A Conceptual Model for Improving Working Conditions at Selected Public Hospitals in Mpumalanga, South Africa

Zodwa Margaret Manyisa
https://orcid.org/0000-0001-8831-890X
University of South Africa
manyizm@unisa.ac.za

Abstract

Employees in public hospitals in South Africa work under dreadful conditions and are at risk of developing psychological stress and occupational diseases as well as occupational injuries. These poor working conditions translate to poor service delivery and as a result, the patients are the ones who suffer the most while under the care of these healthcare professionals. Despite these poor working conditions in public hospitals, there are limited studies that have dealt with this important topic in South Africa. The purpose of this paper was to describe a conceptual model which can be used as a framework of reference to improve the working conditions and the health and safety of employees at selected public hospitals in South Africa. A descriptive, explorative and theory construction research design was used to construct a conceptual model for improving the working conditions in public hospitals in the specific province in South Africa. The model suggests that improvement of working conditions, employee health and safety and quality patient care can only be achieved if employees and managers work interdependently for the betterment of the working conditions of their hospitals. Improvement should focus on enablers such as leadership commitment, infrastructure, resources, safety and security communications, decision-making, interpersonal relationships, support, and education and training. The implication for the managers and employees is that the model can be used as a framework for improving working conditions in hospitals, to promote the health and safety of employees and to improve quality patient care.

Keywords: conceptual model, employees, health, safety, working conditions

Introduction and Background

Despite the efforts by the national department of health to improve the working conditions in public hospitals in South Africa, employees of public hospitals still work

UNISA university of south africa PRESS

Africa Journal of Nursing and Midwifery
https://upjournals.co.za/index.php/AJNM/index
Volume 22 | Number 2 | 2020 | #4655 | 17 pages

https://doi.org/10.25159/2520-5293/4655
ISSN 2520-5293 (Online), ISSN 1682-5055 (Print)

under horrific conditions. Factors such as poor working environments characterised by the lack of involvement in decision-making, job security, staff shortages, poor communication and poor salaries have been documented in literature reviews, both in developing and developed countries (Rad and De Moraes 2009). A study by Aiken et al. (2012) reported that the quality of care in public hospitals rated as fair and poor, varied from 11 per cent in Canada to 66 per cent in South Korea, while job dissatisfaction about the working environment in public hospitals ranged from 20 per cent in Canada to 60 per cent in Japan.

Despite the paucity of published information regarding the status of working conditions, the poor outcomes of employees and patients in South Africa, particularly in the province of Mpumalanga, anecdotal evidence has revealed that a lot has gone wrong with public hospitals in most provinces in South Africa including those in Mpumalanga. The working conditions in public hospitals are poor and are characterised by a number of factors such as poorly maintained lifts, refrigerators and air conditioners, a lack of water, and power outages.

A recent report on the state of public hospitals in Mpumalanga found that most hospitals are in a shocking state of dilapidation and there is a dire need for them to be refurbished (TAC 2018). The report revealed that nurses in this province are overworked and frustrated mainly because of the chronic staff shortages of medical and administrative staff, long queues and most importantly the lack of basic resources such as medicine; as a result sickness absenteeism has become commonplace (Manyisa 2016; TAC 2018). The gross staff shortages are further exacerbated by sickness absenteeism and physical and mental exhaustion (Manyisa 2014). This suggests that the few available healthcare providers have to endure the extra burden of caring for patients using the limited medical resources.

Crucial services such as having to care for patients in dilapidated wards with a shortage of medical equipment, linen, and beds coupled with the lack of water and electricity have been documented in 13 out of 25 hospitals in Mpumalanga (Department of Health 2017). The unavailability of crucial services like lifts has far-reaching implications for healthcare personnel, critically ill patients and patients who need emergency care or surgery (Manyisa 2014). A recent news article on the quality of care in different South African hospitals and clinics, reported that the hospitals and clinics are in a state of collapse as there are no medical equipment and not enough doctors and nurses to provide care to patients (IOL 2014).

The lack of safety in healthcare settings is a matter of concern because with the high levels of crime and aggression in South Africa, violence in the form of assaults have become commonplace in healthcare settings (Mokoka, Ehlers, and Oosthuizen 2011, 1–11). A study by Manyisa (2014; 2016) on the status of working conditions in public hospitals found that employees were not protected from occupational health and safety hazards and as a result they were exposed to a number of physical and

psychological hazards at the workplace. The occupational health hazard was attributed to factors such as poor infrastructure, increased workloads, staff shortages and inadequate equipment (Manyisa 2014; 2016). For example, the study by Manyisa (2016) found that poor infrastructure was a risk factor for the transmission of airborne diseases, particularly TB. The risks of contracting TB were increased by the lack of proper isolation rooms which have led to the mixing of highly infectious MDR-TB patients and those with non-infectious diseases as well as the lack of basic medical equipment such as N95 masks.

The ability of a hospital to provide safe, high quality, effective patient care depends on the availability of adequate skilled and well-motivated staff, for instance, the high rate of absenteeism causes stress and heavy workloads and psychological stress to the few remaining personnel and hence the long queues in outpatient departments. Consequently, employees particularly nurses have to endure verbal abuse, insults and physical abuse from relatives and patients who are angry and frustrated for having to wait excessively long hours ranging even up to two days before being seen by the doctor or transferred to the ward. Similar incidences of gross shortages particularly the nursing personnel which led to patients spending up to two days in casualty before being admitted have been reported in western Australia (Kingma 2007). Oche and Adamu (2013), in their study on the determinants of patient waiting time, reported that factors such as staff shortages, poorly maintained equipment as well as the high number of patients were associated with lengthy patient waiting times in outpatient departments at primary health facilities in western Nigeria. In the same vein, Oche and Adamu (2013) reported that waiting time has been found to be an indicator for the quality of service delivery and the quality of patient care; this therefore calls for a strategy to mitigate the poor working conditions in health facilities.

These poor working conditions do not only have adverse effects on the health and safety of employees but also lead to poor patient outcomes as they translate to poor service delivery, thus affecting the quality of patient care. Despite all these challenges, there seems to be no model that can be used as a framework to improve the working conditions in the selected public hospitals in Mpumalanga in South Africa. The purpose of this paper is to describe the conceptual model for improving the working conditions and employees' health and safety at selected public hospitals in South Africa.

The conceptual model for improving the working conditions in public hospitals in Mpumalanga evolved from an exploratory sequential mixed-method empirical study which explored and described hospital employees' perspectives of the working conditions in 16 selected public hospitals in Mpumalanga, South Africa. Data collection was achieved through a self-administered questionnaire and semi-structured in-depth individual interviews. Ethics approval and permission to conduct the study were obtained from the relevant authorities, namely the Medical University of Southern Africa and the Mpumalanga Department of Health. Furthermore, consent

was sought from the participants and the issue of voluntary participation was emphasised before data collection.

Research Design and Methods

The model design comprised two steps. These steps are described in the next section.

Concept Analysis

Concept analysis is an activity where concepts, their characteristics and relations to other concepts are clarified and classified (Walker and Avant 2011). To clarify and identify the characteristics of the concepts, dictionary, theoretical, literature and subject definitions were used as suggested in Walker and Avant (2011, 176–177). These concepts are briefly defined in the next section.

Concept analysis was guided by Walker and Avant's (2011) eight-step framework. The steps of the framework are listed as follows: (1) select a concept; (2) determine the aims or purpose of the analysis; (3) identify all uses of the concept; (4) determine the defining attributes; (5) identify the model cases; (6) identify additional cases, namely borderline, related, and contrary cases; (7) identify antecedents and consequences; and (8) define empirical referents (a detailed description of this step has been presented in another article and will therefore not be presented here).

Structuring the Model

Chinn and Kramer (2015, 156) define a conceptual model as a symbolic representation of an empiric experience in the form of words, graphic diagrams or physical material.

A model construction design as proposed by Chinn and Kramer (2015) and the survey list of Dickoff, James, and Wiedenbach (1968) were used to construct a conceptual model to be used as a framework of reference for the protection and promotion of occupational health and safety of employees and for improving the working conditions at selected public hospitals in South Africa, thus advancing quality service delivery.

The steps that were followed during the construction of the conceptual model are described in the next paragraphs with reference to the six components as outlined in Chinn and Kramer's (2015) model of theory development. The components of the model will be described with reference to the following: (1) assumptions of the model; (2) purpose of the model; (3) concepts of the model; (4) definitions; (5) relationships; and (6) structure.

Results

Purpose of the Model

The purpose of the conceptual model for improving working conditions and the health and safety of employees at selected public hospitals in South Africa is to provide a framework for managers to support, motivate and equip employees who are affected by poor working conditions in these hospitals with skills and knowledge that they can utilise to improve their working conditions in these hospitals. These intentions are achieved through the utilisation of four phases of improvement as outlined in the model (see Figure 1).

Concepts of the Model

Chinn and Kramer (2015) define concept identification as a process of identifying those fundamental concepts that form the substance of the theory. In this research, central and related concepts of the conceptual model were identified from the integrated results of a mixed-method empirical study which comprised two sections, namely a descriptive, cross-sectional quantitative design and an explorative, descriptive and contextual qualitative design which produced rich information regarding the employees' views of the working conditions in the selected public hospitals. These concepts were used to construct the model for improving the working conditions in the selected public hospitals in South Africa. The following were identified as the concepts of the model: (1) improving working conditions; (2) legislation; (3) policies (4) communication; (5) collaborative interpersonal relationships; (6) resources; (7) infrastructure; (8) involvement in decision-making; (9) safety and security; (10) education and training; and (11) support. These concepts are briefly defined in the next section.

Definition of the main concept: Improving working conditions

The concept "improving working conditions" emerged as a major concept from an empirical study as stated in the previous section. The concept "improving working conditions" was defined from the analysis and its defining attributes or characteristics as follows: improving working conditions refers to a process of bringing change in an environment in which physical and mental activities which are directed at producing something are performed (Manyisa 2014; 2017).

Definition of the related concepts

Legislation

Legislation, also known as statutes or Acts, are written legal rules promulgated by the recognised legislative authority of the state and is intended to regulate any aspect of human behaviour, people's intention with each other and with things, to maintain order in a society, and to determine what is permissible and not permissible (Humby and Kotze 2012) Legislation also incorporates standards which are sets of rules for

determining quality action (Department of Labour 2003). The Department of Labour (2003) standards are sets of rules irrespective of whether or not they have the force of any law, which, if applied for the purposes of the policy on occupational health and safety, will promote their objectives.

Policies

Policies are clear, simple statements of how the organisation intends to conduct its services, actions or business. They provide a set of guiding principles to help with decision-making (Meyer and Popien 1994).

Chinn and Kramer (2015) define a policy as a "prescriptive relation between one or more objects and some reference behaviour. It can be expressed as an obligation, permission or a prohibition."

Communication

Communication refers to the formal as well as the informal sharing of meaningful ideas and timely information from which people get mutual understanding and trust and establish interpersonal relationships (Hu and Liu 2011; ILO 2011).

Collaborative interpersonal relationships

Ferris et al. (2009) define work interpersonal relationships as patterns of exchanges between two interacting members or partners, individuals, groups, or organisations typically directed at the accomplishment of certain goals or objectives.

Resources

Resources refer to the means available to perform a certain activity. The term "resources" refers to both material and human; material resources include support in the form of financial assistance, pharmaceutical supplies, and protective equipment for hospital employees (Harper 2002).

Infrastructure

Infrastructure refers to the basic systems and services that are necessary for an organisation to sun smoothly. These include structures and facilities such as buildings, roads, and power supplies needed for the operation of an organisation (*Oxford Learner's Dictionary*, s.v. "infrastructure").

Safety and security

Safety and security refer to one's freedom from being harmed or killed. Safety and security can be either physical or emotional (South Africa 1993).

Involvement in decision-making

The concept of involvement in decision-making refers to the perspective of employees becoming involved in the processes that affect their practice in a hospital setting (Kowalik and Yoder 2010).

Education and training

Education and training is a process of giving employees and supervisors the information they need about available resources so they have a place to turn to when they must solve complex problems (Van Zolingen and Wortel 2012).

Support

Support refers to the giving of assistance and encouragement by an individual considered equal. It includes encouragement praise and feedback that employees receive from peers and supervisors (Mitchelson, Pitchler, and Cullen 2010; Van Zolingen and Wortel 2012).

Relationship Statements

Relationship statements are the linkages among and between concepts (Chinn and Kramer 2015, 190). The concepts which emerged from the data were used to construct relationship statements between the central and related concepts (Chinn and Kramer 2015, 180). Walker and Avant (2011) refer to synthesis as the process and strategy that provides a mechanism for creating something new from the data that are already available. From the existing definitions, the researcher synthesised the definition of improving working conditions within the context of this model.

Concept Classification

After the concepts were selected and defined, Dickoff, James, and Wiedenbach's (1968, 434) six-item survey list was utilised to classify the concepts of the model. This survey list describes six aspects of activity as follows: (1) the agency; (2) the recipient; (3) the context; (4) the procedure; (5) the dynamics; and (6) the terminus.

Assumptions of the model

The model was constructed based on the assumption that if it is adopted, it will be used as a framework of reference to protect and promote the occupational health and safety of employees and thus advance quality service delivery in public hospitals.

The conceptual model will be described with reference to the context, the agent, recipient, dynamics, procedure, terminus, guidelines for operationalisation of the model and model evaluation.

Context

Dickoff, James, and Wiedenbach (1968) refer to the context as the situation or setting in which the study takes place. It also includes the culture within which the activity takes place, the organisational legislation and the policies. In this model, the context comprises the National Department of Health and the Provincial Department of Health, legislation, policies and the selected public hospitals located in the three districts of Mpumalanga in South Africa, the organisational climate and the organisational culture within which continuous, repetitive interactions and activities are taking place between the different stakeholders. The different levels of context are linked and have important influences on all the processes at the hospitals. The National Department of Health and the Provincial Department of Health, legislation and policies of health have a political and legal commitment towards all the processes such as practice, budgets, staffing, medical supplies and other resources within the hospitals.

Agent

Dickoff, James, and Wiedenbach (1968) define the agent as the person who performs the activity. In this model, agent refers to a person in a management position who interacts with the employees with the aim of improving working conditions in public hospitals. The management in this model includes CEOs, nursing service managers, medical managers, occupational health nurses, employee representatives, the supply chain of human resources practitioners, and finance department managers who enter into ongoing collaborative interactions with the employees (recipients). These are the people who are driving the process of implementation of improvement plan and facilitative strategies with the aim of improving working conditions in public hospitals in Mpumalanga.

Recipient

A recipient is the person who receives the activity (Dickoff, James, and Wiedenbach 1968). In this model, the recipient is a healthcare provider or a health worker who is employed in a public hospital in Mpumalanga and who experiences poor working conditions. The list includes nurses, doctors and other healthcare providers. It also includes health workers such as administrative staff, drivers, cleaners and gardeners.

Dynamics

The dynamics is the energy source of the activity (Dickoff, James, and Wiedenbach 1968). The dynamics in this model refers to infrastructure, resources, safety and security, support; interpersonal relationships, communication, involvement in decision-making, and education and training.

Procedure

Procedure refers to the guiding process of the model, technique or protocol for the activity (Dickoff, James, and Wiedenbach 1968). In this model, procedure involves collaborative efforts between the employer (agent) and the employees (recipients) in trying to improve working conditions of public hospitals. The procedure was adapted from the Deming Cycle four-phase Plan, Do, Check and Act (PDCA) model for continuous improvement of people, processes and products within organisations (Moen and Norman 2010). The four-step Deming Cycle model was considered suitable to be used in the construction of this conceptual model because of its cyclic nature and repetitive approach which help managers and employees to fix problems at any stage of the improvement plan without wasting a lot of resources and committing too many mistakes. A description of the guiding process of improvement as adapted from the Deming Cycle with reference to the four phases is given below.

Phase 1: Planning

The planning phase is important as it sets the terms of reference within which the process will be run. Both the agent and the recipient need to work together in planning how the project will be carried out. It is important that the agent takes the lead in creating awareness of the current working conditions and establishing a need for improvement. The employees' desire to participate and support improvement is also determined. It also involves defining the improvement objective and implementation of facilitative strategies for improvement as well as the implementation of the improvement plan decided upon in the planning phase (Manyisa 2014). Once all employees are aware of the need for improvement, stakeholder expectations are set and clarified; roles, responsibilities and the necessary accountabilities are delegated.

The agent ensures that each group and individual receive sufficient information and training to fulfil their role with respect to the plan. Both the agent and the recipient who are affected by poor working conditions embark on a situation analysis to identify their needs or problems. Together, the agent and the recipients, i.e. all levels of management and personnel, are involved in the development of objectives that will help to accomplish the main goal. Performance measures to guide and gauge progress towards achieving objectives are also developed. Once the needs have been identified, the agent and the recipient work as a team to identify solutions and decide what needs to be done to improve their situation. This phase also involves the delegation of duties, accountability, and identifying and acquiring the resources and the finances that will be needed to carry out the improvement plan. Once all the stakeholders are satisfied with the planning, the implementation of the improvement plan kicks off (Manyisa 2014).

Phase 2: Implementation

In this phase, the implementation of the improvement plan begins. The phase also involves implementing corrective strategies that are intended to mend undesirable situations. Both the agent and the recipients commit themselves to do what they said they would do. The implementation of the plan is guided by relevant policies, regulations, guidelines, standards and procedures that guide the organisation. The agent and the recipients take it upon themselves to ensure that all these guiding legislations are developed, defined and communicated in a clear and readily understood manner to all employees who are involved with the implementation programme (Manyisa 2014). Once the improvement plan is running it is important that the agent keeps control by regular reporting of progress and problems.

In order to be able to improve the working conditions at public hospitals, the agent (management (CEO, nursing service manager, medical manager)), human resources, the supply chain and the finance department should enter into ongoing collaborative interactions with the employees (recipients) with the aim of implementing facilitative interventions to correct those negative factors that have contributed to the poor work conditions (Manyisa 2014). The agent drives the process bringing about change in the organisation through a sequence of activities such as building the relationship, development, employee involvement in decision-making, establishing clear communication channels, provision of both material and human resources, support, and ensuring that the training needs and education of employees on health and safety issues are met.

Phase 3: Monitoring and evaluation

The purpose of this step is to review the success of the activity. In this stage decisions are taken to determine whether it is worth continuing with the facilitative strategies. Depending on the outcome, for example, whether there is improvement or not, corrective actions can be taken, the plan can be abandoned or the process of replanning, implementation and re-evaluation can be considered an opportunity for engaging in a continuous improvement process (Manyisa 2014).

Phase 4: Outcome

This is the last phase of the guiding procedure. Once the plan has been developed, implemented and evaluated the team proceed to the last phase of the procedure which helps them to decide whether the plan can be adopted, depending on whether all its objectives have been met. The success rate of this activity is influenced by initial steps; this implies that proper planning, reviewing and modifying the plan should be done throughout the process in order to achieve the desired outcomes (Manyisa 2014). It is noteworthy to mention that in this phase; the team is able to measure and tell how much of the desired improvement outcomes have been achieved so far. For example, it

is also noteworthy to emphasise that a slight change in some aspects of the working conditions in the organisation such as getting extra staff and medical equipment does not entail complete improvement of the situation. In the event where some areas of concern such as patient outcomes, and employee health and safety have shown no significant improvement, the activity begins from the first step. Hence, improvement is not a once-off process, but a repeatable process which provides a way of measuring and testing solutions as well as identifying potential problematic areas and where the organisation is with the plan. Therefore, this repeatable process as well continual review of all the steps of the improvement plan is crucial to determine the effectiveness of the plan and to determine if there is certainly a significant change that can be successfully applied to similar problems in other healthcare settings.

Terminus

Terminus is the outcome, final product or end point of the activity (Dickoff, James, and Wiedenbach 1968, 423). The terminus is the end product of a repetitive process of all the steps with the aim of getting the ideal solutions for the organisation, employees and subsequently, patients. Hence, the researcher believes that the model will support and empower the healthcare personnel to take control of their situation in public hospitals. It will provide them with the skills that they will use to facilitate implementation of interventions that will bring about the desired outputs. The researcher believes that by using the model as an empowerment tool to mitigate the barriers to the working conditions, the terminus, namely improved working conditions, health and safety of employees and quality patient care will be achieved.

Structural Description of the Model

The conceptual model depicts the context where the agent and recipient are interacting and experiencing poor working conditions. The dynamics that would facilitate achievement of improved working conditions in public hospitals in Mpumalanga were identified as the implementation of legislation and policies, improving infrastructure, mobilising resources, implementing safety and security measures, establishing clear lines of communication, involvement in decision-making and providing support as well as educating employees on health and safety issues were used. In the model, the arrows indicate these relationships as described in the previous section; a procedure or process for improving working conditions occurred in four phases, namely planning implementation, evaluation and monitoring, and outcome (Manyisa 2014).

The model is cyclic in shape which indicates that there are continuous processes that are taking place at any level of the improvement plan. The process of implementation begins with the agent, the left-hand shaped structure to the left, and proceeds to the recipient (right hand) and back to the agent as shown by the two-way piercing arrows within the dynamics. The four rectangular-shaped arrows that surround the agent and the recipient depict the phases of the model (procedure). The arrows indicate a single direction of influence or flow and do not exist in isolation. Once the process has

begun, it becomes cyclical or continuous as the phases of the procedure occur in a sequence of events and are in continuous interaction with each other in an effort to achieve an ongoing improvement of the working conditions. The colour green in the procedure symbolises self-control, hope and growth. Red and orange both symbolise action and vitality, and yellow represents wisdom and control of the situation (Manyisa 2014).

The joined hands and the two directional arrows piercing through the agent and the recipient indicate the continuous interactions and strong collaborative relationships that exist between the systems components, namely all the stakeholders.

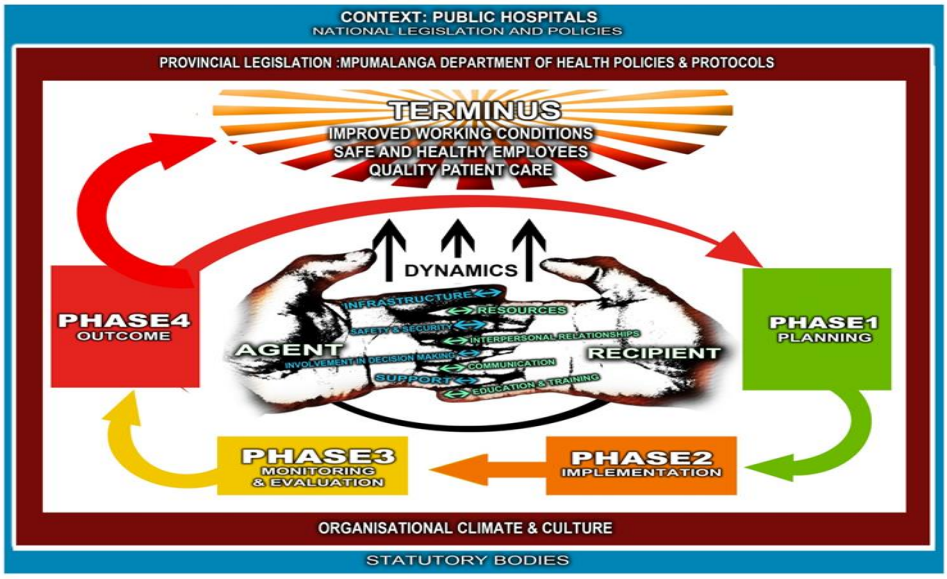

Figure 1: Conceptual model for improving working conditions in public hospitals in a selected province

The blue and maroon shaded area or box that encompasses the cyclic drawing indicates the context or environment in which the activities are taking place. The sun-shaped structure at the top of the model represents the terminus or outcomes of the model. The rising sun in this model is a symbol of hope and a call not to give up. Figure 1 depicts the conceptual model for improving working conditions and employees' health and safety at selected public hospitals in South Africa.

Guidelines for Operationalisation of the Model

The final step in model construction is the application of the model (Chinn and Kramer 2015, 166–210). Application of the model involves a description of guidelines how the model is to be operationalised. The guidelines were derived from the data

analysis and literature review and conceptualisation of the context where improvement is expected to take place in Mpumalanga. The guidelines for the model for improving working conditions and the health and safety of employees in public hospitals in Mpumalanga were described with reference to the dynamics as well as the elements of the systems theory which guided the empirical study and model construction as presented in Manyisa's study (2014).

Evaluation of the model

The guidelines for critical reflection of theory from Chinn and Kramer (2015, 198) were followed to evaluate this model, and are given below.

How clear is the model?

The definition of concepts was achieved through the process of concept analysis in order to ensure the semantic clarity. The model is presented in a way that can be understood by the reader.

How simple is the model?

The overall structure of the working conditions in public hospitals could be followed by using the visual diagram. The major concepts of the model were defined and it was ensured that the basic assumptions are consistent with each other. The model is simple because its use could improve occupational health practice.

How accessible is this model?

The model would be accessible because it has attempted to explain the existing challenges and also predicted the implementation of systems theory to facilitate improvement of working conditions of public hospitals in Mpumalanga.

How general is the model?

The breadth of scope and the purpose of the model could be used in an occupational health setting and other healthcare settings with the aim of improving working conditions to ensure patients' safety and employees' well-being.

How important is the model?

Since the model is closely tied to the idea of its practical value, the model for improving working conditions, if utilised, could improve the practice of occupational health and safety care in public hospitals as well as in any other healthcare settings.

Does the model display the researcher's original contribution?

The model was originally created by the researcher with the aim of improving working conditions in public hospitals. The researcher developed the model from the empirical data as described in Manyisa's study (2014).

The model was evaluated by experts in qualitative research and theory generation through the stages of its development and during presentation at seminars. However, the final evaluation of this model for its practicality will be executed at a later stage by a group of experts.

Recommendations

Implementation in Practice

The model for improving working conditions can be used in various occupational health settings such as healthcare centres and clinics to encourage management and employees to collaborate with each other in identifying their needs, with the aim of finding solutions for their problems thus improving working conditions, employee well-being and quality patient care. There is a need to test the model for its application in hospitals and other relevant contexts.

Implementation in Research

The model provides an opportunity for further research to be conducted in the area of occupational health. It is also necessary to engage in other studies to further refine the model and to evaluate its impact on the facilitation of interventions to improve working conditions in public hospitals in Mpumalanga.

Implementation in Nursing Education

The model can also be used to guide research teaching where the educator teaches the nursing students the practice of research. The model can also be applied by lecturers in their various institutions in improving, maintaining and sustaining good working conditions thus promoting employee well-being and subsequent quality of education for the learners.

Implementation in Nursing Management

The model will be made available at provincial health offices and in health facilities where it will be used as a reference to implement change within organisations as complex systems.

Limitations

This researcher experienced problems with accessing some hospitals for data collection. The model has not been tested for its application at the clinical settings.

Conclusion

The processes and the structure of the conceptual model for improving working conditions and the health and safety of employees at selected public hospitals in South Africa were described. The model suggests that improvement takes place within different levels of the context, namely at national and provincial government level (department of health), legislation which is the ethical and legal framework, and at departmental, institutional and operational level (public hospitals). Improvement occurs within a process and focuses on enablers of leadership commitment, building infrastructure, mobilising material and human resources processes, establishing healthy and collaborative relationships, employee involvement in decision-making, and clear channels of communication, building supportive relationships, and providing education and training on health and safety issues. Improvement is a long-term process that should permeate every aspect of the organisation and can only be achieved if employees and managers work interdependently for the betterment of the working conditions at their hospitals.

References

Aiken, L. H., W. Sermeus, K. Van den Heede, D. M. Sloane, R. Busse, M. McKee, L. Bruyneel, A. M. Rafferty, P. Griffiths, M. T. Moreno-Casbas, and C. Tishelman. 2012. "Patient Safety, Satisfaction, and Quality of Hospital Care: Cross Sectional Surveys of Nurses and Patients in 12 Countries in Europe and the United States." *BMJ* 344: e1717.

Chinn, P. L., and M. K. Kramer. 2015. *Knowledge Development in Nursing: Theory and Process.* 9th ed. St Louis: Elsevier.

Department of Health. 2017. "Mpumalanga Hospitals in Dire Strait – SAHRC." Accessed 20 March 2019. https://www.enca.com/south-africa/mpumalanga-hospitals-dire-state-sahrc.

Department of Labour. 2003. "The National Occupational Health and Safety Policy." Accessed 11 August 2014. http://www.kznhealth.gov.za/occhealth/policy2.pdf.

Dickoff, J. P., P. James, and E. Wiedenbach. 1968. "Theory in a Practice Discipline. Part 1: Practice Orientated Theory." *Nursing Research* 17 (5): 415–34. https://doi.org/10.1097/00006199-196809000-00006.

Ferris, G. R., R. C. Liden, T. P. Munyon, J. K. Summers, K. J. Basik, and M. R. Buckley. 2009. “Relationships at Work: Toward a Multidimensional Conceptualization of Dyadic Work Relationships.” *Journal of Management* 35 (6): 1379–403. https://doi.org/10.1177/0149206309344741.

Harper, P. R. 2002. “A Framework for Operational Modelling of Hospital Resources.” *Health Care Management Science* 5 (3): 165–73. https://doi.org/10.1023/A:1019767900627.

Hu, C., and X. Liu. 2011. “A View of Democratic Management in Colleges and Universities from the Perspective of Communication.” In *Advances in Education and Management*, edited by M. Zhou, 108–113. Berlin: Springer. https://doi.org/10.1007/978-3-642-23062-2_16.

Humby, T., and L. Kotze, eds. 2012. *Introduction to Law and Legal Skills in South Africa.* Cape Town: Oxford University Press.

ILO (International Labour Office). 2011. “OSH Management Systems: A Tool For Continual Improvement: World Day for Safety and Health at Work.” Accessed 21 August 2009. https://www.ilo.org/safework/info/promo/WCMS_153930/lang--en/index.htm.

IOL. 2014. “SA Health Care System on the Brink of Total Collapse.” IOL News. Accessed 27 August 2019. https://www.iol.co.za/news/politics/sa-health-care-system-on-the-brink-of-total-collapse-says-da-15473336.

Kowalik, S. A., and L. H. Yoder. 2010. “A Concept Analysis of Decisional Involvement.” *Nursing Administration Quarterly* 34 (3): 259–67. https://doi.org/10.1097/NAQ.0b013e3181e702d7.

Kingma, M. 2007. “Nurses on the Move: A Global Overview.” *Health Services Research* 42 (3–2): 1281–98. https://doi.org/10.1111/j.1475-6773.2007.00711.x.

Manyisa, Z. M. 2014. “A Conceptual Model for Improving Working Conditions in Public Hospitals in Mpumalanga Province: An Occupational Health and Safety Perspective.” PhD thesis, University of Limpopo.

Manyisa, Z. M. 2016. “The Current Status of Working Conditions in Public Hospitals at a Selected Province, South Africa.” *Journal of Human Ecology* 56 (1–2): 210–219. https://doi.org/10.1080/09709274.2016.11907058.

Manyisa, Z. M. 2017. “A Concept Analysis for Improving Working Conditions.” *Africa Journal of Nursing and Midwifery* 19 (2): 1–17.

Meyer, B., and C. Popien. 1994. “Defining Policies for Performance and Management. Management in Open Distributed Systems.” Paper presented at the IEEE/IFIP Workshop on Distributed Systems Operations, October 1994.

Mitchelson, J. K., S. Pitchler, and K. L. Cullen. 2010. “Clarifying Relationships among Work and Family Social Support, Stressors and Work Conflict.” *Journal of Vocational Behaviour* 76: 91–104. https://doi.org/10.1016/j.jvb.2009.05.007.

Moen, R. D., and C. L. Norman. 2010. “Circling Back.” *Quality Progress* 43 (11): 22.

Oche, M. O., and H. Adamu. 2013. “Determinants of Patient Waiting Time in the General Outpatient Department of a Tertiary Health Institution in North Western Nigeria.” *Annals of Medical and Health Sciences Research* 3 (4): 588–92. https://doi.org/10.4103/2141-9248.122123.

Oxford Advanced Learners Dictionary, 8th ed. (2010), s.v. “infrastructure”.

Rad, A. M. M., and A. de Moraes. 2009. “Factors Affecting Employees’ Job Satisfaction in Public Hospitals: Implications for Recruitment and Retention.” *Journal of General Management* 34 (4): 51–66. https://doi.org/10.1177/030630700903400404.

South Africa. 1993. *Occupational Health and Safety Act, 1993 (Act No. 85 of 1993)*. Pretoria: Government Printers.

TAC (Treatment Action Campaign). 2018. “Limpopo – State of Health.” Accessed 20 March 2019. https://tac.org.za/news/limpopo-state-of-health/.

Van Zolingen, S., and L. Wortel. 2012. “Workplace Learning: A New Model Applied in a Case Study in The Netherlands.” *International Journal of Human Resources Development and Management* 12 (1/2). https://doi.org/10.1504/IJHRDM.2012.044197.

Walker, L., and K. Avant. 2011. *Strategies for Theory Construction in Nursing*. 5th ed. Boston: Prentice Hall.

Zeffane, R., S. A. Tipu, and J. C. Ryan. 2011. “Communication, Commitment and Trust: Exploring the Triad.” *International Journal of Business and Management* 6 (6): 77. https://doi.org/10.5539/ijbm.v6n6p77.