IMPLEMENTATION OF CUSTOMER CARE AT THE CASUALTY DEPARTMENT OF EDENVALE REGIONAL HOSPITAL IN GAUTENG PROVINCE

By

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DECLARATION

I declare that IMPLEMENTATION OF CUSTOMER CARE AT THE CASUALTY DEPARTMENT OF EDENVALE REGIONAL HOSPITAL IN GAUTENG PROVINCE is my own work and that all the sources that I have used or quoted have been indicated and acknowledged by means of completed reference and that this work has not been submitted before for any degree at any other institution.

JKA Buthelezi

Signature

January 2017

Date
ACKNOWLEDGEMENTS

I give thanks and praise to God for having proven to me that with Him everything is possible. Therefore blessed be the Lord who daily provides us with benefits. Psalm 68:19.

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ABSTRACT

The study aimed to investigate the implementation of customer care at the Casualty Department of Edenvale Regional Hospital in Gauteng Province. The research was conducted using a qualitative case study approach, which sought to gain deeper understanding of the impact of customer care in the hospital’s Casualty Department from the employees’ point of view. Data was collected from 16 purposively selected respondents using semi-structured interviews and document analyses were interpreted by the researcher to give voice and meaning to the assessment topic. Data was analysed using the Content Analysis framework and six themes emerged from the data analysis: (1) High expectation levels from the community; (2) Quality of patient care; (3) Lack of resources; (4) Malfunctioning equipment; (5) Compromised safety and security; (5) Strategies to improve customer care; and (6) The effect of policies and guidelines on the quality of services rendered. The study revealed that the surrounding community that is served by the Edenvale Hospital’s Casualty Department had high expectations which the hospital was unable to meet because of the many limitations, especially resource constraints. The issues and difficulties associated with overcrowding in the emergency section were raised by respondents, who reported several challenges experienced in the hospital. These included patients sleeping on floor mattresses and even on stretchers, inadequate beds, shortage of staff, malfunctioning equipment and lack of sufficient infrastructure. These challenges resulted in long waiting periods for patients to be given open beds in the wards, bad attitudes from both patients and employees alike, poor communication among staff and patients and their families, and an unsafe environment for the staff and customers (patients). There is hence a need for the Gauteng Health Department together with the hospital management to review resources allocated to the Edenvale Regional Hospital and to increase awareness among the community about the operations of the level 2 hospitals such as this.

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<table>
<thead>
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<th>Description</th>
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<tbody>
<tr>
<td>ANC</td>
<td>African National Congress</td>
</tr>
<tr>
<td>ASSADPAM</td>
<td>Association of Southern African School and Department of Public and Management</td>
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<tr>
<td>BOR</td>
<td>Bed Occupancy Rate</td>
</tr>
<tr>
<td>CRM</td>
<td>Customer Relationship Management</td>
</tr>
<tr>
<td>DA</td>
<td>Democracy Alliance</td>
</tr>
<tr>
<td>DHMIS</td>
<td>District Health Management Information System</td>
</tr>
<tr>
<td>DOH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DPSA</td>
<td>Department of Public Services and Administration</td>
</tr>
<tr>
<td>EDWIN</td>
<td>Emergency Department of Work Index Number</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>LOS</td>
<td>Length of Stay</td>
</tr>
<tr>
<td>NHI</td>
<td>National Health Insurance</td>
</tr>
<tr>
<td>NHIS</td>
<td>National Health Insurance Scheme</td>
</tr>
<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
</tr>
<tr>
<td>ID</td>
<td>Identity</td>
</tr>
<tr>
<td>IPAA</td>
<td>Institute of Public Administration Australia</td>
</tr>
<tr>
<td>SARS</td>
<td>South African Revenue Services</td>
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<tr>
<td>OPD</td>
<td>Outpatient Department</td>
</tr>
<tr>
<td>OPSR</td>
<td>Office of Public Services Reform</td>
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<tr>
<td>PERSAL</td>
<td>Personnel and Salary Administration</td>
</tr>
<tr>
<td>QA</td>
<td>Quality Assurance</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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CHAPTER 1: GENERAL INTRODUCTION

1.1 INTRODUCTION

The study investigated implementation of customer care at the Casualty Department of Edenvale Regional Hospital in Gauteng Province. This chapter provides a background to the study, including the problem statement, aim and objectives of the study, research questions, brief discussions of the research design and methodology used significance of the study, key concepts employed including a theoretical foundation that offered guidelines to the study, as well as outlining the layout of the entire dissertation.

1.2 BACKGROUND TO THE PROBLEM

Public Administration and Management is one of many academic disciplines, with service delivery based on customer care management being one of its major sub-components (Du Toit, Knipe, Van Niekerk, Van der Walt, & Doyle, 2002:17). With this in mind, a significant amount of discontent exists among the public with regard to the service of South African hospitals. Consequently, there is a need to conduct research to identify mechanisms, best practice, strategy and tools that can be implemented to enhance effective customer care in such hospitals. According to De Jager, du Plooy and Ayadi (2010:8), an increase in “financial aid alone will not improve healthcare systems, but drastic restructuring with sound governance and management principles needs to be implemented. The organisational structure of public healthcare must facilitate the delivery of a responsive and flexible healthcare system that is people centred with the interest of the public, patients and staff guiding the decision-making at all levels”.

Edenvale Regional Hospital has only 230 approved useable beds. The hospital is therefore faced with patients sleeping on stretchers and mattresses in the Casualty (Accident and Emergency) section for two to three days at a time while awaiting open beds in the ward, thereby compromising healthcare as a result. The hospital had unapproved substitutes for beds and/or ways for having extra patients sleeping in the casualty section, which were not covered by the budget and led to multiple complaints.
Often there was no medical cover for patients sleeping in the Casualty Department as it was not meant to be a ward. The patients, however, could not simply be sent back home while they were sick because of the unavailability of open beds, hence the overcrowding and the use of stretchers and mattresses.

The Edenvale Regional Hospital has both internal customers (its own employees) and external customers (patients, patients’ family members, suppliers etc.). Customers are commonly defined as those people who can choose to select a company’s product or service. There are two problems, though, with this definition of what constitutes a customer in the public sector. Firstly, many of the services provided in the public sector, such as tax collection, are not optional. Secondly, it is “often difficult to determine who should be considered the actual recipients of the services”, according to Immordino (in Masago & Mkutukana, 2013:595). Public servants usually do not regard people who have no choice of service as customers. With specific reference to the Department of Health, many people in South Africa are unemployed and have no choice to whom they can turn for their health requirements, but are instead wholly dependent on the department.

There were serious concerns from the users (patients/customers) relating to the limited service that was being provided by the hospital. It was expected that the hospital should render a service in accordance with its core service package, the aim of which is to achieve world-class status and to create dynamic processes that go beyond merely meeting customer demands. Often, however, there were over 40 patients sleeping on stretchers and lying on mattresses on the floor for more than two or three days in the hospital, including in the Accident and Emergency (Casualty) Department.

There is no doubt that the quality of the healthcare service, especially as delivered by public hospitals in South Africa, has become increasingly important, with the South African government presently in the process of implementing a National Health Insurance. These public health institutions must therefore “focus their efforts on quality customer service as a means of differentiation” (Boshoff & Grey, 2004:27). The quality of service serves as a competitive advantage and marketing tool for many private hospitals and firms and also leads to customer loyalty and retention.
According to the *European Journal of Logistics Purchasing and Supply Chain Management*, “Clients’ satisfaction has become the main focus in the healthcare delivery. It is a concept that is used to measure the fulfilment of a company offering, product or service. In order for clients/patients to be satisfied there is the need for health facilities/health institutions to offer services which gives the customer maximum value and satisfaction. Clients choose quality as one of the important criteria in selecting product or services, especially with the introduction of National Health Insurance Scheme (NHIS) where there is a keen competition among health facilities, as a result of globalisation and trade liberalization. High quality service has become the main focus for firm survival. (Cook and Verma, 2002). Muunsamy et al. (2010) found that client satisfaction is the main performance determinant and many health institutions therefore consider it as a key element when developing their business goals”.

The evaluation of the quality of customer service in public hospitals in South Africa is very important in determining the effect thereof on customer care satisfaction, and also for identifying possible areas where improvements could be made. It is hence vital that all hospitals have such evaluation tools in order for them to correctly evaluate their quality of service (Core Standard for Health Establishments in South Africa, 2009:33).

As the healthcare industry strains the nation's financial resources, it has come under increased pressure to provide evidence of quality controls and quality improvements. Increasing evidence that the service aspects of healthcare are closely linked to healthcare outcomes has caught the attention of industry leaders. Furthermore, the current healthcare consumer is better educated and informed than they have ever been (Department of Health Strategic Plan, 2014).

Healthcare organisations must address those service aspects that consumers most readily appreciate, including access to care, relationships between physicians, meaningful and understandable information, and participation in their own healthcare and treatment decision-making processes. One aspect of healthcare quality that is being increasingly recognised for its importance is the influence of patient perception. Even though the patients’ perception of quality relies more on the service
aspects of healthcare, it correlates well with objective measures of healthcare quality. According to the World Health Organisation (2012), “a health care organisation's ability to satisfy consumer demand for convenience and information can significantly influence the quality of health care it ultimately delivers”.

A fundamental requirement of the above is a sound quality policy, supported by plans and the necessary facilities to implement it. Leaders must take responsibility for preparing, reviewing and monitoring the policy, plus take part in regular improvements thereof and ensure that it is understood at all levels of the organisation. The failure to address the culture of an organisation is frequently the reason for many management initiatives failing. It is widely recognised that any major change initiatives will be unsuccessful without a corresponding culture of cooperation and good teamwork at all levels in the organisation (Department of Health Strategic Plan, 2014).

Based on the above background and history of the hospital, it was clearly necessary to implement better customer care within the institution. Enhancing a positive impact in healthcare services through performance management requires, as a foremost requisite, competent and talented people with appropriate management and leadership skills. This necessitates, among other interventions, management training, revival of staff morale and managerial commitment. The researcher focused on assessing the contributory factors for effective customer care in Edenvale Regional Hospital (Gauteng Health Department).

The researcher acknowledges that similar case studies have previously been conducted in the public sector by Masango and M Kutukana (2013), who focused on the Department of Basic Education in the Eastern Cape Province; de Jager, du Plooy and Ayad (2010), who focused on delivering quality service to in- and outpatients in a South African public hospital; and Chawani (2009), who focused on patient satisfaction with nursing care. Other case studies were also conducted internationally where some form of National Health Insurance is fully implemented. These include Aikins, Ahmed and Adzimah (2014), who focused on assessing the role of quality service delivery in client choice for healthcare; and Kenneth, Wangari and Ayodo (2012), whose case study of Kenyatta National
Hospital focused on “Factors Affecting Provision of Service Quality in the Public Health Sector”. The researcher nevertheless felt that it was necessary to further explore customer care, as the South African government is in the process of implementing a National Health Insurance, which will provide a competitive advantage among health facilities as a result of globalisation and trade liberalisation and includes services that are presently not covered by the budget but nevertheless still need to be provided.

1.3 RESEARCH PROBLEM

Customers of healthcare institutions pass through a number of service stations before receiving treatment or being admitted into a ward. This creates areas where problems could arise that were not solved to the customer’s satisfaction. When a customer is eventually admitted into the Casualty Department while waiting for open beds in a ward or, alternatively, ends up in the treatment area, there could be either a negative or positive attitude towards the treatment, service or institution based on the service received thus far. On arrival in the treatment area, most problems are either dealt with or simply left unattended. It is for this reason that there is a need for frequent spot checks of problem identification and solution. This would ensure the necessary quality of service and satisfaction expected by the customer. There were serious concerns from the users (patients) related to the limited service that was being provided by the Edenvale Regional Hospital. It is expected that the hospital must render a service in accordance with its core service package. The aim, as already mentioned, is to achieve world-class status and to create dynamic processes that extend beyond merely meeting customer demands. Often, however, there were more than 40 patients sleeping on stretchers on the floor for more than two to three days at a time, including the Accident and Emergency section. The hospital had regularly faced the anger of the public, and it had often been viewed in a negative way. The hospital forms the backbone of the health service delivery system and is at the core of health service delivery in the region. The healthcare workers working in admission, emergency care and the pharmacy areas within the hospital had frequently been accused of having a bad attitude by the public, of not doing their work professionally, of lacking professional conduct as a result of their negative attitude, and of neglecting the patients when they needed them the most. The researcher felt that this would have a negative impact on the implementation of the National Health Insurance.
The problems discovered by the researcher were as follows:

- Patients complain about the long waiting time for open beds in wards while still in the Casualty (Accident and Emergency) section.
- Edenvale Regional Hospital was faced with patients sleeping on stretchers and matrasses in the casualty section, compromising healthcare as a result. The contributing factors include: services that are not budgeted for, lack of accountability in the system, ineffective monitoring and evaluation, shortage of staff, poor administration and infrastructure, centralisation of authority and lack of implementation of existing policies.
- The hospital had unapproved substitutes for beds and/or ways of having extra patients sleeping in casualty, which were not covered by the budget and led to multiple complaints.

1.4 AIM OF THE RESEARCH

The study aimed to investigate the implementation of customer care at the Accident and Emergency (Casualty) Department, as experienced by patients at the Edenvale Regional Hospital.

1.5 OBJECTIVES OF THE STUDY

The main objective of the study was to investigate the implementation of effective customer care at the Casualty Department of Edenvale Regional Hospital in the Gauteng Province.

In order to achieve the main aim of the study, the following secondary objectives are developed:

- To determine how staff training affects the quality of customer care service in Edenvale Regional Hospital.
- To determine which strategies have been put in place to maximise customer care and its effect on the geographical community.
- To investigate how policies and guidelines affect the quality of customer service in the Casualty (Accident and Emergency) section at Edenvale Regional Hospital.
To provide recommendations to the Department of Health concerning how challenges facing customer care at the hospital can be addressed.

1.5.1 Research questions

According to Pollit & Hungler (1999:67), “a research question is a statement of the specific query the researcher wants to answer, to address the research problem. The research question guides the type of data to be collected in the study. It is sometimes referred to as the problem statement, especially in quantitative studies”.

The research questions for the study were as follows:

- How does staff training affect the quality of customer service at Edenvale Regional Hospital?
- Which strategies have been put in place to maximise customer care and what are its effect on the geographical community?
- How do policies and guidelines affect the quality of customer service in the Casualty (Accident and Emergency) section at Edenvale Regional Hospital?
- How can challenges facing customer care at the hospital can be addressed?

1.6 ASSUMPTIONS OF THE STUDY

- Determinants of patient satisfaction had a role in improving the quality of care in health services;
- Healthcare facilities utilise patient satisfaction reports in measuring or improving the quality of care;
- Management believes that patient satisfaction was an important and valuable indicator in the quest to improve the quality of care; and
- The patient is the best informant regarding their individual preferences and values, and as such the patient must be allowed to rate the services so that the healthcare provider may utilise this information.
1.7 SIGNIFICANCE OF THE STUDY

This research will serve in expanding the existing body of knowledge concerning the challenges that are faced in customer care service delivery. The study provides an insight into the customer care satisfaction levels of the Edenvale Regional Hospital’s health delivery services, with the intention to identify service gaps and thereby improve upon them. By identifying these gaps, the hospital can then revise its strategy and concentrate on cost effective ways of managing its limited resources to improve service delivery. In order to enable the hospital to deliver its service in terms of the National Health Insurance throughout the province, the internal and external customers of the Gauteng Department of Health will be made aware of the Customer Care unit’s existence, so that they can then make an effort to access the service offered by the unit when they need it. Likewise, the staff at both Head Office and the hospital are made aware of the existence, purpose and role of the Customer Care unit.

The research will also provide a perspective for the understanding and measurement of patients’ expectations, service quality dimensions such as clinical effectiveness, patient experience and patient safety that are critical to an efficient healthcare delivery system. This can be determined from the revelations of the patient satisfaction survey, thereby enabling management of the health services to prioritise any gaps that need to be focused on in order to guarantee customer care satisfaction. A measure of patient/client satisfaction levels will enable the hospital management to develop a client-centred service approach to deal with patients so as to enhance their satisfaction levels. By identifying what customers expect and perceive in terms of quality by virtue of this research, the Edenvale Regional Hospital and Gauteng Health Services will be able to invest in the necessary resources and logistics, particularly in those areas that will enhance quality health delivery.

The research will be presented to the Department of Health and is expected to assist in the revamping of the public health system, as the South African health sector is in the process of implementing an NHI. The research can therefore be used to inform policy, budget and resource allocations of the public hospitals in South Africa. The completed study is likely to promote further studies aimed at understanding why the public health system is not functioning the way it is expected to and how this status quo can be changed.
1.8 RESEARCH DESIGN AND METHODOLOGY

1.8.1 Research Design

Research design “represents a master plan that specifies the method and procedures for collecting and analysing the required information” (Tustin, Lighthelm, Martins & Van Wyk, 2005:82). A qualitative case study methodology, as illustrated by Baxter and Rideout (2006), “provides tools for researchers to study complex phenomena within their contexts. When the approach is applied correctly, it becomes a valuable method for health science research to develop theory, evaluate programs, and develop interventions”.

The research was conducted using a qualitative approach, which seeks to gain deeper understanding of the impact of customer care in Edenvale Regional Hospital from the employees’ point of view. These include frontline staff such as administration record clerks, nurses and doctors working in the Accident and Emergency section, and the pharmacy staff who deal directly with customer (patients). The views included those of the quality assurance unit and managers who deal directly with customer complaints. The case study was descriptive, which was “used to describe an intervention or phenomenon and the real-life context in which it occurred” (Yin, 2003: 67). The phenomenon under investigation was the implementation of customer care in Edenvale Regional Hospital in Gauteng Province.

1.8.2 Sampling Techniques

Saunders and Werner (in Mwanda, 2010:13) explain that sampling is justified when it is impractical, expensive and too time-consuming to include the entire population. In selecting the participants a purposive sampling technique was employed, with the participants being selected based on their roles in the facility. This sampling involves the assembling of a sample of persons with known or demonstrable experience and expertise in some specific area. For example, in the hospitals the chief executive officer, the head of nursing services, the head of medical services, the head of administrative services, head of finance, the supply chain manager, human resource manager, quality assurance manager and infection controller coordinator were selected to participate in the study. In
each category represented, under the heads mentioned above, three employees were selected purposively, namely: the head of department, any employee in the unit, and an employee working in casualty and admission. The study involved a total number of sixteen (16) participants.

1.9 DATA COLLECTION TECHNIQUES

1.9.1 Semi-structured interview

For this study, the researcher conducted both semi-structured individual interviews and documentary analysis to collect the data that was needed. Interviewing was conducted in a suitable environment and the documented content was used to analyse how the participants responded and the information thereby derived.

Cresswell (2014: 30), confirmed that “semi-structured interviews are flexible, adaptable and provide direct human interaction”. This is because the semi-structured interview method grants the researcher freedom to probe the interviewee in order to elaborate upon any particular point or question, or else “to follow a new line of inquiry introduced by what the interviewee is saying”, and it is this open-ended nature of the questions that provides opportunities for both interviewer and interviewee to discuss the topic in greater detail (Hofstee, 2011:107). Face-to-face interviews were conducted with clerical staff, nurses and doctors working in the Accident and Emergency Department, as well as with executive managers and representatives from the quality assurance unit. These interviews were personal, intensive and semi-structured, and follow-up interviews were conducted with selected participants in order to verify the consistency of the responses. The researcher took field notes of all discussions.

1.9.2 Document analysis

Document analysis, according to Hofstee (2011:108), is “a form of qualitative research in which documents are interpreted by the researcher to give voice and meaning around an assessment topic. Analysing documents incorporates coding content into themes similar to how focus groups or interview transcripts are analysed”. The types of documents that were assessed included government
documents, the Hospital Information System (HIS), Gauteng health bulletins and operational plans, core standard assessment reports, patient satisfaction surveys, employee satisfaction survey reports and the hospital’s complaints register.

1.10 CONCEPT CLARIFICATION

1.10.1 Customer care

Customer care is about satisfying customer’s needs and exceeding their expectations. Griffiths, in Masago and Mkutukana (2013:595), argues that there are three secrets to satisfying customers: taking time to find out what they expect, meeting their expectations and always trying to exceed them. The purpose of customer care, as outlined in the Provincial Customer Care Policy Handbook, includes: a responsibility to communicate, consult and cooperate with customers and stakeholders, to establish what they need, to provide a wide enough choice matching the required service, to remind public servants to interact with customers, business partners and citizens in a courteous and professional manner, and to respond to their identified needs by integrating those needs into programme planning and implementation.

1.10.2 Customer Relationship Management

Customer Relationship Management (CRM) comprises the business processes an organisation performs to identify, select, acquire, develop, retain and better serve its customers. This process includes a company’s “end-to-end engagement with its customers and prospects over the lifetime of its relationship with them” (Baran, Galka, & Strunk, 2008:4).

1.10.3 Regional Hospital

The role of the regional hospital is to provide specialist care in the key clinical disciplines such as Internal Medicine, General Surgery, Obstetrics & Gynaecology, Paediatrics, Casualty Emergency Care, Theatre, Kangaroo Unit Care and Comprehensive HIV/AIDS treatment. The hospital provides curative service of a level two nature.
1.10.4 Emergency (Casualty) Department

The emergency area is a unit for surgical or medical casualties, with facilities for holding and resuscitation of patients requiring emergency treatment. This area should accommodate the free movement of stretchers, wheel chairs, trolleys and bedside lockers in between each patient.

1.10.5 Public Health Services

In this study, the words service and system will be used interchangeably. Cumbey and Alexander (1998:40) define a public health system as “a complex set of interrelated components, employees, structure, technology, environment, clients, the legislature, and the community”.

1.10.6 Healthcare System

Stanhope and Lancaster (2004:50) define a healthcare system as “one that weaves primary care and public health into a single integrated system”. Basch (in Stanhope & Lancaster 2004:83) states that a healthcare system consists of five fundamental elements, namely “(1) usership, or who can use the system; (2) benefits, or what kind of coverage a citizen might expect; (3) providers who deliver healthcare; (4) facilities or where the provision of healthcare takes place; and (5) power or who controls access and usability of the system”.

Allender and Spradley (2001:101) define a public health service as “an umbrella organization concerned with the broad health interests of the country and is directed by the assistant secretary for health”. A public health service in South Africa means a service that is funded and regulated by the South African government.

1.10.7 Quality

According to Reinartz (2004), quality, as defined by the International Organisation for Standardization, is a relative concept, but if the inherent characteristic/s of a service meets the requirement of the customer, it can then be rated as high quality. Whittaker, Shaw, Spieker and
Linegar (2011:67) further illustrate that “quality in health care refers to the extent to which an organisation meets its clients’ needs and expectations. It is a complex, multifaceted concept which can be assessed and measured against predetermined standards”.

1.10.8 Quality Assurance

Whittaker et al (2011:67) describe quality assurance (QA) as “oriented toward meeting the needs and expectations of the patient and the community; it focuses on systems and processes, uses data to analyse service delivery processes; and encourages a team approach to problem solving and quality improvement”.

1.10.9 Standards

According to Whittaker et al (2011:67), “Standards in health care facilities are statements that define the required key functions, activities, processes and structures so that various departments in a facility can provide quality services. Standards are determined by professional bodies, health care professionals, staff, patients and citizens, and should be regarded as optimal and achievable, and should be designed to encourage continuous improvement. Standards typically go through several phases of development. First, the normative phase, when an ideal is suggested by professionals. Second, the empirical phase, when it is tested in pilot sites. Finally, the consensus phase, when final standards are modified and consolidated to achieve a useful balance between what is ideal and what is real”.

1.10.10 Effectiveness

According to Visser & Erasmas (2007:244), effectiveness refers to the extent to which inputs accomplish outcomes or achieve maximum outcomes by the selection of optimal mixes of inputs. In other words, to select the best alternative method of achieving management objectives by measuring actual against planned performance; i.e. the measure of output.
1.10.11 Efficiency

According to Robbins (2000), “efficiency refers to the relationship between inputs and outputs”. If, for any given input you achieve more output, you have therefore increased efficiency. Similarly, you again increase efficiency if you can achieve the same output with less input.

1.10.12 Control

Control is the “process of monitoring activities to ensure that they are being accomplished as planned and of correcting any significant deviations” (Robbins 2000:171).

1.10.13 Bed occupancy rate (BOR)

Bed occupancy rate (BOR) is defined as the average number of days for admission in the hospital. It is calculated as total patient days (inpatient days plus half day patients divided by separations (Discharges + Deaths + Transfers out to other hospital + Day patients).

1.11 DATA ANALYSIS AND INTERPRETATION

This study used a qualitative approach based on the researcher’s interpretation thereof. Content analysis was conducted to mechanically and physically organise and sub-divide the data into relevant categories, as well as to interpret these categories in meaningful ways (Sewpershed, 2003). The researcher categorised and classified data into meaningful units for the appropriate category, and then verified relationships and developed conclusions therefrom. The data was organised by the questions asked of the respondents and their respective answers in order to identify any differences and inconsistencies in the data from the various sources as mentioned above, namely through open-ended questions, written comments on questionnaires or word-for-word transcripts. The interpretation thereof was based on the questions posed. The following are some of the questions that were asked of the participants in the different units: How can Edenvale Regional Hospital enhance effective customer care? How does the behaviour and personal attention of staff affect patients? How does the hospital’s customer service policy affect its services? How does the infrastructure of the hospital
affect its services? What strategies have been put in place to maximise customer care and its effect on the geographical community? What aspects of customer care provision are satisfactory and which are unsatisfactory? What factors affect the quality of customer care in health service delivery?

These and other questions were asked to ascertain how to maximise customer care in the hospital as well as to source solutions for any identified challenges. This study hence focused on the implementation of effective customer care in some sections of Edenvale Regional Hospital. Coding was used to collate the data and then analyse it as themes, ideas, concepts and interpretations; and, as propositions emerged, to then systematically develop and refine the data interpretation.

1.12 ETHICAL CONSIDERATIONS

“Ethical issues are the concerns and dilemmas that arise over the proper way to execute research, more specifically not to create harmful conditions for the subjects of the enquiry, humans, in research processes” (Schurink, 2005:43). The researcher was aware of the large responsibility for being sensitive and respectful towards the research participants and their basic human rights and to fully endorse the Ethical Code of the University of South Africa. As specified by Muller (2007), the following ethical considerations were observed by the researcher:

- Communicating the aims of the research to participants;
- Communicating anticipated consequences of the research to participants;
- Informing participants of what would happen, according to a script, and ensuring that informed consent was thereby obtained. The script contained the following:
  - Details of approval for the research;
  - A clear statement of what institution was thereby represented;
  - Adequate explanation of what the research was about, the benefits of the research and who would benefit therefrom;
  - Reassurance of the participants that they would be protected from physical and psychological harm;
  - Obtaining informed consent;
  - Explanation of possible risks;
- Explanation that they may opt out at any stage;
  - Debriefing them when and where applicable;
  - Asking them for suggestions to improve the research procedures;
  - Assuring them of confidentiality; and
  - Providing access to results where applicable.

1.13 LIMITATIONS OF THE STUDY

The study focused on the employees, managers and quality assurance personnel who are directly involved with patients’ complaints in Edenvale Regional Hospital, and can therefore not be seen as representative of all the customers of the Gauteng Department of Health. The research was limited to the public documents, best practice in private hospitals, literature, books, journals and articles that deal with customer care. Although the requirement for the sources used in the research were that they fall within five years of the research study, the researcher nevertheless used other sources or content that fell beyond the five-year stipulation if they happened to still be valid. Future research may include a bigger sample within the hospital and incorporate other hospital categories such as district, tertiary, academic and specialised hospitals in the Gauteng Health Department.

1.14 DIVISION OF THE STUDY

This study consists of five chapters as follows.

Chapter 1: General introduction

This chapter provides the general introduction to the entire study and background to the study. The formulation of the research problem, objectives and the study’s hypothesis are outlined. Similarly, the purpose and significance of the study, the literature review and the scope and limitation of the study are presented.

Chapter 2: Theoretical overview of customer care

This chapter focuses on the theoretical overview of customer care and other source documents, such as public service documents that deal with customer care, as well as identifying similar studies with
regard to enhancing customer care, and how this relates to effective customer care at the Casualty (Accident and Emergency) section of Edenvale Regional Hospital.

Chapter 3: Research Methodology

In this chapter, the focus is on the research methodology and design to be followed in order to achieve the research objectives. In other words, emphasis is on the research method, research format, research technique, population and sampling methodology, including sample size, sampling type, sampling technique and data analysis.

Chapter 4: Presentation and analysis of findings

The analysis and interpretation of the data and research findings are presented in this chapter. The results obtained are then compared with the findings of the already published empirical studies and the literature review on which the study is based.

Chapter 5: Summary of findings, recommendations and conclusions

In this chapter the researcher presents the summary of findings, and makes recommendations based on the study findings. From the results it is possible to determine whether the research objectives, as stated in this chapter, were achieved, and if the problem statement as described was relevant. Conclusions are drawn and meaningful recommendations made.

1.15 CONCLUSION

This chapter addresses the background of the problem experienced in the Casualty Department at Edenvale Regional Hospital, the research design and methodology, concept clarification, data analysis and interpretation, ethical considerations, study limitations, budget used for the study and also outlined the division of the study. The next chapter discusses theoretical overview of customer care.
CHAPTER 2: THEORETICAL OVERVIEW OF CUSTOMER CARE

Customer Care at the Casualty Department of Edenvale Regional Hospital in Gauteng Province

2.1 INTRODUCTION

The previous chapter provided an overview of the study by highlighting the background to the study, including the problem statement, aim and objectives of the study, research questions, brief discussions of the research design and methodology used, significance of the study and key concepts employed. This chapter will discuss the literature reviewed on customer care with specific focus on hospital, i.e. Edenvale Regional Hospital. It provides the importance of conducting literature review and other source documents, such as public service documents that deal with customer care, as well as identifying similar studies with regard to enhancing customer care, and how this relates to effective customer care at the Casualty (Accident and Emergency) section of Edenvale Regional Hospital. Some of the headings that are discussed in this chapter include state of the South African public health system, the issue of patients overflow in the casualty department of Edenvale Regional Hospital and it also discussed theories of customer care as well as models.

2.2 THE IMPORTANCE OF CONDUCTING LITERATURE REVIEW

Literature review is defined as an important source for providing detailed and relevant knowledge about the problem (Burs, Grove, & Grey 2013:707). According to Yin (2012:64), Literature review is conducted in order to find out what is already known about the topic of interest. Literature review also helps researches to develop a theoretical or conceptual framework for the topic under study (Brink, Van der Walt & Van Rensburg 2014:54). The purpose of the literature review is, amongst others, to convey to the reader what is currently known regarding the topic of interest. Investigations include several disciplines such as Sociology, Economics, Health and Management Sciences, as well as perusing the literature of the South African Association of Public Administration and Management. Customer care is a frequently studied subject in work and organisational literature. This is mainly due to the fact that many experts believe that taking care of the needs of communities in service
delivery is crucial for any institutions, since it helps improve the quality of the healthcare service delivery processes. One of the initiatives adopted in this regard was the establishment of the Presidential Hotline. In the South African public sector, this fact is acknowledged through policy frameworks such as the Constitution of the Republic of South Africa, 1996, which contains the basic values and principles governing public administration, the White Paper on Transforming Public Service Delivery (Notice 1459 of 1997), commonly known as the Batho Pele White Paper, Public Service Regulations, National Core Standard for Health, Occupational Health and Safety Act, Patient’s Rights Charter and the six key ministerial quality priorities (staff attitude, waiting times, cleanliness, patient’s safety, infection control and availability of medicines). In order to facilitate customer care in their institutions, public officials need, among others, good communication, listening and problem-solving skills, as well as empathy and the ability to receive and address complaints (Masango & Mkutukana, 2013:294).

### 2.3 STATE OF THE PUBLIC HEALTH SYSTEM IN SOUTH AFRICA

The South African healthcare system, like most healthcare systems in the developing world, is faced with huge challenges. These include a shortage of trained healthcare workers, prolonged waiting time and inadequate infrastructure, while at the same time also being burdened with the HIV/AIDS epidemic. In 1994, the African National Congress (ANC) government inherited an unequal and fractured health department, as the apartheid government had allocated far higher budgets to white hospitals (as much as R127 per capita), whilst the allocation to ‘homeland’ hospitals was as low as R45 per capita (Arwyp Medical Centre, 2014:1). According to the World Health Organization (2012), the per capita healthcare expenditure for South Africa in 2012 was R10 173 (US$982). This increase from the apartheid era indicates the huge strides that have been made in the healthcare system.

Despite the increased spending per capita, South Africa’s healthcare is nevertheless ranked 175th in the world, while Singapore, which has a far lower per capita expenditure on healthcare than South Africa, is ranked 6th in the world (Sboros, 2013:2). The country’s public health system is still considered to be giving second rate healthcare to the majority of its citizens. Health Minister Aaron Motsoaledi told a business briefing in 2013 that the country’s healthcare system provided first class healthcare to 16% of the population who could afford expensive private healthcare, whilst the rest of
the 84% settled for what he termed “second rate” healthcare (News24.com, 2013). Private healthcare is usually very expensive and attracts the best-trained healthcare personnel because of the better salaries and benefits. The public health system has however improved for the majority of South Africans since the end of apartheid, but is still faced with challenges regarding customer (patient) care within the service delivery system.

According to Harrison (2009:2), the accomplishments of the South African public health delivery system in the past two decades are nonetheless quite significant. These include free primary healthcare for all citizens, establishment of an essential drugs programme, legislation for the legal choice to terminate pregnancy for women and anti-tobacco legislation. In terms of health management systems, greater parity in district healthcare expenditure has been achieved, including clinic expansion and improvement and improved malaria control. These great achievements have however been overshadowed by the burden of HIV/AIDS.

The delivery of a safe, high quality and efficient health service depends on the competence of health workers and a work environment that supports performance excellence. It is therefore disturbing to note that the ongoing underinvestment in the health sector in many countries has resulted in a deterioration of working conditions. This in turn has had a serious negative impact on the recruitment and retention of health personnel, the productivity and performance of health facilities and, ultimately, on patient outcomes. A positive practice environment must hence be established throughout the health sector if national and international health goals are to be met (Press Release, 2007:4).

According to the International Nurses Council (2001:2), “Unhealthy work environments affect health professionals’ physical and psychological health through the stress of heavy workloads, long hours, low status, difficult relations in the workplace, problems carrying out professional roles, and a variety of workplace hazards. The costs of these unhealthy and unsafe workplaces for health professionals have been well documented”. This includes the following:

- Evidence shows that long periods of job strain have an effect on personal relationships and also increase sick time, conflict, inefficiency, job dissatisfaction and consequent staff turnover; and
A survey of primary care practitioners in Switzerland reported that as much as one third presented either moderate or high degree of burnout, which was primarily associated with work-related stressors. Healthcare workers, working in the public health system, are faced with a number of challenges that result in them being unable to offer the best healthcare expected by the South African public. These challenges include deteriorating working conditions, poor remuneration and increasing loss of nursing professionals, and are said to also affect the private healthcare sector (Department of Health, 2008:7).

2.4 PATIENTS OVERFLOW IN CASUALTY DEPARTMENT

Casualty (Emergency) department (ED) crowding has been described as the most serious problem that endangers the reliability of healthcare systems worldwide (Pines, Hilton, Weber, Alkemade and Al Shabanah, in George & Evridiki, 2015:1). Crowding is defined by the American College of Emergency Physicians as “a situation in which the identified need for emergency services exceeds available resources for patient care in the emergency department, hospital, or both.” Bullard, Villa-Roel, Bond, Vester, Holroyd and Rowe (in Djokova, Plotkim & Jacelon, 2012:8), further illustrated that overcrowding in the emergency department (ED) is not only an issue with critical patients who are boarding, but also poses a problem for any emergent patients in the waiting room.

Congestion, the most significant delay, occurs when “awaiting placement in the emergency department beds and is primarily a result of access block due to boarding admitted patients, a situation that poses serious risks to the majority of patients who have emergent or urgent conditions that cannot be managed appropriately in the waiting room” (Bullard, Villa-Roel, Bond, Vester, Holroyd and Rowe, in Djokova, Plotkim & Jacelon, 2012:8).

According to Olshaker (2009), overcrowding has many other potential detrimental effects including diversion of ambulances, frustration for patients, families and ED personnel, diminished patient satisfaction and, most importantly, greater risk for poor outcomes. Korn and Mansfield (in Djokova, Plotkim & Jacelon, 2012:8), state that because ED boarders use ED staff resources that are generally ‘sized’ to deliver care only to new ED arrivals, care of these boarders endangers new patients by diverting staff from where they are most required. This situation can result in inadequate work
capacity to address newly arriving ill patients or, alternatively, the finite staff might direct their attention to newly arriving patients and thus neglect the boarders and provide nowhere near the requisite attention to these deserving patients.

Congestion in the ED can be attributed to a number of factors, such as waiting longer than 90 minutes to see a provider, patients being placed in the hallway beds, more than 30% of department beds being filled with admitted patients, and having a full waiting room with no place to move new patients (Korn and Mansfield, in Djokova, Plotkim & Jacelon, 2012:9). In a study conducted by Harris and Sharma (2010), which quantified the determinants of the duration of time spent in an ED for patients requiring admission to hospital, reduced time in the ED was associated with the number of nurses, the number of beds and the number of doctors (Harris and Sharma, 2010:11). “Overall, an increase in hospital resources, as measured by the number of nurses, doctors and physical beds, is associated with a significant reduction in patient care time in the ED” (Harris and Sharma, 2010). They concluded that, “Increasing hospital capacity is likely to reduce overcrowding in the average ED, but factors that determine congestion in individual hospitals, such as long holds for admitted patients and lack of movement for triage, are being investigated for improvement” (Harris and Sharma, 2010).

A third study by Bernstein et al (in Djokova, Plotkim & Jacelon, 2012:9) provides several reasons why overcrowding occurs in most emergency departments. Some of the main issues presented are an increase in volume and severity of illnesses, a nursing shortage, uninsured patients, difficulty in obtaining timely consultation and availability of beds. ED crowding is associated with an increased risk of in-hospital mortality, longer times to treatment for patients with pneumonia or acute pain, and a higher probability of leaving the ED against medical advice or without being seen. Results indicated that the inability to transfer inpatients to beds is one of the leading causes of crowding in the ED and increases mortality among critically ill patients. Bernstein et al (in Djokova, Plotkim & Jacelon, 2012:9) concluded that a growing body of data suggests that ED crowding is associated with both objective clinical endpoints, such as mortality, as well as clinically important processes of care, such as time to treatment for patients with time-sensitive conditions such as pneumonia.

When overcrowding becomes an issue due to the factors listed previously, the quality of care is reduced and patient safety issues increase (Mosely et al, 2010). Mosely et al (2010) provided data
that ED overcrowding can harm patients and impair the patient care experience. When a patient has the potential to be harmed due to unforeseen factors it is imperative to re-assess the safety issues at hand such as nurse-to-patient ratios. Nurses become overwhelmed with unsafe patient loads (4-5 patients in the ED, including critical patients) and are at risk for making mistakes, including medication errors and inappropriate monitoring (untimely or lack thereof) (Moseley et al, 2010).

Overcrowding in the ED can lead to congestion of beds, use of hallway beds, and insufficient beds for patients who continually return to be seen (Moseley et al, 2010). With overcrowding being an issue, suggested practice is to move critical patients to the wards in a timely manner (2-4 hours after ED admission) and provide appropriate care for them in the unit (Moseley et al, 2010).

“Decreeing overcrowding in the ED and moving critical patients to the wards can lead to an improved patient health status (e.g. increased oxygen levels, decreased documented hypotension) and a possible improved overall outcome during ED admission” (Moseley et al, 2010). The studies discussed above regarding overcrowding in the ED all agree that when the ED becomes crowded critical patients can suffer.

The ability of any ED to effectively and efficiently treat patients is limited by their constraints. Mayer and Jensen (2009) identified two key points about constraints, in that they “limit performance and can improve performance”. Correcting constraints that prevent good patient flow in a department, such as an Emergency (Casualty) Department, should be a priority. A research study by Martin, Champion, Kinsman and Masman (2011) focused on identifying bottlenecks within an ED that contributed to overcrowding. They found that their “greatest source of delay in patient flow was the waiting times from a bed request to exit from the ED for hospital admission”.

Patient flow is “the movement of patients through the network of queues and service transitions that characterize modern healthcare” (Mayer & Jensen, 2009:9). It is also “the process of adding value and eliminating waste during the course of our patients’ journey through the healthcare system” (Mayer & Jensen, 2009:9). The same definition can be stated differently to define patient flow as “the movement of patients from the time they enter the department until the time they are released or are admitted to the hospital, and if they are admitted, then until the time they are discharged from the ED
to the floor” (Jensen & Kirkpatrick, 2010:6). In other words, a statistical way to picture patient flow would be length of stay (LOS).

2.4.1 Medication Errors

Medical errors such as charting mistakes, medication errors and inappropriate monitoring can all lead to deterioration in a patient’s health status, and in fact medication errors are among the most serious medical errors and can lead to bodily harm or even death (Hillin & Hicks, 2010). When nurses are caring for patients with multiple levels of acuity, the clinical patients do not receive proper care (such as verifying medication, checking names, DOB, ID number) and medication errors may occur as a consequence (Kulstad et al, in Djokova, Plotkim & Jacelon, and 2012:11). Kulstad et al (in Djokova, Plotkim & Jacelon, 2012:11) also provide data based on the Emergency Department Work Index Number (EDWIN), a score to measure crowding and frequency of medication errors in the ED. Some of the main causes of errors included giving medication at incorrect doses, frequencies, durations or routes, and giving contraindicated medication. There was a positive correlation with the daily EDWIN score and number of medication errors. Medication errors due to overcrowding can cause severe metabolic disorders or death. The above-mentioned study helped to identify one of the critical adverse outcomes that can result from an overcrowded ED.

Critical patients who are boarding in emergency departments may also suffer medical errors through the care transitions which occur with providers. Hughes & Clancy (2007) suggest that “the potential for medical errors in critical patients exists whenever more than one healthcare provider or site of care (emergency department or ICU) is involved in providing services”.

Medication errors represent a failure in the medication use process and can increase morbidity and mortality. According to Hillin & Hicks (2010), “the National Coordinating Council for Medication Error Reporting and Prevention maintains a taxonomy that assists in standardized reporting, evaluating, and trending of medication error data. Many emergency departments are overcrowded from the increased responsibility of providing emergency and non-urgent medical care. Nursing staff in emergency departments is inadequate to handle the overload of patient visits. As a result, care is fragmented and methods designed to support patient safety are compromised”.

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According to Michaels et al (2010), caring for critically ill and injured patients with limited information regarding their history also creates a high-pressure environment in which errors, in both type and dosage, of medications may be more frequent. These patients are unable to communicate their allergies, past medical history, or even their desire for treatment. Finally, the transition of care from one emergency physician to another when changing shifts (or from emergency physician to inpatient physician at the time of admission) is a particularly vulnerable time in medical communication that may result directly in medication errors.

Michaels et al (2010) illustrated that medication errors, to which ED patients are particularly prone, include failure to identify known allergies, failure to identify current outpatient medications that could interact with those provided in the ED, inappropriate type or dosing of medications, incorrect route for administration, an incomplete understanding of dosing variability for patients with renal insufficiency or diabetes mellitus, and excessive dosage for a given body weight, particularly in older women.

2.5 THEORIES OF CUSTOMER (PATIENT) CARE

2.5.1 Orlando’s Nursing Process Theory

It is difficult to care for a crucially ill patient in the ED when a nurse has several other patient with various acuity levels. Orlando’s Nursing Process Theory (1961) provides a basic concept for nurses to utilise in order to meet their patients’ immediate needs. The issues of overcrowding and transfer delays to the wards make it more difficult to assess critical patients appropriately and provide them with their basic and immediate requirements.

Utilisation of Orlando’s theory would help nurses to focus on any immediate signs of distress or need/s presented by the patient until they are transferred to the wards. Orlando’s theory provides an ethical understanding of the patient because good nursing, according to the theory, entails recognising and meeting the patients’ needs.

Orlando’s nursing process focuses on improvement in the patient’s behaviour by actions that are based on a patient’s needs found through effective interaction with the patient. (Parker & Smith,
According to Orlando, when a person is unable to meet their needs, s/he becomes distressed and is in need of nursing care. Accordingly, people who are able to meet their own needs are not distressed, and do not require nursing care. If a patient has ineffective skills to express his/her needs and/or a nurse interprets the patient’s behaviour incorrectly, it can cause distress to the patient.

When a nurse starts caring for a patient, an action process begins. This process, where the nurse acts as a nurse-patient contact, is called the nursing process where both the nurse and the patient have their own thoughts, feeling, and opinions derived from the actual situation (Schmieding, 2006, 436). Orlando explains that there are two variable types of action processes in the nursing process, namely: automatic and deliberative (Schmieding, 2006, 436).

Perceptions of both the nurse and patient need to be voiced in order for them to act as a reliable base for the nurse’s actions. During the process of care the observations of patient behaviour – both verbal and nonverbal – help the nurse to assess the level of the patient’s distress and need for assistance. After this assessment the nurse performs actions to relieve the patient from distress. After taking those specific actions, the nurse then observes the patient’s behaviour again to evaluate the outcomes. If distress is still evident, the process begins again. Orlando’s nursing process is therefore describing a continuous reflective cycle where the patient’s role in their own care is crucial (Schmieding, 2006, 439). Orlando reminds us that regardless of how accurate or inaccurate the nurse’s perceptions might be, once expressed to the patient, this opens a door for communication where it is easier for the patient to express their own view (Orlando, 1990, 45). According to Orlando, the nursing process makes it easier for nurses to see a patient from a nursing perspective.

The researcher felt that Orlando’s nursing process could work well if there are adequate beds and enough staff to look after the patients in the ED Unit of Edenvale Regional Hospital while awaiting open beds. The behaviour of the patients and their family could thus be improved.

### 2.5.2 Healthcare Forecasting and Modelling Approaches

Xu and Chan, in Cami (2016:12), built a predictive model of patient arrivals to the ED, with the hope of helping to manage ED congestion by creating proactive diverging policies using future patient
arrival information before the ED gets highly congested. The results showed that such proactive divergence policies yielded improvement in patient waiting times over standard practice. Errors in predictive information were quantified as ‘noise tolerance’ to ensure that the proactive policy outperforms the standard policy (by 15%) in patient waiting times given the same patient census in the ED.

Waiting time for open beds in the wards also has a major impact on patients’ dissatisfaction in the ED Unit of Edenvale Regional Hospital. Patients typically wait two to three days in the ED Unit before being transferred to the wards and sometimes patients even abscond without being seen again. This leads to complaints from the patients’ family and causes litigation in the hospital.

2.5.3 Gap Model of Service Quality

The conceptual framework of service quality can also be applied to health care service and is relevant to this research study, since a healthcare service requires high consumer involvement in the consumption process; hence, the attainment of quality healthcare service relies significantly on the patient’s co-contribution to the service delivery process. Studies have also shown that compliance with medical advice and treatment regimens is directly related to the perceived quality of the service and subsequent health outcome (Irving and Dickson, 2004; Sandoval, Brown, Sullivan and Green, 2006). In line with Edvardsson (2005) and sentiments that customers’ experiences have a strong impact on their quality perceptions, patients’ experience accruing from their encounter with medical and other support staff and the process of obtaining treatment create their cognitive, emotional and behavioural responses of either satisfaction or dissatisfaction with the quality of service they receive.
The Gap Model of Service quality which is provided in Figure 2.1 shows a total of five gaps. The first gap which is Gap 1 represents distance between what customers expect and what managers think they expect (Parasuraman et al. 2002). This gap can be narrowed down using survey research. The second gap is Gap 2 and it represents the difference between management perception and the actual specification of the customer expectations. The managers can address by ensuring that the organisation is defining the level of service they believe is needed. Gap 3 is from the experience specification to the delivery of the experience. Organisational leaders who are the management must audit customer experience which is being delivered by their organization in order to ensure they are delivering to expectations (Parasuraman et al. 2002). The fourth gap entitled Gap 4 is the gap between delivery of customer experience and what is communicated to customers. The final gap which is the fifth gap is not labelled on the diagram on is the gap between expected service and perceived service. Service organisations need to conduct routine transactional surveys after delivering customer in order to measure customer perceptions of service.
2.5.4 Service Quality Dimension

There are two main models of service quality. The Service Quality Model of Glied (2000) indicates that the customer’s expectations depend on the following five determinants: market communication, image, word of mouth, customer needs and customer learning. Experiences depend on the technical quality (what/outcome) and the functional quality (how/process), which is filtered through the image (who). Both expectations and experiences can create a perception gap. The second is the Gap Model propounded by Parasuraman, Zeithaml and Berry (1990), which is a slight modification of the model of Gonzalez, Padin and Romon (2005). This states that the expected service is influenced by word of mouth, patients’ personal needs, past experience and by any external communication to customers. A perception gap can appear between the expected service and the perceived service (Coulthard, 2004). Patrick (2009) identified ten determinants of service quality that may relate to any service: Competence, Courtesy, Credibility, Security, Access, Communication, Understanding/Knowing the customer, Tangibles, Reliability and Responsiveness. Later they were reduced to five, namely: Reliability, Assurance, Tangibles, Empathy and Responsiveness.

2.5.5.1 Tangibility

This involves the appearance of the health facilities’ physical environment, staff, equipment and tools, including communication equipment, used to provide good quality healthcare (Gronroos, in Aikins, Ahmed & Adzimah, 2014:8).

2.5.5.2 Reliability

Johnson, in Aikins et al (2014:8), sees reliability as standardised activities of health professionals, which is very essential in achieving quality healthcare delivery. Their activities must be right the first time round, since making no mistakes in treating patients/clients goes a long way in improving client satisfaction.

2.5.5.3 Responsiveness

Responsiveness concerns the preparedness of health professionals in providing service to clients. This includes timeliness of activities, ensuring that clients go through a successful review, providing immediate services to patients/clients, and prompt payment of suppliers (Gronroos, in Aikins et al, 2014:9).
2.5.5.4 Assurance
With assurance, the skills and politeness of health professionals must positively impact upon the belief and hope of the clients. This aspect includes capability to do the job, competency levels, how clients are handled and treated, and the overall attitude of the health professionals towards the patients’ needs. “Patients … should feel secured assessing healthcare delivery” (Fitzsimmons and Fitzsimmons, in Aikins et al, 2014:9).

2.5.5.5 Empathy
Empathy means that health professionals have the clients’ best interests at heart and hence understand their specific needs (Rizwan et al, 2011). In their study, Rizwan et al (2011) determined the service quality of a hospital in Karachi, Pakistan, using the SERVQUAL theory. The hospital provides care and individualised attention to its clients, and patients were asked to answer questions from the determinants aspect of the SERVQUAL Model. Twenty-two qualities were suggested and patients were asked to forward their expectation using a Likert scale of 1-7.

2.5.5.6 Safety
Safety means “minimising the risk of injury, infection, harmful side effects or medico-legal risks. Safely involves that of both patients and health care providers. Any health care that is delivered to patients should minimise risk; therefore care should be rendered by well-skilled and suitably competent health care providers. Patients must be protected from acquiring nosocomial infections from incompetent health care providers. Therefore, personnel should receive regular in-service education and training about, inter alia, prevention of cross-infection and safe handling of blood and blood products in order to protect themselves from infection” (Brown et al 2006:10; WHO 2006:10). The overcrowding in the ED Unit of Edenvale Regional Hospital is a high risk situation as it causes harmful cross-infection to both patients and health provider.

If employees perceive the working environment as unsafe and lacking in security measures, this could lead to stress and job dissatisfaction. According to the Occupational Health and Safety Act, 85 of 1993 (in Bezuidenhout, Garbers & Potgieter 2005:46), it is the duty of employers and employees to ensure a safe and healthy working environment. The Act stipulates further that “employers provide a reasonably safe and healthy working environment, provide protective equipment where required and
provide the information, training and supervision necessary to ensure health and safety in the workplace”. The Act also obliges “employers to report incidents where a person dies or is injured or where dangerous situations arise in the workplace. In turn, employees are obliged to obey rules and to report incidents.” In this regard, maintenance of buildings and fire extinguishers is essential. Emergency communication equipment such as panic buttons must be available and in good working condition. The hospital management must ensure that all staff are trained in using emergency techniques.

2.5.5 Employee’s capacity

According to Argote (2000), “Highly skilled physicians, nurses, administrators, and ancillary staff are critical to producing high-quality outcomes and effective quality improvement hence hospital growth”. The hospitals need to place “great emphasis on recruiting and retaining top level physicians and nurses, accompanied by an effort to encourage these professionals to form working teams, including case managers, pharmacists, social workers, and others, to promote quality” (Brown and Duguid, 2003). “To facilitate service quality and growth, hospitals must implement effective human resource strategies involving selective hiring, and retention of physicians and nurses” (Cohen and Levinthal, 2001), and “monitoring of doctors on staff (or with privileges) and ensuring that they must continue to meet certain performance and practice standards to retain credentials” (Crewson, 2004). “To improve efficiency in service delivery, public sector hospitals must build the capacity to attract and employ an adequate number of high-quality nurses” (Argote and Ingram, 2000), which suggests that the key to service delivery is adapting to circumstances which are constantly changing and that the long-term winners are those who are the best adapters, but not necessarily the winners of today’s race for market share. “Hospitals’ quality of service often fails because of the sum total of seemingly inconsequential events arising from employees lack of capacity, as in itself service delivery requires specific skill levels and experience which must be continuously learned” (Cohen and Levinthal, 2001).
2.5.6 Communication channel

Communication is the most important aspect of service delivery as communication with patients is vital to delivering service satisfaction. This is because when hospital staff take the time to answer questions of concern to patients, it can thereby alleviate many feelings of uncertainty (Wanjan, Muiruri and Ayodo, 2012). Furthermore, “when medical tests and the nature of the treatment are clearly explained, it can alleviate their sense of vulnerability” (Friedman and Kelman, 2006). This service component is valued highly and influences patients’ satisfaction levels to a great extent (Pickton and Broderick, 2001). Research by Payne (2006) indicates that communication challenges have a negative impact on the following: access to treatment, participation in preventive measures, ability to obtain consent, ability for health professionals to meet their ethical obligations, quality of care including hospital admissions, diagnostic testing, medical errors, patient follow-up, quality of mental healthcare and patient safety. According to the Institute of Medicine of the National Academies (U.S.), communication challenges contribute to reduced quality of care, adverse health outcomes, and health inequalities (2004).

In addition, there is evidence that communication challenges may result in increased use of expensive diagnostic tests and of emergency services, decreased use of primary care services, and poor or no patient follow-up when such follow-up is indicated (Irving and Dickson, 2004). There is compelling evidence that communication challenges have an adverse effect on initial access to health services. These challenges are not limited to encounters with only physicians and hospital care, as patients also face significant barriers to health promotion and disease prevention programs: there is evidence that they face significant barriers to first contact with a variety of providers as well (Arhin, 2000).

<table>
<thead>
<tr>
<th>Quality dimensions</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Effectiveness</td>
<td>The degree to which desired results (outcomes) of care are achieved through appropriate diagnosis and treatment.</td>
</tr>
<tr>
<td>Efficiency</td>
<td>The ratio of the outputs of service to the associated costs of producing those services (taking into consideration both material and time resources).</td>
</tr>
<tr>
<td>Technical competence</td>
<td>The degree to which tasks carried out by the health workers and facilities meet the expectations of technical quality (according to clinical guidelines).</td>
</tr>
<tr>
<td>Interpersonal relation</td>
<td>The level of respect, courtesy, responsiveness, empathy, effective listening and communication exhibited between clinic personnel and clients.</td>
</tr>
<tr>
<td>Access to service</td>
<td>The degree to which healthcare services are unrestricted by geographic, economic and social organisation or linguistic barriers.</td>
</tr>
<tr>
<td>Safety</td>
<td>The level of trust, confidentiality and privacy in the service rendered and the degree to which the risks of injury, infections and other harmful side effects are minimised.</td>
</tr>
<tr>
<td>Continuity</td>
<td>The degree to which consistent and constant care is provided, including the value of visiting the same provider and continuing treatment.</td>
</tr>
<tr>
<td>Physical aspects</td>
<td>The physical appearance of the facility and the level of cleanliness, comfort and amenities offered.</td>
</tr>
<tr>
<td>Choice</td>
<td>It is the client’s choice of appropriate provider, insurance plan and treatment.</td>
</tr>
</tbody>
</table>

Source: Joseph (2012:14-15)
All the above dimensions, according to Brown et al (in Joseph, 2012:14-15), constitute a holistic approach to ensuring quality healthcare delivery which ensures total customer satisfaction.

2.6 DETERMINANTS OF SERVICE QUALITY PERCEPTION

According to Draai (2012:492), there are a number of determinants that influence perception of service quality. The client holds critical influence in defining levels of service quality in the public service. The adoption of public service reforms measures has led to citizens being referred to as clients of the public service. This reference is misleading as the concept client or customer is associated with the private sector where transactional and personal choice can be exercise as well as with competition for clients where profitability and organisational longevity is crucial. Furthermore, the application of the term citizen in the public service raises numerous questions in view of the divergent services and goods provided by government based on legal entitlement or sanction. These services include aspect of social welfare and or legal obligation. Alford (2010:30) argues that citizens can only be seen as beneficiaries and not clients. For example, the provision of social assistance is made available or obligates where law enforcement takes place. However, this inference enables citizens to the state their levels of satisfaction or dissatisfaction with public services. In principle, the relevance of service quality for clients in the public service therefore becomes irrelevant due to lack of competitions. The important issue is that citizens express satisfaction or dissatisfaction with service quality. They also convey their experiences by word of mouth. This type of communication is a strong determinant in the perception of service quality and consequently of the organisational image.

Alford (2010:23), further argues that citizens are co-producers of public services and not passive recipients of services. It is important for government to realise the active role of clients in defining service standards and the type of service required to meet their needs. Citizens also influence the physical and social conditions in which service are produces. Examples of these are the introduction of various outreach programmes and the availability of mobile services in rural areas provided by many departments. The critique and evaluation of service quality informs the government of the levels of satisfaction and dissatisfaction experience with the provision of essential services. The provision of services does in principle not lead to transactional activity. However, it can become
transactional when citizens withhold their vote or refrain from interacting with the government processes because they believe that their criticism of levels of service quality is not being heeded.

Public officials should demonstrate levels of accountability and be responsive in providing service quality. The display of levels of responsiveness and accountability in delivering service quality to citizens can lead to the expression of loyalty by citizens and cooperation with public service and government. The continuous negative criticism of poor service delivery, whether experience or perceived, will be minimised. The expression of loyalty and cooperation can be found during an electoral period. The citizens express themselves less in terms of party political loyalty and more in respect of the results and outcomes from government programmes and/or in the quest for governance which includes aspects on community and/or participation in aspect of policy evaluation. Critique provides an opportunity for government to act expeditiously to address emergent service delivery issues to gain the trust of citizens in the interest of sustaining a relationship of good governance between citizens, officials and the political elite in the interest of maintaining political stability.

Redress is the process which allows government to take heed of negative critique of service delivery through the implementation of complaints procedures as well as monitoring and evaluation processes. The focus of many departments is, however, on output of service. Complaints handling procedures are often not in place or not attended to, which implies that levels of accountability in performance are lacking (Public Service Commission, in Draai, 2012:492). The inability of political leaders to hold public officials accountable for performance can diminish levels of integrity and credibility in the public service assigned by citizens.

The level of courtesy and assistance expected from a customer service representative has increased dramatically over the past decade as a result of customers’ upgraded ‘acceptable’ service standards. More skills are therefore required, such as telephone courtesy and assistance, problem-solving capabilities, maintaining customer satisfaction, and effective use of available systems. Customer care plays a crucial role in service delivery, both in the private and public sector (Griffiths, 2002:73).
2.7 CURRENT STATUS OF THE ACCIDENT AND EMERGENCY UNIT OF THE EDENVALE REGIONAL HOSPITAL

The Edenvale Regional Hospital Casualty (Accident and Emergency) Unit is experiencing a problem of patient overflow and thereby resulting in admitted patients awaiting beds temporarily in the Emergency Department (ED) due to unavailable inpatient beds in the relevant wards. Admitted patients in the ED pose significant barriers to the mission of the hospital, particularly with regard to containment and management of infectious diseases. It is therefore a risk for both the healthcare providers and patients to render care to people with life-threatening infectious illnesses in a casualty unit, especially where there is overcrowding of very ill patients awaiting beds in the other wards. Sometimes the patients even end up sleeping on mattresses on the floor due to overcrowding, which makes it difficult for the nurses and doctors to offer appropriate care to all patients.

This is mainly because the unit was only intended to cater for casualties that require stabilisation before being admitted to the wards, or sent home for full recovery when there’s no need for admission. Overcrowding increases the likelihood that patients who may be admitted and are in the unit while awaiting a bed might stay for some time without being seen by a doctor, as the doctors in the Accident and Emergency (Casualty) unit normally concentrate on patients in need of resuscitation when coming in with severe injuries or medical conditions that require immediate attention. Implementation of both preventive and public healthcare measures is a challenge in an overcrowded Casualty Department due to lack of resources and sufficient privacy with which to cater for inpatients.

Infection prevention and control guidelines are aimed at providing a safe healthcare environment for patients and staff alike. Good infection control practice should be established to improve health outcomes and prevent negative outcomes such as morbidity, mortality, increased healthcare costs and possible litigation. Infection prevention and control measures are a combination of interventions and activities, ranging from hand hygiene, aseptic technique, waste management, rational antibiotic use, cleaning and the use of chemical cleaning agents, pest and rodent control, linen handling and management, isolation, surveillance, risk management, the use of personal protective equipment, employees’ immunisation programmes and personnel hygiene (National Infection Prevention and Control Policy strategy, 2007).
The National Infection Prevention and Control Policy strategy (2007:7) further illustrates that failure to comply with the infection prevention and control policies and guidelines may result in the following:

- Successful litigation against the state for damages suffered by patients or their families as a result of illness or death arising from inadequate infection prevention and control procedures.
- Disciplinary action by professional health councils against individuals where their proven negligence caused harm to patients.
- Criminal and/or civil prosecution of individual employees whose negligent actions caused the infection and subsequent death of a patient.
- Loss of public confidence in the health establishment in question.

Accident and Emergency Unit crowding is one of the leading problems facing emergency physicians, nurses and their patients in the Edenvale Regional Hospital. Compliance with other recognised care standards (such as cleanliness, infection control, quality, the Occupational Health and Safety Act, and Patients’ Rights Charter) are thereby reduced. Patients harmed by crowing in the ED continue to suffer after they have been admitted through crowded EDs as they also have a longer hospital stay as a consequence (Hoot & Aronsky, 2008:167).

The hospital experienced bed occupancy rates (BOR) of higher than 80%, which may increase the risk of hospital-acquired infections. The overflowing of patients forced the hospital to operate outside its directive, with patients admitted to the casualty area being forced to sleep on mattresses on the floor while awaiting formal beds as they were too sick to be sent home. According to DHMIS (2012), the target set for BOR is 80%. If the BOR is above the set target, this means it is more than 100%.

The hospital has only 230 approved beds and has been decanting patients to nearby hospitals, though the bottleneck in transportation means that the casualty area is always overcrowded and unmanageable. The current emergency (casualty) section therefore cannot cater for the load of patients seen on a daily basis. Severe congestion is being experienced in the existing waiting areas, with the orthopaedic outpatient and male circumcision services only being rendered on alternative days. These challenges were not covered by the budget and this staff overload causes the ineffective monitoring and evaluation of implemented policies.
2.7.1 Waiting time for open beds

Patients and their family complained about the long waiting time in the Accident and Emergency (Casualty) Unit for open beds. This attracted the media and political parties such as the Democratic Alliance (DA) to visit the hospital. Waiting time also has a major impact on patients’ satisfaction. In a study conducted by Westaway, Rheedes, Van Zyl and Seager (2003:7) in South Africa, it is reported that the highest levels of dissatisfaction had to do with waiting time. Patients simply do not like to be left alone for a long time (Hasin, Seeluang, Roongrat & Shareef 2001:6). Bankauskaite and Saarelma, (2003:260) and Ericksson and Svedlund (2007:441) point out that long lines and waiting times for services and care are “a waste of time” and have a detrimental effect on health. Patients also express dissatisfaction with inflexible administrations, which leave them not knowing who to contact (Ericksson & Svedlund 2007:441).

Policy on patients’ admission indicates that hospital services must be made available to all persons, without prejudice, and must be limited only by bed availability. The admission of patients when there are limited beds available in the hospital must be based on a system that gives priority to critically ill patients. Since 2006, however, patients had been admitted without vacant beds in the wards and had instead slept on the floor in casualty. The institution had a service level agreement with Selby Park Clinic to take on those patients for step down services. Some patients refused to be transferred to Selby Park clinic indicating that they would rather die here (Edenvale Regional Hospital). The hospital informed each patient, or when appropriate, the patient’s representative (as allowed under State law) of the patient’s rights in advance of furnishing or discontinuing patient care whenever possible. All patients registered were offered the Patient Rights and Responsibilities brochure (Patient Rights Charter).

Selby Park Clinic costs the Edenvale Regional Hospital ± R7 599 254 a year. As a result, the Gauteng provincial office intervened to terminate the service level agreement and came up with the proposal to decant the patients to Bertha Gxowa District Hospital instead. This proposal however did not materialise because Bertha Gxowa District Hospital requested that patients must come with doctors and nurses who would look after them.
2.7.2 Workload and job satisfaction

The Casualty Department, on the ground floor of the hospital, has been extended to create three short-stay wards with four beds each. The time spent at the short-stay wards was reported to vary between 12 and 28 hours. Most of the patients in the short-stay wards were not brought to the hospital by ambulance; therefore they had to be admitted instead of being returned home. However, patients who are transported by ambulance to the hospital are re-routed to other nearby facilities. The opening of three short-stay ward with four beds each was done with the staff approval of fourteen nurses, four medical officers, two clerks and two porters by the Head of Department, but the posts were never created on “PERSAL” by the Gauteng Provincial Treasury. This then resulted in the heavy workload that is currently being experienced.

A heavy workload is related to job satisfaction of registered nurses and is one of the stressors and reasons why registered nurses leave their jobs (Strachota, Normadin, O’Brien, Clary & Krukow, 2003:112). Furthermore, “carrying heavy patient loads while lacking sufficient autonomy to implement procedures and make decisions is frustrating for nurses” (Strachota et al 2003:112). Shader et al (2001:211) found that increased responsibility at work is one of the factors influencing nurses’ turnover, which is positively related to job dissatisfaction. In the researcher’s experience, if the patient ratio is not proportionate to the staff, there will be an increase in the workload for nurses and this may result in poor patient care and contribute to staff absenteeism, unplanned leave, sick leave and turnover of nursing personnel.

Tota (2005:42), reports that nurses work under difficult conditions and under pressure, are overloaded and that absenteeism among nurses is high due to such work overload. This results in poor quality of patient care and higher turnover of experienced nurses in the hospital, and hence more junior staff, or agency staff, delivering an increasingly busy and inefficient service.

Upenieks (2002:571) found that with adequate staffing there would be the ability to deliver quality work because the workload would be manageable. In nursing practice, adequate staffing is essential and will contribute to job satisfaction of experienced nurses and quality care being delivered to patients. The hospital does not have enough staff to cover a 24-hour service in casualty, with the
result that nurse managers are obliged to let the other nursing personnel work overtime, extra shifts and more weekends to cover the healthcare services sufficiently in order to prevent medico-legal risks.

Barry-Walker (2000:77) found that increased pressure/workload affected payments due to overtime and resulted in inadequate delivery systems due to shortage of employees, technology being utilised inefficiently due to time constraints, negative professional relationships due to stresses, and unfulfilled clients’ expectations of care. These aspects resulted in hospitals changing their systems of care; for example, reallocating staff to areas where they were needed more.

2.7.3 Infrastructure challenges

The section of the hospital building where the Outpatient Department (OPD), casualty unit and wards are located is old, albeit kept clean. The hospital building cannot provide for additional wards, and this has affected the ability of the facility to provide adequate hospital beds. The area most affected by the shortage of beds is the female medical ward, which causes overcrowding in the ED while patients await open beds.

2.8 THE RELATIONSHIP BETWEEN COMMUNICATION AND CLIENT BEHAVIOUR CHARACTERISTICS

This study also illustrates that communication, client behaviour characteristics in relation to the public service context, and factors influencing the enhancement of customer care would assist in the implementation of customer care at the Casualty Department of Edenvale Regional Hospital in Gauteng Province.

There is constant pressure on public sectors around the world to deliver highly effective, efficient and responsive public programmes. Private public industries, such as banking, communication, retailing, and media have experienced rapid development in service delivery in combination with private operators, introducing innovative customer-service concepts in the delivery of quasi-public goods including healthcare (Milpark Business School, 2015:6).
According to the Institute of Public Administration Australia (IPAA), “social networking technologies are creating new opportunities for service users and service providers to be in an almost permanent ‘service conversation’ about all aspects of a service as it is being experienced” (IPAA, 2011:3). New technologies, digital tools and platforms provide innovative service-delivery mechanisms, thereby changing the way that society operates and having profound consequences for public governance and administration.

It is expected that future demand for public services will expand with the growing need for better education, training and employment, as well as an aging population’s demand for world-class health and social care (IPAA, 2011). In line with this growing demand, greater knowledge of client behaviour and of effective communication methods and techniques will be required of public-service employees.

2.8.1 Different client behaviour and characteristics are described in relation to the Public Service context

Consumer behaviour is described as “the study of individuals, groups, or organisations and the processes they use to select, secure, and dispose of products, services, experiences, or ideas to satisfy needs and the impacts that these processes have on the consumer and society” (Vijayalakshmi & Mahalakshmi, 2013:15276).

The study of consumer behaviour is set to blend elements from psychology, sociology, anthropology and economics while attempting to understand the decision-making processes of buyers, both individuals and groups (Vijayalakshmi & Mahalakshmi, 2013:15276).

Individual customer behaviour (as in the ‘what, when, how, where and how much’ one buys) is determined by consumer characteristics such as demographics and behavioural variables, as well as other influence from family, friends, reference groups and society in general. Self-perception, self-concept, social and cultural background, age, family cycle and one’s attitude, beliefs, values, motivations, personality and social class are all internal and external factors that influence customer behaviour (Vijayalakshmi & Mahalakshmi, 2013).
In the public sector context, it is not surprising to find that the importance of service quality factors is influenced by the nature of the service this is being provided and the characteristics of the client group in question. In health services, for example, the nature of the transaction can vary for the same service and type of user based on the urgency of the particular need. Clients accessing emergency services are likely to have a different set of priorities compared to those who are using only routine services (Office of Public Services Reform [OPSR], 2002).

Socio-cultural differences, which may include differing levels of literacy, can, with some contextual variation, significantly affect the expectations, experience and behaviour of clients when interacting with public-service employees (Milpark Education, 2014:7).

In the private sector, before marketing a product or service, marketers first attempt to understand the different types of consumers, the needs of different customers, the buying behaviour of each client segment, and both the internal and external factors influencing buying behaviour. No company can afford, no matter how successful, to ignore its customers’ wishes and needs, since dissatisfied customers can easily take their business elsewhere. Catering to the customers’ exact needs, as in when and how they want a specific service, and at a lower cost than a competitor, is essential to business success (OPSR, 2002). However, when it comes to the public sector, consumers/clients/customers have little or no choice in selecting the services they wish to use, as the public service is a monopoly. Mostly, they are forced to use the same public service as everyone else – they cannot pick or choose which SARS office they wish to file taxes at, for example, or which divorce court for filing their papers, or which public hospital they will go to for care, since this all depends on where they live.

The Department of Public Service and Administration (2007) states that the principle of ‘people first’ applies as much to the public sector as it does to the private sector and directly expresses what the Batho Pele Handbook advocates. The need for more effective ways of working for and serving the public is recognised by government and is captured in policy documents such as the Batho Pele Principles (White Paper on Transforming Public Service Delivery, 1997), whose eight principles emphasise that the end-users of public services are customers rather than citizens.
Patients should receive care and treatment that meets their basic needs and contributes to their recovery by ensuring that existing care standards and protocols are strictly followed (DoH 2011c:8). Action should be taken to reduce unintended harm to both patients and staff (adverse effects resulting from the care given, including operations performed and failures of the healthcare system and its workers through ignorance, inadequate inputs and systems failure or, at times, from negligence). Patients with special needs or at high-risk, such as pregnant women, young children, the elderly and mentally ill, should receive special attention. Public service departments failing to satisfy customers do not run the risk of business failure, since many public services are not paid for directly by customers. It is important to keep in mind that even though customers do not have the wherewithal to take their business elsewhere, they do have the power and right to vote government out of power if they feel dissatisfied with the services they are receiving (Department of Public Service and Administration, 2007:27).

In the private sector, as well as for public and public-trading enterprises, the focus is on the marketing to the customer, since income is derived by charging users for their particular products or services (e.g. electricity, water and transport). Public service agencies, on the other hand, do not develop a marketing strategy as such, but focus more on the delivery of services to the client and thus on the development of an effective service strategy (IPAA, 2011).

In the public sector, it is important to first separate the client market into meaningful segments in order to design an effective service strategy. The client base is thereby divided into groups of individuals who share common characteristics. This encourages a better understanding of customers and makes it easier to determine the needs of a particular client segment. It also makes it easier to develop an understanding of a wide range of client behaviours and associated abilities with which to communicate better with them.

There are a number of different criteria/characteristics available for segmenting clients. For example, see Table 2.2 below.
Table 2.2: Criteria for segmenting clients

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need</td>
<td>Desired outcome</td>
</tr>
<tr>
<td>Demographic</td>
<td>Age, gender, income and occupation</td>
</tr>
<tr>
<td>Psychographic</td>
<td>Lifestyle, personality</td>
</tr>
<tr>
<td>Behavioural</td>
<td>Usage, familiarity, loyalty, religion, dress, food, habits and fashion</td>
</tr>
<tr>
<td>Geographic</td>
<td>Size, country, province, city, region, population, urban/rural and linguistic diversity</td>
</tr>
<tr>
<td>Preferred mode of interaction</td>
<td>Digital or human</td>
</tr>
<tr>
<td>Capacity</td>
<td>Skills, abilities and literacy level</td>
</tr>
</tbody>
</table>

Source: IPAA (2011:13)

Private sector models have shifted somewhat from assessing customer satisfaction to looking at customer loyalty, re-purchase and recommendation behaviour. However, the most relevant factor within public services is customer satisfaction. According to IPAA (2011:6), “the vast majority of public services are monopolies, which means that their clients are captive and, as such, often taken for granted”.

The model below, developed by Ipsos MORI in partnership with the Office of Public Services Reform (OPSR, 2002), argues that customer satisfaction within the public service context is just one stage or level in the process of customer engagement. In the MORI model, organisational success comes from building relationships with the relevant target audience, which moves through a hierarchy from awareness to trust, transaction, satisfaction, commitment and advocacy (OPSR, 2002).

![Figure 2.2: MORI Excellence Model: relationship hierarchy](image-url)
In the MORI model (OPSR, 2002:46); customer satisfaction is based on the experience of engagement/transaction with the service provided. High levels of satisfaction among those using the service is not necessarily evidence of an organisation performing effectively, as many people who are eligible to make use of the service may not even be aware of an organisation or the services it offers.

In the public sector environment, it is not uncommon to find customers who have little trust in the public service, and whose expectations are such that they wish to avoid interaction with the organisation as much as possible. In this situation, the organisation cannot consider itself to be successful in satisfying consumers; and, in fact, the opposite clearly applies.

According to MORI, “real success comes not only from customers being satisfied, but then [also] acting in a way which enhances the stature and acceptability of the organisation among other members of the target customer audience, and other stakeholders – in the public sector context this could include service employees, the media, other government departments, etc.” (OPSR, 2002:47).

Research done by van Heerden (2010:5) with regard to customer service at a private hospital in the North West Province shows that the indicators formulated by Boshoff and Grey (2004) demonstrated that the quality of services provided can be defined “as the customer’s overall perception of the inferiority or superiority of service delivery by the organisation” or “the comparison of the customer’s expectations with actual perception of actual performance of services” (de Jager & du Plooy, 2007).

The South African government, post the 1994 democratic elections, adopted the Batho Pele Principles and Patient Rights in 1997 as a tool to achieve effective service delivery. However, it is worth noting that even though these policies have been adopted in order to speed up the implementation of quality healthcare services in the country, transformation still remains a major challenge in the public health sphere, with negative impacts on both health service delivery and financial management. In South Africa, the right to access healthcare is a constitutionally enshrined human right. Nevertheless, due to the evidently poor health outcomes experienced by the country, it is clear that many people are unable to realise this constitutional right.
The white paper on the Transformation of Public Service (South Africa, 1997) emphasised the value of quality service. “Quality is thus a perception that is based on an individual’s value system. It relies heavily on the culture, life experiences and expectations of each individual. Customer expectations can be divided into major areas: expectations regarding the physical attributes, or content, of the output/product that is provided, and expectations about the nature of the interaction between the producer and customer as the transaction take place” (Bent & James, n.d.).

The guiding philosophy that has been adopted in this legal framework is that of Batho Pele (in van Heerden 2010:5), which implies that the healthcare consumer is at the centre of the service delivery, and that these services should be transformed so that the consumers will thereby be satisfied. Its underlying belief is that of belonging, service and caring, and its vision for healthcare is of a coherent, representative, transparent, effective, efficient, accountable and responsive service in line with the needs of the consumer (South African Department of Health, 2007).

Therefore, healthcare institutions should create people-centred services that are characterised by the above-mentioned aspects. It is also necessary that institutions educate their employees about these characteristics, as well as equity, quality and a strong code of ethics in order for them to form the basis for the delivery of service quality (Bryant and Graham, in van Heerden 2010:5). Customer- and service-orientated institutions should measure their quality of service by evaluating the level of customer satisfaction in order to form a basis for improving and reforming their services, as this is crucial for client and customer retention, for enhancing customer treatment and improving the effectiveness thereof.

2.8.2 Encouraging customer care in the public sector

In his speech at the Association of Southern African Schools and Departments of Public Administration and Management (ASSADPAM) annual conference in 2010, the minister of Public Service and Administration, Richard Baloyi, stated that South Africa needs a public administration that is responsive, caring and proactive in dealing with citizens and their challenges. Public service delivery is also encouraged and promoted in the 1996 Constitution of the Republic of South Africa

### 2.8.3 Factors influencing the enhancement of customer care

In order to enhance customer care, officials dealing with customers should, amongst other things, possess effective communication and listening skills, empathy, problem-solving skills, responsiveness, assurance, emotional intelligence and the ability to handle complaints well (Masango & Mkutukana, 2013:596).

#### 2.8.3.1 Communication skills

Communication as a skill is not about the way one sounds when speaking, but about the way one communicates and engages with others. Dealing with people of different cultures, groups, professions, ages and genders requires communication skills. For instance, does the person speak clearly? Does he/she use short sentences as opposed to long-winded sentences that lose the listener halfway? Is there positive body language and good eye contact? (Badler, in Masango & Mkutukana, 2013:596).

Organisations recognise that their customers’ experience is based on their communication or marketing efforts, their branding, their interaction with employees, and on their products or services (Cook, 2008:19). Communication channels might include the internet, organisation’s website, e-mail, cellular phone, telephone, leaflets, television, radio, posters, billboards and/or notice boards.

#### 2.8.3.2 Empathy

Ethical empathy entails an effective sensitivity to the other’s experience without ever confusing the other with one’s self, yet at the same time without turning into distancing, self-serving sympathy. Empathy is a spontaneous emotional response of experiencing emotions alike to those of the other person.
Empathy can be elicited by witnessing another’s emotional state and/or by hearing or reading about another’s condition. Empathy is not always a pleasant experience, as it may be rather too close to experiencing another’s personal distress (Koopman, 2010:241).

Customer care officials must have a sense of feeling and understanding of what the customer is going through and be able to communicate that feeling back to the customer to ensure that it has been captured correctly. Most of the people who approach any organisation’s Customer Care department have been ill-treated in one way or another. How they are served at this point is therefore very important. Empathy should be communicated in a sincere manner, showing acknowledgement and appreciation of the customer’s feelings, not judgment or criticism. Customers want to feel that those attending to them understand exactly how the problem affects them as well as having confidence in the ability of the employee concerned to rectify the problem (Spontaneous Management Consulting, in Masango & Mkutukana, 2013:596).

2.8.3.3 Listening skills
It is crucial for customer care officials to be able to listen in a manner that encourages customers to talk freely, thereby enabling them to view and assess the message from the customer’s perspective. Furthermore, it is important to ask open questions when clarification is required. Open questions encourage the customer to talk and thus allow the official to obtain the necessary information. The customer care official should demonstrate that he/she cares about correcting the situation at hand. This includes allowing the customer to vent his/her frustrations, which is a vital part of the process (Spontaneous Management Consulting, in Masango & Mkutukana, 2013:596). Listening skills are essential not only when dealing with walk-in customers, but also when interacting with customers telephonically or via correspondence. Critical to the delivery of good customer service is the ability of the Public Service to listen to their clients, found what their needs are and determine how the clients wants this need to be met.(Milpark Education, 2014:16).

2.8.3.4 Problem-solving
According to Du Toit, Knipe, Van Der Waldt and Van Niekerk (2002:337), problem-solving involves carefully and deliberately attempting to overcome any obstacles in the path towards a particular goal.
This requires customer care officials to be able to identify, define, analyse and solve the problems they encounter daily, to be flexible and to be able to work well with people from all walks of life.

2.8.3.5 Handling of complaints

A complaint is an expression of dissatisfaction with service standards or with the actions (or lack of action) of the department concerned, and how this affected an individual customer or group of customers (Brennan and Douglas, in Masango & Mkutukana, 2013:596).

Complaints must be viewed as an opportunity to engage in meaningful dialogue with customers – an opportunity that needs to be understood and exploited, noting the valuable information that is thereby conveyed and which could in turn assist the institution to avoid complacency (Spontaneous Management Consulting, in Masago & Mkutukana, 2013:596). Every complaint is an opportunity for the organisation to:

- Correct the situation concerned in order to satisfy the customer;
- Win back a loyal customer, who might otherwise have decided to take their business elsewhere or has already taken their business elsewhere;
- Analyse and identify areas of weakness or bottlenecks within the system so that they can be corrected and eliminated. In this way, the organisation will be satisfying its existing customers who have not complained, as well as future customers;
- Promote its products or services; and
- Reassure its customers that the organisation and its staff are approachable and customer-focused.

Some government departments have toll-free numbers for when citizens, as customers, have questions or problems about the service rendered to them. One example is the toll-free number of the Office of the Presidency, which is available for citizens to telephonically register complaints about service delivery or the lack thereof. Access, information and redress are key components in handling complaints. Proper complaints handling and management is critical for an organisation to identify its weaknesses, prevent the same errors in future and reduce the amount of time and cost spent on such complaints.
2.8.4 Public Service Regulations

Customer care in the public sector is also encouraged through the Public Service Regulations. According to section C.2 of Chapter 2 of the Public Service Regulations (No R.679 of 1999), when dealing with the public, public officials should:

- Promote the unity and well-being of the South African nation;
- Serve it in an unbiased and impartial manner;
- Be polite, helpful and reasonably accessible at all times and treat members of the public as customers who are entitled to service of high standard;
- Have regard for the circumstances and concerns of the public;
- Be committed through timely service to the development and upliftment of all South Africans;
- Not discriminate on account of race, gender, ethnic or social origin, conscience, belief, culture or language;
- Not abuse her or his position to promote or prejudice the interest of any political party or interest group;
- Respect and protect every person’s dignity and rights as contained in the constitution; and
- Recognise the public’s right of access to information, excluding information that is specifically protected by law.

2.9 CONCLUSION

This chapter discussed the literature review on customer (patient) care that was conducted for the study. The literature review covered Orlando’s Nursing Process Theory, Service Quality Dimension with the Model of Glied and Gap, and the MORI Excellence Model, which formed the theoretical framework for the study and analysed the relationship between communication and client behaviour characteristics. Chapter three describes the research design and methodology.
CHAPTER 3: RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

The previous chapter gave a detailed discussion on the relevant literature review regarding customer (patient) care. This chapter describes the research design and study methodology, including the target population sampling, the data collection instrument, data analysis and interpretation, ethical considerations, measures to ensure trustworthiness of the results and study limitations.

The study was conducted to investigate the implementation of customer care at the Casualty (Accident and Emergency) Department, as experienced by patients at the Edenvale Regional Hospital.

3.2 OBJECTIVES

The main objective of the study was to investigate the implementation of effective customer care at the Casualty Department of the Edenvale Regional Hospital in Gauteng Province.

In order to achieve the main aim of the study, the following secondary objectives are developed:

- To determine how staff training affects the quality of customer care services in Edenvale Regional Hospital,
- To determine which strategies have been put in place to maximise customer care and its effect on the geographical community,
- To investigate how policies and guidelines affect the quality of customer service in the Casualty (Accident and Emergency) section at Edenvale Regional Hospital, and
- To provide recommendations to the Department of Health concerning how challenges facing customer care at the hospital can be addressed.
3.3 RESEARCH APPROACH

The researcher followed a qualitative approach. Grove, Burn and Gray (2013:705) defined qualitative research as a systematic, interactive, subjective approach used to describe participants’ experiences and the meaning they ascribe to their experiences.

According to Holland and Rees (2010:71), qualitative research is an umbrella term for a number of diverse approaches that seek to understand, by means of exploration, human experiences, perceptions, motivation, intentions and behaviour. It is commonly used to describe and explore phenomena where little is known about the subject in question. Because little is known about customer (patient) care at the Casualty Department of Edenvale Regional Hospital in relation to healthcare services in general, a qualitative approach was selected to be employed in this study. In this way the researcher strived to uncover the unknown with respect to the customer care experiences at the Casualty Department of Edenvale Regional Hospital in Gauteng Province.

Mateo and Kirchhoff (2009:131) state that qualitative research approaches focus on understanding phenomena in a ‘natural’ setting, and thus the researcher adopted this approach to explore people’s thoughts and feelings, which are not easily reduced to numbered responses to questions on paper and pencil instruments. In relation to this study, the qualitative approach enabled the researcher to provide rich descriptions of the implementation of customer care at the Edenvale Regional Hospital using sixteen (16) participants as data sources (Griffiths 2009:33). The researcher used a semi-structured interview format with the help of an interview schedule, not a structured questionnaire, to collect data from participants (Mateo & Kirchhoff 2009:132). This is because the researcher, like other qualitative researchers, is motivated to know more about the phenomenon studied from the participants’ perspectives who have experienced the same (Grove et al, 2013:264).

The discussion thus far is consistent with Creswell’s (2014:185) view of what constitutes qualitative inquiry. According to Creswell (2014:185), data in qualitative research are to be collected in the participants’ natural setting, and this was the case in this study. The researcher had an opportunity to use semi-structured interviews and document analyses as the two main methods of data collection.
3.4 RESEARCH DESIGN

A research design is a “master plan that specifies the method and procedures for collecting and analysing the required information” (Tustin, Lighthelm, Martins & Van Wyk, 2005:82). This assertion is in agreement with Moule and Goodman’s (2009:168) views that “research design is a map of the way in which the researcher will engage with researcher participant(s) in order to achieve the outcomes needed to address research aims and objectives”. A qualitative case study methodology, as illustrated by Baxter and Rideout (2006), “provides tools for researchers to study complex phenomena within their contexts. When the approach is applied correctly, it becomes a valuable method for health science research to develop theory, evaluate programs, and develop interventions”.

The research was conducted using a qualitative approach, which seeks to gain deeper understanding of the impact of customer care in Edenvale Regional Hospital from the employees’ point of view. These included frontline staff such as administration record clerks, nurses and doctors working in the Accident and Emergency section, and the pharmacy staff who deal directly with customers (patients). The views included those of the quality assurance unit and managers who dealt directly with customer complaints. The case study was descriptive and “was used to describe an intervention or phenomenon and the real-life context in which it occurred” (Yin, 2003:67). The phenomenon under research is the implementation of customer care in Edenvale Regional Hospital in Gauteng Province.

This study was descriptive in nature as it attempted to provide an accurate account of the phenomenon’s characteristics (Burns & Grove 2005:44). The phenomenon under investigation is the “Implementation of Customer Care at the Causality Department of Edenvale Regional Hospital in Gauteng Province”. It was also appropriate to use a descriptive research design in this study since little is known about the phenomenon. For this reason the descriptive approach allowed the identification of shortfalls in the implementation of customer care at Edenvale Regional Hospital.

3.5 RESEARCH METHODOLOGY

Research methodology is the process or plan for conducting a set of specific steps to be used in the study (Grove et al, 2013:707). In this section, the research site, population and sampling, data collection, and data analysis is discussed.
3.5.1 Research site

The study was conducted in only one hospital, namely Edenvale Regional Hospital. The hospital is well placed geographically to serve a needy user population, including the residents of Alexandra, which is in close proximity. The hospital was officially opened in 1903 with 120 beds and at first experienced a low bed occupancy rate, where a pocket of subspecialty services was rendered. Currently the hospital is classified as a regional hospital with 230 approved beds and all beds being usable. The hospital is zoned under the City of Johannesburg Metropolitan Municipality with a population of 4.5 million, and serves a catchment population of over 3.6 million. The hospital renders level 2 (two) health services and refers tertiary services to level 3 (three) health institutions. Referring clinics are within easy reach of Edenvale Hospital. The well-developed relationship between Alexandra Clinic, surrounding clinics and Edenvale Hospital makes the hospital a natural and convenient referral hospital for these facilities. The access by road and hence ease of access for ambulances and other vehicles is particularly good and adds value to the current placement of the institution.

The hospital provides curative service of a level 2 (two) nature, including: internal medicine, general surgery, obstetrics and gynaecology, paediatrics, casualty (accident and emergency) care, theatre, out-patient department, high care unit, kangaroo unit care, comprehensive HIV/AIDS management, TB focal point, rehabilitation centre, special clinics, allied medical departments (pharmacy, physiotherapy, speech therapy, occupational therapy, radiography and social work), nursing, clinical teaching and quality assurance.

All executive management positions are filled, namely the Chief Executive Officer, Clinical Manager, Nursing Manager, Administration Manager, Financial Manager, Human Resource Manager and Procurement Manager.

The total staff establishment at the hospital is 711. The following staff are allocated per category:

- Four clerks (day and night) in the admission unit
- Four nurses (day and night) in the Accident and Emergency unit
- Two doctors (day and night) in the Accident and Emergency area.
The function of the clerks in admission is to open files for the patients, file the patients’ records, retrieve information, accurately record all the patients’ details in the hospital registers (TPH31) and computer/s, retrieve files in records for second visitors, compile statistics and any reports required, receive provincial money and classify patients according to income. On average, about 120 patients visit the hospital daily, and they (the customers/patients) regularly complain about the waiting time to receive their files.

The nurses and doctors in the Accident and Emergency section are responsible for emergency patients. In the Accident and Emergency section there is a separate ward for patients awaiting open beds. Patients sleep in stretchers and mattresses on the floor for sometimes two to three days at a time and this creates extra work among the healthcare workers.

3.5.2 Target population

Collins and Hussey (2009:62) define population as a “body of people or objects under consideration for statistical purposes”. Brink (2009:132) refers to the population in research as the entire group of persons or objects that are of interest to the researcher and who meet the criteria for participating in the research. A target population is defined by Neelankavil (2007:234) as “the total number of elements of a specific population relevant to the research project”. The researcher selected participants who are directly involved with the problem.

The study population was Edenvale Regional Hospital in Johannesburg, Gauteng Province. The target population selected to participate in the study included the Chief Executive Officer, the head of nursing services, head of medical services, head of administrative services, head of finance, quality assurance manager and infection controller coordinator. In each category represented, under the heads mentioned above, two employees were selected purposively; that is, any employee in the unit and an employee working in casualty and admission. The study involved a total of sixteen (16) participants.
3.5.3 Sampling Techniques

Saunders and Werner (in Mwanda, 2010:13) explain that sampling is justified when it is impractical, expensive and too time-consuming to include the entire population. Babbie and Mouton (2009:180) refer to sampling as “the process of selecting the sample from the population in order to obtain information regarding a phenomenon in a way that represents the population of interest”.

Burns and Grove (2009:35), on the other hand, define sampling as a process of selecting subjects, events, behaviours or additional elements for participation in a study.

In selecting the participants a purposive sampling technique was employed, with the participants being selected based on their roles in the facility. Purposive sampling is explained by Babbie and Mouton (2009:166) as appropriate for the researcher who wants to select a sample based on his/her own judgment and the specific purpose of the study.

3.5.4 Sample size

According to Kumar in Vos (2013), “sample size concerns the number of elements from whom the required information is obtained”. In qualitative research, as Burns and Grove (2009:361) point out, the focus is “on the quality of information obtained … rather than the size of the sample”.

In this study, the researcher considered the purpose of the study as well as the in-depth, rich information required to gain insight into the phenomenon under investigation. The sample size was therefore determined by the generated data and the information obtained from the participants. Burns and Grove (2009:361) also indicate that the number of participants is adequate once saturation of information is achieved, which means additional participants do not contribute any new information to the study.

This study involved a total of sixteen (16) participants. This sampling involved the assembling of a sample of persons with known or demonstrable experience and expertise in some specific area. For example, in the hospital the Chief Executive Officer, head of nursing services, head of medical
services, head of administrative services, head of finance, the supply chain manager, human resource manager, quality assurance manager and infection controller coordinator were selected to participate in the study. In each category represented, under the heads mentioned above, two employees were selected purposively; that is, any employee in the unit and an employee working in casualty and admission.

The unstructured, in-depth interviews lasted for approximately 35 minutes each and no new information was obtained after completion of the interviews. The participants were mixed (females and males) and they were well spoken and fluent in English and communicated openly with the researcher.

3.6 DATA COLLECTION TECHNIQUES

Burns and Grove (2009:43) state that a data collection plan details how the study is implemented and how the collection of the data must be specific to the study being conducted. This assertion is in agreement with Polit and Beck (2008:716), who state that data collection is the gathering of information to address a research problem, which is what the researcher intended to do during this investigation.

For this study, the researcher conducted both semi-structured individual interviews and documentary analysis to collect the data that was needed. Interviewing was conducted in a suitable environment and the documentary content was used to confirm how the participants responded and the information thereby derived.

3.6.1 Semi-structured interview

Cresswell (2014:30) confirmed that “semi-structured interviews are flexible, adaptable and provide direct human interaction”. This is because the semi-structured interview method grants the researcher freedom to probe the interviewee in order to elaborate upon any particular point or question, or else “to follow a new line of inquiry introduced by what the interviewee is saying”, and it is this open-ended nature of the questions that provides opportunities for both interviewer and interviewee to
discuss the topic in greater detail (Hofstee, 2011:107). Face-to-face interviews were conducted with clerical staff, nurses and doctors working in the Accident and Emergency unit, as well as with executive managers and representatives from the quality assurance unit. These interviews were personal, intensive and semi-structured and follow-up interviews were conducted with selected participants in order to verify the consistency of the responses. The researcher took field notes of all discussions.

3.6.2 Document analysis

Document analysis, according to Hofstee (2011:108), is “a form of qualitative research in which documents are interpreted by the researcher to give voice and meaning around an assessment topic. Analysing documents incorporates coding content into themes similar to how focus groups or interview transcripts are analysed”. The types of documents that were assessed included government documents, the Hospital Information System (HIS), Gauteng health bulletins and operational plans, core standard assessment reports, patient satisfaction surveys and the hospital complaints register. This study adopted the following steps in order to improve the trustworthiness of the research findings.

3.6.3 Constructing interview questions

The researcher was guided by the research objectives and research questions to ensure the relevance of the information or data gathered. The researcher concentrated on whether the research questions could be answered or not. The questions were divided into four categories, namely: biographic data, the grand tour question, follow-up questions and probes (Annexure F).

3.6.4 Recruitment of participants

The researcher used the opportunity at the head of section (HOS) meeting to recruit participants, as both the hospital management team and potential participants were in attendance at this meeting. The discussions here focused on the aims, objectives and significance of the study. Time was also allocated for potential participants and managers to express their concerns. These concerns were
mainly expressed in the context of anonymity and confidentiality. The concerns were addressed through the use of a pseudonym for the hospital and codes for participants. An information leaflet was given to each potential participant to complement the information offered and to be referred to when necessary. The information contained descriptions of the study including its aim, objectives, issues of confidentiality and anonymity, benefits and significance of the study, and contact details of the researcher. Potential participants were asked to express their willingness for participation by contacting the researcher. All potential participants present at the meeting made contact with the researcher via cell phone, e-mails and expressed their willingness to participate. Appointments were made for each participant, and this included the venue, date and time at which they would be interviewed.

3.6.5 Conducting the interviews

Ethical clearance to conduct the study was obtained from the University of South Africa (UNISA) College of Economic and Management Sciences Research Ethics Review Committee (Annexure A), permission to collect data was obtained from the Gauteng Health Department (Annexure B) and permission to access the study site from the Chief Executive Officer of Edenvale Regional Hospital (Annexure C). Before conducting the interviews the researcher recapped the information provided during the information session. The information leaflet was again given to each participant to enhance their understanding of the study (Annexure D). All participants demonstrated an understanding of the study, and subsequently indicated their preparedness and willingness to partake therein by signing the informed consent (Annexure E). All the interviews were conducted in the ground floor boardroom and all the responses were noted down by the researcher, which was clearly explained to the participants. Each interview lasted for about 35 to 45 minutes on average.

The researcher started each interview by asking the potential participant about their period of service in the hospital, allocation and rotation within the units for better understanding of their background. This was then followed by an open-ended question: “How did you as an employee of the Edenvale Regional Hospital experience customer (patient) care in the Accident and Emergency (Casualty) Department in the past three to ten years?” Participants’ responses were sometimes followed by
probes and prompts to enable them to describe and explain their experiences. Field notes were also taken after each interview.

3.7 DATA ANALYSIS AND INTERPRETATION

Data analysis, according to Polit and Beck (2008:716), is “the systematic organisation and synthesis of the research data”. In preparing for data analysis, the researcher calculated the number of participants who were involved with the research to ensure that no information that was given by them was left out – i.e. that the responses received tallied against the number selected.

This study used a qualitative approach based on the researcher’s interpretation that the problem had been in existence since 2006 and there was thus a need to interview employees who had served in the hospital for three years and more. These interviews were supported by the information collected throughout these years –i.e. post 2006.

Content analysis was used to mechanically and physically organise and sub-divide the data into relevant categories, as well as to interpret those categories in meaningful ways (Sewpershed, 2003). The researcher categorised and classified data into meaningful units for the appropriate category, and then verified relationships and developed conclusions therefrom. The data was organised by the questions asked of the respondents and their respective answers in order to identify any differences and inconsistencies in the data that came from various sources as mentioned above, namely open-ended questions, written comments on questionnaires or word-for-word transcripts. The interpretation thereof was based on the questions posed.

This study focused on the implementation of effective customer care in the Accident and Emergency (Casualty) unit of Edenvale Regional Hospital. Coding was used to collate the data and then analyse it as themes, ideas, concepts and interpretations; and, as propositions emerged, the data interpretation was then systematically developed and refined. This was followed by probing questions to acquire in-depth information with which to allow the researcher to understand the experience of the selected employees above.
3.8 ETHICAL CONSIDERATIONS

“Ethical issues are the concerns and dilemmas that arise over the proper way to execute research, more specifically not to create harmful conditions for the subjects of the enquiry, humans, in research processes” (Schurink, 2005:43). The researcher was aware of the large responsibility to be sensitive and respectful towards the research participants and their basic human rights and to fully endorse the Ethical Code of the University of South Africa. As specified by Muller (2007), the following ethical principles were followed in order to ensure the safety and wellbeing of participants and are discussed below.

3.8.1 Protecting the rights of the institution involved

The researcher maintained honesty and integrity while conducting the study, and also had an obligation to seek approval and permission from the respective institutions at different levels for the research to be conducted. Firstly, the researcher was granted the approval to conduct the study from the Post–graduate Ethics Committee of the University of South Africa (Annexure A). Subsequent to that, permission to conduct the study was granted by the Research Committee of the Gauteng Department of Health and the researcher also requested access to the research site from the Chief Executive Officer of Edenvale Regional Hospital (Annexure B), and the names of the potential participants were protected to ensure confidentiality.

3.8.2 Autonomy

According to Brink et al (2014: 35), the “right to self-determination simply relates to the ability to self-govern and manage one’s own affairs”. The participants were informed that they have the right to decide whether or not to participate in this study without any risk of penalty and judgmental remarks. The researcher did not exercise any form of coercion towards the participants, and assured them that their involvement in the study would do them no harm whatsoever, but if they happened to become exposed to any form of discomfort, the researcher would address it. Participants were informed of their role in the study and promised that their vulnerability would not be taken advantage of, and that no form of compensation would be provided, as participation is solely voluntary. The
researcher provided the participants with detailed information regarding the benefits of the study and informed them that he has no right to coercively engage them into taking part in this study.

3.8.3 Informed consent

The participants of a research study must all agree to participate in the research. According to Speziale, Streubert, and Carpenter (2011:61), “informed consent is a prerequisite for all research involving identifiable subjects”. Before signing the informed consent the researcher took cognizance of the rights of participants and provided information based on the following:

- The participants were made aware that there are no incentives for participating in the study.
- The researcher made the participants aware that their participation is voluntary and they are free to decline at any time without being penalised.
- The researcher informed the participants that there is no risk involved, as the interviews would be held at their ground floor boardroom. This was to emphasise protection from harm and/or discomfort.
- The researcher further explained to the participants that confidentiality would be maintained at all levels, hence the right to privacy.

All the participants in the research indicated their agreement to participate through signing an informed consent form (Annexure E) after the research objectives had been adequately explained.

3.8.4 Beneficence

According to Burns and Grove (2005:728), “the principle of beneficence encourages the researcher to do well and above all to do no harm”. The respondents were assured that they would not be harmed physically from fatigue due to the time needed to complete the face-to-face interviews, or psychologically from stress or fear. This principle is of great importance since it entails multiple dimensions such as freedom from harm, freedom from exploitation, benefits from research and risk benefit ratio. The participants were assured that the information that they will provide will not be used against them during or after their stay in the hospital (Polit & Beck 2004:145).
3.8.5 Confidentiality

According to King and Horrocks (2010:117), confidentiality suggests that whatever a research participant says to a researcher will remain private and not be repeated. The consent form that was given to each research participant assured them of the confidentiality of their participation in this study.

3.8.6 Anonymity

Anonymity refers to hiding the identity of the participants in all documents resulting from the research process, therefore protecting the identity of each research participant (King and Horrocks, 2010:117). In this study the anonymity of the participants was taken into consideration. The research participants were informed through the consent form that no personal information, besides the information which is part of the purpose of the academic research, would be used.

3.8.7 Fair treatment

Impartiality is essentially the requirement that activity be fairly distributed amongst participants (Newell & Burnard 2011:51). The researcher ensured that all potential participants in the hospital under study were given equal opportunity to be included in the study based on their homogenous characteristics. Scheduled appointments for interviews regarding dates, times and venues were honoured by the participants. The researcher took an obligation not to treat the participants who chose to decline to participate unfairly (Polit & Beck 2012:155). Participants’ attitudes, behaviours, beliefs, and background were honoured at all times. Participants were not paid for their participation.

3.9 RELIABILITY AND VALIDITY OF THE DATA

Given (2008:895) defines trustworthiness as “the way in which qualitative researchers ensure that credibility, dependability, transferability and conformability of the study are evident in their research”. In qualitative research, validity is measured through the accuracy and truthfulness of the findings (Brink et al, 2012:172). Cuba’s model, as referred to by Brink et al, (2012:172), was used to ensure reliability of the results. The model identifies the criteria in assessing reliability. In this study,
credibility, triangulation, transferability, dependability and conformability or neutrality were observed as discussed below.

3.9.1 Credibility

Polit and Beck (2012:858) refer to ‘credibility’ as confidence in the truth of the data and data interpretations. Babbie and Mutton (2009:277) further emphasise that credibility is about the truth of the findings in a qualitative study. The supervisor offered constant and regular guidance to the researcher throughout the study. A specialist in qualitative research was also engaged in the validation of superordinate themes and sub-themes. The researcher ensured the accuracy of participants’ responses by checking and triangulation of transcribed data and field notes.

3.9.2 Revisiting the participates

In ensuring the accuracy of the data, the researcher went back to the participants to provide feedback about emerging interpretations and to seek clarifications of some aspects of their responses (Polit & Beck 2012:591). Participants were able to clarify the issues discussed with them.

3.9.3 Data integrity

The main advantage of using the Department of Health and hospital documentation was that it was generated for a purpose unrelated to this research, and therefore there was a high level of confidence in its authenticity and credibility. However, documents are social products and as such reflect the subjectivity of their authorship. For these reasons the data on which the findings of Chapter 4 are based was treated with caution, and its derivation was made obvious in the text of the dissertation.
3.9.4 Triangulation

Data triangulation was also used to ensure credibility of the study as the researcher collected data using interviews and document analysis. The researcher used unstructured interviews and field notes as means of ensuring triangulation (Polit & Beck 2012:590).

3.9.5 Peer debriefing

Peer debriefing is one of the quality enhancement strategies that involves external review as well as sessions with peers to review and explore various aspects of the inquiry (Polit & Beck 2012:594). The researcher presented his summary of the findings to his supervisor, other qualified and experience researchers from his workplace, and academic colleagues for review and discussion. Suggestions for improvement were made and incorporated in the findings.

3.9.6 Transferability

According to Polite and Beck (2012:745), this refers to “the ability of generalizing data, to an extent where the findings from it can be appropriately transferred or extrapolated to other settings or groups”. To comply with this criterion, the researcher fully described the research sites, participants and the data collection methods. The researcher conducted detailed and necessary description of findings from the study participants about their experience of healthcare utilisation.

3.9.7 Dependability

According to Polit and Beck (2012:725), dependability refers to a criterion for evaluating integrity over time and conditions, analogous to the reliability in research. Taylor (2014:204) further refers to dependability as procedural processes where an audit trail is outlined in order to check the routes for discussion making at every stage of the research process. The study was transparent, both with the study participants and the research supervisor, in that the research process was adhered to and followed throughout. From the beginning of the study and all the way through the process until its completion, the researcher maintained a close personal relationship and continuous contact with the
study participants, to assure that the final results included and presented are truthful representations of what the subjects had experienced, and what they have explained from their own points of view or understanding. Therefore, they were updated continuously through different means of communication, according to the preference of each individual. The researcher maintained a close contact, undertook continuous follow-ups, and benefited from the constant input and guidance from the supervisor.

3.9.8 Bracketing

According to Given (2008:555), understanding and description of human views is of utmost importance; however, neutrality is not very easy to maintain, hence bias is a major threat to the validity of the findings (Streubert and Carpenter, 2012:20). Nevertheless, in this study the researcher’s various interpretations of the phenomena, feelings, thoughts and perceptions were bracketed before the beginning of the data collection and analysis process so that the validity of the study results would be maintained throughout (Polit and Beck, 2004:14). The researcher allowed participants to express themselves on all aspects related to the study, and even when he realized that he was more familiar with certain phenomena he did not stop the participants from voicing their views.

3.10 LIMITATIONS OF THE STUDY

According to Marshall and Rossman (2011:76), research limitations are derived from the conceptual framework and study design and there are no perfect research designs. The following limitations were identified in this study:

The study was only focused on the employees, managers and quality assurance personnel who are directly involved with patients’ complaints in Edenvale Regional Hospital, and could therefore not be seen as representative of all the customers of the Gauteng Department of Health. The study provided a broader understanding and insight into the healthcare services in public hospitals with the limitation that it was conducted in only one public hospital in Gauteng Province. The response of the respondents of the hospital under study may reveal different findings if conducted in other settings.
The researcher cannot conclude that the study findings may be generalised to other public hospitals in the same district of Gauteng Province, though the results may be transferable to other public hospitals in other areas.

3.11 CONCLUSION

This chapter focused on the research design and study methodology, including the target population sampling, the data collection instrument, data analysis and interpretation, ethical considerations, measures to ensure trustworthiness of the results and limitation of the study. Chapter four focusses on presentation and analysis of findings.
CHAPTER 4: PRESENTATION AND ANALYSIS OF FINDINGS

4.1 INTRODUCTION

This chapter presents the research findings based on the interviews conducted with the sample of 16 respondents who were drawn from Edenvale Regional Hospital. The study experienced a 100% response rate as all the members of the sample population participated in the research. This can be attributed to the fact that interviews generally enjoy a much higher response rate than impersonal questionnaires (Ruane, 2016:191).

This chapter presents and analyses the findings and then discusses the findings in conjunction with the research objectives. The analysis of the results is what gives meaning to the raw data that has been collected and puts it into perspective. The analysis was conducted based on the research objectives that were presented in Chapter One of the study.

4.2 DEMOGRAPHIC INFORMATION

Description of demographic data of the participants is necessary for qualitative research. It helps to ensure the trustworthiness of the study, as it assists in meeting the criteria of transferability (Bryman, Bell, Hirschsohn, Dos Sentos, Du Toit, Masenge, Van Aardt & Wagne 2014:45) Demographic data enable the readers to understand the sources of data and assist in interpretation of the findings. The first section of the study presents the demographic information pertaining to the study respondents. The respondents were asked to provide their age, gender, category of position, length of experience at Edenvale Hospital and highest educational qualification attained.

4.2.1 Age in Years

The respondents were asked to provide their age in years and the information is provided in the pie chart below.
Figure 4.1: Age in years

Figure 4.1 shows that of the 16 respondents, 13% (2) were aged between 25 and 35 years, 19% (3) were aged from 56 years and above, and 69% (11) were aged between 36 and 55 years. The results in the pie chart indicate that the majority of those who participated in the study were aged between 36 and 55 years. With respect to age, the older the respondent, the greater the likelihood that the individual has more experience as well, meaning that their contributions towards any studies are generally invaluable.

4.2.2 Gender

The respondents were asked to provide their genders at the beginning of the interviews. The information is also presented in the figure below.
The results indicated that 56% (9) of the 16 respondents were female and 44% (7) were male. Health sectors worldwide are usually known to have more female employees than males and this is the situation in the sample that participated in the study (Foldspang & Ministerråd, 2013:31).

4.2.3 Position and Department

The respondents were asked to provide their positions and respective departments in the workplace and the information is presented in the table below.

Table 4.1: Position and department

<table>
<thead>
<tr>
<th>Department</th>
<th>Top Management level</th>
<th>Medical Officers</th>
<th>Middle Management</th>
<th>Junior Management</th>
<th>Operational Level</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Casualty</td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Management</td>
<td></td>
<td>2</td>
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<td></td>
<td>2</td>
</tr>
<tr>
<td>Finance &amp; Supply Chain</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Human Resources</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Patient Affairs</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Nursing</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
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<tr>
<td>Administration</td>
<td></td>
<td>1</td>
<td></td>
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<td></td>
<td>1</td>
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<tr>
<td>Infection and Prevention Control</td>
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<td>1</td>
<td></td>
<td></td>
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<td>1</td>
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<tr>
<td>Surgery</td>
<td></td>
<td>1</td>
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<td>1</td>
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<tr>
<td>High Care</td>
<td></td>
<td>1</td>
<td></td>
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<td></td>
<td>1</td>
</tr>
<tr>
<td>Quality Assurance</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
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<td>1</td>
</tr>
<tr>
<td>Radiology</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>3</strong></td>
<td><strong>4</strong></td>
<td><strong>4</strong></td>
<td><strong>2</strong></td>
<td><strong>3</strong></td>
<td><strong>16</strong></td>
</tr>
</tbody>
</table>

The information in the table revealed that a total of 3 of the 16 respondents were top management; 3 were medical officers, 2 were middle management personnel, 2 were junior management personnel and the remaining 3 were operational level staff. The highest numbers of respondents were medical officers represented by 25% and another 25% were middle managers. The Casualty Department provided most of the respondents, with 4 respondents being drawn from this department. Another 2
of the respondents were medical officers, 1 was a junior manager and the other respondent was an operational level personnel. The fact that most respondents were drawn from casualty meant that more information could be obtained pertaining to the casualty section, considering that the study’s focus is on that particular department.

4.2.4 Length of experience

The respondents were asked how long they had been working at Edenvale Hospital in years. The information provided is presented in the graph below.

![Bar graph showing experience in years](image)

**Figure 4.3: Experience in years**

The results in Figure 4.3 indicate that 19% (3) of the respondents had been working at the hospital for periods of between 3 and 5 years, 31% (5) had been in the organisation for periods of between 5 and 10 years, and 50% (8) of the respondents had been in the organisation for a period of 10 years and above. The results indicate that the majority of respondents had been with the hospital for periods
of 5 years and more, which implies that their contributions to any study pertaining to the hospital is invaluable based on their experience gained over the years.

4.2.5 Highest qualification attained

The respondents were asked about the highest qualifications they had attained and the results are presented in the graph below.

Figure 4.4: Highest qualification attained

Figure 4.4 indicates that only 6% (1) of the respondents did not possess a matric certificate, 13% (2) of the 16 respondents had gone as far as Grade 12, and 38% (6) of the respondents had obtained diplomas and degrees. The results also revealed that 44% (7) of the respondents were in the highest category of qualifications, meaning they had either an Honours degree, Master’s degree or a PhD. The information reveals that most of the respondents in the sample are highly educated as more than 80% had qualifications ranging from diplomas to doctorate degrees.
4.3 DISCUSSION OF THE MAIN STUDY FINDINGS

The findings in this section are based on the objectives that were presented in Chapter One of the study. The main objective that these findings pertain to is the investigation of the implementation of customer care at the Casualty Department at Edenvale Regional Hospital in Gauteng Province, with a special emphasis on customer care. The secondary objectives that guided the study and which also guided the presentation of the findings are as follows:

- To determine how staff training affects the quality of customer care services in Edenvale Regional Hospital;
- To determine which strategies have been put in place to maximise customer care and its effect on the geographical community;
- To investigate how policies and guidelines affect the quality of customer service in the Casualty (Accident and Emergency) section at Edenvale Regional Hospital; and
- To provide recommendations to the Department of Health concerning how challenges facing customer care at the hospital can be addressed.

The findings are presented in terms of themes and in some instances as sub-themes. The following sub-sections present and discuss the results.

4.3.1 High levels of expectations from communities

The communities that make use of Edenvale Hospital’s Casualty Department have high levels of expectations regarding the service that they should receive. These expectations, however, are not in line with the resource capabilities of this healthcare institution’s casualty section. For example, Respondent 1 highlighted that the community expected timeous consultation and treatment regardless of their medical condition. The exceedingly high expectations often led to tension and needless exchanges between the hospital personnel, patients and relatives. Respondent 9 also highlighted in one statement that when patients come to the casualty section they have high levels of expectations:
“Patients after waiting for a long time to see the doctor ... become frustrated and take their frustration [out on] nurses” (Respondent 9).

The community’s high expectation levels are also evident in that they would rather not utilise the other smaller healthcare facilities such as clinics before they come to the hospital. Respondent 10, who is a medical practitioner, complained that some patients preferred to come to the Edenvale Regional Hospital Casualty Department rather than first starting with local clinics. It seems patients believe that since the hospital is a much bigger health facility it will therefore offer them what they want due to its size. However, this assumption is oblivious to the realities of this institution regarding resource constraints. Going back to literature, patients have generally always harboured unrealistically high expectations from healthcare institutions. According to Mishra and Mishra (2014:624), high expectation is a positive indicator of a healthcare institution’s reputation in the society and is very important for attracting patients. However, very high and unrealistic expectations may also lead to patients being dissatisfied despite reasonably good standards of service from medical institutions (Mishra & Mishra, 2014:624). Therefore, while it is fine for patients to have high expectations, unrealistic expectations on the other hand can lead to conflict between patients and hospital staff.

### 4.3.2 Quality of Patient Care

The main theme in this section is quality of patient care, which could also have been called quality of customer care had the casualty ward been a business entity. The quality of patient care in the Edenvale Regional Hospital casualty section seems to be poor. A number of sub-themes have been identified and they are presented in the following sub-sections. It is possible that high quality of care for patients can be achieved in healthcare institutions, but there are a number of constraints that impede this from being achieved. Staffing in particular is said to be a major predictor of the quality of care in a healthcare institution even though the quality of any healthcare system is always difficult to define (Veenema, 2013:40). The provision of quality healthcare is possible as long as there are adequate resources for the department to use, but there are other aspects that do not require resources...
but rather that those providing the services do so with a positive attitude, which in turn requires rectifying any bad attitudes among the staff in question.

4.3.2.1 Bad attitude
The attitude of the healthcare staff at the Edenvale Casualty Department must be suggestive of an organisation wishing to provide good quality healthcare to its patients. A bad attitude has nevertheless been noted among healthcare staff towards patients and their relatives. This negative attitude has also been noted to emanate not only from the Edenvale Regional Hospital staff but also from the patients themselves. The following statements were taken from Respondents in this regard:

“Generally, there has been [a bad] attitude displayed by all parties at all times for even a minor incident that just needed a minor explanation or information” (Respondent 1).

“Doctors and nursing doesn’t communicate in a proper manner. It seems if they try to be difficult on purpose with the patients” (Respondent 2).

“The negative behaviour of the staff develop negative attitude of customer Staff visiting the area, where clerks are working, affect patients because they thing that they are people who are sitting not helping them” (Respondent 3).

“Employees’ positive behaviours have a positive impact on overall customers' satisfaction. Employees negative behaviours have a negative impact on overall customers' satisfaction” (Respondent 4).

“Difference in the attitude and behaviours of the employees in the customer-employee encounter cause reactions and decision by customer resulting in a change in customer satisfaction” (Respondent 5).
“Employees positive attitude have a positive impact on overall customers” (Respondent 6).

“Negative attitude of the staff can results in long queues, loss of hope and distrust” (Respondent 8)

Respondent 2 stated that she had observed that doctors and nurses did not communicate properly with patients and it seemed to her as if they were being purposefully difficult to the patients. The fact that the staff in the casualty section were observed being crude in their interactions with patients indicates that they seem not to care for the patients, hence the negative attitude in their dealings with them. This bad attitude that patients receive translates to poor quality customer care. Burnout among healthcare staff has been found to be the leading cause of poor attitudes towards patients and work and this has also been worsened by negative attitudes from the community towards nurses and doctors (Ojwang et al., 2013:1). The bad attitude of healthcare workers was additionally highlighted in an article published on the Health-e-News website pertaining to Daveyton Main Clinic in the East Rand. According to Mkhwanazi (2012), patients served by the Daveyton Main Clinic complained about the long queues, drug shortages and the poor attitude of healthcare personnel.

4.3.2.2 Long waiting periods

The patients are forced by the overcrowding situation to wait for long periods of time when they visit the casualty section, even though casualty patients are typically those who require urgent attention. This means that if they are forced to wait for long periods before receiving attention, then the whole objective of the hospital to provide quality care for emergency situations is defeated. The challenge and frustration of the long waiting time was highlighted by most of the respondents. According to Respondent 16, patients and their families complained about the long waiting time in the Accident and Emergency (Casualty) Unit. Statements taken from the other participants also highlighting that the long waiting period was a major issue affecting the quality of customer care in the casualty ward are as follows:
“Patients are not coming during working hours due to the long waiting times to see a doctor during working hours” (Respondent 2)

“Patient sleeping on the stretchers and floor waiting for beds” (Respondent 3)

“Time management, (long waiting time)” (Respondent 8)

“Patients waited too long to be admitted in the ward because of unavailability of vacant beds” (Respondent 15).

“Patients wait for a long time to be seen by the doctor. They become frustrated and take their frustration [out on] nurses” (Respondent 9).

“Waiting time for open beds in the wards is too long” (Respondent 13).

“Patients and their family complained about the long waiting time for in Accident and Emergency (Casualty) Unit for open beds” (Respondent 16)

The majority of the respondents raised the issue of the long waiting time, which they said was related to the shortage of beds in the hospital wards. The fact that patients have to wait longer at the casualty ward indicates that the quality of service is severely impacted. The casualty ward, also commonly known as the Accident and Emergency ward, plays the most critical role in caring for the acutely ill and injured patients (Sakr and Wardrope, 2000:315). Such people need urgent medical attention and if they are made to wait in long queues and sleep on the floors while waiting to see a doctor, then the Accident and Emergency (Casualty) section can be seen to be failing in providing adequate emergency medical care. The average number of patients waiting in the Casualty Department to be given beds in the hospital was 68 in 2012, 150 in 2013, 268 in 2014 and it then shot up to 432 in 2015 (Edenvale Regional Hospital Management, 2015). The average number of patients waiting to get beds has effectively increased by 535% between 2012 and 2015 based on these fugures.
4.3.2.3 Poor communication skills

Communication is an essential aspect in any type of healthcare, as this is how healthcare professionals get to know the problems that patients have and also allows patients to relay whatever information can be useful to the medical practitioners. In instances where communication becomes poor, the quality of patient care is therefore negatively impacted. This study indicated that there were instances of poor communication emanating from the doctors and nurses working in the casualty section of Edenvale Hospital. According to Respondent 2, doctors and nurses do not communicate properly and the way they communicated appeared as if it was done in a deliberately difficult manner towards patients in the Casualty Department. Some of the statements were also quoted by the respondents as stating the following regarding the ineffective communication in the hospital’s casualty section:

“Staff, on the other hand, are unable to explain procedures and processes [to patients]....” (Respondent 1).

“Patients are not given enough time to explain ... their treatment and conditions” (Respondent 6).

“The sisters and porters are not in good communication especially regarding equipment that is used by porters” (Respondent 8).

The way healthcare staff communicate with patients is highly predictive of how the hospital’s quality of customer care will be viewed. The issue of poor communication skills was raised by three respondents, but because it’s so important when working within the healthcare system it forms part of this discussion under quality of patient care. According to Grafft and Grafft (2012:256), effective communication is important between the patient and healthcare provider in order for useful patient information to be obtained. Patients are bound to feel that the healthcare institution is caring if they are communicated with effectively.

The issues raised in the previous section were related to the quality of patient care and the factors that have been raised which affected this dynamic. The quality of patient care in the hospital’s casualty
ward is a product of staff training. If the casualty section is not staffed by people who have obtained specific training in this aspect of emergency medical care, customer care may therefore be compromised. According to Sakr and Wardrope (2000:318), in South African emergency departments doctors are referred to as “Casualty Officers” and most of them have never received any specialty training in this regard. Sakr and Wardrope (2000:318) also indicated that a new qualification for casualty staff had been introduced, but that most of those who held this qualification were in the private sector.

4.3.3 Lack of resources

Despite the training that casualty employees can obtain, offering quality emergency healthcare is also dependent on the availability of all the necessary resources for ensuring that the complete quality emergency healthcare package is offered to communities. There is a serious shortage of resources such as beds in the casualty section at Edenvale Hospital, which also happens to be small and inadequate. A number of sub-themes related to the inadequacy of resources at the hospital are discussed in the following sub-sections. Just to emphasize the issue of the shortage of resources, the South African government released a national guideline for home-based care (HBC) and community-based care (CBC) in 2001, which promoted these as opposed to hospital care as far as possible because of the shortage of resources such hospital beds and inadequate number of healthcare professionals in the public sector, which together with overcrowded hospitals could not offer quality customer care to patients, especially to those dying from terminal or long-term ailments (Dageid et al., 2011). The issue of resources is also a major factor affecting the casualty unit at the Edenvale Hospital which is a public hospital.

4.3.3.1 Shortage of staff

There is a serious shortage of staff which impacts negatively on proper emergency medical care being offered at the Casualty Department at Edenvale Regional Hospital. The staff shortage issue was mentioned by almost all the 16 research respondents which indicates that the situation regarding staff is dire. Respondent 13 stated that generally, the casualty section was very busy and there was not enough staff (clerks, nurses and doctors) before even mentioning the issue of non-functional
equipment and availability of medication after working hours. However, another respondent, Respondent 11 mentioned that the initial experience prior to 2006 with regard to patient care at the Accident and Emergency Department was good because there was enough staff, but as the population increased the customer service deteriorated accordingly. In this respect, the respondent was also talking about the shortage of human resources. Some of the direct statements taken from respondents regarding the issue of staff shortage that has affected customer care are listed below:

“Shortage of human resource is the challenge” (Respondent 1)

“After hours and weekend doctors clerks, porters and cleaners does not have a person who is supervising them because of limited staff” (Respondent 2)

“I experienced that casualty needs to have their own clerk to reduce the long waiting time (of files) during the day” (Respondent 8).

“I experience that there is a shortage of staff ranging from professional nurses, full-time doctors, cleaners, porters and admin clerks to support clinicians” (Respondent 7).

“Not enough doctors to cater for the workload in casualty” (Respondent 3).

“The hospital relies on sessional doctors on weekends” (Respondent 13).

The respondents indicated overwhelmingly that their experiences regarding patient care in the Accident and Emergency Department had been tainted by the acute shortage of staff. It was noted that there was a shortage of critical staff such as doctors and professional nurses and this negatively impacted the performance of the Casualty Department. The issue of staffing has been raised within the hospital, especially following the visit of the Gauteng Department of Health MEC in October 2015; a formal request in the form of a letter was subsequently made by management who requested that the hospital’s executive management increase the Casualty Department’s staff complement. The letter clearly stated that the lack of adequate human resources impacted the ability of the department to render efficient and effective patient care at the hospital (Edenvale Regional Hospital Management, 2015). The issue of a shortage of healthcare professionals in South Africa and in the Southern African region is also well documented in modern literature. Dageid et al. (2011:50) indicated that South
Africa had a problem of inadequate health professionals in the public sector. Approximately 40% of the country’s health professionals are said to have left for destinations that include Australia, Canada, United Kingdom and the United States in the past 16 years (Zuniga et al., 2012:340).

4.3.3.2 Overcrowding
The current Casualty Department has proved to be inadequate in terms of size and is hence failing to cope with the overflow of patients. The department cannot accommodate all the patients who come to the hospital with medical issues that require emergency attention, the result being that people have reportedly been spending long periods sleeping on floor mattresses and some even sleeping on stretchers. The problem of overcrowding is caused mainly by the fact that the hospital in general, but especially the Casualty Department, has effectively become smaller as the population it serves has expanded. According to Respondent 1, staff are overwhelmed and are therefore unable to adequately explain procedures and processes to patients. Some of the comments regarding the overcrowding of the Casualty Department are listed below and are then discussed in relation to available literature.

“Patients are sleeping on floor-mattresses and stretchers because of limited beds” (Respondent 2)

“Over the past few years, several patients were sleeping on the floor-matress and stretchers waiting for open bed in a ward which presented clear evidence that ED crowding contributes to poor quality care” (Respondent 5)

“I experienced overcrowding of patients, patients sleeping more than two days on stretchers and floor mattresses waiting for open beds in the wards” (Respondent 7).

“Threat to safety and security of both patients and staff because of overcrowding” (Respondent 15).

“Due to infrastructural challenges patients’ privacy is not maintained” (Respondent 6).

“Overcrowding of patients [because] patients do not want to start in clinics” (Respondent 10).
The Casualty Department is experiencing overcrowding, which is negatively impacting the quality of patient care at the hospital. The overcrowding situation is giving rise to a number of concerns such as security for both patients and healthcare personnel working at the hospital. The overcrowding is also putting the patients at the risk of contracting infections from within the hospital. According to Respondent 16, “The hospital’s higher than normal bed occupancy rates (BOR) may increase the risk of hospital-acquired infections”. The casualty ward is inadequate in terms of space, as it is just too small especially when considering the number of patients who come to use this department from the surrounding communities. Overcrowding at the Casualty Department is hence giving rise to a host of other challenges. The hospital’s BOR averaged 88.8% between January and September of 2016, with the BOR rising to a high of 97% in August of 2016. This is an indication of how serious the overcrowding is at the hospital’s Casualty Department. Multiple studies investigating the issue of overcrowding have discovered that there is an association between overcrowding and reduced access to care, decreased quality measures and reduced healthcare outcomes (Cameron et al., 2015:873). The association between overcrowding and quality measures has removed any doubt that the relationship between overcrowding and mortality is causative.

4.3.3.3 Malfunctioning equipment

The other major concern which falls under the broader theme of resource shortages is related to inadequate equipment. Equipment is an essential part of any healthcare system, as without adequate functional equipment the hospital personnel in the Casualty Department will be unable to sufficiently accomplish their duties. Some of the respondents indicated that the Casualty Department did not have enough equipment to achieve the desired outcomes. According to Respondent 13, it was observed that some of the equipment was not even functioning. The same issue regarding equipment was also reiterated by Respondent 12, who stated that non-functional equipment was an issue that is a challenge within the Casualty Department at Edenvale Hospital. Lack of equipment is one issue pertaining to the South African public healthcare system that is well documented (Akyeampong et al., 2015:237). According to Richter (2015:106), the issue of lack of equipment along with the shortage of space, trained staff and medicine are some of the challenges in the South African public health sector.
4.3.4 Compromised safety and security

The other theme that has been identified regards safety and security of both patients and employees, which some of the respondents indicated they were concerned about in the hospital’s Casualty Department. Respondent 4 complained that there was not enough security allocated to the casualty section. Another respondent, Respondent 9 linked the issue of reduced safety of staff to overcrowding in the casualty section. Statements taken from respondents were as follows:

“Safety, effectiveness, patient-centeredness, efficiency, timeliness, and equity are compromised when patients experience long waits to see a physician, patients are boarded in the ED” (Respondent 5)

“There is lack of safety for staff and patients (staff beaten by patients relatives and there is risk of cross infection)” (Respondent 7)

“The Casualty Department is not well protected in terms of security. Doctors and the sisters are being threatened in here by escorts and have in [the past] been attacked” (Respondent 8).

“Safety of patients and staff is compromised: there is not enough security deployed in casualty and cross infection can be spread” (Respondent 11).

““My experience in the Edenvale Regional hospital customer care is. Lack of safety for patients and staff because of overcrowding” (Respondent 14)

Respondent 8 also linked the issue of safety and security of employees in the Casualty Department to the challenge of overcrowding as well. It seems the issue of overcrowding requires urgent attention because if employees do not feel secure they are less likely to be in a position to provide quality healthcare.
4.3.5 Strategies to improve customer care

The respondents were asked to suggest strategies to improve customer care at the Edenvale Hospital’s Casualty Department. Their suggestions are discussed in the following sub-sections.

4.3.5.1 Expansion of Casualty Department premises

One of the biggest impediments to quality care in the Casualty Department is inadequate space which cannot accommodate most of those seeking emergency healthcare at the hospital. A number of respondents suggested that the Casualty Department needs to be expanded. According to Respondent 11, “Expansion of infrastructure was one way to enhance customer care”. Respondent 2 suggested that infrastructure was supposed to be improved and become more user-friendly and suggested that the number of beds had to be increased as well. Respondent 10 also mentioned that increasing the number of beds was one way to improve customer care in the Casualty Department. Currently the hospital has added 12 temporary beds in the Casualty Department but they do not have sufficient staff to attend to these extra patients. This piece of information was also provided by Respondent 10. It must be noted that expansion of the department would eventually mean that more beds can be added to occupy the additional space, hence expansion of infrastructure has been discussed in conjunction with an increase in the number of beds.

4.3.5.2 Timeous resolution of patient complaints

The other recommendation that was made by the respondents was regarding the speedy resolution of patient complaints. According to Respondent 11, patient complaints were supposed to be resolved within a reasonable time-frame. The respondent also suggested that employees should be empowered with problem-solving skills in order to be able to address patient problems. Respondent 2 stated the following: “Problem-solving is an inevitable companion to improving [the] customer care programme”. Respondent 4 was quoted as saying, “Customer complaints are the magic in improving [the] customer care programme”. The suggestions for improving customer care highlighted that this was inextricably linked to the timeous resolution of customer complaints. When a customer complaint has been addressed, there is a feeling that the system cares about and is speedy in addressing customer complaints.
4.3.5.3 Improvement in communication
Improvement in the effectiveness of communication between healthcare professionals and patients in the Casualty Department was suggested as another way to improve customer care. Respondents 4 and 14 stated that the Casualty Department needed an improvement in communication through different media and through regular meetings. Respondent 11 suggested the use of pamphlets, newsletters and izimbizo (gatherings where questions are answered, concerns raised and advice taken from the public) as ways of improving communication. According to Respondent 5, customer feedback was needed in order to improve the effectiveness of communication in the Casualty Department. The participant emphasised that communication contributes noticeably to the creation of a strong bond between staff (who are the service providers) and customers and consequently improves customer care.

4.3.5.4 Staff training and development
When patients arrive at the Casualty Department of Edenvale Regional Hospital, they interact with the hospital employees, and as long as these employees lack adequate training required for a well-functioning Casualty Department, customer care will therefore be compromised. According to Respondent 6, the employees needed customer service training. Respondent 8 was quoted as saying the following: “Train and retrain staff with regard to addressing negative attitudes towards customers”. When employees are trained they are believed to now possess the necessary skills they require to do well in their job, and which should then assist in improving the quality of patient care in the Casualty Department.

4.3.5.5 Community awareness programmes
The communities also need to be empowered with knowledge regarding how the Casualty Department operates. This can be a way of managing the expectations of patients with regard to what happens in casualty and who should come to casualty and for what purposes. Respondent 1 suggested that a community awareness programme was necessary and that it could be achieved through izimbizo for educating the community about the nature of services rendered in the Accident and Emergency Department. Respondent 1 also suggested that community awareness programmes could be used to
educate members of the community not to bring cold cases to the hospital and that they were supposed to use their local clinics for such cases. Respondent 2 added that patients were supposed to be educated about the healthcare system and the different levels found within the system. Community awareness programmes will help educate communities being served by the hospital about what they need to know regarding the operations of the Accident and Emergency Department. This would improve customer care and therefore patient satisfaction in the future.

4.3.5.6 Increase staff
One of the major causes of poor customer care in the Casualty Department is the shortage of staff to attend to patients and to execute other activities which form part of the Accident and Emergency Department healthcare service package. Respondent 3 suggested that the Casualty Department needed to have “adequate human resources such as doctors, nurses to look after the patients and clerks and porters to support clinicians”. Respondent 10 suggested that full-time doctors had to be employed and the Casualty Department had to desist from using sessional doctors. According to Respondent 7, it was necessary that the Casualty Department employ dedicated ward clerks, cleaners and porters. In order to deal with the issue of staff shortages, Respondent 10 indicated that the Casualty Department requested doctors who worked in other sections to come and assist in the department. The increase in staff would ensure that patients are well attended to as soon as they step into the hospital premises.

4.3.5.7 Better referral system
The improvement in the referral system was also suggested as a way to improve customer care. According to Respondent 4, the implementation of triage was crucial and could involve the hospital only accepting geographical patients and patients with referral letters. Respondent 10 stated that currently the hospital has implemented a minimum triage system and a minimum referral system in the Outpatient Department (OPD). Respondent 4 also stated that a better referral system had to be implemented in order to improve customer care at the Edenvale Regional Hospital Casualty Department. A referral system would mean that only those patients who cannot be attended to by local clinics would be referred to Edenvale Hospital which is a regional hospital. This would reduce
the overcrowding of the Casualty Department and also reduce the overstretching of staff at this institution.

4.3.6 **Policy and guidelines effects**

The research respondents were asked about the issue of policy and guidelines and a number of themes were picked up from the responses and are presented in the following sub-sections. This section addresses study Objective 2.

4.3.6.1 **Policy effectiveness dependent on implementation**

The effectiveness of any policy depends on how effectively it has been implemented. According to Respondent 4, if for example the referral system policy was correctly implemented, the hospital would not suffer from overcrowding. Respondent 13 indicated that deferring policy had negative consequences which included malpractice and patients being harmed. The policy can be in place but if it is not effectively implemented, it is not going to assist the Casualty Department in the improvement of quality healthcare and customer satisfaction. According to Adamson et al. (2000:49), the responsibility of making policies and overall system performance lies with top management, whose commitment in seeing the customer care policy succeed is crucial to its successful implementation.

4.3.6.2 **Policy to increase staff awareness of their roles**

The awareness of policies by staff assisted in the improvement of the patient care service at the Casualty Department (Batho Pele Principles, 1997, and Core Standard, 2009). This was a suggestion made by Respondent 16, who also added that the customer service policy physically improved customer services. According to Respondent 14, the customer care policy stressed that the Casualty Department was supposed to offer high quality customer care and because the policy stated this explicitly, the employees were seen trying their best to implement what it stated. The respondents have therefore indicated that the existence of the policy increased the awareness of employees on what was expected from them as far as customer care in the Casualty Department was concerned.
4.3.6.3 Effective policy implementation improved service

The effective implementation of policy had many positive spin-offs which eventually improved customer care. According to Respondent 13, the customer service policy had capacity to promote workplace safety regulatory compliance, which would in turn assist in the delivery of quality patient care. The respondent also stated that the customer service policy ensured that there was adherence to recognized professional practices and a reduction in practice variation. Policies and guidelines also promoted compliance with regulation statutes and accreditation requirements. The existence of an effectively implemented customer service policy was that it would bring standardisation to practices across multiple entities within a single health system. It can be deduced that if a system is standardised it also becomes simpler to institute checks and balances and allows easy monitoring of variances. When a policy is effectively implemented it can ultimately result in an improved service. A formal policy on customer service will also be of assistance to patients who will thereby be aware of what they are supposed to expect from the hospital. According to Ross (2003:394), a formal service policy will assist customers to formulate proper and realistic expectations of the level of performance they can expect.

4.4 CONCLUSION

The chapter presented the results that were obtained from the primary research that was conducted within Edenvale Regional Hospital’s Casualty Care Department. A total of 16 respondents participated in the interviews aimed at collecting information regarding the functioning of the Casualty Department and how the department fared in terms of customer care. Chapter Five presents the conclusions and the recommendations that have been made from this study.
CHAPTER 5: SUMMARY OF FINDINGS, RECOMMENDATIONS AND CONCLUSIONS

5.1 INTRODUCTION

The final chapter of the study discusses a summary of the findings, recommendations, contribution of the study and conclusions, which are based on the findings that were made from the primary study. The issues facing the casualty ward at Edenvale Hospital negatively impact upon customer care at the hospital and must be adequately addressed before customer excellence can be established. The hospital therefore needs to improve its image and the Casualty Department must participate in that image improvement.

5.2 SUMMARY OF FINDINGS

One of the main findings made from the study was the fact that the surrounding community which was served by the Edenvale Hospital’s Casualty Department had high expectations, but which the department was unable to meet because of the many limitations that it faces, especially resource constraints. The community that is served by the hospital seemed to bring all their emergency and non-emergency cases to Edenvale Hospital, which is a regional hospital. The fact that it is called a regional hospital gives the impression to the community that it has capacity to effectively and efficiently deal with any health-related matter. The community members bypass clinics (primary healthcare) in their areas and choose to come to Edenvale Hospital instead, causing queues to be even longer and further raising frustration levels among patients due to the long waiting periods.

5.3.1 Bad attitude

The second key finding concerns the bad attitude that is exhibited by healthcare workers at Edenvale Hospital’s Casualty Department. The bad attitude apparently comes from both healthcare employees and patients alike, but it is the attitude of the former which concerns the study. This bad attitude was mostly witnessed in the manner in which the doctors and nurses communicated with patients, which
was often contemptuous and therefore impacted negatively on the customer care experience. The bad attitude displayed by the hospital employees towards patients created a bad impression of the hospital from the community. The fact that employees were suffering from too much pressure at work which led to burnouts was blamed for the bad attitude exhibited by employees. As for the bad attitude of the patients, this is mainly due to the perceived poor customer care that they experience from hospitals. The public healthcare system has become synonymous with poor customer care, hence when some patients walk into such public institutions and experience long waiting times and poor service they immediately unleash their frustrations on the already over-worked and over-stressed staff. Davey et al. (2009) reported that “work attitude includes common themes such as job satisfaction, organisational commitment and job involvement. One factor that could influence bad attitude is aversive work conditions (e.g. workplace stress and work conditions related to existing physical conditions)

5.3.2 Quality healthcare communication

Quality healthcare cannot be given without effective and efficient communication. The communication between healthcare workers at the Casualty Department and patients was found to be poor and requiring radical changes. The employees were not even communicating effectively among themselves; for example, the sisters and porters. The doctors and nurses also communicated poorly with those who came to seek emergency healthcare at the Emergency Department. The poor communication problems that inundated the hospital had a negative impact on internal communication. Choi and Kim (2008) noted that service strategy has to be communicated over and over again to everyone; the “employee at all levels must be aligned with a single vision of what the organization is trying to accomplish”, and that effective internal communication was the requisite for integration and harmony of the service organisation’s activities and service quality.

5.3.3 Shortage of resources

The hospital is faced with a shortage of resources ranging from shortage of staff to shortage of beds and space, the latter of which is blamed for the current overcrowding. The Casualty Department had
a shortage of staff which included clerks, porters, nurses and doctors. The department was actually relying at times on sessional doctors to alleviate this shortage. The department’s lack of staff negatively impacted upon its ability to offer quality emergency healthcare. The South Africa public healthcare sector has been affected by an exodus of healthcare professionals who are seeking greener pastures, hence the issue of shortage of staff is well documented. The Casualty Department has become smaller especially when considering the numbers of people it is now serving. The hospital beds are inadequate to serve all the people who come to seek emergency healthcare and this has resulted in overcrowding. The hospital’s bed occupancy rates (BOR) are very high and average more than 88%. This essentially implies that the beds are always occupied at almost all times which has resulted in some patients sleeping on floor mattresses and stretchers. The overcrowding caused by the shortage of space in the Casualty Department and the general shortage of beds results in poor customer care standards. In addition, the equipment that is used in the Casualty Department is also not functioning according to the way it is supposed to, as indicated by the research participants. Malfunctioning equipment was a source of frustration in the Casualty Department as poorly functioning equipment means that the goal of quality emergency care is not always possible. The shortage of resources even impacted the state of security in the Casualty Department. The healthcare personnel working in the always overcrowded casualty section were concerned about their safety, especially in an environment where patients’ anger often flares up due to the perceived poor quality of service which has become synonymous with public healthcare. The hospital staff cannot fully take care of the needs of patients in an environment in which they feel insecure.

5.3.4 Suggestions from respondents

The respondents came up with a number of suggestions regarding how customer care could be improved in the Casualty Department. It was suggested that the department be expanded and more staff be hired, while staff training and development was also suggested along with community awareness programmes. The development of a better referral system was also suggested as a way of reducing the overcrowding at the hospital’s emergency section.
5.3.5 Policy implementation

One of the objectives of the study was related to the impact of policy implementation on quality of service. The general consensus was that policy positively impacted on the quality of service which was rendered by the Casualty Department, as these guidelines ensured that employees offered the standard of services as stipulated by the hospital’s customer care policies. Employees who are guided by such policies are more inclined to adhere to what is stipulated and which in turn reduces variances. Policies and guidelines can therefore be handy companions in the quest to offer quality customer care at the Casualty Department.

5.3 RECOMMENDATIONS OF THE STUDY

The recommendations that are presented below are aimed at improving the quality of customer care that is offered at the Edenvale Regional Hospital’s Casualty Department. The implementation of these recommendations is expected to usher in a new era of quality emergency healthcare and National Health Insurance (NHI) application.

5.4.1 Customer service training

The healthcare personnel who are working in the Casualty Department of Edenvale Hospital need to undergo customer service training. This training is necessary for all the employees of the department, as can be noted from the findings in Chapter 4 whereby they require assistance and guidance in dealing with patients who are in emergency situations. Employee training should focus on the Batho Pele principles and the factors influencing the enhancement of customer care, and should inculcate in the unit’s employees the attributes required in a customer care official. Patients who come to the Accident and Emergency departments of healthcare institutions are generally in a particularly ill or injured condition and they therefore require special care in handling them. For example, people who are brought in with a limb broken and hanging after an accident are often panicked and frustrated and they require someone who can handle the emotional challenges raised by their circumstances. The customer training could be conducted by a consultancy firm that can come to the hospital itself, or it could be offered externally where employees can attend for specific training sessions. This training
can be provided through seminars or training workshops that are specifically aimed at the casualty section’s healthcare personnel, and is expected to equip them with better coping and communication skills regarding how they deal with patients in emergency situations.

5.4.2 Increase community awareness campaigns

The communities seem not to be aware of which cases can and cannot be brought to the emergency care centres. The community members also need to understand that the healthcare system in the country has limitations and this may assist with the management of high expectations. The hospital, in conjunction with the Hospital Board and the Department of Health, needs to organise community outreach programmes where they can educate the community they serve about the operations of the Casualty Department. The community is supposed to be educated regarding which cases should or should not be brought to a regional hospital’s casualty section. The community outreach programmes are also supposed to increase awareness in the respondents regarding the existence of clinics and other community healthcare centres that they can approach for assistance before being referred to Edenvale Hospital. The recommendation is aimed at ensuring that the community has sufficient knowledge about the operations of the Casualty Department and the existence of other healthcare centres, since this will help reduce the numbers of people seeking assistance at Edenvale Hospital and thereby reduce overcrowding and alleviate pressure on the hospital’s limited resources.

5.4.3 Reaffirm the importance of policy and guidelines of the Casualty Department

The healthcare personnel working in the Casualty Department need to be reminded of the policies and guidelines of the department’s operations. Reaffirmation of these policies and guidelines can be achieved through one-day seminars for this purpose and on how patient care could be advanced. The employees have seemingly largely forgotten the importance of the policies and guidelines in the work they do, hence such sessions to remind them of their duties would go a long way in improving customer care in the Casualty Department. Management can also create posters that can be placed in the department to reaffirm the importance of these policies and guidelines. The presence of such
posters in the corridors, offices and wards would then become a constant reminder of what the department is ultimately there to achieve.

5.4.4 Creation of an effective referral system

The referral system that exists in the public healthcare system needs to be strengthened. Patients are supposed to first visit the smaller healthcare centres before they make their way to a regional hospital. There are community healthcare centres (CHCs) which serve almost all areas of Gauteng and these should become the first places that patients visit when they have a health problem which they believe qualifies as an emergency. The first port of call for the patients is supposed to be the community healthcare centres and from there they are supposed to be issued with referral letters that they then take to the bigger healthcare centres. These referral letters are supposed to serve as ‘passports’ to the Edenvale Regional Hospital in that patients should always come via the referral system before they can be attended to at the hospital. The issue of the referral system should be well communicated with the clinics and a clear, simple and efficient referral system should be developed, including effective communication lines among doctors, nurse, porters and clerks in the Casualty Department.

5.4.5 Increase qualified staff

The challenges that have negatively impacted customer care at the Casualty Department are also attributed to shortage of staff, which is usually traced to financial constraints from the government. It is highly recommended that the Gauteng Health Department improves Edenvale’s staff establishment because the current staff establishment stems from 2006, and the hospital now caters for many more patients. There are several factors which have increased the need for a thorough staff review, including the influx of foreigners into the area and a high staff turnover. An audit of the staff that is needed to alleviate the pressure on the current staff complement should be conducted and the necessary staff should then be hired. It is also recommended that the new staff must have suitable qualifications in the accident and emergency field in order for the department to improve its service quality, as opposed to hiring just any healthcare professionals. In other words, the doctors, nurses and other professionals hired must possess qualifications applicable for those who work in casualty
departments and with emergency situations. Customer care cannot be improved if people who do not possess the requisite qualifications and experience are hired instead.

5.4.6 Improve safety and security

The hospital needs to hire a professional security company for managing the crowds that come there to receive healthcare. One of the finding was that overcrowding is being experienced at the hospital, which in turn leads to security issues and reduces the safety of both personnel and patients. Security must therefore be managed by a professional outfit, because when employees feel safe and secure, they are then able to offer quality patient care. Employees working in an environment in which they do not feel secure, on the other hand, cannot possibly be expected to give their best work performance, which then impacts negatively on service quality.

5.4.7 Expansion of the hospital and Casualty Department

The hospital’s General and Casualty Departments need to be expanded and this expansion must also bring with it additional beds and staff. The expansion of the Casualty Department will go a long way in alleviating the problem of overcrowding, though it must be noted that in order for the expansion to effectively address the problem of overcrowding and bring relief to the patients, it must be done in conjunction with an increase in staff, beds, medication and the necessary equipment.

5.5 FURTHER RESEARCH

Further research should be conducted on the following topics:

- Comparison of allocated resources and customer care at the two public hospitals in Gauteng Province.
- Understanding why the public health system is not functioning the way it is expected to and how this status can be changed.
5.6 CONTRIBUTION OF THE STUDY

This research will serve in expanding the existing body of knowledge concerning the challenges that are faced in customer care service delivery. The study provides an insight into the customer care satisfaction levels of the Edenvale Regional Hospital’s health delivery services, with the intention to identify service gaps and thereby improve upon them. By identifying these gaps, the hospital could then revise its strategy and concentrate on cost effective ways of managing its limited resources to improve service delivery. In order to enable the hospital to deliver its service in terms of the National Health Insurance (NHI) throughout the province, the internal and external customers of the Gauteng Department of Health should be made aware of the Customer Care unit’s existence, so that they can then make an effort to access the service offered by the unit when they need it. Likewise, the staff at both Head Office and the hospital should be made aware of the existence, purpose and role of the Customer Care unit.

5.7 CONCLUSIONS

This chapter presented the research design and method, limitations, summary of findings and discussed the recommendations that are aimed at improving the quality of healthcare offered by the Casualty Department at Edenvale Hospital. Some of the recommendations that have been discussed include customer service training for the department’s employees, running community awareness campaigns as a way of educating people about the Casualty Department’s operations, and the need for expanding the department to cater for more staff and patients. This expansion must however be accompanied with qualified staff and sufficient medication and equipment.
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ANNEXURE A

PUBLIC ADMINISTRATING AND MANAGEMENT RESEARCH ETHICS REVIEW COMMITTEE
FROM UNIVERSITY OF SOUTH AFRICA
DEPARTMENT: PUBLIC ADMINISTRATION AND MANAGEMENT
RESEARCH ETHICS REVIEW COMMITTEE

Date: 17 August 2016

Dear Mr Buthelezi

**Decision: Ethics Clearance Approval**

Ref #: PAM/2016/020 (Buthelezi)
Name of applicant: Mr JKA Buthelezi
Student #: 37287877

Name: Mr JKA Buthelezi, Khulekani.Buthelezi@gauteng.gov.za, tel: 082 413 7807
(Supervisor: Mr BC Lekonyane, 012 429 6116, lekonbc@unisa.ac.za)
Research project: Implementation of customer care at the Casualty Department of Edenvale Regional Hospital in Gauteng Province: Qualification: MPA

Thank you for the application for research ethics clearance by the Department: Public Administration and Management: Research Ethics Review Committee for the above mentioned research. Final approval is granted for the duration of the project on the condition that a letter from the Research Committee of the Gauteng Department of Health, in which permission is granted to you to do this research, is submitted to this Ethics Committee within **30 days** of the date of this letter.

The decision will be tabled at the next College RERC meeting for notification/ratification.

**For full approval:** The application was expedited and reviewed in compliance with the Unisa Policy on Research Ethics by the RERC on 17 August 2016. The proposed research may now commence with the proviso that:

1) The researcher will ensure that the research project adheres to the values and principles expressed in the Unisa Policy on Research Ethics.

2) Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study, as well as changes in the methodology, should be communicated in writing to this Ethics Review Committee. An amended application could be requested if there are substantial changes from the existing proposal, especially if those changes affect any of the study-related risks for the research participants.

3) The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study.

Kind regards

Prof Mike van Heerden
Chairperson:
Research Ethics Review Committee
vheerm@unisa.ac.za

Prof MT Mogale
Executive Dean: CEMS

University of South Africa
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Telephone: +27 12 429 3111 Facsimile: +27 12 429 4190
www.unisa.ac.za
ANNEXURE B

E-MAIL FROM GAUTENG HEALTH ETHICS SUPPORT APPROVAL TO CONDUCT RESEARCH FROM EDENVALE REGIONAL HOSPITAL
Dear Khulekani,

This email confirms that we have received your application (GP_2016RP14_75).

The status of your application has changed.

The new status is: "Approved".

Please log in to the NHRD at nhrd.hst.org.za to access your approval letter.

Regards
Gauteng Health Research Committee

Disclaimer and confidentiality note:

Everything in this e-mail and any attachments relating to the official business of Health Systems Trust (HST) is proprietary to HST. It is confidential, legally privileged and protected by law. HST does not own and endorse any other content. Views and opinions are those of the sender unless clearly stated as being that of HST. The person/s addressed in the e-mail is/are the sole authorised recipient/s. Please notify the sender immediately if this message has unintentionally reached you and do not read, disclose or use the content in any way. HST cannot assure that the integrity of this communication has been maintained nor that it is free of errors, virus, interception or interference.
To: Researcher

Attention: Mr. JKA Buthelezl

Student Number: 37287877- MPA

SUBJECT: PERMISSION TO CONDUCT RESEARCH ON THE IMPLEMENTATION OF CUSTOMER CARE AT THE CASUALTY DEPARTMENT OF EDENVALE REGIONAL HOSPITAL IN GAUTENG PROVINCE

Permission is hereby granted to conduct research at the Edenvale Regional Hospital for the above mentioned topic.

The hospital would love to access result of the study, in order to improve and intervene on identified challenges where necessary.

Thank you

Chief Executive Officer
Dr. N.P.Kernes

18 -07- 2016
ANNEXURE C

PERMISSION LETTER TO EDENVALE REGIONAL HOSPITAL
ANNEXURE C

PERMISSION LETTER TO EDENVALE REGIONAL HOSPITAL

680 Khulani Street
Tsakane, Ext 1
1550
13 July 2016

Attention: Dr. N.P. Kernes
The Chief Executive Officer
Edenvale Regional Hospital
Private Bag x1005
Edenvale
1600

REQUEST FOR THE PERMISSION TO CONDUCT RESEARCH ON IMPLEMENTATION OF CUSTOMER CARE AT THE CASUALTY DEPARTMENT OF EDENVALE REGIONAL HOSPITAL IN GAUTENG PROVINCE

I, Jabulani Khulekani Amon Buthelezi, a Master student at University of South Africa hereby request permission to conduct a study on implementation of customer care at the casualty department of Edenvale Regional Hospital. The content under investigation include the ways in which service quality can be improved in the hospital’s Accident and Emergency (Casualty) Department.

I am intending to analyses document such as data, dairy, register and collect in-depth face to face interviews with staff who are direct contact with patients in accident & emergency care in order explore and describe the experience of customers (patients) care. The responsible supervisor in this respect is Mr. BC Lekonyane of the University of South Africa.

The title of dissertation reads, - Implementation of Customer Care at the Casualty Department of Edenvale Regional Hospital in Gauteng Province. The case study in
the Edenvale Regional Hospital. The expected timeframe of completion of data collection is August 2016.

I am committed to follow a prescribed approach to data collection, and to respect ethical values and practices, to protect the integrity of the health care facility. On completion of this project, a copy of the report will be presented to your institution which will assist the institution with benchmarking its service.

I trust that no inconvenience will be caused by this proposed arrangement.

Thank you

Mr. J.A.A. Buthelezi
Student number 37287877
ANNEXURE D
INFORMATION BROCHURE FOR PARTICIPANTS

TITLE OF THE STUDY
IMPLEMENTATION OF CUSTOMER CARE AT THE CASUALTY DEPARTMENT OF EDENVALE REGIONAL HOSPITAL IN GAUTENG PROVINCE

INTRODUCTION
This document serves as information that will assist you to decide whether or not to participate in this study as a volunteer. It is important to understand what is involved in this study and the role that you as a participant will play, before you commit yourself.

PURPOSE OF THE STUDY
The purpose of this study is to investigate Implementation of Customer Care in the Casualty Department of Edenvale Regional Hospital in Gauteng Province

DETAILS OF THE TASKS
The researcher will request you to participate in the face-to-face interviews, where you will elaborate on your experiences regarding (patients’) customer care in the Casualty Department of Edenvale Regional Hospital in Gauteng Province.

The researcher will facilitate the interviews by asking a broad question and allow you to respond to the question, then follow-up questions will be asked. The interviews will be written down with each participant. The interviews will be conducted at the hospital under study or in the ground floor board room provided; if is conductive for the interview to take place. The interview will take about 35 to 40 minutes on average with each participant.
RISK FORESEEN / ANTICIPATED

The researcher anticipates some emotional discomfort in some participants, which may be triggered by some of the questions. In such cases, the participants will be referred for psychological care and support within the hospital under study.

BENEFITS OF THE STUDY

The study will not benefit participants directly, however the broader body of knowledge of the public administration profession and the public health system will benefit from the recommendations and insights thereby derived. To a large extent there should be marked improvement in the provision of healthcare services in public health institutions based on the recommendations of this report.

RIGHT OF THE PARTICIPANT

As a participant, as much as you have the right to volunteer for the study, equally so you have a right to withdraw your participation at any time you become uncomfortable during the proceedings of the interview. The researcher will not use your right of withdrawal against you.

CONFIDENTIALITY

The information you provide in the study will be kept confidential and private throughout the phases of the study. The only time the information will be divulged will be post data analysis but without your identification. The information will be shared through research reports and articles with the University, Department of Health, and hospital under study to assist other South Africans. Your involvement in the study is purely voluntary.
ETHICAL APPROVAL

The researcher obtained a written ethical approval from the Ethics Committee of the University of South Africa in 2016. The approval has been sought with the Department of Health and the hospital management under study. The letters are available on request; if you wish to confirm then copies will be provide to you.

CONTACT PERSON

Any concerns or enquiries regarding this particular study should be directed to:

RESEARCHER
Mr JKA Buthelezi
0824137807

SUPERVISOR
Mr B.C. Lenkonyane
CONSENT FORMS

Section 1: Information

Dear Participant,

My name is Jabulani Khulekani Ancon Buthelezi, and I am a student studying towards a Master’s Degree in Public Administration at the University of South Africa. I am conducting a study entitled: “Implementation of Customer Care at the Casualty Department of Edenvale Regional Hospital in Gauteng Province”.

The study aims to investigate the implementation of customer care at the Casualty (Accident and Emergency) section, as experienced by patients at the Edenvale Regional Hospital, in order to develop and recommend guidelines for supporting the hospital.

I am requesting you to participate in this study to share your experience with me. The study involves an individual face-to-face semi-structured interview which will last between 35 and 40 minutes. Your participation in this study will be highly appreciated.

Data collected from the interview will enable me to gain a broader understanding of your experience regarding “Customer Care at the Casualty Department of Edenvale Regional Hospital in Gauteng Province”.

Your participation in this study is voluntary. All the information discussed will remain confidential. You have the right to withdraw from the study any time without even mentioning the reason. Your right to anonymity and confidentiality will be maintained at all times.

No payment will be offered. In case you become distressed due to participation in the interview, debriefing will be offered by me.

Thank you for your consideration to participate in this study.

................................................................. (Researcher)
Section 2: Participant consent declaration

I ……………………………………………………..(name and surname in full) the undersigned person is willing to participate in the research conducted by Mr Jabulani Khulekani Ancon Buthelezi from UNISA.

I understand that the research is aimed at gathering information about experiences regarding customer care at the Casualty Department of Edenvale Regional Hospital in Gauteng Province. I am aware that I will be one of the participants to be interviewed and discuss my experience for this research project with Mr JKA Buthelezi.

I understand that my participation in this research is voluntary. I will not be paid for my participation. If I feel uncomfortable in any way during the time of the interview, I have the right to decline and end the interview.

I may withdraw and discontinue participation at any time without any preconditions if I feel to do so.

My participation in the research involves being interviewed by Mr JKA Buthelezi, which may last at least 35 to 40 minutes, and I realize that during this notes will be taken by researcher.

I understand that my participation in this research will be confidential and that the researcher will not use my name in any report.

I understand that this research study has been approved by the University of South Africa ethical clearance committee.

I have read and understand the information pamphlet and explanation provided to me.

All my questions were answered to my satisfaction, and I voluntarily agree to participate in this study.

Signature- Participants:……………………………………………………………………

Date:……………………………………………………………………

Mr J.K.A. Buthelezi

Principal researcher:…………………………………………………………

For further questions Contact @ 0824137807
ANNEXURE F

INTERVIEW GUIDE
INTERVIEW GUIDE

QUESTIONS ASKED DURING INTERVIEWS

Framing of qualitative questions was divided into four category, namely: biographic, main questions, follow-up and probes.

Biographic Data

Option with an “X” and narrative

| 1 | Age in years | 1 | 25-35 |
|   |              | 2 | 36-55 |
|   |              | 3 | 56 and above |
| 2 | Gender       | 1 | Male |
|    |              | 2 | Female |
| 3 | Category of your position | 3.1 | Top management level (Level 11 to 13 Senior Manager to Head of the institution) |
|    |              | 3.2 | Medical Officers (Level 11-12) |
|    |              | 3.4 | Middle management level/Professional nurses/Allied (Assistant Director Level 9 to 10 ) |
|    |              | 3.5 | Junior Management Level 7 to 8 (e.g. Chief Administration Clerk to Senior Administration, Officer or PNA2 to PNA3 - nurses up to Professional nurses) |
|    |              | 3.6 | Operational level (Level 1 to 6) (All those workers who are not managers) |
| 4 | How long have you been employee by the hospital? | 4.1 | 3-5 years |
|    |              | 4.2 | 5-10 years |
|    |              | 4.3 | 10 years and above |
| 5 | In which department are you currently allocated? |
| 6 | Highest educational qualification | 6.1 | Lower than Grade 12 |
|    |              | 6.2 | Grade 12 |
|    |              | 6.3 | Diploma / Degree |
|    |              | 6.4 | Honours / Masters / Doctorate |
Main questions
How did you as an employee of the Edenvale Regional Hospital experience customer (patient) care in the Accident and Emergency (Casualty) Department in the past three to ten years?

Follow-up questions
1. How can Edenvale Regional Hospital enhance effective customer care?

2. How does the behaviour and personal attention of staff affect patients?

3. How does the hospital’s customer service policy affect its services?

4. How does the infrastructure of the hospital affect its services?

Sub-questions:
5. What strategies have been put in place to maximise customer care and its effect on the geographical community?

6. What aspects of customer care provision are satisfactory and which are unsatisfactory?

7. What factors affect the quality of customer care in health service delivery?

Probes and prompts will be used depending on participant responses

Probing Questions

What do you then………?
What do you mean………?
How do you feel about…..?
To whom it may concern

This is to confirm that I, David Kaplan, a professional editor and proofreader, have edited Jabulani Khulikani Ancon Buthelezi’s dissertation as per protocol and, furthermore, that I believe it to be of a high standard.

Kind regards,

David Kaplan

(This is an electronic copy and hence remains unsigned.)