

**MOTIVATION FOR PRIMARY HEALTH CARE NURSES TO RENDER QUALITY
CARE AT THE EKURHULENI HEALTH CARE FACILITIES**

by

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SUPERVISOR: PROFESSOR J MARITZ

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DEDICATION

In memory of my parents, Mrs Ngwakwana Constance Baloyi and Mr Daniel Risimati
Baloyi.

Student number: 897 877-8

DECLARATION

I declare that **FACTORS MOTIVATING PRIMARY HEALTH CARE NURSES TO RENDER QUALITY CARE AT EKURHULENI HEALTH CARE FACILITIES** is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references and that this work has not been submitted before for any other degree at any other institution.

Tintswalo Victoria Nesengani

15 March 2014

Full names

Date

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ABSTRACT

The purpose of this study was to explore and describe the factors that motivate the Primary Health Care Nurses to render quality care in the Ekurhuleni Metropolitan Municipality Health Care Facilities (in the Northern Region). The Ekurhuleni Metropolitan Municipality is located in Gauteng, South Africa. To achieve this, a quantitative, descriptive research study was undertaken. A purposive and voluntary sample of (n=54) Primary Health Care Nurses with two or more years' experience of working in the Ekurhuleni Metropolitan Municipality, in the Northern Region, participated in the study. Data was collected using structured questionnaires. Findings from the study indicated those factors that enhance the motivation of the Primary Health Care Nurses and those factors which may demotivate them. The findings further revealed the need for greater motivation for the Primary Health Care Nurses. Based on the study results, guidelines and recommendations were formulated according to the manner in which these nurses' motivation may be implemented and improved.

KEY CONCEPTS

Motivation, Primary Health Care Nurse, Primary Health Care facilities, District Health Plan, quality care, quality improvement, quality assurance.

LIST OF ABBREVIATIONS

ANC	African National Congress
CQIS	Continuing Quality Improvement Strategies
DHC	District Health Councils
DHP	District Health Plan
DHS	District Health System
DoH	Department of Health
DPA	Data Protection Act
EDL	Essential Drug List
EHCF	Ekurhuleni Health Care Facilities
EHD	Ekurhuleni Health District
EMM	Ekurhuleni Metropolitan Municipality
GDoH	Gauteng Department of Health
HE	Health Establishments
IEC	Information Educational Communication
MDG	Millennium Development Goals
MEC	Member of Executive Council
NAQ	Needs Assessment Questionnaire
NCS	National Core Standards
NDoH	National Department of Health
NHCS	National Health Care System
NHI	National Health Insurance
NHP	National Health Policy

NHS	National Health Service or System
NJM	Nursing Job Motivation
NSDA	Negotiated Service Delivery Agreement
NSM	Nursing Service Manager
PCB	Provincial Consultative Bodies
PHC	Primary Health Care
PHCFC	Primary Health Care Facility Committee
PHCN	Primary Health Care Nurse
PHD	Provincial Health Department
QA	Quality Assurance
QAD	Quality Assurance Department
QSD	Quality of Service Delivery
SA	South Africa
SANC	South African Nursing Council
SSPS	Statistical Package for Social Sciences
STG	Standard Treatment Guidelines
UN	United Nations
UNISA	University of South Africa
WHO	World Health Organization

CHAPTER 1
ORIENTATION TO THE STUDY

1.1 INTRODUCTION.....	1
1.2 BACKGROUND INFORMATION ABOUT THE RESEARCH PROBLE.....	1
1.3 RESEARCH PROBLEM.....	4
1.4 OBJECTIVES OF THE STUDY.....	5
1.5 SIGNIFICANCE OF THE STUDY.....	5
1.6 DEFINITION OF TERMS.....	6
1.6.1 PHC Nurses.....	6
1.6.2 PHC facilities	6
1.6.3 Motivation	7
1.6.4 Quality care	7
1.7 RESEARCH DESIGN AND METHOD.....	7
1.7.1 Research design.....	7
1.7.2 Research method.....	8
1.7.3 Population and sample.....	8
1.7.4 Data collection.....	8
1.7.5 Reliability and validity.....	8
1.7.6 Data analysis.....	8
1.7.7 Ethical considerations.....	9
1.8 SCOPE OF THE STUDY.....	10
1.9 STRUCTURE OF THE DISSERTATION.....	10
SUMMARY.....	10

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION.....	12
2.2 MOTIVATION.....	13
2.2.1 The concept motivation.....	13
2.2.2 Motivation, quality care and District Health System.....	14
2.2.3 Theories of motivation.....	20
2.2.3.1 The Expectancy Theory.....	20
2.2.3.2 Needs Theories.....	21
2.2.3.3 Equity Theory.....	23
2.2.3.4 Goal-Setting Theory.....	23
2.2.3.5 Learning Theories.....	24
2.2.4 Work motivation.....	26
2.2.5 Motivation for nurses.....	30
2.2.6 Issues that may demotivate nurses.....	31
2.3 QUALITY CARE.....	32
2.4 QUALITY ASSURANCE.....	37
2.4.1 Principles of quality assurance.....	38
2.4.2 Legal and policy framework.....	40
2.5 QUALITY MONITORING.....	39
2.5.1 Quality monitoring through structures of governance.....	39
2.5.1.1 The Office of Standards of Compliance.....	39
2.5.1.2 The Provincial Inspectorate of Health Establishments.....	40

2.5.1.3 Hospital Boards and Clinic Committees.....	40
2.5.2 Quality monitoring by provider of services.....	41
2.5.2.1 Staff satisfaction survey.....	41
2.5.2.2 Clinical Audit.....	41
2.5.2.3 Supervisory visits.....	42
2.5.2.4 Facility based quality teams.....	42
2.5.3 Quality monitoring by professional bodies.....	43
2.5.3.1 The South African Nursing Council.....	43
2.5.4 Quality monitoring by the user of services.....	43
2.5.4.1 A National Complaints Procedure.....	43
2.5.4.2 A National Patient Satisfaction survey.....	44
2.6 CONCLUSION	44

CHAPTER 3

RESEARCH DESIGN AND METHODS

3.1 INTRODUCTION.....	45
3.2 RESEARCH DESIGN.....	45
3.3 RESEARCH METHOD.....	45
3.3.1 Population	46
3.3.1.1 Sampling.....	46
3.3.1.2 Inclusion criteria.....	47
3.3.1.3 Exclusion criteria.....	47
3.3.1.4 Sample.....	47
3.3.2 Data collection.....	48
3.3.2.1 Development and testing of the data collection instrument.....	50
3.3.2.2 Characteristics of the data collection instrument	51
3.3.2.3 Data collection process.....	52
3.3.3 Data analysis	52
3.4 INTERNAL AND EXTERNAL VALIDITY OF THE STUDY.....	53
3.5 SUMMARY.....	54

CHAPTER 4

ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESEARCH FINDINGS

4.1 INTRODUCTION.....	55
4.2 RESEARCH FINDINGS.....	55
4.2.1 Sample characteristics.....	55
4.2.1.1 Age.....	55
4.2.1.2 Professional registrations.....	55
4.2.1.3 Highest nursing qualifications.....	55
4.2.1.4 Years of service working in the Ekurhuleni Metropolitan Municipality Primary Health Care facilities.....	56
4.3 DEMOGRAPHIC DATA.....	57
4.4 RESPONDENTS' PERSPECTIVES ON FACTORS THAT MOTIVATE THEM TO RENDER QUALITY CARE.....	65
4.4.1 Factors that best motivated the PHC Nurses	66
4.4.1.1 Teamwork and having team-building sessions.....	66
4.4.1.2 Attending of In-Service Trainings.....	66
4.4.1.3 Effective communication.....	67
4.4.1.4 Performance appraisal, supportive and performance feedback.....	68
4.4.1.5 Chairing of the information sessions or facility meetings.....	70
4.4.1.6 Getting allowances and uniform as a benefit.....	70
4.4.1.7 Sense of belonging.....	71
4.4.1.8 Competitive salary.....	71
4.4.1.9 "Employee of the Month" and other recognition events.....	72

4.4.1.10 Attending of supervisory visits and the Programmes Quarterly Reviews by PHC Nurses.....	73
4.4.1.11 Conducting of research activities by PHC Nurses.....	73
4.4.1.12 Flexi-time, Christmas Lunch and time-off before a public holiday.....	74
4.4.1.13 Information sharing sessions or facility meetings.....	74
4.4.1.14 Formation of Quality Improvement Teams and the frequent visits by quality mentors.....	75
4.4.1.15 Empowerment.....	76
4.4.1.16 Autonomy.....	76
4.4.1.17 Skills development programme.....	77
4.4.1.18 Delegated by facility manager with authority to make decisions.....	78
4.4.1.19 Limitation of authority entrusted to PHC Nurses.....	79
4.4.1.20 Age group and competitive salary.....	79
4.4.1.21 Age group, supportive feedback and effective communication.....	79
4.4.1.22 Entrusted with authority by the clinic head and empowerment.....	80
4.4.1.23 Age group, empowerment and autonomy.....	80
4.4.1.24 Age group and skills development.....	81
4.4.1.25 Delegated with decision making and a good work environment.....	81
4.4.2 Factors that demotivated the PHC Nurses the most.....	82
4.4.2.1 Poor leadership styles by facility managers.....	82
4.4.2.2 Shortage of staff (PHC Nurses and Pharmacist Assistants.....	82
4.4.2.3 Unavailability of laboratory supplies and long turnaround-time of laboratory results.....	83
4.4.2.4 Shortage of medical equipment and medicines.....	84

4.4.2.5 Many programme registers and large amounts of data elements.....	84
4.4.2.6 Frequent absenteeism.....	85
4.5 CONCLUSION.....	85

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION	86
5.2 RESEARCH DESIGN AND METHOD	86
5.3 SUMMARY	87
5.4 RECOMMENDATIONS.....	87
5.4.1 Recommendation 1: Teamwork by employees, formation of quality improvement teams and the offering of team-building session by the employer.....	87
5.4.2 Recommendation 2: Reduction or avoiding shortages of medicines, of medical equipment, of laboratory supplies as well as long turnaround time for laboratory results	88
5.4.3 Recommendation 3: Addressing the shortage of staff and frequent absenteeism by PHC Nurse.....	89
5.4.4 Recommendation 4: Performance appraisal, autonomy, empowerment, skills development and in-service trainings.....	90
5.4.5 Recommendation 5: Effective communication by facility managers, supportive feedback and staff meetings.....	91
5.4.6 Recommendation 6: Reducing too many programme registers in consulting rooms and the large amounts of data elements.....	92
5.4.7 Recommendation 7: Time-off before a Public Holiday and time-off for a Christmas Lunch.....	92
5.4.8 Recommendation 8: Mayoral Awards, Employee of the Month, allowances and competitive salaries.....	93
5.4.9 Recommendation 9: Attending of Supervisory Visits, attending of Supervisors' Manual Workshops (Quarterly reviews) by PHC Nurses and conducting of research by PHC Nurses.....	94

5.4.10 Recommendation 10: Leadership styles.....	95
5.5 CONTRIBUTIONS OF THE STUDY.....	95
5.6 LIMITATIONS OF THE STUDY.....	96
5.9 CONCLUSION.....	96

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

The motivation of Primary Health Care (PHC) Nurses is regarded as a very important matter as it influences their positive thinking and their enthusiasm. These nurses are exposed to stressful work environments on a daily basis. Consequently, health care organisations need to value their PHC Nurses, especially their resilience. Organisations need to nurture and protect these nurses and their profession, currently and in the future. Motivation is regarded as a central concept guiding human behaviour, and initiates, directs and sustains it (Jooste 2003:90). According to Glass and Rose (2008:337), nurses throughout the world have long held a marginalised status, although they are expected to continue as professionals, fulfilling their obligations of quality patient care. Valuable nursing work undertaken by PHC Nurses must inevitably be recognised and acknowledged, and any sources of stress should be identified and reduced.

Such nurses are important in the provision of health services in South Africa because they implement the programme activities at the primary level of health care as part of the execution of their duties; thereby contributing to the improvement of health and wellbeing of citizens. They are expected to provide comprehensive quality care to communities to meet their health needs and find solutions to problems faced by patients on a daily basis, rather than referring everything to a higher level of care. They need to be motivated in order to deliver excellent patient care (Berkow, Workman, Aronson, Stewart, Virkstis & Kahn 2012:165).

1.2 BACKGROUND INFORMATION ABOUT THE RESEARCH PROBLEM

The current South African Government, run by the African National Congress (ANC) as the dominant political party, has adopted the District Health Services (DHS) strategy, which is generally accepted as the most effective way of delivering PHC services to the people of this country. These services are extended to everyone who needs them, with the DHS allowing everyone to have access to the PHC services

within close proximity of their living and work areas, within an intended distance of a 5km radius (Gauteng District Health Plan 2006/2007).

To this effect, the current government has developed and implemented a number of policies to ensure the implementation of the DHS as well as planning and implementation of health services to address needs in the whole population throughout South Africa (SA) in addition to advocating the fast-tracking of the training of PHC Nurses. According to Magobe and Muller (2010:181), in 1996, during the period of transition to democracy, the South African National Department of Health (NDoH) formulated a health policy document entitled *“Restructuring the National Health System for Universal Primary Health Care”*. This document indicates that a specialised group of Registered Nurses, traditionally known as PHC Nurses, are expected to function independently as frontline providers of clinical PHC services within public health facilities. The National Health Act (Act Number 61 of 2003 as amended) and the Constitution of the Republic of South Africa (Act Number 108 of 1996 as amended) give South Africa the mandate to provide PHC services in local areas (Gauteng District Health Plan 2006/2007).

According to the Gauteng Department of Health’s *“Framework for Quality Assurance for Health Institutions”* of 2011, quality improvement is defined as a process requiring a well-planned, implemented and carefully monitored system which creates and promotes an environment that facilitates the provision of high quality services. It further states that quality improvement efforts must be focused on quality of care at the site where care is received.

Lin, Marsteller, Shortell, Mendel, Pearson, Rosen and Wu (2005:139) indicate that the implementation of quality improvement efforts in practice settings and the motivation of health care professionals are key factors in the improvement of quality of care. With regard to management’s engagement in quality improvement, their focus on assessment should not be limited to how motivated their employees are at a given point, but also on the factors that may explain their motivational levels.

The National Department of Health is said to have shown an unwavering commitment to improving the quality of health care in recent years since this commitment has been further cast into the spotlight through the publication of the *10 Point Plan for the Improvement of the Health Sector* (2010-2014) in July 2010.

The 2010/2011-2012/2013 *Strategic Plan of the National Department of Health* describes the department's vision to ensure an accessible, caring and high quality health system. Its mission is elucidated as being intended to improve people's health status through the prevention of illness, the promotion of healthy lifestyles and to consistently improving the health care delivery system by focusing on access, equity, efficiency, quality and sustainability (Whittaker et al., 2011:60).

According to Ahmad, Adi, Noor, Rahman and Yushuang (2013:172), nurses' roles and responsibilities contribute to the quality of improvement of health care services and in order to implement the health care reforms, the quality of services provided to patients and clients by the nurses needs to be further enhanced. Healthcare leaders are encouraged to communicate the values, vision and mission of their organisations in order to motivate their employees. Mandel et al., (2003:890) recommends that quality assessments, which are processes of planned activities whose ultimate goal is to achieve a continuous improvement of health care, should be undertaken in PHC facilities.

Promotion of the development and support of innovative roles in PHC Nursing is recommended as a strategy towards quality improvement. Innovative roles in PHC are new nursing roles, which are PHC focused, identified by the health care providers as non-traditional, or taking responsibility for those aspects of care previously undertaken by other groups of health professionals. The implementation of this strategy recommends the training and extension of the scope of practice of PHC Nurses, including the advancement of these nurses in prescribing treatment for patients, promoting the development of a more multi-disciplinary approach, better use of nursing skills and service integration (Mackay 2007:32).

As suggested, the modern day PHC Nurses are regarded as the "backbone" of the PHC delivery system and are responsible for rendering quality comprehensive health care. PHC Nurses are the care givers who help patients to regain health through the process of healing, and protect the human rights of those patients under their care. PHC services are the first point of contact where services are provided by skilled PHC Nurses (Gauteng District Health Plan 2006/2007).

PHC services are aimed at increasing access to services by all citizens, ensuring the availability of safe, good quality, essential drugs in the PHC facilities and the

rationalisation of health financing through budget reprioritisation. Funding of all the health facilities is provided by the National Government. The National Treasury allocated a budget of R21.7 billion for the 2011/2012 financial year to the Gauteng Department of Health. PHC constitutes 22% of the budget (Gauteng District Health Plan 2011/2012).

The Re-engineering of Public Health in Gauteng (2013:5) advocates that the health system needs to find its focus in order to be service and outcome oriented; it should strive to have a motivated, enthusiastic, committed health workforce and maximise all the available essential resources. Providing high quality customer service is essential in health care services. According to the National Health Plan of 1994, a wide range of policies that have fundamentally transformed our health care delivery system, were advanced. HIV/AIDS and the shortage of human resources, especially the PHC Nurses, may be the tipping points in preventing the delivery of quality health care unless these policies are sustained by commitment.

1.3 RESEARCH PROBLEM

Currently, as a result of the toll of the pandemic HIV/AIDS infection in SA as well as other acute and chronic conditions, health care institutions are often overcrowded with patients and more tasks are shifted to PHC where PHC Nurses are responsible for the provision of the full range of integrated PHC services. Such nurses face ever-growing demands associated with a high disease burden and major responsibilities of providing health care to all who require health services in order to reach the set Millennium Development Goals (Gauteng District Health Plan 2006/2007).

Malaikas (2013:24) indicates that the problems experienced by health care facilities become hindrances in the rendering of quality care to patients. These problems may be classified as human-oriented and system-oriented and include factors such as the under-use and overuse of health services, avoidable errors, inconsistency in services, lack of resources, inadequate diagnosis and treatment, inefficient use of resources, poor information, inadequate referral systems, disregard for human dignity, drug shortages and poor record keeping.

The Ekurhuleni Metropolitan Municipality (EMM) PHC nurses are faced with massive workloads and an increased disease burden because all patients coming to the EMM

PHC facilities have to be attended to without being turned away. The employer expects these PHC Nurses to fulfil their obligations as knowledgeable workers. The EMM is the point of entry for many non-South African citizens due to its proximity to OR Tambo International Airport. The majority of these foreign citizens attend the EMM PHC facilities for their health needs placing an ever-increasing burden on the staff and the health care facilities of EMM PHC (Gauteng District Health Plan 2006/2007).

According to Jooste (2003:90), the motivation of nurses is a crucial factor contributing to the effectiveness of health care organisations. Currently, the lack of motivation strategies within the EMM constitutes the greatest challenge faced by the Ekurhuleni Health Department, especially the lack of these for PHC Nurses. To date, no research has been conducted to determine the factors that motivate the EMM PHC Nurses, or the challenges they face every day.

1.4 OBJECTIVES OF THE STUDY

The objectives of this research study were to:

- Explore and describe the factors that motivate the EMM PHC Nurses to render quality care.
- Develop a framework of recommendations to assist Nursing Service Managers (NSM) to implement strategies to motivate the PHC Nurses.

1.5 SIGNIFICANCE OF THE STUDY

This research study was significant because it offered the PHC Nurses in the EMM an opportunity to have their views on motivation heard through the gathered data, which will in turn, offer an opportunity for some recommendations on the motivation strategies to be put in place. The research project helped the researcher to establish baseline information on what may be considered motivating factors for the EMM PHC Nurses. It is further hoped that this study will assist the EMM in developing a policy on motivation of their PHC Nurses and the improvement of the health system through the development of strategies and guidelines, on how to motivate these nurses.

The study will additionally benefit the EMM in that the Quality Assurance Department (QAD) will be made aware that high ratings in patient satisfaction surveys regarding patient care represent an indicator of quality nursing care. In this regard, motivation of PHC Nurses is therefore important in maintaining and sustaining this rating.

This research study was also of significance because the researcher, being an employee of the EMM Health Department, will be instrumental in giving advice to the Nursing Service Managers and the EMM Health Department on the improvement of the motivation of the PHC Nurses.

1.6 DEFINITIONS OF TERMS

1.6.1 PHC Nurses

According to Day (2009:1), a PHC Nurse is a nurse who provides health care in the communities. PHC Nurses are registered nurses with specialist knowledge in PHC; they provide accessible, comprehensive and effective care to clients of all ages. Akin to other nurses in different settings, PHC Nurses have a professional, a legal and an ethical responsibility requiring demonstration of a satisfactory knowledge base, accountability for practice and functioning in accordance with legislation affecting nursing and health care (Day 2009:1).

For the purpose of this study, a PHC Nurse has been defined as a health care practitioner who is eligible for registration by the South African Nursing Council (SANC), whose competence, as specified by the registering authority's license to practise, educational preparation, relevant legislation, standards and codes are specific to (though not exclusive) to the PHC context. Like other nurses, a PHC Nurse has the ethical obligation to act in the best interest of the patients according to the latter's health needs, and possesses a certain amount of knowledge and skill to examine patients, make a health diagnosis, prescribe medicine, with due consideration being accorded to the relevant monitoring of the patients' reaction to such treatment (SANC).

1.6.2 PHC facilities

PHC facilities are non-hospital medical care facilities and constitute an individual's point of entry into a comprehensive health care system. These facilities are designed

to meet all the daily personal health needs of the members of the community (Gauteng District Health Plan 2006/2007).

For the purpose of this research study, PHC facilities refer to the Ekurhuleni Health Care facilities in the EMM.

1.6.3 Motivation

According to Rothman and Cooper (2008:41), motivation is defined as a set of energetic forces that originate within and outside of an individual to initiate work-related behaviour, and to determine the direction, intensity and duration thereof. Being considered as both a state of mind and a desire, it translates energy and interest into action and gives an indication of some of the reasons why some people work hard and well, while others perform poorly.

For the purpose of this research study, motivation refers to the willingness to exert high levels of effort towards the achievement of personal and organisational goals.

1.6.4 Quality care

According to the World Health Organization (WHO) (2010), quality care is defined as the proper performance, according to the expected health care standards of interventions that are known to be safe, affordable to the society in question and have the ability to produce an impact on mortality, morbidity, disability and malnutrition. The services provided should be acceptable to the patients, accessible, appropriate and effective. The nurses should be equipped with the relevant skills and adequate resources in order to render quality care.

For the purpose of this study, quality care refers to the care that is provided using available resources to achieve the best results, care that is essential and acceptable to society. In order to be considered quality care, health care services provided by PHC Nurses should meet or exceed the established professional standards and the patients' expectations.

1.7 RESEARCH DESIGN AND METHOD

1.7.1 Research design

The research design is defined by Botma (2010:108) as the proverbial backbone of the study. This design provided the structure of the research method and design decisions that were taken in planning this study. The research design, as the broader action plan of the study, outlined how observations were to be made and how the researcher had to carry out the study. The researcher used the quantitative research design to explore and describe the factors that motivate PHC Nurses to render quality care at the Ekurhuleni Health Care facilities. A descriptive quantitative survey was used: the focus on nursing research indicated this as appropriate descriptive surveys are carried out in order to describe populations, to study associations between variables and to establish trends (Botma 2010: 108).

1.7.2 Research method

A research method is defined as a research tool and is the method by which research into a subject or a topic is conducted (Botma 2010:108).

1.7.3 Population and sample

A total of 16 PHC facilities participated in this study. The accessible population was 96 PHC trained nurses, of whom 59 were sampled to participate in the study, as the study focused on those PHC Nurses with two or more years of service working in the EMM. Of the 59 sampled PHC Nurses, 54 participated in the study.

1.7.4 Data collection

Data were collected during April and May 2013. A self-administered, structured questionnaire with a multiple-item Likert scale was used in data collection (Bowling 2009:214). Pre-testing of the questionnaire was conducted during the first two weeks of April 2013; 12 PHC Nurses participated in the pilot study.

1.7.5 Reliability and validity

The statistician was asked to read the instrument, evaluate and comment on the content in terms of whether it appeared to reflect the concept the research intended to measure. The data collection instrument underwent pre-testing through a pilot

study before the data of the main study were collected (LoBiondo-Wood & Haber 2010:289).

1.7.6 Data analysis

Data were analysed using SPSS, Version 20, from the IBM SPSS Statistics Base, summarised by means of descriptive statistics including distribution tables and graphic presentations. Distribution tables and graphic presentations were ways of presenting the findings of the study. These tools were useful in helping the researcher to become familiar with the data (Grove et al., 2013: 544).

1.7.7 Ethical considerations

Research dictates a whole range of ethical considerations, meaning that the research procedures must adhere to the professional, legal and social obligations of the study respondents. The researcher was therefore bound to adhere to the relevant ethical norms and standards. The respondents were selected on a non-discriminatory basis where all PHC Nurses with two or more years' experience working in the Ekurhuleni Metropolitan Municipality in the Northern Region were selected to participate in the study for the reasons directly related to the problem under investigation and not because of easy availability or their being able to be manipulated. In other words, the respondents were not selected on the basis of personal preferential choice by the researcher nor because she might have wanted to favour them with the specific benefits of the study (Burns & Grove 2009: 689).

The ethical considerations in this research project relate to ensuring that the study was conducted in a scientifically acceptable manner. UNISA's Higher Degrees Committee granted permission for the study's execution after it was satisfied that the study conformed to acceptable scientific norms and standards. Approval from the Ekurhuleni Health Department Ethics Committee and the health care facilities where the research was conducted was obtained before the study commenced; the approval number is Research Project Number 11-04-2013-03. Prospective research respondents gave written, voluntary informed consent (Botma et al 2010:277).

The principle of beneficence indicates the right to protection from harm. The researcher ensured that the respondents were not exposed to any undue physical or psychological harm; discomfort was prevented by explaining the study to them, its

purpose and how the study would be done, and they were afforded an opportunity to ask questions pertaining to the study (Burns & Grove 2009: 689). The basic principles of respect for persons, beneficence and justice as well as the application thereof were implemented according to the Belmont Report of 1979. Based on the principle of respect for persons, study respondents were treated as autonomous agents who have the freedom to choose without external controls. Study respondents participated in the study without external controls such as coercion, covert data collection and deception in the research process. Their participation was voluntary and they were given the freedom to withdraw at any time they wished, without any negative consequence (LoBiondo-Wood & Haber 2010:202).

In compliance with the principle of confidentiality and anonymity, the researcher ensured that the information shared by respondents was not further shared with others without their authorisation. Their identity cannot be linked to the respondents' individual responses, even by the researcher. In order to protect their privacy, no names, employee/pay numbers or names of facilities where these respondents are working will be used, nor will any identifying information for any respondent appear in the research report (Burns & Grove 2009:693). Data collected will be kept in a locked safe by the researcher and will be destroyed by burning after a period of five years (Burns & Grove 2009:715).

1.8 SCOPE OF THE STUDY

The current study included all the PHC Nurses with two or more years of service in the EMM, working in the Ekurhuleni Health Care (EHC) facilities in the Northern Region (Kempton Park, Tembisa & Edenvale). The aim of the study was to explore and describe the factors that motivate the PHC Nurses to render quality care at the EHC facilities. The study was limited to a very specific focus by virtue of it being a dissertation of limited scope, as prescribed within the University of South Africa's (UNISA) guidelines (UNISA 2013).

1.9 STRUCTURE OF THE DISSERTATION

Chapter 1: Orientation to the study

Chapter 2: Literature review

Chapter 3: Research design and method

Chapter 4: Analysis, presentation and description of the research findings

Chapter 5: Conclusions and recommendations

1.10 SUMMARY

Motivation of PHC Nurses is crucial in order for them to accomplish their tasks and to render quality care. This chapter provided an overview of the District Health Service (DHS) strategy adopted by the South African Government, which is generally accepted as the most effective way to deliver PHC services to the people of this country. PHC services are extended to everyone who needs them, with the DHS allowing them to have access to the PHC services within close proximity of their living and work areas, in a 5km radius. PHC Nurses are important in the provision of the PHC services in South Africa as more tasks are shifted to the PHC level, where such nurses are responsible for the provision of the full range of integrated PHC services. Motivation of the PHC Nurses is central to the improvement of patient care. The valuable nursing work undertaken by them should certainly be recognised and acknowledged as they implement comprehensive services for various healthcare programmes at a primary level of the healthcare system without referring every problem to a higher level of healthcare.

Chapter two presents the literature review.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

“Motivation is like food for the brain. You cannot get enough in one sitting.

It needs continual and regular top ups”.

Peter Davies

As previous research studies on the motivation of nurses have revealed, they need this in order to provide quality care and to contribute to the positive organisational outcomes as providing high quality patient care is essential in the health care services. To provide a comprehensive overview of current thinking and existing research evidence, a thorough review of related literature was conducted to determine the prominent points in the study. A definition of motivation is offered by Syed, Anka, Jamali & Shaikh (2012:85) as “the process that stimulates people to achieve organisational tasks while also stimulating themselves to action to gratify their felt needs”. In addition, the review was concerned with drawing attention to the range of published challenges encountered in the public health care facilities in South Africa, which further exacerbates situations where motivation among nurses is lacking in general. Such a lack is regarded as an important contributor to their suboptimal performance.

Health care delivery is regarded as very labour-intensive, while service quality and efficiency are all associated with and related to the providers' willingness to apply themselves to their tasks in order to achieving their organisational goals. Complying with a shared vision in a workplace is regarded as of fundamental importance to the motivation of employees because it serves as an inspiration and provides a sense of what needs to be done (Lambrou, Kontodimopoulos & Niakas 2010:2).

Jooste (2003:90) indicates that motivation for nurses is a crucial contributing factor for effective health care organisations in South Africa, which obviously has high value for the nursing profession and other health professions. Those nurses who are regarded as being motivated tend to put forward their creative ideas, accept delegated responsibilities, promote open discussions with their colleagues and

supervisors, and tend to be receptive to new ideas. Satisfied individuals are regarded as contributing positively to the realisation of their organisational goals and objectives.

In this period of rapid change, accompanied by various challenges, the need to maintain a creative, committed and productive workplace is regarded as being of crucial importance. It is therefore crucial that nurses need to be motivated to accomplish their professional tasks, provide quality care and contribute to the development of the nursing profession (Kamanzi & Nkosi 2011:119).

2.2 MOTIVATION

2.2.1 The concept of motivation

As Jones and George (2009:464) point out, motivation is the process that accounts for the direction of a person's behaviour, and refers to the many possible behaviours that a person could engage in, aimed at satisfying a need. Persistence is defined as whether, when faced with roadblocks and obstacles, people keep trying or give up. PHC Nurses are more likely to persist and to have higher motivation in a commitment-based management approach than a control-based management approach; since the former would encourage them to put more effort into their activities. Effort may be defined as how hard people work to achieve a goal. As motivation is said to stem from a need that must be fulfilled, this desire leads to a specific behaviour and it is therefore clear that motivation to perform well influences organisational outcomes. Motivation is therefore evidenced by creativity, receptivity to learning, and the ability to see opportunities in everyday situations (Khatri, Halbesleben, Petroski & Meyer 2007:131).

Motivation is considered central to management as it better explains why people behave the way they do in organisations. For example, it clarifies why some employees do what is expected of them to provide high quality service to customers and why some managers put their organisations' interests first (Jones & George 2009:464). People are inclined to be intrinsically, extrinsically or pro-socially motivated. When an individual is intrinsically motivated, he/she is said to perform the behaviour for its own sake; in other words, their motivation comes from doing the work itself. Intrinsically motivated individuals are regarded as deriving a sense of

accomplishment and achievement from helping their organisations achieve their goals and gain competitive advantages. Extrinsically motivated behaviour is described as the behaviour that an individual performs to acquire material or social rewards, or to avoid punishment. Pro-social motivated behaviours are behaviours that people perform to benefit or help others, for example, a financial donation by an individual to a welfare organisation (Jones & George 2009:465).

According to Schreuder and Coetzee (2006:120), issues related to lack of motivation lead to dissatisfaction among staff members, lack of pride in their professional work, and an increased feeling of not being part of the team. It is therefore recommended that motivation should be an on-going process and not be a once-a-year “booster”. Managers are encouraged to take some time daily to appreciate their employees and other people around them who are doing a good job; this might be the only appreciation they receive, and will make a difference in their day.

2.2.2 Motivation, quality care and the District Health System

The PHC facilities are one component of the DHS. They are government organisations that receive public funding to provide comprehensive, coordinated, integrated health care, comprising primary and preventive care services within a single institutional setting for people residing in their service areas. The central mission of the PHC is to increase access to community based PHC services and to improve the health status of medically vulnerable populations (Shi, Starfield, Xu, Politzer & Regan 2003:787).

According to Shi et al. (2003:787), quality attributes of the PHC service refer to accessibility, comprehensiveness, coordination, continuity and accountability. In using these attributes as quality measures, they are seen to be consistent with the prevailing DHS, containing each of the main features of PHC: these are person-focused, providing care over time and accessible care, and are comprehensive in the sense of meeting all common health needs as well as implementing coordination of health care when people have to receive services elsewhere. The Gauteng District Health Plan (2006/2007) indicates that communities are in need of continuity of care, which require the nursing skills of diagnosis, treatment and care where these services are best delivered as community-based services by PHC Nurses. These

nurses are regarded as leading the way and carry much of the responsibility for implementing and supporting the philosophy of PHC.

Manoge, Beukes and Muller (2010:181) indicate that in SA, Primary Clinical Nurses, traditionally known as PHC Nurses, function as the frontline providers of clinical PHC services within public PHC facilities. PHC services form the basis of the PHC Nurses' extended role that demands high quality clinical competency training by colleges and universities, leading to the provision of quality care to patients. Salvage (2009:25) points out that this modern concept of PHC evolved in the 1970's when the Declaration of Alma-Ata was signed during the International Conference on Primary Health Care in Alma Ata, USSR in September 1978, which expressed the need for action by all governments for the training of a different breed of health professionals with an orientation towards healthcare delivery through the application of existing knowledge to the solution of health problems in their holistic setting, which is regarded as being in the community.

DHS began implementing the PHC model that aims to increase service coverage in an inclusive way utilising the PHC facilities, with the expectation of having improved quality of care, better utilisation and coverage results and having, as its aim, an attempt to reach the entire population in the designated catchment area (Fort, Grembowski, Verdugo, Morales, Arriaga, Mercer & Lim 2011:218).

The World Health Organization (WHO 1978: Declaration V111) advocated and has declared PHC as a global approach. One of its concepts is the promotion of PHC as "the essential health care addressing the main health problems in the community, including the provision of appropriate treatment of common diseases and injuries and providing essential drugs", which prompted the Gauteng Department of Health (GDoH) to include this in its framework as the vision and mission that guides its operations. The GDoH's vision aims to promote and protect the health of its people, especially those most vulnerable to illness and injury. Through innovative leadership and management, it aims to provide quality health services and strives to ensure a caring climate for service users, implement best practice health care strategies, create a positive work environment for personnel, provide excellent and appropriate training for health workers (Magobe, Beukes & Muller 2010:181).

According to Salvage (2009:24), PHC Nurses provide 80% of the PHC services and are therefore regarded as ideally placed to provide critically needed, innovative solutions to many global health challenges. In holding this role, PHC Nurses had already long been regarded as the principal providers of essential health services to vast segments of populations, especially those in the developing countries, which includes amongst other clinical activities, the examination and treating of every patient that reports to the PHC facility. Motivated PHC Nurses are therefore necessary in the PHC facilities because they are the first point of contact between the community and the health system.

Thomas, Reynolds and O'Brien (2006:447) indicate that the National Health Service (NHS) reforms and United Kingdom government directives have placed PHC in the forefront of health care provision. Government has also increased its emphasis on the community as the place of choice for much health care delivery, placing PHC Nurses firmly in the centre of the NHS reforms, and PHC is regarded as being of paramount importance in the shaping and influencing the health outcomes of populations.

PHC Services in the Ekurhuleni Metropolitan Municipality (EMM) are rendered according to the PHC Service Package, National Core Standards (NCS) and Norms as laid down for the type of facility. Access to facilities is determined by a 5km radius or refined for more densely populated areas, while planning is done to accommodate 30 to 35 patients per nurse per day (Ekurhuleni Metropolitan Municipality Annual Report 2011/2012:3). It was further indicated that the EMM had 98 operational PHC facilities in the 2011/2012 financial year. The Ekurhuleni Health District (EHD) is divided into three sub-districts, namely, the Eastern, Southern and the Northern Sub-districts.

The EMM comprises various departments that are responsible for service delivery at local sites in the communities, including the Department of Health (DoH). The DoH consists of subdivisions such as Community Development, Support Services, Environmental Health Services and Family Health, with Family Health as the focus of this study. Family Health is identified as the largest division within the department and is mainly responsible for the delivery of PHC services, which includes promotive, preventive and curative health services based on the PHC approach, with all its

priorities being aligned to the priorities of the District Health Plan (DHP) (Ekurhuleni Metropolitan Municipality Annual Report 2011/2012:21).

National legislation, implemented by the National Government, in the form of the National Health Act of South Africa (Act 61 of 2003), provides a broad framework for various actions to improve the health of all South Africans. It serves to provide a framework for a structured, uniform DHS based on the principles of PHC, emphasising access to quality, equitable, comprehensive health care services, as well as effectiveness, efficiency, sustainability and local accountability (National Health Act 2003:4). According to the EMM Annual Report (2011/2012:4), the EMM has as its guiding framework its vision, mission and values, with the vision being: "The Smart, Creative and Developmental City", and the mission being: "To provide sustainable and people centred development services that are affordable, appropriate and of high quality." The focus on social, environmental and economic regeneration of the EMM's city and communities is guided by the Batho Pele Principles and brought about through the commitment of a motivated and dedicated team. The EMM values are: "Performance Excellence, Integrity, Community Centredness and Transparency", which are the attributes of quality. Services are thus designed to meet the needs of the patient, the family and the community, in an acceptable manner.

Maps of the EMM follow.

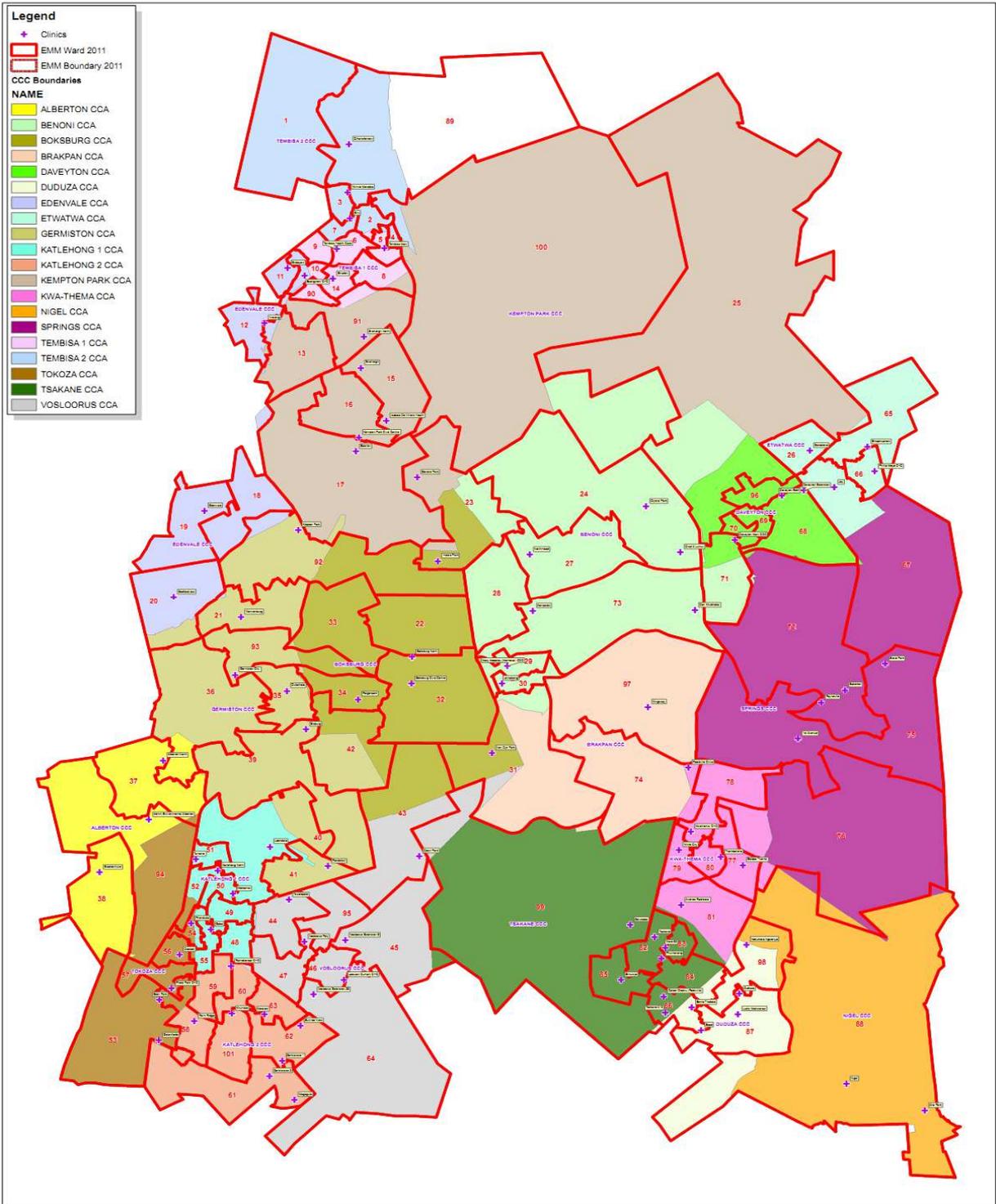


Figure 2.1 EMM map showing Wards and PHC facilities

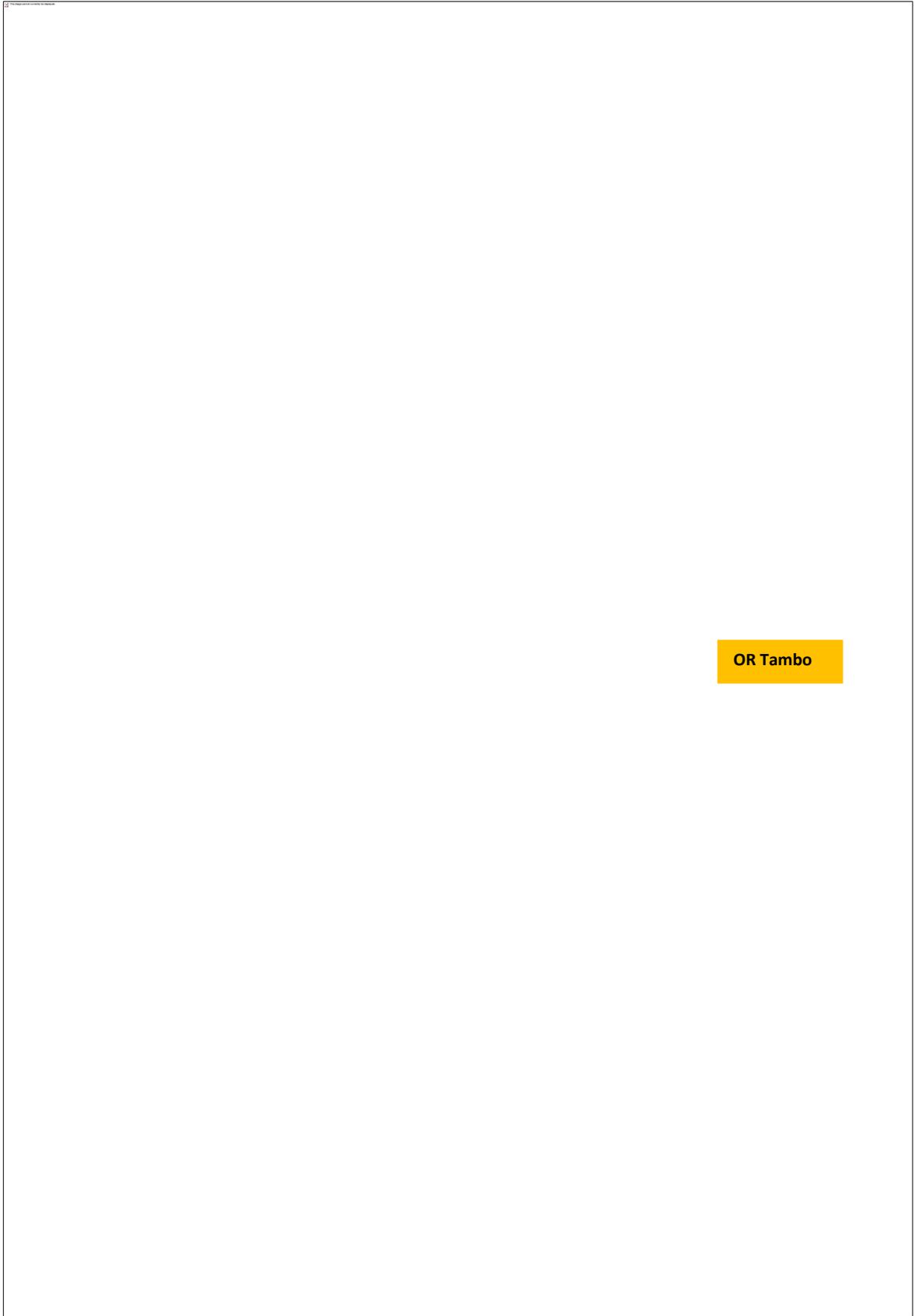


Figure 2.2 EMM map showing the three regions

The document, *Re-engineering of Public Health in Gauteng* (2013:5), indicates that PHC improves the expected health outcomes. The National Health Insurance (NHI) is described as needing strong DHSs that will drive the PHC to, consequently, deliver effective services. The EMM Annual Report (2011/2012:6) makes mention of the fact that there are various principles applied in the DHS, with one of them being the rendering of good quality care, accompanied by due recognition that while many factors go into producing such care, there are numerous ways of improving care and various strategies that may be implemented, such as adapting organisations for change, engaging the health care workforce, quality monitoring by service users, by service providers and by professional bodies and through structures of governance.

Whittaker, Shaw, Spieker and Linegar (2011:60) indicate that the introduction of the Negotiated Service Delivery Agreement (NSDA) in October 2010, with its focus being on PHC re-engineering and NHI as a means to obtain universal coverage, has re-emphasised high-level governmental commitment to improving quality, which is intended to result in a better life for all due to the right to health care access being guaranteed by the South African Constitution.

The document, *Re-engineering of Public Health in Gauteng* (2013:5), advocates that the health system needs to find its focus in order to be service and outcome oriented. It should strive to have a motivated, enthusiastic, committed health workforce and maximise all the available essential resources in order to provide the high quality customer service essential to health care services. According to Lambrou, Kontodimopoulos and Niakas (2010: 2), PHC Nurses allocated across different health care facilities are the most important input in a unique production process, and therefore have a strong impact on the overall health system performance. These nurses are identified as possessing specific, unique features that cannot be undervalued; and, if they are motivated to render quality care, they can play an integral role in those challenges facing health care today, that are regarded as the most compelling.

Khatri, Halbesleben, Petroski and Meyer (2007:128) draw attention to dysfunctional health care cultures and systems that need more attention for quality care to improve further. Health care organisations are encouraged to improve the quality of care and reduce medical errors by enhancing learning from mistakes and boosting the morale

of their employees. Motivation and learning from mistakes indicates a positive relationship with quality of patient care; health care institutions can improve motivation by implementing just and fair management practices that involve employees in decision-making. Low motivation, displayed by negative emotions, leads to poor quality patient care. Employee participation in decision-making accompanied by an open, trusting culture, can lead to high motivation of employees, resulting in high quality patient care.

2.2.3 Theories of motivation

2.2.3.1 The Expectancy Theory

This theory was formulated by Victor Vroom in the 1960s, and posits that motivation is high when workers believe that their better levels of effort lead to better performance, which will lead to their desired outcomes. This theory is one of the most popular theories of work motivation as it focuses on all three parts of the motivation equation: inputs, performance and outcomes. It suggests that people are motivated to put forward a lot of effort in their jobs only if they think that their effort will pay off in high performance (Jones & George 2009:467). With this theory in mind, nurses anticipate or hope for an effective collaboration between them and the other healthcare team members, better social support inside the team as well as a positive team spirit in their work environment, which will facilitate in their motivation. In a situation where all these factors are missing, nurses will actually become frustrated and demotivated (Toode, Routasalo & Suominen 2011:253).

According to Toode et al (2011:254), motivational factors, such as suitable working hours, coupled with better, market related remuneration and job security, are regarded as important by various individuals when taking up employment with a particular organisation. Various nurses working in the PHC facilities consider these factors as significant because the working hours are suitable. Healthcare services are only rendered during the day; there is no night duty or working over weekends and public holidays, so that these nurses are able to combine work and attend to private matters. Daytime workers are regarded as having higher motivation than those who are working shifts. This is regarded as negatively influencing nurses' motivation due to the resultant exhaustion.

Organisations should strive to keep their employees motivated if they expect them to contribute positively to the organisations' realisation of their goals and objectives. Managers are therefore expected to efficiently and effectively demonstrate their human and conceptual skills in order to motivate and retain their staff members (Syed, Anka, Jamali & Shaikh 2012:86).

The sharing of information with nurses by nurse managers is expected in health care facilities. Nurses expect to be involved in routine decisions, which will in turn satisfy their basic needs of belonging, making them feel important in the nursing service. Satisfying their basic needs will assist in the improvement of the nurses' morale, reduce their resistance to formal authority and make them co-operate willingly in their professional activities (Toode et al 2011:254). According to Syed et al (2012:86), two-way communication is very important in a health care organisation which is expected to ensure and facilitate adequate and effective feedback to all members taking care of patients, which is also expected from the PHC Nurses.

2.2.3.2 Needs theories

It is agreed that the basic premise of this type of theory is that people are motivated to obtain outcomes at work which will satisfy their needs. The said theory serves to complement the expectancy theory by exploring, in-depth, which outcomes motivate people to perform at an optimum level. It is recommended that in order for managers to be able to motivate people to contribute valuable inputs to a job and perform at a high level, they should determine the needs that these people are trying to satisfy at work, and ensure that these people receive the outcomes that help to satisfy these needs (Jones & George 2009:471). Regardless of the specific job or daily responsibilities that nurses are entrusted with, each nurse impacts the life and well-being of those they take care of. On the other hand, nurses have chosen to work in the healthcare environment because of the outcome they want to achieve, which is to make a difference in people's lives (Zofi 2007:92).

Each individual needs social contacts. Those contacts in nursing have a positive effect on nurses since such contacts tend to motivate them, making their work challenging and worthwhile. Nurses need to be able to exchange information with regard to the patients they are taking care of as well as getting feedback regarding these patients. PHC Nurses exchange information regarding their patients with

nurses and doctors at various levels of healthcare through referrals and obtain feedback regarding these patients, therefore making it possible for interpersonal and professional relationships to be formed through these interactions. Nurses who work in collaboration with other stakeholders in the health care profession are regarded as providing a better health care service (Toode et al 2011:254).

The psychologist, Abraham Maslow, developed his Hierarchy of Needs theory in 1943, proposing that all people seek to satisfy five basic kinds of needs: physiological, safety, belonging, esteem and self-actualisation. Maslow theorised that these needs motivate behaviour. He proposed that the lowest level of unmet needs is the prime motivator, and that only one level of needs is motivational at a time (Jones & George 2009:473). Nurses, similarly to any other employees in other organisations, are motivated if their work meets certain needs and values which are important to them. They should be helped to find and support their inner inclination. When the workplace characteristics and the working conditions meet the individual nurse's priorities, he or she experiences the work as meaningful and takes personal responsibility for the outcomes. The work is regarded as purposeful by these nurses because the outcomes are personally important to each nurse. If something makes a nurse feel good at work, he/she will try to work even better (Toode et al 2011:255).

Everybody wants to feel useful and important in their workplace, and this is also applicable to the PHC Nurses in the service they render. They, too, have the desire to belong and be recognised as unique individuals. These needs are regarded as more important than money in motivating PHC Nurses to work. Nurses' managers are encouraged to use strategies such as appreciation to encourage involvement of their staff members in all aspects of the nursing service related to their jobs (Lawrence & Jordan 2009:104).

Jones & George (2009:474) further identify Herzberg's Motivator-Hygiene Theory, which is another need theory that distinguishes between motivator needs. The motivator theory is said to relate to the nature of the work itself while the hygiene needs relate to the physical and the psychological context in which the work is performed. This proposes that motivator needs must be met for motivation and job satisfaction to be optimal. PHC Nurses have a great deal of autonomy, especially

when decision making is required, and this is regarded as extremely important in situations where the job demands are considerable (Toode et al 2011:253).

The theory of Needs for Achievement, Affiliation and Power, developed by the psychologist David McClelland in the 1960s, describes the need for achievement as the extent to which an individual has a strong desire to perform challenging tasks well and meet personal standards for excellence. It is also regarded as the extent to which an individual concerns himself/herself in the establishing and maintaining of good interpersonal relations, being liked and having the people around him or her get along with each other. The need for power is described as the extent to which an individual desires the control and influence others (Jones & George 2009:474). According to Syed et al (2012:87), motivation influences people to act in a positive direction and channels behaviour into a specific course. When individuals are thus motivated, they are stimulated to achieve organisational tasks as well as motivated to take action to gratify their felt needs.

2.2.3.3 Equity Theory

This theory was formulated in the 1960s by J. Stacy Adams and is described as the theory of motivation that concentrates on people's perceptions of the fairness of their work outcomes relative to, or in proportion to, their work inputs. It complements the expectancy and the needs' theories by focusing on how people perceive the relationship between the outcomes they receive from their jobs and inputs they contribute (Jones & George 2009:476). Equity is described as the justice, impartiality and fairness to which all organisational members are entitled. Motivation in an organisation will be increased when as many people as possible perceive that they are being equitably treated, with their inputs and outcomes being in balance (Jones & George 2009:478).

Organisations are encouraged to make employees feel that they are receiving fair treatment in their workplaces in terms of their contributions to the job, which includes skills, abilities, educational levels, experience and effort in relation to the rewards they receive such as pay, fringe benefits, recognition, praise and promotion. A considerable amount of inequity can be found in healthcare institutions where different nurses in the same unit perceive themselves to be contributing considerably in the services rendered, have worked for a longer period for the same organisation

but all the nurses are on the same salary scale as their colleagues, irrespective of the amount of work they perform (Lawrence & Jordan 2009:109).

2.2.3.4 Goal-Setting Theory

Jones & George (2009:479) describe this theory as a theory that focuses on identifying the types of goals that are most effective in producing high levels of motivation and performance and explaining why goals have these effects. According to Lawrence & Jordan (2009:103), motivated workers are regarded as having a much better task performance and contextual performance. PHC Nurses perform to the best of their ability in their working environments because they function as independent practitioners in most instances where they are supposed to take decisions on their own. Motivated workers have stronger organisational commitment and are more likely to remain with an organisation for longer periods. Nurse managers in the PHC facilities should realise the value of becoming better motivators in order to retain their staff members. These managers have the responsibility to provide work environments and working conditions where the manager's behaviour is able to affect the PHC Nurses in a positive way, which will assist the latter to achieve work satisfaction.

Managers in all fields of employment have a responsibility to exhibit consideration for their colleagues and subordinates; should show concern for their work and should be able to undertake initiatives to highlight the effort required from staff members to achieve the organisational goals. All managers at the PHC facilities should strive and encourage their PHC Nurses towards reaching all the set targets and indicators for various programmes in accordance with the timeframe, as working towards specific goals leads to better performance output than general goals do. Time limits also affect the employees' behaviours with regard to the set goals because they will be motivated to achieve within the agreed timeframe. Managers' supportiveness and encouragement of their PHC Nurses during rendering of difficult tasks, contribute to these nurses accepting high levels of responsibility and achieving the set targets. Organisations should establish specific rewards that are linked to performance outcomes (Lawrence & Jordan 2009:104).

2.2.3.5 Learning theories

Learning is defined as the relatively permanent change that occurs in a person's knowledge or behaviour and which results from practice. Learning theories focus on increasing employee motivation and performance by linking the motivational incentives that employees achieve to the performance of desired behaviours, and the attainment of goals (Jones & George 2009:480). One of the learning theories, known as operant conditioning theory, provides four tools that may be used by managers to motivate optimum performance and prevent workers from engaging in absenteeism and other behaviours that detract from organisational effectiveness. These are defined as positive reinforcement, negative reinforcement, extinction and punishment. Positive reinforcement, it is asserted, gives people the rewards they desire when they perform organisationally functional behaviours; these are called positive reinforcers and include results such as pay, praise and promotion. Organisationally functional behaviours are those that contribute to organisational effectiveness, and include factors such as producing high-quality goods and services, providing high-quality customer service and meeting deadlines (Jones & George 2009: 481).

According to Toode et al (2011:253), nurses are regarded as being motivated by such tasks that require a variety of different activities involving the use and combination of a number of different skills and talents. This is the reason why PHC Nurses who perform all kinds of nursing activities in PHC facilities are more motivated than those who perform only part of the total care, such as in hospital situations. Achieving specific skills influences nurses to choose specific nursing areas in line with their preferences. They are therefore motivated by opportunities for learning where they associate specific patient populations with possibilities of obtaining extra training, regarding patient populations as job motives that make their work interesting. During their training, PHC Nurses share their cases with colleagues and physicians who supervise them and discuss these cases where problem-solving skills and attitudinal changes are sought. Nurse managers try to influence their subordinates in the PHC facilities through discussion of various problems. Discussions are regarded as an effective means of ensuring the proper resolution of issues. These nurse managers also acquire good standing in the eyes of their colleagues because they are able to transfer new learning, carry out positive

reinforcement and assign more responsibility to their subordinates (Lawrence & Jordan 2009:109).

Nurse managers may also use negative reinforcement, described as the elimination or the removal of undesired outcomes when people perform organisationally functional behaviours. The undesired outcomes are called negative reinforcers and can range from the manager's constant nagging or criticism to the ever-present threat of losing one's job. The theory supports the view that when negative reinforcement is used, people are motivated to perform well because they want to avoid experiencing undesired outcomes. It is however, recommended that where possible, managers should rather try to use positive reinforcement, as negative reinforcement may ultimately create a very unpleasant work environment and even a negative culture in the organisation (Jones & George 2009:481).

Jones & George (2009:481) acknowledge that sometimes members of an organisation engage behaviours that actually detract from organisational effectiveness; therefore extinction should be used. This is defined as the curtailing of the performance of dysfunctional behaviours by eliminating whatever is reinforcing them. It is noted that sometimes managers cannot only rely on extinction to eliminate such behaviours as they do not have control over whatever is reinforcing the behaviour. PHC Nurses should always feel confident to succeed in the health care services they render and feel good about their competence. When think about (their) lack of abilities at particular tasks, they are encouraged to use role-modelling which allows them to learn a whole complex set of skills in a real life situation. Successful role-modelling requires that these nurses admit mistakes and accept suggestions (Lawrence & Jordan 2009:109).

Social learning theory takes into account how learning and motivation are influenced by people's thoughts, beliefs and their observations of other people's behaviours. Vicarious learning, known as observational learning, occurs when a person becomes motivated to perform a behaviour by watching another person (the role model) perform the behaviour and be positively reinforced for doing so. Vicarious learning is regarded as a powerful source of motivation on many jobs in which people learn to perform functional behaviours by watching others (Jones & George 2009:482). According to Lawrence & Jordan (2009:109), PHC Nurses try to perform their best in

their clinical environments while they also try very hard to improve on their past performances at work. Nursing and medical students learn how to treat and care for patients by observing experienced members of the profession perform these behaviours properly and receive reinforcement for them. It is argued that people are more likely to be motivated to imitate the behaviour of models who are highly competent or experts in the field, have high status and are friendly or approachable. Case studies are also regarded as being useful in sensitising the PHC Nurses to basic issues, developing their analytical skills and teaching them problem-solving techniques.

2.2.4 Work motivation

With due consideration of work motivation, it is described as an employee's desire to work for the public interest, doing good for others which results in shaping the well-being of society. Motivation of employees is regarded as an essential part of the effective functioning of the organisation in its quest to meet its objectives. Work motivation is reported to be very important as it helps in influencing people to energise their thinking, fuels enthusiasm and generates mental effort that drives people to apply all their knowledge and skill to their work (Mahazril, Zuraini, Hafiza, Aminuddin, Zakaria, Noordin & Mohamed 2012:239).

Mahazril et al (2012:239) contend that in order to give the best output and excellent performance in the workplace, employees need to be motivated in their jobs, by those factors that encourage them in their work. Research has proved that unless employees are motivated to make efficient use of the potential found in them during the employment process, they may not achieve the level of performance that is desired from them. It is therefore, recommended that for any organisation to record any degree of meaningful success in the pursuit of its goals and aspirations, it should have a strategy and an ability to create adequate motivational values to compensate for the burden imposed upon employees.

According to Young (2007:3), for an employee to be motivated, he/she should perceive that his/her needs are being met; thus, a motivated individual will certainly contribute positively to the realisation of the organisational goals and objectives. Personal motivators related to flexibility in work hours, incentives, not having to work during holidays, weekend and night shifts, better interpersonal relationships, greater

unit morale, lower intra-group conflict and satisfaction with pay are regarded as strongly desired by employees.

All organisations, whether public or private, are goal oriented, and all efforts are geared towards the successful attainment of those goals and objectives. Organisations are therefore encouraged to have the ability enough to create values and motivation for their employees which might be in the form of training policies, facilities for incentives such as fringe benefits, promotions and status symbols so as to satisfy the needs of the employees for enhanced performance (Syed, Anka, Jamali & Shaikh 2012:85).

Nurse managers are encouraged to support their staff in order to maintain the high levels of motivation and commitment that delivering quality care requires. Showing their employees that they value them is said to can give others a sense of recognition and worth. The available staff members need to be recognised and rewarded for doing something good, and they also need to be treated with respect. It is indicated that as little as a “thank you” will give employees the reassurance they need to know that they are being supported (Shaw 2011:2).

Lawrence & Jordan (2009:103) aver that motivated workers exhibit much higher task performance and contextual performance, stronger organisational commitment, are more likely to remain with an organisation and experience a higher level of job satisfaction. Incentives such as good pay, decent accommodation, good conditions of service, opportunity for staff to undergo in-service training motivate employees to increase their productive capacity.

Managers are encouraged to use outcomes to motivate their employees to contribute their inputs to the organisation. Engaging in this strategy aligns the interests of employees with the goals of the organisation as a whole because employees personally benefit when they do what is good for the organisation (Jones & George 2009:466).

The use of rewards and recognition systems in an organisation is considered as a very important tool which management can use to channel and direct employees' motivation in desired ways (Mahazril et al 2012:239). Berkow, Workman, Aronson, Stewart, Virkstis and Kahn (2012:167) posit that rewards and recognition have

proven to be equally impactful when linked to achieving certain predefined milestones with specific criteria.

Nelson (2013:41) identified the fact that, increasingly, the most powerful forms of recognition, as reported by today's employees, are the intangible interpersonal forms of support by management. It is further indicated that praise is priceless in the workplace, and personal praising from managers for doing a good job is therefore regarded as the motivating incentive. Managers are encouraged to ensure that when they praise someone, it should be immediate, sincere, specific, personal, positive and as soon as possible.

In the process of praising, timing is regarded as important in order to achieve a positive reinforcement where praise should be given as soon as an achievement by someone is complete or the desired behaviour is displayed. Managers must be sincere when praising someone; words alone can fall flat if one is not sincere. They should only express praise because they are truly appreciative and excited about the other person's success; otherwise it may come across as a manipulative tactic (Nelson 2013:43).

Nelson (2013:43) further indicates that one should be specific in his or her praise, and avoid generalities in favour of details of the achievement as specifics give credibility to his or her praising. This serves the practical purpose of stating exactly what he/she has realised to be good about an employee's behaviour or achievement. Being personal is a key to conveying his/her message of praising in person face-to-face. This shows that the activity is important enough to him/her as a manager to put aside everything else he/she has to do and just focus on the other person.

According to Ahmad, Idris and Hashim (2013:208), a flexible working environment allows employees to focus on multiple roles in today's competitive working environment where this arrangement between the employer and employees creates a balance between work and lifestyle. Flexible working hours, these authors argue, contribute to higher job satisfaction, motivation and employee engagement. Through the implementation of this strategy, it has been proven that it has the ability to reduce absenteeism, reduce stress, improve staff morale and evidences a marked increase in staff motivation.

In the workplace, managers are encouraged to strive to create a work environment that is open, trusting and fun, with employees being allowed to bring up new ideas and to be creative. Managers should be willing to take time to meet with and listen to employees (Nelson 2013:44). Employees should be provided with information on how the organisation makes and loses money, and given specific feedback about each employee's performance as well as the department and the organisation's performance. It is also recommended that employees should be involved in decisions, especially those decisions that affect them (Nelson 2013:44).

In order to increase employee motivation for its vision, mission and the achievement of its goals, each organisation is encouraged to place emphasis on its employees' welfare. It is recommended that employees should be rewarded, recognised and promoted based on their performance, given a chance to learn new skills; individual employee's successes should be celebrated as should the success of the department as well as the organisation. Creation of partnerships between employees and managers, and the undertaking of team-building meetings are advocated for staff motivation in workplaces. Nelson further indicates that it is very important not to forget to recognise and thank those managers who support individual learning and development among their staff. Managers are encouraged to look for opportunities (such as in staff meetings) to give praise whenever there is positive news (Nelson 2013:44).

2.2.5 Motivation for nurses

This is regarded as essential for enhancing the role of nurses, strengthening their professional image, improving the health care system and increasing the quality of health care (Oshvandi, Zamanzadeh, Ahmadi, Fathi-Azar, Anthony & Harris 2008:426). Vilma and Egle (2007:213) discuss the issue that health care facilities, whether private or public, are in the business of promoting health for their patients. PHC Nurses are expected to extend their service in order to cover the gap between day and evening service provision, which further adds to the increasing service demands while meeting the complex needs of many clients visiting PHC facilities and those living at home. PHC Nurses therefore need to be motivated, by support, learning opportunities, respect and recognition in order to provide quality care. However, Glass and Rose (2008:336) indicate that PHC Nurses remain exposed to

stressful workplace environments, which result in vulnerability and impairment or “psychological fractures” which can impair their ability to maintain compassionate nurse-patient interactions. Therefore, PHC Nurses should be identified as the key workers in the complex situation of PHC as they are the “hands on” professionals in the PHC setups.

Savič, Pagon & Rohda made the point that motivation of PHC Nurses should not be limited to monetary rewards only, but there should be awareness that effective teamwork in health care correlates positively with higher quality of care and staff motivation. Nurses with higher team work scores are considered to be more likely to be satisfied with their jobs, plan to stay in their present jobs and are likely to display lower burnout rates (Savič, Pagon & Rohda 2007:273).

Khatri et al (2007:133) argue that the motivation level of nurses is positively associated with the quality of patient care they provide. Those working in a commitment-based environment are said to assume more responsibility, have positive attitudes toward their work, become more actively engaged and committed to their work. Committed employees are regarded as having a higher degree of trust in their management, are more open to cooperation and support teamwork, all of which are essential and recommended for a seamless health care delivery process.

According to Schreuder and Coetzee (2006:126), nurses need to be recognised, be thanked and appreciated for providing care to patients which will in turn contribute to the improvement of the health care outcomes. Jooste (2003:90) indicates, as noted, that while a great deal of understanding has been gained about the motivation of health care professionals in the European countries, very little has been done in South Africa in this regard.

Berkow et al (2012:165) indicate that nurses are foundational to any organisational goal concerning patient care. Clear performance standards, granting staff autonomy in providing patient care actually drive nurses’ engagement. Employees who have control in their work are rated as experiencing higher levels of “work excitement”.

The EMM Performance Management Principles recommend that staff should be encouraged to be creative and invited to participate in decision making, improvement of the communication process through staff meetings, patient care activities and

team briefing meetings. Technical ability and adding to the nurses' knowledge are not sufficient in themselves to increase their motivation levels, but participation in decision making is regarded as a strategy that may be used to achieve a high level of motivation. It has been noted that being given an opportunity to plan and delegate care, solve problems, make decisions and conduct research are important factors for improving staff motivation.

Lawrence & Jordan (2009:104) indicate that professional growth opportunities and reasonable workloads allow adequate time for patient care; the potential for growth invents energy and excitement which leads to a joyful workplace and a strong sense of accomplishment.

2.2.6 Issues that may demotivate nurses

Issues such as lack of Nursing Job Motivation (NJM), including factors such as job difficulty, powerlessness, lack of autonomy, low income, lack of support, harassment and violence to nurses may demotivate them. The lack of a clear nursing job description has been identified as one of the issues that have a negative effect on the health and safety of patients (Oshvandi et al 2008: 434).

Mosadeghrad and Ferdosi (2011:122) suggest that nurses' motivation levels decrease when they are not empowered in their professional duties or do not engage in autonomous activities. They also state that when managers do not show concern for their employees, their job satisfaction and motivation declines.

Research demonstrates that changes perceived by employees as threatening are negatively related to job satisfaction and motivation, and these same issues are positively related to distress and absenteeism. Those changes experienced as challenging are said to be positively related to job satisfaction, motivation and eustress. Low general job satisfaction, followed by lack of praise from nurse managers, having to perform unprofessional work, an uncompetitive work environment and the lack of respect for the nursing profession by other health care professionals results in lack of interest being taken in their work by nurses and poor morale that may ultimately lead to unsafe patient care (Sveinsdottir & Blondal 2013:1).

Glass & Rose (2008:338) earlier observed that factors such as increased workloads, staff shortages and lack of resources all place additional pressure on PHC Nurses, which results in their demotivation. It is further argued that heavy workloads may have both positive and negative influence on nurses' work motivation. Aggregated job demands and exhaustion are also considered to significantly decrease the employees' motivation (Toode, Routasalo & Suominen 2010:254).

2.3 QUALITY CARE

Malaikas (2013: 8) describes quality care in terms of effectiveness and efficiency, the balance of health benefits and harm to a patient or client, as well as the appropriateness of care rendered. Quality comprises conformance with the set standards from the internal and external customers' point of view. It therefore exists to the degree that the service is efficient, well executed, effective and appropriate. Quality of care also addresses how well the work was performed.

Quality in health care further refers to the extent to which the organisations meet their clients' needs and expectations; it reveals the characteristics and pursuit of excellence, with excellence being established by determining whether the outcomes compare favourably to the standards that were set (Malaikas 2013:14). The National Department of Health points out that the provision of quality health care is a legitimate expectation in a democratic society, an essential safeguard in which the vulnerable are protected, with all citizens having an equal access to health care. The GDoH has stated its commitment clearly in The Framework for Quality Assurance (2011:7) as being to deliver quality health service through undertaking to treat patients with respect for their dignity, uphold equal treatment for all, ensure that all health care workers are adequately trained to deliver a quality health service, provide satisfaction for patients through the care they receive and use financial resources to achieve the greatest benefit to the public.

Adindu (2010:3) indicates that on a personal level, quality is described as something that satisfies one's expectations. Patients are said to receive quality care when the principle of the caring relationship is maintained between the patient and the nurse, with this principle being visible and evident in the care delivery process, and being based on the values and ethics of the nursing practice (Malaikas 2013: 8).

“Commit yourself to quality from day one...it’s better to do nothing at all than do something badly”.

Mark McCormack

In this context, Fort et al (2011:219) define quality care as the PHC Nurse’s ability to adhere to the National Clinical Guidelines in his or her treatment of all patients during each clinical encounter with patients made on demand to receive a preventive or curative service at the community clinic. The GDoH’s Framework for Quality Assurance for Health Institutions (2011) indicates that quality is the responsibility of all staff members in a health institution and should not be seen as a separate activity, but as a way of rendering services. It is recommended that quality should be regularly monitored and the findings used as a basis for quality improvement. Quality care, it emphasises, can only be delivered together with good governance, therefore well-developed systems and sub-systems are essential for quality patient care to occur.

It has been shown that over a period of 60 years, evaluation of the quality in health care has evolved into a dynamic and exciting modern science which is regarded as playing a significant role in patient safety, quality assurance, benchmarking and continuous quality improvement. Improved quality is reported to have a positive impact on patient and staff satisfaction, improving the efficiency and effectiveness of healthcare provision in both the public and private sector, which leads to increased trust in the health system (Whittaker, Shaw, Spieker & Linegar 2011:60).

Quality of care requires that health services provided by every health worker benefit patients without causing them any harm, and therefore demands attention to the needs of both patients and clients, using tested methods which are regarded as safe and affordable, that reduce deaths, illness and disability. It is therefore essential that all health care professionals should have standards for every practice, used to determine quality and performance (Adindu 2010:3).

According to Grace and Higgs (2010:945) the accepted principles of quality in health care include focusing of all health care interactions with the patient, customising treatment approaches to individual patient needs and values, as well as the provision of effective, safe and equitable health care. They further explained that indicators of

quality such as access and effectiveness are most meaningful in the context of health care provision to individuals, whereas equity, efficiency and cost are relevant in the provision of health care to populations.

Brewer (2006:240) points out that an important indicator of quality is meeting patients' needs. Nurses are required to be diligent in advocating for quality patient care. The provision of evidence of the quality of health care services has become the responsibility of all nurses. In the past, it was considered that quality in health care was judged by reputation, programme features, compliance with policies and procedures. These traditional methods are now said to fall short of providing the level of assurance that society currently demands.

According to principles of quality assurance, quality care is an essential part of health care. The health care consumer, be it the patient, family or community, deserves quality care. Health care providers therefore have the legal and ethical responsibility to deliver the best possible care. Quality of care in the health care services became an issue in the 1990's, with the objective set being to provide quality health care in the most appropriate health care setting, at the most economical cost (Malaikas 2013: 9).

Berkow et al (2012:165) argue that health care delivery reform has supported the formalisation of specific goals for health care institutions to deliver, which embrace high quality patient care. Nurses have to demonstrate a commitment not only to the delivery of excellent patient care, but also to the advancing of the larger institutional performance. PHC Nurses, being regarded as the critical providers of such care, are said to be vital to the success of any organisational goal, and those organisations that support the key components of accountability, such as holding staff to clear performance standards and staff autonomy in providing patient care, drive their nurses' engagement.

According to Malaikas (2013:28) there are basic concepts about quality in health care services which show that quality can be defined and measured both from the patients' as well as from the providers' perspectives. From the former perspective, regular national patient satisfaction surveys are conducted where these patients' views and experiences are used to assess the performance of the health services. Quality is regarded as dynamic as it develops by a process of continuous

improvement. Quality care relates to the nursing outcome because it is not what the nursing staff or health care services put in, but it is what the patients or clients get out of the service rendered. These surveys enable health establishments to assess their own progress and compare their performance with services elsewhere.

According to Shi, Starfield, Xu, Politzer and Regan (2003:789), quality care means the availability of ongoing care, the existence of a regular source of care and the characteristics of the interpersonal relationship between that source and the patient. Coordination of care requires some form of continuity, either by practitioners, medical record keeping or both, the recognition of problems that are addressed elsewhere and the integration of solutions for those problems into the total care of patients.

A policy on Quality in Health Care for South Africa (2007) advocates for improved access to quality health care by patients, creation of an environment in which quality care will flourish, increased patients' participation and greater dignity afforded to them, reduction of errors and increasing safety in health care, strengthening the hand of the user by promoting public and private partnerships, building the capacity to improve quality through training and professional development of health care professionals, ensuring the appropriate use of services, targeting quality assurance interventions which are aimed at health care professionals, patients, community and systems.

According to Curtis and O'Connell (2011:1), achieving and sustaining high quality patient care, which will result in containing costs, are important aspects of nurse managers' roles. It is noted that in order for managers to be successful, they should have the ability and skills to motivate and develop staff, as well as the ability to maintain a motivated work environment.

The American Society of Registered Nurses (2008:1) mentions that the nursing profession has in it the essential elements of accountability and autonomy, which means that the nurse is responsible professionally and legally for the nursing care provided. Being autonomous indicates that the nurse is reasonably independent and self-governing in making decisions in his/her practice. The availability of PHC Nurses is regarded as of fundamental importance in respect of their knowledge, skills, motivation and identification with the system, goals and values, as well as the

rendering of quality care (Mandel, Zimlichman, Ash, Mimouni, Ezra & Kreiss 2003:890).

In their work, Lambrou et al (2010:2) make it clear that in the health care service, the attainment of the health objectives in a population depends largely on the provision of effective, efficient, accessible, viable and high-quality services. They also mention that there is a strong association between efficacy and clinical supervision which is accompanied by trust, advice and support in the work environment. Efficacy of clinical supervision is also regarded as a significant predictor of job satisfaction and quality of care (Sveinsdottir & Blondal 2013:2).

Malaikas (2013: 8) argues that quality care in nursing is achieved when health care and nursing leadership further the professional practice of nurses as independently accountable professionals who meet professional standards. Quality in health care services accompanies the principle that quality is non-negotiable: organisations are to implement Continuing Quality Improvement Strategies to ensure compliance with standards that enhance the quality of service delivery.

According to Malaikas (2013:15), health care encompasses elements or perspectives of quality which form the basis of the National Core Standards developed by the NDoH as the six dimensions from the WHO. These elements comprise the so-called 3As and 3Es.

The 3As describe: Acceptability, Accessibility and Appropriateness:

- Acceptability requires health care professionals to supply correct information to patients; encourages patients to be involved in decision-making regarding the care that they receive and the acknowledgement of the patients' rights by health care professionals.
- Accessibility: health care facilities should be convenient to patients in terms of distance, transport, days and hours of health care provision when it is needed by the patients.
- Appropriateness: health care services should meet the patients' physical, psychological and social needs, and the services should be adjusted to the patients' age, knowledge and their abilities.

The 3Es describe: Effectiveness, Efficiency and Equity.

- Effectiveness: this element encourages the correct utilisation of equipment, accompanied by measurements and monitoring the set standards.
- Efficiency: indicates the skilful use of resources, advocates for the availability of medicines and other equipment when needed as well as using health care professionals' time efficiently in meeting a variety of needs.
- Equity: special services should be arranged to meet particular needs without discrimination towards patients by age, gender, disability, race, culture nor religion (Malaikas 2013:15).

2.4 QUALITY ASSURANCE

This is defined as a process oriented towards meeting the needs and expectations of the patients and the community. It is involved in taking positive actions to assess and evaluate performance against the agreed, defined standards in order to create and manage services and to detect that desired levels of quality are always present. The delivery of quality care in the public sector is considered to require a Quality Assurance culture and approach in order to achieve the desired outcomes, with its aim being to make services accessible, provide value for money, render good quality services and to constantly improve on the services rendered (Malaikas 2013: 15).

The GDoH's Framework for Quality Assurance for Health Care Institutions (2011) maintains that Quality Assurance focuses on systems and processes, uses data to analyse service delivery processes and encourages a team approach to problem solving and quality improvement. Its goal and objectives are to consolidate and encourage efforts by all stakeholders in the health care profession to improve the quality of care of patients by preventing, reducing clinical errors and improving hospitality and the standard of customer service. Quality Assurance programmes are developed to support health care institutions in the rendering of quality patient care, to monitor and to make recommendations for the improvement of quality care in health care institutions in order to identify strengths and weaknesses and act as the basis for quality improvement.

Khatri et al (2007:137) note that quality of patient care cannot be managed by creating a separate quality assurance department, but must be integral to the health care delivery process. They therefore recommend that management should establish a commitment-based management approach by emphasising employee participation, cooperation, information sharing and teamwork, which will focus on quality of care without a separate department or mandate.

2.4.1 Principles of quality assurance

The GDoH's Framework for Quality Assurance for Health Care Institutions (2011) further makes mention of the fact that quality should not be seen as a separate activity, but as a way of rendering services with the expectation that quality should be each health care professional's responsibility. Well-developed systems and sub-systems are recommended because they are regarded as essential for quality patient care to occur. Monitoring and evaluation of the care provided is very important as the findings are used as the basis for quality improvement, leading to the development of standards of care, which are the foundation of any quality assurance programme. Good governance in facilities leads to the delivery of quality patient care that can be created and sustained in health care institutions.

2.4.2 Legal and policy framework

The GDoH indicates that the documents which inform its Quality Assurance Framework are:

- Section 27 of the Constitution of South Africa
- Access to Information Act No 2 of 2000
- The Public Services Act of 1994
- The Patient Rights Charter
- The Batho Pele Principles
- The National Department of Health's policy on quality assurance
- The Hospital Ordinance No 14 of 1958 as amended
- The Gauteng Provincial Health Bill
- The District Health Services Act of 2000
- The Strategic Plan of the Gauteng Department of Health
- The Health Act No 61 of 2003

- Diverse Practice Acts of health professionals e.g. Nursing Act

2.5 QUALITY MONITORING

2.5.1 Quality monitoring through structures of governance

2.5.1.1 The Office of Standards Compliance

The National Core Standards (NCS) have been developed in recent years as a mode of increasing public sector attention to improving quality of care and on the setting of standards of health care. Section 30 (2)17 of the National Health Act (No 61 of 2003) relates to the District Health System and it states that services rendered must have due regard to the principles laid down in the Constitution of South Africa (Sections 27 and 195) 18 as well as inter alia, quality, effectiveness and efficiency (Malaikas 2013: 11).

Malaikas (2013:11) adds that the NCS were developed to set a common definition of the care which should be found in all health care establishments in South Africa as a guide to the public, health facilities' managers and staff at all levels. The NCS were established as a benchmark against which public health establishments may be assessed, gaps identified and strengths appraised. The National Department of Health's policy, Quality in Health Care for South Africa (2007), mentions that the NCS are the basis for quality and achievement of compliance where these standards will assist in proactively putting the systems in place to avoid the most important risks to quality care, or to reduce their impact.

The NCS for health establishments in SA are intended to reflect the NDoH's vision for SA and focus on what needs to be done to meet that vision. These standards are based on the existing policy environment, and therefore tailored to suit SA's health care context, reflecting international best practice. The NCS document reflects what is expected and what is required in order to deliver decent, safe and quality care, and is complemented by a set of measurement tools to assess compliance with these measures (Malaikas 2013:12).

The South African PHC Supervisory Manual indicates that PHC facilities are supposed to receive a supportive monitoring visit at least once a month to assist personnel, to monitor the quality of service and to identify needs and priorities. It is

recommended that each PHC facility should have at least one PHC trained nurse, while doctors and other specialised professionals should be accessible for consultation, support and referral. Mechanisms should be available for monitoring of services and quality assurance which is accompanied by at least one annual service audit to ensure compliance with the National Norms and Standards, all these being done to ensure quality care.

The PHC Supervisory Manual further indicates that Standard Treatment Guidelines (STGs), Essential Drug List (EDL) manuals, all relevant National and Provincial Circulars and Policy documents, Acts and Protocols that have influence on service delivery should be readily available in PHC facilities to ensure quality of care. The availability of Patients' Rights and Responsibilities Charter, Batho Pele documents, supplies of appropriate Information, Educational and Communication (IEC) health material in local languages is required. The competence of the health care personnel, organisation of the health care facilities to reduce long waiting times and the availability of medical supplies and equipment are regarded as very important in the provision of quality care. This supervisory manual was developed to support programme managers as well as the facility managers in their specific roles.

2.5.1.2 The Provincial Inspectorate for Health Establishments

A Policy on Quality in Health Care for South Africa (2007:19) indicates that the Provincial Health Departments are responsible for the control and improvement of the quality of all health services in their provinces. This strategy is to be achievable by utilising their respective Inspectorates for Health Establishments, Provincial Health Councils, Provincial Consultative Bodies (PCB) and the District Health Councils (DHC). Each Provincial Health Department (PHD) is expected to establish a dedicated unit to manage all provincial initiatives regarding quality assurance and continuous quality improvement.

2.5.1.3 Hospital Boards and Clinic Committees

Every hospital and PHC facility is expected to establish a board or committee with members from their local communities and from management. These boards and committees are responsible for dealing with matters relating to the quality of care provided to the community. PHC Committees, better known as Clinic Committees,

are appointed by the Members of Executive Council (MEC's) for the Departments of Health in the various provinces to serve as community representatives in the PHC Facility Committees (PHCFC) on a three year basis. These committees are established in terms of Section 42 of the National Health Act, no. 61 of 2003, with their main objective being to assist the PHC facilities in addressing the health needs of their local communities, as well as ensuring accountability and effective management of the facilities (A Policy on Quality in Health Care for South Africa 2007:21).

Clinic committees have as their roles the promotion of the mission, vision and the values of the Department of Health, and they ensure that appropriate measures are taken by management to improve the performance and quality of service. They also ensure that measures are in place to address the needs, concerns and complaints of clients and communities and that are properly managed. Clinic committees foster community participation and accountability and to provide information about the facilities, including services, programmes and campaigns of the department (A Policy on Quality in Health Care for South Africa 2007:21)

2.5.2 Quality monitoring by the provider of services

2.5.2.1 Staff satisfaction survey

This is the process through which information on the experiences and views of health care providers is gathered and used to identify those aspects that impact negatively on the quality of care being provided. These surveys usually run in tandem with the national patient satisfaction surveys (Malaikas 2013:29).

2.5.2.2 Clinical Audit

According to Malaikas (2013:30), it is recommended that all health professionals at all levels of care should participate in clinical audits. Clinical audits are regarded as essential in patient care because they bring together professionals from all divisions of health care, consider clinical evidence, promote education and research, develop and implement clinical guidelines, enhance information management skills and contribute towards better management of resources.

Clinical audit teams are established to determine what aspects of current work are to be considered for auditing, to describe and measure current performance trends, develop standards if not available, decide upon what needs to be changed, negotiate change, effect change through the mobilisation of resources as well as the review and renewal of processes (Malaikas 2013:31).

2.5.2.3 Supervisory visits

These are undertaken by facility supervisors at a pre-scheduled time on a monthly basis. Clinic supervisory visits follow a formal format, and these visits will ensure that aspects such as provision of support in solving problems, reviewing individual performance, monitoring of clinic services and inspecting mandatory or statutory functions are covered (Malaikas 2013:32).

The PHC Supervision Manual developed by the NDoH indicates that there is a renewed focus which is placed on strengthening the delivery and improving the quality of PHC services, and is considered the cornerstone of the National Health Care System. A structured supervision strategy is adopted in the collective quest for improving the quality of PHC. Issues such as patients' access to PHC facilities and the reduction of errors in the quality of service are addressed through the provision of information about training and professional development to promote capacity that will improve delivery of quality care, identifying and responding to the PHC providers' and users' needs.

PHC supervisors are encouraged to identify issues that need to be addressed in order for them to be able to drive the PHC in the most effective direction. It is recommended that for this purpose, the supervisor should be able to facilitate healthy teamwork and promote healthy working relationships among all structures of the PHC system. The PHC manual ensures solid quality provision of care in PHC facilities by providing a guide to structured supervision that is evidence-based and whose requirements are able to be implemented and measured.

2.5.2.4 Facility based quality teams

These are established to facilitate consistent local action to ensure that national standards and guidelines are reflected in the delivery of services. Such teams are responsible for improving quality care and for resolving problems. They employ

various principles that include a focus on user needs, on systems and processes, on data-based decisions, participation, teamwork and on leadership (Malaikas 2013:27).

Malaikas (2013:27) further points out that user needs and desires are central in the planning and performance of any activity. External users are the beneficiaries of the health care services whereas internal users are those within the organisation who rely on fellow workers for products and services that assist them in the fulfilment of their part in the provision of quality care to the external users.

A focus on systems and processes concentrates on those procedures that function together such as the supply chain of medicines. The spotlight on data-based decisions falls on acquiring information about how they function in order to improve processes. A focus on participation and teamwork involves ensuring that all health workers participate in making changes in their facilities. The concentration on leadership deals with its development and nourishment to ensure that each district and each hospital has a group of leaders and managers available (Malaikas 2013:28).

2.5.3 Quality monitoring by professional bodies

2.5.3.1 The South African Nursing Council

The Nursing Act's 2005 (Act No.33 of 2005), Objects of the Council, addresses the issues of serving and protecting the public in matters involving health services generally and nursing services in particular, ensuring that they perform their functions in the best interests of the public and in accordance with National Health Policy (NHP). Such services should promote the provision of nursing services to the inhabitants of the Republic of South Africa (RSA) that comply with universal norms and values, establish, improve and control the conditions, standards and quality of nursing education and training. They should also maintain the professional conduct and practice standards for practitioners within the ambit of any applicable law, and uphold and maintain professional and ethical standards within nursing.

2.5.4 Quality monitoring by the user of services

2.5.4.1 A National Complaints Procedure

The Policy on Quality in Health Care for South Africa (2007:19) indicates that all users of health services within the National Health System are entitled, personally or by representative, to obtain a full explanation and a speedy and effective remedy for a professional or other fault from a public, private or non-governmental health establishment. Health care institutions have an established National Complaints Procedure (NCP) that is upheld by their governing bodies, directors or employees and their health care providers. This NCP allows for the resolving of complaints at the point of service delivery, as well as referral of the unresolved complaints, and provides feedback on the outcome of the procedure. Use of feedback from patients' complaints should improve services.

2.5.4.2 A National Patient Satisfaction Survey

According to the Policy on Quality in Health Care for South Africa (2007:20), it is mentioned that a National Patient Satisfaction Survey run simultaneously with the National Staff (Provider) Satisfaction Survey where the information on the experiences and views of health care providers will be collected and used to identify those aspects that negatively impact on the quality of care that is being provided. Aspects of the patient surveys include the assessment of compliance with standards that relate to the National Patients' Rights Charter. These surveys are regarded as important because they enable health establishments to assess their own progress and to compare their own performance with services elsewhere. It is recommended that the results of these surveys be published in the national reports are made available to the public.

2.6 CONCLUSION

Recognition of professional identity by both the employer and members of the community is an important motivating factor for health care staff. Many PHC Nurses are said to be proud to be nurses, are proud of their ability to cope, but are frustrated that this is not formalised or recognised. Each staff member, it is argued, needs to be valued, supported and assisted to develop in their roles. The main factors that are mentioned earlier may cause demotivation among healthcare workers, especially PHC Nurses.

CHAPTER 3

RESEARCH DESIGN AND METHOD

3.1 INTRODUCTION

In this chapter the researcher demonstrates in a theoretical and practical manner how she achieved the specific objects of the study. A wide range of research-related factors such as the research problem, purpose of the study, research questions, research design and method, as well as data collection and the analysis procedures influenced and shaped the extent of the study's achievement (Botma, Greeff, Mulaudzi & Wright 2010:41).

3.2 RESEARCH DESIGN

The research design guides a researcher in planning and implementing a study in a way that is most likely to achieve the intended goal. According to Sibanda (2009:6), an appropriate study design is essential in ensuring the validity of the results that the researcher will eventually report. The control provided by the design is described as increasing the probability that the study results are accurate reflections of reality (Grove, Burns & Gray 2013:43). According to Fouché, Delpont and de Vos (2010) cited in de Vos et al 2011:143), a research design is defined as a plan outlining how observations will be made and how the researcher will carry out the project. In this study, the researcher used a quantitative research design to explore and describe factors that motivate PHC Nurses to render quality care at the Ekurhuleni health care facilities in the Northern Region. Such research designs focus on gathering numerical data and generalising it across groups of people. For this research study, a descriptive quantitative survey was adopted to capture the characteristics of the phenomenon under study (Grove et al 2013:224).

3.3 RESEARCH METHOD

As a research component, the research method involves the conduct of experiments, tests and surveys and aims at finding solutions to the research problems. The methods and procedures used for this study included the development of a data collection instrument, conducting a pilot study, identification of the population,

sampling and data collection as well as testing of the reliability and validity of the measurement tool (Botma et al 2010:174).

3.3.1 Population

A population is defined as the entire group of persons or objects which are of interest to the researcher, or that meet the criteria the researcher is interested in studying. The population is further defined as the totality of persons, events, organisation units, case records or other sampling units with which the research problem is concerned (Strydom (2010) cited in de Vos et al 2011:223).

The targeted population for this study, as mentioned, were the PHC Nurses with two or more years' experience as such nurses, working in the PHC facilities in the EMM in the Northern Region (Kempton Park, Tembisa & Edenvale). The given region was the most suitable research site as it was easily accessible to the researcher. In 2012, the entire Northern Region consisted of a total universe of 202 registered nurses, of which 96 were PHC trained nurses, including those who had completed the PHC certificate course or the PHC Diploma. This comprised the target population for the study. The said region consists of 16 fixed PHC facilities and one mobile clinic (Ekurhuleni Metropolitan Municipality Annual Report 2011/2012).

It was anticipated that the target population would yield sufficient information with regard to the variables under study, to facilitate understanding of the PHC Nurses' viewpoints and to clarify the rendering of quality care in the Ekurhuleni health care facilities.

3.3.1.1 Sampling

Sampling is the process of selecting subjects, events, behaviours or elements for participation in a study (Grove et al 2013:37). It is defined as taking a portion or a smaller number of units of a population as representative or as displaying a particular characteristic of that population. Sampling is studied in an effort to understand the population from which it was drawn because complete coverage of the total population is seldom possible. As described above, in this study, not all the members of the population of interest could be reached due to logistical reasons. The notion behind the sampling theory is that a small set of observations can give an idea of what can be expected in the total population of the intended study as the

quantitative paradigm focuses on randomisation, generalisability, representativeness, and both probability and non-probability sampling techniques (Strydom in de Vos et al 2011:222).

In order to establish the representativeness of the research respondents, a targeted research population had to be obtained as not all the PHC Nurses in the EMM could participate in the research study due to distance and time constraints. A considerable effort was made by the researcher to ensure that the sample extracted from the population was as representative as possible. A non-probability sampling method was used in this study, and a purposive sampling technique was adopted.

3.3.1.2 Inclusion criteria

Grove et al (2013: 352) explain the inclusion sampling criteria as the characteristics that a subject or element must possess to be part of the target population. In determining potential subjects, key inclusion criteria were applied:

- That the study respondents be qualified PHC Nurses working in any of the PHC facilities in the Northern Region of the EMM.
- That the study respondents had worked as PHC Nurses for at least two years or more in the EMM.

3.3.1.3 Exclusion criteria

The exclusion sampling criteria are those characteristics that may cause a person or element to be excluded from the target population (Grove et al 2013:352). In this study, the exclusion criteria were:

- Those subjects who did not have the required qualification or the level of experience within the PHC facilities in the Northern Region of the EMM, as well as all the subjects in the Eastern and the Southern Regions.
- Facility Managers (Clinic Heads), Nursing Service Managers and Executive Managers were excluded because they did not comprise a category of PHC Nurses who render direct nursing care to patients on a daily basis.

3.3.1.4 Sample

According to Strydom (2010) cited in (de Vos et al 2011:224), a sample comprises the elements or a subset of the population considered for actual inclusion in the study. The term “sample”, is regarded as implying the simultaneous existence of a population or universe of which a sample is a smaller section, or a set of individuals selected from the population.

Researchers are encouraged to work with samples of their study subjects rather than full populations. In order to generalise from the sample to the population, the sample should be representative of the population, and if it is realised that the sample is not representative of the population, selection bias is said to be a possibility (Strydom (2010) cited in de Vos et al 2011:224).

Out of 16 fixed PHC facilities in the Northern Region, five were identified to form part of the sampled facilities for the pilot study, two were in the Kempton Park area, two in the Tembisa area and one in the Edenvale area, and the main study was conducted in the remaining eleven PHC facilities.

As described, in this study the entire population was 202 registered nurses; of the said target population of 96 PHC trained nurses, 12 PHC trained nurses were sampled to participate in the pilot study. Of the 59 PHC Nurses in the sample, only 54 participated in the study. During the period when the questionnaires were collected back by the researcher, it was discovered that two study respondents had lost their questionnaires, one was on sick leave for six weeks and did not submit his/her questionnaire, while two declined to participate in the study when approached by the researcher at the onset of the data collection stage.

3.3.2 Data collection

According to Botma et al (2010:131), data collection is defined as the precise and systematic gathering of data to be able to resolve the research question. According to Matthews and Ross (2010:181), data collection is a practical activity carried out within time, spatial and resource constraints. In this study, the researcher compiled a self-administered, structured questionnaire as a data collection instrument. A questionnaire is defined as a printed self-report form designed to elicit information that can be obtained from a subject's written responses. The questionnaire was

developed to help the researcher to organise and manage the task of data collection (Matthews & Ross 2010:182).

The advantages of this data collection method are that large amounts of data may be gathered in a relatively short period; that is, within reasonable limits of time using the available resources. Having ensured the validity and the reliability of the instrument, the researcher was confident of the quality of data produced. The anonymity offered by the data collection instrument, she argues, was presumed to have improved the honesty with which the study respondents answered the questions. The disadvantages of the data collection method were that not all questions were answered (Botma et al 2010:135).

According to Matthews & Ross (2010:206), designing a questionnaire entails working out how the researcher is going to measure the presence of something and the practicalities of finding a set of questions and answers that will enable him/her to ask questions that are meaningful to and answerable by all the research respondents. The nature of data collected determines how the researcher will be working with it during the analysis stage. Categories of data collected in this study included items such as age, which was grouped in ten year intervals, (e.g. 20-29, 30-30), gender, race, years of service at EMM as well as PHC Nurse qualifications. The questionnaire also provided a section in which the respondents were asked to choose from a list of possible answers, e.g. Yes/No/Not Applicable and Refused to answer. Another category of questions was designed in such a way that the researcher was able to ask questions about respondents themselves and their work environment, in such a manner that it was easy for the latter to give the data accurately. The respondents' ideas, values and opinions were determined by whether they agreed or disagreed with the statements devised. A number of statements on a particular topic were made to find out how the respondents thought or felt about particular situations (Matthews & Ross 2010:209).

Using the questionnaire, the researcher was able to collect the primary data from the respondents during her absence where they had to complete the questionnaires alone during their spare time. The researcher ensured that they were supplied with detailed instructions for completing the questionnaires, and were provided with the relevant information they needed in order to be able to produce the requested data.

This included a comprehensible description of the research, its aims and purpose, what would happen to the data, how data would be used, discussion on issues of confidentiality, as well as the development of a framework of recommendations that would be given to the EMM Health Department with regard to the study findings. This should have assisted in the building of trust between the researcher and the study respondents (Matthews & Ross 2010:184).

Data collection took place over the period April and May 2013. The researcher involved the respondents only as collaborators and all the respondents were treated equally. Respect for potential power imbalances and exploitation of respondents were maintained during the period of data collection where the researcher avoided disclosing sensitive information to them, avoided collecting harmful information and also withheld sharing personal impressions with them. The PHC facilities where the respondents were based were respected in such a manner that as few disruptions as possible were created by the researcher during working hours (Creswell 2014:93).

3.3.2.1 Development and testing of the data collection instrument

This questionnaire served as a blueprint of specifications that identified the essential content to be covered by it (Grove et al 2013:426). The researcher ensured that the questionnaire was designed in such a fashion that it would most effectively collect data that could “stand in” for the social experience it represented, because data were collected in categories and groupings of the respondents. Time and attention were given to the preparation of the questionnaire (Matthews & Ross 2010:183).

Designing the questionnaire was the most important stage for the researcher during the research process, as it was designed after the researcher had determined the questions and the answers to be included in the questionnaire. This was because she would have been unable to go back and obtain further information after the respondents had completed their questionnaires. The researcher ensured that the questions asked would gather the appropriate data needed for the research. The researcher kept on referring back to the operational definitions in the study (Matthews & Ross 2010:206).

Firstly, the researcher identified the information to be covered. Secondly, she undertook a literature search regarding questionnaires and the relevant items to be

included, and a Needs Assessment Questionnaire (NAQ) compiled by Lawrence and Jordan (2009) was identified as suitable for this type of study. Permission was sought and granted from the McGraw Hill Companies to use this questionnaire as a “borrowed” questionnaire (see Annexure E). Poorly written statements were modified. The questionnaire was adapted to suit the area where the study was conducted (Grove et al 2013:426).

Items on the questionnaire covered two dimensions: a stem and a response set that provided the parameters within which the respondent could answer. Each statement was carefully designed and clearly expressed. The response set was open and flexible, as is typical of open-ended questions, but was also narrow and directive as is typical of closed-ended questions. The response set included a specific list of alternatives from which to select the answers (Grove et al 2013: 426).

Instructions were included at the beginning of the questionnaire; each instruction was piloted, and each contained clear instructions on how the respondents should answer. Statements related to a specific topic were grouped together, with general items being included first, progressing to items of more importance. A cover letter for the questionnaire was attached to explain the purpose of the study and identify the researcher, the approximate time required to complete the questionnaire and the organisations supporting the research (Grove et al 2013:427).

According to Matthews & Ross (2010:216), a newly developed questionnaire must be pre-tested before the actual data gathering commences. An expert who is knowledgeable about questionnaire construction was given the questionnaire to evaluate it to determine whether the sequence of the items was sensible; he evaluated the questionnaire for content-related validity, including face validity, construct validity as well as the readability of the instrument. Additional space was made available to allow him to indicate what he understood, whether anything was unclear to him, and to write comments. The questionnaire was pre-tested involving 12 PHC Nurses who were not included in the main study, in order that they could help to identify issues of validity and other problems with the questionnaire which could be changed prior to the main study; also, to determine the clarity of questions, effectiveness of the instructions, completeness of the response sets, time required to complete the questionnaire and the success of the data collection technique. As is

typical of any pilot study, the respondents and techniques used were as similar as possible to those planned for the main study.

3.3.2.2 Characteristics of the data collection instrument

A structured questionnaire was compiled, which collated basic background information about the respondents such as their ages, years of experience and their educational level. Specific aspects such as their knowledge, perceptions and information that cannot be easily observed or measured were included in the questionnaire. This took the form of a Likert scale with declarative statements (Botma et al 2010:133).

The questionnaire was in English and consisted of three sections. Careful planning was done regarding how the questionnaire items would be ordered. Section A contained biographical information while Sections B and C dealt with motivation and quality care respectively (Grove et al 2013:425).

A covering letter, in which the status, contact details of the researcher and the purpose of the study were explained, accompanied the questionnaire. Reasons were provided as to why the specific respondents were chosen. The anonymity and confidentiality of the respondents were emphasised. Reference was also made to the ethical approval of the study (Botma 2010:137).

3.3.2.3 Data collection process

Grove et al (2013:45) define data collection as a precise, systematic gathering of information relevant to the research purpose or the specific objectives, questions or hypotheses of a study. The basic principles of respect for people, beneficence and justice were honoured.

The individual PHC Nurses who were study respondents were issued with a questionnaire each, to complete at home during their spare time. These were discussed with them to clarify any questions they might have. The researcher gave the respondents a target date for when she would collect the questionnaires. These offered a unique opportunity for the researcher to explore issues relating to PHC Nurses working to the principles of PHC, the factors that motivate them and their rendering of quality care (Botma et al 2010:133).

3.3.3 Data analysis

According to Grove et al (2013:46), data analysis is the process by which the researcher reduces, organises and gives meaning to the research data. In this study, a formal data-analysis plan was designed before the study was conducted. Data management began when the batch of the pilot study questionnaires was returned; a coding frame was developed and the researcher received a pre-coded computerised tool from the abovementioned research expert in preparation for the numerical data analysis (Saks & Allsop 2013:200).

The development of the coding frame as well as its operationalisation served as a method whereby the data collected were translated from the respondents' answers to the survey questions to a database where aggregate data were analysed. The researcher developed the coding frame based on the questions asked. The completed, returned questionnaires were entered into an Excel spreadsheet (a trademark of Microsoft Office System), and the entered data was verified for accuracy (Saks & Allsop 2013:201).

All the variables on the coding frame had unique labels so that the researcher could easily identify them. She printed the data and checked against the original documents. Outliers were detected and corrected, missing data points were identified, obtained and added to make the data set complete (Botma et al 2010:148).

The statistician analysed the data using the Statistical Package for Social Sciences (SPSS Version 20), a trademark of IBM SPSS Statistics. A computer was used to perform the statistical analyses. The data were compared in the form of frequencies and cross tabulations and subsequently expressed in the form of percentages (Grove et al 2013:46).

Descriptive statistics were used to summarise the data set. The results are presented in a comprehensive visual format in the form of tables and graphs in Chapter 4; the measures used will be described in terms of frequency distributions, cross tabulation and percentages (Botma et al 2010: 149).

According to Botma et al (2010:149), univariate analysis, which includes the frequency distributions and the percentages to describe the variables of a study, allow the researcher to make descriptive inferences about the population. Based on

this approach the researcher was able to describe the variables of the study. Bivariate analyses in the form of cross tabulations were also used in this study to analyse two variables at the same time, in order to determine the empirical relationship between them. The analysis focused on the variables of the study as well as the manner in which the variables influenced each other (Botma et al 2010:160).

3.4 INTERNAL AND EXTERNAL VALIDITY OF THE STUDY

Botma et al (2010:174) define a study's validity as "the approximate truth of an inference". As validity is said to be always a matter of degree, not an absolute, it therefore indicates whether the conclusions of the study are justified based on the design and interpretation. Study validity provides a major basis for making decisions about which findings are sufficiently valid to add to the evidence base for research (Grove et al 2013:197). In this study, the researcher tried to understand if the theoretical proposition indicated an accurate reflection of the reality that the study was measuring, as well as whether the study was adequately designed to be able to provide a valid test of the proposition (Grove et al 2013:197).

Grove et al (2013:199) define internal validity as the extent to which the effects detected in a study are a true reflection of reality rather than the result of extraneous variables. In this study, the respondents were exposed to the questionnaire once and after completing it, they were not later allowed to modify their responses as this would have altered the outcomes.

External validity is concerned with the extent to which the findings may be generalised beyond the sample used in the study. The key issue is the degree to which the sample represents the population. The researcher used non-probability sampling to ensure a representative sample of the population. This sampling method gave all the PHC Nurses with two or more years' experience within the population an equal chance to participate in the study. The percentage of those who declined to participate was also taken into consideration as it might have influenced the findings (Grove 2013:202).

Botma et al (2010:174) mentions that because the data collection instrument had been used in previous studies, therefore indicated that issues regarding the validity of this instrument, the conclusions of the studies were justified based on the design

and the interpretation of the study results. The reliability of the instrument was represented by the consistency of the measures achieved. The instrument was applied to different groups under various circumstances yet produced the same results (Botma et al 2010: 177). In this study, the data collection instrument underwent pre-testing before data were collected in order to ensure its validity. The reliability of the method of measurement used was examined. The Cronbach's Alpha Coefficient was calculated and its value was 0.8001, which signifies that it is acceptable.

3.5

SUMMARY

This chapter described the research design, research method, population, sampling, ethical issues related to sampling, inclusion and exclusion criteria. It also discussed the sample, data collection, development and testing of the data collection instrument, characteristics of the latter, the data collection process, ethical considerations related to data collection and data analysis. Finally, it considered the internal and external validity of the study.

CHAPTER 4

ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESEARCH FINDINGS

4.1 INTRODUCTION

This chapter explains the means by which data were analysed, interpreted and presented. They were gathered by means of a self-administered, structured questionnaire. The items in the questionnaire reflected the respondents' views and opinions with regard to what motivated them to render quality care. Fifty-nine questionnaires were distributed to the respondents, of which 54 were returned. Therefore, the statistical analysis of the questionnaires was based on a response rate of (91.5%).

4.2 RESEARCH RESULTS

4.2.1 Sample characteristics

4.2.1.1 Age

The EMM PHC Nurses made up an age range of 20 years to over 60. The respondents' age groups were arranged in decades, e.g., 20-29, 30-39, 40-49, 50-59 and 60+, with the lowest being 20 years because there were no EMM PHC Nurses below the age of 20 years (Grove et al 2013: 551).

4.2.1.2 Professional registrations

All the respondents were registered with the South African Nursing Council as the legal registration body.

4.2.1.3 Highest nursing qualifications

A minority (26%) of the Registered Nurses had attained a PHC Diploma as their highest nursing qualification whereas (74%) of the Registered Nurses had obtained various nursing qualifications such as the Diploma in General Nursing Science, Midwifery, Psychiatric and Community Health Nursing as their highest qualifications, while (22%) had BA Nursing Degrees as their highest qualification.

4.2.1.4 Years of service working in the Ekurhuleni Primary Health Care facilities in the Northern Region

The EMM employs PHC Nurses who have varying years of service, ranging from six months to more than thirty years. As this study investigated those PHC Nurses with two or more years' service working specifically in the EMM, in the Northern Region, all others were excluded. As previously stated, 59 met the set requirements (Strydom (2010) cited in de Vos et al 2011: 223).

Table 1: STAFF COMPLEMENT OF PHC NURSES IN THE PHC FACILITIES IN THE NORTHERN REGION IN 2012

FACILITY	Total number	PHC trained	Not PHC trained
Winnie Mandela Clinic	20	8	12
Spartan Clinic	12	8	4
Kempton Park Civic Clinic	17	5	12
Bonaero Park Clinic	6	2	4
Birchleigh Clinic	7	5	2
Birchleigh North Clinic	7	4	3
Bedfordview Clinic	9	5	4
Edenvale Clinic	8	5	3
Tembisa Health Care Centre	15	8	7
Tembisa Main Clinic	18	10	8
Ethafeni Clinic	16	7	9
Itereleng Clinic	11	8	3
Endayeni Clinic	11	4	7
Esangweni Clinic	23	7	16

Erin Clinic	11	6	5
Olifantsfontein Clinic	11	4	7
Total	202	96	106

The figure below graphically represents the EMM PHC trained nurses and those not trained.

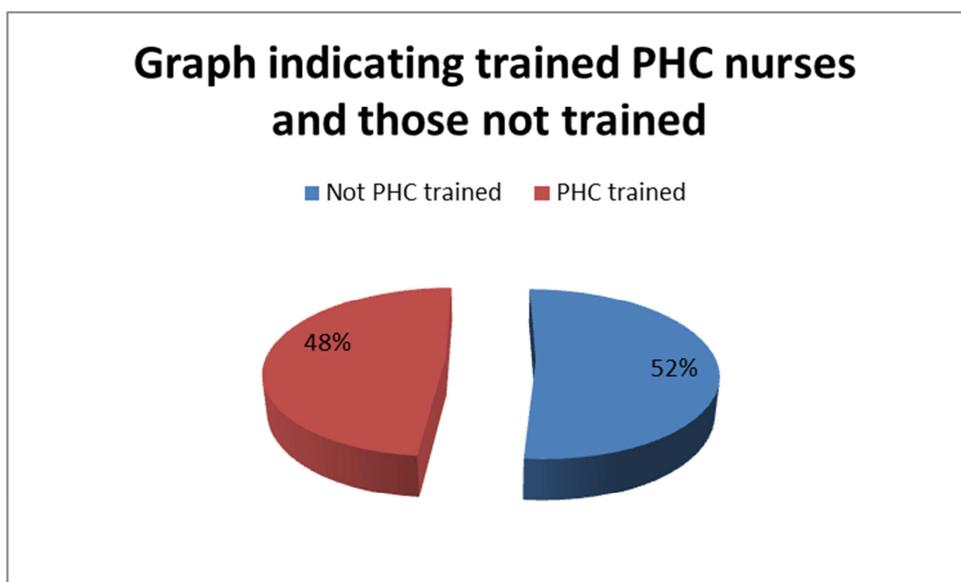


Figure 4.1: Graph indicating trained PHC Nurses and those not PHC trained (n=54)

A large proportion (52%) of the Registered Nurses in the PHC facilities in the EMM in the Northern Region are not PHC trained although (48%) are.

4.3 DEMOGRAPHIC DATA

Section A of the questionnaire dealt with the respondents' demographic data, which included their age, gender, race, years of service at EMM and their qualifications.

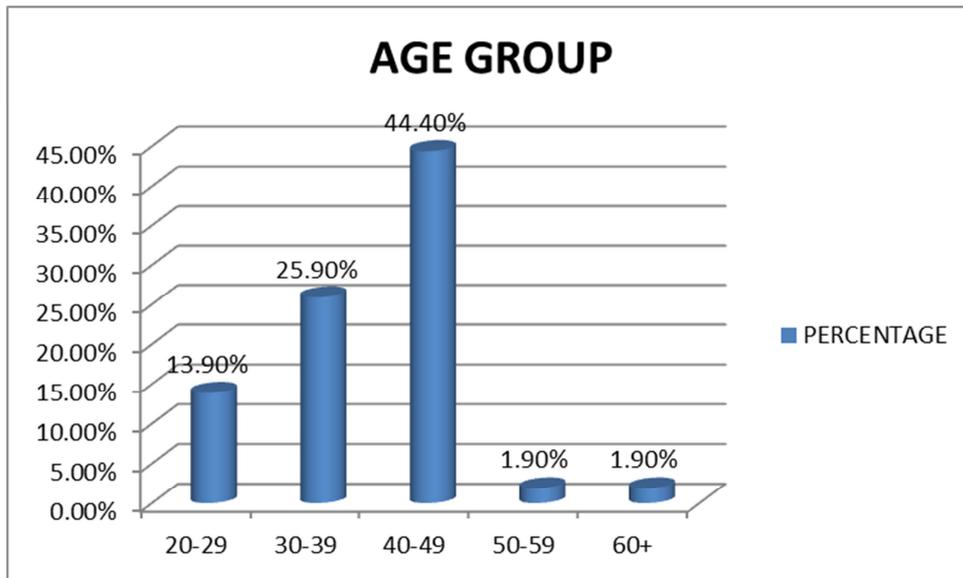


Figure 4.2: Graph indicating age groups (n=54)

The findings indicate that the respondents' age distribution ranged between 20 and 60+ years of age (Figure 4.2). Twenty-four (44.4%) of the 54 (100%) of the respondents were between the ages of 40 and 49 years old. A proportionately large percentage of respondents (25.9%) were between 30 and 39 years of age (Figure 4.2). The group comprising those less than 30 years old made up (13.9%) while the 50-59 year age group and the 60+ age group together comprise (1.9%) respectively. South Africa reported a population of 11679 PHC Nurses in the year 2012 (SANC 2012a).

Managers in the EMM Health Department should be aware of the aging population of the employees in the organisation and fast-track the training and the development of the younger generation to counteract any professional malaise. The aging of the nursing workforce has several implications for the organisation as they leave with their expertise and experience. Young professional nurses enter the nursing profession with a high degree of interest and motivation; therefore, managers are encouraged to ensure that the policies and procedures they have in place treat all employees fairly, regardless of their ages, to avoid rapid turnover among the skilled employees (Hampton & Hampton 2004:1043).

Turnover and absenteeism are recorded as highest among the young employees, especially when confronted with the grim realities of the excessive responsibility that accompanies the nursing profession. Lack of adequate authority and staff shortages

rapidly lead to diminution of their enthusiasm, causing these nurses to abandon the nursing profession for more agreeable occupations. Employers need to find ways to motivate and utilise the skills and knowledge of the older employees to guide the younger ones in various skills (Pillay 2009:3). The older workers are ready and able to meet their job requirements and are less likely to quit their jobs than the younger employees are. Organisational strategies on motivation should be aimed at retention of employees of diverse age groups, as they are able to learn from each other, work well together and take advantage of the different perspectives each has to offer (Jones & George 2009:438).

Findings by De Gieter et al (2009:2) indicate that after in-depth, semi-structured interviews were conducted with 20 Dutch-speaking nurses working in five Belgian private, non-profit hospitals, the findings are that older and more experienced nurses reported feeling significantly more rewarded by having job security and working for a hospital with a good reputation than their younger and less-experienced colleagues did. The younger and less-experienced nurses reported valuing rewards and promotion more than the older and more experienced colleagues have.

In another study by Jolner and Hafner (1983) cited in De Gieter et al (2009:4), the study findings revealed that the older and more experienced nurses in their sample expressed a higher preference for the retirement reward and additional health insurance than the younger ones. On the other hand, the younger and less experienced nurses revealed an obvious preference for more days off. Another aspect, which is important to note, is that employees in their early adulthood value future career success and status while late adulthood is often regarded as time for reflection, combined with a desire for financial security after retirement.

Koivula et al (1998) cited in Toode et al (2010:250), in a study conducted by the former, in Finland, revealed that nurses under 30 years of age displayed higher motivation than that of their older colleagues.

The figure below graphically represents the gender of the PHC Nurses in EMM.

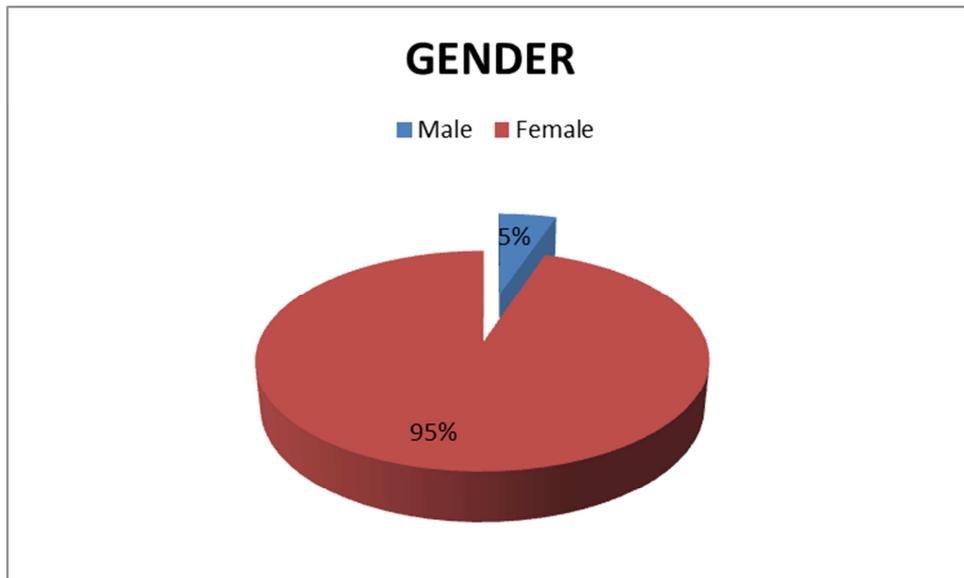


Figure 4.3: Graph indicating gender (n=54)

The current study discovered that the gender distribution of the 54 (100%) of respondents was female (n=51, 94.4%) while (n=3) (5.6%) were male (Figure 4.3). Of the 11679 PHC Nurses in South Africa in 2012, 10804 were females while 875 were males. EMM Northern Region had 3 trained male PHC Nurses in 2012, which represents (0.34%) of the male PHC trained nurses in South Africa, according to the referenced statistics. There were 51 female PHC Nurses in EMM Northern Region making up (0.47%) of the total number of female PHC Nurses in the whole of South Africa, according to statistics (SANC) (2012b)

Males and females were not equally represented in the EMM work force. This might still be due to the stereotypes that were long held where nursing was regarded predominantly as a female profession. Men still do not enter the nursing profession in large volumes due to the nursing profession earning its practitioners less respect than that accorded to members of other health occupations, because of the effect of sex discrimination. Gender stereotypes perpetuate the belief that different traits and abilities make men and women particularly well suited to different roles (Jones & George 2009:427).

According to De Gieter et al (2009:3), in their study conducted in Belgium in 2006, which was undertaken to identify nurses' response to rewards, it was revealed that rewards play an important role in organisations where they influence a variety of work-related behaviour as well as the motivation of employees. The study further

revealed that the majority of the nurses who participated in it indicated that they perceived their monthly pay as a reward for the job, which suggested that it was important for them that their salary was adequate. Gender seemingly did not have any effect on the importance of reward as no significant difference in reward perception was found between male and female nurses. All the nurses, male and female, were motivated by the same characteristics of nursing that included a competitive monthly salary, recognition, rewards and promotional opportunities (Toode et al 2010:254).

The Equal Employment Opportunity (EEO) principle dictates the equal right of all citizens to have the opportunity to obtain employment regardless of their gender, age, race, religion or disabilities. The local, state and national laws and regulations that managers and organisations must abide by, add to the complexity of human resource management (Jones & George 2009:427). Affirmative action measures are designed to ensure that suitably qualified people from designated groups are accorded equal employment opportunities and are equitably represented in all occupational categories and levels in the workforce of a designated employer (Employment Equity Act No 20 of 1998).

According to Pillay (2009:2), in a study he conducted in 2008, to determine the work satisfaction of professional nurses in South Africa, the results revealed that public-sector nurses, both male and female, were most dissatisfied with their pay, the workload and the resources available to them. The social context of their work was the only area in which they indicated satisfaction. Private-sector nurses, also both male and female, indicated dissatisfaction with regard to their pay and career development opportunities.

Given these factors that are regarded as dissatisfiers in the nurses' professional lives, and given the pivotal role that nurses play daily in determining the efficiency, effectiveness and sustainability of health care systems, it is therefore important for health care organisations to understand what motivates nurses and the extent to which the health care organisations and other contextual variables satisfy them.

The figure below represents the race of the PHC Nurses in EMM.



Figure 4.4: Graph indicating race (n=54)

The study findings indicate the race categories where 50 (92.6%) of the 54 (100%) respondents were Black, 2 (3.7%) were White and 2 (3.7%) were Coloured respectively. Race is defined as each of the major divisions of humankind, based on particular physical characteristics (South African Pocket Oxford Dictionary (2004). The decreasing racial diversity of the EMM workforce underscores the importance of effectively managing diversity. Racially diverse employees must be provided with equal opportunities. According to Jones and George (2009:154), managers and organisations are therefore increasingly reminded that stakeholders in all environments and different sectors are diverse and expect organisational decisions and actions to reflect this diversity.

An organisation's diversity in terms of its members can be a source of competitive advantage where it helps the organisation to provide customers with better goods and services. Effective management of diversity can effectively affect profitability in a way that increases retention of valued employees, which in turn decreases the costs of hiring replacements for those who leave, as well as ensuring that all employees are highly motivated (Jones & George 2009:154).