

# CHAPTER 1

## Orientation to the study

### 1.1 INTRODUCTION

The quality of care can be defined according to how effectively it improves the patient's health status and how well it meets professional and public standards of how the care should be provided (Bowling 2002:7). Bowling refers to Higginson's (1998) statement that the attributes of quality of care favour the customer utilization of services. The main purpose of this study is to explore and describe professional nurses' perception of the implementation of a quality circles programme in a public hospital in the Eastern Cape Province. This chapter discusses "quality" and "quality improvement" as well as the purpose and objectives of the study. The dissertation is also outlined.

### 1.2 BACKGROUND TO THE STUDY

*Collins English Dictionary* (1991:1268) defines *quality* as "a distinguishing characteristic, property, or attribute; the basic character or nature of something; ... degree or standard of excellence, esp. a high standard". Gillies (1997:2) describes quality as the features and characteristics of a product or service that bear on its ability to satisfy customers' specified or implied needs. According to Muller (2000:63), quality exists within products or services in varying degrees and can be measured qualitatively or quantitatively.

Donabedian (1980:3) states that with regard to health care and administration, defining and measuring quality is about judging whether and to what extent a specified instance of medical care has this property. Nzanira (2002:11) points out that quality can be measured by the providers and the customers.

Quality is multi-dimensional, multi-faceted and comprehensive, and may mean different things to different people, hence it is crucial that providers of services should consult the customers to understand their expectations and perceived needs better (Muller 2000:64). Muller (2000:63) identifies the dimensions of quality as accessibility of services, equity, acceptability, efficiency,

effectiveness, appropriateness, applicability, safety, amenities, continuity of care, and interpersonal relations. Muller emphasises that these dimensions of quality are crucial and should be considered when assessing the quality of health services.

In a study of health care in South Africa, Whittaker, Green-Thompson, McCusker and Nyembezi (1998:248) used quality to evaluate the accessibility of health services in KwaZulu-Natal. They identified the legacy of apartheid as the main cause of the fragmented health services and the preferential delivery of health services, namely, first-world health care to white citizens and third-world health care to the rest of the population. In addition, Whittaker et al (1998:248) found that provincial health departments and local authorities provide 80% of public health services (hospital, primary health, laboratory and ambulance services) and the private sector provides the remaining 20%.

In the light of the above, the majority of the South African population receive third-world health care as the legacy of apartheid still impacts negatively on the health care delivery systems. In a three-year study of primary health care provision from 1997 to 2000, Mahlalela, Rohde, Meidany, Hutchinson and Bennett (1997-2000:5) determined that the Eastern Cape Province is the hardest hit because it is the poorest as well as the third most populated province in South Africa. They found that poverty in this province is rife in the rural former homeland of Transkei as well as the informal settlements surrounding the towns. The province's unemployment (48,5%), infant mortality (61,2%) and under-5 mortality (80,5%) rates support the findings (Mahlalela et al 1997-2000:5).

This grave socio-economic status is aggravated by a health care service delivery characterized by serious staff shortages. A network of 920 public health facilities, 653 fixed clinics and 124 mobile clinics provides public health services in the Eastern Cape Province. Although this infrastructure is well distributed throughout the province, the problem is the distribution of human resources (staff) in these facilities. Mahlalela et al (1997-2000:33) state that all categories of staff are below the recommended levels with the shortfalls in the various categories ranging from 17% to 97%. Furthermore, the distribution of staff between regions and among facilities is extremely unbalanced. This results in nurse workloads that vary from 4 patients per nurse per day to 106 patients per nurse per day, which compromises the safety of service delivery, the effectiveness of nursing intervention, interpersonal relationships, continuity of care, and the efficiency of health care services (Mahlalela et al 1997-2000: 27).

The Eastern Cape Province has a serious shortage of staff as well as experienced personnel, such as medical superintendents, district nursing managers, and professional administrators. This leads to poor leadership and management of health facilities, which, in turn, results in poor health service delivery (Mahlalela et al 1997-2000:25). Moreover, the exodus of experienced health professionals has exacerbated the crisis.

The province's grave socio-economic status has a knock-on effect on the public hospital where the study was conducted. In this institution, the accessibility of services is compromised in several ways. Linguistic access is compromised because there are no providers conversant with sign language. The researcher is of the opinion that cultural access is compromised because the core values of the hospital do not accommodate traditional healers. Apart from the compromised accessibility of health care services, the continuity of care is compromised through poor documentation of patient care. Continuous (day and night) progress reports on patient care interventions are not kept, thereby compromising the continuity and hence the quality of patient care. The nursing practice is consequently unsafe, which can also be ascribed to poor supervision of patient care. This unsafe environment endangers both the customers and the providers of health care services.

The above situation has left nurses discouraged and burnt out and the customers are at the receiving end. Nzanira (2002:9) maintains that quality improvement in health care worldwide is an imperative. In its National Health Plan for South Africa, the African National Congress (ANC) views health as an integral part of South Africa's socio-economic development. The White Paper on the Transformation of the Health System in South Africa stipulates that it is the function of the provincial health departments to control the quality of all health services and facilities (Whittaker et al 1998:248).

Nzanira (2002:10) contends that health service delivery can be transformed through quality improvement and accreditation. He cites two approaches to quality improvement: a comprehensive and a problem-oriented approach. In a comprehensive approach, quality improvement policies, procedures and processes are implemented simultaneously, starting at the top and moving down the organisation. A problem-oriented approach emphasises practical, small-scale quality-related activities that produce increased quality improvement.

In this study, the researcher adopted a problem-oriented approach to quality improvement. The researcher introduced a quality circles programme in the nursing division of an Eastern Cape public hospital. Six quality circles emerged: one internal medicine, two surgical, one paediatric, one psychiatric, and one women's health.

Snow and Orlikoff (1984:2) define a quality circle as a group of between four and fifteen employees, who work in the same or similar area of an organization and who meet voluntarily on a regular basis to identify, assess and solve problems in their area of work. In this study, a quality circle refers to a particular category of nurses, professional nurses (PNs), enrolled nurses (ENs), and enrolled nursing assistants (ENAs) providing clinical assessment (outpatient care) and bedside nursing care (ward) in the same clinical area. Each group meets voluntarily and ranges from 4 to 15 in number.

To provide effective leadership and good governance, each quality circle has a steering committee. The steering committee is representative of all the nursing units in that nursing department or section. The steering committee consists of

- the leader, who is the other members' supervisor
- professional nurses and enrolled nurses and enrolled nursing assistants

Each steering committee develops a purpose (mission) and vision for quality improvement, fosters commitment to quality, conducts a preliminary review of quality improvement-related activities, allocates resources for quality improvement, strengthens quality improvement skills, and manages change.

To empower the steering committees, the researcher trained the steering committee members of all the quality circles in

- customer care in order to ensure and sustain patient satisfaction
- strategic planning in order to formulate a relevant vision and mission statement, and departmental objectives so as to harness quality improvement initiatives
- quality improvement strategies in order to transform the nursing practice in various nursing departments

- problem-solving to enable them to solve problems inherent in change – quality improvement

As a result of this training, the quality circles undertook various quality improvement strategies. The researcher facilitated and coordinated these strategies, which included

- shortening the waiting time at outpatient care
- improving the referral system in psychiatric units
- reviewing the admission policy for patients in an intensive care unit
- minimising puerperal sepsis in women's health
- eliminating the abuse of official time
- establishing a complaint system for the entire hospital

Quality improvement teams were allocated to work on quality improvement strategies/activities, identify the causes of the identified problems, and work out and implement effective solutions to the problems. The steering committee and the quality circle recorded and monitored the progress of the quality improvement activities/strategies. The researcher is of the opinion that the quality circles programme succeeded in motivating the nurses and transforming service delivery processes. The literature review on quality improvement in health care revealed little reference to quality circles. The researcher consequently decided to evaluate the implementation of a quality circles programme in a public hospital of the Eastern Cape Province by exploring and describing professional nurses' perception thereof.

The fundamental principle in continuous improvement in health care is based on considering how work is done and how it might be done differently to meet and exceed patients' needs and expectations.

Ovretveit, Bate, Cleary, Cretin, Gustafson, McInnes, McLeod, Molfenter, Plsek, Robert, Shortell and Wilson (2002:345-351) found that quality improvement in health care is achieved rapidly by using quality improvement collaboratives and teams. MacPhee (2002:450-454) identifies the critical components of quality improvement as scientific method, employee participation, teamwork, accountable leadership, appropriate training and on-going education, and client focus.

Weeks (2002:55-64) states that for quality improvement projects to be implemented successfully in health care, health care organisations need to understand and adapt to the financial environments in which they operate. This means that health care organisations need an implementation strategy that is inexpensive and in keeping with their financial environment. In the researcher's view, a quality circles programme fulfils this requirement.

Johnsson, Carlsson and Lagerstrom (2002:850-865) evaluated the training in patient handling and moving skills among hospital and home care personnel according to the Stockholm training concept. The training programme consisted of two models of learning: traditional groups and quality circles. For the evaluation, the participants were video-recorded in one standardised transfer situation: moving the patient from a bed to a wheelchair, before and after training. The participants' work technique during the patient transfer was assessed according to seven points. The participants completed a questionnaire covering individual features, physical exertion, job strain and musculo-skeletal problems, before and six months after training. The results indicated that the training in patient handling and moving skills led to improved work technique. The participants improved their transfer technique and experienced less discomfort during the transfer, and patients experienced greater comfort and safety when being transferred

In an assessment of the quality of nursing service management in South African hospitals that had implemented the Council for Health Service Accreditation of Southern Africa (COHSASA) programme, Muller (2000:64) found a significant improvement between the baseline assessments and the final external surveys.

The researcher formulated the research problem from the above background.

### **1.3 PROBLEM STATEMENT**

According to Koch (1991:1), a top-down approach to quality assurance does not involve everybody in the organisation, hence many workers perceive this as management's personal agenda and feel alienated and misused.

Muller (1995:67) espouses a bottom-up approach because quality assurance is everybody's business. Gillies (1997:23) concurs, pointing out that the best people to understand a process are

the ones who carry it out on a daily basis. Gillies describes quality circles and clinical audit as examples of the bottom-up approach, which energises, motivates and instils self-worth in employees.

Quality circles originated in Japan in the late 1940s to educate and train workers and first line supervisors in the techniques of quality control (Snow & Orlikoff 1984:4). The United States of America (USA) adopted and introduced quality circles in the health industry and by 1982 at least 200 American hospitals had implemented the programme. In South Africa, however, the quality circles programme is still a new and informal concept. Accordingly, the researcher initiated and facilitated a quality circles programme in a public hospital of the Eastern Cape Province. In order to yield valuable information to expedite the expansion of quality circles in South Africa, the researcher formulated a research question to guide the study.

#### **1.4 RESEARCH QUESTION**

This study is intended to answer the following question:

How do professional nurses perceive the implementation of a quality circles programme in a public hospital in the Eastern Cape Province?

#### **1.5 OBJECTIVES OF THE STUDY**

The objectives of the study are to

- explore and describe professional nurses' perception of the implementation of quality circles
- develop guidelines for the facilitation of the implementation of a quality circles programme in public hospitals

#### **1.6 PARADIGMATIC PERSPECTIVE**

In this study, the researcher followed Donabedian's (1980) model/approach for the evaluation of health services. According to Shaw (1980) (in Bowling 2002:9), evaluation is central to health

services research and audit. Furthermore, evaluation is more than audit because it aims to record not only what changes occur, but also what led to those changes (Bowling 2002:9).

According to Donabedian (1980:81), the evaluation of health services based on the collection of data about the structure, inputs, process, outputs and outcomes of services.

- Structure/input refers to the organisational framework for activities, including the building, equipment, staff, and beds needed to meet the defined standards. In this study this included professional nurses who were part of the implementation of a quality circles programme.
- Process refers to the activities themselves. The process entails how the service is organized, delivered and used .It also includes accessibility, that is, proximity to public transport, the way in which personnel and activities interact, and interaction between personnel and patients. The process in this study was the implementation of a quality circles programme.
- Outcome relates to the impact (effectiveness) of activities of interest (e.g. health services and interventions) in relation to individuals (patients) and communities. It also refers to rates of hospital discharges, number and types of supplies given, the number of patient-professional contacts (Bowling 2002:9). Since this study only assessed the professional nurses' perception of the implementation of quality circles, baseline scores were not identified prior to the implementation process. Accordingly, it is not necessary to look at the impact.

## 1.7 DEFINITIONS OF CONCEPTS

The following concepts are used in the context of this study as indicated below:

**Quality.** Gillies (1997:2) defines quality as the totality of features and characteristics of a product or service that bear on its ability to satisfy the specified or implied needs.

**Evaluation** is the use of the scientific, rigorous and systematic collection of data to assess the effectiveness of organisations, services, and programmes. Evaluation may be formative or summative. Formative evaluation involves the collection of data while the programme or organisation is still active, with the main purpose of developing or improving it. Summative evaluation involves the collection of data about the active or terminated program or organisation with the aim of deciding whether it should be continued or repeated (Bowling 2002:9).

**Continuous quality improvement.** Continuous quality improvement is a systematic, structured organisational process involving personnel planning and executing a continuous flow of improvements to provide health care that meets and exceeds customers' requirements (McLaughlin & Kaluzny 1999:3).

**Professional nurse.** Any person entered in the South African Nursing Council registers who has obtained a diploma in general nursing science and arts, or equivalent. This person is a leader of the nursing practice.

## **1.8 RESEARCH DESIGN AND METHODOLOGY**

A research design guides the researcher in planning and implementing the study in a way that is most likely to achieve the intended goal (Burns & Grove 1997:225). In this study, the researcher used an explorative, descriptive and contextual qualitative research design. The design is discussed in detail in chapter 2.

The study is conducted in two phases. Phase 1 deals with the exploration and description of professional nurses' perception of the implementation of a quality circles programme. Phase 2 deals with the development of guidelines for the facilitation of the implementation of a quality circles programme in public hospitals.

In this study, the qualitative research design is explorative, descriptive and contextual.

## **1.9 POPULATION AND SAMPLING**

Purposive sampling is suitable for qualitative studies because it requires "information-rich cases". The respondents have direct and personal knowledge of the phenomenon under study, which in this case is a quality circles programme.

The population consisted of subjects who had been part of the implementation of quality circles program in the public hospital. They were expected to relate to their perception of the implementation of quality circles programme (see chapter 2).

The sample size was determined by saturation of data. The researcher interviewed participants until no new themes emerged from the data (Morse 1995:147).

Data was gathered using two techniques: in-depth individual semi-structured interviews, and observations in the form of field notes. Data gathering was done through in-depth individual semi-structured interviews. Data was recorded, audio-taped and later transcribed verbatim. Field notes were taken as a way of recording events. A pilot interview was conducted with two participants in order to train the researcher in qualitative data collection.

The researcher utilised Tesch's method of descriptive data analysis (Cresswell 1994:155). Interviews were transcribed verbatim and analysed manually by the researcher. Consensus discussion was held between the researcher and an independent expert in qualitative research, in order to arrive at the main theme and categories for this research. Literature was also used during data analysis to control findings of this study.

The guidelines for the implementation of a quality circles programme will be based on the findings of phase 1 and the literature review.

## **1.10 TRUSTWORTHINESS**

To ensure valid results the researcher will use Lincoln and Guba's (1985:290) model of trustworthiness. The following criteria for trustworthiness will be applied: truth-value, applicability, consistency, and neutrality (see chapter 2).

## **1.11 OUTLINE OF THE STUDY**

The study (dissertation) is presented as follows:

Chapter 1 introduces the study by outlining the background to, purpose and objectives of the study. Chapter 2 discusses the research design and trustworthiness. Chapter 3 covers the research findings and literature control. Chapter 4 presents guidelines for the implementation of a quality circles programme in public hospitals. Chapter 5 concludes the study, discusses its limitations and makes recommendations for further research.

## 1.12 CONCLUSION

This chapter discussed the background to the study, stated the problem, defined key concepts used in the study, and briefly described the research design and methodology. Finally, the researcher outlined the chapter demarcation of the dissertation. Chapter 2 describes the research design, data-collection methods and data analysis.