provide feedback for driving the improvement effort

Wadsworth *et al*. (2002:99) maintain that, in health care, patient performance is at the core of the best health services where high competitive standards and measures are compiled. This study concentrates on effective management of positive quality and process improvement. In this regard, the best quality assurance in health

amongst the best health organization is patient performance through continual process improvement.

This chapter has explained the quality management practice in any organization willing to succeed in the competitive arena particularly the health care sector. The next section focuses of the summary of this chapter.

3.19 CONCLUSIONS

This chapter discussed the concepts of quality management as an essential 21st century process to transform and improve organizational performance. A conceptual issue in relation to quality management systems as well as quality management systems requirements are discussed. The important role quality plays in the healthcare and public hospitals was explained at the beginning of this chapter. The increasing demand for high quality products or services by the customers is also discussed. An explanation of the importance of knowledge and applications of process improvement in terms of patients' health care and increased efficiency was deliberately clarified. According to Oakland (2003:76), products, services and processes need to be designed in a way that adds value to customers; aremore profitable and inspiring so as to hold on to the competitive advantage. Organizations must view processes and services development often as a means of enhancing their performance and quality.

It should however be noted that over the past years there has been more continuous improvement in the organizations that successfully implemented QMS applications. However, many other organizations including the government departments find it difficult to implement to sustain quality management processes. In this chapter, the key aspects of QMS were discussed in detail.

An explanation of the importance of quality management and being for continuous improvement was provided. A conceptualisation of quality management tools and techniques was provided. Service quality management developed over the past decade to better meet the needs of customers. In the healthcare context, for

instance, patients don’t have a clear idea of their own needs. However, both the patients and health workers feel frustrated in these kinds of situations.

The next chapter then looks at the methodology which was used in this study.

CHAPTER FOUR

RESEACH METHODOLOGY AND ITS IMPLEMENTATION

4.1 INTRODUCTION

Zikmund & Babin (2010:56) define research design as a master plan which specifies the methods, approaches and procedures used to collect and analyse the information needed. They further state that an advantage of the research design is the framework of the action plan for the study. Mouton (1996:101) states that research gives a broad indication of what researchers wish to achieve in their study. Zikmund (2003:99) notes that the study objective is the researcher's version of the business problem.

This chapter looks at the methodology used in the study. The researcher discusses the research methodology, data collection techniques, procedures and the statistical data applied. In addition to this, ethical considerations will also be included.

4.2 RESEARCH APPROACH

A mixed method has been applied in this research project, adopting contextual, descriptive and exploratory approaches. A mixed method is becoming an important tool in nursing research, particularly in evaluation research (Houser, 2012:38). Quantitative research, within the context of a descriptive design, is applied to identify or describe theories and events that involve respondents who resemble the population in which the researcher is interested (Woods, 1988:121). Zikmund & Babin (2010:45) assert that descriptive research addresses who, what, when, where, why and how questions. They further explain that the research method means that the result of the main section of the investigation conducted can be described. According to Creswell (1994:4), the quantitative research approach views reality as "objective," "out there" independent of the researcher. Creswell (1994:4) remarks that objectives can be measured by using a questionnaire or an instrument.

In this study, the measuring instruments used were self-administered a questionnaire survey using Likert scales, open-ended and closed questions (Zikmund & Babin, 2010:255). The semi structured interview was used to generate qualitative data. For the qualitative researcher, the only reality is that constructed by the individuals involved in the research situation.

4.3 RESEARCH DESIGN

The subject studied is an under researched area in quality management practice in public hospitals, particularly in the Ekurhuleni Metropolitan Municipality, and therefore the researcher adopted contextual, descriptive and exploratory designs.

4.3.1 Contextual design

A contextual design denotes the environment and the circumstances in which the researcher should aim at describing and understand all the elements or events that are relevant to a study in the natural context in they which they occur (Burns & Grove, 2005:732). The researcher selected respondents within the Ekurhuleni region in the Gauteng province including the patients who were admitted in these hospitals.

According to Rubin & Babbie (1989:80), descriptive design means the researcher observes and describes the situations and events. This approach can be useful in assisting the researcher to better define and narrow the observed problem or issue requiring investigation (Zikmund & Babin, 2010:44).Researchers need to identify or describe situations and events that involve participants who resemble the population of interest (Woods, 1988:121). Zikmund & Babin (2010:45) stated that descriptive research addresses who, what, when, where, why, and how questions. This could however be linked to the fact that the result of the main section of the investigation conducted can be labelled as descriptive research (Zikmund, 2003:55).

Parahoo (1997:143) explains that descriptive research can be quantitative or qualitative or a combination of the two. It encourages a researcher to describe the characteristics and phenomena as well as to discover a defined system or process. Creswell (2009:217) argues that descriptive research is based on both open

(qualitative) and closed ended– questions (quantitative) that must be collected with the purpose of portraying characteristics of a situation and the frequency with which the central phenomena occur. Jooste (2010:299) argues that health care researchers might, for example, embark on a descriptive design to gain more information regarding a particular phenomenon or characteristic within the field of nursing

4.3.2 Exploratory research design

For this study, exploratory meant exploring phenomena and necessarily seeking explanations or relationships between variables. This approach can be useful in assisting the researcher to better define and narrow the observed problem or issue requiring investigation (Zikmund & Babin, 2010:44). The purpose of exploratory design as exploring a research question about which little is already known, in this instance, an exploratory study of nurses and patients' perceptions of quality management practices in public hospitals (Mouton & Marais, 1990:43; Parahoo, 1997:143). This exploratory study should include open-ended questionnaires as a means of quantitative data collection methods and proposed measuring tools within the Ekurhuleni government hospitals in Gauteng province.

It is also important to understand the disadvantage of using exploratory design as it is limiting due to the fact that it does not make provision for description of phenomena although it discovers relevant connections or differences (Woods, 1998:150).

4.4 QUANTITATIVE AND QUALITATIVE METHOD OF CHOICE

Creswell (2009:15) and Jooste (2010:297) define quantitative research as interpretive, descriptive, naturalistic, explorative, contextual and flexible. They agree that the explorative approach is employed to explore and describe a given phenomenon. Creswell (1994:4) perceive quantitative research as the positivist, the experimental, or the empiricist paradigm. Specifically, quantitative purists believe that reality is an objective, systematic process in which numerical data are used to obtain information about the research topic (Burns & Grove, 2005:23-24; Creswell,

1994:4). These purists argued that quantitative research is concerned with the studying facts or principles that are generally true. Burns & Grove (2005:23-24) further state that quantitative research may be broadly characterized as:

i. The researcher describes and examines the relationships between the variables
ii. The researcher determines the cause and effect relationships between the variables.

In addition the quantitative approach will be to collect the data from questionnaires be analysed in a quantitative approach. Bailey (1987:33) states *"By methodology we simply mean the philosophy of the research process. This includes the assumptions and values that serve as a rationale for research conclusions. A researcher's methodology determines such factors as how he or she writes the hypothesis and what level of evidence is necessary to make the decision and the standards or criteria the researcher uses for interpreting data and reaching a conclusion whether or not to reject the hypothesis".* Creswell (2003:17) describe the research methodology as a specific method of data collection and analysis.

Houser (2012:38-39) states that mixed-data investigations may be applied in an ad hoc way, meaning the study begins by using a primarily quantitative or qualitative method, and elements of the alternative approach are integrated as an afterthought. Additionally, mixed-data approach investigations may also be used to obtain statistical and text analysis results (Creswell, 2009:15). Mixed methods are complex, however, and require that the researcher have a command of both quantitative and qualitative skills (Houser, 2012:45). This view is also supported by Creswell (2009:180) who state that different approaches permit the researcher to know and understand different things relating to the real world.

Research methods, which were the primary emphasis of this research, require a combination of quantitative and qualitative methods. Creswell (2009:19) states in the situations of mixed methods, collecting both closed ended quantitative data and open-ended qualitative data proves advantageous. In the context of this study, there was no formal hypothesis because of the exploratory and descriptive nature of the

research study. However, the research was guided by the following theoretical assumptions, namely:

i. Quality Management System
ii. Nursing Management
iii. The Patient's (Client's) Rights Charter (Jooste, 2010:35)
iv. Health policy and policy reforms (Van Rensburg, 2011:118)
v. Ethical-legal framework
vi. Labour Act No 66 of 1995

In addition, Creswell (1994:4) stated that qualitative research is also known as constructivist and naturalistic. Qualitative research is aimed at deeper understanding of how specific populations are impacted, based on the changing economic times, and accessing the results of a representative sample of that universe or population (Bless *et al*., 2006:44).The purpose of qualitative research is to probe more deeply on words and observations (Mouton, 1996:130; Creswell, 2009:181; Lincoln & Guba, 1985). Zikmund (2003:110) pointed out that qualitative research is also called exploratory; it is often conducted as a preliminary step to future research on this topic.

In this project, the master plan was structured in the form of written documents in such a way that the eventual validity of the study findings is maximized (De Vos, Strydom, Fouche & Delport, 2006:168). According to Mouton (2006:144), when considering the research design and scope of qualitative study, methodologies can be utilized between the following primary data:

i. Interviews
ii. Surveys
iii. Observations
iv. Comparative studies
v. Evaluation research

Davis (2000:265) points out that both the qualitative and quantitative research designs are more helpful approaches in classifying the primary data studies. The data that will be used is both numerical (simulation) and textual (semi-interviews). The document analysis involves focus or individual interviews and self-administered questionnaire surveys. Self-administered questionnaires were used to collect data from respondents particularly those working public hospitals, particularly Ekurhuleni region. In response to the increasing worldviews, strategies and methods of research design, Houser (2012:45) agrees, summarizing that both quantitative and qualitative data are most effective for evaluation research and for developing and testing models of action and interaction.

The most important aspect of justifying a mixed-data approach research design is that both single data approaches (qualitative and quantitative) have strengths and weaknesses. Therefore, the combination of data approaches, on one hand, will be discussed focusing on each data approach's relevant strengths. Creswell (2009:15) acknowledged the central role to be played by the researcher's experiences and skills to produce a final product that can highlight the significant contributions of both. Qualitative data can support and explicate the meaning of quantitative approach (Houser 2012:45). Putting context to the qualitative paradigm, Zikmund and Babin (2010:94); Creswell (1994:4) indicated that:

i. Qualitative research methods observe and interpret, discover ideas used in exploratory research with general research objects.
ii. Qualitative researcher results are subjective and the researcher is intimately involved.
iii. Qualitative research is predominantly inductive.
iv. Qualitative researchers typically gather data in the form of words, pictures or narratives
v. Qualitative research approaches use small samples-often in natural settings

Added to the above, in contrast quantitative researchers involve specific research questions or test hypotheses. This reality relies on measurement and testing (Zikmund & Babin, 2010:94). Quantitative research aims at getting larger samples and causal research designs, and results are objective (Creswell, 1994:4).

From the above it is evident that each approach has its strengths and weaknesses. What caused the researcher to employ a mixed-data approach in this study? The answer originates from the two approaches discussed. In this study, quantitative approaches will allow the researcher to design the questionnaires, and keep statistical records and draw a numerical value with relevance to participants' responses. On the other hand, qualitative methods will allow the researcher to conduct interviews with the unit managers at the public hospitals. In this regard, their views and experiences of quality of care practice will be explored, described and interpreted in order to gain insight of quality management systems as it is presently implemented. Therefore, the interviews will be conducted in their working places, their hospitals and offices. Within the Ekurhuleni region there are predominantly black nurses with fewer white nurses at the public hospital situations.

4.5 SAMPLING STRATEGY

4.5.1 Target Population

In order to ensure that the aims of this study are met, respondents were selected according to specific criteria which will be discussed in detail in this section. Population can be defined as any complete group of people or communities where they are able to share a common set of characteristics (Zikmund & Babin, 2010:412). Population refers to an identifiable group of elements (people, organizations) of interest to the study and pertinent to the problem statement (De Vos, 1998:131; Burns & Grove, 2005:348). In this study, the researcher targets two types of populations. The first target constituted registered professional nurses working in public hospitals, while the second constituted patients admitted to these hospitals. In order to meet the objectives of the study, the researcher interviews the unit manager to get insights of the phenomena being studied.

To compile a sampling frame, the researcher purposefully selects three hospitals through the assistance of the Ekurhuleni region map in Gauteng. The Unit manager assists with the selection of the registered professional nurses and admitted patients. On the other hand, the hospital CEOs and senior health employees also assists in

offering orientation of those people that are chosen to help the patients in completing the questionnaires. The researcher distributes the questionnaire himself by means of hand delivery to the participants.

The Ekurhuleni region is a geographical area which stretches from Tembisa in the Southern East of Gauteng Province to Springs in the North East of Gauteng Province (see Figure 2.1). The researcher then focuses on three areas due to the time and financial constraints to conduct the study in other areas like Springs and Benoni. In other words this study is limited to the above areas and hospitals situated in the Ekurhuleni region of the Gauteng Province.

4.5.2 Sampling design

Zikmund & Babin (2010:58) have defined a sample as a subset from a larger population. Sampling involves any procedure that draws conclusions based on measurements of a portion of the entire population. A sampling unit is the element or set of elements considered for selection in some stage of sampling (Babbie, Mouton, Vorster & Prozesky, 2010:174). Boeije (2010:35) indicate that a sample consists of the cases (units or elements) that will be examined and are selected based on a defined research population. In this regard the researcher will able to find out if the chosen procedures will actually work as intended. Non-probability sampling methods are often the most appropriate (Babbie *et al*., 2010:166).

In order to meet the objectives of this study, the researcher used a purposive sampling or non-probability sampling technique. According to (Burns & Grove, 1993:246), this is suitable for selecting registered professional nurses, admitted patients' and unit managers using these services. The purpose of this sampling is to ensure that different subgroups in a population are represented on pertinent sample characteristics to the extent the researcher desires (Zikmund & Babin, 2010:313; Burns & Grove, 1993:246).The desired numbers of participants were then selected according to the set criteria and characteristics that the researcher wanted from the administered questionnaire survey. This type of sampling is mainly used to ensure that the researcher searches for rich information and will stay within the field of the study until data saturation has been reached (Jooste, 2010:304-305).

Furthermore, the sample used for this study was made up of three public hospitals selected from Ekurhuleni region in Gauteng province. The number of nurses who responded was 285 and the number of available patients was 29, and one unit manager was available for the semi scheduled interview conducted by the researcher himself.

4.6 INSTRUMENTS FOR DATA COLLECTION

In order to meet the objectives of this study, the researcher used literature sources and research as guidelines to design and develop self-administered questionnaires. Both instruments of data collection included questions regarding demographic profiles and quality of health care information relating to working conditions and service delivery of the participants. In this study, the three methods of collecting data were a pilot study, self-administered questionnaires (closed and open-ended questionnaire) and interviews. The purposes of employing these three methods were to improve credibility and cover the short comings of each method. Furthermore, the following aspects were highlighted and described in section 3.2 as significant dimensions of quality:

i. Reliability
ii. Maintainability
iii. Availability
iv. Planning, control and improvement
v. Standards
vi. Performance
vii. Quality Improvement processes
viii. Responsiveness

4.6.1 Initial Phase (Pilot study)

In this study, both questionnaires were pre-tested. Prior to pre-testing, the researcher submitted the questionnaire to his supervisor and statistician from the University of Johannesburg- STATKON as well as the Quality Assurance Unit

Manager at Tembisa Hospital. This view is also supported by Leedy & Ormrod (2005:110) who stated that pilot study is an excellent way to determine the feasibility of the project study. Thus, the researcher started with the pilot study as a way of knowing the approaches which helped in terms of solving the overall research problem. The researcher also employed purposive sampling to choose a sample for the pilot study. Firstly, the researcher opted to conduct a literature review. He thereafter attempted to request a list of all registered professional nurses and admitted patients using these services, this was done to compile a sampling frame. In addition to this, changes were made relating to the structure of the questionnaires.

Secondly, the pilot study was done in two settings, i.e. one at Tembisa and one at Germiston public hospitals within a period of three days. The main purpose was to check validity and get clarity of the questionnaire. The sample for this pilot study was 10 nursing professionals and 6 were patients from two hospitals. Burns & Grove (1993:246) suggest that in the pilot study the researcher must identify the study tools required to address matters in relation to those who will be investigated in the actual research. In this regard, the researcher employed semi-structured interviews with the pilot sample in order to complement data emerged from the questionnaire.

This phase focused on the data emerging which may be necessary to gain insight into the nature of a situation and also to guide the researcher for a larger study to see if the selected procedures will actually work as intended (Zikmund & Babin, 2010:54). They further stated that the use of a pilot study and accurate literature review prior to the implementation of the research tools also helps the researcher to address some of the matters related to reliability and validity, in a way that will test if the questions will be valid or invalid. The process of employing a pilot sample assisted the researcher, to clarify the phrasing of certain questions. This also assisted in eliminating ambiguity of questions. It is important to note that some bias on the researcher's part might have seriously affected findings if the researcher had not conducted the pilot study.

4.6.2 Second Phase (Questionnaires surveys)

Parahoo (1997:247) describes a questionnaire as a method that seeks written or verbal responses from people to a written set of questions or statements. Questionnaires are common survey data collection tools (Houser, 2012:232). The questionnaire survey was designed to evaluate nurses' and doctors' views given the fact that they represent the government health institutions where quality management is practised.

The respondents of this research were drawn from nurses, patients and a hospital unit manager in public hospitals within the Ekurhuleni region. In this regard, the researcher remained in the background and could also encourage the participant with a few words to continue with his or her contribution (De Vos *et al.*, 2006:168).

Questions used in surveys can be open-ended or closed questions (Zikmund & Babin, 2010:272-273; Houser 2012:232). The authors further indicate that open-ended response is most beneficial when the researcher is conducting exploratory research due to the fact that the range of responses is not known. Open-ended questions allow the respondents to express their opinions in their own words. According to Houser (2012:232), the responses are analysed using content analysis to find themes in the words of participants. In this study, questionnaires were designed in a way that space was allocated to respondents in order for them to record their own words or ideas. Thus, open-ended question responses are useful tools to gather information, and supplements closed questions in a number of ways. These include space constraints if the researcher cannot really ask all the closed ended questions he or she would like to get answers on.

Closed questions are used when there are a fixed number or alternative responses and the participant has to select from the responses provided by the researcher (Houser, 2012:233). To summarize, the researcher used semi-structured self-administered questionnaires (open ended and closed questions) which yielded both quantitative and qualitative data. This is supported by Cooper and Schindler (1998:338) who stated that this structure gives a chance not only to express their views of the topic at hand in their words, but they can highlight areas not covered in

the questions. If the researcher might fail to address the problem adequately, his/her recommendations to solve the problem might be completely inadequate. Fowler (2008) cited in Houser (2012:237) remarks that questions must be clear, succinct, and unambiguous.

The researcher used the questionnaires to the participants using a 5-point Likert style scale ranging from 5=strongly agree to 1=strongly disagree. This was developed for the respondents (Creswell *et al*., 2010:167). Each response is given a numerical score to reflect its degree of attitude favourableness, and the score may be totalled to measure the respondent's attitude (Cooper &Schindler, 1998:189; Houser 2012:235; LoBiondo-Wood & Haber, 2006:326). The survey was conducted to acquire a participant's point of view regarding the quality of the health system in terms of patient care in the public hospitals.

According to Zikmund & Babin (2010:255), the research instrument is used to evaluate the respondent's attitude. Respondents were asked to indicate a degree of agreement or disagreement in order to rate the items to indicate their attitudes and the levels of satisfaction with the key factors of principles and values of quality service in the public hospitals

Zikmund & Babin (2010:255); Cooper & Schindler (1998:189) and Houser (2012:236) suggest that the Likert scale proposed the following principles:

1. "Strongly disagree",
2. "Disagree",
3. "Neutral",
4. "Agree",
5. "Strongly agree"

According to Jooste (2010:311), some of the examples of open-ended questions are as follows:

i. What do you think?
ii. How do feel?
iii. What is to you the most/least....?
iv. In your opinion....

Self-administered questionnaires were hand delivered directly to the participants by the researcher himself. This approach usually minimized costs associated such as postage and mailed questionnaires. In other words, the researcher also tried to cut the costs of postage where it could happen that participants are not available for the questionnaire which contributes to low response rates and thus leads to high cost. The researcher delivered and requested the respondents to answer the questionnaire at their own time. Again, the researcher arranged to collect questionnaires after completion.

4.6.3 Interviews

Interviews are a data collection technique in which the researcher interacts directly with the respondent one-on-one by the telephone or in person (Houser, 2012:23).This view is also supported by Cooper &Schindler (1998:291) who define interviews as a two-way conservation initiated by an interviewer to obtain information from a respondent. De Vos (1998:298) described the use of interviews as the commonly recognized forms in a qualitative research method. The difference in the roles of interviewer and respondent are pronounced. They are typically strangers, and the interviewer generally controls the topics. The purpose is to obtain rich descriptive data that will help the researcher to understand the participant's construction of knowledge and social reality (Creswell, 1994:155). In this regard, the researcher used a face-to-face interview (structured) with a selected hospital unit manager conducted to gain insight and in-depth understanding of the phenomenon. The researcher remained as neutral as possible during the interview and made sure that the respondent answered the question before asking a new question (Houser, 2012:239). It must also be noted that the researcher requested if the interview could

be recorded using auto-tape. Unfortunately, the participant did not agree to be audio-taped.

In nursing research, according to Houser (2012:444-5), the following key steps could help the nurse researcher create a qualitative approach that meets standards for trustworthiness and makes a strong addition to the evidence for nursing practice:

i. Determine a broad research question
ii. Select a broad research tradition
iii. Determine criteria for selection of participants that can best inform the question
iv. Locate a source of informants and invite participation through informed consent
v. Design general data collection procedures
vi. Transcribe data in their entirety and add field notes
vii. Analyse data as they are collected
viii. Develop a codebook of themes and code units of meaning
ix. Check the conclusions with participants
x. Report the themes with supporting examples from informants

4.7 DATA ANALYSIS

Zikmund & Babin (2010:66) defined data analysis as the application of reasoning to understand that data that have been gathered. They further points by stating that descriptive analysis is the *"transformation of raw data into a form that will make them easy to understand and interpret; rearranging, ordering, manipulating to provide descriptive information".* The study used both qualitative and quantitative data collection techniques, therefore both qualitative and quantitative data analysis had to be used. The questionnaire was post coded for computer analysis. Houser (2012:458) describes coding as the formal categories of meaning based on what has been gathered and analysed in qualitative research.

A statistical computer program, Statistical Package for Social Sciences (SPSS) for Windows, version 17.0 was used to analyse the data. Independent statisticians from the University of Johannesburg did this. These included analysis and presentation of data in terms of statistical tables and graphs where necessary in preparation for analysis. In terms of variables in this study, a spread sheet was created where all closed-ended questions of the self-administered questionnaire were captured. During this process the researcher captured the data with the object related the study's investigation (Creswell, 1994:154).

Qualitative data resulting from open-ended questions in the self-administered questionnaire and semi-structured interviews were analysed according to emerging themes. The researcher collected, sorted and formatted and constructed meaning out of the text (Creswell, 1994:127). The qualitative data analysis involves the following (Houser, 2012:458)

i. Reducing the raw data
ii. Identifying themes with subsamples
iii. Comparing themes across subsamples
iv. Creating a coding scheme
v. Determining reliability of the coding scheme

The six rules for qualitative analyses which can assist the novice researcher to conduct a trustworthy analysis that results in meaningful themes (Houser , 2012: 471-472):

i. Establish the goal of the analysis. The design of the study will provide guidance as to the overall goal of the analyses
ii. Organize the data. Determine a way to identify each piece of data by source, timing, and type as it is collected.
iii. Begin analysis early. Data should be evaluated and analysed as they are collected.
iv. Read individual pieces of data in their entirety for tone. The first read of a data source should be purely to get a sense of the tone of the overall response, not for analysis

v. Develop codes. During this phase of analysis, units of meaning are categorised into codes.

4.8 TRIANGULATION

Triangulation in research means combining different methods, theories, data sources such as data collected from different sites or at different times to confirm a single construct (LoBiondo-Wood & Haber, 2006: 141). Tashakkori & Teddlie (1998:18) contend that triangulation evolved from the pioneers, Campbell and Fiske (1959:81-105), who used more than one quantitative method to measure a psychological trait, a technique that they called the multi-trait-multi-method matrix. Triangulation is a useful strategy for the enhancement of credibility (Houser, 2012:427). Other specific definitions of triangulation as stated by LoBiondo-Wood & Haber (2006:167) are the expansion of research methods in a single study or multiple studies to enhance diversity, enrich understanding, and accomplish specific goals.

Triangulation in qualitative research can be described as the convergence of multiple perspectives which can provide greater confidence that which is being targeted is accurately captured (Padgett, 1998:32). According to LoBiondo-Wood & Haber (2006:142), both quantitative and qualitative measures can be used simultaneously during data collection, and the results can then be “triangulated” or put together. Triangulation requires the research inquiry be addressed from multiple perspectives (Campbell & Fiske, 1959: 81-105; Houser, 2012:427). They further outlined the kinds of triangulation possible:

i. Multiple methods of data collection and analysis
ii. Multiple data sets
iii. Multiple researchers analysing the data depending on different research perspectives
iv. Data collection in multiple time periods
v. Answering research questions

With the above statements in mind, the following are the types of triangulation (Padgett, 1998:32; Creswell, 2009:178-9)

i. Theory–an assessment of the utility and power of competing theories or hypotheses
ii. Data-the use of multiple data sources with similar facts to obtain diverse views about a topic for the purpose of validation
iii. Researcher-the use of two or more 'research-trained' researchers with divergent backgrounds to explore the same phenomenon
iv. Analysis- the use of two or more approaches to the analysis of the same set of data
v. Methods – the use of two or more research methods in one study
vi. Multiple- the use of more than one type of triangulation to analyse the same event.

The research was comprised of multiple quantitative data collection and analysis supported by qualitative data. However, priority was given to quantitative data whilst qualitative data was basically utilized to strengthen the argument as well as to support the obtained argument. It is in this context that data collection was connected, and integration occurred at the data interpretation process as well as in the discussion.

According to Padgett (1998:97), a typical methodological triangulation approach denotes the use of multiple approaches to study a single topic, combining qualitative and quantitative methods in a single research study. This is one of the six types of triangulation methods, as described by Kimchi *et al* (in (Parahoo, 1997:65) and applied throughout this research project.

4.8.1 Reliability of the instruments

Reliability of an instrument means, according to Houser (2012:211) and LoBiondo-Wood & Haber (2006:346), the degree to which an instrument is stable internally, which measures the characteristics, and is measured with the alpha coefficient statistic. This concerns whether the participants answer the same questions in the same way if they were asked again. Punch (2003:52) states that if they would, then the questions asked provide data with a high reliability. This coefficient may be called

Cronbach's alpha, or internal reliability, and it should have a value of 0.7 or greater (Punch, 2003: 52). The reliability coefficient ranges from 0 to 1 (LoBiondo-Wood & Haber, 2006:346). It also must be noted that in this study, as discussed earlier, the reliability was measured using Cronbach's alpha.

In this study, a reliability coefficient of a measure reported to be greater than 0.70. Thus, the instruments were considered to have an acceptable level of reliability.

4.8.2 Content validity

Zikmund (2003:302) described this as the "ability of a scale or measuring instrument to measure what it is intended to measure". According to Punch (2003:52), validity refers to whether the data represents what the researcher intends to represent. In the context of this study, the concept needs therefore to be measured, if measured correctly; the study will be more valid. The matter here is whether the participants have answered the questions honestly and conscientiously. Punch (2003:52) further goes on by stating that this depends on whether the participants were able to answer the questions asked by the researcher. A pre-test of the questionnaire is therefore needed. Pre-test of a questionnaire can be described as a test conducted with a group of participants to discover problems in terms of the instructions or design of a questionnaire (Zikmund, 2003:229; Leedy & Ormrod, 2005:110). In this study, as mentioned in Chapter 1, a pilot study of the questionnaire was done before distributing out the final questionnaire to the participants at the state hospitals.

In this study, external validity can be compromised as Tembisa, Germiston and Natalspruit Hospitals are not representative of other cities and urban townships. There are a larger number of public hospitals with registered nurses. Quality in healthcare management may be different in different areas.

Furthermore, the questionnaire was formulated in such a way that it measured accounts for all the elements of the variables including quality in healthcare, knowledge and practices. Thus, this ensured content validity.

4.9 ETHICAL CONSIDERATIONS

Ethics is defined as the study of right and wrong (Houser, 2012:50). This study was conducted in the demand for the protection of human subjects, particularly the national and international health standards governing studies with human participants (Houser, 2012:50; LoBiondo-Wood & Haber, 2006:166; Merriam, 1998:212). Human rights are the claims and demands that have been justified in the eyes of an individual or by a group of individuals (LoBiondo-Wood& Haber, 2006:297). Houser (2012:59) suggests the ethical responsibilities of a nurse researcher as the following:

i. To protect individuals' autonomy in consenting to participate in a study
ii. To protect those prospective subjects for whom decisional capacity is limited
iii. To minimize potential harm and to maximize possible benefits for all subjects enrolled
iv. To ensure that benefits and burdens associated with the study protocol are distributed equally when identifying prospective subjects
v. To maintain competence in one's identified area of study
vi. To notify institutional officials of breaches of study protocols and incidents of scientific misconduct
vii. To maintain proficiency in research methods
viii. To protect privacy, to ensure confidentiality, and to guarantee anonymity when promised

In the context of this study, the following methods used to adhere to ethical considerations for this study will be discussed next:

4.9.1 Right to self-determination

Based on the ethical principle of respect for persons, people should be treated as autonomous agents who have the freedom to choose without external controls (LoBiondo-Wood & Haber, 2006:298). In this study, the researcher under the watchful eye of his supervisor adhered to the highest possible standards of research planning, implementing and reporting .The right to self-determination was ensured by

informing participants about a proposed study and they were allowed to choose to participate or not participate.

The study was conducted with the element of honesty, without any misconduct, fraud or acts of bad faith at any stage in the process. All the findings were reported fully, without the omission of significant data, and included details regarding methods and research designs which might have influenced the interpretation of the data. The inputs of all the respondents were acknowledged. Termination of respondents was permitted in case of:

i. Any participant wishing to withdraw despite initially consenting to participation (Burns & Grove, 2005:189); and
ii. The project no longer adhering to the standards set in planning

4.9.2 The right to privacy

Participating was voluntary and those who wished not respond to the questionnaire were not questioned. In addition, the research questionnaire did not ask the respondent to give their names on the questionnaire (Burns & Grove, 2005:186). The researcher took care of the organization's code of conduct. The findings of the study would be reported anonymously and the study was not intended to harm any participant in any way. The participants were fully aware of the purpose of the study and the way in which the information was used.

4.9.3 Right to autonomy and confidentiality

According to LoBiondo-Wood & Haber (2006:298), anonymity exists when the subject's identity cannot be linked, even by the researcher, with her or his individual responses. Confidentiality means that individual identities of subjects will not be linked to the information they provide and will not be publicly divulged. To protect the participants, the data collected was kept confidential. Respondents were ensured that their participation of the information they provided would not be used against them in any way (Burns & Grove, 2005:188).

With reference to the above statements, the researcher respected the participants' right to privacy and respects in a sense that confidentiality and anonymity was guaranteed.

4.9.4 Right to fair treatment

The ethical principle of justice means people should be treated fairly and should receive what they are due or owed (LoBiondo-Wood & Haber, 2006:300). The right to fair treatment was ensured by fair distribution of risks and benefits regardless of race, culture or socio-economic status (Burns & Grove, 2005:189).

4.9.5 Right to protection from discomfort and harm

The researcher informed the participants of any reasonable foreseeable consequences from participation. According to Burns & Grove (2005:190); LoBiondo-Wood & Haber (2006:300), discomfort and harm include physical, psychological, social, or economic. The participants were also informed of the nature of the study and the responsibilities of each participant.

4.9.6 Obtaining informed consent

Informed consent is a process of information exchange in which participants are provided with accurate information in order for them to understand the risks and benefits, and the assurance that withdrawal is possible at any time without consequences (Houser, 2012:57). The respondents were informed of the research results on request, and they were made aware of their right to withdraw their consent if they wished so, despite their initial consent to participate.

With reference to the above statements, the researcher respected the participants' right to privacy and respects in a sense that confidentiality and anonymity was guaranteed.

4.9.7 Obtaining permission from ethical committees

The researcher obtained an approval letter from the Head of Department: Quality and Operations Management at the University of Johannesburg before any data were collected in the 2012 academic year (see Annexure 3). Further to this, the necessary permission to conduct research in sampled hospitals under the jurisdiction of the Gauteng Department of Health was made. The researcher himself signed an indemnity form at the Hospital Human Resource department. A cover page was attached to ensure that important points were outlined (See Annexure 1), which also highlighted utmost human basic rights. In all aspects respondents, could expect the highest degree of professionalism by the researcher.

4.10 CONCLUSION

In this chapter, the research design and methodology, as a framework was employed to explore and describe the phenomenon to be investigated in a mixed-method employed. The multi-methods of data collection (self-administered questionnaire, interviews, document analysis and observation) were described. The population, sampling, analysis and interpretations were also discussed in this chapter. Measures to ensure the validity and ethics of the mixed-method approach were also discussed, particularly in the context of this study focusing on the research question. Data are analysed and research findings are discussed in the next chapter.

CHAPTER FIVE

PRESENTATION AND DISCUSSION OF FINDINGS

"Getting quality results is not a short-term, instant-pudding way to improve competiveness; implementing total quality management requires hands-on, continuous leadership"

Armand V. Feigenbaum

5.1 INTRODUCTION

The previous chapter provided an overview of the research approach adopted for the present study. Chapter five concentrates on the findings of the empirical study through analysis of the results. The responses to the questions posed and data was analysed using the Statistical Packages for Social Sciences version 17.0 for Windows. Firstly biographical information of the participants such as gender, age, highest educational level, employment status, length of service and race will be analysed after which further descriptive statistics will be examined. This will enable the researcher to make conclusions and recommendations regarding health service delivery and quality management practices. The questionnaires were distributed at the public hospital in the Ekurhuleni region in 2012.

The significant and non-significant results of the descriptive data analysis on the health service and quality management practices of hospital nurses will be discussed. In this regard, the differences of selected biographical variables such as name of hospital, staff position, highest educational level and years of service and health service delivery and quality management practices of nurses' results will be examined. Furthermore, the researcher will explain the parametric statistical procedures used to test evidence, significance and non-significant variances among and between the selected variables.

5.2 OBJECTIVES OF THE STUDY

The purpose of this study is to evaluate quality management practice in the public hospitals of Gauteng. In order to achieve this, the following objectives were formulated for this research project:

i. To explore the nurses' and patients' perceptions on the specific quality management practices in terms of improving quality care
ii. To investigate the nurses' and patients' views on general systems in relation to patient care
iii. To provide an overview on what nurses understand regarding quality management practices as a strategy for managing the healthcare system

The results are presented and interpreted as well as summative discussions thereof are provided. The main survey results were divided into three phases:

i. Phase One: Hospital nurses results
ii. Phase two: In-patient results at the public hospital
iii. Phase three: Hospital unit manager structured interview results.

5.3 HOSPITAL NURSES' RESULTS

Section A focuses on the biographical information data- gender, age, name of hospital, staff position, highest educational level, years of service and health service delivery. Quality management practices of the hospital staff nurses were analysed using nominal-scale measurements of the respondents. The total sample of respondents was 185 resulting in a 52.9% response rate of the 350 questionnaires distributed.

5.3.1 Section A: Biographical information (N=185)

The researcher carried out the biographical interviews (see Annexure 5) which contains questions that were used to obtain important background information on each respondent. It must be noted that these questions were specifically formulated

in relation to this research and to attempt to elicit information about the respondents' upbringing.

5.3.1.1 Gender distribution

Table 5.1: A Summary of gender of the respondents

Gender	Frequency	Per cent
Male	50	27.0
Female	135	73.0

Table 5.1: Gender distribution

Table 5.1 indicates the gender distribution in the sample which reports that out of 185 respondents, 135 were females (73.0 %) and 50 were males (27.0%). This pie chart indicates that the majority of respondents were female. Based on this evidence, it was assumed that in the Gauteng province, nursing profession is female dominated which seems to be a general challenge filtering through the South African nursing profession population. This is a negative result.

It was also assumed that a gender issue can be one of the reasons males are not interested in the nursing profession due to the argument advanced by some respondents that nursing employment is meant for women. On one hand, the researcher also found there is a shortage of experienced and skilled nurses. Again it was also suspected that the fact that women have other responsibilities such as taking care of partners and their children can be considered as an obstacle to retaining the nursing personnel in the hospitals. The results are graphically depicted in Figure 5.1

Figure 5.1. A Summary of gender of the respondents

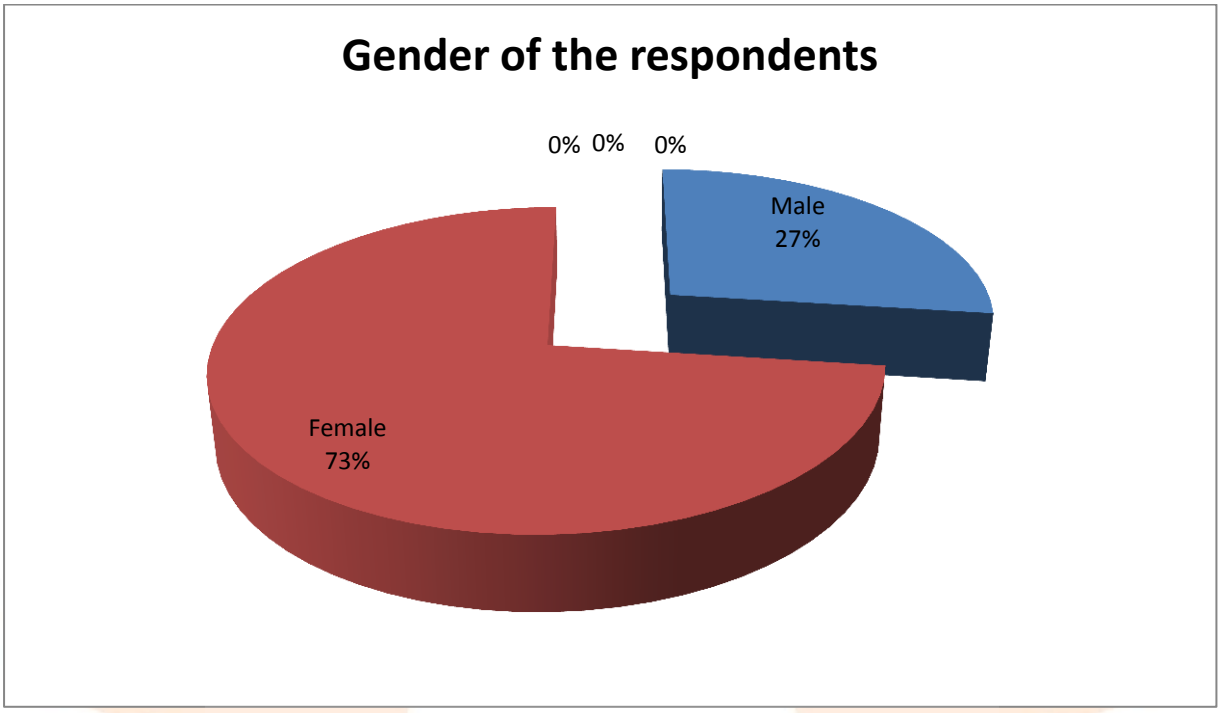


Figure 5.1: Gender of the respondents

5.3.1.2 Age of the respondents

Table 5.2: A Summary of age categories of the participants (nursing staff)

	Frequency	Percentage
Between 19-30 years	85	46.4
Between 31-40 years	69	37.5
Between 41-50 years	23	12.4
Older than 51 years	6	3.2
Total	185	99.5
Missing	1	0.5

Analysis per category is indicated in Table 5.2. The age group 19-30 years comprised the highest percentage (46.4 %), followed by the age group 31-40 years

(37.5%), age group 41-50 years (12.4%) and age group older than 51 years (3.2%) respectively. This result indicates that there was a statistical difference between the percentage of young nurses (19-30 years) and the percentage of matured nurses (older than 51 years).It was suspected that the mature nurses have occupied better positions than the young nurses. These results are also graphically depicted in Figure 5.2

Figure 5.2: A summary of age categories of the participants

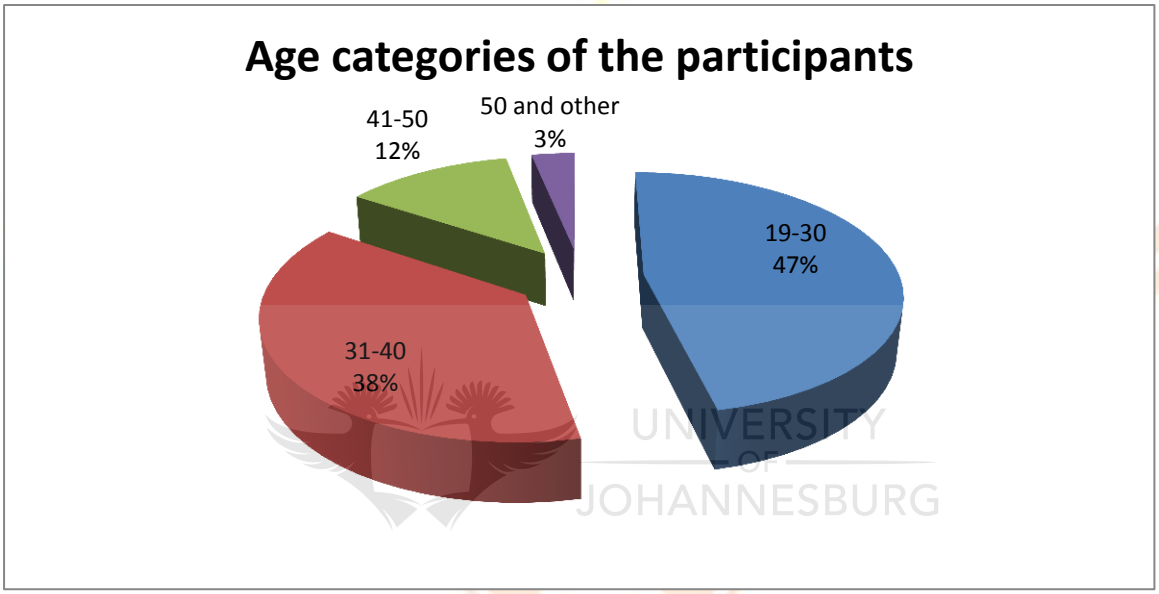


Figure 5. 2: Age categories of the participants

5.3.1.3 Name of hospital

Table 5.3: A summary of the name of hospitals selected

Name of hospital	Frequency	Per cent
Tembisa	54	29.2
Germiston	65	35.1
Natalspruit	66	35.7

Table5.3indicates that the largest number of respondents were from Natalspruit hospital (n=66; 35.7%), followed by Germiston hospital (n=65; 35.1 %), while the

smallest number of the respondents were obtained from Tembisa hospital (n=54; 29.2%).These results are graphically depicted in Figure 5.3.

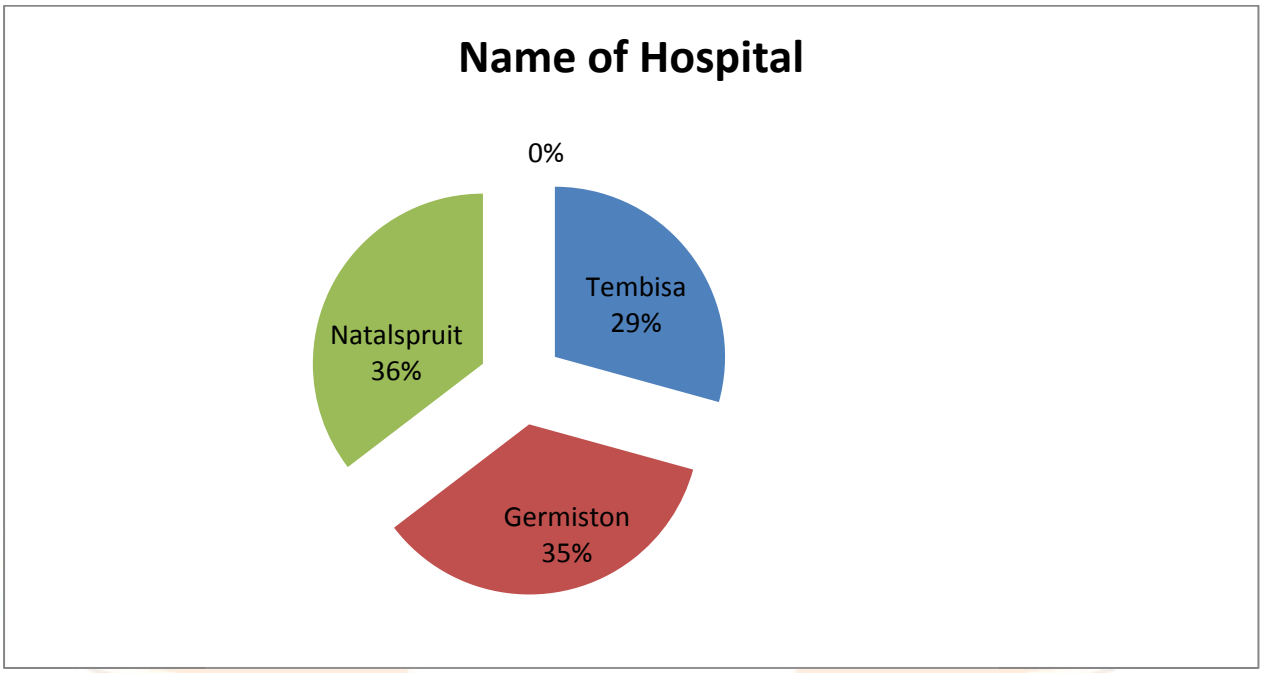


Figure 5.3: Name of hospital

5.3.1.4 Staff position of the respondents

Figure 5.3 reflects the staff position frequency of the respondents. Approximately 26.8 per cent (n=53) of the respondents indicated that they were working as assistant nurses, 20.5 per cent (n=40) were working as paediatric nurses and 20.4 per cent (n=38) are working as Gynaecology and Obstetrics unit nurses, 18.4 per cent (n=34) reported working in the internal medicine ward as nurses whilst 2.7 per cent (n=5) indicated that they were working as nurses in the general surgical ward. The smallest number of the respondents (n=1; 0.5) reported they were working as a quality assurance sister.

The researcher assumed that the majority of assistant nurses working at participated Katlehong hospital had freedom to express their feeling about quality care within their working environment. This assumption was made because of the feedback received from the assistant nurses with other nursing practitioners' related patient

care, who confirmed that patients tended to be receive poor patient service delivery due to lack of human capital and potential. These results are also graphically depicted in Figure 5.4.

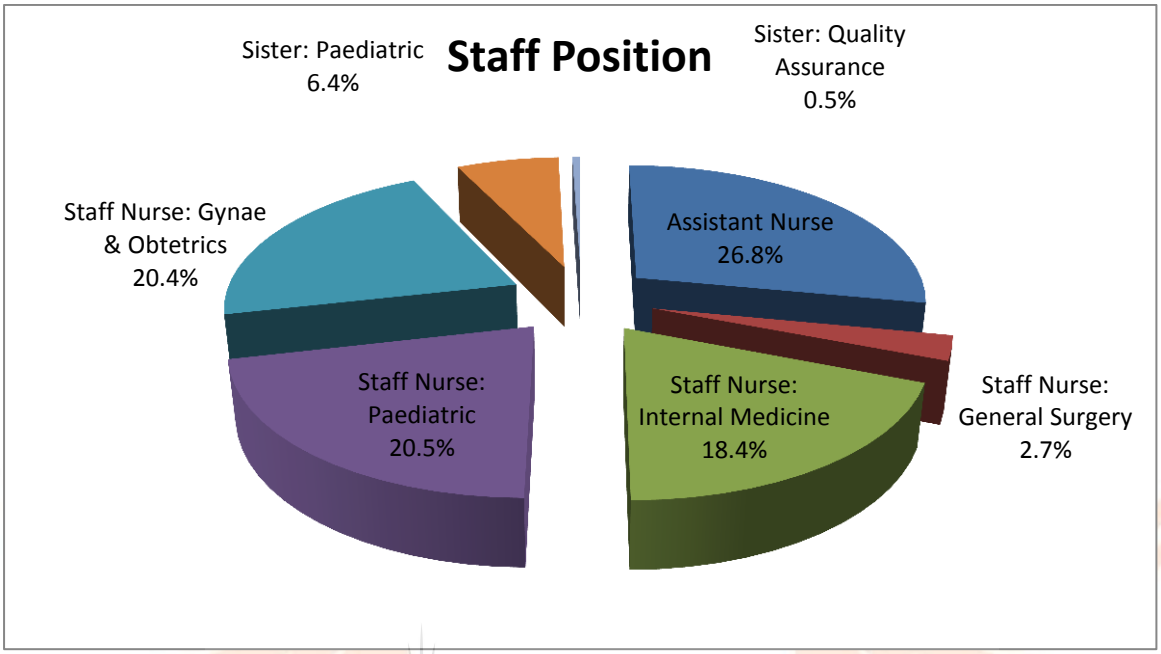


Figure 5.4: Staff Position of the respondents

5.3.1.5 Highest educational level

Table 5.4: A Summary of the respondent's highest educational obtained

Table5.4 illustrates categories of the respondents' highest educational level. Most of the respondents (n=148; 80.0%) had a post-matric diploma or certificate, followed by respondents with degree (n=34; 18.4%). The smallest number of the respondents (n=3; 1.6%) represented those with grade 12 (Matric, Std 10).

It was expected that the majority of highest educational level of nurses would fall between Grade 12 and post-matric certificate or certificate. It was assumed that the majority of nursing practitioners completed with their pre-nursing studies directly after completing their matric (Grade 12). In addition, the nurses were asked to whether they perceived there to be gap between the degree and post-matric diploma. Table

5.4 lists the data generated in order tom establish if nurses regard the importance of achieving highest health educational qualification.

Highest educational level	Frequency	Per cent
Grade 12 (Matric, std 10)	3	1.6
Post-Matric Diploma or certificate	148	80.0
Degree (s)	34	18.4

Table 5. 4: Highest educational level of the respondent

5.3.1.6 Years of current service

Table 5.5: A summary of years of current service working at the selected EMM public hospitals

Years of current service	Frequency	Percent
Less than 3 years	35	19.6
3-5 years	54	30.2
6-10 years	21	11.4
10 years and more	69	37.3

Table 5.5 provides an overview of the respondents working at the public hospital. The largest number of respondents (n=69; 37.3%) indicated that they were employed for more than 10 years and more, 30.2% (n=54) reported they are working for between 3-5 years, 19.6 % (n=35) are worked for less than 3 years whilst 11.4 % (n=21) are worked for 6-10 years. Furthermore, these results are also graphically depicted in Figure 5.5.

Figure 5.5: Years of current service working at the selected EMM public hospitals

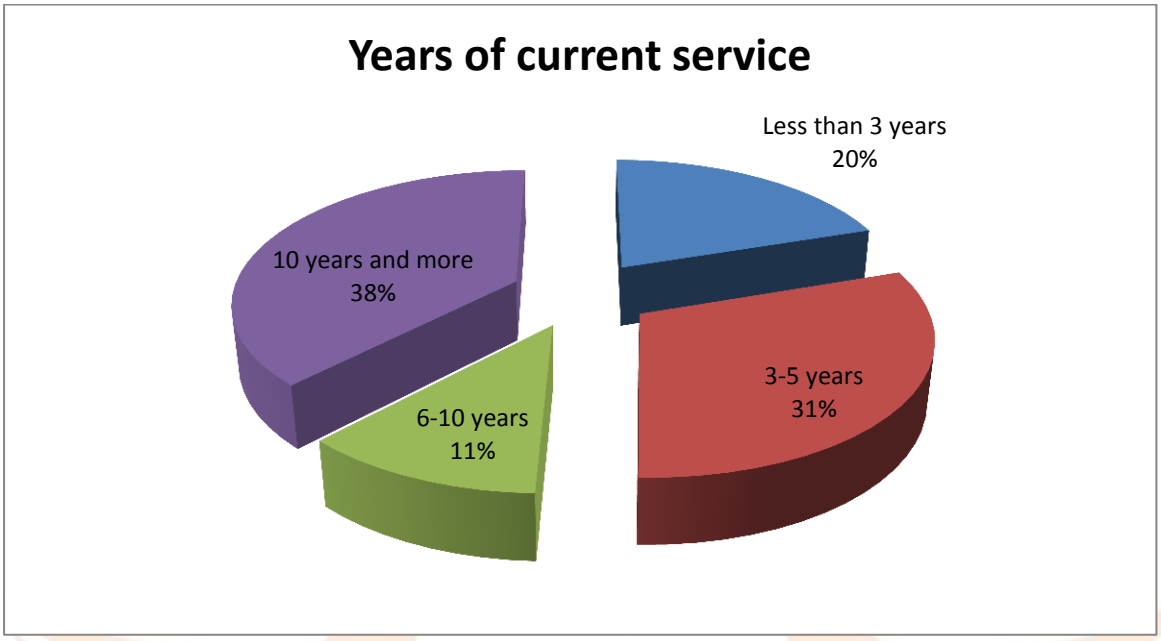


Figure 5.5: Years of current service

5.4 EXPLORATORY FACTOR ANALYSIS

This section provides an overview of Kaiser-Meyer Olkin (KMO) and Bartlett's test of sampling adequacy, methods of extraction, interpretation and discussion of constructs.

The KMO measure of sampling adequacy is an index used to examine the appropriate of factor analysis (Field, 2000:446). A value of 0.5 or above indicates that factor analysis is appropriate. On one hand, values below 0.5 imply that factor analysis may not be appropriate.

In this study, the factor analysis was carried out with the extraction done by principal component analysis and oblique rotation. According to Black &Porter (1996), this is consistent with the general agreement that factors of quality management are not unrelated to one another, that is, not orthogonal.

Table 5.6: KMO and the Bartlett's tests

	KMO measures of sampling adequacy	**Bartlett's (Chi-square) test**	**df**	**Sig**.
Policy Development	.852	915.284	28	.000
Training and skills support	.779	440.268	10	.000
Extensive specific assets	.621	460.975	10	.000
Reward and recognition systems	.790	777.409	21	.000

Table 5.6indicates that factor analysis is appropriate. According to Table 5.6the values were above 0.6, which indicates that KMO, Bartlett's test, degree of freedom (df) and significance (sig) were also considered satisfactorily for factor analysis. For factor analysis to be appropriate, the variables must be correlated (Field, 2000:437-8). Factor analysis with principal components was conducted on the policy development scale items. All the quality management practices had 25 items and each was rated on a five-point scale, ranging from '1' (strongly disagree) to '5' (strongly agree). Thus, the instrument has been tested, validated and refined with an attention in the context of public health institutions.

Overall these tests reflect that the dimensions used to measure the constructs of interest in this dissertation possess adequate internal stability and validity to provide confidence that they measure what they purport to.

In this dissertation, analysis of variance was carried out to determine if there is any significance or non-significance in the results of quality management practice. The four dimensions of practice of quality management in the public hospital, namely, the

policy development, training and skills support, extensive specific assets, and coordination and cooperation are discussed in the next section.

It is evident from Table 5.6that policy development; training and skills support, extensive specific assets, as well as reward and recognition systems are related with quality management practices. Pearson's chi-square test proves that a number of staff nurses did not practice quality of healthcare management in the public hospitals. This result indicates that there was no statistical difference between the percentages of the staff nurses practising quality of healthcare in the public hospitals, which can be termed as a positive moderate correlation at the given levels whereby p<.000 for all four scales measured . As a significant positive relationship exists, therefore, there is support for this research question.

5.4.1 Percentage of variance

Hair, Anderson, Tatham & Black (1998) asserted that the percentage of variance approach implies that the number of factors extracted is determined so that cumulative percentage of variance extracted by the factors reaches a satisfactory level, and the author recommends that the factors extracted should account for at least 60% of the explained variance.

Table5.7: Percentage of variance explained and eigenvalue

Component	Eigenvalue	% of Variance	Cumulative %
1	4.426	55.324	55.324

5.4.2 Eigenvalue

An eigenvalue represents the amount of variance associated with the component. This view is supported by Hair *et al*. (1998) who noted that only components above 1.0 are retained and the other factors with an eigenvalues less 1 should not be included in the measurement model. In this study, principal axis factoring revealed the presence of one component with eigenvalue exceeding 1, accounting for 55.3% of the variance, which is acceptable (Black & Porter, 1996)

Based on the value shown in Table 5.7, component 1 captures much more of the variance than the remaining components. Thus, this component returned an eigenvalue above 1. The finding, as shown in Table 5.7, suggests that factors of quality management are not practised in the selected Ekurhuleni state hospitals accordingly. After the extraction of components, the scales were labelled taking into account the appropriateness of the variable loading within each scale, and each component is discussed in the following section.

5.5 Section B: QUALITY MANAGEMENT PRACTICES IN THE HOSPITALS BY NURSING STAFF

The following section provides descriptive results of quality of health care practices

According to data generated from Table 5.8 (following later) the following aspects were considered as ***strongly agreed/agreed*** by the respondents regarding policy developments

i. understand healthcare policy (55.6%)
ii. management support healthcare system (58.4%)
iii. implement quality of care (43.2%)
iv. quality management related problems (52.7%)
v. aspects of quality management (59.4%)
vi. quality management processes (52.4%)

The following positive aspects were commented on by one of the respondents, when asked how they understand and implement policy developments. Here are some of the responses received:

"...From my own viewpoint, healthcare policy emphasis better service quality to patients. Introduction to the booking system where patients book their files for the next visit. Files are found readily available when they come back" (Nurse 10, Male, 32).

In addition, two nurses revealed, that if provided with educational and skills support they would able to apply health care policy to their work. This is evident from the first nurse who said: *"...it is very difficult to practice care because I do not understand healthcare policy. There is need for on-going support from managers especially unit managers, especially the learning of quality care principles" (Nurse 11, Female 40)*

The other one said in reference to hospital operational management"...*Quality management is not thoroughly professional in this institution. There is no equipment, human resources personal are no longer motivated because of lacking resources. Quality management is declining there is no support from management and no participants" (Nurse 12, Female 38)*.

According to Table 5.8 the following aspects were considered as ***strongly disagreed/disagreed*** relating to training and skills support.

i. adequate training for quality of health care (83.2%).
ii. committed in quality management training (72.3%).
iii. nurses are motivated to advanced training and education (68.5%).
iv. nurses to learn new skills (61.7%).

The nurses commented that the training and skills provided were not enough and this made it difficult for them to apply their knowledge and skills. This was evident from one nurse who commented that: "....*Nurses are not happy with the content of training because we are learning old modules (syllabus) like private nursing college; there you learn one similar information about patient care" (Nurse 2, Female 42).*

The nurses felt that the training programmes are not well offered and this made it hard for the nursing practitioner to provide quality of health care in their hospitals. In one hospital, the researcher observed the patients waiting a period of one hour in the paediatric ward due to the fact that there is shortage of nurses working in this ward. This was supported by comments that: "...*training programmes are in the institution where new skills are taught but no motivation to advance training and education. Nurses to be sent to proper nursing colleges and not private nursing colleges. Recruitment to be done at younger age (Nurse 12, Female, 38)*

According to Table 5.8 the following aspects were ***strongly disagreed/disagreed*** according to the respondents' perceptions:

i. hospital is well resourced (51.1%)
ii. sufficient nurses in this hospital (64.1%)

The research explores extensive specific assets used by nurses in the hospitals as resources, materials and skills in their work environment. The findings show that there is need for more resources such as experienced and skilled nurses. This is shown by one of the responses received: "*...there is a shortage of equipment that must be used to render quality service. Nurse patient ratio is one to fifty four in paeds, neonatal is one to sixty, which is wrong. More nurses need to be employed and have the necessary skills in neonatology, paeds NICU" (Nurse 5, Female 34).*

The researcher found that there is a need for proper planning, organization and coordination relating to hospital assets. This was evident from one of the nurses who commented that: "....*there are insufficient nurses in this hospital. Ward needs to be renovated and no time to get all my work done efficiently. There is workload and also need for younger generations with passion and determination (Nurse 4, Male 39).*

According to Table 5.8the following aspects were ***strongly agreed/ agreed*** according to the participants' perceptions:

i. performance reward (34.3%)
ii. reward systems used (32.4%)
iii. motivated and committed nurses are promoted (28%)

In the case of reward and performance recognition, the researcher found that nurses do not agree that the performance reward system is fair and clear to them. The statistical results indicate that only 28 % of the respondents are motivated and promoted. Here are some of the responses received: "...*Employees are not motivated here because performance appraisals are not done fairly. Senior*

managers need to support every nurse and also make sure that performance appraisals lead to motivated and committed nurses (Nurse 1, Female 36).

Another nurse commented: "...*Performance appraisal is not compliant to the guidelines it's not properly done, people are not served as motivation factor to encourage personnel to perform excellent in their work (Nurse 3, Female 41).*
It was suspected that the majority of nurses, who are not motivated and committed at any given organization, did at first not possess higher educational qualifications in order to recognize him or her as competent and skilled employee.

Table 5.8: Quality of health care practices of respondents (*n*=185)

POLICY DEVELOPMENTS		Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Total
I understand healthcare policy from an emphasis in primary care clearly	**COUNT**	30	49	3	90	13	185
	ROW %	16.2%	26.5%	1.6%	48.6%	7.0%	100%
Management support for healthcare system leads to developments in primary care	**COUNT**	10	57	10	87	21	185
	ROW %	5.4%	30.8%	5.4%	47.0%	11.4%	100%
The practice to implement quality of care is clear to me	**COUNT**	12	74	19	74	6	185
	ROW %	6.5%	40.0%	10.3%	40.0%	3.2%	100%
I achieve an appropriate level of quality management in my work	**COUNT**	13	70	20	68	13	185
	ROW %	7.1%	38.0%	10.9%	37.0%	7.1%	100%
I implement quality management for most task	**COUNT**	20	57	16	78	14	185
	ROW %	10.8%	30.8%	8.6%	42.2%	7.6%	100%
My manager supports me when I have quality management related problems	**COUNT**	14	59	14	86	11	185
	ROW %	7.6%	32.1%	7.6%	46.7%	6.0%	100%

I like some aspects of quality management but not others	**COUNT**	15	53	7	70	40	185
	ROW %	8.1%	28.6%	3.8%	37.8%	21.6%	100%
I think the quality management processes used in this hospital are a waste of time	**COUNT**	26	49	13	72	25	185
	ROW %	14.1%	26.5%	7.0%	38.9%	13.5%	100%
TRAINING AND SKILLS SUPPORT		**Strongly disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly agree**	**Total**
I have received adequate training for quality of health care practices	**COUNT**	59	94		29	3	185
	ROW %	32.1%	51.1%		15.8%	1.6%	100%
Management is committed in Quality Management training	**COUNT**	30	103	11	37	3	185
	ROW %	16.3%	56.0%	6.0%	20.1%	1.6%	100%
Every nurse is happy with the content of training	**COUNT**	33	105	17	29	1	185
	ROW %	17.9%	57.1%	9.2%	15.8%	0.5%	100%
Health managers encourage nurses to learn new skills	**COUNT**	26	87	11	50	9	185
	ROW %	14.2%	47.5%	6.0%	27.3%	4.9%	100%
EXTENSIVE SPECIFIC ASSETS		**Strongly disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly agree**	**Total**
The hospital is well resourced	**COUNT**	57	37	8	67	15	185
	ROW %	31.0%	20.1%	4.3%	36.4%	8.2%	100%
I feel safe working in this hospital	**COUNT**	34	59	3	69	19	185
	ROW %	18.5%	32.1%	1.6%	37.5%	10.3%	100%
There are sufficient nurses in this hospital	**COUNT**	48	70	6	45	15	185
	ROW %	26.1%	38.0%	3.3%	24.5%	8.2%	100%
In this hospital, there is a shortage of experienced and skilled nurses	**COUNT**	39	50	3	46	46	185
	ROW %	21.2%	27.2%	1.6%	25.0%	25.0%	100%

I have enough time to get all my work done efficiently in a normal work day	**COUNT** **ROW %**	52 28.3%	42 22.8%	5 2.7%	56 30.4%	29 15.8%	185 100%
REWARD AND RECOGNITION SYSTEMS		**Strongly disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly agree**	**Total**
Performance reward for being the best worker is fair and square	**COUNT** **ROW %**	50 28.1%	67 37.6%		60 33.7%	3 1.6%	185 100%
Reward systems used in this hospital allow nurses to reflect on their performance	**COUNT** **ROW %**	22 12.4%	95 53.4%	3 1.7%	55 30.9%	3 1.7%	185 100%
In this hospital, every nurse goes through a reward system	**COUNT** **ROW %**	24 13.6%	90 50.8%	18 10.2%	42 23.7%	3 1.7%	185 100%
I am satisfied with the salary I receive	**COUNT** **ROW %**	141 79.2%	33 18.5%	3 1.7%	3 1.6%	3 1.6%	185 100%
Employees are motivated in this hospital	**COUNT** **ROW %**	53 29.8%	90 50.6%	10 5.6%	25 14.0%	7 3.5%	185 100%
Senior managers support system lead to satisfied employees	**COUNT** **ROW %**	33 18.5%	84 47.2%	17 9.6%	42 23.6%	2 1.1%	185 100%
Highly motivated and committed nurses are promoted	**COUNT** **ROW %**	41 23.4%	72 41.1%	13 7.4%	45 25.7%	4 2.3%	185 100%

5.6 Section C: RELIABILITY OF THE INSTRUMENT

Table 5.9 Reliability analysis of nurses for quality management practices.

Scale	No. of items	Mean	Standard Deviation	Cronbach's Alpha
Policy development	8	24.88	9.719	0.805
Training and Skills support	5	11.62	5.223	0.849
Extensive specific assets	5	13.99	7.171	0.708
Coordination and cooperation	7	15.58	7.094	0.864

Table 5.9 shows a listing of the Cronbach's Alpha coefficient values on all 25 items of the questionnaire that consistently measured the constructs of the quality management practices in the hospital service delivery dimensions and justified the analysis of the data from the instrument. The instrument was found to have Cronbach's coefficient alpha of 0.70, which is considered the acceptable level (Hair, *et al*., 1998). In this study, all except two of the items were found to have item –total correlations greater than the acceptable limit of 0.3 (Houser, 2012; Hair *et al*.,1998). Since the increase in alpha was marginal if these items were to be deleted, thus they were retained for further studies. In addition, these items were also regarded as important to this dissertation since policy development is one of the important scales of quality management.

5.7 RESULTS OF THE QUALITY MANAGEMENT PRACTICES OF NURSES

The results of the data on the quality management practices of public hospital nurses were drawn from a questionnaire using a Likert-scaled items from 1(strongly disagree) to 5 (strongly agree). In this regard, the numbers 1 to 2 of the scale indicated moderate need for quality management practices; 3 indicated neutral and the numbers from 4 to 5 indicated strong moderation for quality care management. The significance and non-significant results of the following service quality

management scales were considered: Policy development, Training and Skills support, Extensive specific assets, Coordination and cooperation. The reliability of the questionnaire is summarized in Table 5.9. Cronbach's Alpha coefficients were calculated for the reported need for quality management practice and service delivery.

It can be therefore stated that the reliability of the items in the scales of the questionnaires Cronbach's Alpha was above7, as indicated in Table 5.9. According to Burns and Grove (2005:454), the purpose of Alpha coefficient values of the items is to justify the analysis of the data from the questionnaire. This section will focus on the examination of data description. This will be done on each dimension using mean scores; standard deviations and a listing of Cronbach's Alpha of the quality management practice scale of nurses (see Table5.9).

5.7.1 Policy development

The professional nurse has a major responsibility for his or her employer to ensure that the care given is safe and effective (Searle, 2005:195). It is for this reason that nurses must have a clear understanding of any health professions Act including the Nursing Act in South Africa. Kemp and Richardson (1994:84) discuss the Code of Professional Conduct which is expected from nurses to practice quality of nursing for patients, colleagues and the practitioners themselves. They further state that measuring the setting standards for nursing care is a way of assuring society of the quality of the profession's practice. There were 8 items on policy development in the instrument. The Cronbach's alpha coefficient indicated an acceptable level of 0.805, resulting in an internal consistency and reliability of the items in the instrument on the policy developments dimension.

Table5.10Quality management practice regarding policy development

Policy development	Mean	Standard Deviation
B1.1 I understand healthcare policy from an emphasis in primary care clearly	3.04	1.300
B1.2 Management supports the healthcare system, leading to developments in primary care	3.28	1.173
B1.3 The practice to implement quality of care is clear to me	2.94	1.092
B1.4 I achieve an appropriate level of quality management in my work	2.99	1.150
B1.5 I implement quality management for most tasks	3.05	1.213
B1.6 My manager supports me when I have quality management related problems.	3.11	1.151
B1.7 I like some aspects of quality management but not others	3.36	1.316
B1.8 I think the quality management processes used in this hospital are a waste of time.	3.11	1.324

The data analysis of the items within the policy development scale indicated that the participants reported a moderate need to be practised on the following items: healthcare policy in primary care (mean=2.30, SD=1.300); management support healthcare system (mean=3.28, SD=1.173); quality management related problems (mean=3.11, SD=1.151); quality management processes used (mean=3.11, SD=1.324) - see Table 5.7. It is important to learn and understand new health policies and new principles in health care in order to increase a higher quality of patient care (Searle, 2005:393). It is in the South African health care system that the nurse's education must equip him/her to meet this growing need for policy development (Mashaba & Brink, 1994:100). Thus, there is a need to strengthen nursing practitioners in support of strategies for health for all.

Strategy on policy development

Understanding healthcare policy, management supporting healthcare system, as well as quality management processes and problems regarding the nursing practitioners need to be monitored

5.7.2 Training and skills support

Training and skills can be defined as a process in which a person acquires knowledge to perform specific activities in a working environment (Houser, 2012:19).There were 5 items on training and skills support in the instrument. The Cronbach's alpha coefficient reported an acceptable level of 0.849 (see Table 5.9), resulting in an internal consistency and reliability statistic of the items in the instrument on the training and skills support scale. The statistical results, the values range from 2.02 to 2.61, which corresponds to a 'moderate' to 'high' level of practice. In addition, the results indicated that nurses reported that there was a moderate need for practising quality management on all of the 5 items. Thus, training and skills support of nurses mean values for the perception of importance and practice were analysed on the following items: management is committed in quality management training (mean=2.35, SD=1.029); nurses are motivated to training and education (mean=2.41, SD=1.093); health managers encourage nurses to learn new skills (mean=2.61, SD=1.171); content of training (mean=2.23, SD=1.093); committed in quality management training (mean=2.35, SD=1.029) are shown in Table 5.11.

Table 5.11 Training and Skills support

Training and Skills support	Mean	Standard Deviation
B2.1 I have received adequate training for quality of health care practices.	2.02	1.005
B2.2Management is committed in quality management training	2.35	1.029
B2.3 Every nurse is happy with the content of training	2.23	.925
B2.4 Nurses are motivated to advanced training and education	2.41	1.093
B2.5 Health managers encourage nurses to learn new skills	2.61	1.171

The success of health care, and patient well-being, depends on the quality of management at every level of service (Searle, 2005:77). The senior and hospital managers need to understand the significance of training and education for the nurses to ensure patient care. According to Searle (2005:57), a person who is enrolled under a section of a Nursing Act, needs to enter the four year comprehensive programme. The recent study by Houser (2012:19) suggests that there is an increasing amount of literature supporting the view that education and training improve knowledge and competence. This can be accomplished by creating a culture in which the quality training programme is valued and supported.

Strategy plan on training and skills support

Every nurse is required to enrol and equip themselves with advanced quality management courses. Facilitation of educational and training programmes for all nurses are essential leadership qualities on which nurse managers ought to be monitored.

5.7.3 Extensive specific assets

Assets can be defined as material, resources and funds acquired by the profession from society at large (Chinn & Kramer, 1999:44). There were 5 items on extensive specific assets in the questionnaire. The Cronbach's alpha coefficient indicated an acceptable level of 0.708, resulting in an internal consistency and reliability of the items in the questionnaire on extensive specific assets.

Table 5.12: Quality management practice regarding extensive specific assets

Extensive specific assets	Mean	Standard Deviation
B3.1The hospital is well resourced	2.71	1.434
B3.2 I feel safe in this hospital	2.89	1.359
B3.3There are sufficient nurses in this hospital	2.51	1.326
B3.4In this hospital, there is a shortage of experienced and skilled nurses	3.05	1.543
B3.5 I have enough time to get all my work done efficiently in a normal work day	2.83	1.509

Resources, safety and sufficient nurses are required in a hospital to have operational and clinically influential evidence-based practices in place (Houser, 2012:510). In view of this argument, it is interesting to observe that nurses have indicated that there is a shortage of experienced and skilled nurses in the public hospital wards. It is believed that hospitals must be well equipped. It implies a move toward retention of skilled nurses. Doing so requires extensive support and moral courage by the top management level. Bowman (1995:87) confirmed this dimension on patients' needs. It is believed that hospitals must be well equipped. As Chinn &Kramer (1999:158) put it, the health care organization requires adequate assets if the nursing's purpose is to be realized. It implies a move toward retention of skilled nurses. Doing so requires extensive support and moral courage by top management level.

Strategy plan on extensive specific assets

A hospital ward manager demonstrates the ability to coordinate multiple nurse and patient care through allocation of human and material resources in order to meet the specific needs of nurse and patient. Human resource development including staff retention and work scheduling are important activities requiring attention from hospital senior managers, line-managers and supervisors. In summary, it is important to develop team work consisting of all stakeholders within any organization.

5.7.4 Coordination and cooperation

Coordination and cooperation ensures all equipment, nursing staff and patients are adequately maintained in good order and are properly used (Riehl- Sisca, 1989:311). There were 7 items on coordination and cooperation in the questionnaire. The Cronbach's alpha reported an acceptable level of 0.864, resulting in an internal consistency and reliability of the items in the instrument on coordination and cooperation.

Table 5.13: Coordination and cooperation

Coordination and cooperation	Mean	Standard Deviation
B4.1Performance reward for being the best worker is fair and square	2.41	1.233
B4.2 Reward and systems used in this hospital allows nurses to reflect on their performance	2.56	1.104
B4.3 In this hospital, every nurse goes through a reward system	2.49	1.051
B4.4 I am satisfied with the salary I receive	1.24	.499
B4.5 Employees are motivated in this hospital	2.04	.959
B4.6 Senior managers support system lead to satisfied employees	2.42	1.077
B4.7 Highly motivated and committed nurses are promoted	2.42	1.171

The statistical results on cooperation and coordination reflected that nurses indicated a moderate need to be coordinated in this area (see Table 5.10). A summary of the items include a need to be coordinated: performance reward for being the best worker is fair and square (mean=2.41, SD=1.233); Reward and system allows nurses to reflect on their performance (mean=2.56, SD=1.104); every nurse goes through a reward system (mean =2.49, SD=1.051); satisfied with the salary I receive (mean=1.24, SD=0.499); employees are motivated (mean=2.04, SD=0.959); senior managers support system leads to satisfied employees (mean=2.42, SD=1.077); highly motivated in this hospital (mean=2.42, SD=1.171).

When discussing coordination of care, it is important for the hospital ward manager to have time to show the work to their colleagues and allow his or her subordinates to relay suggestions related to the work to be performed. This will create an atmosphere that enables the nurses to share ideas and critically analyse what and how they are doing. An analysis of poor quality of care, unmotivated and lack of commitment are essential in cooperation management for remedial actions.

It can be observed that all participants rated at 'moderate' to 'high' for degree of coordination and cooperation in their hospitals, reflecting that public hospitals are struggling to coordinate human resource planning and planning successfully. In addition, it must also be noted that this requires positive support which includes education and time (Kemp & Richardson, 1994:99).

Strategy plan on coordination and cooperation

It is important that nursing department members who are responsible for evaluating the nursing performance are clear on what is to be evaluated and good performance is to be conducted and rewarded to stakeholders. Employee performance, quality healthcare practices, and reward system are important needs on which hospital managers ought to be coordinated.

5.8 PATIENTS SURVEY RESULTS

The biographical variables of the sample were analysed employing nominal-scale measurements of the participant's gender, age, race group, hospital where admitted and present activity. The total sample of the participants (N=29) resulting in a 0.36% response rate of the 80 questionnaires distributed.

5.8.1 Section A: GENDER OF RESPONDENTS (N=29)

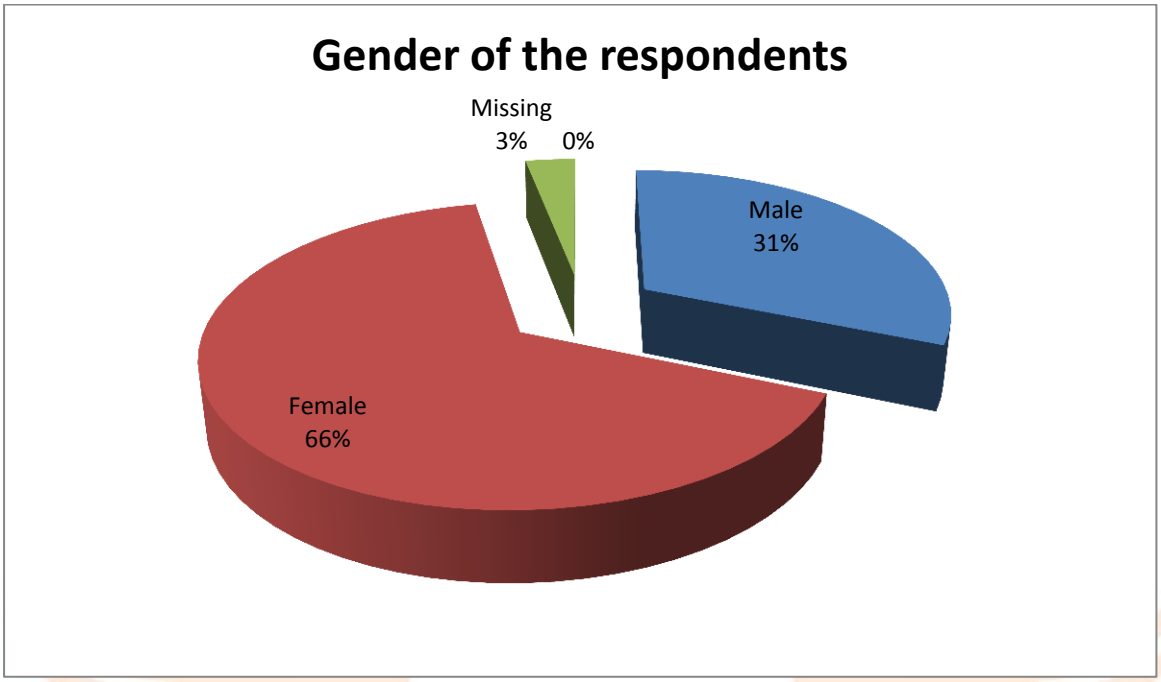
Table 5.14: A summary of gender of the respondents (Patients) (N=29)

Gender of respondents	Frequency	Per cent
Males	9	31.1%
Females	19	65.5%
Missing	1	3.4%
Total	29	100

Table 5.14: Gender of the respondents (patients)

Table 5.14 presents the gender of the biographical data of the respondents. The majority of the respondents were females (N=19; 65.5%) whilst 31.0 % were male (N=9; 31.0%). Based on this evidence an assumption can be made that in the Ekurhuleni region, gender of the respondents was predominantly female. These results are graphically depicted in Figure 5.8

Figure 5.8: A Summary of gender of the respondents (patients)



5.8.2 Age of the respondents (N=29)

Table 5.15: Age of the respondents

Age of the respondents	Frequency	Per cent
19-30	15	51.3%
31-40	8	27.6%
41-50	3	10.3%
Older than 51	2	6.9%
Missing system	1	3.4%
Total	29	100.0%

Table 5.15: Age of the respondents (patients)

Of the 29 respondents, the majority of the respondents were in the age 19 to 30 (N=15; 51.3%); whilst age of the respondents 31 to 40 (N=8; 27.6%); age group 41 to 50 (N=3; 10.3%) and older 51 age group (N=2; 6.9%).

5.8.3 Race group of the participants (N=29)

Table 5.16 (below) presents the race group of the respondents. The majority of the race group were African (N=23; 79.3%); whilst the white group (N=4; 13.8%) and the coloured group were smallest (N=1; 3.4%).

Table 5.16: A summary of race group of the participants

Race group of the participants	Frequency	Per cent
African	23	79.3%
White	4	13.8%
Coloured	1	3.4%
Missing	1	3.4%
Total	29	100.0%

Table 5.16: Race group of the respondents

5.8.4 Hospital where admitted

Table 5.17: A summary of hospital where patients admitted

Name of hospital admitted	Frequency	Per cent
Tembisa	11	37.9%
Germiston	10	34.5%
Natalspruit	8	27.6%
Total	29	100.0%

Table 5.17 indicates the hospital where patients were admitted. The majority of the respondents were from Tembisa Hospital (N=11; 37.9%); the second largest number of respondents were recorded from Germiston Hospital (N=10; 34.5%) and the smallest number were recorded from Natalspruit Hospital (N=8; 27.6%). In addition to this, it is important to note that the reasons provided for non-completion are discussed in Chapter 7 under limitations. These results are also graphically depicted in Figure 5.9

Figure 5.9: A summary of hospital where patients admitted

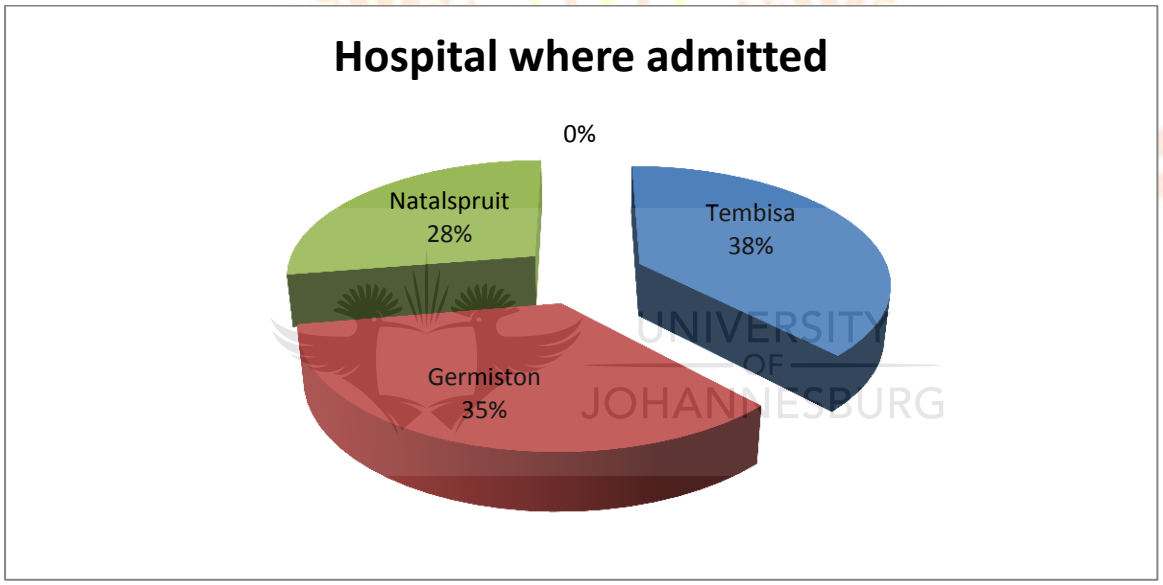


Figure 5.9: Hospital where admitted

5.8.5 Present Activity of the respondents

Table 5.18 reports on the present activity of the respondents. Both unemployed and part-time paid work categories indicated that the majority of respondents constituted (N=7; 24.1%) from each category within the present activity sample. Approximately 20.7 per cent (N=6) of the respondents indicated that they were full time students or learners, 13.8 per cent (N=4) were permanently sick or disabled, 10.3 per cent (N=3) reported that they were full time workers, while 3.4 per cent (N=1) indicated retirement category.

Table 5.18: Present activity of the respondents

Present activity of the respondents	Frequency	Per cent
Full time paid work (40 hours or more each week)	3	10.3
Part time paid work (less than 40 hours per week)	7	24.1
Full time education at school, college or university	6	20.7
Unemployed	7	24.1
Permanently sick or disabled	4	13.8
Retirement	1	3.4
Missing System	1	3.4
Total	29	100.0%

5.9 RELIABILITY OF THE INSTRUMENT

Table 5.19 Results of analysis (Reliability) for quality of patient care services

Scale	No. of items	Mean	Standard Deviation	Cronbach's Alpha
Satisfaction	5	15.58	6.187	0.903
Commitment	4	11.44	4.196	0.798
Specific assets	7	21.63	8.351	0.912
Coordination and cooperation	3	9.62	3.284	0.739

In establishing the reliability of the patient questionnaire, Table 5.19 reflects a listing of the Cronbach Alpha coefficient values of the items in the questionnaire that consistently measured the constructs of the quality care service delivery dimensions. According to Hair *et al.* (1998), a reliability value of 0.70 is an acceptable reliability coefficient and justifies the analysis of the data from the instrument.

5.10 Section B: PATIENTS' DIMENSIONS

5.10.1Satisfaction

Questions pertaining to the qualities of the public health environment explored whether patients had problems receiving care which affected patient recovery rate, had problems with administration clerks, and/or experienced problems with positive or negative relationships between the nursing personnel and other senior managers. Furthermore, the patients were asked whether they perceived there to be a sign of respect between the hospital and patients.

Table 5.19 indicates that most of the patients (N=18; 62%) responded that they were satisfied; some of the patients (N=11; 37.9%) responded that they experienced poor customer/patient satisfaction at the government hospitals. It is also interesting to note that (N=17; 58.6%) felt more positive about their relationship with the administration clerks, whilst 41.3 per cent (N=12) experienced negative relationships with the administration officers.

When asked to reflect on the relationship with the nursing practitioners, 55.1 per cent (N=16) responded that they had a high level of relationship with the nursing personnel, whilst 41.3% (N=12) indicated a serious need for nurse-patient relationship improvement. Meanwhile 3.4 per cent (N=1) was uncertain if he knew about existence of such relationships. In investigating these factors, it was also necessary to determine if the nursing staff had a relationship with their senior managers before concluding. A majority of the respondents 62.1 per cent (N=18) agreed that the relationship between senior managers and nursing practitioners is satisfactorily. The patients also indicated that their privacy was respected (N=16; 48.3%), whilst 44.7 per cent (N=13) claimed they did not agree that their privacy was respected by all the staff. Six point nine per cent (N=2) was uncertain. Here are some of the responses received:

"...I am not satisfied with the manner in which patient care is being offered in this hospital because there is shortage of medicine and experienced staff nurses"(Patient 1, Male 30)

"...There is a positive relationship between the patients and administration clerks. We are well respected in this hospital" (Patient 3, Female 45)

5.10.2 Commitment

The commitment questions explored whether the nursing staff and hospital management were committed or had to take care of uncommitted nursing practitioners at the public hospitals during patient care, which allegedly has negatively affected their healthcare service delivery performance.

Table 5.20 below reports that there were some patients who experienced high levels of quality of service delivery due to either committed or uncommitted hospital managers 51.7 per cent (N=15), whilst 48.2 per cent (N=14) suggested that quality of healthcare needs both the nursing staff and top management commitment. Furthermore, it was also necessary to determine the level of dedication in order to continue provide service quality. The results indicated that only a few nurses (N=11; 37.9%) were dedicated to continue providing service quality, whilst 62 per cent (N=18) claimed that nurses are not committed to offer quality of healthcare at the hospitals. These results indicate that the majority of patients had to be taken care of either by themselves or their family members during visits at the hospital. It was suspected that only a few nurses had been able to provide patient care due to many uncommitted nursing staff.

Draper *et al.* (2008:2) study on quality improvement activities in public hospitals reported that leadership and commitment are significantly higher in district and government hospitals than in the national referral centre. To that effect, it is acknowledged that the organizational structure could have an effect on practice of quality management (World Health Organisation, 2006).

5.10.3 Specific assets

The questions in this section explored whether patients perceived the hospital assets to be of a high quality standard and whether patients understood that health workers provide care to them and expected patients to know further in order to receive quality care in the public hospitals. The results indicate that few patients (40.39 %) did not perceive some of the hospitals to be well resourced. It was assumed that some of the patients did not understand that there is a patient' rights charter (see Chapter 3, sections 3.2.2, 3.2.3).

Here are some of the responses received:

"*…I feel there is need for improvement in terms of waiting hours in this hospital because sometimes administration clerks go for lunch-time while there is more people waiting at the administration office which shows that there is a shortage of staff members particularly clerks"(Patient 4, Female 29).*

"*…It seems nurses are not motivated to work in this hospital because they always talking about getting less money or salary from the department of health" (Patient 5, Female 33).*

5.10.4 Coordination and cooperation

The coordination and cooperation questions explored whether patient's rights are respected and coordinated. In summary, the results indicated that the majority of patients (57.43 %) agreed that patients' privacy and complaints are handled effectively. This factor was a main concern and was corroborated by the reviewed literature, which highlighted that patient's rights should be respected (see Sections 2.8.2).

Here are some of the responses received:

"…*I am not proud of this hospital simply there is need for urgent solutions. When dealing with patients' complaints patients are not handled immediately" (Patient 9, Female 48)*

"…I am proud of this hospital because it is based in my township and also grown up knowing it as my preferential hospital" (Patient 11, Female 29)

These responses strengthened the necessity for the staff nurses' training and skill development in the public hospitals, where nurses were taught how to communicate effectively and were patients were made aware of the medication processes, rather than the medication schedule, but also some healthcare organisations find it valuable to point out that the best way to achieve organisation success is by involving and empowering employees at all levels.

Table5.20: Patients' views of how quality of healthcare could be improved

SATISFACTION		Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Total
I am satisfied with the manner in which patient care is being offered in this hospital	**COUNT** **ROW %**	6 20.7%	5 17.2%		17 58.6%	1 3.4%	29 100%
In this hospital, there is positive relationship between the patients and administration clerks	**COUNT** **ROW %**	5. 17.2%	7 24.1%		16 55.2%	1 3.4%	29 100%
My relationship with the nursing workers reflects a happy situation	**COUNT** **ROW %**	3 10.3%	9 31.0%	1 3.4%	15 51.7%	1 3.4%	29 100%
The relationship between senior managers and nursing employees is satisfactory	**COUNT** **ROW %**	2 6.9%	8 27.6%	1 3.4%	14 48.3%	4 13.8%	29 100%
I think there is a sign of respect for the patients in this hospital	**COUNT** **ROW %**	1 3.4%	12 41.4%	2 6.9%	12 41.4%	2 6.9%	29 100%
COMMITMENT		**Strongly disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly agree**	**Total**
Service quality in this hospital is adequately provided	**COUNT** **ROW %**	1 3.4%	13 44.8%		15 51.7%		29 100%
Management is committed in quality health service as well as patient care	**COUNT** **ROW %**		13 44.8%		16 55.2%		29 100%
In this hospital, every nurse is dedicated to continuing to do service quality	**COUNT** **ROW %**	1 3.4%	17 58.6%		11 37.9%		29 100%
I think nurses have high levels of commitment with this hospital	**COUNT** **ROW %**	3 10.3%	15 51.7%	1 3.4%	10 34.5%		29 100%

SPECIFIC ASSETS		Strongly disagree	Disagree	Neutral	Agree	Strongly agree	Total
Nurses are empowered to concentrate on the welfare of patient care	**COUNT** **ROW %**	2 6.9%	10 34.5%	2 6.9%	14 48.3%	1 3..4%	29 100.0 %
The hospital is well resourced	**COUNT** **ROW %**	1 3.4%	12 41.4%	1 3.4%	8 27.6%	7 24.1%	29 100.0 %
The nurses are highly motivated in this hospital	**COUNT** **ROW %**	2 6.9%	13 44.8%	1 3.4%	12 41.4%	1 3.4%	29 100.0 %
I think there are enough nurses to perform to provide service	**COUNT** **ROW %**	3 10.3%	8 27.6%	1 3.4%	16 55.2%	1 3.4%	29 100.0 %
In this hospital, there are shortages of experienced and skilled nurses	**COUNT** **ROW %**	1 3.4%	11 37.9%		11 37.9%	6 20.7%	29 100.0 %
There is evidence of long waiting hours in this hospital	**COUNT** **ROW %**	1 3.4%	13 44.8%	1 3.4%	11 37.9%	3 10.3%	29 100.0 %
I would advise my friends to come to this hospital if they were sick	**COUNT** **ROW %**	1 3.4%	15 51.7%	2 6.9%	10 34.5%	1 3.4%	29 100.0 %
COORDINATION AND COOPERATION		**Strongly disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly agree**	**Total**
I am proud of this hospital	**COUNT** **ROW %**	2 6.9%	6 20.7%	3 10.3%	15 51.7%	3 10.3%	29 100.0 %
A patient's privacy is respected by the staff	**COUNT** **ROW %**		13 44.8%	2 6.9%	13 44.8%	1 3.4%	29 100.0 %
In this hospital, patients' complaints are handled effectively	**COUNT** **ROW %**	2 6.9%	9 31.1%		18 62.1%		29 100.0 %

The main objective of this study is to evaluate quality management practice in the Ekurhuleni public hospitals in Gauteng province. Thus, comparative analysis on quality management practices is made among the three selected EMM public hospitals. Furthermore, barriers to the implementation of quality management are also evaluated and again, comparison is made between the three chosen EMM hospitals. The perception of outcome of quality management implementation between nursing staff of Tembisa, Germiston and Natalspruit state hospitals is also analysed. Comparative analysis between the three selected hospitals can also shed some light into the effectiveness of the Ministry of Health in South Africa for national health systems (NHS).

5.11 CONCLUSION

This chapter presented the findings obtained from the questionnaire survey completed by nurses and patients within the quality management practice at the hospitals. The findings of this study found that there is strong evidence of challenges faced by state hospitals in implementing quality management due to the organizational structure and culture of the public hospitals. These shortcomings endanger the health and lives of all patients, add cost to the health care system, and reduce productivity (Department of Health, 1997:3). Accordingly, findings from this research project indicated that the following factors had a negative effect on nurses' healthcare performance and patients' care quality service:

i. The majority of nurses could not provide the quality of health care delivery service. Many nurses did not have any experience of how to utilize quality improvement activity as they never attended any formal training and professional development quality programme in hospital.
ii. Nurses are not coping with the quality of healthcare environment because they have limited resources to do so.
iii. There were nurses who indicated that they had to contend with extra domestic duties and responsibilities because they have family depending on them.

The finding from this research seems to suggest that although government may lack resources, they have to sustain and endure the quality improvement efforts over

time. Thus, to achieve necessary improvements, health policy for quality of health care is required, together with commitment from health employees, starting with leadership from the Ministry of Health Office, nursing staff, and patient education.

In addition to the above statements, this dissertation was directed to evaluate the quality management practice (policy development, training and skills support, specific assets, patient satisfaction, reward systems, commitment, coordination and cooperation), and quality of healthcare in Ekurhuleni public hospitals. The study started with the exploration of the present state of quality management practice in government hospitals and the relevant factors that may result in the application of quality management practices that can be utilized to facilitate improved quality systems in state hospitals. In summary, it is also hoped that the findings of this dissertation will contribute to the body of knowledge and the understanding of quality management practices in hospitals which has not been offered special attention.

CHAPTER SIX

GUIDELINES AND OPERATIONALISATION

"Since quality programs are dependent on good information systems, chief information officers have the opportunity to plan an integral and highly role in shaping the quality of the corporation"

Curt Riemann, Director
Malcolm Baldrige Award

6.1 INTRODUCTION

This chapter serves as a summary of the guidelines, motivation and the contribution of the study. It also provides extensive knowledge and skills for the health ministries, hospital CEOs, ward managers, nursing practitioners and all persons interested in implementation of the quality improvement activities in terms of healthcare environment. The empirical data gathered (see Sections 3.12.7, 3.15,3.16;Chapter 5) in terms of phase one and two including the conceptual framework related to phase 3 of this study are discussed and applied (see Sections 3.12.1, 3.13.1;Chapter 5). In this section, the researcher focuses on phase four of this research.

The purpose of the study is to describe guidelines to prevent poor quality care in order to promote quality management practice in public hospitals.

The data was gathered in four phases namely:

i. Phase One is to explore and describe the perceptions of the registered nurses relating to quality management practices of patient care in Ekurhuleni public hospitals
ii. Phase Two is to explore and describe the perceptions of the patients relating to quality management practices of registered nurses in Ekurhuleni public hospitals

iii. Phase Three describes the conceptual framework gathered from the empirical data in phase one and two
iv. Phase Four describes guidelines to prevent lack of quality care in order to promote quality management in the public health sector

In order to meet the objectives of this study, it is important for the registered nurses and other nursing practitioners to promote high quality care service delivery. It is therefore important to have understanding of the following guidelines. Furthermore, it should be noted that, for each guideline a rationale as justification and actions will be described.

6.2 GUIDELINEONE

The hospital unit manager/general manager employs a combination of quality standards development and associated methods for bringing about improvements in state hospital facilities.

6.2.1 Rationale

Based on the findings of the study, as the underlying causes of poor quality care in the public health institution, it was evident that the registered nurses worked long hours, a shortage of nurses existed and they were not trained to understand the intention behind the process of setting standards, and how to implement the health system recommended by the top management committee.

6.2.2 Action

As highlighted in chapter five (see Section 3.5.2, 3.5.4; Chapter 5), in order to prevent poor quality care and under-use and overuse of services in the public health sector, the hospital management must provide a quality improvement programme. This must include quality manuals and procedures aimed at educating and empowering every registered nurse and nursing practitioner to understand the established systems, processes required for safe, quality service provision in all clinical support, technical and management support.

The public hospitals must be structured in a way that reflects a health systems approach, and be accessible to all registered nurses and other nursing practitioners so that there is no confusion about who they are supposed to contact when quality of healthcare management arises. Formal evaluation of quality in healthcare services is also used to facilitate the process of patient care. Given the long-term nature of quality improvement programmes to address poor delivery of services and lack of resources, every professional nurse must be asked for their opinion regarding the quality standards setting at the hospital. This can create a sense of belonging and being part of the quality nursing care team. It must be noted that this study included a literature overview of poor quality in the healthcare situations. The registered nurse and other nursing members must be involved in the discussion of getting solutions. This means meetings and workshops must be conducted on a regular basis.

6.3 GUIDELINE TWO

The recruitment, selection and placement of nursing personnel must be done in terms of the competencies of candidates after interviewing and reviewing the applicant's attitudes and values, towards the quality of healthcare principles.

6.3.1 Rationale

Results obtained for the phase two of the empirical study in Chapter 5 revealed underlying causes of inadequate quality of healthcare practice within the Ekurhuleni state hospitals. Registered nurses and other nursing personnel who participated in this study indicated that recruitment and appointment into public service were not based on competence and ability. It was further found that there were no established criteria for the administration of posts. Employment was done to fill improperly determined nursing posts because recruitment and selection is conducted by the Department of Labour. This is why it is important to attract scarce skills and select highly competent individuals by applying sound recruitment and selection practices when interviewing the registered nurse and unit managers, before accepting them as nursing practitioners, to enhance service excellence.

From the patients' results obtained, the factors identified include lack of nursing skills and expertise. Some of the health workers do not meet the minimum qualifications for the post, lack responsibility, show negligence, ill-discipline, no patience, lack of dedication and are de-motivated. Promotions were based more on longevity of service than merit and insufficient hospitality and lack of knowledge in terms of quality improvement activities. This resulted in selecting the wrong candidates.

6.3.2 Action

In order to redress the above mentioned challenges, the hospital human resource management must establish the Recruitment Secretariat Board which will assist and facilitate appointments in the Ekurhuleni public hospitals. This will reduce costs associated with paying the Department of Labour for performing the recruitment and selection process of the hospitals. This is very important to ensure that a recruitment procedure is transparent. In this regard, this procedure is also important for evidence during investigations or audits to determine whether there were merit practices or not.

Furthermore, senior nursing positions must be filled from within the hospitals and this will assist in creating morale, career development and motivation of the hospital nurses.

Thus recruitment and selection would be meaningful. The health department has the role of ensuring that it establishes sound pay and incentive schemes which would be competitive within the current labour market in order to attract the qualified employees and be able to retain the existing labour force in the department of health.

6.4 GUIDELINE THREE

Quality improvement programmes and nursing process programmes must be in place and continually facilitated.

6.4.1 Rationale

This study focuses on the theory of quality management practices in the public hospitals. It is very important to note that some general discussion was made of the quality management literature in this dissertation. Based on the findings of the study, there is an existing health policy guiding the quality of care, however, the major training found to be provided to nursing practice for unit managers, senior nurse members, and the hospital division managers, is very inadequate for effective performance particularly in a sensitive sector such as hospitals. The study also revealed that registered nurses are not motivated and this was due to insufficient formal training in executing the desired quality programmes in hospitals.

6.4.2 Action

In the evaluation of importance skills for an effective nursing practice, quality programmes and nursing process programmes are necessary. Quality programmes must include the philosophy of the primary health care service, customer focus and satisfaction. Quality improvement manuals and procedures must be utilized to facilitate the registered nurse and other nursing practitioners as to their scope of practice and educate them about the scope of practice within the public hospital working environment. Nursing process and quality programmes must be in the form of lecturing sessions, practical demonstrations, videos and handbooks to ensure that the registered nurse possesses the required skills for the quality management practice in terms of patient care. In addition, quality teams must be formed to visit these lecturing sessions, observe the practical procedures and nursing process of supervision of the registered nurse in the working environment

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6.5 GUIDELINEFOUR

The ethics in professional nursing practice is used as a guideline for quality of health care management in the public hospitals.

6.5.1 Rationale

In this study it was identified that registered nurses were not aware of the professional codes of ethics in nursing and legal principles included in nursing practice for the patients. Based on the findings of the research, there was strong evidence of lack of accountability, negligence of nursing practice towards patients, no patience and lack of dedication.

6.5.2 Action

The acts shall underpin the following principles as highlighted in Chapter 2:

i. Quality Management System
ii. The Patient's (Client's) Rights Charter (Searle, 2005:101)
iii. Ethical codes of nursing professionals
iv. Constitution of the Republic of South Africa, 1996
v. Labour Relations Act No. 66 of 1995(Government Gazette no 17427)
vi. Public Service Regulations, 2001

6.6 CONCLUSION

In this chapter the guidelines have been described about nursing personnel, quality and health management and ethical and legal principles to deal with poor quality of healthcare in public hospitals.

The guidelines were based on the study findings (see Sections; Chapter 6)regarding poor quality of healthcare practice identified as contributing to patient healthcare, especially the Ekurhuleni based urban/townships hospitals.

The fact is that government and hospital management is the primary key in a process that is intended at enabling hospitals to offer efficient and effective health. The health ministry office is publicly agreed to be concerned with the transformation and adoption of health policy, whilst Management is responsible for the day-to-day operations of public health service.

CHAPTER SEVEN

SYNTHESIS, CONCLUSIONS AND RECOMMENDATIONS

At the heart of Total Quality Management (TQM) is the concept of intrinsic motivation. Empowerment-involvement in decision making- is commonly viewed as essential for assuring sustained results"

Healthcare Forum

7.1 INTRODUCTION

The quality improvements activities were developed from the findings of the study. It contains six main concepts: total quality management, quality benchmarking, quality function deployment, organizational culture, quality improvement tools and techniques (check-sheet, histogram, Pareto charts and analysis and cause-and –effects diagrams). There are nurses who have the potential to succeed within the public health sector. The patient at both the private and public hospitals has the right to be treated in a quality of health care manner. It is for this reason the researcher proposed this study to address this problem. In order to justify the quality improvement activities and nursing processes or the patient care at the Ekurhuleni public hospitals, this study included an overview of the literature. In this study, empirical research was conducted with the purpose of highlighting guidelines for quality improvement activities that can possibly also be used by other public hospitals in the country.

Chapter 1 provided the background of the study, introducing the objectives relating to the identified research problem and value of the research project. Chapter 2 offered a literature review to obtain perspectives on the nursing practice and quality care in South Africa. Chapter 3 dealt with the review of the literature to obtain perspectives on quality management systems, and reflected on aspects of importance related to Ekurhuleni public hospitals (abroad and national). Chapter 4 discussed the details of the research design, methodology, and collection of data

procedures which were utilized in this study. The quantitative data analysis for Phase 1 and 2 of the empirical study were presented in Chapter 5, while phase 3 findings were further described and analysed in Chapter 6. Additionally, Chapter 6 discussed the quantitative and the qualitative data analysis for Phase 4.

However, evaluating the social phenomenon of quality care from diverse perspectives and angles allowed triangulation of the comprehensive literature with the obtained dual set of empirical data. This permitted the researcher to elaborate, corroborate, and discuss the findings in order to accomplish the rationale of the study that comprised the nursing practice and patients for the public hospitals at the EMM. The final chapter dealt with the synthesis of the study and presents the conclusions and recommendations of the empirical study. This includes nursing process and quality of health care for the public health sector at the EMM.

7.2 SYNTHESIS OF THE STUDY

The main objective of the study was to evaluate quality management practices in the public hospital within the Ekurhuleni Metropolitan Municipality region. Therefore, the research questions were formulated as follows:

i. What is the system being used?
ii. How is this system supposed to work?
iii. Why is it used?
iv. What are the attitudes of staff to the management system?
v. How do the attitudes influence the implementation of the system?

In this study, an attempt has been made to investigate nursing practice and quality care in the area of Ekurhuleni. From the background to the problem researched in the study, it seemed that the nursing profession were not practising quality care services in the selected three Ekurhuleni public hospitals. This is mainly due to a lack of educational and training support; negligence, poor quality care, and shortage of nurses (see Sections 1.2, 1.3). An appropriate education and training programme for the nursing professionals has to comprise high-quality care to ensure the effectiveness and efficiency of health care delivery. This will enable staff to develop

standards or indicators of quality, monitor and evaluate the service being offered, and take action on the findings. Consequently, an appropriate quality care programme leads to setting up a steering group to advise and coordinate all quality activities. This, in turn, assists to redress the significant shortage experienced within the public hospital wards and operations divisions

The study was contextualized relating to the public health care sector as well as the good practice in the South Africa health care professions (see Section 2.10.1, 2.10.2).Over the last decade, the Department of Health has developed and implemented the concept of quality improvement activities and policies changes within the primary health care environment and, consequently, offered a basis for Batho Pele programmes to be implemented within the health environment. If the nurses could be educated to address a wide range of quality improvement activities and to use nursing resources effectively, this will likely provide insights about how hospitals can optimize resources to improve patient care quality. In order for the quality improvement activities to be successful, leadership support is important.

An overview of the primary health care sector in South Africa (see Section 2.2) described the Constitution of the Republic of South Africa, Act 101 of 1996, Chapter 2, No 27 in the health department, stating that everyone has the right to have access to health care services. It further revealed that the aim of the Health White Paper is to facilitate various implemented strategies designed to meet the basic needs for all citizens in the country. However, not all people needs are met in terms of public health resources available (see Section 2.12.1; Chapter 5).

National patient care quality benchmark tests are not yet available for selecting nurses who are most likely to succeed with their health studies at public health institutions. In this study, the researcher therefore focused on nursing practice and quality improvement that could be done in a more multidisciplinary fashion. Several respondents said that hospitals' identifying and promoting nurses and unit managers to quality improvement efforts reportedly assists and empowers registered nurses to engage in and move patient care quality initiatives forward. Respondents cautioned, however that knowledge, skills, abilities and competencies are the key to effective quality improvement efforts (see Section 1.3, 2.12.2). The fact that professional

nurses in the health sector should be trained and demonstrate technical skills is a major challenge for hospitals because it impacts not only their ability to provide caring in nursing, but also to provide sufficient nursing resources for key activities (see Section2.12.1; Chapter 5).

Data generated from the selected EMM public hospitals confirmed the causes underlying nurse failure to provide patients with quality of patient care within the public health sector. This justifies the need for intervention programmes at the public hospitals (see Section2.2).It is very important that the professional nurses understand the dimensions of quality service which involve responsibility and accountability. In the findings of this study, it became evident that inadequate quality care programmes had a profoundly negative impact on health care performance of nurses in public hospitals. Negligence and poor patient care of current EMM nursing professionals emphasised the need for a comprehensive quality of care programme for the primary health care to patients, hospitals and quality assurance programmes at public hospitals (see Sections 3.5.2, 3.5.3; Chapter 5).

The patients at the public hospitals have the right to be provided with high-quality health care services, and so the researcher proposed this study to address this statement of the problem.

In this study, the design was divided into four phases:

i. Phase One was to explore and describe the perceptions of the registered nurses relating to quality management practices of patient care in Ekurhuleni public hospitals
ii. Phase Two was to explore and describe the perceptions of the patients relating to quality management practices of registered nurses in Ekurhuleni public hospitals
iii. Phase Three describes the conceptual framework gathered from the empirical data in phase one and two
iv. Phase Four describes guidelines to prevent lack of patient care in order to promote quality management in the public health sector.

The objectives of the study were described in further detail in the next section.

7.2.1 Phase One

In this phase, the objectives were to explore the factors related to quality management practice by registered nurses in EMM public hospitals. A mixed method approach, contextual, descriptive and exploratory was utilized in this study (Houser, 2012:38; Woods, 1998:121).

According to Zikmund & Babin (2010:255) presenting a self-administered questionnaire survey using Likert scales, open-ended and closed questions to the target population, enabled data collection. Various questions related to patient care quality management were asked. All participants were given a questionnaire consisting of a covering page explaining the important points and purpose of the study (Refer to Annexure 1). The participants were offered 10 minutes of their own time to complete the questionnaire. The questionnaire was hand distributed and collected by the researcher himself.

In this study, confidentiality was assured and the participants were provided with the opportunity to withdraw if they wished or to partake in the study. Registered nurses working at the EMM public hospitals were the target population. A total sample of the participants was 185 registered nurses, particularly those providing primary health care service delivery to patients.

Non-probability sampling was employed in this study (Babbie *et al*., 2010:174).Purposive or judgemental sampling method was applied to achieve saturation of data and selection of registered nurses(N=185) and 1 unit manager in patient wards in Ekurhuleni public hospitals in Gauteng province, and to ensure the trustworthiness of this study (Burns & Grove, 1993:246; Houser, 2012:424;Lincoln & Guba, 1985).

The statistical software package SPSS version 17.0 was used to analyse raw data, as it is the standard software package used to analyse data in research projects, and the factors which could contribute to poor quality of patient care in public hospitals at

the Ekurhuleni region were explored. Results obtained for the phase one resulted in the problem of practising quality management in public hospitals for the patient care being attributed to lack of a quality assurance training programme, lack of coordination and mentoring, lack of support from top management, insufficient resources and motivation, and lack of knowledge about the aspects of the scope of the practice for the registered nurse.

The findings were presented, discussed and interpreted using table format, graphs and quotes from the respondents in Chapter 5, and factors were discussed in terms of corresponding quotes from the raw data.

7.2.2. Phase Two

The objectives of phase two were to describe the factors related to quality management practice by in-patients in EMM public hospitals.

Open-ended and closed questions were used to describe the factors involved in lack of quality care in public hospitals for the in-patients within the Ekurhuleni area. Four dimensions were used to measure quality of patient care (Phase 2 Chapter 2). A total sample was used of 29 patients, admitted in the selected three EMM state hospitals.

Results obtained for the second phase of the empirical study were analysed, resulting in the problem of poor patient care quality of registered nurses being attributed to incompetence, inadequate patient education programme, negligence, accountability, management, lack of resources such as qualified nurses and health care equipment, lack of knowledge of the patient's charter. The results of phase two were described in Chapter 5 with corresponding quotes from raw data that had been transcribed from the semi structured administered questionnaire designed for the patients admitted within the chosen public hospitals.

7.2.3 Phase Three

The objectives of phase three were to describe the conceptual framework gathered from the empirical data in phase one and phase two. Results obtained from the analysis in phase one and phase two, indicated that the areas attributing towards poor quality health practice in public hospitals for the patient care were, training and skills development, patient education, resources, management , and legal principles related to nursing practice.

7.2.4 Phase Four

In this phase, the objectives are described in Chapter 5 and the guidelines to promote high-quality service in public hospitals for primary health care by registered nurses and unit managers. Based on the findings of this study, these guidelines will focus on comprehensive training and skills development, patient education programmes, management commitment, employee involvement and legal principles, and quality assurance programmes.

7.3 RESEARCH EVALUATION

In this study, evaluation will be presented in terms to positive, negative issues, methods, section A and B of the instrument in terms of the process of the actual research.

7.3.1 Positive aspects

The findings of this research will be re-examined, the conclusion and implications will be highlighted and the positive and negative aspects will be summarized. Quality of care is conceptualised in this research as a process in which the health care institution meets its clients' needs and expectations, which can be assessed and measured against predetermined standards (Juran & Gryna, 1993:33; Ross, 1993:124; Omachonou & Ross, 1994:86; Oakland, 2003:145). According to Ross (1993:125), the purpose of the quality management for health care is to provide a

framework to assist hospitals organize for, communicate about and monitor continuously all aspects of health care delivery.

Internationally and nationally, QM practice has been recognized as an essential intervention to reduce the risks of poor care and inadequate management. As discussed in the literature review, Chapter 2 and 3discussed a wealth of data which was quantitative in nature mostly from the South African health care perspective and European countries and the quality consultants. Furthermore, this study also can add to the very limited amount of studies available within the South African public hospitals and can shed insight about understanding the phenomenon of quality care.

In this study, it was highlighted that practising quality management principles is the new paradigm in managing public hospitals, and attention should be given to the way in which it is responsibilities are assigned, developed, implemented and maintained.

The review of the literature revealed that while there are several studies on hospital management principles, there is not much study that focuses directly of the quality management practice in the public health institutions. Furthermore, this chapter highlighted that the results of the mixed method approach in terms of quality of patient care are somewhat contradictory in nature. The findings of the present study make sense somewhat relating to the literature provided in Chapter 2 and 3. Additionally, these findings are also meaningfully described within the scope of the registered nurse framework.

A mixed method approach was used in this study, which involved the self-administered questionnaire (closed and open-ended questions), and phenomenological interview (semi-structured). The open-ended questions method provided the respondents with the freedom to relate their most relevant nursing practice experiences of the quality of healthcare services. This allowed the researcher to expose the information and understanding of quality management practice from the nurses, patients and unit manager in the state hospitals. In this regard, various correlations emerged, which confirm the study's findings. In addition, this was performed in order to help with the research's validity and reliability and reduce the possibility of biases.

The results of the present research may be applicable within the contexts of public health environment at hospital and clinical practice. Based on the findings of the study, there exist potentialities with regard to future studies. Recommendations regarding these potentialities are detailed later in this chapter.

7.3.2 Negative aspects

The following limitations of this study were also acknowledged and are discussed below:

Firstly, it took about two months before the researcher received permission from the public hospitals' management to conduct the study. The sample of respondents especially the patients and senior managers in this study was small. There were only 29 patients and 1 unit manager. The majority of the participants were blacks who were admitted during the study. In this regard, these factors may limit generalization of the research's findings. Having said this, the researcher decided to use a patient questionnaire as qualitative studies do not generally concern themselves in relation to issues of generalization and representation

Secondly, it was not just the hospital management and sample of the patients who created limitations for the research; even the appointment with the patients for conducting the completing the questionnaire proved to be challenge for the researcher. This resulted in the researcher extending the data collection period over six months. Conducting the study related to patient care quality was viewed by some of the unit managers as very sensitive and who could not be made available for the study.

Thirdly, due to the researcher's time constraints not all areas of the hospital could be included in the questionnaire and interviews. Thus, for any future studies there should be enough time, to involve all areas to improve the reliability of data. It must also be noted that some participants were not prepared to elaborate on some of the questions asked, even though the researcher reassured them that their names would not be revealed in the study. The study was conducted in only three public hospitals

within the Ekurhuleni area, Gauteng and it is suggested that further research may be necessary to include and test the findings of this study in other public hospitals. For further research, it is important to note the characteristics of the sample already conducted should be the same as the one already completed.

It was further acknowledged by the researcher that the findings may not be generalizable due to the fact that only three public hospitals were covered and other Gauteng hospitals may differ markedly from provinces or regions. Quality care in health care literature is very limited in South African nursing profession and the findings should be interpreted within this context.

7.3.3 Methods

The instrument was designed to question participants about a topic that a review of the literature suggested was relevant to the quality of health care services delivery by the registered nurses to patients. The 25-item and 19-item questionnaire was reviewed by registered nurses and in-patients respectively, and amended accordingly. The researcher purposefully selected respondents responsible for primary health care of patients at the three selected state hospitals. It is very important to note that amendments were made after a pilot study was conducted, and reliability was measured with the assistance of an external statistician in order to ensure the validity of the data analysis and interpretation. The researcher further conducted a semi-structured interview with one unit manager at the hospital to ensure trustworthiness of the study (Lincoln &Guba, 1985:192). The interview took place in the unit manager's office. As a result the researcher did not disturb the smooth running of the hospital.

Further literature on quality of care in the health care sector was reviewed to ensure the content validity of the self-administered questionnaire. In this case both registered nurses and patient questionnaires consisted of two sections each.

7.3.4 Section (A) one of the instrument

This section described the characteristics of the population being studied, while Section 2 concentrated on the quality management practice within the registered nurses and patients in the Ekurhuleni public hospitals. The total sample of the registered nurses (N=185) resulting in a 52.9 % response rate of the 350 questionnaires distributed. This could be regarded as satisfactory due to the fact that a low response rate is generally associated with surveys. In this study, the researcher maintained anonymity and confidentiality, as participants remained anonymous to the researcher (Burns & Grove, 2005:188). Thus, the quantitative data from section A and B were analysed using the Statistical Package for Social Sciences (SPSS) version 17.0.

It must be noted that in this biographical information, the researcher was looking at the name of hospital, staff position, highest qualification level and years of service followed. Zikmund (2003:491) defined descriptive analysis as the process of transforming raw data into understandable information that so it is easier to interpret. Furthermore, the total sample in-patients (N=29) resulting in a 0.36% response rate of the 80 questionnaires distributed. In the case of this study, the researcher decided to transform the patient's raw data into a qualitative approach. A low response rate can raise questions about whether the responses obtained were representative of the sample or were in some way biased (Punch, 2003:52). This means section A& B of the patient survey were analysed using the combination of SPSS and content analysis.

7.3.5 Section (B) of the instrument

In this study, quality is more than a concept. Besterfield *et al*. (2003:4) indicate that Deming defined quality as a predictable degree of uniformity and dependability at low costs in service industries. The primary aim of the quality was to meet the needs of the customer, present and future. The data on the quality in healthcare of patients and registered nurses was yielded from a questionnaire using a 5 point Likert-scale. In this regard, the numbers 1 and 2 of the scale reflected disagreements for high-quality standards performed at the hospitals, to 3 neutral quality standards whilst 4

and 5 indicated extreme high quality performance and standards at the hospitals. Burns and Grove (2005:454) state that the questionnaire items indicated internal consistency using Cronbach's alpha coefficient and this reported an acceptable level of 0.7. The limitations of this study highlight a context for recommendations for future study in this area.

7.4 RECOMMENDATIONS

Based on the research findings and its applicability to public hospitals, the researcher would make several recommendations. Furthermore, the major problems of poor healthcare service delivery were identified, in particular the Ekurhuleni region, needs to consider the following presenting from the conclusions obtained in this dissertation.

7.4.1 Recommendation 1

The selection and recruitment process of the EMM state hospitals should be benchmarked against other comparable public health institutions. Currently, many people with grade 12 are recruited by the Department of Labour to work as nursing practitioners. It was concluded that an inadequate nursing qualification has a negative effect on the health care service delivery in the public hospitals. Therefore, human resource departments at the hospitals should be responsible for recruiting and selecting qualified professional nurses.

7.4.2 Recommendation 2

From a nursing point of view, the EMM hospitals have to consider quality improvement activities orientation and education programmes, and programmes for practice for registered nurses and other health workers. An important part of this practice is to maintain consistency and transparency within the public health sector. Nurses should be consulted and involved in the decisions regarding offering a nursing practice, quality care, and participate meaningfully in aspects. This will aid in ensuring the development and implementation of quality of health care service delivery.

7.4.3 Recommendation 3

The EMM hospital managers have to consider placing developing and implementing quality assurance /standards of care in their day-to-day operations. The shortage of experienced nurses within the public health sector also added to the long queues and long waiting hours of administration rooms and hospital wards, few experienced and qualified nurses had to help the excess patients at those hospitals. Authorities should also ensure that the qualified and experienced staff nurses are retained at the hospital. This might enable the registered nurse to deliver quality health care to patients, which, in turn, has a positive impact on the success of the organization.

7.4.4 Recommendation 4

Executive management in public hospitals need to realize that the appropriate coordination and cooperation of every nursing staff member in all hospital management divisions, as indicated and analysed in this, research is essential to achieve the objectives of the institutions. There is a need for the quality care facilities to manage and make available resources and information, including quality manuals, documentation, and software programmes to all hospitals within the Ekurhuleni area. "The nurse practitioner is concerned with all aspects of the quality of human life and health, for this is essential to socio-economic development" (Searle, 2008:392). Thus, nursing personnel need to be empowered with a higher quality of care knowledge.

7.4.5 Recommendation 5

Policies play an important role in any organization. The executive management of the hospital need to motivate the nurses to understand the legal framework within which nursing functions within the country. This will aid in ensuring professional practice is based on knowledge, responsibility and accountability. If there is a nurse who does not understand the concept and theory underlying nursing practice, professional practice cannot be said to exist. Therefore, the needs of the nurses must be identified and be equipped with the relevant knowledge necessary in this discipline.

The authorities need to assist their nursing personnel to understand its policies with regard to general management, patient care (all aspects) and high risk situations (Searle, 2008:236).

7.5 RECOMMENDATIONS FOR FURTHER STUDY

The identified problems about the Ekurhuleni based state hospitals' quality of patient systems affected the nursing practitioner performance and patient's health.

The following recommendations for further study were identified from this research:

i. The lack of quality of life support provided to nurses and /or patients' needs to be investigated.

ii. The problems relating to standards within the health care sector seems to pose huge problems to hospitals such as Natalspruit, Tembisa and Germiston. Thus, limited resources identified within this study need to be investigated further in order to determine whether the growth rate of hospital capacity realistically matches the growth rate of the patient population.

iii. The hospitals sampled currently have no total quality management systems to help ward nurses in providing patients with high-quality care. Further study needs to be conducted into developing and implementing Total Quality Management (TQM) programmes, benchmarked against other comparable public hospitals

iv. An assumption was made that nursing recruitment and selection should be conducted by the human resource departments within the organization. Further research should be conducted into preferred systems/process for the recruitment of qualified nurses in Ekurhuleni based government hospitals.

v. In addition, in any future studies there should be adequate time to include all areas to improve the reliability of data. It must also be noted that some staff members and patients were not prepared to elaborate on some of the asked

questions, although they were reassured that their names would not be stated in the study.

7.6 CONCLUSION

Based on the findings of the study, various conclusions could be drawn and are consequently described.

In this study, a majority of the conclusions were obtained from the first phase and the second phase of the empirical study about the reasons for registered nurses providing poor health care service delivery to patients at the Ekurhuleni public hospitals. Nursing refers to promoting the quality of life of their patients and to alleviate suffering (Searle, 2005:158; Draper, 1997:57).

The study investigated quality management practice in the Ekurhuleni public hospitals. The purpose was to describe how healthcare systems could be used and implemented to lead to quality of life in the area. The study was conducted in the three selected Ekurhuleni state hospitals. It was conducted with 185 professional nurses; 29 in-patients and 1 unit manager. A mixed method approach was used to collect data. Self-administered questionnaires (both closed and open-ended) were hand distributed by the researcher himself for the participants to complete. In order to meet the objectives of this study, documents were also analysed. Semi-structured interviews were conducted with one unit manager to gain insight into quality management practice in the hospital regarding health care service delivery.

Based on the findings of the study, registered nurses are not improving quality of life. The current system implemented is not developing them economically, as there was increased evidence of poor quality of health care and life. The research indicated lack of knowledge, comprehensive training and education. This if offered can lead to the quality improvement activities as well as personal growth and development. It also revealed the need to develop and implement TQM programmes relevant to the specific needs of public health care environment for the community of the Ekurhuleni region.

It can be concluded that this situation was studied and the objectives of the study into quality of life by registered nurses and in-patients in the chosen three public hospitals were achieved. Within the context of this research, it is relevant to quote the famous words of Charlotte Searle, the legendary and internationally renowned Professor who worked for universities in Africa such as Botswana, Namibia, South Africa, Lesotho and many other countries, who said: *"A human life is at stake, now or in the future, and that life has the right to protection by concerned persons so that in the end society as a whole may feel secure"* (Searle, 2008:103)

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APPENDICES

Appendix 1: registered nurse survey questionnaire

2430 Edenmore Street
Rabie Ridge Ext.5
MIDRAND
1632

May 2012

Dear Participant

RESEARCH PROJECT

I am a Masters student at the University of Johannesburg under supervision of Dr Andre Vermeulen. I am presently undertaking research about health workers and their perception on service quality. The purpose of this questionnaire is to evaluate quality management practice that is implemented in the area of your work. The questionnaire should take approximately no more than 10 minutes of your own time.

Your response in completing the following questionnaire is highly appreciated and much valued. Be assured that confidentiality is guaranteed and you remain anonymous. Your information will be used for RESEARCH purposes only.

You are requested to answer the question from your own views or experiences. There are no wrong or correct answers. Thank you for time and effort in completing the questionnaire enclosed.

Should you have any questions or comments regarding this survey, please feel free to contact us at:

Mr. Stephen Nyakala
Dept. Of Quality & Operations Management
University of Johannesburg
200574841@student.uj.ac.za

Study Leader: Dr. Andre Vermeulen
Faculty of Management Science
avermeulen@uj.ac.za

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CROSSING (**X**) IN THE APPROPRIATE BLOCK OR BY FILLING IN YOUR ANSWER IN THE SPACE PROVIDED.

EXAMPLE of how to complete this questionnaire:

Your gender?

If you are Male:

Male	1
Female	2

SECTION A:

This section seeks some background or biographical information about you. It is important to obtain this information, as this will allow the researcher to compare groups of participants. The information you provided will be anonymous because you are not required to give your name and will be confidential because your individual response will not be disclosed with anyone else

Please indicate your answer by crossing (x) in the relevant block or by filling in your answer in the space provided.

1. Gender

Male	1
Female	2

2. Indicate your age (in years)

3. What is the name of hospital that you are working at.....

4. What staff position do you occupy presently.....

5. Your highest educational level?

Grade 11 or lower (std9 or lower)	1
Grade 12 (Matric,std 10)	2
Post-Matric Diploma or certificate	3
Degree (s)	4
Post-Graduate Degree (s)	5

6. How many years of service do you have in the Department of Health?

Less than 3 years	1
3-5 years	2
6-10 years	3
More than 10 years	4

SECTION B:

This section explores your experiences regarding service quality. There are no wrong answers; all the study is interested in is a number that truly reflects your opinion. Please indicate the extent which you agree with each of the following statements by crossing (x) ONE of the five numbers to the statement using 5-point scale where:

1. =Strongly disagree, 2. =Disagree, 3. =Neutral, 4. =Agree, and 5. =Strongly Agree

POLICY DEVELOPMENTS						
No.	**Statement**	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
1.	I understand healthcare policy from an emphasis in primary care clearly?	1	2	3	4	5
2.	Management support healthcare system lead to developments in primary care.	1	2	3	4	5
3.	The practice to implement quality of care is clear to me	1	2	3	4	5
4.	I achieve an appropriate level of quality management in my work	1	2	3	4	5
5.	I implement quality management for most tasks	1	2	3	4	5
6.	My manager supports me when I have quality management related problems.	1	2	3	4	5
7.	I like some aspects of quality management but not others	1	2	3	4	5
8.	I think the quality management processes used in this hospital are a waste of time.	1	2	3	4	5

In your own words, please give your opinion on quality management practices that management implemented to control quality of care in the public hospitals. Please provide any recommendation regarding possible developments if any

.....

.....

TRAINING AND SKILLS SUPPORT						
No.	**Statement**	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
1.	I have received adequate training for quality of health care practices	1	2	3	4	5
2.	Management is committed in Quality Management training	1	2	3	4	5
3.	Every nurse is happy with the content of training	1	2	3	4	5
4.	Nurses are motivated to advanced training and education	1	2	3	4	5
5.	Health managers encourages nurses to learn new skills	1	2	3	4	5

In your own words, please give your opinion on level of education and training programme and any recommendation relating to training programme.

.....

.....

EXTENSIVE SPECIFIC ASSETS						
No.	**Statement**	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly agree**
1.	The hospital is well resourced	1	2	3	4	5
2.	I feel safe working in this hospital	1	2	3	4	5
3.	There are sufficient nurses in this hospital	1	2	3	4	5
4.	In this hospital, there is a shortage of experienced and skilled nurses	1	2	3	4	5
5.	I have enough time to get all my work done efficiently in a normal work day	1	2	3	4	5

In your own words, please give your opinion on resources, duties and working conditions with the hospital and any recommendation towards possible improvement.

.....

.....

REWARD AND RECOGNITION SYSTEMS						
No.	Statement	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1.	Performance reward for being the best worker is fair and square	1	2	3	4	5
2.	Reward systems used in this hospital to allows nurses to reflect on their performance	1	2	3	4	5
3.	In this hospital, every nurse goes through an reward system	1	2	3	4	5
4.	I am satisfied with the salary I receive	1	2	3	4	5
5.	Employees are motivated in this hospital	1	2	3	4	5
6.	Senior managers support system lead to satisfied employees	1	2	3	4	5
7.	Highly motivated and committed nurses are promoted	1	2	3	4	5

In your own words, please give your opinion on performance appraisals and motivation that health managers offer to employee used as an incentive regarding work performance. Please provide any recommendation regarding possible developments if any.

.....

.....

Thank you for taking the time to complete this survey

Appendix 2: Patient survey questionnaire

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CROSSING (X) IN THE APPROPRIATE BLOCK OR BY FILLING IN YOUR ANSWER IN THE SPACE PROVIDED.

EXAMPLE of how to complete this questionnaire:

Your gender?

If you are Male:

Male	1
Female	2

SECTION A:

This section seeks to obtain background or information about you. It is important to obtain this information, as this will allow the researcher to compare groups of participants. The information you provided will be anonymous because you are not required to give your name and will be confidential because your individual response will not be disclosed with anyone else

1. Gender

Male	1
Female	2

2. Indicate you age (in years)

3. What is your race group?

African	1	White	2	Coloured	3	Indian	4

Other

(specify).....

4. The name of the hospital that you are admitted.....

5. Which of these best describes what you are doing at present?.....

.....

.....

If more than one of these applies to you, please **X** the main ONE only

Full-time paid work (40 hours or more each week)	1
Part-time paid work (less 40 hours per week)	2
Full-time education at school, college or university	3
Unemployed	4
Permanently sick or disabled	5
Retirement	6

Other (specify) .....

SECTION B:

This section explores your experiences regarding service quality. Please indicate the extent which you agree with each of the following statements by crossing (x) ONE of the five numbers to the statement using 5-point scale where:

1. =Strongly disagree, 2. =Disagree, 3. =Neutral, 4. =Agree, and 5. =Strongly Agree

SATISFACTION						
No.	**Statement**	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
1	I am satisfied with the manner in which patient care is being offered in this hospital	1	2	3	4	5
2.	In this hospital, there is a positive relationship between the patients and administration clerks	1	2	3	4	5
3.	My relationship with the nursing workers reflects a happy situation	1	2	3	4	5
4.	The relationship between senior managers and nursing employees is satisfactory	1	2	3	4	5
5.	I think there is sign of respect for the patients in this hospital	1	2	3	4	5

In your own words, please give your opinion on level of relationship situation and any recommendation towards possible improvement.

.....

.....

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COMMITMENT						
	Statement	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
1.	Service quality in this hospital is adequately provided	1	2	3	4	5
2.	Management is committed in quality health service as well as patient care	1	2	3	4	5
3.	In this hospital, every nurse is dedicated to continuing to do service quality	1	2	3	4	5
4.	I think nurses have high levels of commitment with this hospital	1	2	3	4	5

In your own words, please give your opinion on level of commitment, dedication and support service that patient staff should provide that can be a factor contributing towards service quality.

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.....

.....

SPECIFIC ASSETS						
	Statement	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
1.	Nurses are empowered to concentrate on the welfare of patient care.	1	2	3	4	5
2.	The hospital is well resourced.	1	2	3	4	5
3.	Nurses are highly motivated in this hospital.	1	2	3	4	5
4.	I think there are enough nurses to perform to provide service quality.	1	2	3	4	5
5.	In this hospital, there is a shortage of experienced and skilled nurses.	1	2	3	4	5
6.	There is evidence of long-waiting hours in this hospital.	1	2	3	4	5
7.	I would advise my friends to come to this hospital if they were sick.	1	2	3	4	5

In your own words, please give your opinion on assets or resources provided by the hospital and how this is benefiting the hospital. You can also provide any recommendation regarding improvement if possible.

.....

.....

COORDINATION AND COOPERATION						
	Statement	**Strongly Disagree**	**Disagree**	**Neutral**	**Agree**	**Strongly Agree**
1.	I am proud of this hospital	1	2	3	4	5
2.	A patient's privacy is respected by the staff	1	2	3	4	5
3.	In this hospital, patients' complaints are handled effectively	1	2	3	4	5

In your own words, please give your opinion on patient handling problem processes and cooperation by the management with the family as well as patient towards achieving a common goal.

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.....

.....

Thank you for very much for cooperation

Appendix 3: Approval letter to conduct the study

To whom it may concern

TITLE OF RESEARCH PROJECT: Evaluation of Quality Management Practices in the Ekurhuleni Public Hospitals.

RESEARCHER: Mr. Stephen Nyakala

SUPERVISOR: Mr. Andre Vermeulen

The Department of Quality and Operations Management evaluated the research proposal and consent letters of the above research project and confirms that it complies with the approved Research Ethical Standards of the University of Johannesburg.

The study supervisor and the researcher demonstrated their intent to comply with the approved Ethical Research Standards during the conduct of the research project.

Yours sincerely

22 June 2012

JOHN AGWA-EJON (MR)
HOD: QUALITY AND OPERATIONS MANAGEMENT

Approved

TEMBISA PROVINCIAL TERTIARY HOSPITAL
GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA
CEO: Dr S.B Mfenyana
12.06.12
Date

OFFICIAL ADDRESS | Cnr Kingsway and University Road Auckland Park
PO Box 524 Auckland Park 2006 | Tel +27 11 559 4555 | www.uj.ac.za
Auckland Park Bunting Campus | Auckland Park Kingsway Campus
Doornfontein Campus | Soweto Campus

UNIVERSITY OF JOHANNESBURG

Appendix 4: Informed consent for semi structured interview

INFORMED CONSENT FOR SEMI STRUCTURED INTERVIEW

Informed consent is necessary to be obtained from the participants as an agreement to participate in the study

The respondents' participation is entirely voluntary and will not cause you any harm

The purpose and objectives of the research are:

- To explore the professional nurses and patients perceptions on the specific quality management practices in terms of improving quality care
- To investigate the nurses and patients views on general systems in system in relation to patient care
- To provide an overview on what nurses understand regarding quality management practices as a strategy for managing healthcare system

I have been informed as to the procedures in the study titled AN EVALUATION OF QUALITY MANAGEMENT PRACTICES IN THE EKURHULENI PBLIC HOSPITALS. Your name and details will not be included in the study or revealed to anyone, thus anything you write will be treated as confidential. You also have the right to withdraw from this research at any time. I hereby freely consent to take part in this study.

Thanking you,

Respondents signature Date

If you have any questions, the following persons are available to be conducted:

Researcher:	Mr .Stephen Nyakala	(084 4358730)
Supervisor:	Mr. Andre Vermeulen	(011 5591206)

Appendix 5: Affidavit: Master's and Doctoral Students

UNIVERSITY OF JOHANNESBURG

AFFIDAVIT: MASTER'S AND DOCTORAL STUDENTS
TO WHOM IT MAY CONCERN

This serves to confirm that I KGASHANYE STEPHEN NYAKALA
(Full Name(s) and Surname

ID Number 8002125551083

Student number 200574841 enrolled for the

Qualification MTECH : OPERATIONS MANAGEMENT

Faculty OF ENGINEERING AND THE BUILT ENVIRONMENT

Herewith declare that my academic work is in line with the Plagiarism Policy of the University of Johannesburg which I am familiar with.

I further declare that the work presented in the DISSERTATION
(minor dissertation/dissertation/thesis) is authentic and original unless clearly indicated otherwise and in such instances full reference to the source is acknowledged and I do not pretend to receive any credit for such acknowledged quotations, and that there is no copyright infringement in my work. I declare that no unethical research practices were used or material gained through dishonesty. I understand that plagiarism is a serious offence and that should I contravene the Plagiarism Policy notwithstanding signing this affidavit, I may be found guilty of a serious criminal offence (perjury) that would amongst other consequences compel the UJ to inform all other tertiary institutions of the offence and to issue a corresponding certificate of reprehensible academic conduct to whomever request such a certificate from the institution.

Signed at JOHANNESBURG **on this** 25 **day of** APRIL **20**13.

Signature _____ **Print name** STEPHEN NYAKALA

Rabie Ridge on 29-04-2013 at 12:25

(PUBLIC PERSON) KOMMISSARIS VAN EDE
(SIGNATURE) COMMISSIONER OF OATHS

WICKMAN MATHANZIMA
FULL FIRST NAMES AND SURNAME IN BLOCK LETTERS

W/O Matatiele
BUSINESS ADDRESS (STREET ADDRESS)

Rabie Ridge SAPS
1312 stall street Rabieridge

STAMP COMMISSIONER OF OATHS
Affidavit certified by a Commissioner of Oaths
This affidavit conforms with the requirements of the JUSTICES OF THE PEASE AND COMMISSIONERS OF OATHS ACT 16 OF 1963 and the applicable Regulations published in the GG GNR.1258 of 21 July 1972, GN 903 of 10 July 1998; GN 109 of 2 February 2001 as amended.

Appendix 6: Declaration : Master's and Doctoral Students

UNIVERSITY OF JOHANNESBURG

DECLARATION: MASTER'S AND DOCTORAL STUDENTS
TO WHOM IT MAY CONCERN

This serves to confirm that I IGYASHAYE STEPHEN NYAKALA
(Full Name(s) and Surname

ID Number 8002125551083

Student number 20057484 1 enrolled for the

Qualification MTECH : OPERATIONS MANAGEMENT

Faculty OF ENGINEERING AND THE BUILT ENVIRONMENT

I hereby declare that the thesis/dissertation/minor dissertation submitted for the MTECH degree to the University of Johannesburg, apart from the help recognized, is my own work and has not previously been submitted to another university or institution of higher education for a degree.

Signed at JOHANNESBURG **on this** 25 **day of** APRIL **20**13.

Signature [signature] **Print name** STEPHEN NYAKALA

Appendix 7: Letter of Language Quality Assurance

LANGUAGE QUALITY ASSURANCE

Dr N.R. Barnes
20 Hekla Road
The Hill
Johannesburg
2197
Tel: +27114352609
Cell: +270737314129
Email:neilbarn@telkomsa.net

TO WHOM IT MAY CONCERN

I hereby certify that I have language edited the dissertation, "Evaluation of Quality Management Practices in the Ekurhuleni Public Hospitals", prepared by Kgashane Stephen Nyakala for the for the Master's Degree of Technology in the department of Operations Management, University of Johannesburg and am satisfied that provided that the changes I have made to the text are effected, the language is of a standard fit for publication.

N R Barnes

Neil R Barnes
PhD (Psychology, Unisa),
Research Consultant

Appendix 8: Transcript raw material from the interview conducted with the hospital unit manager

TRANSCRIPT

INTERVIEW WITH THE UNIT MANAGER OF THE PUBLIC HOSPITAL (MRS.SEGOOA)

DATE: 06 AUGUST 2012 **VENUE: TEMBISA HOSPITAL**

INTERVIEWER: MR.STEPHEN NYAKALA (RESEARCHER)
INTERVIEWEE: MRS.SEGOOA (FICTITIOUS NAME)

NYAKALA: My name is Stephen Nyakala. I am a Research Student attached to the University of Johannesburg at the Department of Quality and Operations Management. First of all, I would like to thank you for having given me opportunity to meet you and discuss a few issues. The purpose of this interview is to get insights of how quality of health care is managed in this Hospital. There is no right or wrong answer. And thank also for allowing me to bring along my colleague to assist with field notes and observations during the interview. This is a voluntary and confidential matter and it is for research purposes only. And with the permission of the University after completing this research project, we get a copy of the final product. Thank you.

NYAKALA: What is your understanding about service quality in terms of patient care in this hospital?

MRS.SEGOOA: The aim of quality service to prove the best possible care to the patients who are either sick or ill. This means providing quality care to clients holistically i.e. treating and managing them as individuals with different health needs taking into consideration their emotional psychological, spiritual and the physical needs. Health department has been using the National Care Standards to render total quality care in terms of patient care. This is done in order to ensure that the performance of nurses is measured. It is very important to measure the level of care

being rendered. The bottom line is that standards performance can be measured and improved.

NYAKALA: Thank you. What is purpose of quality training programmes?

MRS.SEGOOA: Quality training programmes are set to improve on service delivery improves the life of the people and reduces the burden of disease such as Prevention from mother to child treatment (PMTCT) included in mother and child programmes in Gauteng province.

NYAKALA: Do you think quality training programmes is yielding positive results.

MRS.SEGOOA: Yes

NYAKALA: Still on the question of positive results. Please provide more information on it?

MRS. SEGOOA: Mrs Segooa claims that there is evidence of positive results as evaluations are done periodically in order to see if staff nurse who attended those training programmes implement them. In our institution, those who went for training in neonatal resuscitation can resuscitate a new-born baby with success but on the other hand this programmes do not take place due to lack of commitment of the facilitators, counselling of training programmes etc.

NYAKALA: What are your views towards quality management practices and how do you feel about it?

MRS.SEGOOA: Mrs Segooa felt that quality management practices need buy in from top management. She claimed that top management support will be valuable and encouraging to the staff at Junior Level who is the one to implement the strategies. She further stated that a quality management practice is a political game where the health care user suffers at the end.

NYAKALA: In your own words, please give opinion on quality management system that is implemented to control quality care in the public hospitals

MRS. SEGOOA: Mrs. Segooa felt that management systems are implemented to improve or control quality care for example, those systems which control the long queues in the hospitals, the booking system has improved in reducing long queues, people with disabilities and the elderly are seen and attended to first.

NYAKALA: Thank you very much. Furthermore, if there is any other point that I will need for more information I will give you a call and then we will just talk about it and then take from there. Once again, thank you very much.

MRS. SEGOOA: Thank you. Good Luck

END