

Unit Managers' Perceptions of Implementation of National Core Standards in Tertiary Hospitals

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Abstract

Globally, all healthcare systems face challenges in improving the quality of healthcare services delivery. In South Africa, the National Department of Health introduced the National Core Standards (NCS) tool in 2011 as affirmation of what is predicted to deliver decent, safe and high-quality care in healthcare establishments. The study presented in this paper aimed to determine unit managers' perceptions of the implementation of the NCS in tertiary hospitals in KwaZulu-Natal, South Africa. This was a cross-sectional, descriptive survey. A purposive sampling technique was used to select hospitals offering secondary and tertiary services in KwaZulu-Natal. A census method was used to recruit all unit managers in the study. A census method is an attempt to list all elements or to use every unit in a group and to measure one or more characteristics of those elements. Out of the 169 population of unit managers counted in these hospitals, only 95 participated in the study. The collected data were analysed using SPSS Statistics version 25. The study showed that the participants' perceptions were positive about the availability of material resources. However, a shortage of human resources in terms of numbers, skills, and skills mix was noted. The results also revealed that the participants' perceptions of the availability of a positive working environment were negative. This study recommends that the healthcare authorities develop a strategic approach to manage scarce human resources by attracting, sourcing, selecting, training, developing, and retaining healthcare workers. This includes creating a positive working environment to promote staff retention.

Keywords: National Core Standards (NCS) tool; perceptions; tertiary hospitals; unit managers

Introduction

Globally, all healthcare systems face challenges in improving the quality of healthcare delivery owing to the complexity of the healthcare systems caused by changing health needs and growing public expectations that are reshaped by the high use of technology (Kruk et al. 2018, e1197). In South Africa, the National Department of Health (NDoH) introduced the National Core Standards (NCS) tool in 2011 as affirmation of what is predicted to deliver decent, safe and high-quality care in healthcare establishments (NDoH 2011, 8). The NDoH calls upon the leadership in the healthcare establishments to facilitate inventiveness and change in practice through the NCS tool (Lourens, 2012, 4). According to Parand et al. (2014, 1), health service managers have a legal and ethical responsibility to ensure high quality care delivery and to strive to improve it, because they are, as leaders, in a position to influence policymaking as well as to change procedures and organisational climates. Unit managers are the key drivers in coordinating patient care activities and ensuring quality care delivery in healthcare institutions (Armstrong, Rispel, and Penn-Kekana 2015, 104). Moreover, unit managers have massive demands as they are required to fulfil many roles and functions that are placed upon them by their scope of practice, as regulated by the South African Nursing Council (SANC) (Matlakala, Bezuidenhout, and Botha 2014, 1146).

The unit managers in South Africa are expected to ensure that their units comply with the accreditation standards (in terms of structures and processes) as set by the Office of Health Standards Compliance through the NCS tool. The selected tertiary hospitals have had experience with this tool since its inception hence the decision to establish the perceptions of the main users (unit managers) of this tool and its implementation. This paper reports on part 4 of the study titled, “Analysing the process of implementation of national core standards, as a tool for ensuring quality care delivery in public tertiary hospitals in KwaZulu-Natal Province”.

Background

According to Ghebreyesus (2018, e1140e), no human being should ever accept healthcare services that are not effective, safe, and people-centred, and that are not supported by four essential values: equity, timeliness, integration, and efficiency. In order to improve the quality of healthcare delivery, it is important to understand what is meant by “quality” in the healthcare system and also to reflect on the outcomes produced for both individual service users and whole communities (World Health Organization 2006, 9). The definition of quality varies among several authors, nevertheless, Allen-Duck, Robinson, and Stewart (2017, 379) believe that quality refers to the characteristics or features associated with excellence.

For the purpose of this study, the definition of quality by Halasa et al. (2015, 91) will be used. These authors define quality care as the degree to which the health facility delivers services that are trustworthy with up-to-date professional knowledge, that meet

consumer's expectations, and that have an increased possibility of achieving anticipated health outcomes (Halasa et al. 2015, 91). This definition is based on Donabedian's conceptual framework of quality. Donabedian (1988, 1744) developed innovative methods to measure the structures, processes and outcomes in healthcare facilities. According to Donabedian, good structures increase the likelihood of good processes and good processes increase the likelihood of good outcomes (Kelley, Brandon, and Docherty 2011, 155).

The study aimed to determine unit managers' perceptions of the implementation of the NCS as a tool to improve the delivery of quality healthcare in healthcare establishments. The paper aimed to report on unit managers' perceptions of the structures and processes available for the appropriate application of the NCS tool.

Problem Statement

Despite the efforts of the South African government to ensure the delivery of safe and quality patient care through the introduction of many excellent policies and regulations like the NCS, the media revealed that many citizens still experience poor healthcare delivery in public health establishments. In the study conducted by the NDoH in 2012, the results showed very low levels of compliance with the NCS tool, and especially with the basic critical requirements (NDoH 2012, 34). The South African Medical Association (SAMA) argues that the framework for accreditation offered by the NCS is too narrow and that it does not cover all the relevant dimensions of quality defined by the World Health Organization (SAMA 2015, 34). As an experienced user of the tool, the researcher has heard staff complaining about the application of this tool. Thus, the principal researcher believed that there may be more factors which contribute to poor healthcare outcomes in South Africa, hence the aim of the study was to establish unit managers' perceptions of the implementation of the NCS tool.

Research methodology

Study design

A cross-sectional descriptive study was carried out from 5 August 2017 to 30 August 2017 among unit managers in selected hospitals. This was a quantitative approach which reduces data into numbers.

Research Site

This study was conducted in four hospitals that offer tertiary services in KwaZulu-Natal, South Africa. Two of the tertiary hospitals (A and B) are situated in the eThekweni district and provide both secondary and tertiary services. The third tertiary hospital (C) is located in Pietermaritzburg in the Msunduzi district, serving the western half of KwaZulu-Natal, which includes the following districts: uMgungundlovu, uThukela,

uMzinyathi, Amajuba, and Harry Gwala. The fourth hospital (D) is situated in Empangeni in the uMkhanyakude district, serving the uThungulu, uMkhanyakude, and Zululand health districts.

Study Population

The target population for the study included all unit managers in the four selected hospitals. There were 169 unit managers that met the criteria in these hospitals.

The inclusion criteria were:

- registered as a professional nurse (PN), registered for an additional qualification for nursing administration or nursing management according to SANC regulations (R.1501) and employed as a unit manager;
- two years' experience in the post;
- consent given to participate in the study; and
- male and female unit managers.

The exclusion criteria were:

- other nurse categories and nursing service managers;
- unit managers who were on leave (vacation, maternity, sick, or study leave) during data collection;
- unit managers who refused to give consent;
- unit managers who were acting in other positions; and
- less than two years' experience.

Sample and Sampling Technique

A purposive sampling technique was used to select hospitals offering only tertiary services in KwaZulu-Natal. The census method was used to recruit all unit managers in the hospitals offering tertiary services in KwaZulu-Natal. A census method is an attempt to list all elements or to use every unit in a group and to measure one or more characteristics of those elements (Lavrakas 2008). The intention was to include all unit managers who were on duty during data collection to participate in the study in order to get a deeper understanding of their perceptions of the structures and processes that are involved in the implementation of the NCS as a tool for improving the quality of healthcare delivery.

A total of 169 unit managers were in the staff establishment of these hospitals as provided by human resource manager. About 95 of them participated in the study as determined by the number of participants who were present during the data collection

period, excluding those who were on various types of leave. Table 1 shows the number of participants in each discipline.

Table 1: Distribution of unit managers in different departments

Departments	Number of unit managers	Participants per unit
High care units	12	10
Critical care units	15	15
Specialty units (Haemodialysis, cardiology, etc)	20	15
Clinics	53	19
General wards	69	36
Total	169	95

Instrument for Data Collection

A structured questionnaire with predominantly closed-ended questions was used for collecting data. This questionnaire was designed by the researcher in English, based on the specific items of the NCS tools which were modified to suit the purpose of the study. Section A of the questionnaire contains five items on the structure of the unit, section B contains 18 items on the perceptions of unit managers about the structure in their units, and section C contains 26 items on the perceptions of unit managers about the process standards available for the implementation of the NCS.

Reliability and Validity

A total of 15 per cent of the actual sample was obtained for a pilot study conducted under conditions similar to those of the actual study, using two hospitals situated in the eThekweni district, which was convenient for the researcher. These participants were not included in the actual study. Comprehension and readability of the questionnaire were verified by the supervisor who had a research background and two quality managers from two participating hospitals. A content validity was also done whereby the items of the research instrument were compared with the objectives of the study to ensure that the tool was measuring what it was supposed to measure. The degree to which the items in a scale correlated with each other was validated using Cronbach's alpha coefficient. Cronbach's alpha for this study was 0.619 and Cronbach's alpha based on standardised items was 0.713.

Data Collection Technique

Data were collected through the use of a self-administered questionnaire. After permission was granted by the chief executive officer of each hospital for the study to be conducted, the researcher approached the nurse managers of each of the four hospitals selected to explain the nature and purpose of the study. Suitable dates for the

unit managers' meeting was obtained from the nurse managers of each department. The researcher met with unit managers after their meeting, which was arranged by the nurse managers in each hospital to brief them on what the research entailed and what was expected from them as participants.

A total of 136 questionnaires were self-distributed by the researcher during the unit managers' meeting. The researcher also visited different departments during the data collection and checked with unit managers in each department if they were aware of the study. For those who were not in the meeting, the study was explained and they were asked to participate in the study, which made the total of distributed questionnaires to be 143. The participants were allowed to complete the questionnaire in their own time. The questionnaire required approximately 30 to 40 minutes to complete. Each participant put his/her own completed questionnaire in the envelope provided with each questionnaire and sealed it. These envelopes were to be dropped in a sealed box located in the nurse manager's door of each field discipline. The researcher collected the completed questionnaires after three weeks from the sealed box that was provided. Those who decided not to take part in this study returned the uncompleted questionnaires. The return rate of completed questionnaires from the selected hospitals was 95 (66.4%).

Ethical Consideration

Ethical approval was obtained from the Humanities Research Ethics Committee of the University of KwaZulu-Natal (HSS/1905/016). Permission from the gatekeepers was obtained from the KwaZulu-Natal Department of Health and the managers of participating institutions and departments. Written consent was obtained from the participants after explaining the research study, including the potential risks and their mitigation. Participation in the study was voluntary. Confidentiality and anonymity of the participants were maintained throughout the study by using assigned codes and numbers to each questionnaire so that it was not possible to link the questionnaire to an individual participant.

Data Analysis

Upon collection, the precoded questionnaires were checked for completeness and errors and stored under lock and key. The data were then captured and analysed using the Statistical Package for the Social Sciences (SPSS), version 25, in a password-controlled personal computer. Descriptive statistics were used. A one-way analysis of structure and process variances was also done.

Results

The highest level of unit managers that responded was from Hospital A, 32 (33.7%), followed by Hospital C, 25 (26.3%), Hospital B, 20 (21.1%), and Hospital D, 18 (18.6%). Responding to the number of beds in units, 32 (33.7%) reported above 10–20

beds, 28 (29.5%) had from 5–10 beds, 19 (20.0%) indicated having more than 30 beds, and 16 (16.8%) had 21–30 beds. Regarding the departments involved in the study, general wards (GWs) consisted of 36 participants (37.9%), clinics consisted of 19 (20.0%), intensive care units (ICUs) had 15 (15.8%), specialty wards were also 15 (15.8%), and high care units (HCUs) had 10 participants (10.5). Table 2 depicts the distribution of the units and staff.

Table 2: Distribution of units and staff

Department	Number of units	Professional nurses (PNs)	Enrolled nurses (ENs)	Enrolled nursing assistants (ENAs)
ICUs	15 (15.8%)	547 (38.8%)	41 (7.0%)	23 (6.0%)
HCUs	10 (10.5%)	182 (12.9%)	80 (13.7%)	59 (15.5%)
Specialty	15 (15.8%)	148 (10.5%)	77 (13.2%)	65 (17.1%)
Clinics	19 (20.0%)	178 (12.6%)	108 (22.4%)	56 (14.7%)
GWs	36 (37.9%)	353 (25.1%)	277 (47.5%)	178 (46.7%)
Total	95 (100%)	1 408 (100%)	583 (100%)	381 (100%)

Responding to the total number of PNs in different ICUs, all 15 ICUs had a total of 547 PNs, 89 (16.3%) of whom possessed diploma certificates from colleges of nursing, 54 (9.9%) had a basic degree, 31 (5.7%) had postgraduate degree certificates, 8 (1.5%) possessed specialist degrees, and 365 (66.7%) of the nurses were ICU trained. The ICUs had a total of 41 (7.0%) ENs and 23 (6.0%) ENAs. Ten HCUs had a total of 182 (12.9%) PNs in total and only 54 (29.7 %) were trained nurse specialists, 111 (61.0%) had a basic nursing diploma, 10 (5.5%) had a basic degree, and 7 (3.8%) had a postgraduate degree. In all HCUs there were 80 (13.7%) ENs and 59 (15.5%) ENAs.

Fifteen specialty wards had a total of 148 PNs, of whom 58 (39.1%) had a basic diploma, 16 (10.8%) had basic degree, 6 (4.1%) had completed short courses, and 68 (45.9%) possessed specialty qualifications in their field (nephrology, advanced midwifery, oncology, and palliative care). There were 77 ENs and 65 ENAs.

In 19 clinics there were a total of 178 PNs, of which 86 (48.3 %) had a basic diploma, 11 (6.2%) had a basic degree, 1 (0.6%) had a PhD, and 80 (44.9%) had achieved specialist qualifications in different fields of their department. These clinics had 108 ENs and 56 ENAs.

In 36 GWs there were a total of 353 PNs, of which 252 (71.4%) had a basic diploma, 28 (7.9%) had a basic degree, 14 (4.0%) possessed a postgraduate degree, 5 (1.4%) had completed short courses, and 54 (15.2%) had specialist qualifications in their field. These wards had 277 ENs and 178 ENAs. Table 2 shows the distribution of staff per discipline.

Responding to the question of ratio of nurses to patients, the participants were negative and the level of agreement was 19 (20%).

Unit Managers’ Perceptions of the Structure Standards

The participants were asked about the staffing in terms of numbers, staff mix, and skills. For all three variables the response was negative, only 14 (14.7%) believed that their units had an adequate number of staff, while 13 (13.7%) asserted that there was proper staffing in terms of staff mix and 16 (16.8%) agreed that their units were properly staffed in terms of skills.

The perceptions of the participants were positive regarding the availability of basic equipment; 94 (99%) of the participants indicated that they had resuscitation trolleys available in their units, 83 (87.3%) agreed to the availability of oxygen cylinders, 79 (83.2%) responded positively to the availability of bedding, 80 (84.2%) agreed that drip stands were available in their units, and 86 (90.5%) confirmed having medical utilities such as syringes and needles in their units. In addition, 88 (92.6%) of the participants reported that stationery for the documentation of care was available.

Regarding the adequate supply of the above equipment, the participants had negative perceptions because only 32 (33.7%) believed that they had adequate supplies. The participants’ perceptions of adequate support services were also negative; when asked whether they had adequate support services, the level of agreement was 31 (31.4%). However, 49 (51.6%) affirmed that the basic equipment or materials (for example a defibrillator) were functioning properly.

In the realm of hospital catering services, the perceptions of participants were positive that the meals were provided by catering services and the level of agreement was 75 (78.9%). When asked about infrastructure, the perceptions of participants were negative; results indicated that only 47 (49.5%) indicated that there were adequate toilet facilities for staff and 44 (46.3%) agreed that there were adequate toilet facilities for patients. Table 3 shows the unit managers’ perceptions of the structure standards.

Table 3: Unit managers’ perceptions of the structure standards

Item	Agree	Neutral	Disagree
1 The ratio of nurses to patient is adequate	19 (20%)	14 (14.7%)	62 (65.3%)
2 My department has an adequate number of staff	14 (14.7%)	9 (9.6%)	72 (75.7%)
3 My department has proper staff mixing	13 (13.7%)	14 (14.7%)	68 (71.6%)
4 My department has proper staffing skills	16 (16.8%)	10 (10.5%)	69 (72.6%)
5 Availability of the resuscitation trolley	94 (99%)	0	1 (1%)

Item	Agree	Neutral	Disagree
6 Availability of oxygen cylinders with necessary tubing	83 (87.3%)	3 (3.1%)	4 (4.2%)
7 Availability of bedding	79 (83.2%)	4 (4.2%)	12 (12.6%)
8 Availability of drip stands	80 (84.2%)	3 (3.2%)	12 (12.6%)
9 Availability of medical utilities	86 (90.5%)	2 (2.1%)	7 (7.4%)
10 Availability of stationery/forms	88 (92.6%)	1 (1%)	6 (6.3%)
11 The above-mentioned equipment is in adequate supply	32 (33.7%)	17(17.9%)	46 (46.6%)
12 The above-mentioned equipment is functioning	49 (51.6%)	7 (7.4%)	39 (41.1%)
13 Staff have access to new technical knowledge and skills	49 (51.6%)	13 (13.7%)	33 (34.7%)
14 Department has adequate support services, e.g. porters	31 (31.4%)	23 (24.2%)	41 (41.7%)
15 The meals for patients are provided through a catering company	75 (78.9%)	7 (17.4%)	13 (13.7%)
16 There are adequate toilet facilities for staff	47 (49.5%)	14 (14.7%)	38 (40%)
17 There are adequate toilet facilities for patients	44 (46.3%)	14 (14.7%)	37 (38.9%)

Unit Managers' Perceptions of the Process Standards

Concerning the participants' perceptions of support from their supervisors, 60 (63.2%) affirmed that they were supported by their supervisor. Furthermore, in response to the evaluation of clients' feedback in their units, 37 (38.9%) participants attested that they were done daily, 24 (25.3%) said they were done weekly, 42 (44.2%) indicated that they were done monthly, while 36 (37.9%) stated that they were done yearly. The results indicated that there was no structured client evaluation process among the hospitals.

The participants were positive that patients' feedback was used as a tool to improve healthcare delivery services with an agreement level of 68 (71.6%). The responses on how adverse events were handled were positive, with 79 (83.2%) agreeing that the system of reporting adverse events was not intimidating. About 80 (84.2%) reported that adverse events were used as a platform for learning and 89 (93.7%) affirmed that adverse events identified were treated promptly.

The participants were positive about the availability of essential programmes, 94 (98.9%) of them asserted that they had an infection prevention and control programme. About 82 (86.3%) reported health promotion programmes and 91 (93.3%) attested that they had regular meetings in place to discuss patient care. Of the responses to the availability of health and safety guidelines that were implemented to ensure the environmental safety of patients, 89 (91.3%) were positive, 88 (92.6%) responded

positively to the environmental safety of family, and 88 (92.6%) responded positively to the environmental safety of the staff.

Most participants were positive that nurses’ practices were evaluated regularly with a level of agreement of 86 (90.5%), and 68 (71.6%) said that performance feedback was used to promote continuous skills development.

Responses to the question of collaboration were positive; 82 (86.3%) of the participants agreed that they collaborated with patients and their families in providing care, while 88 (92.6%) believed they also collaborated with other healthcare workers. Furthermore, 92 (96.8%) of the participants affirmed that nurses developed a plan of care and interventions that were individual to each patient.

About 85 (89.5%) of the participants were positive that the nurses’ code of ethics was recited on a regular basis in their departments. Responses to the question of whether or not there was regular discussions of ethical issues to deal with ethical dilemmas were negative and only 12 (12.6%) agreed to have those meetings. Again, responses to a positive workplace environment were negative; only 22 (23.1%) agreed that they had a positive work environment in their hospitals. About 60 (63.1%) agreed that the policies and guidelines that were in place were customised for patient-centred care.

The perceptions of unit managers were negative when asked whether their administrative workload was reasonable, and the level of agreement was only 11 (11.6%). Table 4 shows the unit managers’ perceptions of process standards.

Table 4: Unit managers’ perceptions of the process standards

Item	Agree	Neutral	Disagree
1 I feel supported by my supervisors	60 (63.2%)	17 (17.9%)	18 (18.9%)
2 Client feedback is done daily in my department	37 (38.9%)	18 (18.9%)	40 (42.1%)
3 Client feedback is done weekly	24 (25.3%)	9 (9.5%)	62 (65.3%)
4 Client feedback is done monthly	42 (44.2%)	12 (12.6%)	41 (43.2%)
5 Client feedback is done yearly	36 (37.9%)	11 (11.6%)	48 (50.5%)
6 Patient feedback is used to improve healthcare delivery	68 (71.6%)	14 (14.7%)	13 (13.7%)
7 System for reporting adverse events is not intimidating	79 (83.2%)	4 (4.2%)	12 (12.6%)
8 Adverse events are used as a platform for learning	80 (84.2%)	3 (3.2%)	12 (12.6%)
9 Adverse events identified are treated promptly	89 (93.7%)	0	6 (6.3%)
10 Availability of infection control programmes	94 (98.9%)	0	1 (1.1%)
11 Availability of health promotion programmes	82 (86.3%)	8 (8.2%)	5 (5.3%)

Item	Agree	Neutral	Disagree
12 The health and safety guidelines ensure patients' safety	89 (91.3%)	5 (5.3%)	1 (1.1%)
13 The health and safety guidelines ensure families' safety	88 (92.6%)	6 (6.3%)	1 (1.1%)
14 The health and safety guidelines ensure staff safety	88 (92.6%)	6 (6.3%)	1 (1.1%)
15 Regular meetings are in place to discuss patient care	91 (93.3%)	0	4 (4.2%)
16 Nurses collaborate with patients in providing care	82 (86.3%)	11 (11.6%)	2 (2.1%)
17 Nurses collaborate with family	82 (86.3%)	10 (10.5%)	3 (3.2%)
18 Nurses collaborate with patients	82 (86.3%)	11 (11.6%)	2 (2.1%)
19 Nurses collaborate with other healthcare providers	88 (92.6%)	5 (5.3%)	2 (2.1%)
20 Nurses' practice is evaluated regularly	86 (90.5%)	4 (4.2%)	5 (5.3%)
21 Feedback from staff performance was done	84 (86.5%)	6 (6.3%)	5 (5.3%)
22 The nurses' code of ethics is recited on regular basis	85 (89.5%)	4 (4.2%)	6 (6.3%)
23 Ethical issues are discussed regularly	12 (12.6%)	10 (10.5%)	73 (76.8%)
24 Positive workplace promotes job satisfaction	22 (23.2%)	7 (7.4%)	66 (69.5%)
25 The policies and guidelines are patient-centred care	60 (63.1%)	15 (15.8%)	20 (21.0%)
26 Administrative workload is reasonable	11 (11.6%)	13 (13.7%)	71 (74.7%)

One-way Analysis

A one-way analysis of variance was done and showed no difference between the structure and processes in terms of hospitals. The p-value for structure was 0.078 and the p-value for process was 0.848. A calculated ratio comparing the number of beds and the number of PNs showed that 41.1 per cent of units had a ratio of less than 1:1, meaning each PN looked after more than one patient, and which includes all departments.

Correlation between Variables

The correlation between structure and process was done and showed no significant association between the structure and process with a p-value of 0.586.

Discussion

Perception of the Structure

This study revealed that the participants in all of the selected hospitals believed that there was a shortage of staff in the three areas: numbers, skills, and staff mix. This is in line with the study done by Eygelaar and Stellenberg (2012, 7), with 97 per cent of participants indicating that the number of staff allocated, including nurses skilled in executing all nursing tasks, was inadequate.

Uys and Klopper (2013, 3) reported that the ratio of ENAs to ENs to registered nurses in 2006, as recorded by the SANC, was 3:2:1. Different ratios of nursing categories will be vital for different levels of the healthcare system; ideally the estimated patient to nurse ratio in a tertiary hospital is 1.3 ENs: 1.2 PNs: 1.5 specialist registered nurses (Uys and Klopper 2013, 4). For this study, the ratio was ENs 1.3: PN 1.3: specialists 1.07, meaning there were more PNs with no speciality.

In agreement with the current study, the NDoH admits that there is a critical deficit of nurses and doctors in public health institutions owing to an increased burden of diseases and a failure to increase the healthcare workforce through training and recruitment (Mburu and George 2017, 1; Rispel 2015, 1). Deficiencies in scarce skills in the public health sector are often worsened by poor working and living conditions, inadequate salaries and benefits, and the lack of training and career development opportunities (Van Rensburg 2014, 26). According to Hardine (2017, 84), when patient loads exceed staff capacity, the ability to render safe and effective care to patients is compromised.

The study also revealed that the participants were positive about the availability of essential basic equipment, with a score ranging from 73.2 per cent to 99 per cent. Most participants believed that the equipment was functioning properly. However, the score dropped to 33.7 per cent when asked whether this basic equipment was in adequate supply. The study by Mburu and George (2017, 2) contradicts the current study in that it indicated a severe shortage of equipment and supplies at certain high volume clinics, for example infectious disease control equipment like masks.

Perceptions of the infrastructure were negative in relation to the availability of toilet facilities for staff and patients. The report released by the Centre for Applied Legal Studies (CALS) also agrees that there is a sharp worsening in healthcare at hospitals and clinics in Gauteng, manifested by shortages of medicines, collapsing infrastructures, broken equipment, a shortage of human resources, theft, and the misallocation of funds (CALS 2013, 1). Some clinics lacked basic infrastructure like water and electricity (Mburu and George 2017, 2).

Unit Managers' Perceptions of Processes

This study showed that the majority of the participants were positive about how adverse reports were dealt with in their departments. This contradicted a study done by

Wakefield et al. (2001, 131) which tabulated several reasons why up to 95 per cent of adverse events are not reported in their study, such as failure to detect errors, fear of punishment, and lengthy forms, including a lack of communication as identified by Vermeir et al. (2015: 1262).

When asked about client feedback, all the participants had negative perceptions of the frequency of client feedback. The authors of this study got the impression that there was no standardised time to obtain client feedback. However, Reeves, West and Barron (2013, 259) believe that the major hindrance for client feedback is its impact on the quality of nursing care delivery, which may be due to the fact that the feedback is not unit-specific but done for the whole facility. Client feedback is also not communicated and most nurses in the study denied that this was done in their departments.

Other concerns raised by Kieft et al. (2014, 249) about monitoring, accreditation, and feedback are that they serve more as a means of external accountability to health insurers and the government rather than aiming to directly improve nursing care.

The study revealed negative responses with regard to regular meetings to discuss ethical dilemmas in the respective units. According to Holt and Convey (2012, 51), ethical dilemmas have become part of today's healthcare environment owing to patients' growing awareness of their rights leading them to demand high quality patient care (Mosadeghrad 2014, 78).

The participants were positive regarding the reciting of the nursing code of ethics in their units. The Nurses' Pledge of Service contains norms and values which provide a framework that assist nurses in identifying ethical dilemmas and enable them to make informed decisions to deal with those ethical dilemmas (Mbangula 2015, 53).

Most participants were positive about the feedback on staff performance evaluation. However, Kanyane and Mabelane (2009, 58) contend that poor service delivery in the public sector is caused by skills inadequacy among managers, since they usually fail to implement performance appraisals effectively.

A significant number of participants believed that the administrative workload was unreasonable due to increased demand. Kieft et al. (2014, 249) are in agreement that the administrative workload is out of balance with clinical work.

Conclusion

The results revealed that essential equipment and programmes are in place in these tertiary hospitals, but that there is an insufficient workforce therefore delivering the quality service according to the Donabedian quality model is far-fetched. The public healthcare institutions must follow a well-planned programme in managing scarce

human resources by attracting, selecting, training, developing, sourcing and retaining health workers (Mburu and George 2017, 5).

The government of South Africa has to improve facilities which lack material resources and which have poor infrastructure. It is obligatory for manufacturers, the government and the healthcare workers to ensure that high quality equipment is in place, operational and maintained in good working condition. Absent or use of defective equipment can lead to serious consequences resulting in injury or death and subsequent malpractice litigation (Al-Saeed 2010, 124).

This study also highlighted that there was no standardised time to obtain client feedback. According to Reeves, West, and Barron (2013, 259), client feedback should be unit specific so that it can impact the quality of nursing care delivery. This will allow the nurses in the unit to relate to their performance.

Recommendations

The most important drawback in the implementation of the NCS tool, as reflected in this study, is the lack of human resources. Every institution must identify strategies that enhance staff retention through the creation of positive practice environments. The first step will be the assessment of the work environment at micro and macro level. Differences in the practice environment may be obvious at a unit level due to factors such as unit size, number of support staff and rate of patient turnover (Twiggy and McCullough 2014, 88).

The NDoH must encourage a culture of excellence through ensuring continuous professional development and monitoring of staff performance on a regular basis. The NDoH should initiate motivational programmes in terms of awards and recognition of good performance.

Limitations of the Study

The first limitation of the study was the non-randomisation of the sample which was mitigated by considering a whole population (census) and many units per hospital because unit managers are usually few in each unit. The researcher also did not regard units as single units of study but as a whole. Data collection was limited to unit managers at the selected hospitals in KwaZulu-Natal. The study was confined to one province in South Africa. Therefore, the results cannot be generalised to other provinces. The NCS tool is only used in public institutions in South Africa, therefore the results cannot be generalised to private hospitals and other non-governmental institutions.

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