

## CHAPTER 3

### Research findings and literature review

#### 3.1 INTRODUCTION

Chapter 2 described the research design and methodology of the study. This chapter presents the research findings with reference to the literature review. The main purpose was to examine professional nurses' perception of the implementation of a quality circles programme in a public hospital in the Eastern Cape Province.

The data collection and analysis revealed the nurses' perception of a quality circle as a forum for discussing patient care problems and future plans as the major theme. This theme had four categories:

- Staff empowerment
- Teambuilding in nursing
- Maintenance of standards by nurses
- Challenges to the momentum of a quality circles programme

#### 3.2 SAMPLE DESCRIPTION

In this study, the sample was drawn from a population of 425 professional nurses working in a public hospital of the Eastern Cape Province. The sample comprised eight professional nurses who volunteered for in-depth individual semi-structured interviews. Although data saturation was reached in the fourth interview, the researcher continued with all the interviews and no new themes emerged. Table 3.1 below represents the distribution of the participants in the study.

**Table 3.1 Sample description of different nursing care units/disciplines**

<b>PARTICIPANTS</b>	<b>NUMBER</b>
Surgical	3
Paediatric	1
Women's health	2
Psychiatric	1
Internal medicine	1
<b>TOTAL</b>	<b>8</b>

### **3.3 FIELDWORK EXPERIENCE**

In his approach to the study, the researcher bracketed his preconceived views about the research topic and did not experience much difficulty in entering the research field, since the research participants know him. Permission to conduct the study was requested from the hospital authorities in writing and the aim of the study explained (see appendix 1).

The participants consented in writing to participate in the study. Their initial response to having the interviews tape-recorded was reluctant since they associated tape recorders with special branch police of the apartheid regime. However, the researcher explained the purpose of the use of the tape recorder and assured the participants of anonymity and confidentiality. The written consent of each participant was sought (see appendix 2).

For the purpose of feedback, the researcher planned to conduct two individual pilot interviews with two participants who were not included in the sample population. However, both participants arrived at the same time so a focus group interview was consequently conducted. The researcher found it necessary in the focus group interviews to continue interviewing one participant until no more information was forthcoming for the time being (data is saturated). The pilot interview enabled the researcher to practise his interviewing skills and the use of probing questions to clarify participants' answers, where necessary, and lastly to recap by paraphrasing the participants' responses.

During in-depth individual semi-structured interviews, the researcher was in control of the situation and knew how many interviews to conduct per day. The researcher facilitated communication effectively during the interviews, and was able to obtain rich information from each interviewee.

Field notes were kept during the interviews, including observational, personal, methodological and theoretical notes.

The data analysis revealed that the participants approached the same question differently. Transcribing and coding was challenging and exciting. The researcher and the co-coder, a qualitative research expert, derived the same theme from the data analysis and interpretation. The study has been of great value to the researcher and taught him that qualitative research is about human interaction and exploring human perception and approaches participants in a holistic manner.

### 3.4 THE ROLE OF THEORY IN THE STUDY

This study was guided by Donabedian's (1980) model (in Bowling 2002:9), which assesses health services on the basis of structure/input, process, and outcome of services. In this study, the professional nurses who were members of the quality circles constituted the structure/input, and the process was the implementation of a quality circles programme. The impact of the implementation of the quality circles programme was not within the scope of this study because the baseline scores were not identified prior to the implementation process. This study only examined how the professional nurses perceive the implementation of the quality circles programme. The theme, categories and subcategories that emerged supported Donabedian's model because all the categories were processes, namely staff empowerment, teambuilding in nursing and maintenance of nursing standards.

### 3.5 THEME: PERCEPTION OF QUALITY CIRCLES AS A FORUM FOR DISCUSSING AND PLANNING QUALITY PATIENT CARE

As indicated earlier, the only theme was the nurses' **perception of quality circles as a forum for discussing and planning quality patient care**. This theme deals with the interaction of professional nurses, as they care for their patients. This means that the professional nurses regard a quality circles programme as a forum that brings them closer to each other; that is, they emerge as a team that has a common goal of sustaining continuous quality improvement. This team ensures that team members are empowered so that problems that ensue from nursing practice are

solved effectively and thereby maintain high quality patient care standards. In this study, the nurses view quality circles as follows:

*The quality circle is a departmental improvement process consisting of individuals from each individual place, to solve a particular problem ...*

*I do appreciate that at this point in time in the nursing profession we are having quality circles as a forum whereby all stakeholders in patient care could be involved to address problems pertaining to the patient care ...*

*A quality circle is a platform where we discuss our problems pertaining to patient care.*

*The quality circle engages in quality improvement projects in the surgical ward.*

*A quality circle provides the chance to exchange view.*

According to the Quality Circle Forum of India (QCFI) (1999:1), a quality circle is a forum for solving departmental problems, using A, B, C classification. This classification means that a list of problems for a department is generated through a brainstorming session in a quality circle and problems are classified. Category A problems have minimum involvement of other departments in solving them; category B problems necessarily require the involvement of other departments, and category C problems need management sanction and support. Ovretveit et al (2002:345-351) maintain that collaborative teams stimulate improvements in patient care and organisational performance.

The data analysis revealed four main categories in the theme, namely, staff empowerment; team building in nursing, maintenance of standards by nurses and challenges to sustaining continuous quality improvement. Table 3.2 depicts the categories revealed by the data analysis.

**Table 3.2 Categories of the theme perception of a quality circles programme as a forum for discussing and planning quality patient care**

EMPOWERMENT OF STAFF	
Emergence of team building in nursing <ul style="list-style-type: none"> <li>• Roles and responsibilities of team leader</li> <li>• Improved interpersonal relations</li> <li>• Improved problem-solving</li> <li>• Improved intradepartmental communication</li> </ul>	Maintenance of standards by nurses <ul style="list-style-type: none"> <li>• Challenges to sustaining continuous quality improvement</li> </ul>

Figure 3.1

### 3.5.1 Staff empowerment

A quality circle is a forum that brings departmental staff together and cross-pollination of ideas, skills and information occurs among them. Increased staff interaction leads to decision-making at departmental level, which is an indication of increased empowerment. In this study, the nurses understood empowerment as:

*Quality circles consist of individuals from each individual place to solve a particular problem and their skills and knowledge make them the likely source of solutions.*

*Quality circles serve to empower all professionals so as to enable them to effectively organise and administer all tasks pertaining to the nursing profession.*

*Our professionals need to develop and sharpen their skills, their knowledge.*

*Through the quality circles the following courses are organised, HIV/AIDS, computer literacy, resuscitation, leadership and management, total quality management, bridging for enrolled categories.*

Naude (1997:34) defines empowerment as a process that occurs when the traditional hierarchy starts to fade or fall away and the need arises for the employee to take responsibility for the success of the organisation. Naude asserts that empowerment is a process that should be harnessed by leaders who should increase their self-awareness and empower the followers to utilise their unique knowledge, skills, experience and creativity in the support of the process. Apps (1994:147) maintains that the process of empowering is both giving power (power sharing) and acknowledging the power that already exists in people.

Fullam, Lando, Johansen, Reyes and Szaloczy (1998:255) state that empowerment depends on the symbiotic relationship of nurse, environment, and leadership style. According to them, nurses' professional traits are like fertile ground waiting to be cultivated, the environment must support nurses through their professional growth and patient care, and leadership style nurtures nurses towards empowerment. Jooste and Booyens (1998:24) indicate that empowerment means more than merely giving consent to nurses to exercise control over their management tasks, but also refers to the use of people's potential and competencies, the discovery of new expertise and the creation of new opportunities to apply such competencies. Individuals who are physically, emotionally and psychologically independent are ready to serve in a team.

### 3.5.2 Team building in nursing

The quality circles programme became a catalyst for the staff of a department to act together as a team. Before the implementation of the programme, they did not have the common goal necessary to transform into a team. The function of the steering committee is to enable the group to have and achieve a common goal. Each quality circle has a steering committee. The steering committee is representative of all the nursing units in that quality circle in order to facilitate effective communication. The steering committee ensures that quality circle meetings are held weekly, that everybody participates in the discussions, that decisions taken are implemented and monitored and that timely feedback is given to the quality circle. According to the respondents:

*Quality circles are for everybody; all categories are included.*

*The chairperson should be a responsible, diligent and committed person with good communication and leadership skills.*

*The other people in the quality circle should own it, and claim it, should have the same aims.*

*Everybody should have one common role, that is, the upliftment of our department.*

Bateman (1997:1) defines team building as an effort in which a team studies its own process of working together and acts to create a climate that encourages and values the contributions of team members. Bateman (2002:1) adds further that team building is the process of enabling that group of people to reach their goal. Bateman notes that team building is about creating courteous behaviours, improving communication, becoming better able to perform work tasks together, and building strong relationships. The data analysis revealed four sub-categories of team building, namely

- Roles and responsibilities of the steering committee/team leader
- Improved interpersonal relationships
- Improved intradepartmental relations
- Improved problem-solving skills.

### 3.5.2.1 Roles and responsibilities of the team leader

The quality circle members regarded the team leader as the pivot of the steering committee of the quality circles programme.

The leader of steering committee is responsible for the strategic planning for each department, which culminates in a vision, a mission statement, objectives and the action plans for the department and strengths, weaknesses, opportunities and threats (SWOT) analysis for the department. Gunden and Crissman (1992:7) point out that leaders in organisations have a responsibility to bring out the best in those they serve by acknowledging that the person doing the job knows better than anyone else how to improve it. The data analysis revealed two more subcategories: **values of the chairperson** and **attributes of the chairperson of the steering committee**. With regard to the chairperson's role, the respondents stated that "the team leader should be able to plan in advance, implement, monitor and evaluate the programme".

Gunden and Crissman (1992:6-7) declare that it is the leader's responsibility to set the stage for transformation by eliminating disempowering behaviours like controlling and domineering leadership styles. They add further that a leader's empowering behaviours, such as enabling others to act, teaching, coaching and role modelling the way, and inspiring a shared vision, promote creativity and autonomy in decision-making among staff (Gunden & Crissman 1992:8).

- *Values of the steering committee chairperson*

The respondents identified credibility, competence, and good judgement in decision making as values of the person who is to lead them:

*The chairperson should be a responsible, diligent, committed person with good communication and leadership skills.*

*The other people in the quality circle should own it, and claim it, should have the same aims.*

*Everybody should have one common role, that is, the upliftment of our department.*

Gunden and Crissman (1992:8) maintain that leaders should lead and manage themselves effectively before leading others. In addition, followers want their leaders to be honest, competent, forward looking, and inspiring.

- *Attributes of the steering committee chairperson*

The respondents indicated that the chairperson should have leadership skills, especially transformational leadership skills, and be creative, interactive, empowering, visionary, and passionate about nursing:

*The leader, for example, is supposed to initiate and facilitate the meetings, encourage team members to speak their minds.*

*The team leader should work hand in hand with a quality assurance coordinator.*

*The team leader should be competent and should communicate effectively, should be able to plan in advance, implement, monitor and evaluate the process.*

Hackman and Johnson (1996:92-96) identify five attributes of transformational leaders: they are highly creative, effective communicators, visionaries, empowering, and passionate about their work. Flarey (1996:189-190) identifies four crucial leadership features of facilitating quality improvement programmes, namely visioning, empowerment, communication and commitment. Nazarey (1993:10) holds that the leader must coax staff to be active participants in designing their own development.

### *3.5.2.2 Improved interpersonal relations*

Before the implementation of the quality circles programme, the nurses were content to stay in their nursing units, not interacting with the other nurses in their department. In other words, the nurses did not discuss patient care and professional issues, like wearing the proper uniform and treating patients holistically. The standards of patient care were poor. After the implementation of the quality circles programme, the nurses used the quality circle as the forum for interacting meaningfully. The nurses became aware of their goal and their role in order to uplift the standards of their departments. Since the implementation of the programme, there is increased dialogue with the nursing departments:

*The quality circles were introduced as a tool for members of the whole department to meet.*

*Sources of conflict could be a lack of good relations amongst service providers.*

*The meetings are held weekly.*

*Doctors also do attend though not frequently.*

*Attitudes have really improved, because when we started the quality circles programme people were stubborn to attend, saying that we are busy and a quality circle is a waste of time.*

*As time goes by people are involved so that even if you (chairperson) meet nurses in the passages they would ask what we are discussing in the quality circle this week.*

*Since we have been attending these quality circles, everybody has a conscience.*

*In the quality circle everybody has an opportunity to make his input, everybody is given a chance to say whatever s/he want to say as long as the aim is for the upliftment of hospital standards.*

*How would you feel if a patient just came into your ward without you being told or informed?*

Bateman (2002:2) points out that people cannot work together if they are not clear about the terms of reference. He identifies four central issues that keep people talking in the team, namely, goal, role, procedural and interpersonal issues. Bateman (2002:3) goes on to say that the extent to which people feel comfortable with each other beyond the facilitation meetings does influence the effectiveness of the team. Lurie, Merrens, Lee and Splaine (2002:825-845) state that communication is the cornerstone of effectiveness of multidisciplinary teams in quality improvement in health services. Good interpersonal relationships are the foundation of good intradepartmental relations.

### *3.5.2.3 Improved intradepartmental relations*

Besides interpersonal relations, the participants also referred to intradepartmental relations or communication amongst the nursing units that constitute a department. This communication was minimal before the implementation of a quality circles programme, leading to a lack of cooperation amongst the units and poor patient care. Both material and human resources were not managed efficiently. The participants regard a quality circle as a forum that brings these units closer thus improving utilisation of resources and conflict management:

*Before the implementation of the quality circle programme, nursing units of the same department found it very hard to sort out their problems, and as such there was so much conflict between units of the same department.*

*If the unit cannot solve the problem, it has to be referred to the quality circle meeting.*

*Each nursing unit works on its own.*

With regard to interpersonal relations, Bateman (2002:1) states that a group becomes a team when the individual members are sure enough of themselves and their contribution to praise the skills of others and, furthermore, the team values the fact that whatever they achieve they do together. According to Bateman (2002:2), a common goal is a unifying force in any team and role clarification among the members is a factor in minimising conflicts in a team. Good interpersonal and intradepartmental relations therefore form the foundation for good management of problems.

#### *3.5.2.4 Improved problem-solving*

Problem solving is characterised by the technique of brainstorming to generate and classify a list of problems as A, B, C and so on. Category A problems include minimum involvement of other departments in solving them; category B problems of necessity involve other departments, and category C problems may require management sanction and support in implementing the solution (QCFI 1999:1).

Before the implementation of the quality circles programme, it was very difficult to solve problems effectively at departmental level in all the nursing departments, because there was minimal interaction among staff and nursing units of the same department. This meant that it took a long time for a problem to be solved, which impacted negatively on patient care. Due to a lack of interaction, there was serious duplication of services in the same department that led to inefficiency in the utilisation of resources. The implementation of quality circles provided a forum for discussing problems within the department. At the quality circle meetings, interpersonal, interdepartmental and intradepartmental problems are tackled. The steering committee represents all the nursing units so all the nursing units are involved in problem-solving. The common goal of the quality circle, namely the provision of quality patient care, has a unifying effect.

*Nursing units of the same department find it very hard to solve their own problems by themselves.*

*There is a feeling of belonging in these people. People become very vocal with a good attitude then collective partnerships develop.*

*In the quality circle we try to identify problems that are common in different nursing units of that quality circle and then discuss them largely at the meetings once a week.*

*All stakeholders in patient care would be involved to address problems pertaining to patients, especially in the nursing units.*

### **3.5.3 Maintenance of standards by nurses**

In any health care facility there are both normative and empirical standards. Normative standards come from the employing authority, the professional councils and professional association bodies. Empirical standards are set by people involved "hands on" in the clinical areas, based on their observations of the current nursing practice.

Before the implementation of the quality circles programme, problems and conflicts were solved in isolation therefore everybody did not own the standards set. Once a quality circles programme has been implemented though departments use quality circles as a forum for solving problems and reviewing *standards*. Setting standards involves three steps: setting, monitoring and revisiting (reviewing and, if necessary, revising) standards. In a quality circle, people are empowered and work in teams thereby creating an environment conducive to standard setting and maintenance. These standards are monitored by mechanisms like nursing auditing decided on in the quality circle.

*There are hospital standards but as a department we felt the need to make our own standards and if it happens that a standard is not met, that one is discussed with the persons involved in the quality circle.*

*If, when a standard was set, there were loopholes, these must be corrected, and it means that the standard is revisited.*

*In Women's Health we set our own standards within the department with all members of the department who are expected to function within these standards so that we minimise conflicts amongst us.*

*Since the implementation of the quality circles programme, patient care has improved so much because now we are able to consult each other. If you do not understand something, you are able to consult the next person, and we are able to liaise with doctors about patient management.*

In regard to the pivotal role of standards in any profession, Searle and Pera (1995:122) state that professional recognition in nursing has its roots in many factors, particularly professional solidarity, competence, accountability and strict adherence to a professional code of ethics with the public weal as the primary concern.

Mellish and Brink (1990:42-45) point out that the National Department of Health is responsible for the coordination and provision of additional health necessities for a comprehensive health service for South Africa. This implies that normative standards should be made available to health care professionals. Bowling (2002:8) contends that reviewing and monitoring current practice can only be done against the predefined standards.

### **3.5.4 Challenges to sustaining quality circles**

The implementation of the quality circles programme challenged and changed the way of doing things and initially the nurses were apprehensive.

#### *3.5.4.1 Staff attitudes*

Some of the respondents regard the quality circles programme as bringing too much work and a waste of time. Some maintain it is ill timed because with the serious shortage of staff there is no time to attend the meetings. According to the respondents:

*The quality assurance department was taken for granted probably due to ignorance.*

*Some complain about shortage of staff, thinking that the programme was a waste of time and such that we still experience problems in coping in all the quality circles.*

*I would like to cite the problem of senior people being intimidated by juniors.*

Moreo (1996:11) observes that 68% of customers just switch to the competitor because of the attitude of the personnel. Moreover, attitudes are not innate traits of individuals, but the product of conditioning people's minds either by others or themselves. This implies that attitudes can be manipulated either by co-workers or leaders or managers (Moreo 1996:12).

#### 3.5.4.2 Election of steering committee

There was a strong feeling amongst the respondents that the election of the steering committee threatens the existence of quality circles because sometimes the chairperson has no leadership quality but was elected on the basis of popularity:

*I would like to improve the election of the steering committee; sometimes people just elect popular people without looking at leadership attributes.*

Snow and Orlikoff (1984:37) found that in several hospitals in the USA, the steering committees were composed of administrators and middle managers, all of whom were selected because of their commitment to participative management.

#### 3.5.4.3 Staff shortage

Another problem was the shortage of staff in the hospital where the study was conducted. The participants responded as follows on this issue:

*Hindrances we are experiencing so far are a shortage of staff, shortage of equipment, shortage of skilled personnel. The present democratic era has made people have an attitude of being work shy.*

*Doctors do not adequately attend quality circles as would be preferable because of time constraints.*

*Due to bridging courses, the number of enrolled categories is dwindling and few manage to attend the quality circles.*

#### 3.5.4.4 Attending quality circle meetings

It became clear that holding quality circle meetings was a major problem in other departments. This might have been due to the fact that the people who were in charge of the quality circles did not consult with other staff members before planning the dates and times of meetings.

*The days and time of holding the meetings are very important so that people do not choose days that are busy in the department, such as operation days, major doctors' rounds, when we need more staff in the ward and therefore people will not be able to attend the quality circle.*

#### 3.5.4.5 *Loss of focus during quality circle meetings*

There was a tendency for some of the quality circle meetings to lose focus due to staff members who shifted focus from patient issues to their personal issues.

*The people in our departments have a tendency to change the aim of the quality circles and they want to involve their social issues than the patient care.*

*Truly speaking, I am not happy with the way we are running our quality circle at Women's Health; we need clarity on what issues need to be discussed at the quality circle level.*

### 3.6 CONCLUSION

This chapter discussed the research findings with reference to the literature reviewed. It became clear that certain issues make quality circles successful, including staff empowerment, team building and improvement of nursing standards.

Besides these driving forces for quality circles, the study also revealed certain challenges, such as staff attitudes, election of steering committee, staff shortages, days of holding quality circles meetings and loss of focus at such meetings, that make it impossible to run a quality circles programme.

Chapter 4 presents guidelines for the implementation of a quality circles programme in public hospitals.