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CHALLENGES TO ATTAIN EXTREME MEASURES FOR PATIENT SAFETY, CLINICAL GOVERNANCE AND CARE OF THE NATIONAL CORE STANDARDS FOR HEALTH ESTABLISHMENTS IN A DISTRICT HOSPITAL IN TSHWANE, GAUTENG

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SUBMITTED IN FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE

Magister of Nursing Science (Nursing Education)
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at the University of Pretoria

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DECLARATION

I, **Mmule Lucia Lephogole**,

Student Number: 274 730 92,

hereby declare that:

"CHALLENGES TO ATTAIN EXTREME MEASURES FOR DOMAIN 2 OF THE NATIONAL CORE STANDARDS FOR THE HEALTH ESTABLISHMENTS IN A DISTRICT HOSPITAL IN TSHWANE, GAUTENG"

is my own work and that all sources used or quoted have been indicated and acknowledged by means of complete references. I further declare that this work has not been submitted for any other degree at any other institution.

______________________________ ______________________

Mmule Lucia Lephogole **Date**

DEDICATION

I dedicate this study to the following people who contributed positively and supported me throughout the study:

- My late parents, Mabothe and Grace Nthite who taught me to treasure education. I know you would have been proud. May your precious souls rest in peace.
- My husband, Joseph Tate Lephogole, who has always encouraged and supported me in studying and was willing to assist with technology and finances.
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ABSTRACT

"CHALLENGES TO ATTAIN EXTREME MEASURES FOR PATIENT SAFETY, CLINICAL GOVERNANCE AND CARE OF THE NATIONAL CORE STANDARDS FOR HEALTH ESTABLISHMENTS IN A DISTRICT HOSPITAL IN TSHWANE, GAUTENG"

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In 2008, the South African National Department of Health committed to improving the quality of healthcare service delivery in public healthcare institutions. The implementation of the National Core Standards for Health Establishments was one such commitment, which is now viewed as essential to the quality of care, resource management and inter-professional work. The aim of this study was to explore and describe the challenges to attain extreme measures for patient safety, clinical governance and care of the National Core Standards for the Health Establishments in a district hospital in Tshwane, Gauteng. A qualitative descriptive exploratory design was employed to conduct the study. A non-probability purposive sampling method was used for recruiting the participants, who included professional nurses working in a district hospital. The professional nurses were directly involved in the implementation of the National Core Standards. Three focus groups, using a semi-structured interview guide, were conducted to collect data from the participants. The data was analysed according to Tesch's method. An independent co-order was used to confirm the findings.

The following themes emerged: challenges to clinical governance, challenges to patient safety and challenges to patient care. It was recommended that the study be replicated, using all the nine provinces of South Africa, including other hospitals on different levels and using a well-represented racial group and males in the district hospital with different disciplines in the Gauteng Province. This

was to investigate whether similar findings would be achieved. A task team had to be formed, consisting of multidisciplinary team members to perform monthly audits and continuous follow-up to resolve the challenges to attain extreme measures of the National Core Standards for the Health Establishments.

Keywords:

Challenges, Extreme measures, patient safety, clinical governance and care, National Core Standards for Health Establishments

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LIST OF ABBREVIATIONS AND ACRONYMS

ABBREVIATION	MEANING
IOM	Institute of Medicine
NCS	National Core Standards
WHO	World Health Organisation
US	United States of America
SA	South Africa
OHSC	Office of Health Standards Compliance
NDoH	National Department Of Health
CEO	Chief Executive Officer
MHCU	Mental Healthcare Users
IPC	Infection Prevention and Control
OPD	Out-Patient department
PPE	Personal Protective equipment
MRD-TB	Multi drug resistant Tuberculosis
TB	Tuberculosis
XDR-TB	Extensive drug resistant Tuberculosis

CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION

The health outcomes for hospitalised patients remain a concern globally owing to adverse health outcomes related to long hospitalisation time, associated complications including healthcare associated infections and factors affecting the mortality rate. According to Grol, Wensing, Eccles and Davis (2013:3), care concerns the provision of patient-centred treatment, care and evidence-based best practices. Most importantly, patient care is interrelated with both the quality and the safety of patients, forming an integral aspect of patient safety and clinical governance (Hughes, 2008:4). However, worldwide, patient safety is a challenge that is not met in healthcare settings in either developed or developing countries.

According to the Institute of Medicine (IOM) (cited in Hughes, 2008:2), patient safety is the prevention of harm to patients by reducing medical errors. Thus, patient safety encompasses the prevention of medical errors and healthcare practices by healthcare practitioners and patients, based on the culture of safety. Therefore, improving the quality of care and patient safety is fundamental to reducing costs and reconciling the growing demand for healthcare with budget constraints. Clinical governance is a system that facilitates compliance with quality care and patient safety provision by professionals. Further, the clinical governance process outlines the protocols for the procedures that ensure patient safety and its measurements (Health Service Executive Report, 2014:3).

According to the World Health Organisation (WHO) (Issenberg, Chung & Devine, 2011:843), patient safety is not automatic. The authors explain that globally, patients are prone to adverse healthcare outcomes and incorrect healthcare treatment, which contributes to poor patient safety and care. This need to ensure patient safety was evidenced by the annual number of deaths, which was estimated to be 44 000 to 98 000 patients in United States (US) hospitals due to medical errors. To confirm the lack of patient safety in America, the study conducted by Blasiak, Stokes, Meyerhoff, Hines, Wilson and Viera (2014:18) found that patient safety and quality improvement among medical students

revealed that most of the respondents' knowledge was limited. The results further revealed that the scores for assessing knowledge of patient safety among the 790 medical students who participated was as low as 56% and 58%. The findings were the same as those of the study conducted in India by Mahajan and Bedi (2015:136) among dentists, which indicated that 67% of the respondents had inadequate knowledge of patient safety issues. A study conducted by Wilson, Michel, Olsen, Gibberd, Vincent, El-Assady, Rassian, Macharia, Sahel, Whittaker, Abdo-Ali, Letaief, Ahmed, Abdellatif and Laritzgoitia (2012:347) on patient safety in 26 hospitals in developing countries showed that patients' records revealed that 83% of adverse incidences were preventable. Additionally, 30% to 34% of adverse patients' outcomes were related to fatalities and mortalities because patient safety had been undermined (Mayeng & Wolvaardt, 2015:1).

Similarly, in South Africa, findings from a National Healthcare Facility Baseline Audit (2012:2) showed that public healthcare institutions collectively scored 34% compliance in patient safety and security during this national audit. Notwithstanding, the South African National Health Department embarked on the establishment for National Core Standards (NCS) for Health Establishments in 2008 to ensure positive health outcomes. However, a decade later, patient safety remains a challenge. For example, findings from the study conducted by Mayeng and Wolvaardt (2015:1) in the Free State Province among allied professionals, doctors and nurses revealed that knowledge pertaining to patient safety among the participants was inadequate. In addition, Coetzee, Klopper, Ellis and Eiken (2013:162) posited that one in five nurses reported poor quality of care due to non-compliance with patient care protocols because of the staff ratio to patients. Further evidence of the lack of patient safety emerged during the study conducted in a public hospital in the Limpopo Province of South Africa, where knowledge gaps among thirty (30) line managers were identified during the implementation of the NCS (Mogashoa & Pelser, 2014:153). That means poor performance, as health facilities attained less than 100%, which is the expected performance level. Further, it is possible that some hospitals are not complying with the criteria and in turn are unable to attain the extreme measures (100%) for patient safety, clinical governance and care of NCS.

The National Core Standards for Health Establishments refers to a legal framework developed by the office of health standards compliance (OHSC) to benchmark quality care, against which the delivery of services can be monitored and measured (National Department of Health [NDoH], 2011:8). There are seven cross-cutting Domains of the National Core Standards (NDoH, 2011:6) namely: 1. Patient Rights; 2. Patient safety, Clinical Governance and Care; 3. Clinical Support Services; 4. Public Health; 5. Leadership and Corporate Governance; 6. Operational Management

and 7. Facilities and Infrastructure. The NCS address the six Ministerial priority areas. Which are: Staff attitudes, waiting times, cleanliness, patient safety and security, infection prevention and control and availability of medicines and supplies. Monitoring and evaluation regarding compliance with NCS is conducted periodically by OHSC, while healthcare institutions are monitored against the standards. Therefore, the certification of healthcare institutions that comply with the requirements in the standards are awarded according to the predetermined scores. Scores range from developmental (60% and above) to extreme measures (100%). Extreme measures ensure that the safety of patients and staff is protected to prevent unnecessary harm or death. Hence, it is mandatory for healthcare institutions to obtain 100% in extreme measures of the NCS for the Health Establishments, otherwise patient safety is compromised and health outcomes may be negative.

1.2 BACKGROUND

Historically, quality assurance in healthcare is an overarching health outcome. Quality assurance has developed into dynamic and exciting recent knowledge in healthcare institutions, and plays an important role in patient safety (Whittaker, Shaw, Spieker & Linegar, 2011:60). Patient safety is one of the three competencies of Domain 2 of NCS, which are patient safety, clinical governance and care. The NCS are designed for South Africa's health context based on policies that reflect international evidence-based best practices (NDoH, 2011:6). The Office of Health Standards Compliance mandated for all health managers to adhere to this as a vehicle for attain quality patient care, which was introduced by the NCS for Health Establishments in SA. Quality assurance is measured in most healthcare settings according to Donabedian's Model, Domains of which are aligned with NCS. The three Domains of the model suitably position the seven NCS, thus making it possible for the review panel to write a report on structures, processes and outcomes. Domains 1, 2, and 3; patient rights, patient safety, clinical governance and care and clinical support services, are directly involved with the core business of the health system and the remaining Domains are the support system that ensures the system delivers its core business (NDoH, 2011:10). These Domains are the processes and outcomes in Donabedian's Model, while the structures and some processes are embedded in Domains 4, 5, 6, and 7. Patient safety, clinical governance and clinical care are in Domain 2, on which this study focuses, particularly regarding how to ensure an ethical, safe clinical environment and positive health outcomes (NDoH, 2011:11). Thus, patient safety, clinical governance and care incorporate both processes and outcomes.

The NCS has four non-compliance measurements which are extreme (100%), vital (90%), essential (80%) and developmental (60%) measures (NDoH, 2011:13). Extreme and vital measures are those that ensure that the safety of patients and staff is protected and do not result in unnecessary harm

or death. Essential measures are those reflected as important to the delivery of safe, decent, quality care and are intended to provide a detailed view of what is expected within the available resources. The research setting does not comply on this Domain as it is evaluated to be in the developmental measures, which were below 75% performance during the last provincial audit (Hospital audit report, 2016). Nurses are the leaders in patient care and are members of clinical governance team, so they bear the responsibility for ensuring patient safety and care, regardless of resource allocation, be it lack of medical equipment or lack of appropriate policies and standards (Hughes, 2008:4). Hence, their role of facilitating the attainment of extreme measures, ensuring patient safety, clinical governance, and caring, thereby upholding the NCS, is deemed vital in this study.

The researcher decided to explore and describe the challenges to attain extreme measures for patient safety, clinical governance and care of NCS in a district hospital in Tshwane, Gauteng. This was in order to make recommendations based on findings from the professional nurses to improve the quality of attainment of the extreme measures for the NCS.

1.3 PROBLEM STATEMENT

Quality healthcare is an overarching outcome and is viewed as a triad of patient safety, clinical governance and care. Mosadeghrad (2013:278) refers to quality healthcare as a deliberate effort to offer healthcare that is safe, efficient, cost-effective, and accessible and contributes to improved patient health outcomes and satisfaction. Patient safety, clinical governance and care are described by NDoH (2011:7) as ensuring quality clinical care, which includes preventing harm, adverse events and healthcare associated infections to healthcare users and healthcare practitioners and management if they do occur.

The NCS review period 2015 to 2016 quarterly self-assessments results of patient safety, clinical governance and care of the NCS as presented by the Quality Assurance team in the selected hospital has not attained the extreme measures (100%) needed by the NDoH measures for NCS. The internal quarterly NCS audit results are as follows; October 2015 82%, December 2015 85% and March 2016 87%, July 2016 82,02%. The external auditor's results were 7.5% lower, as the hospital attained 74.5% in comparison with October 2016, using the same tool for patient safety, clinical governance and care. The score for internal review was within essential measures while the external review was lower and was within developmental measures, which is the lowest score in NCS scores (Hospital audit report, 2016).

The researcher was a member of the internal review team for NCS for health establishments in one of the hospitals in the Tshwane district. The results of the review showed that a selected district hospital in Tshwane did not attain extreme measures (100%).There are structures in place (for Domains 4-7), that is, public health, leadership and corporate governance, operational management, facilities and infrastructure, which are expected to facilitate the attainment of extreme measures for NCS, including patient safety, clinical governance and care. However, the performance levels are below the required standards. The frameworks for quality assurance in the research setting are the quality assurance unit, the infection prevention and control unit, and the occupational health, and safety unit. The three units further ensure that guidelines, protocols, standard operating procedures, training/workshops, and surveillance are conducted to curb infections and the transmission of nosocomial infections, which undermine patient safety as outlined inpatient safety, clinical governance and care Domain (NDoH, 2011:7;NDoH, 2007:6). In addition, the occupational health and safety programme (OHS), the cornerstone of quality, supports healthcare practitioners and ensures patients' safety in the event of emergency evacuation. Therefore, it is regarded as the cornerstone of quality.

Despite efforts implemented for quality assurance in healthcare settings, the attainment of extreme measures for NCS to ensure quality patient care remains low in South Africa (Mogashoa & Pelser, 2015:153; Hospital audit report, 2016). Similarly, the international healthcare settings are challenged to attain patient safety, as referred to by Jha, Prasopa-Plaizier, Larizgoitia and Bates (2010:42), who say that between 3% and 16% of hospitalised patients are exposed to harm from healthcare. Another study conducted among healthcare professionals by Gauld and Horsburgh (2014:3) in New Zealand shows that, although a national policy on clinical governance is in place, an extensive determination is vital to building clinical governance at the healthcare institutions. In South Africa, Lourens (2012:4) concludes that to meet the requirements of NCS, patient safety and clinical governance need evidence-based practice. The results from the studies raise concerns regarding the attainment of NCS scores, specifically for patient safety, clinical governance and care. The abovementioned results made the researcher ask a question: "What are the challenges for the selected hospital if it is to attain extreme measures as required by NDoH?"

1.4 RESEARCH QUESTION

The following research question guided the study:

- What are the challenges to attain Domain 2 for extreme measures of the NCS for the Health Establishments in a district hospital regarding patient safety?

- What are the challenges to attain Domain 2 for extreme measures of the NCS for the Health Establishments in a district hospital regarding clinical governance?
- What are the challenges to attain Domain 2 for extreme measures of the NCS for the Health Establishments in a district hospital regarding patient care?

1.5 AIM AND OBJECTIVES

1.5.1 Aim of the study

The overall aim of the study was to explore and describe the challenges to attain extreme measures for patient safety, clinical governance and care of the National Core Standards for the Health Establishments in a district hospital in Tshwane, Gauteng.

1.5.2 Research Objectives

The objectives of the study were:

- To explore and describe the challenges to attain extreme measures for Domain 2 of the National Core Standards for the Health Establishments in a district hospital in Tshwane, Gauteng regarding patient safety.
- To explore and describe the challenges to attain extreme measures for Domain 2 of the National Core Standards for the Health Establishments in a district hospital in Tshwane regarding clinical governance.
- To explore and describe the challenges to attain extreme measures for Domain 2 of the National Core Standards for the Health Establishments in a district hospital in Tshwane, Gauteng, regarding patient care.

1.6 SIGNIFICANCE OF THE STUDY

The study could raise awareness on the part of professional nurses regarding the implementation, gaps in and results of the NCS reviews on patient safety, clinical governance and care in a public hospital. The hospital could use the study findings and recommendations to guide them in planning and implementing strategies for addressing the challenges. Addressing challenges, coming up with solutions and attending to them would enhance current clinical practice regarding the attainment of extreme measures for Domain 2 of the NCS for the Health establishments.

Continuous comprehensive in-service programmes related to extreme measures for Domain 2 of the NCS could be developed for the clinical facilitators and the nurse educators and could be integrated into the curriculum. Such programmes could therefore assist clinical facilitators in providing quality

clinical practice while at the same time enabling nursing students to integrate theory and practice. The researcher will also disseminate the study findings by means of publication in various national scientific journals.

The data gathered from this study could produce key information for policy-makers and other stakeholders to develop effective healthcare interventions and education relevant to the NCS. Future research on issues related to NCS could be encouraged in order to facilitate positive changes in healthcare practices and to improve patient safety outcomes and clinical governance both locally and internationally.

1.7 PHILOSOPHICAL ASSUMPTIONS

1.7.1 Assumptions

According to Burns, Grove and Gray (2013:41), assumptions are statements that are taken for granted or that are considered to be true, even though they have not been scientifically tested. In this study, the researcher has taken the participants' subjective views to be the essence of what was real for them in order to find the possibilities and understandings contained there. The assumptions used in this study are as follows: ontological, epistemological, methodological and theoretical.

1.7.1.1 Ontological assumptions

According to Brink et al. (2012:24), ontological assumptions refer to the nature of reality. The researcher's worldview is from the Interpretivist paradigm, as it is envisaged that individuals have multiple realities in this world. The Interpretivist lens was used as an approach to social science. This highlights the importance of the insider's viewpoints as to understanding social reality (Brink et al., 2012:25). In this study, the reality was multiple and subjective, and was constructed by the participants, who were involved in the setting where the phenomenon explored was the challenges to attain extreme measures for patient safety, clinical governance and care of the NCS in the selected hospital.

1.7.1.2 Epistemological assumptions

Epistemology is concerned with how knowledge is generated (Burns, Grove & Gray, 2012:693). In this study, the researcher and the moderator interacted with the participants during data collection, following semi-structured interviews. New knowledge emerged which was collaborative, and inductive processes on challenges to attain extreme measures for patient safety, clinical governance and care of the NCS for Health Establishments in a district hospital likewise emerged.

1.7.1.3 Methodological assumptions

According to Polit and Beck (2012:13), methodological assumptions refer to how information is best obtained. In this study, the researcher interacted with the participants by asking questions and probing to verify and confirm facts until data saturation was reached. The researcher sought in-depth understanding and the information was narrative. This study was context-bound and contextualised. Therefore, a qualitative, explorative, descriptive design was used in this study. Finally, the aim of the study was to make recommendations for addressing the challenges with regards to the attainment of extreme measures of Domain 2 for NCS.

1.7.2 Paradigm

According to Polit and Beck (2012:11), a paradigm is a world view; a general perspective on the complexities of the real world. The post-positivism paradigm was used to guide this study. The paradigm provided the researcher with the opportunity of having "a way of looking at the natural phenomenon, which includes a set of philosophical assumptions that guides one's approach to inquiry" (Polit & Beck, 2012:11). This study was context-bound and contextualised. The researcher was committed to understanding and relying on the participants' views pertaining to the challenges to attain extreme measures for Domain 2 of the NCS as it occurred in a public hospital as described by Mogashoa and Pelser (2015:153). The researcher took the participants' subjective views as the essence of what was real for them.

1.7.3 Theoretical framework

The Donabedian model is the theoretical framework that the researcher used for the study. Moore, Lavoie, Bourgeois and Lapointe (2015:1168) emphasise that the Donabedian model focuses on and provides a framework for evaluating the quality of healthcare. According to Visnjic, Velickovic and Jovic (2015:54), structure, process and outcome are three important components of the healthcare system. The NCS fit in with the Donabedien model in that Domains 1-3 are the processes and outcomes, while Domains 4, 5, 6 and 7 are the structures. In this study, shortage of staff, insufficient medical supplies/equipment and an inefficient referral system were among the challenges that emerged from the focus group interviews. These are the processes, which lead to the negative outcomes in the health system, that is, inadequate patient safety and care. If clinical governance is not in place, patient safety and care will not be upheld.

1.8 CONCEPT CLARIFICATION

1.8.1 Challenges

According to the Oxford Dictionary (2011:235), a challenge is defined as a situation whereby one is faced with something that needs great mental and physical effort in order to be successful and therefore tests a person's ability. In this study, challenges refer to hindrances to attain extreme measures for patient safety, clinical governance and care of the National Core Standards for Health Establishments in a district hospital.

1.8.2 Extreme measures

According to (NDOH 2011:13), the NCS has four non-compliance cut-off levels, which are extreme (100%), vital (90%), essential (80%) and developmental (60%) measures. Extreme measures are those that ensure that the safety of patients and staff is protected so there will be no unnecessary harm or death. In this study, extreme measures refer to attain 100% during internal and external reviews for patient safety, clinical governance and care.

1.8.3 Patient safety, clinical governance and care

In this study, patient safety, clinical governance and care will refer to processes and outcomes that are in place in the hospital. These three concepts are clarified as follows:

- According to the WHO (2016:1), patient safety is the prevention of harm to patients, and is built on a culture of safety that involves healthcare professionals, organizations and patients. In this study patient safety refers to activities employed by healthcare professionals to ensure that patients are protected from any harm.
- Clinical governance is the system in which healthcare teams are responsible for the quality of the safety experience of the patients in their care (Health Service Executive, 2014:3). In this study, clinical governance is concerned with a framework in place in the selected hospital that supports the healthcare practitioners in the standards of care delivered, and protection of patients from harm.
- According to Grol et al. (2013:3), patient care is the provision of treatment and information established on the best evidence, in a manner, which includes the patient in decision-making. In this study, patient care refers to practices employed by healthcare practitioners to improve patients' outcomes.

1.8.4 National Core Standards for Health Establishments

This refers to a legal framework, which was developed by the Office of Health Standards Compliance, which will assist in setting the benchmark of quality care against which the delivery of services can be monitored (NDoH, 2011:8). There are seven (7) domains in NCS and these are: patients' rights; patient safety; clinical governance and care; clinical support services; public health; leadership and corporate governance; operational management; and facilities and infrastructure (NCS, 2011:8). In this study, the NCS is Domain2, which focuses on patient safety, clinical governance and care.

1.9 RESEARCH METHODOLOGY

1.9.1 Study design

According to Botma, Greef, Mulaudzi and Wright (2010:201), the research design refers to the entire plan for finding answers to the initial research question. As suggested by Yin (2011:76), the chosen design should be appropriate for and applicable to the identified problem statement and should be in accordance with the methodological elements. A qualitative, explorative and descriptive design was used in this study to explore and describe challenges to attain extreme measures for patient safety, clinical governance and care of the NCS for Health Establishments in a district hospital in Tshwane, Gauteng.

- **Qualitative design**

According to Burns, Grove and Gray (2013:705), qualitative design is a systematic, interactive approach used to describe life experiences and to give meaning to those experiences. The qualitative method in this study consisted of a focus group interview (FGI). This approach was chosen by the researcher as it is the most appropriate method to explore and describe the challenges to attain extreme measures for patient safety, clinical governance and care of the NCS for health establishments in a district hospital and it allowed her to conduct in-depth interviews relating to the phenomenon being investigated, namely, the challenges to attain extreme measures for Domain 2 of the NCS in a district hospital.

- **Explorative design**

Polit and Beck (2017:784) refer to explorative design as a full investigation of the phenomenon in order to explore human experience. In this study, an explorative design was used to gain in-depth

information on the challenges to attain extreme measures for patient safety, clinical governance and care of the NCS for the Health Establishments in a district hospital.

- **Descriptive design**

According to Burns and Grove (2013:696), descriptive design refers to an accurate account of characteristics of a particular phenomenon in a contextual setting for the purpose of discovering meaning, describing what exists, and categorising information. A descriptive design focuses on the richness and depth of the experience with the researcher being the tool for data collection and listening to individual descriptions of the quality of life through the interview process (Streuben & Carpenter, 2011:81). The researcher described the challenges of professional nurses to attain extreme measures for patient safety, clinical governance and care of the NCS for Health Establishments in this study.

In this study the challenges relating to the attainment of extreme measures for Domain 2 of the NCS for Health Establishments were fully described to bring clear meaning to the study. The independent facilitator was used as a tool for data collection. The researcher then studied the data as they had been transcribed verbatim and reviewed repeatedly what the participants had described as the challenges they encountered regarding attainment of extreme measures for Domain 2 of NCS for Health Establishments.

1.9.2 Research setting

Leedy and Omrod (2010:99) refer to research setting as research conducted in the real world that could yield more valid results with broader applicability to other real-world context. Qualitative data collection is usually done in a real world, naturalistic setting because the researcher may deliberately strive to study phenomena in a variety of natural contexts (Polit & Beck, 2017:568). Therefore, conducting a study in a natural setting means that the researcher does not make any effort to change and manipulate the environment for the study (Burns & Grove, 2011:40).

In this study, the setting was conducted in a district hospital which also provides general healthcare services to in and outpatients on referral from a community health centre. Furthermore, it has a 197bed occupancy and renders a 24-hour healthcare service. The permanent employees on the staff establishment of the hospital are 625. The researcher is a member of the internal review team for NCS for Health Establishments in a selected district hospital.

1.9.3 Research methods

According to Brink, van der Walt and van Rensburg (2012:92), research methods refer to the collaborative procedures followed by the researcher to address the research question, finding population to collect data, analyse data and interpret results. In this study, purposive sampling was chosen, which is a non-probability sampling technique whereby the researcher selected participants based on personal judgment regarding the knowledge on the phenomenon to be studied (Polit & Beck, 2017:739). In this research study, focus group interviews were the method used to collect data as it was considered relevant to explore the challenges to attain extreme measures in Domain 2 of the National core standards of the Health Establishments in a district hospital in Tshwane, Gauteng. Three focus group interviews were conducted, consisting of five participants per group. Data collection involved three phases, which included preparation for the interview, interviewing and the post- interview phase.

1.9.4 Table 2.1 Summary of methods

POPULATION	SAMPLING	DATA COLLECTION	DATA ANALYSIS	TRUSTWORTHINESS
Professional nurses	Purposive sampling	Focus group interviews	**Method**: qualitative analysis	**Strategies utilised included:** • Credibility • Dependability • Transferability • Authenticity

An in-depth discussion on research design and methods is provided in Chapter 2. Tesch's method of qualitative data analysis was used, as explained well in Cresswell (2013:192). Details will be also be explained in Chapter 2.

1.10 ETHICAL CONSIDERATIONS

Botma et al. (2010:277) indicate that the ethical principles are the principle of respect for human dignity, beneficence and justice. Permission to conduct a study was obtained from the Faculty of Health Sciences Research Ethics Committee at the University of Pretoria, the Chief Executive Officer (CEO) of the selected hospital and the Gauteng Department of Health. The ethical principles that were applied in this study are as follows: Principles of respect for human dignity, beneficence and justice.

1.10.1 Respect for human dignity

According to Polit and Beck (2017:154), this ethical principle includes the right to self-determination and the right to full disclosure.

- **Self-determination**

Self-determination means that participants have the right to decide voluntarily whether to participate in a study without penalties or prejudicial treatment (Polit & Beck, 2017:154). In this study the researcher ensured verbally and in writing that the participants understood that their participation was of their own free will and that they could choose to withdraw from the study at any time they wished to do so (Annexure B).

- **Full disclosure**

For the participants to make an informed, voluntary decision regarding participation in this study, the researcher had to fully describe the nature of the study, the person's right to refuse participation and the researcher's responsibility and the risks and benefits involved in the study. The participants were fully informed that they were not coerced, and participation was voluntary (Polit & Beck, 2017:154). Full disclosure of the information was done on the information leaflet (Annexure B) that the participants received, which also served as a consent form.

1.10.2 Beneficence

According to Maltby, Williams, McGarry and Day (2014:348), the principle of beneficence is based on the requirement to benefit the individual, which includes the requirement to safeguard the welfare of the participant and the society as a whole. The principle of beneficence includes: the right to freedom from harm and discomfort and the right to protection from exploitation.

- **Right to be free of harm and discomfort**

The principle was ensured by doing the following: Permission to conduct the study was obtained from the University of Pretoria's Ethics Committee and the Chief Executive Officer (CEO) of the selected hospital where the study was conducted. The participants were not subjected to unnecessary risks, harm or discomfort. The moderator was very thoughtful and considerate when using wording and probing strategies.

- **Right to protection from exploitation**

The participants were assured that their participation and the information they provided would not be used against them in any way. The participants were asked for consent and were informed about the discussion time. The researcher took steps not to exploit the participants rather remaining in the role of researcher-participant. The focus group interviews were conducted for study purposes only (De Vos et al., 2011:117).

1.10.3 Justice

The principle of justice involves the right to fair treatment and the right to privacy (Polit & Beck, 2017:155).

- **Right to fair treatment**

In this study, the principle was ensured by the researcher through informing the participants about the criteria used for sampling the prospective participants. The participants were informed that if they refused to participate in the study they would not be subjected to unfair treatment or any kind of ridicule, so therefore they would be respected all the time (Polit & Beck, 2017:155). The benefits of the study were communicated to the participants as well as the fact that their participation in this study would contribute to encouraging healthcare practitioners to monitor the quality pertaining to patient safety, clinical governance and care and improve quality healthcare. They would be empowered in the implementation of the National Core Standards in the Tshwane District, Gauteng.

- **Right to privacy**

The principle was applied in this study. The researcher ensured that the participants' privacy was respected throughout the study. The participants were informed that the data provided would be kept in the strictest confidence. No names were used that would identify the participants. The recorded data was identified as focus group 1, 2, 3 and the participants were assigned numbers (Polit & Beck, 2017:155).

1.11 ORGANISATION OF CHAPTERS

CHAPTER ONE: Overview of the study.

CHAPTER TWO: Research design and methodology

CHAPTER THREE: Discussion of results and literature control.

CHAPTER FOUR: Conclusions, recommendations and limitations of the study.

1.12 CONCLUSION

Chapter 1 provided an overview of the research, an introduction and the background, and the significance of the study. The chapter also outlined the significance, the setting, the paradigm and the assumptions. Qualitative, descriptive and explorative research methods were used to address the study aim and objectives. Ethical consideration was briefly discussed and the organisation of chapters in the entire dissertation was given. In Chapter 2 detailed research design and methodology will be discussed.

CHAPTER 2

RESEARCH DESIGN AND METHODOLOGY

2.1 INTRODUCTION

In Chapter 1 the overview of the study was discussed in detail. In Chapter 2, the researcher describes the research design, which was used to conduct the study on challenges to attain extreme measures for Domain 2 of the National Core Standards for Health Establishments in a district hospital in Tshwane, Gauteng. The researcher used the qualitative, descriptive, exploratory method and conducted focus group interviews as a data collection method.

2.2 AIM OF THE STUDY

2.2.1 Research Aim

The aim of the study was to explore and describe the challenges to attain extreme measures for Domain 2 of the National Core Standards for the Health establishments in a district hospital in Tshwane, Gauteng.

2.3 RESEARCH DESIGN

A research design is an overall plan for obtaining answers to research questions and for handling some difficulties encountered during the research process (Grove, Burns & Gray, 2013:195). The design also serves as a logical plan, which involves the link between the research question, the data to be collected and the strategies for analysing the data so that the findings will address the intended research question (Yin, 2016:76). In this study the researcher used a qualitative, explorative and descriptive design to explore and describe challenges to attain extreme measures for patient safety, clinical governance and care of the National Core Standards (NCS) for Health Establishments in a district hospital in Tshwane, Gauteng.

2.3.1 Qualitative design

According to De Vos, Strydom, Fouché and Delport (2011:142), a qualitative design is a systematic, interactive approach used to describe life experiences and give meaning to those experiences. Maltby, Williams, McGarry and Day (2014:363) define qualitative design as an aspect of the research process that may be "anticipated by meaning or language and the results thereof are expressed in non-numerical terms." The process of qualitative research as outlined by Cresswell (2013:246) involves emerging questions and procedures, collecting data from participants, setting and analysing the data by building from particular to general themes and making interpretations of the meaning of the data. This approach was chosen by the researcher based on the following reasons:

In a qualitative approach, the researcher tends to collect data in a natural setting where participants experience challenges under the study. Information is gathered by talking directly to participants and seeing them behave or act within the context (Cresswell, 2013:185). In this study, data were collected at the hospital setting where the professional nurses are employed permanently.

According to Cresswell (2013:185), face to face interaction is an important aspect of data collection. As outlined by Yin (2016:8), the events and ideas emerging from qualitative research can represent the meaning given to real life events by the people who live them, not the values, preconceptions or meanings held by the researcher. In this study, the real-life situation in a hospital setting was given by professional nurses concerning the challenges to attain extreme measures for patient safety, clinical governance and care of the NCS for Health Establishments.

In qualitative research, data can be obtained by having conversations with the participants and by making detailed notes about how participants behave in a natural setting (Polit & Beck, 2017:723). Using a focus group interview (FGI), narrative data were provided regarding the challenges to attain extreme measures for patient safety, clinical governance and care of the NCS for Health Establishments. According to Yin (2011:8), qualitative research covers contextual conditions such as social, institutional, and environmental conditions within people's lives that may strongly influence all human actions. The approach in this study covered the challenges to attain extreme measures for Domain 2 of the NCS for Health Establishments that influence the quality of healthcare.

A qualitative approach, according to Punch (2014:269), is appropriate for questions that relate to the difference in the meaning of experiences for different people, such as starting with the questions “Why?” or “What?” In this study the approach was relevant to the intended question: “What are the challenges to attain extreme measures for Domain 2 of the NCS for the Health establishments in a district hospital in Tshwane, Gauteng regarding patient safety, clinical governance and care?”

A qualitative approach is used to classify phenomena such as barriers to the situation or nature of dissatisfaction (Punch, 2014:269). Using a qualitative approach provided the researcher in this study to arrive at a better understanding of the professional nurses’ challenges with regards to attainment of extreme measures for Domain 2 of the NCS for Health establishments that influence the quality of healthcare.

2.3.2 Explorative design

Polit and Beck (2017:723) refer to explorative design as full investigation of the phenomenon in order to explore human experience. In this study, the researcher used an explorative design to gain in-depth information on the challenges to attain extreme measures for Domain 2 of the NCS for the Health Establishments in a district hospital and made some recommendations to address such challenges.

In this study, focus group interviews were conducted with professional nurses from different departments. Open-ended questions were posed, which allowed them to communicate freely on their challenges related to the attainment of extreme measures for Domain 2 for NCS for Health Establishments. The moderator was used to facilitate the data collection. Thereafter the researcher studied the data after it had been transcribed. She reviewed it repeatedly to gain more knowledge on what the participants had described as challenges to the attainment of extreme measures for Domain 2 of the NCS for Health establishments in a district hospital in Tshwane, Gauteng.

2.3.3 Descriptive design

According to Burns and Grove (2013:692), descriptive design refers to an accurate account of the characteristics of a particular phenomenon in a contextual setting for the purpose of discovering meaning, describing what exists, and categorizing information. Streubert and Carpenter (2011:8)

state that descriptive design focuses on the richness, breadth and depth of the experience with the researcher being the tool for data collection and listening to participants' quality of life through the interview process. In this study, the researcher became more involved in the phenomenon under investigation and avoided all criticisms and opinions, but paid attention to the phenomenon under discussion.

Fade and Swift (2011:112), affirm that thick descriptions in qualitative data present the voices, feelings, actions and meanings of interacting individuals that are heard and the significance of an experience is discovered. In this study, the voices of the professional nurses were heard as they described the challenges to attain extreme measures for Domain 2 of the NCS for Health Establishments in a district hospital.

2.3.4 Research setting

Leedy and Omrod (2010:99) refer to a research setting as research conducted in the real world that could yield more valid results with broader applicability to other real-world context. The study was conducted in a selected district hospital in Tshwane, Gauteng. The selected hospital provides general healthcare services to in and out-patients on referral from a community health centre. Furthermore, it has a 197-bed occupancy and renders a 24-hour healthcare service. The researcher is a member of the internal review team for NCS for Health Establishments in a selected district hospital. The hospital consists of one paediatric ward (20 beds), a postnatal ward (20 beds), a labour ward (19 beds), male medical wards (28 beds), female medical wards (30 beds), male general wards (30 beds), female general wards (30 beds), high care (20 beds) casualty, an out-patient department, theatre and an ARV clinic.

2.4 RESEARCH METHODS

According to Brink, van der Walt and van Rensburg (2012:92), research methods refer to the collaborative procedures followed by the researcher to address the research question, finding a population to collect data, analyse data and interpret results. In this study, to describe research methods attention was paid to population, sampling, data collection and data analysis.

2.4.1 Population

The population is the entire group of people of interest to the researcher (Polit & Beck, 2017:273) and Ellis (2013:53) suggest that between 6 and 12 people is an appropriate number of participants for a target group whereby a minimum number of 6 participants will enable a significant discussion and a maximum of 12 participants will allow the whole group to engage in a meaningful discussion.

The accessible population for this study was professional nurses working permanently in the selected hospital. Therefore, this population was appropriate to yield rich information on challenges to attain extreme measures for patient safety, clinical governance and care of the NCS for Health Establishments in a district hospital because they are responsible for implementing the NCS.

2.4.2 Sample and Sampling

A sample is a sub-set of the population selected to participate in a study (Whittaker & Williamson, 2011:11) and sampling is defined by Botma et al. (2010:124) as the process of selecting the subset of the population to represent the entire population. In this study, the sample was professional nurses who are directly involved in providing healthcare to patients in the selected hospital and bear the responsibility for the implementation of patient safety, clinical governance and care of the NCS.

In this study, a non-probability purposive sampling method was used whereby the researcher chose the professional nurses based on personal judgment concerning their knowledge of the phenomenon to be studied (Brink et al., 2012:140).

2.4.2.1 Purposive sampling

Purposive sampling is a non-probability sampling method in which the researcher selects participants based on personal judgment about which one will be the most informative (Polit & Beck, 2017:763). According to Green and Browne (2011:122), purposive sampling involves the deliberate choice of participants or settings to reflect some features or characteristics of interest. Yin (2016:88) suggests that when selecting the participants, the researcher should deliberately interview some people whom he or she suspects might hold different views relating to the topic

under study. Participants were recruited for this study based on their knowledge of NCS and their responsibility regarding the implementation of patient safety, clinical governance and care of the NCS.

The researcher considered purposive sampling as the most appropriate approach in which the participants selected were likely to give useful information. The selection was based on the participants' knowledge and experience (Whittaker & Williamson, 2011:62) and on the anticipated richness and significance of information in relation to the research question (Yin, 2011:311). The participants were selected for the purpose of describing the challenges to attain extreme measures for patient safety, clinical governance and care of the NCS for Health Establishments as they are already working in the research setting.

2.4.2.2 Sample size

According to Burns and Grove (2011:548), sample size is the number of subjects, events, behaviour or situation that is examined in the study. The sample size is determined according to informational needs and data saturation (Polit & Beck, 2017:321). Fifteen professional nurses were given the opportunity of voluntarily participating in three focus group discussions. Focus group 1 had 5 participants; focus group 2 had 4 participants and focus group 3 had 6 participants. Four more participants voluntarily participated in the interviews so that the researcher could obtain more information on the phenomenon. De Vos et al. (2011:305) suggest that a focus group should include six to ten participants, whilst Green and Browne (2011:65) recommend between eight and twelve participants, as the size of the group allows all the participants to take part in an interview.

- **Inclusion Criteria**

The inclusion criteria specify the population for the research study (De Vos et al., 2011:232). Therefore, in this study, the inclusion criteria were that the participants should be professional nurses who were permanently employed and had been working or directly involved in providing healthcare to patients for more than one year in the selected hospital. They had to agree to participate in the research study.

2.5 DATA COLLECTION

Data collection refers to the orderly, organised and formalised method of collecting the data required to answer the research question (Lo-Biondo-Wood & Wood, 2010:576). Data was collected after the research proposal was approved and permission granted by the relevant authorities to conduct the study. The researcher obtained permission from the Chief Executive Officer from the selected hospital where the study was conducted. In this study, information on challenges to attain extreme measures for Domain 2 of the NCS for the Health Establishments was explored, using focus group interviews. A focus group interview is a discussion carefully planned between the researcher and a group of individuals who are involved with the same phenomenon and are gathered to answer questions on a given topic (Polit & Beck, 2017:728). A focus group should consist of between five and twelve people (Polit & Beck, 2017:537). Focus group interviews were conducted until data saturation occurred. Three questions were asked during the data collection and probing strategies were used. The researcher had to go back to the study setting to interview four participants after the initial focus group interviews in order to get positive aspects of the phenomenon. See annexure A for the interview guide, which was used during focus group discussions.

2.5.1 Invite participants

The researcher invited the participants to participate in the study on the grounds of their experience and involvement relating to the research topic as suggested by Jayasekare (2014:414). Thorogood (2013:127) confirms that an FGI should include from six to twelve participants. Three focus group interviews were conducted to decide on the days and times scheduled.

After the introduction of the research study, the researcher discussed and agreed with the head of the nursing department as well as operational managers on three dates. Agreement on the time for the focus group discussions was arranged with the operational managers to determine the most appropriate time to release participants from their duties and it was made known to the participants. Therefore, the secured appointments for the focus group interviews were based on the availability of the participants who volunteered to participate. The researcher addressed the questions posed by the participants for clarity. The researcher also informed the participants that she would be accompanied by a moderator who would conduct the interviews, and that an audio

recorder would be used, as well as notes written by the researcher. Participants from the same wards did not take part in the same FGI to ensure that service delivery was not compromised. As agreed with the operational managers and participants, the hour spent in the FGI was their lunch break and refreshments were made available for the participants.

The researcher noted the participants' contact numbers in order to remind them of the appointment and to ensure that a sufficient number of professional nurses would participate. Further, the researcher contacted the participants a day before the focus group to confirm their availability. On the day of the focus group interviews, the researcher made follow-up phone calls to every participant and went personally to some wards to remind them of the interviews. The three FGIs were conducted on three different days and data saturation was reached at the end of the third interview.

2.5.2 Focus group interview

A focus group is defined by Punch (2014:271) as a group of people brought together to discuss a topic with one or more facilitators who introduce and guide the discussion and record it in some way. Further, Webb and Doman (2011:51) explain the focus group as a form of interview used in qualitative research consisting of a small number of people brought together by the researcher to discuss a specific topic. The focus group interviews for this study were introduced by the researcher and guided by the moderator. Focus group interviews were conducted using semi-structure questions as listed in page 25 based on Domain 2. Interviews were conducted in three focus groups, each focus group consisting of five professional nurses. Further, four participants were interviewed after the researcher went back to the research setting to obtain more data on positive aspects of Domain 2 of the NCS for the health establishments.

- **Preparation of the venue**

Doody, Slevin and Taggaart (2013:171) suggest that providing a conducive environment with adequate lighting and a cool temperature ensures that participants discuss their challenges without fear and enhance in-depth discussions. Therefore, the researcher booked a venue in the hospital that was conducive to the meeting, that is, the hospital boardroom, would be free of disturbances of any kind, and was large enough to accommodate all the participants (De Vos et al., 2011:365). The venue had adequate lighting and a cool temperature. The researcher, the moderator and the participants were seated in a U-shaped arrangement around the boardroom

table and used comfortable chairs. The participants knew where the venue was as it was located at the hospital where they were working.

- **Preparation of equipment**

A high quality audio recorder to record focus group interviews was purchased. Pens and pencils, highlighters and paper for writing field notes were available. According to Polit and Beck (2012:725), field notes are the notes taken by the researcher to record the unstructured observations made in the field along with the interpretation of those observations.

- **The researcher's role**

The researcher is a member of the review team for NCS for Health Establishments in the hospital where the research study was conducted. The researcher arranged and prepared the venue and ensured that the participants were comfortably seated. The researcher welcomed the participants and introduced the moderator and described her role. Thereafter, she explained the purpose and objectives of the research and assured the participants that the ethical considerations would be maintained throughout the study. The researcher was not actively involved in the discussions in the focus group interviews so as to enhance the credibility of the study. The researcher's role was to organize the interviews and take field notes.

- **Moderator**

The moderator conducted the FGIs. She was a competent interviewer for focus group interviews and guided the interview according to written questions (Polit & Beck, 2012:538). She is an experienced psychiatric lecturer with experience in conducting focus group interviews. The rationale for this decision was that the researcher is involved as a member of the review team of the NCS in the hospital. The researcher discussed the proposal, aim and objectives of the study a day before commencing with the interviews. Therefore, she was familiar with the proposal prior to the interview.

The moderator created an open environment to ensure that the participants were at ease. She read the information leaflet. The participants were assured that the participation was voluntary and they were given the opportunity to read the information leaflet and sign the informed consent (Annexure B). The moderator requested permission to use the audio recorder during the FGI. Ground rules were established, such as switching off mobile phones and respecting others' opinions.

The moderator asked FGI questions, such as the following: starting with the general questions, asking open questions, using neutral questions, using appropriate vocabulary and use of concrete questions as suggested by Green and Browne (2011:56). Further, the authors state that starting with general questions orientates the participants to the topic and makes them feel more comfortable with the study. The moderator started by asking general questions, such as "What do you understand by NCS?"

According to Doody et al. (2012:31), the use of "why" questions may put the participants on the defensive. In this study the moderator used neutral questions, such as "How do you handle that?'' Appropriate vocabulary was used. This was also used in connection with the data obtained. The participants responded to the questions posed. Concrete questions were applied as closing questions at the end of the FGI. The moderator asked questions such as: "Any other challenges?'', "Anything else?" The main questions that were put to the participants were:

- What are the challenges to attain Domain 2 for extreme measures of the NCS for the Health Establishments in a district hospital regarding patient safety?
- What are the challenges to attain Domain 2 for extreme measures of the NCS for the Health Establishments in a district hospital regarding clinical governance?
- What are the challenges to attain Domain 2 for extreme measures of the NCS for the Health Establishments in a district hospital regarding patient care?

The moderator used probing, reflection, clarification, listening skills and paraphrasing during the FGIs.

In this study, probing assisted the moderator in exploring the challenges professional nurses are encountering when it comes to attain the extreme measures for Domain 2 of the NCS for the Health Establishment. De Vos et al. (2011:77) state that probing influences the participants to provide more information about the topic to be explored. The moderator used the following probing method: repeated questions to give the participants more time to think about the questions and the participants were asked to provide details if the responses were not clear. The moderator avoided asking leading questions during FGI as these could have reflected her opinions and assumptions. Follow-up questions were asked on key points.

The moderator used reflection, such as repeating a participant's opinions relating to the challenges to the attainment of extreme measures for Domain 2 of the NCS to ensure that she correctly understood the information given.

According to Doody and Noonan (2013:30), interviews involve the use of prearranged questions whereby the researcher is free to seek clarification. In this study, the moderator used clarification to explain statements made by the participants so as to obtain detailed information about the topic.

Gravett and Geyser (2013:50) state that the quality of listening is important, as it enables the moderator to interact with the participants and obtain clarity regarding the opinions offered by the participants. In this study, the moderator acknowledged that she understood and heard the participants by nodding her head.

Paraphrasing was also used in this study. Doody et al. (2013:172) explain paraphrasing as repeating what has been said. The moderator used paraphrasing during the FGI and at the end when summarizing the main challenges identified during the discussions. Finally, the moderator thanked all the participants for their contribution and time. The researcher informed the participants that they may be contacted regarding the data obtained should the need arise. The researcher and the moderator had a debriefing session to discuss the outcome of each of the FGIs after the participants had left. The researcher did the verbatim transcription of the audio recorded data and field notes after each focus group interview so as to identify what needed to be probed.

The discussions were recorded by an audio recorder and in field notes.

- **Audio recorder**

In this study, the audio recorder was used with the permission of the participants. Liamputong (2012:84) suggests that, when recording, the researcher has to ensure that there are no background noises, as they may impact on the quality of the audio sound, thereby making it difficult to hear the discussions on the audio recorder when transcribing. The quality of the audio

recorder was tested before starting the interviews to make sure that it was in working order. The participants were made aware of the audio recorder and of the fact that it would be used to capture the discussions accurately. Field notes were used as a backup for the audio recordings during the data analysis.

- **Field notes**

Field notes should be made during interviews to record immediate responses to the discussions and to capture non-verbal responses from the participants (Birks & Mills, 2011:78). Field notes were made by the researcher during the FGIs and included the observation of participants' verbal and non-verbal responses and they assisted the researcher in understanding how the participants felt about challenges to attain extreme measures for Domain 2 of the NCS in the research setting. Non-verbal responses that were recorded by the researcher included the use of hands and nodding the head when other participants were expressing themselves.

2.6 Data Analysis

According to Polit and Beck (2012:725), data analysis is the systematic organisation and synthesis of the research data. Audio recordings of the interviews were transcribed verbatim into English, as the interviews were conducted in that language. Tesch's method of qualitative data analysis was used, as explained by Cresswell (2013:192), to analyse the data for this research. The following steps were used:

- The researcher transcribed audio-recorded FGI, verbatim after every focus group interview. Thereafter, the researcher read the transcripts carefully, and when new ideas came to mind, she noted them down in the margin of the transcripts.
- In this step, the topics emerged from careful reading of the transcripts and listening to the audio recording of the focus group interviews several times. Similar topics were clustered together by writing notes in the margins of the transcribed data on the A4 paper for the purpose of identifying possible categories. The researcher read the data several times and formed sub-categories from the information gathered during the focus group interviews.
- Notes were written next to the data to explain what it meant. The researcher organised the data into categories and sub-categories. Thereafter, similar categories were grouped

into themes. Themes are the outcomes of coding, categorization and analytic reflection (Saldana, 2013:123). According to Elliot and Gibbs (2010:123), categories are creative constructs in which discrete events, action and behaviour are placed for later data analysis.

- The transcripts were shown to the participants to see whether they agreed that it a true reflection of what was discussed during the focus group interview.
- The verbatim transcripts were taken to an independent co-coder who conducted independent data analysis. Thereafter, the researcher met with the supervisors to compare the findings. They reached consensus on the themes, categories and sub-categories identified.
- A final decision was made after repeated refining and naming of the main themes, categories and sub-categories.

2.7 TRUSTWORTHINESS

Trustworthiness refers to the degree of confidence the qualitative researcher has in their data (De Vos, Fouché & Delport, 2011:365). The researcher ensured that the criteria of trustworthiness: credibility, dependability, confirmability, transferability and authenticity were met.

Credibility refers to confidence in the truth of the data and the interpretation thereof (Brink et al., 2012:172). Prolonged engagement and constant observation ensured that sufficient time was spent with the participants before and during the focus group sessions to capture their views and behaviour displayed. The researcher attained prolonged engagement as she was a member of the review team for NCS for Health Establishments in the selected hospital where the study was conducted and has been involved with the phenomenon at her work for two years. The researcher and the moderator collected data and experienced supervisors went through it as such data collection was triangulated. The researcher went through the focus group interviews and the field notes. Audio recordings were used to assist in gathering and recording the data.

Field notes, which also included non-verbal communication cues and facial expressions were documented during the focus group interviews by the researcher. Member checking was done by the researcher before leaving the research setting by engaging the participants to check the accuracy of the information. According to Yin (2011:310), member-checking allows the participants

to correct the accuracy of the study while at the same time reinforcing the ethical consideratons. The co-coder was used to confirm the themes, categories and sub-categories identified.

Data saturation is the collection of qualitative data to the point where a sense of closure is reached because new data yield redundant information. The researcher analysed the vebatim transcribed FGI data and assessed it for data saturation.

Dependability refers to the provision of data that, when repeated with the same or similar participants in the same context, the findings will yield the same results (De Vos et al., 2011:585). The researcher used a moderator during the interviews. Transcription of the audio recording of the focus group interviews was done after repeatedly listening to the audio recorder. All interview materials, audio taped data, transcriptions and findings were made available and accessible to the supervisor for the purpose of conducting an audit trail. The process of themes and categories was followed through the supervisor's expertise and the qualified experienced researcher was asked for the verification of the coded data.

Confirmability refers to the potential for congruency of data in terms of accuracy, relevance or meaning (Polit & Beck, 2012:585). Confirmability was enhanced by the researcher who was objective in avoiding bias or imposing her own values and ideas on the participants. Therefore, the researcher and the moderator used bracketing, which refers to setting aside preconceived beliefs and opinions about the phenomenon to be studied (Brink et al., 2012:122). An experienced moderator conducted the focus group interviews while the researcher observed and took field notes. Data was thereafter transcribed verbatim, analysed, coded and handed to the independent co-coder to conduct the independent data analysis. Thereafter, conclusions were reached based on consensus between the researcher and the supervisors on categories, sub-categories and themes identified. The findings were shown as quotations in the participants' own words to give evidence of the information provided.

Transferability refers to the extent to which findings can be transferred to or are applicable to the other research setting or group (De Vos et al., 2011:41). The transferability of the findings was not possible as the professional nurses from only one district hospital in Tshwane, Gauteng were included in the study. Comprehensive field notes containing rich descriptions of what had transpired in the study setting were kept.

Authenticity refers to the extent to which the qualitative researcher indicates a range of realities in a fair and faithful manner (Brink et al., 2012:173). The researcher ensured that the exact words and non-verbal cues of the participants are captured and documented using the experienced moderator to conduct the discussions. Quotations in from the participants' own words to show evidence of the information were provided so that readers could understand exactly what the participants had said. The data triangulation methods used were made as clear as possible during the data collection and the data analysis had already been explained in this chapter.

2.8 CONCLUSIONS

In this chapter, the research design and methodology used were discussed in detail. The specific sampling used was discussed. Details of data collection were included from the preparation for the interview up to the post-interview phase, including details of the focus group interviews. The data analysis process and measures for enhancing trustworthiness during the study were outlined. Chapter 3 provides an overview of the study findings and discussions of the related literature.

CHAPTER 3

DISCUSSION OF THE RESULTS AND THE LITERATURE

3.1 INTRODUCTION

Chapter two described the research design and methodology used for the study. Chapter three focuses on the research findings and discussion in order to obtain the meaning from what the participants say about the challenges to attain extreme measures for Domain 2 of the National Core Standards for the Health establishments in a district hospital in Tshwane, Gauteng. The data derived from the challenges experienced by the participants in this chapter was arranged into themes, categories and sub-categories after the data analysis.

3.2 OVERVIEW OF THE RESEARCH FINDINGS

The professional nurses provided input on the challenges to attain extreme measures for Domain 2. Data was gathered by means of three focus-group interviews. However, the researcher had to go back to the study setting to interview other participants in order to obtain positive feedback on the study. Each group consisted of five professional nurses who had been working in the hospital for a period of one year or more. The participants were all female professional nurses whose ages ranged from their late thirties to their early fifties. Their educational qualification included certificates, diplomas and degrees. The researcher read and listened to the audio recorder and read the field notes, and the data was transcribed verbatim. Tesch's method for qualitative data analysis was used to analyse the data as described in Chapter two. The researcher also had a meeting with the co-coder and supervisors to discuss and reach consensus on themes, categories and sub-categories.

The research findings were based on the following open-ended questions posed to the professional nurses during the focus-group interviews.

"What are the challenges to attain extreme measures for Domain 2 of the National Core Standards for the Health Establishments in a district hospital in Tshwane, Gauteng regarding patient safety?"

"What are the challenges to attain extreme measures for Domain 2 of the National Core Standards for the Health Establishments in a district hospital in Tshwane, Gauteng regarding clinical governance?"

"What are the challenges to attain extreme measures for Domain 2 of the National Core Standards for the Health Establishments in a district hospital in Tshwane, Gauteng regarding patient care?"

The themes, categories and sub-categories are presented as follows in Table 3.1

THEMES	CATEGORIES	SUB-CATEGORIES
3.2.1 Clinical governance challenges	3.2.1.1 Factors related to clinical practice	Inadequate patient mix Patient overcrowding Shortage of staff Insufficient medical supplies or equipment
	3.2.1.2 Vulnerability to clinical risks	Risk of infection Risk of injury
	3.2.1.3 Inadequate leadership and management	Management listening skills Management support
	3.2.1.4 Inefficient referral system	Delayed referral system Delayed health interventions
	3.2.1.5 Relevant expertise in various departments	Inappropriate skills Issues with procurement
3.2.2 Patient safety challenges	3.2.2.1 Documentation/Record keeping	Medication Patient progress records
	3.2.2.2 Patient risk of pressure sores	Screening/assessment Monitoring
	3.2.2.3 Patient education	Inadequate patient information Inadequate preoperative counselling

THEMES	CATEGORIES	SUB-CATEGORIES
3.2.3 Patient care challenges	3.2.3.1 Knowledge on emergency preparedness	Emergency equipment Resuscitation of patients Use of mobile phones

3.3 THEME 1: CLINICAL GOVERNANCE CHALLENGES

The NCS for Health Establishments are created by the Department of Health as a means of showing commitment to providing quality care to patients in what is expected, and required to improve service delivery. Cloete (2017:38) stated that NCS recognises that staff are vital to ensuring that the health system delivers quality healthcare and therefore require protection against the risk of injury, infection and other occupational hazards, consistent with the South African Occupational Health and Safety Act of 1993 (Act 85 of 1993: section 8(1)). Therefore, they assist healthcare institutions to control health and safety risks by putting in place the policies, procedures and controls needed to attain quality care.

In this study, Domain 2 of the NCS, which is patient safety, clinical governance and care, focuses on how to ensure quality healthcare and conforming to accepted standards by reducing unintended harm to patients; preventing or managing patient safety incidents, including healthcare associated infections (NDoH, 2011:10). The Domain is involved directly with the core business of the health system of delivering quality healthcare to patients.

Extreme measures of the NCS for the Health Establishments are measures ensuring that the safety of patients and staff is safeguarded to avoid unnecessary harm or death (NDoH, 2011:13). Structure measures include human resources, infrastructure, availability of equipment and supplies, while process measures address activities or interventions carried out within the healthcare institution in the care of patients or the management of the organisation or staff such as patient education, medicine administration, equipment maintenance and clinical guidelines. On the other hand, outcome measures look at the effect of the intervention used on a specific health problem like patient mortality and wound healing without complications like infection control. Consequently, with clinical governance in healthcare institutions whereby structures and processes are inadequate, outcomes and service delivery will be affected.

Clinical governance is the collective of officials according to which healthcare institutions are responsible and accountable for continuously improving the quality of their services, upholding high standards of care, and ensuring the best clinical outcomes for patient care by creating an environment in which excellence in clinical care will flourish (Health Service Executive, 2014:3). In this setting, the system of clinical governance includes: mortality and morbidity reviews, patient or client record reviews, clinical audits, adverse events reviews, evidence based clinical practice, and measurement of clinical performance. The committees thereof are core management committees in which all heads of departments are involved, quality assurance, serious adverse events and complaints committee, infection prevention and control committee, the occupational health and safety committee, mortality and morbidity committee, pharmaceutical and therapeutic committee and clinical audits committee.

Therefore, in this study, clinical governance challenges concern having a framework in place in the selected hospital that adequately supports the healthcare practitioners. The standards of care delivered, and the protection of patients from harm caused by hindrances to attain extreme measures (100%) also require support. Hence, clinical governance requires commitment at all the levels of management within the healthcare institution, including the key providers of clinical care. Therefore, procedures and practices should be in place to ensure that healthcare providers are informed on how well patient care is being provided and on how healthcare risks are managed, ensuring clinical efficiency and effectiveness.

The first theme that emerged during the data analysis was that of challenges to clinical governance. Clinical governance is an overarching outcome and is viewed as the link with the other two NCS Domain 2 outcomes, which are patient safety, and care. Five categories emerged from this theme, namely: factors relating to clinical practice, vulnerability to clinical risk, inadequate leadership and management, an inefficient referral system, and relevant expertise in various departments.

3.3.1 Category 1.1: Factors related to clinical practice

According to Kredo, Bernhardsson, Machingaidze, Young, Louw, Ochodo and Grimmer (2016:122), clinical practice relates to clinical matters, generally dealing with clinical conditions, and is typically directed by healthcare providers and clinical managers. Thus it includes best practices or a combination of concerns regarding screening, diagnosis, management or monitoring. In this study, factors related to clinical practice are aspects that inhibit healthcare providers from attain extreme measures for clinical governance of the National core standards in their institution.

Factors relating to clinical practice is the category that emerged from the theme clinical governance challenges. This category has four sub-categories, namely: an inadequate patient mix, patient overcrowding, staff shortage and insufficient medical supplies and equipment

- **Sub-category: Inadequate patient mix**

According to the Mosby medical Dictionary (2009:917), a patient mix is defined as the number of patients presenting with a certain diversity of diagnoses. They are grouped together, reflecting the range of patient characteristics, such as diagnoses, disease severity, gender, age, socio-economic status or functional status. In this study, an inadequate patient mix means patients who are allocated to the same wards with different diagnoses, such as psychiatric and medical patients without being cohorted. In this institution, some of the departments have been renovated, introducing high-technical facilities, which allows for the separation of patients with different diagnoses, specifically infectious patients. Some renovations are underway for certain departments. The structure and layout of the other wards and departments do not allow for patients with different diagnoses to be separated.

The participants in this study pointed out that patients with different diagnoses, such as psychiatric and medical patients, are sometimes admitted to the same wards, which are open spaces without partitions. In this institution, the psychiatric patients are admitted for 72-hour observation and await referral to Hospital B after being assessed. However, patients stay in the ward for more than five days, in the worst cases for more than a month, awaiting admission to hospital B. This makes the separation of patients into different wards difficult.

This was expressed as follows:

FG1 (P4):

> *"You may find that we've got five of them (psychiatric patients), we've got five orthopaedics (orthopaedic patients), we've got five gynae (gynaecology patients) there, and you name it, all these conditions. I've said we are a mixed ward."*

FG3 (P10):

> *"… then you find that our patient from theatre go to the ward that is mixed, that is psychiatric and post-operative patients and it is affecting us directly or indirectly."*

In contrast with previous participants, one of the participants reported that the renovated departments, like the maternity complex and the paediatric ward, are structured in a way that allows infectious patients to be separated, because certain rooms are set apart for patients who have to be isolated. This was expressed as follows:

FG4 (P16):

> *"In this hospital, maternity complex which is separated in labour ward and postnatal ward were renovated with high standards equipment (high technicalities) and even separated in cubicles. Paediatric ward was also renovated with safety doors and separated rooms with toilets and bathrooms whereby children with infectious diseases are allocated so that they are not mixed with the other patients with other diagnosis".*

The findings show that patient separation is a problem in the setting where the study was conducted. The healthcare service separates or mixes the patients so as to reduce risks, as there is a high number of patients. Bekker, Koole and Roubos (2016:2) show that patient mix is a critical aspect of the patient care process within a hospital when patients have to be organised according to their illness. The authors further assert that the flexibility of patient allocation can have some disadvantages, as different systems are more difficult to manage. Issues such as the lack of infrastructure require multi-skilled teams to manage this, while patients are mixed in a

single ward. Therefore, the allocation of beds should be in accordance with medical disciplines, such as medicine, surgery, cardiology, obstetrics, neurology, and gynaecology.

According to Lindvig, Teisner, Kjeldsen, Strøm, Toft, Furhmann and Krag (2015:8965), there is a need for proper triage to guide the physicians in decision-making regarding the appropriate patient mix. This information complements the findings in this study. The professional nurses confirmed that triaging is done in the casualty ward and the OPD, but patients are allocated to the same ward for different health disciplines.

- **Sub-category: Patient overcrowding**

The participants expressed their concerns that, in the OPD department, the patients are booked but some come as walk-in patients without being booked and then patients have to wait in the small waiting rooms. Some participants were concerned about the paramedics, who bring patients from everywhere, without considering the catchment areas. The researcher has been working in this institution for two years and catchment area issues are not considered; patients are not returned without being assessed. Even the gatekeeper discourages the former, so with the overflow of patients. In this institution, triaging is conducted in the out-patients' department (OPD) and the casualty section. As well as this, a booking system is used for patients in the OPD. However, patient overcrowding emerged as a sub-category. The latter is evident in the patients' experience of care in the institution.

This is what the participants said:

FG2 (P8):

> *"… then we've got a challenge with the paramedics. The hospital, everybody wants to come to this hospital. They can take a patient from (Township A not our catchment area) straight to our hospital knowing that we won't chase them away of which there are some hospitals. Patients from (Township B) and (Township C our catchment areas) come to our hospital and it's overcrowded and there is no enough staff."*

FG2 (P7):

> *"It is too much for us. Some of the patients and relatives when they come and we tell them that there are no beds then they don't understand, they think that we want to chase them away. Even now beds are full".*

The outpatient department is also congested as pointed out:

FG2 (P6):

> *"OPD is divided into three departments. Okay, we have eye clinic but in OPD we have room 1, it's a triage and we've got OPD whereby we see those patients who are booked and we've got 120 patients who are booked for today. In triage, they just come in like that. So I can't say we've got so many but most of the time, there is a backlog of patients. I mean congestion."*

Congestion leads to lack of privacy, as indicated by one participant:

FG1 (P4):

> *"It is and there is no privacy. You are talking to patient number one and as you sitting then patient number two is here and we don't have rooms to conduct interview especially with MHCU (mental healthcare users) patients."*

There are several reasons for overcrowding patients in the study setting. According to the Batho-Pele white paper (1997:20), access to services should not be denied to any user. Thus the hospitals are in a difficult position and there are risks of overcrowding, as they cannot deny access to users outside of the catchment areas.

According to Yarmohammadian, Rezaei, Haghshenas and Tavakoli (2017:23), patient overcrowding is defined as the situation in which the healthcare professionals' function is hindered, mainly because of the excess number of patients waiting to be seen, undergoing assessment and treatment, or waiting for discharge or referral to other hospitals. The authors

further state that patients' safety, privacy, suitability for the services and frustration among staff are some of the aspects affected by overcrowding.

Similarly, Boyle, Beniuk, Higginson and Atkinson (2012:1) identify patient overcrowding as the excessive number of patients waiting to be seen along with a delay longer than 5 minutes from the time of arrival to the beginning of the initial triage, or when an emergent patient waits longer than 30 minutes to be seen by a physician. The authors further state that, worldwide, overcrowding has become a widespread problem in hospitals.

Pascasie and Mtshali (2014:178) assert that patient overcrowding exists when there is no space left to meet the timely needs of the next patient requiring healthcare and the care of urgent problems is delayed owing to congestion. The authors further state that overcrowding, specifically in the emergency department, causes problems for patients and staff, including increased waiting times, ambulance diversion, length of stay, medical errors and patient mortality. Furthermore, patient overcrowding has a negative impact on the quality of care. Medication errors have been shown to increase in frequency as overcrowding occurs (Pascasie & Mtshali, 2014:178).

Chan, Meckler and Doan (2017:377) affirm that general emergency department overcrowding impacts negatively on patient care, and increases patient morbidity. The results in their study confirm that there is a correlation between adverse events and overcrowding. In this institution the quality assurance committee is responsible for patient overcrowding in order to control the increased waiting times, which can affect the occurrence of serious adverse events.

- **Sub-category: Shortage of staff**

The third sub-category that emerged from the study is the "shortage of staff". It is evident from the study that the participants are concerned about this. The participants reported that they were overwhelmed by work responsibilities as nurses and it is the same for doctors, because sometimes only two doctors are duty for the whole institution. As a result, there is a delay in resuscitating patients. This was a challenge as it reduced the opportunity of delivering good quality patient care, ultimately affecting patient safety and care. This was phrased as follows:

FG2 (P7):

> *"… the challenge the doctors have is you find that it's weekend and there are two doctors and are interns, they are juniors. So when there is emergency, we (nurses) have to call them from casualty to come. So, I think for their sake, they prefer to push patients to resuscitate in casualty."*

FG1 (P4):

> *"They (doctors in the referral hospital) asked in the morning saying that you can send three or four patients. And not one nurse will escort because as they get to (Hospital Breferral hospital), they (escorting nurses) take different directions and it's a long distance and we end up with the ward without nurses".*

The core management committee plays a significant role in clinical governance and care when it comes to human resource provision in the work place. The committee facilitates the overall function of the institution, with human resources as one of its core concerns. The Department of Health is mandated by both the Constitution of the Republic of South Africa 1996 (Act no 108 of 1996) and the National Health Act 2003 (Act no 61 of 2003) to deliver health services to South African citizens. This means ensuring the provision of adequate human resources to enable the health system to deliver on that directive.

According to Matsoso and Strachan (2012:7), in human resource strategy for the health sector, there is the necessity of developing and employing new healthcare professionals to meet health needs, and to increase the number of personnel to achieve the delivery of quality care. Similarly, the national strategic plan for nurse education, training and practice (2012:13) emphasised that the development of a model which provides information on the future supply of nurses for the public and private sector hospitals should be looked into for quality service delivery. Therefore, without adequate human resource capacity, clinical governance and care, which is one of the components of Domain 2 of the NCS, will not be attained.

Willcox, Richardson, Bone, Foulis and Morgan (2015:10) conclude that staff shortages are greatest in healthcare institutions, resulting in medical errors and compromising patient safety

and care. These results are consistent with the findings of Willcox et al. (2015:10), which point out that there are healthcare centres which are not adequately staffed and often do not provide comprehensive healthcare services.

In South Africa, the nursing shortage is among the factors affecting the performance of healthcare professionals, hence the risk to quality patient care. The Practice Environments (PPE) of which human resource is one of the necessary attributes of healthcare settings that support nursing quality, has an influence in improving clinical governance, patient safety and supporting patient care (NDoH, 2012:13).

- **Sub-category: Insufficient medical supplies or equipment**

There were numerous reports in the findings that medical supplies and equipment are inadequate in the research setting. According to the participants, tenders for procurement are made but there are challenges when it comes to paying the suppliers. It is evident that the participants go as far as phoning the suppliers when they are out of stock but the response is that no payments have been made to the suppliers. Some of the participants stated that, in their wards they have limited or no resources and they felt that this affected their service delivery negatively.

The participants were concerned about the lack of the medical consumables needed for infection control, and said:

FG1 (P1):

> *".... and even in pharmacy when we are asking for disinfectants then they say they don't have. With audits and core standards, with observations they look for the disinfectants and we have to explain that pharmacy doesn't have."*

FG2 (P8):

> *"We are struggling with consumables in an emergency trolley. In stores they don't supply us with different sizes that we want for example the endotracheal (ET) tubes. The standards need them from paeds (paediatric) to adults."*

Some participants complained that the equipment needed for routine patient care was not available. They said:

FG2 (P6):

"I think in OPD, we struggle with blood pressure machines."

FG3 (P14):

> *"OPD, we've got a problem of equipment. Equipment are not there. We've got only one dinamap (blood pressure machine) in Ward A. Ward A is where patients are taken vital signs, the first time and we do our dressings. In room A, we have one machine."*

Contrary to the preceding reports, one of the participants acknowledged that the gatekeeper, who is the CEO of the study setting, ensures that everything in the healthcare institution is in order. This was expressed as follows:

FG2 (P9):

> *"We have a CEO who is more involved in the running of the hospital. He ensures that the equipment is available unless it is stuck at the Vetting committee. He's really trying his best to ensure that things are in order in our hospital."*

The supply chain committee, which is the core management sub-committee, is responsible for ordering the equipment. However, before it can be purchased and repaired, ordering equipment has to be approved by the vetting committee.

The vetting committee looks into specifications and compares quotations, so the process takes a long time if the committee members disagree on ordering and purchasing the equipment.

Resources must be available so that an effective, well-organised working environment can be created. Medical supplies and equipment must be organised and controlled so as to ensure cost control measures. Eygelaar and Stellenberg (2012:3) state that the quality of nursing care is affected by the inadequate supply and provision of consumables and equipment and this impacts negatively on patient care. The authors further state that medical supplies and equipment are important to improving working conditions and t the achievement of quality care for a better life.

It is therefore imperative that the necessary medical supplies and equipment be made available to employees so that they can complete their tasks (Manyisa & Aswegen, 2017:37). This information correlates with the findings of the study.

In terms of the category factors related to clinical practice, it appears that this category relates to the structural component of the Donabedian model. The challenge to the healthcare providers regarding patient mix, patient overcrowding, the shortage of staff and inadequate equipment further affects them when it comes to attain patient safety. Without the structural components, processes which are the services rendered will not be delivered and outcomes will be affected negatively. As a result, the healthcare providers’ performance in this regard will be affected, with negative consequences for quality patient care.

3.3.2 Category 1.2: Vulnerability to clinical risks

Farokhzadian, Dehghan, Nayeri and Borhani (2015:294) indicate that clinical risks have created challenges to the healthcare system, such as serious adverse effects on patient safety, consequently compromising the quality and safety of services to healthcare. The vulnerability to clinical risks means compromising patient safety as well as the safety of visitors, and healthcare practitioners. This includes adverse events or harm and healthcare associated infections. A clinical risk policy, protocol and standard operating procedure are available in the study setting, which indicates the healthcare institution approach to the management of clinical risks.

The second category that emerged from the theme clinical governance challenges is vulnerability to clinical risk. This category is supported by two sub-categories, namely: the risk of infection and the risk of injury. The sub-categories are discussed below.

- **Sub-category: Risk of infection**

Infection is the invasion of an organism's body tissues by disease-causing agents, their multiplication, and the reaction of the host tissues to the infectious agents and the toxins they produce (GDOH, 2016:10). In this study, the risk of infection is what exposes healthcare providers and patients to infections, thus hindering the attainment of the extreme measures of Domain 2 of the National Core Standards.

In this institution, there is an Infection prevention and control (IPC) programme. The IPC committee comprises the IPC coordinator, the medical officer, the nursing manager, the heads of all the departments, a pharmacist and a microbiologist. The legal frameworks that regulate the programme are the policies, protocols, guidelines and standard operating procedures that are available and accessible. In-service training is conducted on infection prevention and control. However, there is the risk of infection, which compromises patient safety and care, inadequate consequently leading to litigation. A few participants in this study said the infection control practices which could result in infection were inaquate as were the isolation rooms in some departments, where isolation patients use the general toilets. However, some participants mentioned positive aspects of infection prevention and control relating to the environmental cleanliness that is conducted adequately by the cleaners during the stay and discharge of the infectious patient. The correct personal protective equipment worn by healthcare practitioners during contact with patients prevents exposure.

The lack of space and the overcrowding affected the isolation guidelines. For instance, this adds to the risks of contracting healthcare associated infections, and the participants said:

FG1 (P3):

> *"Like in casualty, we've got an isolation ward but it is also a challenge because PTB (pulmonary tuberculosis), MDR-TB patients and also meningitis need to be isolated but we've got only one isolation. So it is also a problem."*

FG3 (P12):

> *"We do isolate them but the structure of our isolation is not good because it doesn't have adequate facilities. That patient that has infections like Klebsiella pneumonia, they move from the side wards (isolation rooms) to the same toilets as the others."*

On the positive side, some of the participants reported that the IPC programme is a good intervention implemented by the Department of Health. They explained that the IPC coordinator and the operational managers empowered them with knowledge on infection control. However, at the same time, they sometimes found infection control challenging when it came to the infrastructure. When the moderator posed probing questions, the explanation of positive aspects was that they have guidelines and they are given in-service training infection control.

This was cited as follows:

> *FG1 (P4):*
>
> *"There is infection control guidelines in place and we make sure we communicate it to everyone and we let them sign at the back of this as a matter of acknowledgement and again if we do walkabouts we can also identify where there's a need for training for instance with waste segregation. We are checking for the sharp containers for recapping of needles."*
>
> *FG3 (P12): "We do admit MDR patients and when those patients are discharged, the cleaners know that the room should be cleaned thoroughly even during the stay of the*

patient in the ward. They are using biocide to clean. The challenge is we don't have toilets and bathroom in the isolation rooms."

FG2 (P10): "We have PPE (Personal protective equipment) to use as one of infection control measure, for instance if we have a patient with MDR-TB (multi drug resistant TB), we have the N95 masks, gloves and aprons and in case of klebsiella, we use gloves and aprons. It depends on the type of infection. Even the Infection control coordinator advises us on the infection control measures depending on the infection at that time. Again she advises us that every patient should be treated as infectious."

FG1 (P4): "What I know is that sometimes the infection control team comes and takes swabs."

Legally, it is stated in the Gauteng Department of Health Infection Prevention and Control policy guidelines (2016:53) that specific precautions, such as adequate facilities and standard precautions, namely, PPE, should be in place or should be provided in healthcare institutions for patients with infectious diseases. This would prevent the spread of healthcare associated infections. Therefore, with the prevention and reduction of healthcare associated infections, a safe environment for patients and staff that is not harmful to their health and well-being should be maintained (South Africa, 1996:8; NDoH, 2003:29). Even though, there is a legal framework regulating the healthcare institutions regarding the infection control measures, risk during infection control is still a challenge.

According to Churchyard, Mametja, Mvusi, Ndjeka, Hesseling, Reid, Babatunde and Pillay (2014:244), tuberculosis (TB) remains a global health risk, and South Africa (SA) is experiencing one of the world's worst TB epidemics. The authors further state that SA has made outstanding progress in reducing TB prevalence and deaths and improving treatment outcomes for new smear-positive TB cases. However, the burden of TB remains enormous. Furthermore, TB is an infectious airborne disease that can be transmitted through coughing and sneezing.

Multidrug-resistant TB (MDR-TB) is a major challenge to the TB control program, as it is expensive to treat. MDR-TB is resistant to treatment with first-line treatment of anti-TB drugs isoniazid and rifampicin (Khazaei, Salehiniya & Mohammadian-Hafshejan, 2016:114). In this institution, the major concern is the probability of MDR-TB transmission to patients, healthcare professionals and visitors because of administrative and environmental control measures, such as personal protective equipment and adequate facilities for isolation rooms that are not considered. The findings revealed that the greatest fear among healthcare personnel working in drug-resistant TB wards was that of contracting multi-drug resistant tuberculosis (MDR-TB) or extreme drug resistant tuberculosis (XDR-TB) and the risk of infecting others. Such a fear could negatively impact the provision of quality patient care.

Klebsiella pneumoniae is a common healthcare associated infection causing bloodstream infections and it is resistant to antibiotics like Cephalosporins and Carbapenems (Xiao, Wang, Wu, Zhao, Gu, Ni, Guo, Qu& Han, 2017:250). Furthermore, Klebsiella pneumonia is a contact disease that can be transmitted from an infected person to a healthy person or contaminated innate objects through physical touch. The major concern is that it is difficult to treat because it is resistant to many antibiotics. Patients with Klebsiella pneumonia should be isolated to curb outbreaks in healthcare institutions, which could indirectly affect the duration of the patient's hospital stay, the cost of healthcare, the risk of death and litigation.

Khan, Baig and Mehboob (2017:478) point out that infections in the healthcare environment can be transmitted through equipment and the environment, so an unhygienic environment serves as the best source in which the micro-organisms can thrive. The authors assert further that infections can be transferred from healthcare professionals, so it is their duty to play a role in infection control by using personal protective equipment in healthcare delivery. In addition, the nurse is negligent if the risk of infection transmission occurs when she is not wearing protective equipment (Damani, 2012:338).

- **Sub-category: Risk of injury**

Norton and Kobusingye (2013:1723) define injury as physical damage to a person and it is characterised by unintentional aspects, which include falls, drowning and burns. In this study, the risk of injury is understood to be a hazardous act that exposes patients and healthcare providers to falls, assaults and physical attacks, thereby jeopardising safety in the institution.

Despite the occupational health and safety programme, the committee, the risk officer, the security officers and the policies available in this hospital, there is still the risk of injury. According to the participants, the patients are even checked for blunt objects on admission. It is evident in this study that patient and staff safety is compromised. The participants felt that the risk of injury, that is, patient falls, and physical assault of patients' and staff are constant in this hospital because of psychiatric patients who threaten the healthcare providers with deadly weapons. The consequences compromise both workers' and patients' safety. A safe environment for patients and staff is a legal requirement (RSA, 1996: section 8).

The participants expressed the risk of injury due to mental healthcare users as follows:

> *FG2 (P7): "Our challenge, we've got so many challenges with the establishment and ward itself, safety of the patients, safety of the staff and our nursing station, we don't have nursing station. It is a table in the middle of the ward and we are seeing psychiatric patients and they are aggressive and some of them will be sitting quiet and then the aggressiveness will pop out at any time and maybe you are busy writing, facing the other side, you will hear the patient pulling your hair…"*

> *FG3 (P11): "…another patient took the sharp object and from nowhere we don't know and he came with that object, he was admitted with that object and he cut another one (restraints) and he just let that patient to go away."*

> *FG2 (P7): "Where I'm working, we've had some employees attacked by some psychiatric patients."*

Contrary to the preceding reports, some positive aspects regarding risk of injury were mentioned by one of the participants, as follows:

FG3 (P12): "There are security officers in every entrance, we do check them (MHCU) and their belongings so that they don't bring objects that can harm other patients or staff members."

According to Policy Guidelines on 72-hour assessment of involuntary mental healthcare users which is taken from the Mental healthcare Act (Act no 17 of 2002), staff allocated to facilities that conduct 72-hour assessment must have the skills to assess and to diagnose mental disorders as well as to exclude underlying physical conditions which may have caused the clinical manifestation. Infrastructural requirements for facilities that conduct 72-hour assessments should be as follows:

- The layout and design must allow for easy supervision and observation of users by staff at all times.
- The layout and design must prevent areas of concealment for purposes of hiding or launching surprise attacks on others or staff.
- The position of the nursing station should provide for secure and effective surveillance of all activities in the ward.
- The windows and doors to the single rooms must be burglar proofed.
- Safe and secured treatment rooms must be available for medical procedures and other neurological/or physical assessments.
- The seclusion room or maximum-security room where applicable must be situated close to the nursing station to allow for constant supervision by staff.

Lastly, according to the Mental Health Act 2002 (Act no17 of 2002, section 34 (4)), 72-hour assessment and the subsequent provision of further involuntary care, treatment and rehabilitation observation, the mental healthcare user is to be cared for, treated and rehabilitated on an in-patient basis and the user has been admitted to a health establishment which is a psychiatric hospital, that hospital must keep, care for, treat and rehabilitate the user; or if not a psychiatric hospital, that user must be transferred to a psychiatric hospital for care, treatment and rehabilitation services.

In this institution, 72-hour assessment for mental healthcare users is conducted. However easy supervision and observation of mental healthcare users is not efficient as a result of the shortage of staff, which renders healthcare providers and patients prone to attacks and physical assaults from mental healthcare users. Patients with special needs or at high risk, such as pregnant mothers, children, the mentally ill or the elderly, receive special attention. Patients belonging to high-risk groups, including violent, suicidal and mentally challenged patients, are kept safe.

Adverse events are routinely analysed and managed to prevent recurrence and to learn from mistakes.

The quality assurance committee, with the assistance of the risk management committee and the occupational health and safety committee ensures that patient safety incidents, of which risk of injury is one, are minimised in the hospital.

According to Spoelstra, Given and Given (2012:4), the physical environment increases falls, which, occur around the bed, the bedside chair, or while transferring the patient. Similarly, Gu, Balcaen, Ni, Ampe and Goffen (2016:8) state that individuals who are in hospital settings are at risk of injury, such as fractures, lacerations and significant internal bleeding. Thus, the increment overall of healthcare utilisation in a hospital system, drives up costs and affects patient when a patient is admitted.

Furthermore, Pompeii, Schoenfisch, Lipscomb, Dement, Smith and Upahyaya (2015:2) assert that the risk of injury is common in hospitals and healthcare providers themselves are at high risk, as are those employed in hospital emergency departments and in in-patient psychiatric units. According to the National Health Act 2003 (no 61 of 2003), risk assessments are obligatory in healthcare institutions to reduce the ever-present risk of injury. South African citizens have a right to a healthy and safe environment, as stated in the Patients Rights Charter (1999).

3.3.3 Category 1.3: Inadequate leadership and management

According to Thabethe (2011:13), leadership initiates changes and the empowerment of others and management is necessary for coordination and the continuity of activities. The author further indicates that a leader is required to determine direction, so leadership is the special skill of getting other people to follow and do willingly the things that the leader would want them to do. Therefore, leadership requires a variety of competencies, personal qualities and attitudes to be able to get people to perform certain duties and it influences the way the organisation is shaped and transformed. Leadership and management have been seen in practical terms such as planning, leading, organising and controlling. Therefore, strong leadership and management with vision will enable improved service delivery with good health outcomes, such as patient safety and care. In this study, inadequate leadership and management are the inability of the management to listen to the healthcare provider’s needs and as a result they feel discouraged about doing their work

effectively. This means that the attainment of the extreme measures for clinical governance is hindered.

Inadequate leadership and management is the third category that emerged from the theme clinical governance challenges. This category is supported by two sub-categories, namely: management listening skills and management support.

Two sub-categories are discussed concurrently with literature as follows:

- **Sub-category: Management listening skills**

It is evident that in this study, the participants regarded the gatekeeper of this institution as a good active listener, which is positive, while other participants felt negative about the management listening to them and felt that work was imposed on them. As a result they were demotivated.

The participants expressed their views as follows:

> *FG3 (P15): "The challenge is with our management; their leadership is not up to standard. They demotivate us. When you go to them you come back demotivated. They are not ready to listen to us."*

> *FG3 (P10): "You know there is a difference between showing policy and guidelines and enforcing stuff to be done if you know very well that if you do this you are compromising patient care. With us when the outside people come and interview us about the leadership here we just be honest and they (management) will be saying why are you doing that. But isn't it that's how they (management) behave. We can't say anything to them and that's not right. We are being treated like children."*

In this institution issues of staff shortage, infrastructure and procurement are a challenge. However, when the healthcare providers address these issues in the monthly meetings, then the management do not attend to those issues. Instead the response is negative.

Issues that are addressed with management are:

> *FG3 (P10): "In our general meetings for professional nurses sometimes we raise issues like staff shortage, infrastructure for instance isolation rooms and procurement problems, and say when will these stop because it's affecting our performance as a hospital towards patient safety and they say no it's been like that, let's work with what we have now and nothing is improving."*

Management should listen in order to create good relations with employees so as to have quality patient care. If management have good listening skills then it is easy for the employees to approach them with difficulties encountered in the workplace, then achievement of organizational goals will be possible. This will be driven by employee performance and productivity. There are different styles of management in institutions: the one that listens to subordinates and the management that disregards everything that employees have to say. The following are defined:

Autocratic management style is the style whereby managers do not listen to ideas or suggestions of the subordinates. Instead, the sole responsibility for taking decisions lies with them. Therefore, the subordinates in such a working style simply adhere to the guidelines and policies formulated by their managers or supervisors and as a result employees are demotivated (Nanjundeswaraswamy & Swamy, 2014:57).

According to Amanchukwu, Stanley and Ololube (2015:7), a democratic management style is the style whereby managers welcome feedback from the subordinates; employees are invited to discuss the pros and cons of plans and ideas. In this way, a democratic management style ensures effective and healthy communication between the management and the employees.

According to Jahromi, Tabatabaee, Abdar and Rajabi (2016:2123), active listening is the important skill specifically for managers in a hospital because ineffective communication is one of the causes of medical errors and unintentional harm to patients. Weerasinghe and This era (2014:33) concur with the above finding that the effective listening skill is considered to be one of the critical skills in communication. Therefore, for a manager to be a good listener, it is a skill that should be improved to achieve good relations with staff, resulting in quality patient care.

Weger, Bell, Minei and Robinson (2014:13) highlight the fact that active listening produces better outcomes in interaction, especially if the outcomes benefit patient care. The participants echoed the same sentiments about listening skills and patient care. Further, Sullivan (2011:1) affirms that we frequently encounter people we consider difficult in our workplace and usually it can be the fault of our supervisors, who lack communication, specifically, lack of effective listening skills. The above relates to this study, as the professional nurses stated that management do not have good listening skills.

- **Sub-category: Management support**

The participants in this study reported that they did not receive support from management and stated that if their needs could be considered then challenges could be avoided.

This was related as follows:

FG1 (P1): "If we can have management support then we can avoid these challenges… The zonal matrons. They must just support their nurses."

FG1 (P2): "Just to say, we (the management) are here with you guys and hear our needs sometimes..."

FG3 (P10): "I don't know if I am relevant but the management is there and we are communicating our challenges but you find that you are not being listened and supported. They rather call you and discipline but for them to correct things it's a problem."

Leadership styles can affect organisational commitment, work satisfaction and work performance positively (Veliu, Manxhari, Demiri & Jahaj, 2017:60). Amanchukwu, Stanley and Ololube (2015:7) list four leadership styles, which are as follows:

- **Autocratic Leadership Style**

Autocratic leadership is leadership, whereby leaders have complete power over their staff. Staff and team members have little opportunity to make suggestions, even if these are in the best interest of the team or organization. Employees are demotivated under this leadership, as their ideas are not heard.

- **Bureaucratic Leadership Style**

Bureaucratic leaders follow rules rigorously, and ensure that their staff also follow procedures precisely. The drawback to this type of leadership is that it is ineffective in teams and organizations that rely on flexibility, creativity or innovation.

- **Democratic/Participative Leadership Style**

Democratic leaders make the final decisions, but include the team members in the decision-making process. They encourage creativity, and team members are often highly engaged in projects and decisions. There are many benefits in democratic leadership. Team members tend to have high job satisfaction and are productive because they are more involved. This style also helps develop employees' skills.

- **Laissez-faire Leadership Style**

The laissez-faire leadership may be the best or the worst of leadership styles as it describes leaders who allow employees to work on their own. Laissez-faire leaders hand over responsibilities and avoid making decisions. They may give their employees complete freedom to do their work and set their own deadlines. This leadership style can be effective if the leader monitors performance and regularly gives feedback to the team members. The main disadvantage of laissez-faire leadership is that employees often fail to manage their time well or do not have the knowledge, skills, or motivation to do their work effectively.

- **Transactional leadership style**

The transactional leadership style includes the exchange of favour for a vote and it is governed by values such as fairness, honesty, loyalty and integrity (Meyer, Naude, Shangase & van Niekerk, 2012:212).

- **Transformational leadership style**

The transformational leadership style is one whereby leaders are charismatic, inspirational, intellectually stimulating and considerate of others (Meyer, Naude, Shangase & van Niekerk, 2012:212).

According to Tsotetsi (2012:63), for change to occur it needs to take place in a nurturing and well structured environment in which there is the responsibility of providing support, managing change and facilitating open communication. The findings of the study reflect that some participants did not find it easy to communicate as it was a challenge to be listened to. The author further states that inadequate support in a working environment is one of the poorest working situations in the workplace.

Further, Buttigieg, Cassar and Scully (2013:618) state that management support and interdisciplinary teamwork are key to quality care in the institution, and serve as a system in preventing medical errors, as it motivates health practitioners' well-being and patient safety. Support in the workplace is vital for the proper functioning of the institution (Newman, Thanacoodi & Hui, 2011:170). The authors further reveal that management support increases job satisfaction and commitment, and decreases turnover and absenteeism in a workplace. Consequently, inadequate support in a workplace leads to unprofessional acts and the result will be patient safety incidents.

3.3.4 Category 1.4: Inefficient referral system

Eskadari, Abbaszadeh and Borhani (2013:229) maintain that a referral system ensures a close relationship between all the levels of the health system and helps to ensure that people receive

healthcare services, including access to better quality care. In this study, an inefficient referral system indicates one that is ineffective and inhibits the attainment of the extreme measures for clinical governance of the National Core standards for this hospital. In this institution, the healthcare providers are conducting the referral process well. However, the challenge is with the receiving hospitals, where the overflow of patients will be stated as a reason for not admitting the patients. Patients will thus be held in a study setting for weeks awaiting further management, specifically mental healthcare users.

The fourth category that emerged from the theme of clinical governance challenges is an inefficient referral system. The category has two sub-categories, which are: a delayed referral system and delayed health interventions.

- **Sub-category: Delayed referral system**

Based on the statements by the participants, the referral of patients to other hospitals, specifically mental healthcare users (MHCU), is a challenge. In the case of MHCU, the institution admits those patients for 72-hour observation. However, when they are referred to the dedicated hospital, then the challenges will be either that the hospital is full or the doctors for that day are not available. The referral process thus takes a long time. The participants related that these are the high risk patients and the institution does not have a dedicated ward for MHCU.

This was expressed as follows:

FG1 (P4): "No, every patient goes with a nurse and many a times when they get there, the doctor is not there and they have to come back and we rearrange a rebooking. It's a delay of the service and rebooking means you are going to be talking to the new doctor if you are unfortunate and it's going to delay the patient going over."

FG3 (P11): "(Hospital B) is full and we are still waiting for beds in hospital B. The referral system is poor because these are high risk patients and we keep them for long so the core standards people do not understand our challenge. They say this should be communicated and corrected but our management knows these things. It's a challenge…"

FG2 (P7): "And when we admit psych (psychiatric) patients, they end up staying for weeks because (hospital B) will be full".

Psychiatric patients are high-risk patients who are supposed to be admitted to a psychiatric institution, depending on the outcome of the assessment. However, in this institution these patients are observed for 72 hours and referred to the relevant healthcare institution, such as a psychiatric institution.

According to Kamau, Osuga and Njuguna (2017:1), the right to an attainable standard of health is a fundamental human right and the existence of a well-functioning referral system that allows for continuity of care across the different spheres of care is also a right. The authors further affirm that a referral system allows for management of client health needs. Therefore, for a referral to be functional, it must operate in a functional system.

Mthethwa and Chabikuli (2016:2) assert that an effective referral system ensures a close relationship among all the levels of the health system and ensures that people receive the best possible care closest to home. Furthermore, in the study that they conducted, the referral system was shown to be inefficient.

- **Sub-category: Delayed health interventions**

According to the WHO (2016:1), a health intervention is an act performed on behalf of a person or population, the purpose of which is to assess, improve, maintain, promote or modify health functioning or health conditions.

Data from the study show that health interventions are delayed. The study setting is a district hospital, which provides general healthcare services to both in- and out-patients on referral from a community health centre. There are no specialised areas and the hospital is situated next to the tertiary level hospital, which focuses on specialised healthcare services. Normally, the patients are referred from the study setting. However, some of the patients go directly to the tertiary hospital without referrals or with acute conditions that can be treated in the study setting. Therefore, the patients have to be referred back to the research setting. In this study, the participants reported that, when the patients are referred from the tertiary hospital, the healthcare

practitioners do not tell them what the process will be when they arrive in the research setting because they bring only the triage form and the patients' expectations are that they are there to collect the medication as the whole process of assessing them was done in the other hospital.

They do not want a medical examination to be done in Hospital A. Thus, when they wait for so long for a proper assessment; they complain and it affects the waiting times.

This was expressed as follows:

> *FG1 (P6): "The other challenge is that most of the patient when they are sick they start at hospital C; they wait there for hours then the doctors see them that side. They give them the triage forms and say go to Hospital A, you are going to do x-rays and you are going to take medication, when they come here, we (nurses) find that the patient arrives here and is number 74, already was seen that side and he doesn't understand why must he wait here again to be seen by the doctor and we have to explain and most of them don't understand, they expect the doctors to just write the medication here. The patients are taken up and down without proper explanation and remember with audits they do get the waiting times are checked in the files and most of the time in OPD, waiting times are delayed."*

> *FG1 (P1) "... Patients go to Hospital C and they don't know that it is a specialised area. When they are referred down to us then they want to be given treatment and leave. At Hospital C, they don't explain to them that for their condition they have to start at our hospital and they will queue like other patients and be assessed and if there is a need for admission they will be admitted and if discharged with medication to take at home then they have to queue again for pharmacy. From our side it seems as if our waiting times are long."*

The participants felt that patients were delayed for health interventions, which reflects negatively on the waiting times and the service delivery for patients in the study setting. Delayed health interventions can be detrimental in that they delay the process of healthcare, which in turn affects

the clinical outcomes negatively. Thus, patients' rights are affected and extreme measures for Domain 2 of the NCS will not be attained.

According to Vitullo, Soboh, Oskarsson, Atatrah, Lafi and Laurance (2012:518), delays in healthcare access can compromise patients' health. Legally, access to healthcare is a fundamental human right that must be respected to improve the quality of patient care.

Thorsen (2012:241) states that the current healthcare system is overwhelmed by delays in care, which dissatisfy patients, and health practitioners while also increasing healthcare costs and affecting clinical outcomes. They further indicate that patients experience long waiting times in the healthcare institutions while awaiting access to care once the doctor has decided to refer the patient.

3.3.5 Category 1.5: Relevant expertise in various departments

According to Merritt (2016:10), expertise amounts to skills and knowledge in a particular field. In this study, the relevant expertise in various departments is the skills and knowledge that belongs to the professional nurses, while procurement personnel do not have these. This impedes the attainment of extreme measures for clinical governance in the institution.

Relevant expertise in various departments is the sixth category that emerged from the theme clinical governance challenges. This category has two sub-categories: inappropriate skills and issues with procurement.

The sub-categories are discussed simultaneously with the literature as follows:

- **Sub-category: Inappropriate skills**

Although in this hospital the legal framework that regulates the functionality of the healthcare institution; namely: the policies and guidelines are available, some of the healthcare providers are not qualified nor have the skills and knowledge to function in their dedicated departments specifically the psychiatric ward. The participants reported that some of the professional nurses are not qualified to be in other departments.

The participants explained their concern about inappropriate skills as follows:

> *FG1 (P4): "Let me say, the registered nurses that we have, not all of them are psych (psychiatric) trained, some they are and some are not."*
>
> *FG3 (P12): "We have the policies and guidelines but the problem is with the staff. Most of the staff is not qualified in the units that they are working in."*
>
> *FG3 (P13): "We don't have trauma sisters."*

It becomes a challenge when healthcare providers do not possess the appropriate skills required at all levels to meet the healthcare needs. Skills development is crucial in healthcare institutions where patient safety and quality healthcare are focused on, as this reduces inefficiencies in service delivery and the management of healthcare institutions is mandated by the Skills Development Act 1998 (Act no 97 of 1998) to expand and capacitate healthcare providers with skills in the workplace. The findings of the study are supported by research conducted by Slipicevic and Masic (2012:106), which shows that in order to achieve healthcare systems goals in a competent manner, health practitioners must have various skills and be conversant with the problems in healthcare. The authors further state that the need for improved knowledge of certain areas in healthcare has been recognized as a top priority.

Manyisa and Aswegen (2017:32) found that nurses are required to develop higher skills levels in order to keep up with advances in the healthcare system in order to deliver quality patient care. Therefore, appropriate skills are vital in a healthcare institution for patient safety and care to be realised. The authors further state that effective implementation of interventions requires healthcare workers to acquire knowledge and skills regarding their profession. On the other hand, Mulaudzi, Phiri, Peu, Mataboge, Ngunyulu and Mogale (2016:1) affirm that the effective implementation of the health system requires training of healthcare practitioners to acquire knowledge and skills regarding their profession so that they can have skills and the competency needed to boost their confidence and be able to deliver quality patient care.

- **Sub-category: Issues with procurement**

In this institution, there is a procurement department, which is responsible for purchasing, ordering and issuing supplies to the departments. However, it is evident in this study that procurement personnel have insufficient knowledge when it comes to procuring resources.

This was phrased as follows:

> *FG1 (P1): "If there was a nurse who knows what resources we need, it was better especially with us at theatre. They (procurement personnel) don't know what it is. So, if there was a nurse there, they will just issue us with what we really need."*

> *FG3 (P10): "They (procurement personnel) don't know honestly and wrong things are being ordered. Sometimes you will find that they say they don't have something (resources) then if you go there those things are there.*

> *FG2 (P5): "...you find that procurement (personnel) does not know what they issue and we have raised that with them and the management but nothing is being done."*

The results of relevant expertise in various departments were reported as affecting issues with procurement. Procurement personnel are issuing the wrong consumables to the staff. Issues with procurement personnel affect service delivery.

According to Tukuta and Saruchera (2015:2), procurement involves purchasing, renting, leasing or otherwise acquiring any supplies and services. It includes all the functions pertaining to the process of acquisition, selection and requests for supply sources, the preparation and award of contracts and all the stages of supplier contract administration. It can be viewed as the combined functions of purchasing, inventory control, transportation, receiving, inspection, storekeeping, and retrieval and disposal operations.

There is thus a demand for experienced procurement professionals who possess all the skills and technical expertise needed (Arora,2014:2). Further, Tukuta and Saruchera (2015:2) point out that institutions are failing to employ highly qualified procurement personnel who understand all the necessary procedures and risks in procuring. Thus the procurement personnel in institutions are seen as being insufficiently knowledgeable, which affects the institutions in providing quality patient care.

The category relevant expertise in various departments reflects the structural component of the Donabedian model. It is evident that the healthcare providers' inappropriate skills and issues with procurement results in challenges to patient safety as an outcome in the healthcare services. On the other hand, if healthcare providers are not empowered, compliance with the extreme measures for Domain 2 of the NCS for the health establishment will not be realised.

3.4 THEME 2: CHALLENGES WITH PATIENT SAFETY

According to World Health Organisation (WHO), patient safety is the prevention of harm to patients, and is built on a culture of safety that involves healthcare professionals, organizations, and patients. In this study, patient safety challenges are things that inhibit the professional nurses from attain extreme measures (100%) for Domain 2 of the National core standards (NCS) of the Health Establishments regarding the prevention of harm to patients.

Patient safety challenges is the second theme that emerged during the data analysis. It is linked to the other two NCS Domain 2 outcomes, which are clinical governance, and patient care. Three categories emerged from this theme, namely: documentation/record keeping, patients' risk of pressure sores and patient education.

3.4.1 Category 2.1 Documentation/Record Keeping

Documentation/record-keeping is the written instructions or records that are used for evidence in the delivery of quality patient care. Hence it requires further management or referral of the patient, or as a reference for successive admissions (Meyer, Naude, Shangase & van Niekerk, 2012:329). In this institution, there are legal frameworks regulating the documentation or record-keeping. However, the correct procedure is not followed accordingly. The participants were concerned about the omission of certain information on the records, specifically when it came to the

prescription chart and the patient progress report. Inaccurate records interrupt the continuity of care and impair communication between staff. Hence, the legality of all documents requires legible entries that are written in black ink, the use of approved abbreviations, clean and neat documents, cancellations to be done correctly and signed for and signatures with qualifications following every entry (Muller, 2011:326).

The first category that emerged from the theme challenges to patient safety was that of documentation/record-keeping. This category is supported by two sub-categories, namely: medication and patient progress records. The sub-categories are discussed below:

- **Sub-category: Medication**

According to Dykstra (2013:12), medication is any chemical substance, which may be natural or synthetic that has a medical or pharmacological effect on the body. According to the patients' file guidelines, a prescription chart is valid when the patient's name and registration number, date of prescription, name of medication, dosage, route, frequency, and duration are indicated (Meyer, Naude, Shangase & van Niekerk, 2012:329). Further, the name of the doctor, their signature and rank should be legible on the prescription chart. In the institution under discussion, there are protocols, which indicate which medication forms to use and how to fill them in; clinical audits are conducted monthly and in-service training is done relating to the documentation. However, the participants reported that documents were filled in with omissions, specifically when it came to the prescription chart. With the omission of some information on the prescription chart, patient safety incidents can occur which may increase the length of stay in hospital, the pharmacy and laboratory costs, while eventually death can occur and litigation can be brought against the institution, which will be costly. Therefore the result will be inadequate patient safety and inefficient patient care.

The participants reported on documentation/recordkeeping as follows:

> *FG1 (P3): "...there are challenges that doctors do not write the date and time on the progress notes or on the prescription and even nurses sometimes do not write the time on their notes and it is a challenge in that this is what is wanted in National core standards regarding patient safety. We know that if there is a lawsuit then it will be easy to know the*

sequence of events. We don't know what time was the patient admitted, given medication or discharged to the wards or who handed over the patient."

FG1 (P3): "We(nurses) do in-service trainings even with the doctors, we tell them on spot but sometimes it becomes tiring because they know what to do even with the medication they don't write how long should the patient get the medication and when you tell them that this will come back with the audits then they become angry."

It is evident that participants experience challenges with doctors prescribing medication. Documentation for medication is a challenge in itself. It is a legal document, which can lead to a lawsuit if some of the information is omitted by healthcare providers when prescribing the medication'aspatient safety in this regard can be compromised.

Medication errors are a common cause of severe patient safety incidents, as is reported by Karthikeyan, Balasubramanian, Mohammed-Ibrahim and Rashifa (2015:1). The authors state that educational programmes are needed to improve prescription skills as well as the prescribers' knowledge in order to improve the quality of medication prescription and administration. In this study, in-service training is conducted regarding the prescription of medication, but there is no progress.

The findings in a study by Tully (2012:1) concur with the findings of this study. Prescription errors that occur in hospitals have been a source of concern for a long time as they result in long hospital stays, healthcare costs and death. Therefore, compliance with the prescription guidelines that govern the healthcare professionals should be in accordance.

Bohomol (2014:1) is of the opinion that the medication system is regarded as complex. Prescription is one of its stages and the system should be adequately administered in the institutions, and the procedural conditions in which it is included. However, the professionals who act in the system should be in compliance with the specific legislation and should be supported by quality standards. Therefore, deviations from the quality standard of the medication system may result in reduced patient safety.

- **Sub-category: Patient progress records**

According to Meyer, Naude, Shangase and van Niekerk (2012:329), patient progress records are mainly for further management of the patient and communication between health providers in order to observe whether there is any improvement. The patient's name, registration number, identified needs or problems are clearly described, clear nursing prescriptions are given, medical prescriptions are referred to and the patient's reactions to interventions are evaluated.
It is evident in this study that there are omissions in patients' progress records. The participants reported that documents are not filled in correctly, specifically documents from the casualty section. The patient's progress should be known, specifically when the patient is transferred from other departments therefore improving medical record completeness is an important step towards improving the quality of healthcare. Moreover, it provides valuable information to help monitor the progress of the patient and the effect of care given. The patient progress record is an important legal document, so good patient progress records are essential not only for the progress or care of the patient but also as a legal document to protect the patient and the healthcare institutions from litigation.

The participants reported challenges to patient progress records as follows:

> *FG1 (P2): "…the patient has to come with a document that's mentioning that she came with them (pressure sores). For instance in our case, in the ward, we are going to request those record from casualty. So if the patient is from home then the sister in casualty is responsible and she has to document every single lesion on the patient and measure it but we do have problems with documents, but sometimes they are being filled and sometimes they are not."*

> *FG1 (P2): "….if there's more problems then you identify, you write those problems and we implement plan but because there are many patient records like the other wards and it is either they are filled incorrectly or not filled and if not filled then it means nothing was done. Documents are a challenge and we are failing with the audits even with the core standards because the core standards auditors will say if you didn't record then you didn't do it*."

According to Tola (2017:1), the patient medical record fulfils two significant functions; firstly, it helps to support direct patient care by assisting healthcare providers on clinical decision-making and communication. Secondly, it provides a legal record of care given and helps as a source of document to support clinical audit, research, resource allocation, monitoring and evaluation, and service planning. The author further indicates that patient progress records are key performance indicators that are related with delivery of healthcare services in the hospital and poor quality of the information in patient progress records may be a cause or a consequence of poor quality of care and patient safety, hence the relation to patient safety incidents.

Franco, Akemi and Inocento (2012:163) concur that patient progress records are a means of demonstrating the work performed by the health providers and are an indicator of quality care. Incorrect completion can convey the opposite. Vijayakumar (2016:129) asserts that documentation is crucial in ensuring that the patient care provided is evident, not only for patient safety and continuity but also for cases where compensation and quality of care are being tested legally.

The studies cited correlate with the current study, showing that incomplete patient progress records are a significant problem affecting the quality of healthcare services in many hospitals. Legally, it is stated in Acts and Omissions, Regulation 387 (section 35) that the South African Nursing Council may take disciplinary action in the case of negligent omission to keep clear and accurate records of all actions, which the professional nurse performs in connection with a patient. Even though the acts and omissions are stated legally, it is still a challenge in this institution when it comes to writing adequate patient progress reports.

3.4.2 Category 2.2: Patient risk of pressure sores

Agrawal and Chauhan (2012:244) define pressure sores as a localized injury to the skin or underlying tissue, usually over a bony prominence, as a result of pressure, or pressure in combination with shear or friction. Pressure sores prevent the attainment of extreme measures (100%) of the National core standards in the Health Establishments. There is an omission of information on the Waterlow Scale, which is the tool used to identify and assess whether the patient is predisposed to pressure sores.

Further, the scale consists of seven components: build/weight, height, visual assessment of the skin, sex/age, continence, mobility, and appetite, and special risk factors, divided into tissue malnutrition, neurological deficit, major surgery/trauma, and medication. The tool identifies three 'at risk' categories; a score of 10-14 indicates 'at risk', a score of 15-19 indicates 'high risk', and a score of 20 and above indicates very high risk. However, the redness on the patient's skin can be a sign of poor skin integrity, which can predispose a patient to developing pressure sores.

Patient risk of pressure sores is the second category to emerge from the theme patient safety challenges. This category is supported by two sub-categories, namely: screening/assessment and monitoring.

The sub-categories are discussed below as follows:

- **Sub-category: Screening/assessment**

According to Oyekale (2017:17), screening/assessment is a strategy used to identify the possible presence of an undiagnosed disease in an individual without signs or symptoms. It is evident in the study that patients have the potential for developing pressure sores or are admitted with them without their being noticed. In this institution, there are forms for screening and monitoring patients on admission who are at risk of developing pressure sores or who present with them on admission. However, these forms are not filled in by nurses. Without the use of the Waterlow scale forms, nurses will not know whether the pressure sores are inherited or acquired.

Coleman, Smith, Nixon, Wilson and Brown (2016:18) define inherited pressure sores as pressure sores that are present during the patient's admission, while the acquired pressure sores are pressure sores that develop during the patient's stay in a healthcare institution. Pressure sores are patient safety incidents that are supposed to be reported within 24 hours. If it is established that the sores have been acquired in the hospital then the hospital can be charged with misconduct. The participants reported that the Waterlow scale forms are used to screen patients in the departments. However, those forms are not completed and these are the legal documents that are used to assess patients for pressure sores on admission so that they can be either avoided or detected early.

The participants reported screening of pressure sores as follows:

> *FG1 (P4): "... when we do admissions is where now we are failing to screen this patient properly but that's where now the potential risk can emerge. We've got also additional forms to fill in like Waterlow scale to assess the risks for potential developing pressure sores, we've got risks for potential assessment and these forms are not filled in by nurses and they are important forms because through them we can detect other conditions that the patient did not disclose and if missed then it's a problem. For us to deliver quality nursing then it means we have to make sure that our patients are safe and without checking other things like Waterlow scale, then we are out that's why we are failing when it comes to patient safety. It's an ongoing problem."*

> *FG1(P2): "I just want to add on what we spoke about with regards to documents. We have that form where we identify; we assess all patients on admission. There is a document that we use to write the problems and the action plans if maybe a patient has risk of developing pressure sores then we have to mention the measures that we are going to do in order to prevent the patient from developing pressure sores, if there's more problems then you identify, you write those problems and we implement plan but because there are many forms like the other wards and it is either they are filled incorrectly or not filled and if not filled then it means nothing was done. Documents are the problem and we are failing with the audits even with the core standards because National core standards people will say if you didn't record then you didn't do it."*

Certain participants indicated a positive view of the assessment of pressure sores as follows:

> *FG1 (P4): "Yes, we are checking the skin integrity because on admission, the very same specimen that I've compiled and there is somewhere that it is listed, skin integrity of the patient and the skin covers the entire body and it's on the feet or face. It is easy to identify but some of the admissions are not done well when you monitor or when the core standards people come and we are lacking there and there. I've indicated that we have forms and specimens that guide us but there are gaps in admissions which indicated lack of patient safety to the outsider."*

> *FG1 (P2):"We check the entire body to identify whether there could be wounds. It's like nearly all our patients, the elderly, once the patient is transferred without walking, bedridden, that patient is a suspect of potential pressure sores and because of the immobility."*

It emerged in the findings that nurses actually know what must be done. However, they omit to do so correctly. Marin, Nixon and Gorecki (2012:522) define pressure sores as localised injuries to the skin or underlying tissues, usually over a bony prominence or in association with care devices. The sores result from sustained pressure and vary in size and severity of the tissue layer affected.

However, Ľubica, Poledníková, Alica and Slamková (2015:428) point out that assessment of the patient specifically for pressure ulcers is also integrated into the nurse's activities as a measure for improving nursing care, which significantly affects patient safety.

This observation is further supported by Silva, Bezerra, Costa, Luz, Lopez and Nogueira (2017:1), who maintain that pressure sores significantly impact on the patient's family members and the health systems, in that they are recurring and, debilitating, negative influencing the patient's quality of life by causing pain, suffering, an increased stay in the hospital, or even death. Hence, assessment for pressure sores has become integral to the quality improvement in healthcare.

- **Sub-category: Monitoring**

Monitoring is the systematic process of collecting, analysing and using information to follow progress towards reaching objectives and guiding management decisions (Dealy, Postnett & Walker, 2013:3). Monitoring usually focuses on processes such as when and where activities occur, who delivers them and how many people are reached.

The participants in this study mentioned that monitoring patients for the risk of pressure sores to facilitate improved care quality and patient safety should be done in the wards during interdepartmental transfers. However, this critical process is missed sometimes, resulting in litigation.

The participants related monitoring of the risk to pressure sores as follows:

> *FG1 (P4): "... when nurses transfer the patient from the trolley to the bed, immediately check with casualty nurse who take over the patient then they have to take off the diapers so that we can see the entire body for pressure sores so that you can ask whatever you need to ask from the nurse who is transferring the patient and sometimes this is not done and I've indicated that we do in-service trainings and this affects us with the core standards or litigations or when the relatives are complaining."*

> *FG2 (P2): "We know pressure sores are part of clinical risks or serious adverse events. Sometimes you will find that the patient came with the pressure sores and they were not identified then later the relatives will be saying it is acquired from the hospital and they complain to the management and we do not have the evidence in the documents that it was not present during the transfer to our ward and there are many cases like that."*

Nurses commit to providing care. Omission to do so is an ethical and legal offence. Pressure sores are patient safety incidents for which healthcare institutions should account. The only way to protect the healthcare institutions is to monitor properly and keep records, as narrated in the above verbatim.

De Andrade Moraes, de Araújo, Áfio, Caetano, Lopes and da Silva (2012:2) maintain that patients should be monitored for the risk of pressure sores or the development of an injury during hospitalisation. The authors further state that most pressure sores occur before patients are admitted or after hospitalisation. For this reason it is suggested that patients are monitored on admission and daily after that.

Smith, Nixon, Brown, Wilson and Coleman (2016:16) show in their study that there are high levels of under-reporting on pressure sores, including monitoring and the completeness of clinical forms. Furthermore, Dobbins, Merabti, Fergus and Llewellyn-Jones (2012:3) state that, in order to reduce the risk of patients developing pressure sores, the skin integrity should be monitored. Studies share findings similar to those in this study and concur that monitoring skin integrity and record-keeping for the risk of pressure sores should be considered.

The category patient risk of pressure sores relates to the processes component of the Donabedian model. Pressure sores may happen if thorough screening and monitoring are not conducted in healthcare institutions, resulting in patient safety incidents. The consequences will be legal action, which will impact negatively on patient care in the healthcare institution.

3.4.3 Category 2.3: Patient education

Meyer, Naude, Shangase and van Niekerk (2012:174) describe patient education as providing people with information to enable them to live more productively, both physically and mentally. Therefore, patient education informs the patient about how his or her physical condition, use of medication, culture and psychosocial aspects affect his or her health. In this setting, patient education is the information given to patients on their health for prevention and treatment of the illness to effect the attainment of (100%) extreme measures of the National Core Standards of the Healthcare establishments.
The second category that emerged from the theme patient safety challenges is that of patient education. From this theme, two sub-categories were identified: inadequate patient information and preoperative counselling.

The sub-categories are discussed below as follows:

- **Sub-category: Inadequate patient information**

According to Muller (2011:351), inadequate patient information is the lack of information given to the patient regarding his or her health. Patient information is vital in that it empowers and enlightens the patient precisely as to the necessary knowledge and assists in decision-making, thus avoiding errors and bringing about liberation from myths.
The participants in this study stated that patients are given health education on medication. However, some healthcare providers fail to do so which affects the quality of their care and results in patient safety incidents.

This is what the participants said regarding inadequate patient information:

> *FG1 (P2): "Health education is part of giving information and when they audit they look for that or where you've written that you gave health education and we are missing that as part of patient safety and care."*

> *FG1 (P4): "We know as nurses and doctors that we should explain everything that we are doing to the patients but it seems as if we fail sometimes."*

On the positive side, some of the participants expressed their views on patient information as follows:

> *FG2 (P5): "Yes, when we are giving medication we let them know why we are giving it and what it does and the side effects."*

> *FG1 (P3): "…in our ward because it is a general ward, we've got different types of patients so the health education is per patient depending on what their condition is, what they are admitted in the ward for. It can be on admission or in the ward during patient giving medication or before breakfast. It's a diabetic patient or hypertensive patient, we educate on spot."*

Inadequate patient information seems to be consistent among professional nurses. There is a need to give patients information, as is reported in research by Aghakhani, Nia, Ranjbar, Rahbar and Beheshti (2012:12), who state that patient information is a vital nursing practice standard that meaningfully impacts on a patient's health and quality of life. Therefore, to succeed in the above, there should be both teaching and learning. The authors further indicate that education empowers the patient and is an important aspect of quality improvement, given that it has been associated with an improved health outcome.

The findings of the studies done are in line with this study's findings, as the participants reported that the patient education in the hospitals was inadequate. It is important for patients to be empowered for easy decision-making. Inadequate patient information is the main cause of the

patient's inability to consult in the healthcare environment, resulting in inappropriateness in the provision of care as well as poor health outcomes (Annarumma & Palumbo, 2016:611).

- **Sub-category: Inadequate preoperative counselling**

According to Grossweiler (2012:117), preoperative counselling is advising, preparing and guiding a patient regarding the surgery to be performed to alleviate and reduce anxiety. The authors assert in their study findings that the degree of anxiety is significantly changed as a result of the effectiveness of preoperative counselling they receive.
The participants in this study reported that preoperative counselling is not conducted for some patients and that anxiety and stress are difficult experiences in patients undergoing surgery. Schlitz and Valentina (2013:155) point out that the integration of body, mind, and spirit has become a key dimension of health education and disease prevention and treatment.

This is what the participants related:

> *FG3 (P10): "We had a case in theatre from the ward whereby a patient did not know what the surgery was all about and he couldn't understand that and was afraid and hyperventilating. He actually had cancer and according to him he wasn't told. I called the doctor to explain and the doctor tried and the patient said no he can't do the surgery. It shows that the patient was not counselled, told anything about cancer or the condition and we tried to calm him down and the doctor said he cannot continue with the surgery because the doctor who send the patient should have explained everything. We are really failing our patients. Imagine if this was done and he found out later that he can't bear children. That was a big case and remember everything is recorded and this came out during the audits."*

> *FG3 (P11):"Actually that patient was from our ward, we even called the matron to explain to the patient and the matron told the patient that the surgery won't take long and not explaining the actual surgery that the patient is going to undergo."*

On the other hand, one of the participants alluded to positive aspects, as follows:

> *FG1 (P1): "Yes, the first document is the consent form that you have agreed to do the operation that they are going to perform. Did the doctor explain to the patient and does the patient understand what is going to be done and there's a checklist. We check if vital signs have been taken and if the patient is allergic and the treatment given and cleanliness because in theatre, we are more cautious of infection. The patient should come to theatre being very clean in all aspects."*

It becomes evident in this study that healthcare providers are not counselling patients preoperatively to obtain informed consent. Legally, it is stated in the Patients' Rights Charter (1999) that patients have a right to full and accurate information on the nature of the illness, diagnostic procedures and treatment so that individuals can make an informed decisions.

Sharma and Joshi (2013:11) describe preoperative counselling as the physical and psychological preparation of a patient prior to surgery to alleviate anxiety and fear. The authors further state in their study that participants who were not pre-counselled before surgery showed signs of anxiety. Similarly, Erkilic, Kesimc, Soykut, Doger, Gumus and Kanbak (2017:291) assert that the inadequate counselling of patients before surgery limits the reduction of patients' anxiety and fear.

The cited study information shares similar findings with this study in that patients who are not counselled prior to surgery will hyperventilate and sweat, which are signs of anxiety. However, informed consent is a legal document and one important aspect of patient autonomy and the counselling of patients and family members impacts on the improvement in the quality of the health services.

The category patient education accords with the processes of the Donabedian model. The healthcare providers' inability to give patients information on their illnesses can eventually result in negative consequences for the work environment and impacts directly on patient safety and care.

3.5 THEME 3: PATIENT CARE CHALLENGES

Patient care is the service rendered by members of the health profession and non-professionals for the benefit of the patient (Dorland Medical Dictionary, 2017:269). Further, patient care is defined as providing care that is respectful and responsive to individual patient preferences, needs and values, ensuring that patient values guide all clinical decisions. In this study, patient care challenges refers to inefficient practices employed by healthcare providers to improve patient outcomes, hence the hindrance to attain extreme measures (100%) of the National core standards in the Health Establishments. Proper coordination of care should be applied in a health institution, which means that patients should be treated with dignity, respect and sensitivity to their cultural values and autonomy in order to alleviate feelings of vulnerability and powerlessness. To do what is right for the patients is not just a matter of respecting their autonomy and acting correctly towards them, but it also involves trying to see things from their perspective and understanding them with compassion.

Patient care challenges is the third theme that emerged during data analysis. The category that emerged from this theme is knowledge of emergency preparedness.

3.5.1 Category 3.1: Knowledge of emergency preparedness

According to Dillon (2014:13), emergency preparedness refers to the steps taken to be ready to respond to and survive during an emergency. In this study knowledge of emergency preparedness is the information that professional nurses should possess to deliver patient care in order to attain extreme measures (100%) in this institution.

The second category that emerged from the theme patient care challenges is the knowledge of emergency preparedness. This category is supported by three sub-categories, namely: emergency equipment, resuscitation of patients and the use of mobile phones. The sub-categories are discussed below as follows:

- **Sub-category: Emergency equipment**

According to (Dillon, 2014:13), emergency equipment refers to the tools used during an emergency.

In this hospital there is a standardised emergency trolley and the checklists that are supposed to be compiled after checking the trolley in the morning and in the afternoon. However, the participants complained that whenever there is an emergency in the wards or departments, they have to go in search of it because either the equipment has expired or the wrong sizes have placed in the emergency trolley. The participants further stated that in medical wards in the isolation rooms there are no oxygen points and patient safety and care is compromised.

Some participants expressed their views on emergency equipment as follows:

> *FG1 (P2): "I think this problem cut across all the wards because somebody will just tick every box on the checklist only to find that some of the things are not there, they have expired or there are wrong sizes for instance with ET tubes, then when it comes to emergency then we run around and it is too late by then or to an outsider we seem incompetent."*

> *FG3 (P12): "… some of them do not have oxygen points and they are looking at it with the core standards and again if a patient needs resus (resuscitation) in that room we are struggling. So if we admit four patients from the side wards that we are having a challenge during resuscitation."*

Some participants spoke positively about emergency equipment. However it was stated that subordinates needed training on the emergency trolley.

The participant reported:

> *FG3 (P12): "The emergency trolleys, I think we (the hospital) are not bad with the equipment preparedness. It's just that most senior know about it but the nurses are the ones who need training."*

> *FG1 (P3): "We have emergency trolley and there is also a checklist. So, every morning and evening, the night staff, they have to check the emergency trolley. Check whether everything correspond with the checklist. We check for expiry dates and also the equipment that we use is it in working order."*

When they require resuscitation, patient safety is assured. The preparation of emergency equipment and the checklist may translate into improved patient-centred outcomes, so proper daily checking of the emergency equipment is required (Long, Fitzpatrick, Cincotta, Grindlay & Barett, 2016:1). Patients' conditions change at anytime in the wards, while emergency patients are entered into the healthcare institutions without the healthcare providers' prior knowledge. For this reason, emergency preparedness must be kept in mind. Compliance with emergency equipment standardised protocol has to be a priority in preserving life and improving the quality of patient care. With supervision of the latter in the morning and in the afternoon, omissions can be avoided and the standard of care improved because the safety of patients requiring resuscitation will be assured.

Lu, Ng, and Xie (2015:295) concur with the study, pointing out that poorly maintained, incomplete or damaged equipment on the emergency trolleys has previously been documented in various studies. It is regarded as a major factor contributing to death and delayed response to resuscitation efforts. This finding seems to be supported by this study, as the participants commented on incomplete, expired equipment, which is often the wrong size.

- **Sub-category: Resuscitation of patients**

Ehlers and Rajeswaran (2014:1259) explain that resuscitation as a critical component of basic life support is the first-line response to cardiac arrest. It is followed by defibrillation and advanced life support.

The participants in this study complained that patients from the out-patient department (OPD) and the wards who need emergency resuscitation have to be wheeled to casualty, which sometimes results in a patient's death. Even though there are emergency trolleys in the OPD and the wards, the doctors prefer patients to be resuscitated in the casualty department because of the doctors' capacity in OPD.

Participants reported their views as follows:

> *FG2 (P8): "… the moment you call them (doctors) and you are still busy with the patient and they look at the patient and they say wheel the patient to casualty. Doctors don't want*

to resuscitate the patient in the ward. All the patients that are for resuscitation in the ward they go to casualty."

FG2 (P6): "Normally, nurses send the patients for emergencies to casualty for them to handle the case but then it takes time to go to casualty and sometimes we lose the patients because of time."

Safety protocols are in place to protect patients undergoing high risk procedures like resuscitation.

Vallet, Pinsky and Cecconi (2013:1653) state that the resuscitation of critically ill patients is vital and that safety protocols should be in place to protect patients undergoing resuscitation. The time taken to start with resuscitation determines the outcome of the resuscitation, that is, whether the patient will be alive or not. Knowledge on the resuscitation of patients is vital in that many lives can be preserved and the quality of patient care retained.

Sohn, Ryoo, Seo, Lee, Oh, Lim and Kim (2014:671) with the findings in their study show that delayed compliance with the resuscitation of patients who need it in an emergency carries a significantly high mortality rate. The studies share the finding that when it comes to the resuscitation of a patient, the time factor is vital, in that deaths can be minimised.

- **Sub-category: Use of mobile phones**

According to Martiz (2015:218), a mobile phone is a wireless handheld device that allows users to make calls and send text messages, among other features. Mobile phones are helpful in personal matters, but during working hours they are disruptive.

The participants in the study viewed the use of mobile phones by healthcare providers during working hours as a distraction from patient care. There was a general feeling that healthcare providers are using the mobile phones more than they have to. Even if there is an emergency in the ward, attention to their mobile phones takes priority. Further, in hospitals, patient care is crucial and the use of these devices can hinder healthcare providers from delivering quality patient care. Moreover, both patients and visitors feel neglected.

The participants expressed their views as follows:

> *FG2 (P8): "Patient safety and care won't be realised because of use of cellphones. A patient's relative will be talking to the nurse in the ward asking for assistance then she's on the phone. They are really ignoring patients. Emergency come they are still on the phone. In my ward there are many complaints regarding patient care and some of them it's just ignorance from our side. I wish there was a policy regarding cellphones."*

> *FG2 (P6): "…we won't go anywhere with cellphones. I remember in my ward, one of the relatives laid a complaint saying she greeted one of our colleagues wanting to know whether the patient was in the ward or not and this nurse took time to respond because she was on the cellphones. We are here for patient care, nothing else. Remember, we are dealing with emergencies but some people (nurses) do not care."*

In hospitals, where the vigilance on the part of healthcare workers is essential to patient care, the potential distraction by these devices could be hazardous to patients. According to McBride (2015:2020), the distraction of healthcare providers by the use of mobile phones is the interruption of a health provider's primary task of delivering adequate health service. Furthermore, distractions in the form of mobile phones affect the performance by the entire health team and introduce errors that can be preventable.

McBride, Le Vasseur and Li (2015:1) concur with the above findings, stating that personal mobile phones and other communication devices have the potential to distract healthcare providers from patient care. Studies examining the effect of mobile phones on work performance have demonstrated that mobile phone use in hospital settings results in a decline in performance, including the impaired ability to focus and remember important information (Attri, Khetarpal, Chatrath & Kaur, 2016:87). In addition, this distraction could result in inadequate patient care in clinical environments.

However, Gill, Kamath and Gill (2012:105) assert that smart devices, including smartphones, clearly form an integral part of our connected lives. However, they compromise safety and the quality of patient care, and are sources of distraction, so vigilance is a crucial component of performance in the work environment. This information correlates with the findings in the study

that the use of personal mobile phones by healthcare providers while working has a negative effect on patient care (Katz-Sidlow, Ludwig, Miller & Sidlow, 2012:595).

The category knowledge of emergency preparedness relates to the structural component of the Donabedian model. It is a challenge if healthcare professionals keep expired stock and the wrong sizes of equipment in an emergency trolley because, should an emergency occur, patient care would be compromised. This would result in patient safety incidents, thereby allowing a negative impact on patient care. Another challenge is that, owing to the inadequate knowledge of emergency preparedness, healthcare professionals would not comply with the extreme measures of the NCS for the health Establishments on resuscitation of patients and the use of mobile phones would be a distraction in the processes to be delivered in healthcare. The end result would be inadequate processes, thereby allowing a decline in the quality of patient care.

3.6 DISCUSSION OF FIELD NOTES

According to De Vos, Strydom, Fouché and Delport (2011:359), field notes are notes taken by the researcher to record what was seen; heard and experienced and records what the researcher thought in the course of the interview. In this study, the researcher made all the logistical arrangements, which included the arrangement for the venue, and the organisation of the participants for the focus group interviews. The researcher ensured that audiotapes were functional and that note pads and pens for writing notes were available. The moderator was used to conducting focus group interviews and the researcher took field notes. The moderator asked the participants questions and she listened to their experiences, making comments and probing for more information on their challenges to attain extreme measures for Domain 2 of the National Core standards. The researcher observed the non-verbal responses and expressions as the participants were responding to the questions. In this study, the field notes included personal, observational and methodological notes.

3.6.1 Personal notes

Personal notes are the comments and expressions of the researcher's own feelings while collecting data in the field (Polit & Beck, 2012:737). In this study, the researcher was able to

record her personal feelings. During the interview sessions I realised the importance of the decision taken in my protocol not to conduct the focus group interviews. I felt like some participants should be putting their challenges in a certain way, as I also experienced the phenomena myself while working in the same study setting. I was impressed seeing some of the participants bringing up the challenges that initially inspired the study. Further, using someone else to conduct the interviews was a good thing, as it ensured trustworthiness. It felt good seeing people responding spontaneously to questions and the discussions going well.

3.6.2 Observational notes

Observational notes are objective descriptions of observed events and conversations; information about actions, dialogue and context (Polit & Beck, 2012:736). During the interview sessions, the researcher recorded the dialogue that occurred when a focus group interview session was conducted in one of the district hospitals. During the interviews, it was observed that there was a very active participation by all the participants. Most of them were discussing their challenges at length, showing that they were disturbed by the phenomenon. The conversations came naturally. The participants were not disruptive; they gave each other a chance to speak. However, there was so much enthusiasm for this topic. The participants followed one another in the background with verbal cues like, hmmm and yes… yes…, in support of what the other participant was saying at the time. Non-verbal cues like nodding the head and frowning were observed when relating to some challenges regarding the clinical governance issues.

3.6.3 Methodological notes

Polit and Beck (2012:733) define methodological notes as reflections about the strategies and methods used during data collection. In this study, the moderator did not address the participants by name for the sake of confidentiality. She asked the question and welcomed anyone to start. However, she addressed the participants as sister as she was sure which discipline the participants belonged to. For the sake of transcriptions, the participants were referred to as P1, P2, and P3 etc. depending on the number.

3.7 CONCLUSION

Chapter 3 outlined the discussion of the findings that emerged from the focus group interview data collection process. Further, this chapter also focused on information reported by the participants during the qualitative data collection. The summary of findings of the study is presented in Table 3.1. The chapter contains data from three focus group interviews presented according to the following three main themes: “Clinical governance challenges”, “patient safety challenges” and “patient care challenges”. From each main theme, categories were identified. The categories were supported by sub-categories that were discussed simultaneously with the relevant literature control. The next chapter will address the conclusion of the study and the recommendations.

CHAPTER 4

CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

Chapter three focused on a detailed discussion of the study findings and the literature control. The main themes and categories were identified during the three focus-group interviews. In this chapter, conclusions, limitations and recommendations will be outlined.

4.2 CONCLUSIONS

The objectives as stated in chapters one and two were attained and are:

- To explore and describe the challenges to attain extreme measures for Domain 2 of the National Core Standards for the Health Establishments in a district hospital in Tshwane, Gauteng regarding patient safety.
- To explore and describe the challenges to attain extreme measures for Domain 2 of the National Core Standards for the Health Establishments in a district hospital in Tshwane regarding clinical governance.
- To explore and describe the challenges to attain extreme measures for Domain 2 of the National Core Standards for the Health Establishments in a district hospital in Tshwane, Gauteng regarding patient care.

The subsequent findings of the study confirm that the objectives of the study were achieved. The following three themes elicited from the study on challenges to attain extreme measures for Domain 2 of the National Core standards for the Health Establishments guided the recommendations made:

- clinical governance challenges

- patient safety challenges
- patient care challenges.

4.2.1 Theme 1: Clinical governance challenges

Three categories were developed from the theme “clinical governance challenges which are: factors related to clinical practice, vulnerability to clinical risks, inadequate leadership and management, inefficient referral system and relevant expertise in various departments. The categories and sub-categories identified were discussed and literature control was conducted.

Category 1.1 Factors related to clinical practice

The study revealed four sub-categories that affected the factors related to clinical practice: Inadequate patient mix, patient overcrowding, shortage of staff and insufficient medical supplies/equipment.

The participants in this study pointed out that patients with different diagnoses, such as psychiatric and medical patients, are admitted to the same wards, which is a general open space without partitions. It was pointed out that patients stay in the ward for more than five days and in the worst cases, they stay more than a month awaiting admission to hospital B because the study setting admits the psychiatric patients for 72 hours observations, making it difficult to separate the patients in the wards.

In contrast to previous participants, one of the participants reported that there are renovated departments with high technical facilities like the maternity complex and the paediatric ward. These are structured in such a way that it allows infectious patients to be separated because there are rooms for isolation patients.

The other concern that participants expressed was that triaging of patients is conducted and a booking system is in place in the Casualty and Out-patients departments. However, patients come as walk-in patients without booking, leading to patient overcrowding. As a result, there is congestion, which affects the waiting times and the quality of the care. On the other hand, the participants were concerned about the paramedics who bring patients from other places, without considering the catchment areas and the legal frameworks that protect them. The gatekeeper discourages the catchment area issue, hence the overflow of patients in the study setting. Some of the participants felt that patients’ rights, specifically mental healthcare users’ rights to privacy

are not considered, because interviews are conducted in the presence of other patients, causing disruptions because of congestion.

The professional nurses said that the shortage of staff is a challenge in the study setting. Consequently, the work responsibilities are overwhelming and it is the same with doctors because sometimes there are only two doctors on duty for the whole institution, mainly during the weekend. As a result, there is a delay in resuscitating patients. The nurses reported that they have been vocal about the issue and the challenge had not been addressed. This denied them the opportunity of delivering good-quality patient care, which consequently affected patient safety and care.

The participants mentioned that tenders for the procurement of medical supplies and equipment are available. However, there are challenges when it comes to paying the suppliers. Sometimes the nurses are forced to phone the suppliers when they are out of equipment stock and the response is that payments were not processed by the institutions. Some participants concurred that, in their wards, they have either limited or no resources, which affects service delivery negatively. Inadequate medical supplies and equipment is a challenge in this study setting. In contrast, some of the participants stated that the gatekeeper, who is the CEO of the study setting, ensures that there is a sufficient supply of medical supplies and equipment but the outcome lies with the vetting committee and procurement for the payment of the suppliers.

Category 1.2: Vulnerability to clinical risks

The findings contain two sub-categories, which affect vulnerability to clinical risks. These sub-categories were the risk of infection and the risk of injury.

A few participants in this study related that there are inadequate infection control practices, which affected the isolation guidelines, such as lack of space and overcrowding. They added he risk of contracting healthcare associated infections. They explained that this is because of inadequate isolation rooms in some of the departments, where isolation patients use the general toilets instead of having ablution facilities in their rooms. On the other hand, some participants alluded to positive aspects of infection prevention and control relating to the environmental hygiene practised by cleaners during a patient’s stay and the discharge of the infectious patients. There is also the correct personal protective equipment worn by healthcare providers during contact with patients, thereby preventing exposure to infection.

The participants in this study put forward the fact that the IPC programme is a good intervention implemented by the Department of Health and they explained that the IPC coordinator and the operational managers empowered them with knowledge on infection control and the guidelines, but, at the same time, they found infection control to be challenging, sometimes in relation to the infrastructure.

The participants felt that the risk of injury when a patient falls, and the physical assault of patients and staff are always present in this hospital, because of the psychiatric patients, who use deadly weapons against the healthcare providers. Some of the participants alluded to positive aspects of the risk of injury, saying that there are policies on the matter and security officers in every entrance. Further, belongings are checked on admission to exclude blunt objects or anything that could put the other patients and healthcare providers at risk.

Category 1.3: Inadequate leadership and management

Findings in this study revealed that there are sub-categories that support the theme inadequate leadership and management, which were management's listening skills and management support.

The participants in this study were concerned about leadership and management in this study setting, as their needs are not heard and, as a result, they feel discouraged about doing their work effectively. Thus, the attainment of the extreme measures for clinical governance is being hindered. On the other hand, the participants regarded the gatekeeper of this study setting as a good active listener, who listens to every healthcare provider regardless of their positions, but they are not getting the same response from their immediate supervisors, so they felt that work was being imposed on them.

The other concern that the participants mentioned was that, in this study setting, issues of staff shortage, infrastructure and procurement are a challenge. However, when the healthcare providers address these issues in the monthly meetings, the management dismisses their views and opinions, showing that management does not support them, and the issues are not attended to.

Category 1.4: Inefficient referral system

The findings in this study show that an inefficient referral system can result in two things, namely: a delayed referral system and delayed health interventions.

The participants pointed out that the referral of patients to other hospitals, specifically mental healthcare users (MHCU), is a challenge. In the case of MHCU, the institution admits those patients for 72 hours observation. However, when they are referred to the dedicated hospital, then the challenges will be either that the hospital is full or the doctors for that day are not available, hence the process of the referral is delayed. The participants said that these are the high-risk patients and the institution does not have a dedicated ward for the MHCU. As a result, clinical governance and patient safety are compromised. Therefore, the outcome for quality care is at stake.

The professional nurses in this study pointed out that some of the patients go directly to the tertiary hospital without referrals and some have acute conditions that could be treated in the study setting, as it is a district hospital. Subsequently, the patients are referred back to the research setting where they have to queue again and health interventions are delayed. They even clarified that when the patients are referred from the tertiary hospital, the healthcare providers do not tell the patients what the process will be when they arrive in the research setting, because they bring along only the triage form. The patients' expectations are that they are there to collect their medication, as the whole process of assessing them was done in the other hospital. Thus, when the patient waits a long time for proper assessment, they complain and it affects the waiting times and delays the health interventions for the patients.

Category 1.5: Relevant expertise in various departments

The study found that professional nurses were overwhelmed by the lack of expertise in various departments because of inappropriate skills and issues with procurement.

Findings from this study were that, in this study setting the legal framework that regulates the functionality of the healthcare institution; namely: the policies and guidelines, are available, some of the healthcare providers are not qualified or else do not have adequate skills and knowledge to function in their dedicated department, particularly in the psychiatric ward. They pointed out that it is a challenge when even the healthcare providers do not possess the appropriate skills

needed at all levels to meet the healthcare needs. According to the Ministerial task team at a nursing summit held in April 2011, the nursing strategy should ensure that our country has nurses of high calibre who can contribute to addressing the healthcare needs of all South African citizens. However, without skills and competencies in the relevant departments and in clinical practice, the healthcare providers are bound to have a negative impact on patient outcomes. The overall quality of patient care will be jeopardised.

The other concern that the participants pointed out was that, there is a procurement department, which is responsible for purchasing, ordering and issuing supplies to other departments. However, procurement personnel issue the wrong consumables to the departments. Therefore, they are considered to have insufficient knowledge of the procured resources, which is supposedly their area of expertise. The consequences affect service delivery and the quality of patient care.

4.2.2 Theme 2: Patient safety challenges

Three categories emerged from the theme patient challenges, namely: Documentation/Record-keeping, patient risk of pressure sores and patient education.

Category 2.1: Documentation/Record-keeping

The findings in this study indicated that there were sub-categories that supported documentation/record-keeping, which were medication and patient progress records.

The participants in this study pointed out that doctors present a challenge when prescribing medication. They stated that doctors omit certain information such as the dosage, and they sign their names in print on the prescription chart instead of their signatures, which are not legible. They said this was a common practice that could lead to litigation, because it compromises patient safety.

The other concern was that there are omissions in patient’s progress records as documents are not filled in correctly, specifically when it comes to documents from casualty. The participants even explained that a patient’s progress should be specifically explained when the patient is transferred from other departments in order to keep track of the patient’s progress and the effect of the care provided.

Category 2.2: Patient risk of pressure sores

The findings show that there are two sub-categories that affect patients' risk of pressure sores, namely: screening/assessment and monitoring.

The study found that Waterlow scale forms are used in the study setting to screen patients in the departments. However, in some departments those forms are not completed and these are the legal documents that are used to assess patients for pressure sores on admission so that they can be avoided or detected early. The participants even explained that pressure sores that are acquired from the hospital are considered as misconduct. Thus, it is imperative for healthcare providers to screen patients before admission. In contrast to some of the previous participants, a few indicated that in their departments screening of pressures sores is conducted and the in-service trainings are done even the pressure sores are reported within 24 hours, as patient safety incidents.

The other concern that participants stated was monitoring of pressure sores from casualty. They explained that, to facilitate improved quality of care and patient safety should be done in the wards during interdepartmental transfers. However, this critical process of monitoring pressure sores is missed and it results in litigations.

Category 2.3: Patient education

The findings of this study show that two sub-categories supporting patient education were identified, which were inadequate patient information and inadequate pre-operative counselling.

The participants stated that some healthcare providers do not give the patients information on the medication. They explained that this impacts on the quality of care, which can result in patient safety incidents. An important aspect of empowerment of the patients is to give them the relevant information, which is the correct process if there is to be positive patient care outcomes. On the other hand, one of the participants alluded to the positive fact that patient information is relayed in their department, specifically to a patient's guardians if the patient is underage.

The participants reported that pre-operative counselling was unfortunately not done for some patients as was evident when one of the patients who was in the theatre went into shock, having found out what the surgery about to be performed actually entailed. They explained how the patient was sweating and showing signs of anxiety and stress. Patients who are undergoing surgery go through the experience of anxiety and stress but this patient had not been given the

appropriate information and pre-operative counselling. On the other hand, one of the participants said that patients are given information pre-operatively and thereafter they are allowed to sign the consent form, on which they write details of the surgery the doctor is going to perform. They are expected to explain what they understand by that surgery.

4.2.3 Theme 3: Challenges to patient care

One category was identified under the theme patient care challenges, which was knowledge on emergency preparedness.

Category 3.1: Knowledge on emergency preparedness

Findings in this study indicate that knowledge on emergency preparedness involves emergency equipment, resuscitation of the patient and the use of mobile phones.

In this hospital, there are standardised emergency trolleys and the checklists that are supposed to be filled in after checking the trolley in the morning and in the afternoon. However, the participants said that whenever there is an emergency in the wards or departments, it is found that either the equipment has expired or the wrong sizes of equipment are on the trolley. They explained that there are no oxygen points in some of the rooms. This impacts on patient safety and care during an emergency.
Some participants pointed out that while, there was no challenge with emergency equipment in their departments, some of their subordinates needed training on the subject of the emergency trolley.
The participants stated that patients who need emergency resuscitation from the Out-patient Department (OPD) and the wards must be wheeled to the Casualty Department and sometimes this results in the patient's death. They mentioned that even though the emergency trolleys are available in OPD and the wards, the doctors prefer patients to be resuscitated in Casualty because of the doctors 'greater capacity in that department.

The participants stated that the use of mobile phones by healthcare providers during working hours is a challenge to patient care. They pointed out that healthcare providers use mobile phones more than they have to in rendering the service. Even if there is an emergency in the ward, attention to their mobile phones takes priority. Furthermore, in hospitals, patient care is crucial and the use of these devices can hinder healthcare providers from delivering quality patient care.

Moreover, patients and visitors feel neglected and the complaints about staff attitudes towards patient care are bound to increase.

4.3 RECOMMENDATIONS

In view of the findings of this study, the researcher realised that professional nurses in the district hospital are faced with challenges to attain extreme measures for Domain 2 of the National Core Standards. Therefore, the researcher posits the following recommendations, based on the findings of the study:

4.3.1 Clinical practice

- In-service education regarding extreme measures of Domain 2 of the National Core Standards should be conducted regularly by the hospital to ensure that healthcare providers are following the guidelines.
- A task team should be formed, composed of multidisciplinary team members who can conduct monthly audits and continuous follow-up to resolve the challenges to attain extreme measures of the National Core Standards.
- All the departments should have uniform review periods for NCS to resolve the challenges to attain extreme measures of the National Core Standards.
- Making available healthcare providers in their departments who have skills and expertise to ensure that extreme measures for Domain 2 are attained.
- The hospital should put guidelines in place that address issues of non-compliance with the extreme measures for Domain 2 of the NCS and should distribute these to all the departments so that the health providers know and understand the process.
- An in-depth project plan should be designed pertaining to leadership training and development so that top management should be involved in leadership workshops on a regular basis together with professional nurses. The inclusion and involvement of professional nurses could improve and strengthen the relationship between managers and subordinates, which would heighten the confidence and the support system. The study setting would thus provide good quality patient care.

4.3.2 Education

- Continuous comprehensive in-service programmes relating to extreme measures for Domain 2 of the NCS should be developed for the clinical facilitators and the nurse educators to be integrated into the curriculum. Therefore, such programmes may assist clinical facilitators in providing quality clinical practice while at the same time enabling nursing students to integrate theory and practice.
- The study findings should be included through publication in different national scientific journals, and should be used for study purposes among the healthcare profession.

4.3.3 Research

- The study used a limited number of professional nurses. Based on the findings, the researcher recommends the replication of the study using a well-represented racial group and males in the district hospital with different disciplines to find out whether similar findings would be achieved or not.
- The study was confined to one district hospital in the Gauteng province; it is therefore recommended that the study should be replicated, using all nine provinces of South Africa, including other hospitals at different levels in the Gauteng province.
- The researcher recommends that future studies be conducted on the following areas:
- Investigating healthcare professionals' views on National Core Standards for the Health Establishments.
- Investigating factors that would enhance the effective attainment of extreme measures for Domain 2 of the NCS for Health establishment.

4.4 LIMITATIONS OF THE STUDY

- The results of the study are limited to only one district hospital in the Gauteng province. However, the literature was used to support the study.
- The study was limited to professional nurses and other disciplines were not represented, which results in their voices not being heard. Further research could concentrate on other disciplines.
- The study was contextualised and if it were to be generalised to other settings further research would be required.

4.5 SIGNIFICANCE OF THE STUDY

A qualitative, exploratory, descriptive and contextual study was conducted to explore and describe the challenges to attain extreme measures for Domain 2 of the National core standards in the health establishments in a district hospital in Tshwane, Gauteng.

In South Africa, the National core standards are new to the health fraternity and its implementation is also a new venture. However, they are supported by the Health Act. A wide-range of information on the challenges to attain extreme measures for Domain 2 has been revealed in this study. Therefore, the findings of the study will assist the policy-makers in gaining a better understanding of the challenges to attain extreme measures for Domain 2 of the National Core standards in the Health Establishments in a district hospital in Tshwane, Gauteng, which will influence the changes in the policies for the benefit of health delivery. The researcher believes that this study will improve the quality of care in the study setting. Furthermore, the findings of the study will contribute to the limited South African literature on National Core Standards, which will, in turn, assist other researchers who want to replicate the study.

4.6 CONCLUSION

The purpose of the study was to explore and describe the challenges to attain extreme measures for Domain 2 of the National Core Standards in a district hospital, Gauteng and this aim was achieved.

Based on the findings of the study, it is concluded that the objectives of the study have been attained. The researcher has made recommendations to improve healthcare outcomes. Therefore, it is anticipated that measures will be put in place to improve the quality of healthcare in the district hospital when it comes to the attainment of extreme measures for the National Core Standards for the Health Establishments.

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ANNEXURE A

PARTICIPANT'S LEAFLET AND INFORMED CONSENT TO PARTICIPATE IN THIS STUDY

Principal Investigator: Mmule L. Lephogole: University of Pretoria, Department Nursing Science,

P O Box 58985 Karenpark Pretoria 0118 – Republic of South Africa

Enquiries / Navrae: llephogole@vodamail.co.za Tel: 012 354 779/ 072 419 9583

Information leaflet and informed consent to be completed and signed by Professional Nurses in the District who voluntary participate in a focus group interviews on the challenges to attain extreme measures for patient safety, clinical governance and care of the National Core Standards for the Health Establishments in a district hospital in Tshwane, Gauteng.

Faculty of Health Sciences

SCHOOL OF HEALTHCARE SCIENCES

Department of Nursing Science

Title: Challenges to attain extreme measures for patient safety, clinical governance and care of the National Core Standards for the Health Establishments in a district hospital in Tshwane, Gauteng.

Dear Participant

Dear Mr. / Mrs. ___________________________ date of consent procedure _____./______./______

1) INTRODUCTION

You are invited to volunteer for a research study. This information leaflet is to assist you to decide if you would like to participate. Before you agree to take part in this study you should fully understand what is involved. You should not agree to take part unless you are completely satisfied about all the procedures involved. If you have any questions, which are not fully explained in this leaflet, do not hesitate to ask the principal investigator, Ms ML Lephogole, or supervisor Ms MAR du-Plessis on 012 354 1328, Dr S Mataboge on 012 3541073 .Please note that your participation is voluntary and no compensation will be given for your participation.

2) THE NATURE AND PURPOSE OF THIS STUDY

The aim of this study is to explore and describe challenges to attain extreme measures for patient safety, clinical governance and care of the NCS for the Health Establishments in the selected hospital in Tshwane, Gauteng. You are an invaluable source of information in this study.

3) EXPLANATION OF PROCEDURES TO BE FOLLOWED

The researcher will arrange a 60-90 minutes focus group interview, session whereby the questions will be asked and probing will be used to clarify and confirm facts. You need to respond to the question asked by telling the researcher about your challenges to attainextreme measures for patient safety, clinical governance and care of the NCS for the Health Establishments in the selected hospital in Tshwane, Gauteng.

4) RISK AND DISCOMFORT INVOLVED.

There is no risk participating in this study and there is no experiment involved. The interviews can take up 60-90 minutes to complete.

5) POSSIBLE BENEFITS OF THIS STUDY.

Your participation in this study will contribute in encouraging healthcare practitioners to monitor quality pertaining to patient safety, clinical governance and care continuously and improve quality healthcare and be empowered in the implementation regarding National Core Standards in Tshwane, Gauteng.

6) WHAT ARE YOUR RIGHTS AS A PARTICIPANT?

Your participation in this study is entirely voluntary. You can refuse to participate or stop at any time during the completion of the questionnaire without giving any reason or penalty.

7) HAS THE STUDY OBTAINED ETHICAL APPROVAL?

This study has received written approval from the ethics committee of the faculty of Health Sciences at the University of Pretoria. A copy of the approval letter is available if you wish to have one. The contact person at the ethics committee of the University of Pretoria is Ms D Behari and she can be contacted on 012 356 3084 or fax number 086 6516 047 or e-mail her at deepeka.behari@up.ac.za.

8) INFORMATION AND CONTACT PERSONS

The contact person for this study is Ms ML Lephogole. In case you have any questions about the study please contact her at 072419 9583 or 012 354 7790 or llephogole@vodamail.co.za respectively.

9) CONFIDENTIALITY

***Confidentiality cannot be guaranteed among participants of a focus group*.**Research reports and articles in accredited scientific journals will not include any information that may identify you.

10) CONSENT TO PARTICIPATE IN THIS STUDY: INFORMED CONSENT

I confirm that the person asking my consent to take part in this study has told me about nature, process, risks, discomforts and benefits of the study. I have also received, read and understood the above written information (Information Leaflet and Informed Consent) regarding the study. I am aware that the results of the study, including personal details, will be anonymously processed into research reports. I am participating willingly. I have had time to ask questions and have no objection to participate in the study. I understand that there is no penalty should I wish to discontinue with the study and my withdrawal will not affect me in any way. I hereby volunteer to take part in this research.

I have received a signed copy of this informed consent agreement.

Participant's name: …….. (Please print)

Participant's signature: ....………………… Date............................

Investigator’s name ....………………………..(Please print)

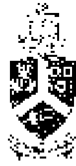
Investigator’s signature ....………………… Date….........................

Witness's Name ....…………….................Please print)

Witness's signature ....…………………... Date..….........................

ANNEXURE B

LETTER OF APPROVAL FROM THE RESEARCH ETHICS COMMITTEE, FACULTY OF HEALTH SCIENCES, UNIVERSITY OF PRETORIA



UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

31/05/2018

Mrs Mmule Lucia Lephogole
Department of Nursing
University of Pretoria

Dear Mrs Mmule Lucia Lephogole

RE.: 185/2017 – Letter dated 15 May 2018

185/2017 Lephogole	Initial Application
Protocol Title	CHALLENGES TO ATTAIN EXTREME MEASURES FOR DOMAIN 2 OF NATIONAL CORE STANDARDS FOR HEALTH ESTABLISHMENTS IN A DISTRICT HOSPITAL IN TSHWANE, GAUTENG
Principal Investigator	Mrs Mmule Lucia Lephogole Tel: 072 419 9583 Email: lephogole@vodamail.co.za Dept: Nursing Science

We hereby acknowledge receipt of the following document:

- Extension until 31 December 2018

which has been approved at 30 May 2018 meeting.

With regards

Dr R Sommers; MBChB; MMed (Int); MPharMed; PhD
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

☎ 012 356 3085 fhsethics@up.ac.za http://www.up.ac.za/healthethics
✉ Private Bag X323, Arcadia 0007 - Tswelopele Building, Level 4-59, Gezina, Pretoria

ANNEXURE C

LETTER OF REQUEST FOR PERMISSION TO CONDUCT THE RESEARCH STUDY

Letter of request to conduct a research study.

The Chief executive officer

I am a Master's student at the University of Pretoria, Department of Nursing Science. The research I wish to conduct for the Master's degree involves the challenges to attain extreme measures for Domain 2 of the National Core standards for the Health establishments in a district hospital in Tshwane, Gauteng. This project will be conducted under the supervision of Ms MAR du-Plessis and co-supervised by Dr MLS Mataboge (University of Pretoria, Pretoria-South Africa). I hereby seek your consent to collect data from the hospital's professional nurses.

I have provided you with a copy of my proposal which includes copies of the measure and consent and information leaflet to be used in the research process, as well as a copy of the approval letter which I have received from the University of Pretoria Ethics Committee.

The aim of this study is to explore and describe challenges to attain extreme measures for Domain 2 of the NCS for the Health Establishments in a district hospital in Tshwane. Gauteng. The researcher will arrange a 60-90 minutes focus group interview session whereby the questions will be asked and probing will be used to clarify and confirm facts. There is no risk participating in this study and there is no experiment involved.

The participation in this study will contribute in encouraging healthcare practitioners to monitor quality pertaining to patient safety, clinical governance and care continuously and improve quality healthcare and be empowered in the implementation regarding National Core Standards in Tshwane District, Gauteng.

The participation in this study is entirely voluntary. The Participants have the right to refuse to participate in the study. The names and other identifiable information of the participants will be kept strictly confidential. Research reports and articles in accredited scientific journals will not include any

information that may identify the hospital. All information obtained during this study will be regarded as confidential.

Upon completion of the study, I undertake to provide the hospital with a bound copy of the full research report. If you require any further information, please do not hesitate to contact me on:

Cell: 0724199583; Email: llephogole@vodamail.co.za

Thank you for your time and consideration.

Yours sincerely.

Mmule Lucia Lephogole

ANNEXURE D

PERMISSION TO CONDUCT A RESEARCH STUDY FROM THE DISTRICT HOSPITAL

PERMISSION TO CONDUCT A RESEARCH STUDY FROM THE DISTRICT HOSPITAL

GAUTENG PROVINCE

"RICA

Tshwane District Hospital

Tel no: 012 354 7602

E-mail: naing.soe@gauteng.gov.za

24 May 2017

Dear Ms ML Lephogole

Re: Challenges to attain extreme measures for patient safety, clinical governance and care of the National Core Standards for the Health establishments in a district hospital in Tshwane, Gauteng

On behalf of Tshwane District Hospital this letter serves to inform you that your request letter was received and read regarding the abovementioned topic.

Therefore, a permission to conduct a research in our institution is granted on condition that you comply with all the necessary requirements from the Ethics Committee.

Kindly ensure that all the necessary confidentiality and data privacy issues are observed and no services should be interrupted.

Yours sincerely,

Dr N Soe

Chief Executive Officer

Tshwane District Hospital

Signature :ure:

Date: 24/5/2017

ANNEXURE E

INTERVIEW GUIDE

UNIVERSITEIT VAN PRETORIA
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Denkleiers • Leading Minds • Dikgopolo tša Dihlalefi

Faculty of Health Sciences

SCHOOL OF HEALTHCARE SCIENCES

Department of Nursing Science

INTERVIEW GUIDE QUESTIONNAIRE: TO BE COMPLETED BY PROFESSIONAL NURSE IN A DISTRICT HOSPITAL IN TSHWANE.

In the Interview we will be talking about the challenges to attain extreme measures for patient safety, clinical governance and care of the NCS for the Health Establishments in the hospital.

The questions are as follows:

- What are the challenges to attain extreme measures for Domain 2 of the NCS for the Health Establishments in a district hospital in Tshwane, Gauteng regarding patient safety? Probe for follow up questions)

- What are the challenges to attain extreme measures for Domain 2 of the NCS for the Health Establishments in a district hospital in Tshwane, Gauteng regarding clinical governance? (Probe for follow up questions)

- What are the challenges to attain extreme measures for Domain 2 of the NCS for the Health Establishments in a district hospital in Tshwane, Gauteng regarding clinical care? (Probe for follow up questions).

ANNEXURE F

VERBATIM TRANSCRIPTS OF FOCUS GROUP INTERVIEWS

Focus Group 1

R-Morning everyone, as she has indicated the purpose of this interview. Can you please provide more information as much as you can. Be honest as possible. Feel free to say anything so that the standard of this hospital can be improved. If I may ask ma'am. In which ward are you working?

P1- I am working in theatre.

P2- I'm in a general ward.

R- Paeds?

P2- Adult, general ward (male).

R- Male general ward. So, the type of patients you admit?

P2- We have surgical, medical and psychiatric patients.

R- In one ward? Okay.

P2- Yes.

R- And you ma'am?

P3- I'm from Casualty.

P4- Mixed ward. Mental health, 72 hours observation, female.

R- Okay. In your ward. Isn't it like she said, its 72 hours observation.

P2- It is 72 hours observation but for males.

R- Okay. We start with the first question. What are challenges to attain extreme measures for Domain 2 of the National Core Standards for the Health establishments in a district hospital in Tshwane, Gauteng regarding patient safety? That means in your hospital.

P1- When we talk about safety, we refer to the point where the patient is cared for psychologically, emotionally, physically and patient is separated from medico-legal risks.

P2- How I understand safety, it's just about to prevent harm, anything that can harm the patient.

R- Okay. When we talk about the National Core Standards, what are we talking about?

P4- National Core Standards are similar things like what is done in our hospital should also be done in another hospital.

P2- We have to follow protocols, guidelines and standard operating procedures.

P1- We must also emphasize quality nursing care.

R- Seeing that you are coming from different wards and you are saying what is done in another ward should be done in the hospital from different wards. What are your criteria for admissions? Do you have any documentation for criteria for admissions?

P1- Yes, we do have patients from the ward and we should have this other document, we do specific checks, whereby the patient is going to be identified and they shouldn't come with their own clothes, they should wear the theatre attire because it is risky and some will be wearing the nylon type material and it might cause some sparks in theatre because we are using different kinds of machines and many a times the wards are failing us on that because they bring the patients with their own attire and you find that the theatre team is waiting and now we have to shift the case to another rather postpone because of that silly mistake and it can cost someone's life because the whole list will change now for that day and this leads to poor patient safety in our case. When the core standards people come and do audits it will seem as if we only do the cancellations and these delays can cost somebody's life.

R- So, are these are the only things that you look at. Do you have a checklist?

P1- Yes, the first document is the consent form that you have agreed to do the operation that they are going to perform. Did the doctor explain to the patient and does the patient understand what is going to be done and there's a checklist. We check if vital signs have been taken and if the patient is allergic and the treatment given and cleanliness because in theatre, we are more cautious of infection. The patient should come to theatre being very clean in all aspects.

R- And you ma'am in your general ward, what documents do you use?

P4- In general wards, we've got the standard operating procedures.

R- Yes.

P4- It's a file that compose of the, I mean each procedures required depending on ward to ward. Now, in our wards besides that I've compiled this specific guideline to mental healthcare users. It is more based on their rights, general rights but their rights. They actually are more specific to them and again, I've got this specimen that works as a quick check when we admit the patient, level of consciousness, mode of arrival, accompaniment, reason for admission, any allergies, socio-

economic of the patients, intake and output. All those things, I mean eeh, they are comprehensive admission as a quick guide so that if there should be a potential risk because most of the time when we do admissions is where now, we are failing to screen this patient properly but that's where now the potential risk can emerge. We've got also additional forms to fill in like Waterlow scale, Moslow scale to assess the risks for potential developing pressure sores, for potential falls and we've got risks for potential assessment and some of these forms are not filled in by nurses and they are important forms because through them we can detect other conditions that the patient did not disclose and if missed then it's a problem. For us to deliver quality nursing then it means we have to make sure that our patients are safe and without checking eeh other things like Waterlow scale or Moslow scale then we are out that's why we are failing when it comes to eeh patient safety. It's an ongoing problem.

R- Okay. You indicated that you check potential risks. Do you check any injuries that the patient has sustained when she came.

P4- Yes, we do check skin intergrity because on admission, the very same specimen that I've compiled and there is somewhere that it is listed, skin integrity of the patient and the skin covers the entire body and it's on the feet or face. It is easy to identify but some of the admissions are not done well when you monitor or when the core standards people come and we are lacking there and there. I've indicated that we have forms and specimens that guide us but there are gaps in admissions which indicated lack of patient safety to the outsider.

R- How do you handle that?

P4- We do in-service trainings regarding the forms because you'll think people know these things only to find that there is lack of knowledge.

R- When you talked about skin integrity, were you saying you don't specify whether it's on the face or body?

P4- No, no. I didn't mention that. I'm saying when I say skin integrity.

R- Yes.

P4- It means you check the entire body to identify whether there could be wounds. It's like eeh, nearly all our patients, the elderly, once the patient is transferred without walking, bedridden, that patient is a suspect of potential pressure sores and because of the immobility. That is where the nurses are being taught to say, when you receive the patient. It's a common practice, when you transfer the patient from the trolley to the bed, immediately check with casualty nurse who take over the patient then they have to take off the diapers so that we can see the entire body so that you can

ask whatever you need to ask from the nurse who is transferring the patient and sometimes this is not done and I've indicated that we do in-service trainings and this affects us with the core standards or eeh litigations or when the relatives are complaining.

P3- In my ward when the patient comes, we take history, we write the time he came in and the time when the file was opened and also the doctor who's seeing the patient and also inside casualty, we use also cardexes, where we also write in that cardex , the doctor prescribe medication and we sign to show that the patient was given the medication so that there won't be any repetition. There are also protocols which are in place on how to take care of psych patients and there are challenges that doctors do not write the date and time on their notes or on the prescription and even nurses sometimes, they do not write the time on their notes and it is a challenge in that this is what is wanted in National core standards regarding patient safety. We know that if there is a lawsuit then it will be easy to know the sequence of events. We don't know what time was the patient admitted, given medication or discharged to the wards or who handed over the patient.

R- So, how do you deal with this?

P3- We do in-service trainings even with the doctors, we tell them on spot but sometimes it becomes tiring because they know what to do even with the medication they don't write how long should the patient get the medication and when you tell them that this will come back with the audits then they become angry.

P4- It is the same in my ward, we are experiencing the same challenge with doctors and this comes back to us as a ward during audits or the relatives have complained about the patient care or attitudes of staff or nurses and when we go through the file then you'll find those gaps. And like I've indicated before, in my ward, we do give in-service trainings but there's no change and remember we can't change people's attitudes.

R- Do you tell patients what medication is for when giving them?

P5- Yes, when we are giving medication we let them know why we are giving it and what it does and also the side-effects**.**

R- Okay, assuming I'm a family member and I came with the patient then you give the medication. As a family member, do you tell me as well?

P3- It depends. If the patientis conscious, we talk to the patient. Isn't it the patient is the one who has the right to know what is happening depending on the age and you just highlighted some of the challenge that we have because in case of minors parents will be interviewed and they will say nothing was explained to them. Imagine nothing. These parents if they see many people around

them then they tell lies but these are some of the challenges that we have. We know as nurses and doctors that we should explain everything that we are doing to the patients but it seems as if we fail sometimes.

R- Okay.

P2- I just want to add on what we spoke about with regards to documents. We have that form where we identify, we assess all patients on admission. There is a document that we use to write the problems and the action plans if maybe a patient has risk of developing pressure sores then we have to mention the measures that we are going to do in order to prevent the patient from developing pressure sores, so it's a nursing care plan document and we do it and it has to be reviewed, maybe every two days and if there's more problems that we identify, we add on and if they are resolved. If there's more problems then you identify, you write those problems and we implement plan but because there are many forms like the other wards ah and it is either they are filled incorrectly or not filled and if not filled then it means nothing was done. Documents are the problem and we are failing with the audits even with the core standards because they will say if you didn't record then you didn't do it.

R- As soon as the patient comes with the bed sores, what do you do?

P2- Okay if the bed sores are already there. It's an identified problem and how are you going to help the patient with regards to that, you are going to mention the dressings, medication and keeping the wound clean but if the patient comes with the bedsores also, the patient has to come with the document that's mentioning that she came with them. For instance in our case, in the ward, we are going to request that form from casualty. So if the patient is from home then the sister in casualty is responsible and she has to document every single lesion on the patient and measure it but we do have problems with documents, but sometimes they are being filled and sometimes they are not. We know pressure sores are part of clinical risks or serious adverse events. Sometimes you will find that the patient came with the pressure sores and they were not identified then later the relatives will be saying it is from the hospital and they complain to the management and we do not have the evidence that's not from our hospital and there are many cases like that.

R- If identified. Do you tell the family?

P2- Yes, we do.

R- Let me ask. Do you have procedure manuals in your ward?

P1- Yes, we do. We do but they filed some of them are not known to staff because they are in cupboards.

R- What other forms do you have?

P2- We have compliments forms, we do patient satisfaction survey.

P3- In casualty after we do a resuscitation, we sit down and we talk about it, like what happened.

R-Okay, you debrief after a resus.

P4- In addition to just what she has mentioned, we has in-service program after need analysis after we see what does the staff need to be developed with. It's an objective in a sense that I give them a chance to write what they need to be developed with. Orientation is very important with new employees and that's what we do because in every four days , you can see a new face like doctors and new nurses but when coming to the core standards where now you are not gonna do that good because of one of the team member so we try to bring back that uniformity then I've got in-service training file and let them sign and I have attendance register particularly the doctors where now the very same tool I discuss it with to say core standards or clinical audits tool put emphasis on 1,2,3,4 particularly on those that have to do with the nurses. The nurse has to know the whole tool, of course but now each stakeholder or each team has to partake in this because one has to become better for quality sake.

R- Okay, ma'am.

P3- We also have a challenge when the core standards come, sometimes you will find that I'm working at male units and I don't get feedback for the whole unit. At least if we get feedback then we can improve.

R- Okay. When the negative occurs in the ward, maybe medicolegal hazards happen in the ward. Do you freely talk about it?

P4- Definitely, we talk about it. Like I've said many at times it's about you in need of a support. Remember, as team members, it's not always to say an adverse incident will occur independently facing the person who committed the act or something like that.

R- May you please clarify your statement?

P4-Meaning that we sit as a team and discuss it to see where did we go wrong and management is involved.

R- How do you report the serious adverse event?

P4- They are being trained on what serious adverse event is and what the potential, I mean cause, like I say one way or the other we can find that somewhere we didn't comply and worse still I tell

them rather you overreport than underreport. Another thing we audit files daily, it's one of the task for the sister in charge for the day but now when I'm not around then it's not done and many a times, there are gaps.

R- So, you audit all the files everyday?

P4- Audit, not in the sense of core standards. When I say audits I take a file and check page one to number last and there should be a page where I didn't go through.

R- In your ward do you have time to audit files?

P2- You know, if you are a shift leader for a day or supervisor doing overall supervisory role for the day, you'll have to but there is no specific time for it. Just by the end of the day, you should have gone through.

R- The other question will be, what are the challenges to attain extreme measures for Domain 2 of the National Core standards for the Health establishment in adistrict hospital in Tshwane, Gauteng regarding clinical governance?

P4- Let me say, the registered nurses that we have, not all of them are psych trained. Some, they are, some are not. As I've mentioned to say, we do 72 hours observation but not in a sense that we are dedicated psychiatric ward. You may find that we've got five of them, we've got five orthopaedics, we've got five gynae there, and we've got eeh,you name it, all this conditions that I said we are the mixed ward. Some, they used to labour in the ward as well.So, there isn't such a thing where you tell so and so that since you are psychiatric trained, you will be looking after the mental health patients.

R- So, meaning even myself if I'm not psychiatric trained, I can work in your ward?

P4- Yes, but it's a problem when coming to mental healthcare users tool or audits.

R- Okay. Let me say the signs and symptoms, do they need the expertise of a psychiatric trained nurse? How do you deal about them?

P4- If some, they are not. Senior sisters are being developed and taken for workshop to say, this is how we manage this condition, to assess and to say this is a guideline. So, this is how we survive with regard to the MHC users and this really affects patient safety and care thus the decline in core standards. Honestly quality nursing care is poor because of that but we are trying.

R- Okay. In your ward, are you conversant with the mental health Act because a 72 hour observation for it to be there is part of Mental health Act, that's why I'm saying, do you know how to go about it?

P4- Yes, we do but I assume those who are not psych trained are not.

R- And If I may ask, where do you get your patients from?

P4- Where do we get our patients from?

R- Yes.

P4- From home. They via casualty. We don't have like booked cases, that we say come here, then you'll be admitted. Patients that come from casualty saying that she presented with aggression and some brought by police. As you screen that's where you will pick up that some of them, it might be a defaulted case. And some of them newly diagnosed who needs a workup for 72 hour observation but all of them come through via casualty.R- The other thing when you are talking about that challenge, it's taking me back to what she was saying that not everybody is psych trained neh. Which is the challenge and the resources and the medication. Which you are saying if medication is not available then it might pose a problem on the post-op patient at that time.

P1- Like now, it is a national thing that BCG vaccines are not available and if we discharge a baby without getting BCG then at home the mother or uncle has TB and without immunising the child what will happen. I know this is a national problem. Jah such things. Influx of patients is causing a problem in the entire health sector and there is shortage of staff even basic medicines. And even in pharmacy when we are asking for disinfectants then they say they don't have. How do we run theatre without disinfecting, really infection control is our number one priority. With audits and core standards, with observations they look for the disinfectants and we have to explain that pharmacy doesn't have but ah we make means to get something though it is not what is required in the core standards or audits.

R- When you are still talking about infection control, do other wards have any challenges with infection control?

P3- Like in casualty, we've got an isolation ward but it is also a challenge because we've aah, PTB patients and also meningitis, they need to be isolated but we've got only isolation. So it is also a problem.

P4- There is infection control guidelines in place and we make sure we communicate it to everybody and we let them sign at the back of this as a matter of acknowledgement and again if we do walkabouts we can also identify where there's a need for training or so. Things like waste segregation. Checking for the sharp containers. Early in the morning, the same sister is expected to do the walkabouts in the ward. Just a quick to check are waste being segregated properly. Sharp containers. Is there stock availability? I remember, there was a problem with gloves, the only size available was big, so people with smaller hands they couldn't fit properly in those gloves whereby

someone was not wearing a glove saying that the two big gloves, if the glove is big, it's better when you are bare handed because at the end of the day how do you do your work. I happen to phone the stores, I could identify that this is a general problem because they told us that this is what they have. And based on the shortage and all those influx that sister has mentioned the other thing is also a problem is that it's communication.

R- Tell me more about that?

P4- Do our supplier knows what is it that we want? What is it that we consume more than any other thing? It's just like when we order medication. And with this medication, you need one ampoule and you will be given fifty and also our control measure of receiving. We don't have the measure to. How can I say it? The recipient and the issuer. There is no control measure to sign for that they sign to say that they've given you stock. Yes, here is a stock but come the time that you open the box, it become now a big surprise. That's where now the other challenge is and the very same thing that you don't need it's a wasteful expenditure in the sense that it is here in front of you, and secondly if you have to return it, it's time consuming. Much as we don't have nurses. It's going to stay there for some time not having someone who is responsible of returning it. Dealing with this all the nurses who say can't they give us the right thing, or having us to return that whereas we are short staffed. On the daily basis, nurses escort patient to Steve Biko and Weskoppies and it's a pre-planned thing as such Weskoppies doesn't have a single bed opened from booking patients. They asked in the morning saying that you can send three or four. And not one nurse will escort because as they get to Hospital C, they take different directions and it's a long distance and we end up with the ward without nurses. R- So, meaning that there is a possibility that when you have to transfer patients to Steve Biko or Weskoppies, you might have two patients and one nurse?

P4- No, no. Every patient go with a nurse and many a times when they get there, the doctor is not there and they have to come back and we rearrange a rebooking. It's a delay of the service and rebooking means you gonna be talking to the new doctor if you are unfortunate and it's going to delay the patient going over.

R- Okay. Are you happy with how quality assurance tries to make things right

P1- Yes.

P4-Yes and no.

R- What do you mean?

P4- They are not doing walkabouts or giving the staff any training regarding quality assurance things. They do not support us. Even with the complaints, we are not getting feedback. They only

communicate with us when the audits, national core standards are coming or when we have a complaint from the ward.

R- Okay. Again, what are the challenges to attain extreme measures for Domain 2 of the National Core Standards for the Health Establishment in a district hospital in Tshwane, Gauteng regarding patient care?

P3- We have emergency trolley and there is also a checklist. So, every morning and evening, the night staff, they have to check the emergency trolley. Check whether everything correspond with the checklist. We check for expiry dates and also the equipment that we use is it in working order. And honestly, we are failing on that because you'll find that during resus some things are not there or during the core standards, some things have expired and this leads to poor patient safety. I don't know whether this one falls under patient safety or care but I think it's both.

P2- I think this problem cut across all the wards because somebody will just tick every box on the checklist only to find that some of the things are not there, they have expired or there are wrong sizes for instance with ET (endotracheal) tubes, then when it comes to emergency then we run around and it is too late by then or to an outsider we seem incompetent.

R- Tell me, do you give health education?

P2- Whenever, there is a need to. It's just unfortunate that in our ward because it is a general ward, we've got different types of patients so the health education is per patient depending on what their condition is, what they are admitted in the ward for. It can be on admission or in the ward during patient giving medication or before breakfast. It's a diabetic patient or hypertensive patient, we educate on spot. You know, whenever there is a need to. You don't have to wait for the patient to be discharged to give health education and health education is part of giving information and when they audit they look for that or where you've written that you gave health education and we are missing that as part of patient safety and care.

R- If a patient comes in the ward, then you find that the medication that he is using is not effective. What do you do?

P2- We've got doctors. We work together with the doctors, so the doctor will see. I mean we spend a lot of time with the patient not the doctors. So you'll find that, I will give you an example, like a hypertensive patient is not responding to all medication that has been prescribed. Then you'll tell the doctor that the blood pressure has been high and you've taken all the measures but it's still not resolved then the doctor can come and review the medication and write something else or discuss with the physician on the other side (Hospital B).

P1- And ma'am still on that we do have challenges, we have influx of patients these days whereby sometimes we can't even deliver our quality patient care because medication will be out of stock. It happens that we order something from pharmacy and we can't get. And previously, we used to get but now because we've got many numbers of patients especially from African countries, sometimes we are running short of stock. And again, there is a shortage of staff, we do mention this and we can't reach our standards because we've got shortage of staff that's why even when the national core standards come the you will find that we are lacking and concerning patient safety, isn't it we have to improve quality but there are wards where there are mentally challenged patients and those patients sometimes come to theatre and we are concerned because those patients post-operatively they are going back to the wards where there are also mentally challenged patients and our concern is patient safety and carefor post-op patients.

R- So are you saying you have a challenge regarding the resources, equipment and the challenge regarding personnel. As a theatre nurse, you are saying, you are concerned about the safety of the patients especially in the mixed wards where patients who are mentally challenged are nursed next to a patient who is from theatre. So that is the challenge that you have neh?

P1- Yes.

R- The other thing that I want to ask is that you indicated that it's a problem regarding suppliers of resources and procurement is a challenge for you. So, how can you improve this?

P1- If there was a nurse who knows what resources do we need, it was better especially with us at theatre sometimes they don't understand when I say…they don't know what it is. So, if there was a nurse there, they will just issue us what we really need.

R- Okay

P1- If we can have management support then we can avoid these challenges.

R- Management, you mean?

P1- The zonal matrons. They must just have a listening ear to their nurses and support them.

P2- Just to say, we are here with you guys and here our needs sometimes, we are overworked. You know in the wards, there will be more number of psychiatric patients over a number of patients. They will be out of control and you cannot manage them and Weskoppies if full and you are stuck with patients and they remain in the ward for long, long and long. It's stressful. It's stressful.

R- Okay, then the laboratory system are you happy about it?

P1- Yes, we are.

P4- Yes.

P1- The service is good, unless maybe from the doctors when they checked the results, we don't know whether they get it right on time but with them coming to collect the sample, it's very, very effective.

P2- But, currently they are on strike.

R- Do they take sample for infection control?

P4- What I know is that sometimes the infection control team comes and takes swabs.

P1- Even in theatre, the environmental practitioner test water as well.

P4- What I want to say is that mixing patients on its own, it has never rendered quality easy than when patients are in a specialized ward.

R- Okay.

P4- Secondly, each and every patient has his or her rights. Now, it's my rights overriding your rights. The complaints I receive from patients is of patients mixing with the MCH users because they feel it's not safe and I support them and I used to take four extra patients without beds. As I've said theatre cases are just walk ins. They just say here is the patient, he has to be operated today and there is no bed but you have to device some means.

R- Can I ask, do you have seclusion wards?

P4- No.

R- It's a 72 hour observation.

P2- It's an open plan.

P4- Bed one to bed last.

R- Can we say, in our shortages or our challenges, that there's no space as well?

P4- It is and there is no privacy. You are talking to patient number one and as you sitting then patient number two is here and we don't have rooms to conduct interview especially with MHCU patients.

P1- If there was a nurse who knows what resources do we need, it was better especially with us at theatre sometimes they don't understand when I say… they don't know what it is. So, if there was a nurse there, they will just issue us what we really need.

R- and everybody?

P4- No, with them it's worse because the interview time is not like with ordinary patients where we have to sit here and we have to talk. There isn't space to do that talking and you open the dressing room, you find it locked and around the corner is a doctor and the patient as you open the other dressing room, you will find the doctor who is examining the patient quickly to get to theatre sitting on the chair and all those things. Like I don't have an office, right now as we speak. The environment is a little bit confusing.

P1- I think the number should be considered as well, for instance each cubicle must have eight beds and we must not admit more than that or double that because that's where we compromise quality service. We are going to compromise a lot of things.

P4- I forgot to mention the social problems. Eeh, people cross the sea to come here not knowing anybody, not knowing where they aregoing and they are admitted in the ward and after being treated, the social workers and the psychologist will say this was just depression and post-traumatic stress. It was painful experience for them to arrive here. Now come the time of discharge, this person has nowhere to go and you are going to get stuck with this person. Placements are full, NGO's are running dry of funds because it's just increasing and on a daily basis. We've got this social problem occupying the beds but initially they are not patients and some will get ill while they were not patients to win their stay in the wards.

P2-If admitted, they do all these funny things and remember, there's a patient in casualty who is critically ill who needs the bed but the bed is occupied by somebody who is not sick. It's just a social problem.

R- Okay.

P3- Like shortage of staff, we are overworked, we become tired and it also causes absenteeism and it compromises the quality of care that we give to the patients.

P4- Some nurses will like to leave the health sector and go for private sector. They say no private sector will tell you about stock or staff shortage and you are expected to perform to your optimum level. No. There are many challenges and they can't be resolved. They've been there for ages

R-Okay. In closure. Thanks for the information. This will really help in improving quality of care in your hospital. Thank you.

Focus Group 2 (Transcriptions)

R- Good afternoon ladies. I just want to know where you are working. As she has indicated that the purpose of this is to improve quality of care in our institution and just be as honest as possible as she has indicated.

P5- I'm from paeds.

R-Paeds?

P6- OPD

P7- Casualty

R-Paeds. Which age groups?

P5- Its 0 to 12 years.

R- So if I may ask, what are the challenges to attain extreme measures for Domain 2 of the National Core standards for the Health Establishments in a district hospital in Tshwane, Gauteng regarding patient safety?

P5- I think documentation.

R- Can you elaborate more?

P5- Okay. In a paediatric unit, we have eighteen documents that we are using.

R- Are you saying eighteen?

P6- Yes, because we do have prescription, vital signs, nursing care, intake and output. We do have blood glucose, weight chart, weight plotting, immunizations and we do have IMCI and we do have some protocols for the lodger mothers and we do have the health education papers as well and additional are for the epileptic, neuro-observations and there are also the TB and cerebral palsies. So those documents are so many to the extent that as a nurse you are doing the admission alone and it gives us a bit of a challenge for completing all those documents and it is a requirement for all the children that are entering there to have the documentations so that we can nurse them holistically after gathering of the information then we can classify them accordingly. So our challenge there with

these documents is shortage of staff. You see that maybe we have five babies in the unit and then we are three in number and they will ask another nurse to go and assist somewhere outside to do another adult ward. They say there is shortage and there comes admissions in and then we fail to complete all the documents at the same time because we need to work as a team, when somebody takes this and we gather all the information so that we can write a fruitful progress report. So, at some stage, we fail to do so because of they will leave us being two in the unit and we must proceed with all the process. Normally, you can't do all the work being two, there will be discrepancies and that's our challenge.

R- What is your bed occupancy?

P5- Twenty.

R- Twenty babies, two nurses?

P5- Mostly the unit is not always full. If we say we are full, maybe we have twelve.

R- Twelve babies?

P5- But not twenty but we have the daily surgical procedures. Tonsillectomy and minor surgery. There are days, Tuesdays and Fridays. We do have those procedures within the unit.

R- If I may ask, during those days, how many personnel do you have allocated?

P5- At some stage, we do have four and but they will ask for one to go and assist and when you do those procedures, you don't have a porter who is taking patients, assisting us to take patients to theatre and go back and take the patient doing post-operative care after the procedure and then I will be alone.

R- If I hear you well, you are saying with the four personnel, they take one and you are three and somebody will be doing the preparations and post-operatives and possibility of admissions.

P5- Normal daily routines, medications and feedings, some children don't have parents. They will be there and they need us to assist. Nappy changes, giving some nebulisations. We need to stand on …

R- Ma'am, any challenges?

P9- Sorry ma'. I'm from OHS. We have established a staff clinic, we do baselines, TB screening, Hepatitis B. We refer roughly three staff members for EAP in a week and this is a challenge because these numbers are needed in the national core standards.

R- Are you saying staff members are not utilizing your service?

P9- Definitely. Most of the members have medical aids.

R- Ma'am, you said you are working at OPD.

P6- In OPD, it is divided neh into three. Okay, we have eye clinic but in OPD we have room 1 , it's a triage and we've got the OPD whereby we see those patients who are booked and we see like today, we've got 120 patients who are booked for today. Triage, they just come in like that. So I can't say we've got so many but most of time. There is a backlog of patients. I mean congestion.

R- So, you've got three clinics.

P6- It's three because one is eye clinic.

R-okay. Eye clinic.

P6- In OPD, we have one doctor who sees all patients.

R- Are you saying one doctor sees 120 patients per day?

P6 -Yes, in OPD we have a challenge of doctors because most the time we don't have enough doctors and when the audits come like other departments, forms are written wrongly, it's either there is no time or date on the notes and even the prescriptions are written wrongly. Stamps with their details have being ordered to make things easy for them but they are not using them.

P5- Even in my ward, doctors are doing the same thing. They do not prescribe well nor write the dates and time but when I see that then I return the file back to casualty to that doctor to correct the mistake but sometimes they are fighting with me. Those doctors are failing us and they know what to do but I don't know whether to say it is ignorance or what.

R- Do you have primary healthcare nurses?

P6- No, we don't have.

R- You don't have. So, it's just general nursing?

P7-Yes.In OPD

R- And then, what did you do?

P6-Okay, like yesterday, I found out that there are no doctors because I have to wait until 09h00 to see if everyone is coming and I informed their senior, that are you aware of that . There are no doctors today and he was not aware and I had to check how many patients are booked for that day.

R-Is there a time when you feel that youcan send back the patient home or the person in the triage sometimes send some of the patients home? If I may ask?

P6- Okay we don't just send them home we check whetherthe condition allows us to book the patients.

R- Do you screen them?

P6-Jah, we do screen them, for example, maybe the patient has got arthritis, we do explain the procedure to the patient before we send them off. The other challenge is that most of the patient when they are sick they start at Hospital B, they wait there for hours then the doctors see them that side. They give them the triage forms and say go to Hospital A, you are going to x-rays and you are going to take medication, when they come here, we find that the patient arrives here and is number 74, already was seen that side and he doesn't understand why must he wait here again to be seen by the doctor and we have to explain and most of them don't understand, they expect thedoctors to just write the medication here. The patients are taken up and down and remember with audits they do get the waiting times from the files and most of the time in OPD it is delayed.

P7- I work in ward 3 which is a medical, surgical,psych for 72hours observation. Our challenge, we've got so many challenges with the establishmentand ward itself, safety of the patients, safety of the staff and our nursing station,we don't have nursing station. It is a table in the middle of the ward and we are seeing psych patients and they are aggressive and some of them will be sitting quiet and then the aggressive will pop out at any time and maybe you are busy writing, you are not facing the patient, facing the other side, you will hear the patient pulling your hair and mixing psych and medical it's also a challenge because sometimes we have to escort. We have nurses escorting,for nurses escorting patients to Hospital C and they will say scans to Hospital B and we are three nurses and while you are busy giving the medication the other psychiatric patients, when you turn back,you will find them in the side rooms feeding those helpless patients and some of them are not supposed to be fed. So, we end up losing control to our patients because for instance we've got about fifteen psychiatric patients and while we were busy with the doctors rounds giving medication,carrying out doctors some are changing patient, some are feeding patient and they don't know the risks of feeding patients. And when we admit psych patients, they end up staying for weeks because Hospital C will be full. With a suicidal, we don't. Yes, they said we must do suicidal in the ward but how can you do suicidal if you are behind the screens, changing the CVI patients, being there for the patient that is helpless. Because they watch us and some of them tell us that if you want to commit suicide while you are busy behind the screens, that's our chance. For a medical ward, general medical ward to have patients that are suicidal, it's also not safe because they can take an oxygen and strangle themselves because they cannot reach the high stoop. What I've witnessed two times is that patient

has time to strangle themselves. What they do is that they take anything and they go to the bathroom while you are busy there and they tie whether it's attire she is wearing or a cellphone charger, they tie it to the rail of the bathroom and to the back. So for that it is also …If those things happen, if a patient can be successful to commit suicide. We've got to account for it. What were you doing? We've got to go into details. Sometimes, we've got challenges from our doctors who do not want patients to be sedated, they want patients to be fully alert for themselves to take history and do interviews but shortage of staff. Yes, if we were not, if like the hospital could establish an escort service for nurses then we will be well staffed. But now for the same staff that we will be eight on duty and four will go to Hospital C, two are going to Hospital B to escort the patients and I'm left with two. How am I going to see a fifteen minutes suicidal patients. When you go to the bathroom and check if they smoke, you must check and on the other side you are having a cardiac arrest. So it's not safe. It's chaos. Sometimes, we have theatre patients. Patients are supposed to go to theatre. Maybe you have four patients or three.

R- So, the personnel. So, it's like you are running three wards in one ward.

P8- Yes.

R- What are the challenges to attain extreme measures of Domain 2 for the National Core Standards for the Health Establishments in a district hospital, Gauteng regarding clinical governance?

P7- The training for personnel, psychiatric training in the ward is not there. Most of the nurses are supposed to be trained on psychiatry.

R- For doctors?

P7- No. For nurses. I've got psychiatric nursing because I've done D4. Sister in charge also have psychiatric nursing.

R- Yes.

P7- Some, we'll be just people coming from bridging course. I think it's about three sisters who've got psych. Some of them are just general nurses. Appropriate skills are needed in that ward.

R- But do you make it a point that everyday there is somebody who is psych trained?

P7- At the moment because on the opposite shift. Yes, at the moment there is somebody but there are times. Like in night duty, like in night duty it's somebody who is coming from the bridging course, she didn't do psych. Like on the other shift there will be somebody who is psychiatric trained and on the other side it's somebody who is not trained. And even if they complain, nothing is gonna happen, you are just put there in ward three and you are gonna survive.

P5- We do have in-service training, we do have topics. Every week, let's say in the ward, three or four days, we present before we start with the routine so that we can be more conversant with the conditions that we are nursing and some other documents. For example, conflict management, grievance procedures and also the adverse events so that everybody can have knowledge.

R- Okay.

P5- We do conduct those lectures.

P9- The other thing quality is doing this patient experience survey with regards to patient care.

R- So, they ask the patient in the ward or as they come.

P9- In the wards and all the entrances.

R- Okay, OPD.

P9- Yes.

R- Do you have complaints box or something?

P9- We've got suggestion box.

R- Okay.

P8- We also have like now, a book where we write details of what the patient was complaining about and what action did we take or to rectify whatever.

R- Somehow, somewhere safety of patients is compromised.

P7- Yes, it's compromised.

R- I hear you. Sometimes, we expect the institution to look at expertise of the personnel to take care of the patients. I hear you, saying other doctors do not want their patients to be sedated when they are, which is a rule, it's a norm because it's a 72 hour observation. If you sedated them, it's like they won't get what they want and with you manpower you feel that you can't cope.

P7- Yes

R- Okay. Ma'am

P8- Casualty, so many challenges because everybody who come to the hospital must start there and we have triage unit, we have trauma unit, we have resuscitation unit, we have male unit and female unit and paeds unit. So we've got so many challenges.

R- Okay. Tell me more.

P8- Eeh, as the patient start before admission, the staff are at risk of many infectious diseases because we touch patients, we do observations, not knowing the diagnosis before the doctor come and see the patients and sometimes those diseases can be transferred to other patients.

R- Mmh

P8- And we will know that the patient has this after we saw him and we touched the patient maybe we are not supposed to touch, we are suppose to get safety measures before we know the illness before the doctor saw the patient and then we've got a challenge with the paramedics. The hospital, everybody wants to come to this hospital. They can take a patient fromtownship B straight to our hospital knowing that we won't chase them awayof which there are some hospitals. Patients from HospitalD, township A come to our hospital and it's overcrowded and there is no enough staff. We have shortage of staff. Sometimes when we are working, they call for emergency, maybe resuscitation. We have to leave one unit and go for resuscitation, sometimes they come home with a pregnant women delivering in the car, we must leave everything and go there. There is shortage of staff.

R – So, from what you have just said, I heard that shortage off staff is the key. You don't have enough staff.

P8- Yes

R- Can you see, you experience clinical risks,because of the shortage of staff?

P7-yes

R- Now do you deal with infectious patients.

P8- Eeh, ward 7 is supposed to deal with these patients and some doctors will hide this disease and if it's an elderly lady, they will say the patient has CCF. They won't check for TB,like now in a warduntil we've got a patient who's coughing. We've put her in isolation and it's an HIV positive patient taking ARV's, starting two weeks ago. When you look at her clinical symptoms and they said that we must not take sputum. When you look at her she's got clinical symptoms of TB. Yes, anarsaca is there but also there are those things you'll think that is PCP or maybe she's got TB and we've actually diagnosed patients in the ward with TB and we've actually send them to ward 7. We've actually diagnosed patients with meningitis in the ward.Yes, we do have N95, we wear them but there are these psych patients, they like befriending everybody, they will go to them. Now and again, it's like people... Now and again you find them sitting bed because when you are writing, they think

you are neglecting the patient and maybe you are writing what you have done then they will say we are just helping. So, they go to those patients and sometimes more especially if there's meningitis, she must go.

P10- We have PPE (Personal protective equipment) to use as one of infection control measure, for instance if we have a patient with MDR, we have the N95 masks, gloves and aprons and in case of klebsiella, we use gloves and aprons. It depends on the type of infection. Even the Infection control coordinator advises us on the infection control measures depending on the infection at that time. Again she advises us that every patient should be treated as infectious."

R- With surgical patients, how do you deal with them in that very ward or assuming that you have a patient who needs to be resuscitated in the ward. What do you do?

P8- Doctors have developed. We do have the emergency trolley. What they do now, the moment you call them and you are still busy with the patient and they look at the patient and they say wheel the patient to casualty. All the patient that are for resuscitation in the ward, they go to casualty. It's not like they don't know resuscitation.

R- I understand.

P7-But with them they feel like in casualty it will be safe for intubating, there is a life support machine, the ventilator. So they will ventilate there. So, it's a challenge.

R- Are you saying in your ward, irrespective that you know how to resuscitate, you don't have enough equipments and defribrillator?

P7- We do have. We do have an emergency trolley but I think the challenge the doctors have is because you find that it's weekend and there are two doctors and are interns, they are juniors. So when there is emergency we have to call them from casualty to come. So, I think for their sake, they prefer to push patients to resuscitate in casualty.

R- For support?

P7- For support. Yes. They don't want to intubate because if you intubate in the ward then you have to bag the patients to casualty.

R- Okay, the other thing that I want to ask is that, do you do audits?

P9- Yes, eeh, eeh, quarterly. We are supposed to do them quarterly with the quality assurance but in the wards, they are encouraged to do them how often?

P7- We do them each and every patient is discharged, we audit and send the files and records.

R- So, when the patient is discharged, do you send them to records?

P5- Mmh.

R- Okay, like you have indicated that the challenge that you have is that number of forms that you are having. So, do you have the checklist?

P5- Jah. I do have an admission checklist and discharge checklist.

R- Okay.

P5- So that we can make sure that all the documents are in and if something is missing so that we can put in that.

R- And what do you do with the babies who are for immunisations?

P5-We do have catch-up stations. Ward 1 is one of them but at the moment we don't have an immunisations fridge. So we did order it with plan for the immunisations because the one that we have is broken.

R- So, you don't have a fridge.

P5- The fridge is for cold chain purpose but if there is a baby who needs catch-up immunisations we do have OPD and we do have Skinner clinic.

R- Do you send the babies or do you refer the mothers?

P5- We accompany the mother and the baby to the clinic and to OPD.

R- So, it's additional, reduction of staff. There's a lot of movement.

P5- Mmh.

R- Okay. Meaning if there is that mmh, a child who needs to be immunised for that day. It's still another personnel responsibility.

R- What are the challenges to attain extreme measures for Domain 2 of the National Core Standards for the Health establishments in a district hospital in Tshwane, Gauteng regarding clinical care?

P5- For escorting as well. Maybe another child needs an EEG at hospital B so we need to accompany the child to hospital band come back. We don't have more nurses to escort the patients.

R- I assume all the wards have an emergency trolley, even OPD.

P5- Mmh

R- In OPD, how do you deal with the emergency? I understand for the triage. What do you do?

P6- Normally, we send them to casualty for them to handle the case but then it takes time and sometimes we lose the patients because of time.

R- Okay. And regarding the resources, do you have enough equipment to work with? What is the challenge regarding that?

P5- When coming to resources, we do have but we struggle with procurement because they don't know some of the things we order.

P6- We do have medical consumables as well.

P7- We do have but not enough.

R- Are you ordering enough stock?

P5- Yes but you find that procurement does not know what they issue and we have raised that with them and the management but nothing is being done.

P8- We are struggling with consumables in an emergency trolley. Eeh in stores they don't supply us with different sizes that we want for example the ET tubes. The standards need them from paeds to adults.

P9-Yes.

P6- I think in OPD, we struggle with blood pressure machines there.

R- Okay.Blood pressure machines. Elaborate.

P6- Sometimes, we feel like if we've got two versus the number of patients then we are going to push the blood pressures but one...

R- You use one for how many patients?

P6- 120 patients.

R- Did you motivate for that?

P9- We have a CEO who doesn't want to hear that we are short of equipment. He's really trying his best to ensure that things are in order in our hospital.

P5- Jah.

R- But for now you use one.

P6- Jah, for now we are using one.

P9- In room 55?

P6- Yes, We wrote the motivation but we are still waiting.This thing, if they are not there, it is not a problem. So, if you don't have resources, quality is compromised. The delay. Sometimes the patient waits for very long time, unnecessarily neh. What do you think is the cause of shortage of staff?

P9- For instance, every month, they send absenteeism stats to me.

R- Yes.

P9- It might be low morale or maybe social problems, you find that people are packing social problems. I think absenteeism also counts in shortage. At the same time, you find that managers in the wards are not doing their job. People will book leave and I will also come and say I need leave and it's urgent. I think that also counts.

R- As a cause of shortage.

P19- Yes, as a cause of shortage.

R- Are you happy of the number of patients that you see in the institution?

P7- It is too much for us. Some of them when they come and we tell them that there are no beds then they want to beat us, they think that we want to chase them away. Even now beds are full.

R- You are forever fully occupied. Do you talk about adverse events that you experience in the wards?

P8- yes, we do.

R- How so?

P8- Where I'm working, we've had some employees attacked by some psych patients.

R- Yes.

P8- So, we do talk about them and discuss. For instance, what is it that made them to attack them. These patients demand attention from us. Maybe, we are busy with some ill patients or something and then they will take as if you are not listening to them.

R- Yes.

P8- And then they will become more aggressive. We have also talked about treatment; we've got to observe them. If you see that the patient is becoming aggressive, still verbal you don't entertain that she's just being verbally aggressive because after verbal, she is gonna be physically aggressive. So, what we do, we just sedate them because some of us especially those who are not psychiatric trained are not observant.

R- Yes.

P8- They will say she hasn't done anything yet and they won't sedate. So, we encourage them, like you know what you should sedate them. Some of the, like what is it? We had some patients stealing from other patients because psych patients are wondering around from the very ill patients. So, the moments that happens, we've got to involve, like, eeh. Sometimes, we've got to call security especially if the patient is aggressive, we restrain, and we have to search the bag and we find that there are things for the other patient. These are some of the adverse events; we are always facing in the ward and some of the families bring the drugs to the patients.

R- In the ward?

P8- We had psych patient who was sleeping in the casualty chairs there. After sometime, we realised that this patient is high. She was being weird, insulting us and we knew she is a drug addict. We cannot drug her to sleep. What we did was just to restrain her and told the doctor to prescribe something that's not gonna add to her drug addiction. And we told the husband not to come again before she was discharged. Because, honestly we cannot have patients doing drugs in the ward. So we are having such incidents.

R- Do you report?

P8- We report them. We have to write a statement and we call a doctor to examine the patient and if there are some injuries then the patient is referred for X-rays to check the injuries and we tell the family what happened and we give the statement to the matrons. There must be an evidence of what happened and we have a copy of what we should give to CEO because when they complain they don't come to the ward. They go straight to the CEO hence he must be aware of what happened but we record of what happened but we do record everything of what happened especially with psych patients. We've got to report.

R- If you are having a baby in the ward who doesn't improve on a certain medication. What do you do?

P5- We normally have this first line antibiotics. After we have a time frame for five days and then when the baby doesn't improve, they do some other investigation, maybe they do some bloods. We

check how high is the infection and then they switch to second line antibiotics. And if that one also doesn't work because we give it a three days duration, then they consult with Hospital B and paediatrician and if possible we do transfer them.

R- Okay, you do transfer them.

P5- Yes, we transfer them to Hospital B, to tertiary level after collecting doing all the investigations procedures if temperature is high and not coming down and the patient is distressed, they do take them to Hospital B.

R- With medication, do you inform parents, the type of medication that the baby or the child is receiving or in your case do you ask why the patient is receiving whatever medication.

P5- We do explain for example, augmentin suspension, sometimes it makes the baby to have diarrhoea. Yes, we do explain. We do give health education regarding the medication that we are giving. The panado as well, for reducing temperature and for pain management but at some stage it makes them drowsy so they need to know to expect that if the baby is on panado he might be forever sleepy. You see and that diarrhoea, they need to know not to worry about it and that is one of other side effects of the antibiotics.

R- I just want to know, are there any, I mean for quality assurance do they take swabs in the ward to check nosocomial infections and whatever?

P5- Yes, we do have the Environmental officer who takes swabs.

R- Okay.

P5- Yes, they do test for water and the environment as well and after they do give us the results.

R- In the wards.

P5- Yes.

R- Is there any research that is done in the wards related to where you are working. How long does the patient stay with the doctor? How long do you take history from the patient?

P5- We do have a time frame.

R- Time frame?

P7- Ja, like from admissions until everybody who sees the patient and we write what time I started with the patient until you finished with the patient.

R- What is it that you are doing to assess the care that you are giving?

P6- Another challenge regarding patient care is bringing cellphones in the ward. We've got problems with people who are playing with phones during the visiting hours or procedures even if the senior people come, they just ignore them. During our trainings, we didn't have cellphones but these days technology has taken over and it disturbs us from rendering patient care.

P9- Respect for seniors is not there. Patient safety and care won't be realised because of cellphones. A patient's relative will be talking to somebody in the ward then she's on the phone. They are really ignoring patients. In my ward there are many complaints regarding patient care and some of them it's just ignorance from our side. I wish there was a policy regarding cellphones.

P6- Ai, we won't go anywhere with cellphones. I remember in my ward, one of the relatives laid a complaint saying she greeted one of our colleagues wanting to know whether the patient was in the ward or not and this nurse took time to respond because she was on the phone.

R- Is it?

P7- Yes.

P6- Our reputation is going down the drain. Patient care is no longer for nurses.

R- Okay, I hear you. Thank you so much for the information. I think this will help in improving patient safety and care in your hospital. Thank you so much.

Focus group 3 transcriptions

R- Afternoon everyone. If I may ask, in which ward are you working? Can you please introduce yourselves? Just be honest as possible. Feel free to say anything.

P10- Theatre.

P11- Casualty.

P12- I'm in general ward. Male adult general ward.

P13- Infectious ward

P14- OPD.

P15- TB focal point.

R- The first question is, what are the challenges to attain extreme measures for Domain 2 of the National Core standards for the Health Establishments in a district Hospital in Tshwane, Gauteng regarding patient safety?Meaning in your hospital. Please be frank and be open as much as you can.

P10- Anyone can start.

R-Yes,any other person can start for us. Thank you for breaking the ice for us. Am I clear?

P10- I think from my department, we are having challenges of beds. So I don't know where it's gonna fall from top or whatever because we do not have equipment. What we call it siderails. We are having a problem of siderails. Most of our patients come out being done under general anaesthesia. They come out with this. Our patient safety is still a problemand according to people up there they will be saying no, no, no we have ordered siderails in theatre right now as we speak there will be one bed with one side rail. Right now they are using stretchers which are helping.

R- So, meaning that the patient from theatre especially in the recovery room do not have bed. What if the patient is restless?

P10- Yes that is the problem. Right now they are bringing stretchers, not all the time because when we are phoning them then they will be saying they do not have stretchers but will get a bed with one siderail.

R- Meaning it is mainly the resources?

P10- Yes, mainly it is the resources. Shortage of equipment, it's a major challenge.

R- So this time, is it only the beds or other equipment?

P10- Yes, it is. I will give you an example, not even like two days ago we had water gush from where we don't know.

R- From ceiling?

P10- Yes between the ceiling. So in theatre the water gushed. When we opened the theatre there was water all over the show.

R- The environment was flooded.

P10- Our theatres are supposed to do babies and obstets. Yes,it was bad,so bad and our OM had to call the big guys up there and then they did come, one came and I remember we said oh it was

nothing,it was nothing and when he went there then it was a lot of water and now our concern was the infection control maybe we are leaking the support because when we explain the major problems about infection control, when you go to this courses they will let you know that eeh infection control, you can't see it or infection control you can't see it and if water is gushing from somewhere, the better thing is to close that area for now and work in another area until you get the source and maybe air sample is done and that's how it's supposed to be done but what happened on that day is that after the gush of water, works people were called and there was still dripping and we had to wait and then the people upstairs said let's call the cleaners to mop and the water was too much and we wanted them to give us a go ahead and when we come back, our people came more and more and we continue with the case and we are not supposed to do that.

R- Somewhere, somehow it was a compromise of patient safety. This time, you are not sure whether you are exposing them to infection or whatever and with that gush of water, it was more related to the structure and you don't know what is happening to the plumbing. Can you see how this thing is interrelated. Something is not right with the structure, it affects patient safety. At the same time it influences your nursing care. Can you see how this thing is interrelated neh.

P10- We end up compromising patient safety. Most of the time, we have to get the job done.

R- Because there are bookings that you have made for the day. So those cases have to be done and it was like any other person for that day, those who don't know theatre expectations.

P10- At that moment, we are unhappy but we have to do it because the bookings were to be done. It was a word from up.

R- Is it a directive from above?

P10- They did come but they said let's get the cleaning people but it was a bit worrying because we don't know where the water come from even the maintenance people came and checked and they could understand where the water came from.

R- But it was like a burst of the pipes. Plumbing problem and the like.

P10- Ja, still something, something because he couldn't explain what is it that really caused it but he thinks of the steam, some to do with pipes.

R- Something like pressure and you had to do that, taking a risk to continue with the whole thing not knowing whether that thing will continue and everything.

P10- And even now not knowing how is the bacteria or having bacteria and even now we are just hoping and the worrisome is that what happened is going to be responsible should maybe the patient can file the lawsuit if they find out that , that day there was aguish of water and what did we do about it. It is something that worry us as professionals who's going to take the rep .

R- Are you talking about responsibility? Remember if I am commanding you to do something. You do it and I am shifting my responsibility to,did u make a fellow up regarding infection control.

P10 – In that aspect because it was on, today is Wednesday. Tuesday. No, no it was Monday

R – Swabs were taken or not?

P10 – Not yet but it was. But you know we have our OM, everything goes to her. And remember, we are working as a team and sometimes you find that it slips somebody's mind but at the same time we have to take swabs to check because we are worried about infection because we don't know whether the water was mixed with dust. Though we utilize the chemicals in theatre when you clean but you are at the…

R- Are you worried about the infection?

P10- Yes, I am. With core standards they check our bacterial count that was taken be it with water or the environment and sometimes this affect the results.

R- Okay.

P10 – I don't know if it directly to me or the ward people and maybe it comes back to the structuring of the hospital then you find out that our patients from theatre go to the ward that is mixed, that is psych and post patients and it is affecting us directly and indirectly. Then you will hear stories that there was a patient who boom-boom post-op patients. Patients from theatre go back to the same. We don't have this ward where our patients are nurse.

R – Post operative ward

P10 – Post operative ward. We don't have that.

R – You don't have recovery room?

P10- We have a recovery but from recovery they go back to the ward.

R – It is surgical ward.

P10 – No it's not surgical ward.

P11 – It's a general ward.

P10 – It's a general ward.

R – Do you have different cases?

P10 – Ja, we have psych patients and some infectious patients. I am sorry but they do and our patients.

R – When you say our patients, do you mean operated patients?

P10 – And it's something that is worrying though they say they are on the path to get the special unit for surgical and for our patients who come from home but presently we are having patients that are coming from and back.

R – It's a challenge because presently that's what you are supposed to deal with.

P10 – A serious one because our patients are mixed even with audits we do not comply.

R – Psychiatric patients mixed with surgical patients mixed with medical patients in one ward freshly from the theatre mixing with infectious patients mixing with mentally ill patients in one ward. And then who is running this ward? Who is in charge of this ward? Are you?

P11 – No, I am working there.

R – Are working there? What is your position there?

P11 – Yes. I'm a professional nurse there.

R – This time as a general nurse who is not psychiatric trained, you are expected to nurse this patient. Are you okay with the mental healthcare Act?

P11 – No you know what, that is why you are surprised when we are saying the general ward because firstly if I can say general ward to those people on top they are saying it's a medical ward.

R – It's a medical but psychiatric and surgical ward.

P11– They are saying it's a medical ward, surgical ward and orthopaedic and there are all types of illnesses. Although everything is included but if another patient complains, the medical patient who is admitted in that ward they say that is a general ward so we don't know what type of ward it is.

R– So it’s all the patients nursed in one ward. Surgical, psychiatric, ENT and whatever? And then some of nurses, you are supposed to nurse psychiatric patients without having being trained as psychiatric nurses. Meaning you compromise the Act. You are forever scared. This is a challenge that you have because this comes back to safety regarding safety.

P11- Ja, we are admitting many different types of psych and I don’t know which one is dangerous. I don’t know nothing.

R- Are they coming for 72hours observations?

P11- It’s more than 72hours. We have patients who are having two months in that ward.

P10- They are suppose to wait for 72 hours.

P11- Hospital C is full and we are still waiting for beds in Hospital C. The referral system is poor because these are high risk patients and we keep them for long so the core standards people do not understand our challenge. They say this should be communicated and corrected but our management knows these things. It’s a challenge. Another thing is that psych patients are at second floor and sometimes they fall from second floor to ground floor. We must be accountable.

R- Those are the adverse things that do happen. Do you report them?

P11- We report them and we write incidents though some of the nurses or doctors hide that and we will be aware of them when there’s a complaint from the patient or the family. I wrote one, the patient just absconded. Another patient took the sharp object and from nowhere we don’t know and he came with that object, he was admitted with that object and he cut another oneand he just let that patient to go away.

R- Okay, the patient was restrained and the other patient cut those restraints.

P11- When they admit the patient from casualty they write the sedation and restraints so we are restraining them then we find that the one that is alert assist the other ones.

R- Because he is a patient, he doesn’t know what’s happening and they cannot accept at looking at the patient tied up. So, he is going to cut those restraints and let them to be free and be normal.

P11- You see when medical patients are lying there those psych are trying to help, they are just going to take the bedridden one, the cardiac patients out of the beds. When you ask them, they are saying we are helping yousister, this patient must sit on the chair. It’s a challenge.

R- The biggest challenge and at the same time that’s compromise patient safety at its best especially that general ward. Do you voice out this type of challenges in your meetings?

P10- In our general meeting for professionals sometimes we raise them, when will this stop because it's affecting our performance as a hospital towards patient safety and they say no it's been like that they are going to build, they are going to build.

P12- We do admit MDR patient and when those patients are discharged, the cleaners know that the room should be cleaned thoroughly even during the stay of the patient in the ward. They are using biocide. The challenge is we don't have toilets and bathroom in the isolation rooms.

R- Are you saying, you use disinfectant in case of infectious patients?

P12- Yes, that is D-Germ.

R- With bedding. Do you disinfect the bed after and change the mattress.

P12- Yes, they do use it on all the furniture in the room but I do not know about other wards.

R- Do you air your mattress?

P12- No. We do not do that but with cleaning it is fine.

R- it's a challenge neh.

R- What are the challenges to attain extreme measures for Domain 2 of the National Core Standards for the Health Establishments in a district Hospital, Gauteng regarding clinical governance? Meaning in your hospital.

P15- The challenge is with our management, their leadership is not up to standard. They demotivate us. When you go to them you come back demotivated. They are not ready to listen to us.

P10- You know there is a difference between eeh showing policy and guidelines and enforcing stuff to be done if you know very well that if you do this you are compromising patient care. With us when the outside people come and interview us about the leadership here we just be honest and they will be saying why are you doing that. But isn't it that how they behave. We can't say anything to them and that's not right. We are being treated like children.

P15- Like for instance when we do have challenges and we go to them and we just tell them I'm having this challenge. I don't know whether they are having selective listening or what because when you tell them they say you don't want to work and next time when you say I have reported to you that I'm having this challenge and they will say we hear it for the first time.

P11- In my department there are protocols and some of them are on the walls and they are saying we must familiarise ourselves with them but at the end of the day if you are in the situation, it is a problem.

R- Yes.

P10- We do have guidelines, policies but at the end of the day when you are down there and hit with that challenge, it doesn't serve. We can't render service, we can't render patient care.

R- It's true if a patient comes from theatre with one rail and the policy says all the patients from theatre must have side cot . There is nothing that you can do about it.

P10- Yes. That's one of the hospital's downfall when we are coming to audits because they see that when they are doing observations.

P12- We have the policies and guidelines but the problem I think it's with the staff. Most of the staff are not qualified in the units that they are working in.

R- Do you have enough personnel.

P13- We don't have trauma sisters.

R- The challenge there is with the qualified personnel and the mixing of patients.

P10- I don't know if I am relevant but the management is there and we are communicating our challenges but you find that you are not being listened. They rather call you and discipline but for them to correct things it's a problem.They do not want to build adequate wards for patients.

R- Okay, I understand but building is long term thing, we are looking at clinical governance. What are the policies saying about management of psychiatric patients? What are the policies saying regarding post-op care?

P10 – I don't know if it is going to fall under that part or second part of clinical governance. With respect to the clinical associates or any students that is coming to theater, we are having a problem that they are not accompanied but not knowing what is expected of them. I don't know if it's coming back to the shortage of healthcare professionals that is making that now is our job when they are coming to theatre to assist for whatever the cases that will be there. We are supposed to be helping starting from how to hold a brush. And this comes back to training of staff during the audits. We are confused who should be training them.

R – Remember, one our roles as nurses is a teaching role. Maybe it can be we are stretched because the focus is with patients.

P11- For in case in that general ward, we do admit TB patients and we do have TB ward but they will say we are admitting those TB patients, we don't have isolation first then they said we must make sure that we keep them away. Away, we don't know how.

R- Where?

P11- And then we admit them sometimes from OPD, they will say we must screen that patient for TB whilst that ward is not a TB ward and we must admit.

R- In case where you have MDR, what do you do?

P10- We are actually exposing our patients and it's risky, very risky and those sedation and restrain rightfully they are suppose to have seclusion or just a room where the patients can be managed especially those who are unruly with sharp objects. That's some of the reasons we fail core standards and we have so many complaints. No seclusion rooms, patients are mixed and no isolation rooms. It's just chaos.

R- What do you do when you admit patients? I'm looking at the guidelines and the Mental Health Act.

P12- There are security officers in every entrance, we do check them (MHCU) and their belongings so that they don't bring objects that can harm other patients or staff members.

P11- The Mental Health Act says no weapons are allowed in the hospital, that is we must take anything sharp from the patient and we are trying to do that but we miss them sometimes. They break the windows and they are pick up the pieces and use that as weapons. It is a challenge, it's a challenge.

R- Do you have psychiatric trained personnel in the ward?

P11- Most of us, we don't have psych.

R- Most of you are not psych trained, how do you manage the ward?

P11- I can't say most of us, there's none. The one who was trained is the matron now. With audits they take three files of psychiatric patients, they go through them and they always get loopholes.

R- Some of the patients are males and majority are females. Do you have male nurses?

P11- We have assistant male nurses.

R- Okay, they might be part of it. You know we need people who are experts on the fields, like if, for instance it says general ward but the psych part is the worrying factor because these patients actually interferes with other patients.

P11- So we take time looking at psych patients.

P10- I think another reason that we hear that people do not wanna go for advanced psych because when you go for advanced psych training, they expect compensation anyway, so it says that we are level 1 district, so it's just the same, so it won't change anything. I don't know if that's discouraging some RN's to go and do the advance psych. They just end up with basic.

R- Well even if it's not advanced. If they are psych trained. You don't have to have advanced psych but you must have knowledge of psychiatry.

P11- Yes I understand but most of us do not even have that basic psych.

R- What are the challenges to attain extreme measures for Domain 2 of the National Core Standards for the Health Establishments in a district hospital in Tshwane, Gauteng regarding patient care?

P11- The challenge is regarding the escort nurses. You'll find that the assistant nurse and the driver are using the private car to take the patient to Hospital C.

R- And the driver?

P11- And the driver uses the small car.

R- Do they escort them restrained or not?

P11- They escort them not restrained or sedated. My challenge is that from the ward if you can restrain and sedate the patient according to prescription and the top people from management come, they are still fighting and saying you must be vigilant and we must not sedate and restrain, they say they are people, they must walk. But then when something happens they say, they say the doctor wrote those restraints and you didn't comply.

R- So, the question will be, why didn't you do it. So you are in a dilemma?

P11- We are in a dilemma. This is very challenging to you people and restraints are part of the care.

R- So if patient is admitted from outside and is not yet sedated or the medication that is given is not yet effective. What do you do?

P11- Those referred patients ones, we don't sedate at all because they said they are interviewed that side and they should be able to communicate.

R- Ma'am.

P12- In a medical ward, it's actually a medical ward but it is infectious ward.

R- Please, elaborate more on that.

P12- Most we admit the normal medical patients, TB, MDR, we admit. Diabetic patients, we do admit.

R-MDR you do admit, do you isolate or they are just there?

P12- We do isolate them but the structure of our isolation is not good because it doesn't have adequate facilities. That patient that has infections like Klebsiella, they move from the side wards that we say we isolate then to the same toilets as the others.

R- What do you mean by inadequate?

P12- The isolation rooms do not have bath and toilets.

R- So, they use same bath and everything?

P12- Yes, it's not good.

R- So it is the structureor is it the management of this patient?

P12- I can say it's a structure because it is an isolation room and some of them do not have oxygen points and they are looking at it with the core standards and again if a patient need resus in that room we are struggling. So if we admit four patients from the side wards that we are having, we are having six side wards. It's a six bed isolation rooms.

R- How do you deal with the situation in case you have a patient who needs resus in that same room?

P12- We have to shift patients to accommodate the patient who is being resuscitated. Remember it takes time that's why sometimes we lose patient that we should have saved because of moving the beds and eeh again we are giving the infections to others but at that stage we are not aware. Isn't it we want to save the life. Core standards people are strict, they don't want to hear that they want to see what they want.

R- Okay.

P12- Yes.

R- It is a compromise, still about patient safety and care because we need to have those oxygen points.

P12- If we have a patient, we shift others sometimes. There was this challenge when there were core standards coming. We have admitted TB patients, meningitis, medical patients and others and that's when they said that why are we admitting them in the same ward and our major doctor said that meningitis is not infectious, so we have to move them from isolation rooms to the ward.

R- What if it's TB meningitis, and maybe it's a fresh case that didn't get any medication?

P10- I think another problem is that they tend to display another look because when core standards people come, we display that everything is okay. We are window dressing.

P11- Mmh.

P12- Yes.

R- You are window dressing.

P10- Mmh.

R – That's why we say with inspections, let's do it randomly. When you don't expect us because that's the only time the reality of the institution comes out because you don't prepare anything.

P10-We need to upgrade if we know that. So the people, the core standard people or the MEC comes, they think our hospital have 100% but we are struggling, we are having a lot of shortcomings. I used to say because I'm not a manager that's why I don't understand what is happening but truly if I was a manager, I order stuff and it doesn't come or it's me . It's a structure problem. This structure problem has been long here, how can I hide that there was a water gush. We will find a patient probably two years down the line, who will have acquired infection, stuff like that.

P12- Patients complain especially the family, they ask what ward is this? And I say it is an infectious ward and the management will complain saying it is an infectious ward.

R- Family of the eeh, patient?

P12- Family of the patient that is admitted in the ward.

R- Do they enquire which ward is this?

P12- They enquire which patients we are admitting.

R- Yes.

P12- And if you can just mention the word infectious, you are in trouble.

R- You are in trouble?

P12- And the management will say that it's not an infectious ward. It's a medical ward.

R- But there are medical wards?

P12- Isn't it we have MDR, TBand meningitis patients?

R- It's an infectious ward.

P11- Even in my ward.

P10- Even in the policies and the hospital whatever, we know that this ward is infectious, this ward is medical but when you are getting to the real practica, aah.

P11- Even now after this, you can go to one of our manger and ask what type of the ward is Ward 5, they will say medical.

R- But there are psychiatric patients.

P11- But when the family complains then they say, it's a general ward.

R- It's chaos neh?

P10- And the sad thing is that it has been chaotic for a long time because this hospital started in 2006.

P11- I'm one of those people who started this hospital and it has been like that. The sad thing is that when we attend the meeting they are saying, we are fixing, we are fixing and I don't think it will be solved. That is a sad. It's not going to be resolved.

R- It's a challenge, so medical wards are mainly female and your challenges about eeh, you don't have enough isolation rooms and the challenge is that maybe others do not have oxygen points. Any challenges about the emergency trolleys?

P12- The emergency trolleys, I think we are not bad. It's just that aah most senior know about it but the nurses are the ones who need training.

R- Regarding what?

P12- Like how to, if there's an emergency, at least they should know how to assist regarding the opening or how to connect.

R- The laryngoscope and in the wards seeing that it is a problem, didn't you suggest as a professional nurse to say, okay let's have an in-service training in the ward because it's part of you to improve those challenges.

P12- But I also think that the hospital must actually do training because there is in-service training for all staff maybe two years or one about BLS or fire fighting that should also happen.

R- Don't you have in-service in the ward? How may per week or per month?

P12- Per month maybe two.

R- Okay, two per month.

P12- Yes.

R- About topics. Where do you get topics from?

P12- The conditions that we admit in the ward.

R- Mainly. Okay, seeing that you have identified that most of the personnel don't have skills to attend to emergencies. Do you have an emergency checklist in the ward?

P12- Yes.

R- With induction, when the personnel come, what do you do? Is it part of the establishment?

P12- We don't have an induction.

P11- Things have changed.

R- Maybe you don't know because it's an HR thing.

P10- I got an induction. Maybe with this shortage, they decide that people should come but they used to do things.

R- Meaning shortage of personnel is also a challenge.

P10- It's a major challenge and it is for every discipline. From OPD to cleaning. Everywhere.

R- It's a challenge serious challenge.

P10- It's a serious challenge and that's compromising patient safety and care. I think it is the main core. Some things are out of stock and they will say, we don't have this, we don't have this. No consumables. Like in theatre, we must have disinfectant. The ones that the guidelines or core standards stipulate. We end up using wrong things for the sake of the situation. We always get scared in theatre for the disinfectant. Presently, we are using the product called saluzine, it's a disinfectant that is approved, that is expected in theatre and we use it to clean in CSSD. It

R- Is it all about people or patient safety and care?

P10- It's about patient safety and care and there's nothing that we can do about it. We actually phone the companies directly that are on tender and they will say the hospital doesn't pay but at the end of the day we don't have stuff to disinfect. Remember I just highlighted that there are things that are stipulated on the guidelines and we need to have them in theatre. If we don't have them then it means we are failing and yes we are failing because of that.

R- Do you mean, it's a basic thing to have.

P10- It's there on the guidelines. If you go to CSSD and ask for disinfectants then it is written there.

R- But it's not there when they order. Do they order enough according to minimum and maximum stock?

P10- Ja, I think another challenge for theatre staff. Isn't it, we are more specialized and we have medical and general stores, the people there do not know anything and we tell them but they will come and ask sister what is an ET tube. I think maybe if we can have a nursing staff then maybe it can help. For general stuff, we have but for theatre we don't have.

R- Is it because of the people in stores who do not know what is it that you want?

P10- They don't know honestly and unfortunately we can't find somebody from here to work there because of shortage. We write a list for procurement but still they order wrong things.

R- Don't you have codes for equipments?

P10- Yes, they need to have codes.

R- Are you saying the challenge is the equipments because people in stores do not know?

P10- They don't know honestly and wrong things are being ordered. I will give an example ET tube with no cuff. We are talking about safety but it will lead to care as well here. There is a patient who needs size 8 tube and it's an emergency and the ET tube doesn't have a cuff. Remember when they deliver stock very seldom, we open all the boxes. When there is an emergency you find that the doctor wants an ET tube and there I no cuff and this compromise patient safety. Sometimes you will find that they say they don't have something then if you go there then those things are there.

R- What about your department ma'am?

P13- Casualty, most of the things they are saying are the same. Everything starts there, so mixture of patients because every patient has to be screened and we don't know if that patient has infectious diseases or not. In a way, we as staff we are compromised as well. It's a challenge that we cannot change.

R- If a patient is discharged, do you tell what's wrong with them, how to take care of themselves?

P13- That definitely we do.

R- The challenge is with the mixing of patients.

P13- Yes, it's just the mixing. Even the relatives, they do complain and ask if this patient is psych then why mix them. Sometimes you will find that it's one isolation and then the patients are queuing in the corridor and the relative ask if the patient can sleep in the isolation room and on the other bed it's a TB patient and when you start explaining then they fight.

R- Are you having resources?

P13- Yes, we do have. The challenge is only when we don't order enough stock. Mixing of patients because you might find that the patient has defaulted and they will never disclose. They have defaulted and you put them with other patients and once you start screening the patient then you find that the other patients are there.

R- Okay. The other departments.

P14- OPD, we've got a problem of equipments. Equipments are not there. We've got only one dinamap in Ward 55. Ward 55 is where patients are taken vital signs, the first time and we do our dressings. In room 1, we have one machine.

R- How many patients do you see per day?

P14- Roughly 120 or 150 people per day.

R- Are you saying you are using one BP machine?

P14- Yes, with one BP machine. We are giving them the notes to go to room 55 for BP and they have to come back.

R- What if the BP is high and you don't know and that patient has to walk up and down?

P14- Yes, they usually come back with elevated BP because they were never diagnosed and the patient might fall but we are just fortunate because they don't fall. Besides that space is the challenge in OPD. In room 55, there is a room where one takes bloods, straight it's a POP room and it's a dressing room. It's not a clean place. Doctors do apply POP and they leave their things. It is a very, very small place and dirty.

R-What about the aseptic technique?

P14- It worries me a lot. The thing of dressings and OPD. You just do it. You open the dressing pack and you wipe. What do you wipe really? The whole place is full of dust. Everything is packed in one place. There are trolleys here. It's not the right place for dressings.

R- Do they end up in serious adverse events and poor clinical risk management?

P14- Yes, because none of those procedures should happen in that small place. Wounds are always being done there.

R- What about infection prevention and control?

P1- Where do you wash hands?

P14- There is no space for that. People are all over then you have to say sorry, sorry. You know what with OPD I think they must just break down and build something round.

P11- Something spacious.

R- Okay. From what you are saying I have realized that there has been a compromise and to the extreme level.

P10- That's wrong. You can imagine infection.

P14- The other people are coughing there. They have to collect the sputum there and the other side we are opening wounds.

R- Are the windows opened?

P14- It's just a passage, just like this (showing of hands). Others are there, we are doing dipstick. Others are here taking blood pressure and standing just in between. Others are here, they want to go to this room for blood test. You don't wash hands in between. We have handspray but the hands crack because you are always doing this.

R- So, it is a challenge for infection control and quality assurance?

P12- The core standards and the TB people come and they say they want the sputum room and I said where? They say your matron said there is a room where you collect sputum.

R- So, with the contacts for TB, are they checked?

P15- In TB focal point, we have challenges as well, the problem is that, we have that thing of mixing patients. TB focal point is in Room 26 and the eye clinic is in room 25.The TB patients mix with them on the queue and imagine if they are diabetic. We are really exposing the patients to MDR and right

now we are a decentralized place and all clinics are send their patients here for the initiation for MDR treatment more especially on Bedaquiline and management so they start on vital signs because we don't want them to do the fast-tracking and we tell them to go and see the doctor at home.

R- Is the place cramped?

P14- It's a passage.

P15- It's a long passage. We give the TB patients the masks but when you go inside then they take them out and they will be coughing. The even do that when we have audits and it seems as if eehwe are not giving them masks. According to the MEC, each and every patient is supposed to be screened and we have visitors from TBSAP and they came to introduce the idea of FAST. Me and the other sister gave the report to the other matron because CEO must get the report and the matron said that there is no way that we can screen all the patients and the staff members because we don't have money. We are concerned that that if we don't screen everybody will be infected with TB.

R- Yes, It's true.

P15- Even the CEO said there is no money for that and the minister must write a letter forgetting that this is part of patient safety and it is an expectation from us on the National Core Standards.

R- So, even other outpatients are at risk of getting infections. What do you do with contacts?

P1- We send them to the clinic and we do have a tracer team. There is a linkage with UP and the doctor there works with WBOTS team and they come to us every week.

R- What do you do with the sputum? Do you make follow-up.

P15- Yes we do but we send the follow-ups to the clinics.

R- Okay. With MDR patients, do you tell them the implications?

P15- Yes because before we initiate we sit with them, counsel them and tell them the implications of MDR.

R- Do you have the HIV positive patient? What do you do about them?

P15- We put them on treatment for two weeks and refer them to ARV clinic but the challenge that we had was with the health education that was given to patients, we didn't record that and with audits they said we are not doing it because on the records it doesn't show. The other thing is with follow-up the patients do not find the file and now the continuity of care is broken, the patients starts from scratch to explain.

R- Do you do audit in the institution?

P10- They come, the external auditors to audit us.

P15- We have internal audits as well.

P14- We do them in OPD, once a month. We are supposed to do five files and submit those files.

P10- We had a case in theatre from the ward where by a patient did not know what the surgery was all about. The testicles were going to be removed and eeh he couldn't understand that. He actually had cancer and he wasn't told. I called the doctor to explain and the doctor tried and the patient said no he can't do that. It shows that the patient was not counselled, told anything about cancer or the condition and we tried to calm him down and the doctor said he cannot continue with the surgery because the doctor who send the patient should have explained everything. We are really failing our patients. Imagine if this was done and he find out later that he can't bear children. That was a big case and remember everything is recorded and this came out during the audits.

P11- Actually that patient was from our ward, we even called the matron to explain and the matron said that it is nothing big.

R- How was the case handled?

P10- It was a complaint and I think the case is still on.

R- Okay. Thank you. Thank you very much for the information. That will be used in improving the quality of care in your institution.

ANNEXURE G

ACKNOWLEDGEMENT OF LANGUAGE EDITING

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