Article

Perceptions of Nurse Managers regarding Clinical Relicensing Audits at Private Hospitals

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Abstract

The National Health Insurance (NHI) in South Africa aims to provide access to quality health services for all South Africans. The NHI will only accredit and contract eligible health facilities that meet nationally approved quality standards both in the public and private sector. Detailed tools for measuring compliance with the National Core Standards (NCS) and Batho Pele principles have been developed and implemented in the public sector. To date and since its implementation in the public sector, very little is known about the national audit tool and the method used to evaluate quality and patient safety standards in private hospitals in the eThekwini district, South Africa. The aim of the study was therefore to assess nurse managers' perceptions regarding the clinical relicensing audits performed at selected private hospitals in the eThekwini district. A qualitative, exploratory, descriptive design using an interview guide was used to conduct the study. The group of hospitals (N = 4) studied has approximately 40 clinical managers who were sampled for the study. A total of 24 nurse managers were interviewed, guided by data saturation. The results of the study showed that the selected private hospitals in the eThekwini district have not fully implemented the approach to clinical practice standards and healthcare audits in relation to the three clinical domains of the NCS, namely patient rights, patient safety and clinical care, and clinical support services, and the Batho Pele principles. Recommendations are for the internal and external factors influencing the national audit process to be dealt with based on the results of the study.

Keywords: Batho Pele principles; health audit; licensing; National Core Standards

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Introduction and Background Information

In recent years, the South African Department of Health has shown an unwavering commitment to improving the quality of healthcare in South Africa. The National Core Standards (NCS) were first launched in April 2008 as a response to concerns regarding the multiplicity of different standards and guidelines for managers throughout the health system and the consequent difficulty in measuring performance against a common benchmark (Department of Health 2011, 9). The National Health Council had resolved that the NCS be complied with in every province, health district and public health facility. Detailed tools for measuring compliance and baseline audits for the NCS and Batho Pele principles have been developed and health establishments in the public sector have begun to self-evaluate quality standards using these tools in preparation for the launch of the National Health Insurance (NHI) in South Africa (Department of Health 2012, 1–67; Department of Public Service and Administration 1997, 9–22).

The private sector healthcare facilities in the eThekwini district in South Africa continue to be audited against the structural audit tool R158 (Department of Health 1996, 1).With the onset of quality improvement in healthcare on an international scale, a growing interest in the evaluation of the quality of health services has now been noted. Licensure, accreditation, and certification are systems available to meet the need for quality and performance information. The Department of Health is the custodian of healthcare delivery in South Africa. This includes care delivered at public as well as private facilities. This commitment has been further cast into the spotlight through the development of the 10-point plan for the improvement of healthcare (Whittaker et al. 2011, 60).

According to Ensor and Palmer (2009, 5), licensing is often distinguished from facility certification and accreditation, although in practice the distinction is increasingly blurred. Licensing is compulsory and is administered by a government entity thereby granting legal permission to practices based on an inspection by the regulator. This is different to accreditation or certification approaches that are based on optimal and achievable standards or a demonstration of special knowledge or capability. The purpose of licensure requirements is to protect basic public health and safety (Whittaker et al. 2011, 60).

However, there has not been a standardised system or legislative requirement for private hospitals to submit information on clinical outcomes (Matsebula and Willie 2007, 171). Implementation of quality, patient safety and infection control at private hospitals has thus been left to the discretion of each hospital. According to the Health Evidence Network (HEN) of the World Health Organization (WHO), implementation of audit and feedback requires clear goals and a thorough analysis of the healthcare environment in question, especially if this approach is combined with incentives or penalties, or is made mandatory (WHO 2010, 8). The lack of a common definition of quality and patient safety across private and public sector hospitals has implications for patient care. With

this in mind, the study aimed to assess nurse managers' perceptions regarding the current relicensing audit process at selected private hospitals in the eThekwini district.

Problem Statement

To date and more than five years since its implementation in the public sector, very little is known about the national clinical audit tool and the method used to evaluate quality and patient safety standards in private hospitals in the eThekwini district. Regulation R158 is a structural audit tool (Department of Health 1996, 1). During relicensing inspection walkabouts, clinical audits are performed. There are no measurable elements for the clinical standards inspected and the expectations of the regulator are unknown prior to the inspection. While all these steps are critical to ensure continuous quality improvement in private hospitals, there are no evidence-based guidelines or auditable standards that can trace back to the measurable elements of the clinical care expected by the regulator.

Significance of the Study

Nursing as a discipline has clearly been concerned with defining and measuring quality long before the current national- and state-level emphasis on quality improvement. Florence Nightingale analysed mortality data among British troops in 1855 and accomplished a significant reduction in mortality through organisational and hygienic practices. She is also credited with creating the world's first performance measures of hospitals in 1859 (Burns and Grove 2011, 34; Mitchell 2008, 4). In the past, nursing responsibility in patient safety was viewed within narrow aspects of patient care, for example, avoiding medication errors and preventing patient falls. While these dimensions of safety remain important within the nursing purview, the breadth and depth of patient safety and quality improvement are far greater. The most critical contribution of nursing to patient safety, in any setting, is the ability to coordinate and integrate the multiple aspects of quality within the care directly provided by nursing and across the care delivered by others in the setting. The All-party Parliamentary Group in the UK on global health, in its Triple Impact of Nursing Report in 2016 (WHO 2016), argued that strengthening nursing will have a triple impact on improving health, promoting gender equality and supporting economic growth in meeting the needs of its citizens in ensuring accessibility to universal health coverage. Nurses around the world have concerns about staffing problems, poor facilities, and inadequate education, training and support. The inability of nurses to practice to their full extent of their competencies, with fewer opportunities to develop into leadership roles that influence policy decisions, may result in poor quality of patient care (WHO 2016, 4).

The conceptual framework chosen for the study was based on the NCS and the Batho Pele principles of South Africa. The NCS is structured into seven cross-cutting domains to reflect a health systems approach and to define the scope or intent of assessing a health area where quality or safety might be at risk (Figure 1). The first three clinical

domains of the NCS incorporate the Batho Pele transformational principles ("putting the people first") and relate to the core business of the health system while the final four domains refer to the support system that ensures that the former are delivered (Department of Health 2011, 10–16; South Africa 2017, 1–80). It is difficult to explain the exact measures of quality and patient safety variations within private hospitals without a standardised audit tool for evaluation.

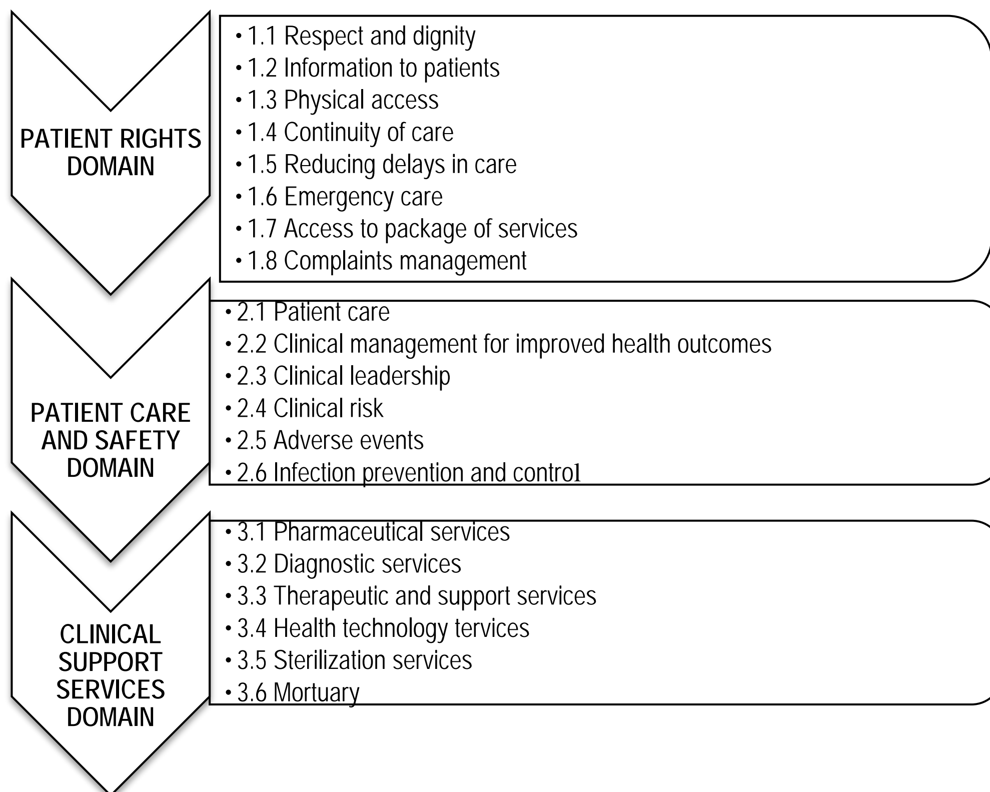

Figure 1: Clinical domains and sub-domains of the National Core Standards (Department of Health 2011, 10–16)

Aim of the Study

The aim of the study was to assess nurse managers' perceptions regarding the current relicensing audit process in relation to the NCS and Batho Pele principles at selected private hospitals in the eThekwini district.

Objective of the Study

To assess nurse managers' perceptions regarding the clinical relicensing audits in relation to the following domains:

- patient rights;
- patient care; and
- clinical support services.

Definition of Keywords

Batho Pele principles: Batho Pele, a Sesotho phrase which means "people first", is an initiative that was launched in 1997 to transform the Public Service at all levels. Batho Pele was launched because democratic South Africa inherited a Public Service that was not people-friendly and lacked the skills and attitudes to meet the developmental challenges facing the country (Department of Public Service and Administration 1997, 6).

health audit: a methodologically unbiased examination of health establishments by comparing what is done with agreed best practice and identifying and resolving problems in healthcare service delivery (Department of Health 2012, 9).

licensing: a statutory mechanism by which a governmental authority grants permission to a healthcare organisation to operate and deliver services. Licensing allows governments to ensure basic public health and safety by controlling the entry of healthcare providers and facilities into the healthcare market and by establishing standards of conduct for maintaining that status (Whittaker et al. 2011, 60). Relicensing takes place at regular intervals.

National Core Standards: In fulfilling its strategic and legislative imperatives, the Office of Health Standards Compliance developed the National Core Standards for health establishments in South Africa, which will assist in setting the benchmark of quality care against which delivery of services can be monitored (Department of Health 2011, 8).

Research Methodology

Study Design

A qualitative research methodology guided the research process. Data collection in the qualitative phase consisted of using individual face-to-face in-depth semi-structured interviews with the participants.

Study Setting

The research setting was a group of four private hospitals situated in the eThekwini district. The group comprises 650 beds with an average bed occupancy of about 80 per cent. The hospitals are regulated by the eThekwini Department of Health and seek relicensing on an annual basis.

Pretesting

A pretest was conducted on three managers to determine if the questions were understood. No changes were made to the questionnaires. The pretest data were excluded from the final data set.

Sampling and Sampling Technique

A purposive, non-probability sampling strategy was employed to recruit nursing managers to participate in the study. This group of hospitals has approximately 40 clinical managers who were included in the study as they are directly involved in the relicensing inspections.

Data Collection

A total of 24 participants were interviewed across four hospitals over six weeks between mid-October to the end of November 2016. The qualitative phase was used to describe the experiences of nurse managers regarding relicensing inspections. The primary research question was "how do you perceive the current relicensing audits in relation to the patient rights, patient care and support services domains of the NCS and Batho Pele principles?"

Those who agreed to take part in the study signed an informed consent form which included an explanation of the handling of all interview materials, confidentiality issues and anonymity procedures for the participants, and the option to withdraw at any time. All interviews were scheduled at a time that was most convenient for each participant and also for the health service. A private room was organised at each study site to ensure that the interviews were conducted in a suitable environment that facilitated the participants talking freely. The time taken to complete the interviews was aimed at 30 minutes. The interviews were recorded and transcribed verbatim by the researcher with the permission of the participants. The researcher used probing where necessary to obtain in-depth information on the issue. The data collection continued until the point of data saturation that is when the researcher stopped collecting data because fresh data no longer sparked new insights or revealed new properties (Creswell 2014, 297).

Data Analysis

The approach adopted for the qualitative data analysis was an inductive approach. After each interview, the researcher reviewed how the participant responses would help the study to answer the research questions. The researcher personally transcribed each interview within 48 hours of conducting the interview. Information from the field notes was compared with that on the audiotape to make sure that all the data had been captured correctly. The researcher focused on describing how many times different categories appeared in the data and linked the codes to create meaning. Important quotations from the participants' responses were identified. The concepts were then translated into codes, codes into themes and categories. The themes according to which the data were

organised were predetermined according to the conceptual framework that guided the study.

Validity and Reliability

In qualitative research the techniques to ensure trustworthiness followed Lincoln and Guba's recommendations (cited in Loh 2013, 5), using the criteria of credibility, dependability, confirmability, and generalisability. Procedural rigour was ensured through precise documentation of all the steps and processes taken to conduct the study and how the decisions were reached amounting to the establishment of an audit trail. Interpretive rigour was ensured by basing the data analysis on the three clinical domains of the NCS and the Batho Pele principles. The researcher strived to ensure authenticity by using direct narratives from the study participants. As qualitative research has an element of subjectivity, and is open to criticism, it is important that the study and the findings provide evidence of validity and reliability (Polit and Beck 2012, 174).

Ethical Considerations

The researcher has the responsibility of ensuring that the research is conducted in an ethical manner. Protection of the rights of the participants is a significant factor to consider when planning the research. In South Africa, ethical issues relating to a proposed research are evaluated by an accredited research ethics committee, who are also responsible for granting permission to proceed with the study. Ethics clearance was obtained from the Ethics Committee (IREC 113/16) of the Durban University of Technology. Permission was obtained from the manager and Ethics Committee of the group of hospitals in the study before distribution of questionnaires began. Information regarding the research study was fully explained in the information letter, which was given to the participants by the researcher. Written consent was obtained and anonymity was maintained as the participants did not have to reveal their identities. The participants were free to withdraw from the study at any point without an explanation. No personal details were captured during the data capturing process, instead each questionnaire was coded. The researcher ensured that all information pertaining to the participants was kept confidential.

Results

A total of 24 interviews were conducted; 9 from Hospital A, 7 from Hospital B, 5 from Hospital C and 3 from Hospital D. The people in the study were senior nursing staff of which 23 were females and one was a male nursing manager. The experience levels measured the years of service in the nursing profession and ranged as follows: 3 participants had between 5–10 years of experience, 8 between 11–20 years, 7 between 21–30 years, and 6 more than 30 years.

Major Themes and Sub-themes

The following three major themes and a number of sub-themes emerged from the data during the analysis as illustrated in Table 1.

Table 1: Major themes and sub-themes

Theme 1	*Inadequate checking of the patient rights domain during relicensing inspection*
Sub-theme 1.1	Inconsistent checking of the patient's right domain during relicensing inspection
Sub-theme 1.2	Lack of an audit tool for clinical audits during relicensing inspection
Sub-theme 1.3	Recommendations for a standardised tool for clinical audits
Theme 2	*Inadequate checking of the patient care domain during relicensing inspection*
Sub-theme 2.1	Inconsistent checking of evidence-based patient care practices during relicensing inspection
Sub-theme 2.2	Inconsistent checking of clinical management during relicensing inspection
Sub-theme 2.3	Inconsistent checking of aspects of clinical leadership during relicensing inspection
Sub-theme 2.4	Inconsistent checking of clinical risk monitors during relicensing inspection
Sub-theme 2.5	Inconsistent checking of adverse events and monitoring systems during relicensing inspection
Sub-theme 2.6	Inconsistent checking of infection prevention and control during relicensing inspection
Theme 3	*Inadequate checking of the clinical support services domain during relicensing inspection*
Sub-theme 3.1	Inconsistent checking of clinical support services during relicensing inspection

Major Theme 1: Inadequate Checking of the Patient Rights Domain during Relicensing Inspection

When the participants were asked if the annual relicensing inspection included aspects of the patient rights domain during relicensing inspections, the majority of the participants expressed their unconscious prejudices against the current relicensing process based on their interpretation of the NCS and Batho Pele principles, and also shared their own personal experiences. The three sub-themes that emerged under this major theme during the interviews were inconsistent checking of the patient rights domain during relicensing inspection, the lack of an audit tool for clinical audits during relicensing inspections, and recommendations for a standardised tool for clinical audits.

There were mixed responses to this question as participants articulated their own viewpoints in line with their perceptions. Two participants expressed the following sentiments regarding this domain:

> The audit is based on the R158 … very little to do with clinical … and infection control. More focused on bed spacing … structure … It is relevant to infection control. I agree it is interrelated but they do not look at respect and dignity. (Participant 3, Hospital C)

> Honestly, inspections are very generic inspections … they should firstly have an audit tool to give us guidance. There is no checklists as well … not done completely with regard to … respect and dignity … this is not being checked. It would be nice to have a tool … benchmarking will really work well for each hospital. (Participant 3, Hospital B)

Major Theme 2: Inadequate Checking of the Patient Care Domain during Relicensing Inspection

Six sub-themes emerged under this major theme during the interviews. There were mixed responses to this question. Many participants expressed sentiments regarding their own evidence-based practices. Excerpts from the participants included:

> My ward is an infectious unit … the only thing they checked was the dispensers … They should check the sputum room, policies, smoke tests done … check our isolation wards for negative pressure, check the hygrometers on the wall … my infectious policies … should question about multiple drug resistance patients curtain washing plan … how we soak our dishes … how we isolate our patients, our PPEs and our staff medicals. There was not a single question regarding infection control. (Participant 5, Hospital A)

> Yes, they look at this at unit level … they look at negative pressure. Not all isolation rooms are checked … They should have an audit tool … based on the tool they should check for TB … if screened … isolated and management of MDR and XDR-TB patients. (Participant 3, Hospital B)

Major Theme 3: Inadequate Checking of the Clinical Support Services Domain during Relicensing Inspection

One sub-theme emerged under this major theme, namely there is inconsistent checking of clinical support services during relicensing inspection. Excerpts from the participants included:

> Diagnostic services … no, I have not seen this. They don't check and audit blood gas machines and critical equipment checks are not audited. (Participant 3, Hospital A)

> Yes, they did check my ventilators, they checked my last service date on my ventilator. They even checked my certification of services … my yearly certification of services whether they done and concurrent and then I had to submit a critical care register to annotate the next service date. (Participant 7, Hospital A)

Discussion

The results of the study showed that the expectations of the regulator are not being met during relicensing inspections for the selected private hospitals in the eThekwini district. The patient rights, patient care and support services domains are inadequately checked against the NCS and the Batho Pele principles during relicensing inspections. These inconsistencies in relicensing audits can relate to previous studies which have indicated that the lack of effective communication on the part of the regulator may lead to major target areas being unchecked, especially in the high-risk areas of the organisation (Ensor and Palmer 2009, 5–7). Although the organisation has its own internal clinical audit structure for regulatory relicensing inspections, the participants indicated that an auditable tool by the regulator will provide for much needed guidance and support to ensure that all hospitals follow a common set of guidelines for relicensing inspections. They also expressed their sentiments in their ability to measure their performance with other organisations through the use of a common audit tool with a structured feedback in the form of ratings to benchmark with other organisations.

Under the Batho Pele framework, there is zero tolerance for the lack of respect and privacy for patients, and leaders must therefore ensure that the environment of care for patients is satisfactory. According to Chellan and Sibiya (2017, 4), the clinical domains of the NCS and the Batho Pele principles further incorporate aspects of the scope of practice of nurses in the Nursing Act R2598 (South Africa 2005, 1) in which caring must be enhanced. Improving the quality of healthcare today requires a commitment to delivering healthcare based on sound scientific evidence aimed at continuously introducing innovative, effective healthcare practices and preventive approaches (Hafner et al. 2011, 697–704). The overall results of the study revealed inconsistencies in clinical audits during relicensing inspections.

Limitations of the Study

Although the study area included a group of hospitals in the eThekwini district, the limitation was that owing to the nature of the business other private hospitals were not included. Furthermore, this was the first study in which the perceptions of nurse managers in the eThekwini district were assessed and comparisons could therefore not be made.

Recommendations of the Study

Recommendations stem from the results of the study which suggest that attention be paid to each of the standards in the NCS and the Batho Pele principles during relicensing inspections. A standardised clinical audit tool for relicensing inspections has been recommended by the participants. A situational analysis should be performed with an understanding of what needs to be done and how it should be done to meet the requirements of the national clinical audit during relicensing inspections. This should entail hospitals comparing their current practices with the requirements of the NCS and

Batho Pele principles. The process should create an understanding of those standards that should be retained and strengthened in the current practice. All standards related to the NCS and the Batho Pele principles framework that are missing in current practice should be identified as standards that need to be introduced and strengthened.

Recommendations that the researcher further proposes in this section are based on actions on three fronts: management responsibility, education and training, and operational management. It is important that the three levels of hierarchy cooperate to put systems and processes in place to implement the National Quality Framework (NQF) of the NCS and Batho Pele principles. Strategies for monitoring, evaluation and feedback are important and these should be in place at all levels. More importantly, it is necessary to create a positive organisational culture and workforce that are committed to strengthening the NQF in the eThekwini district. Further recommendations are for the internal and external factors influencing the national audit process to be dealt with by the relevant parties as the country moves towards the NHI. Communication between the three levels and with relevant stakeholders is important. Learning may be further enhanced through effective communication through road shows arranged by the regulator to keep all health establishments updated on the progress, failures and achievements, as success stories, in the implementation of the NCS. It is also recommended that future researchers on the topic engage in a broader study involving other private hospitals and groups in the eThekwini district.

Conclusions Based on the Findings

Conclusion 1: Senior Nurse Managers Lack Confidence in the Current Relicensing Inspection Process

Conclusions based on the findings revealed that senior managers lacked confidence in the current relicensing audit process. The participants perceived the relicensing clinical audits as inconsistent with each visit as there is no clinical audit tool to guide the inspection process. The conclusions also revealed that there is inadequate checking of the clinical domains of patient rights, patient care and clinical support services. Many of the senior managers related their responses to their organisations' quality process, in an attempt to link them to the clinical domains of the NCS and the Batho Pele principles. The need for objective feedback was highlighted by the participants in order to benchmark with other private hospitals in the eThekwini district.

Conclusion 2: There are Certain Internal and External Factors Influencing the Lack of Confidence in Senior Managers during Relicensing Inspections

Conclusions based on the findings indicated that various factors influence the senior managers' lack of confidence in the current relicensing process. Internal factors are those related to the internal work environment and external factors are those related to the government's national quality strategy. The analysis of these factors has implications for both quality and patient safety. Recommendations are for the influencing factors to be resolved by senior management and by the National Health

Department in South Africa. The internal and external factors are summarised in Table 2.

Table 2: Internal and external factors identified by senior managers

Internal factors contributing to the lack of confidence	*Internal factors that could improve confidence*
Lack of management exposure to relicensing audits based on the NCS and Batho Pele principles	Internal audit procedures must incorporate aspects of the three clinical domains
Ineffective communication between the teams	Improve communication through regular quality forums
Lack of timeous feedback regarding audits	Improve feedback to the managers and provide constructive criticisms
Inadequate preparations for audits	Encourage continuous quality improvement and readiness for audits at all times
Uncertainty of what is going to be checked	Prepare for audits within the national audit guidelines
Lack of experience of unit managers to conduct external audits	Incorporate accompaniment and mentorship into leadership programmes
External factors contributing to the lack of confidence	*External factors that could improve confidence*
Lack of a standardised audit tool with benchmarks	Implement the national audit tool for private sector relicensing inspections
Audit not based on the NCS and the Batho Pele principles	Apply the NCS and Batho Pele principles framework of quality and patient safety to private sector hospitals
Lack of consistency within the audits	Provide standardised auditable checklists for clinical inspections to ensure consistency
Lack of timeous and objective feedback	Provide feedback in the form of a score rating identifying the high-risk areas while on site
Combined structural and clinical audits	Separate the R158 structural audit from the clinical audit
The approach and attitude of audit staff	Friendly attitude will put staff at ease
Not recognised as an educational opportunity	Use the process as an opportunity to educate staff at all levels

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