

**THE IMPLEMENTATION OF THE BATHO PELE PRINCIPLES FROM PATIENTS'  
EXPERIENCES**

BY

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## **ABSTRACT**

### **THE IMPLEMENTATION OF THE BATHO PELE PRINCIPLES FROM PATIENTS' EXPERIENCES**

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The purpose of this quantitative, descriptive study was to identify shortcomings in the implementation of the Batho Pele Principles in a public hospital. Findings were obtained from a range of patients who had been admitted to specific units for three or more days, and more evidence was gathered from articles in mass media. Data was collected through a structured questionnaire from one hundred respondents (n=100) and analysed by means of descriptive statistics. The research findings revealed that none of the Batho Pele Principles were implemented effectively and that patients in general were not satisfied with treatment in public hospitals. Shortcomings are attributed to insufficient management skills and knowledge on different levels of the health care system, as well as a lack of awareness among patients of their rights and responsibilities in health care.

### **KEY CONCEPTS**

Batho Pele, Charter, right, responsibility, principles, policy, quality, health care.

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- Annexure B Research clearance certificate from the Ekurhuleni Health District ethics panel granting permission.
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- Annexure E Structured questionnaire schedule.
- Annexure F Newspaper articles.

## **LIST OF ABBREVIATIONS**

ANC	African National Congress
BPP	Batho Pele Principles
GP	Gauteng Province
GDOH	Gauteng Department of Health
NDOH	National Department of Health
RDP	Reconstruction and development programme
NHP	National Health Plan for South Africa
PRC	Patients' Rights Charter

## **CHAPTER 1**

### **INTRODUCTION AND BACKGROUND INFORMATION**

#### **1.1 INTRODUCTION**

The White Paper on the transformation of the public services was published in October 1997, (South Africa: 1997). This document is also known as the “Batho Pele principles, which is a Sesotho expression meaning “people first”. The White Paper sets out eight national priorities, amongst which transformation of service delivery is the key criterion that a transformed South African public service will be judged on, namely its effectiveness in the delivery of services which meet the basic needs of all South African citizens (South Africa 1997:9). This study focuses on public services in a specific public hospital with reference the delivery of to the implementation of the Batho Pele principles (BPP) or the lack thereof.

#### **1.2 BACKGROUND TO THE PROBLEM**

In the years before 1994 in South Africa authorities in charge of hospitals prescribed to nurses how patients should be cared for, and this was done in accordance with the system of hospital regulations. Health care in hospitals was rendered according to the accepted medical model which advocated domination by the professional providers of care. Patients were regarded as passive recipients of care and decisions relating to health and illness were the domain of the doctor (Pera & Van Tonder 1996:56, 61). Apart from this prevention of decision-making powers from patients, health services were influenced by colonialism and racism throughout the history of South Africa. This was evident in the fact that predominantly white and wealthy people received privileged health care and black people were deprived of the same quality health care (Van Rensburg 2004:77). During the apartheid era health care was allocated not in terms of need but in terms of access to power. Furthermore health care professionals were trained, deployed and paid according to skin colour, facilities were unequally distributed and the majority of the population was not allowed to participate in decision-making processes concerning the design and distribution of services and resources (Van Rensburg 2004:79). After 1994 and the first

democratic election, the Constitution of the Republic of South Africa, Act 108 of 1996 (South Africa 1996:6) introduced a Bill of Rights which forms the cornerstone of democracy in South Africa. It enshrines the rights of all people in the country and affirms the democratic values of human dignity, equality and freedom.

Because all national departments have to adhere to the principles and rights in the Constitution, the National Department of Health (NDOH) is committed to upholding, promoting and protecting the rights of patients. This commitment is guided by several policy and legislative documents, of which the following are relevant to this study:

- The Reconstruction and Development Programme (RDP)
- The National Health Plan (NHP)
- The White Paper on transforming Public Service Delivery (Batho Pele White Paper) No 18340 of October 1997(BPP)
- The Patients' Rights Charter (PRC)
- The Policy on Health Care for South Africa (April 2007)

These documents and their importance specifically with regard to the BPP are discussed in chapter 2.

During the execution of her normal duties the researcher observed that the Patients' Rights Charter introduced by the NDOH and BPP are not implemented as recommended in these documents yet, as evidence exists that many complaints from patients about health care delivery are still reported.

*An example of such a complaint was published in The Weekly Mail and Guardian (2005:1) where Van der Westhuizen states that her ill mother was taken to a nearby public hospital where, after being seen by the doctor she was put on a trolley and left all night without being offered food or water. When she asked how long her mother would have to lie there she was told it might be a few days until a bed would become available. The patient's daughter had reported that the patient was diabetic and hypertensive, yet her vital signs were never checked.*

### **1.3 STATEMENT OF RESEARCH PROBLEM**

Although the concept of human rights is fairly new in South Africa, one would expect positive results since the implementation of BPP in 1997. However, the position in a specific public hospital has revealed information about incidents contrary to the BPP to the researcher. The incidents range from not having beds to admit patients from Casualty Department, to insufficient stock and patients complaining about nursing staff being disrespectful to them.

The researcher also found in newspaper reports and informal conversations that the public is not satisfied with service delivery in health care. The reason could be that patients and health care workers have varied understanding of the implementation of BPP.

### **1.4 AIM OF THE RESEARCH**

The study aimed to investigate the implementation of BPP as experienced by patients in a public hospital.

### **1.5 RESEARCH OBJECTIVES**

The objectives of this study are to

- describe how patients experience the implementation of Batho Pele principles
- identify shortfalls in the implementation of Batho Pele principles as identified by the patients.

### **1.6 SIGNIFICANCE OF THE STUDY**

This study focussed on the importance of evaluating the implementation of policy and procedures with regard to BPP. An investigation into the implementation of BPP from patients' experience will identify shortcomings in the implementation of these principles and assist decision- and policy-makers in addressing areas of concern.

The research further provided information to the management of public hospitals in order to revise the human resource development programmes to encourage the implementation of BPP in hospitals. This approach will ensure improved service delivery and benefit the patients and personnel of public hospitals.

## **1.7 OPERATIONAL DEFINITIONS USED IN THE RESEARCH REPORT**

The following terms are defined as used in the study:

### **1.7.1 Batho Pele**

Batho Pele is a Sesotho expression which means “people first” (South Africa 1997:9). In the context of this study, Batho Pele refers to an official national document on public services formulated to improve public service delivery in South Africa, including the health care services.

### **1.7.2 Charter**

A charter is an official document granting or defining rights (Oxford English Dictionary 2004:89). In this study charter refers to a document stating the rights of patients, which is part of a national strategy to ensure improvement in the quality of health services at all levels of care.

### **1.7.3 Right**

A right means that which is morally good or justified (Oxford English Dictionary 2004:479). In the context of this study patients’ rights refer to the care which a patient can expect from health care workers according to the PRC and BPP.

#### **1.7.4 Responsibility**

This term means to act in return, to have an obligation, to account for something that is to be answerable to someone or something (Searle 2004:174). Responsibility refers to the obligations of health care workers in public hospitals, to respect the rights of patients and to deliver services in accordance with the BPP and related policies.

#### **1.7.5 Policy**

According to Van Rensburg (2004:117) a policy is developed by decision-makers to guide role-players in their endeavour to implement a strategy. Policies ensure standardisation and provide guidance to all health practitioners (Bezuidenhout 2008:42). In this study the term policy refers to national and hospital policies that guide the actions of health care personnel in order to implement the BPP.

#### **1.7.6 Procedure**

A procedure is an official way of doing something (Oxford English Dictionary 2004:439). Bezuidenhout (2008:59) regards a procedure “as a more specific guide to action than a policy that indicates how a policy should be carried out”. In this study the term refers to the prescribed way of executing the BPP when rendering health care to patients.

#### **1.7.6 Quality**

Muller, Bezuidenhout and Jooste (2006:534) describe quality as the degree of excellence or the extent to which an organisation meets clients' needs and exceeds their expectations. In the context of this study quality means that patients are to receive health care in line with the official government and hospital policies and other related documents.

### **1.7.7 Quality Assurance**

Jooste (2003:263) defines quality assurance as “a guarantee of compliance with predetermined standards and usually relates to legal requirements”. In this study quality assurance refers the process that is based on official national documents, such as the Batho Pele Paper and the Policy on Health Care for South Africa, and that was designed to improve quality standards of care in the health services.

## **1.8 RESEARCH METHODOLOGY**

Research methodology refers to the methods, techniques and procedures that are employed in the process of implementing the research design (Babbie & Mouton 2001:647). The methodology used in this study will now be briefly explained and described, with more detail in chapter 3.

### **1.8.1 Selecting a research design**

A research design is the blueprint for planning the layout of the study and maximizes control over factors that could interfere with the validity of the findings (Burns & Grove 2005:211). This study used a quantitative, descriptive and exploratory research design.

#### **1.8.1.1 Quantitative**

Quantitative research is a formal, objective, systematic process to describe and examine cause-and-effect interactions among variables (Burns & Grove 2005:747). This study is quantitative since the responses by patients were processed and presented in a numerical way.

### **1.8.1.2 Exploratory**

An exploratory study explores and investigates the full nature of the phenomenon, the manner in which it is manifested and the factors to which it is related (Polit & Beck 2004:20) The phenomenon in this study is the implementation of the BPP in a public hospital and this phenomenon was explored in relation to other policy documents and the management of a nursing unit.

### **1.8.1.3 Descriptive**

This study is descriptive because it attempted to describe and explore a phenomenon in a real life situation, and also generate new knowledge about a topic (Burns & Grove 2005:44), in this case the implementation of the BPP.

## **1.8.2 Population**

The term population refers to all elements such as individuals, objects, events or substances that meet the sample criteria for inclusion in a study (Burns & Grove 2005:746). The target population in this study is all patients admitted to state hospitals. According to Polit and Beck (2004:711) the accessible population is the population of people available for a particular study, often a non-random subset of the target population. The accessible population in this research would be patients of a specific provincial hospital in Ekurhuleni District, Gauteng Province (GP), meeting specific inclusion criteria.

## **1.8.3 Demarcation of the study**

The public hospital in which the study was conducted is an academic hospital in Ekurhuleni District. Health Care Services are delivered by the multidisciplinary health team of which all members are public servants. The BPP are thus applicable to all workers in this hospital.



#### **1.8.4 Sample and sampling procedure**

Sampling refers to the process of selecting a portion of the population to represent the entire population (Polit & Hungler 1999:279). The sampling technique that was used in this study, is convenience sampling. Convenience sampling is the use of the most readily accessible person or object as subject in the study (LoBiondo-Wood & Haber 2006:265). In this study the readily available respondents was patients selected at the time that the researcher visited the three different nursing units, namely adults medical, surgical and orthopedic.

The inclusion criteria were as follows:

Adults, both male and female eighteen years and older from all races that are:

- admitted in the ward (medical, surgical or orthopedic) for at least three days or more;
- fully mentally orientated;
- in possession of literacy and writing skills.

#### **1.8.5 Data collection**

According to Burns and Grove (2005:733) data collection is the precise and systematic gathering of information relevant to the research purpose or the specific objectives, question or hypothesis of the study. In this study a structured questionnaire was used to collect quantitative data. The reason for selecting this method was that questionnaires are a quick way of collecting data from a large group of people.

#### **1.8.6 Data analysis**

Polit and Hungler (1995:525) state that data analysis entails the methods of organising data in order that research questions can be answered. The method of descriptive and statistics was used to analyse data in this study with assistance from a professional statistician. Data was organised and presented graphically to describe patients' experiences on how BPP are implemented.

### **1.8.7 Measures to ensure validity and reliability**

Validity refers to whether an instrument accurately measures what is supposed to be measured (LoBiondo-Wood & Haber 2006:338). The reliability of a research instrument is defined as the extent to which the instrument yields the same results on repeated measures (LoBiondo-Wood & Haber 2006:345). The researcher implemented measures to ensure face and content validity as well as reliability as the research progressed. These measures are described in detail in Chapter 3.

## **1.9 ETHICAL CONSIDERATIONS**

Researchers and reviewers of research have an ethical responsibility to recognise and protect the rights of human research respondents (Burns & Grove 2005:181). Ethical principles that were considered in this study are the principles of permission for the study, informed consent, beneficence, respect for human dignity, anonymity and confidentiality. These considerations are described in detail in chapter 3.

## **1.10 OUTLINE OF THE STUDY**

Chapter 1 Introduction and background information

Chapter 2 Literature review

Chapter 3 Research methodology

Chapter 4 Data analysis, presentation and interpretation

Chapter 5 Summary, conclusion and recommendations

## **1.11 SUMMARY**

This chapter discussed the background of the study, statement of the research problem, aim of research, objectives of the research study, significance of the study as well as definitions used in the research report. It further highlighted the research methodology and the selection of a research design, population, sample and sampling technique, including

selection criteria and the method of data collection and data analysis. Measures to ensure validity and reliability as well as ethical considerations that will be of great importance in this study were also briefly mentioned. Chapter 2 will discuss the literature review relevant to the implementation of BPP.

## **CHAPTER 2**

### **LITERATURE REVIEW**

#### **2.1 INTRODUCTION**

Literature review is a process that involves researching, reading, understanding and forming conclusions about published works and literature on a particular topic (Brink 2006:67). According to LoBiondo-Wood and Haber (2006:80), a literature review determines what is known and unknown about a subject, concept or problem.

The literature reviewed for the topic 'The transformation of the health care system in South Africa' has shown that since the introduction of the BPP in South Africa in 1997 no research has been done on the implementation of these principles.

The purpose of the literature review was to obtain information on the transformation of the health system in South Africa, specifically focusing on the implementation of the BPP as means of transforming the system. The literature search for this study included relevant national policy documents and nursing management information. Documents, textbooks, journal articles and internet information were researched. The subject librarian at the Unisa library, Mucleneuk campus, assisted in identifying relevant literature.

#### **2.2 THE RECONSTRUCTION AND DEVELOPMENT PROGRAMME (RDP)**

The RDP is an integrated and coherent socio-economic policy framework that seeks to mobilize all people as well as South Africa's resources towards the final eradication of apartheid and the building of a democratic, non-racial and non-sexist future. This document addresses, amongst others, the reform of the health care system in South Africa. The aim is to ensure that all South Africans receive better value for money spent on health services and to increase quality of life (ANC 1994b:43).

The following issues addressed in the document are of importance for this study:

- Review of all relevant legislation to redress the harmful effects of apartheid (ANC 1994b:45).
- Introduction of management practices that promote efficient and compassionate delivery of services, and that ensure respect for human rights and accountability to users, clients and the public at large (ANC 1994b:46).
- A charter of patients' rights that will be displayed in all health facilities (ANC 1994b:47).

The RDP document serves as basis for many of the national policy documents that were developed as a result, and this framework document plays an important role in the delivery of public services in South Africa.

### **2.3 A NATIONAL HEALTH PLAN (NHP) FOR SOUTH AFRICA**

The NHP for South Africa was initiated in May 1994 as an extension of the RDP to redress social and economic injustice, to eradicate poverty and reduce waste (Van Rensburg 2004:114). This plan has as its aim the increase of efficiency as well as ensuring greater control by communities and individuals over all aspects of their lives.

In the health sector this national health plan involves complete transformation of the national health care system with its goal as attaining the following:

- Ensuring that the emphasis is on health and not only on medical care. This statement implies that it is expected of doctors, nurses and other health care workers to inform patients about a healthy lifestyle before initiating medical treatment (ANC 1994a:7).
- Encouraging and developing comprehensive health care practices that are in line with international norms, ethics and standards (ANC 1994a:7).
- Introducing the PRC to help patients know their rights and responsibilities in all health care facilities (ANC 1994a:7).

- Introducing management practices that are aimed at efficient and compassionate health care delivery (ANC 1994a:7).
- Ensuring respect for human rights and accountability to the users of health facilities and the public at large. This goal further obliges health care workers to respect and protect patients' human dignity (ANC 1994a:7).

## 2.4 BILL OF RIGHTS

The Constitution of the Republic of South Africa, (no 108 of 1996), contains the Bill of Rights in chapter 2. From the list of rights for all citizens those relevant to this study were selected and are paraphrased and described within the context of the study as follows:

- **Human dignity**

Patients are entitled to be treated with respect and dignity. Health care professionals must ensure that patients are treated in a humane and dignified manner.

- **Life**

Everyone has the right to life. Nurses must protect this right of the patients in their care.

- **Freedom and security of the person**

Patients have the right to biophysical and psychological safety and security and no medical research can be done without a patient's informed consent. Informed consent is important, even in the case of executing nursing procedures.

- **Privacy**

This refers to the search of persons and possessions as well as to information that is communicated with regard to another person. Confidentiality of all information pertaining to any citizen should be protected.

- **Freedom of expression**

People are free to receive or convey information. In this study this right refers specifically to the freedom to complain.

- **Freedom of religion, belief and options**

Patients are free to practice their religion and beliefs. This should be respected by health care providers if it does not cause harm.

- **Environment**

This right secures a safe and healthy environment for all persons. This right is relevant also in a hospital environment with regard to cleanliness and hygiene.

- **Health care, food, water and social security**

All citizens are entitled to health care services and especially emergency care.

- **Language and culture**

Patients have the right to use a language of their choice and by implication to be addressed in a language they understand.

- **Access to information**

Patients have the right to be informed. In this case the right will include information about their condition, diagnosis, treatment and rehabilitation.

- **Just administrative action**

Patients can expect administrative action that is within the law and reasonable. The management of a public hospital should adhere to this right.

Several of these rights protect health rights or are related to health (Van Rensburg 200:116). The seven rights that are directly linked to one or more right in the PRC, one or more principles in the BPP and aspects in the Policy on Quality in Health Care for South Africa are *the right to human dignity, life, freedom and security of the person, privacy, environment, health care, food, water and social security and access to information* (South Africa 1996:7.8.13,15).

Where applicable, the specific relationship to the national documents is discussed throughout the literature review.

## **2.5 PATIENTS' RIGHTS CHARTER (PRC)**

The PRC was adopted in 1999 as common standard for achieving the realization of the rights of patients to access health care services. This document also addresses the responsibility that patients need to fulfill (Van Rensburg 2004:119,120). However, the responsibilities of the patient are not discussed here as this study focuses on the obligation of the health care personnel and thus on the rights of patients. Following the patients' rights as stated in the PRC are paraphrased according to its relevance for this study.

### **2.5.1 A healthy and safe environment**

Everyone has the right to a safe and clean environment, which includes clean water supply, sanitation, waste disposal, protection against pollution, infection and all forms of danger. This will ensure physical and mental well-being.

### **2.5.2 Participation in decision-making**

Patients have the right to take part in decisions regarding their health.

### **2.5.3 Access to health care**

This right refers to the right to emergency care, treatment and rehabilitation and the explanation of such care to the patient. Persons with special needs are mentioned such as infants, children, pregnant women, the aged, disabled and people living with HIV or Aids. This right compels health care providers to treat patients with dignity, empathy and tolerance and to explain the availability and use of health services to patients in a language understood by them.

### **2.5.4 Treatment by a named health care provider**

Patients have the right to know who is providing health care, thus health care providers should be identified and introduced themselves.



### **2.5.5 Confidentiality and privacy**

All information pertaining to the health and treatment of a patient may only be disclosed with informed consent from the patient, unless it is done under an order of the court. Patients' privacy during examinations and interviews should be protected.

### **2.5.6 Informed consent**

To help patients make informed choices and give consent they have the right to full and accurate information regarding their illness, diagnostic procedures and proposed treatment.

### **2.5.7 Refusal of treatment**

A patient may refuse treatment verbally or in writing provided it does not endanger the health of other persons.

### **2.5.8 Referral for a second opinion**

Patients may request referral for a second opinion to a health provider of their choice.

### **2.5.9 Continuity of care**

Health care professionals may not abandon a patient for whom they have taken responsibility. When patients are discharged, information on follow up services should be given.

### **2.5.10 Complaint about health services**

All patients have the right to complain about health care services and to expect the complaint to be investigated.

Some of the rights in the PRC are linked directly to one or more principles of the BPP, namely *access to health care, treatment by a named health care provider, confidentiality and privacy, informed consent, referral for a second opinion, continuity of care and the right to complain about health services*. Some of these rights relate directly to the Bill of Rights namely *life, privacy, environment and access to information*.

## **2.6 THE WHITE PAPER ON TRANSFORMING PUBLIC SERVICE DELIVERY (BATHO PELE WHITE PAPER) NOTICE 1459 OF 1997**

The White Paper, also known as the “Batho Pele”, (which is a Sesotho expression meaning “people first”), is a document on the transformation of public service delivery that was published in October 1997, notice 1459 of 1997. The content of this White Paper deals primarily with how public services are provided, and specifically with improving the efficiency of the delivery of services. The document seeks to introduce a fresh approach to service delivery, an approach that will put pressure on systems, procedures, attitudes and behavior within the public service and re orientate service delivery in the customers’ favour, an approach that puts the people first (South Africa 1997:12). The Batho Pele policy framework consists of eight service delivery principles, namely:

- Consultation
- Service standards
- Access
- Courtesy
- Information
- Openness and transparency
- Redress
- Value for money

The implementation of these principles is explained in Section 4 of the White Paper and will be discussed in relation to this study.

### 2.6.1 Consulting users of services

*“Citizens should be consulted about the level and quality of the public services they receive and, wherever possible, should be given a choice about the services that are offered”.* (South Africa 1997:15).

Consulting users of services will not be discussed in this study as it is not of direct relevance to this study.

### 2.6.2 Setting service standards

*“Citizens should be told what level and quality of public services they will receive so that they are aware of what to expect”* (South Africa 1997:15).

Standards for the quality of services should be published at national, provincial and departmental levels. These standards must be relevant and meaningful to the individual user and be specific and measurable. Users should be able to judge whether the promised services were received or not. Standards should be published and displayed and performance of health care providers must be measured at least once a year (South Africa 1997:16,17).

In a public hospital, certain service standards pertaining to the functioning of the ward are to be displayed on the wall in the units so that they can be visible to patients and their families. These include:

- Shift roster for the nursing staff
- Ward rounds
- Schedule for serving of meals to patients
- Schedule for nurses' tea breaks and lunch times
- Schedule for visiting times

The Policy on Quality in Health Care in South Africa is an example of a service standard document and will be discussed later in this chapter. It appears that some of the service standards as mentioned above are not yet implemented properly because complaints about poor health service delivery are reported in the media. Examples of such complaints are provided as evidence of the above statement.

In the Pretoria News Nthite, (2006:1) reports that various patients complained that they were not attended to when they presented themselves at a certain academic and district Hospital, although they were injured and bleeding. They had to queue for longer than six hours and were ignored by the nurses who were either on tea or lunch breaks. One of the patients said, "they make you feel they are doing you a favour here" (Refer to Annexure F).

Premdev in the Sunday Tribune (2006:3) reported on a woman who was referred to a hospital to deliver her baby who later died of complications. She was left by herself to deliver the baby and her screams for help fell on deaf ears. (Refer to Annexure F)

According to the Daily Sun (2007:5) a mother took her baby to the hospital because her seven month old baby girl was suffering from diarrhea. During her hospital stay the baby lost four fingers when nurses forgot to unstrap a band around her arm after inserting a drip. She said when the mistake was discovered the baby was transferred to another hospital for an emergency operation. As a result the baby had to undergo four more operations and was discharged from the hospital three months later. A health department spokesperson said a clinical investigation would have to be conducted to determine whether there was any negligence on the part of the hospital. (Refer to Annexure F)

### **2.6.3 Increasing access**

*"All citizens should have equal access to the services to which they are entitled" (South Africa 1997:15).*

This service delivery principle includes access of health services to patients who were previously disadvantaged as a result of the lack of infrastructure and barriers to access

such as social, cultural, physical, communication and attitude factors. (South Africa 1997:18)

Access to health care is addressed in the PRC (refer to 2.5) and in the Accreditation program that describes the availability of adequate resources in order to deliver health care services. This accreditation program indicates that special provision should be made to accommodate patients who have disabilities, for example an entry door of the toilet in the unit should open outward, and at least one toilet and bathroom in the unit should be provided with a wide enough door or entrance for a wheel chair to gain access (Gauteng Department of Health 2003:15). The principle of access to health care services is not yet properly implemented, as can be justified by the following media reports.

The Diamond Field Advertiser (2006:1) published a report about a 60-year old male patient, who, according to the family, was seriously ill. On arrival at the hospital there were no beds available and they were told that he must sleep in his wheelchair or go home. (Refer to Annexure F)

Tyali (2006:4) reported on a hospital in Mthatha not having blankets for patients during winter time. Families had to either bring blankets from home or buy blankets in town. (Refer to Annexure F)

#### **2.6.4 Ensuring courtesy**

*“Citizens should be treated with courtesy and consideration”* (South Africa 1997:15).

Health care services must ensure that members of the public are treated as customers who are entitled to good service. Departmental codes of conduct should cover at least:

- how to greet and address customers
- identification of health care workers
- principles for conducting interviews
- timeframe within which to respond to enquiries

- procedure for dealing with complaints
- language (South Africa 1997:19).

Patients are to be treated as individuals, with fairness, in an unhurried manner, with empathy and understanding, as well as with consideration and respect. Discourtesy must not be tolerated. Staff performance should be monitored and managers are expected to set an example of behavioral norms to junior health care workers (South Africa 1997:19).

Respect and courtesy is also addressed in the Bill of Rights (refer to 2.4), the PRC (refer to 2.5) and the Policy on Quality in Health Care in South Africa (refer to 2.7.2).

Violation of the basic right to respect can be observed in newspaper reports, for example: The Citizen published a report by Mbuyisa (2006:1) about a 20-year old woman who vowed never to set foot in a specific hospital again after being subjected to “dog-like treatment” by nurses who were discourteous (Refer to Annexure F).

### **2.6.5 Providing more and better information**

*“Citizens should be given full, accurate information about the public services they are entitled to receive” (South Africa 1997:15).*

This principle on the provision of information aims to empower patients to understand the health services they are entitled to receive, their illness, diagnosis and treatment. The White Paper states that health care providers should determine what patients need to know and then decide on the best way to provide the information in understandable language and free from jargon (South Africa 1997:19).

The right to information is addressed in the Bill of Rights (refer to 2.4) as well as the PRC under access to health care; informed consent and participation in decision-making (refer to 2.5). The Policy on Quality in Health Care for South Africa states that patients who are treated with dignity and are well informed are able to participate in the treatment decisions and are more likely to comply with their treatment plans (South Africa 2007:13). In practice,

patients in hospitals are to be informed about ward routines like ward rounds, schedules for serving of meals and schedules for visiting times.

Failure to provide information to patients results in the lodging of complaints, often in the media, such as the following:

Mbuyisa (2006:1) published a report in the Citizen where a patient said she was left to sit on a bench and the nurses did not explain what she was supposed to do (Refer to Annexure F).

### **2.6.6 Increasing openness and transparency**

*“Citizens should be told how national and provincial departments are run, how much they cost and who is in charge”. (South Africa 1997:15).*

This principle of openness and transparency will not be discussed as it is not of direct relevance to this study.

### **2.6.7 Remediating mistakes and failures / Redress**

*“If the promised standard of service is not delivered, citizens should be offered an apology, a full explanation and a speedy and effective remedy; and when complaints are made, citizens should receive a sympathetic, positive response” (South Africa 1997:15).*

The principle of redress requires an effective approach to handling complaints. Staff should be encouraged to welcome complaints as an opportunity to identify and address problems and improve service delivery. The complaint system should be accessible in writing, face-to-face or by telephone. Complaints should be dealt with without delay and must be investigated fully and impartially. Complaints must be treated confidentially to protect the complainant. The hospital must have a strategy for providing feedback about complaints that will serve as training opportunity for health care providers. All staff must know the procedure for handling complaints (South Africa 1997:21, 22).

The BPP is accordant with the PRC by stating that everyone has the right to complain about the health care services, to have such complaints investigated and to receive a full response on such an investigation (Refer to 2.5).

Complaints that are not dealt with are often reported in the media, for example:

In the Sunday Tribune, Premdev (2006:3) reported that a patient's complaint about being left alone while delivering her baby, was not dealt with because the person handling the report died and for 11 months she had no response from other officials (Refer to Annexure F).

Engelbrecht (2006:5) reported two incidences in a Kimberley hospital where family members could not get a response on complaints lodged. (Refer to Annexure F).

The Daily Sun (2006:8) published a report about a patient who was admitted to hospital with chest pains on 23 September. Four days later he disappeared. The hospital admitted that they had lost him and no one could tell the man's family where he was or how he went missing. The Hospital Chief Executive Officer confirmed that the patient was missing and said the hospital had involved the police in the search for him. (Refer to annexure 7)

### **2.6.8 Getting the best possible value for money**

*“Public services should be provided economically and efficiently in order to give citizens the best possible value for money”. (South African 1997:15)*

The White Paper states that services should be cost effective and delivered within departmental resource allocations. Procedures should be simplified and waste and inefficiency eliminated (South Africa 1997:22). This principle is of importance for unit managers to plan, organise and control all resources in such a way that cost effective patient care can be rendered. Nursing units must control their resources in order to prevent



unnecessary shortages, for example shortage of linen. This principle is closely related to *access to health care* as discussed in the PRC (refer to 2.5).

## **2.7 POLICY ON QUALITY IN HEALTH CARE FOR SOUTH AFRICA**

The Policy on Quality in Health Care for South Africa (NDOH 2007:2) states that improving quality in health care is a key national challenge for the next five years.

The national aims for improvement of quality in health care relevant to this study include:

- addressing access to health care
- increasing patients' participation and confirming the dignity afforded to them
- reducing health care errors.

These are briefly discussed in the following paragraphs.

### **2.7.1 Improved access to health care**

The national health care capacity should be balanced to ensure that under-served populations also have access to health care services and equity is attained. Setting norms and standards is one way of ensuring that minimum standards are met and equity is addressed (NDOH 2007:4,10).

### **2.7.2 Increasing patients' participation and confirming the dignity afforded to them**

This aim addresses the empowerment of patients by providing information and involving them in decision-making. It states that patients who actively participate in their own care can improve the effectiveness thereof as well as their own satisfaction with the care. Patients who are treated with dignity, are well informed and able to participate in treatment decisions are more likely to comply with their treatment plans (NDOH 2007:3,4).

### **2.7.3 Reduce errors in health care**

Health care can be improved by increasing patients' safety and reducing the level of error in health care delivery. Systems must be designed and health professionals trained to improve patient safety. This can be done by reducing hazards in health care, and limiting the seriousness of the consequences of errors when they do occur (NDOH 2007:15).

Several basic and specific rights are implied in the aims set above, such as *access to health care, informed consent, participation in decision-making, providing more and better information, getting the best value for money and human dignity*. These were discussed under the Bill of Rights, PRC and the BPP respectively in 2.4, 2.5 and 2.6.

## **2.8 MANAGEMENT OF HEALTH SERVICES AT UNIT LEVEL**

This section gives a brief overview of the management issues which may impact on the implementation of BPP in a public hospital. The quality of service delivery in a nursing unit depends to a large extent on the management of the unit. The management process is guided by legislation, policy documents, management processes, practices and ethical principles.

Management is defined as a process whereby human, financial, physical and information resources are employed in order to achieve the goals and objectives of the organisation, by applying the fundamental management activities of planning, organising, leading and control (Muller, Bezuidenhout & Jooste 2006:19).

There are different levels of management, namely top management, which is accountable for the performance of the organisation, middle management, responsible for the execution of the organisational strategies, plans and policies and operational management that takes place on the level of the nursing unit (Muller et al 2006:20). The four management activities namely planning, organising, leading and control as well as staffing are briefly discussed below as practiced by the unit managers at a unit level.

### 2.8.1 Planning

This is the fundamental element of management that predetermines what the unit proposes to accomplish and how this is to be accomplished (Muller et al 2006:19). The unit manager has the responsibility to ensure that the unit has enough equipment and that this is in a good working order according to the needs of the unit. This will influence the BPP *Getting the best possible value for money* (refer to 2.6.8).

The unit manager is responsible for supervising the execution of the core business, clinical and non-clinical, of the organisation in accordance with specified standards and indicators (Muller et al 2006:20). These standards include:

- **Cleanliness of the unit**

The unit manager has the responsibility of implementing a system to ensure that the floors and accessories are cleaned, toilets and taps are functional, and that there is adequate disposal of rubbish and medical waste including sharps. (Gauteng Department of Health 2003:12).

- **Food service**

The unit manager must ensure that the meal ordering system considers special needs and preferences of patients, and that patients receive the correct food as ordered. The manager also needs to monitor whether patients eat the food provided or not. (Gauteng Department of Health 2003:9).

- **Record-keeping**

Such a system should ensure that the patient's information is accurately and completely recorded according to legal and ethical requirements, hence the unit manager has the responsibility to ensure that policy guidelines with regard to the legal statutory requirements for record keeping inpatients' files are available and implemented. (Gauteng Department of Health 2003:12).

## 2.8.2 Organising

This is concerned with the allocation of the resources required for goal achievement (Muller et al 2006:27). The unit manager must ensure that the resources allocated are within the core needs of the patients in the unit. The resources must be accessible to all types of patients including those with special needs. (Refer to the BPP and PRC addressing *access to health care* in 2.6.3 and 2.5 respectively.)

Factors that need to be considered and organised for patients' safety in the hospital nursing units include, among others, adequate:

- lighting,
- ventilation,
- safety and
- hygiene.

Adequate and appropriate lighting is important to ensure recovery and health. In the hospital, especially at night where artificial lighting is used, health care providers must avoid using bright lights (Vlok 1996:186). Ventilation, humidity and temperature levels in nursing units should be kept comfortable at all times. Patients with respiratory conditions may find it difficult to breathe in instances where artificial heating is used (Roos 2008:129).

Medico-legal hazards that might hamper the safe delivery of patient care in a unit are slippery floors, unprotected windows, faulty equipment and unlocked medicine cupboards (Roos 2008:128).

The cleanliness of bathrooms, toilets and floors contributes to aesthetics of wards and safety for patients and visitors (Gauteng Department of Health 2003:12). According to Roos (2008:129) neatness of the general environment and more specifically of the bathrooms and toilets is very important to patients.

The above-mentioned factors are all ways of ensuring a safe and healthy environment, which is one of the rights of patients (refer to 2.5).

### **2.8.3 Leading**

This is the third management activity and is concerned with the dynamic interaction between the leader and the followers, aimed at the facilitation of organisational goal attainment by means of leadership and strategies (Muller et al 2006:31). The unit manager applies leadership in supervision, motivation, and empowerment of the subordinates in the unit. The unit manager will act as role model to junior staff, instilling behavior that enhances dignity and respect for others. The unit manager has the responsibility of promoting harmony in teamwork to ensure a conducive environment that will promote the quick recovery of the patient.

The BPP and rights in the PRC addressing interpersonal interaction, such as *informed consent, providing more and better information and remedying mistakes* are all at stake and should be an integral part of the managers' functions.

### **2.8.4 Controlling**

The unit manager should constantly establish whether the goals set for the unit have been achieved. Control plays a vital role in the responsibility of promoting quality nursing and cost-effectiveness in the unit. (Muller et al 2006:20, 33). Adequate control in the nursing units can improve quality of care to patients. The unit manager should ensure that faulty and damaged equipment is repaired or replaced immediately and has to monitor the provision of adequate resources such as medicine, linen and towels.

Strategies to monitor the quality of health care services include self-evaluation, peer group evaluation, direct observation, document auditing, patient satisfaction interviews and monitoring of incidents (Du Toit 2007:51, 52). The unit manager will implement such strategies in accordance with the hospital policy and procedures.

### **2.8.5 Staffing**

Staffing refers to the allocation of human resources to service the units. Nurses form the largest component of health care providers who have to provide the required care for patients in the nursing units, depending on their level of training, experience and qualifications. The issue of staffing and scheduling is complex and entails providing sufficient numbers of qualified nursing personnel to ensure adequate, safe nursing care for all patients 24 hours a day, seven days a week, every week of the year (Muller et al 2006: 311). For health care managers to best meet staffing needs the following information is of great importance:

- Patient census
- Patient acuity classification system
- Diagnostic related groups
- Staff or skills mix (Muller et al 2006: 311, 312, 313).

The BPP addresses the staff, as public servants, and the unit manager should manage her staff component in accordance with the BPP and PRC.

## **2.9 LEGISLATION AND POLICY TO ENSURE IMPLEMENTATION OF THE BATHO PELE PRINCIPLES IN A HOSPITAL**

The implementation of the BPP in a public hospital is not an isolated or selected event. Management structures and all categories of health care providers should know and understand how different legislative and policy documents underpin and strengthen the importance of the BPP.

For this study the RDP, the NHP, the Bill of Rights, the PRC and selected quality assurance documents were reviewed to describe the obligation of health care providers in implementing six of the eight BPP.

## **2.10 SUMMARY**

A literature review on BPP and related issues influencing quality in health care in South Africa was done in this chapter. The research methodology which includes research design, population, sampling, data collection, data analysis, reliability and validity and ethical considerations is discussed in chapter three.

## **CHAPTER 3**

### **RESEARCH METHODOLOGY**

#### **3.1 INTRODUCTION**

The purpose of this chapter is to describe the research design that was used in the study. The target population, sample and sampling method, data collection and analysis, methods to ensure validity and reliability as well as ethical considerations involved are explained.

#### **3.2 RESEARCH DESIGN**

The research design is an overall plan for obtaining answers to the questions being studied and for handling some of the difficulties encountered during the research process (Polit and Beck 2004:49). The aim of this study was to investigate the implementation of BPP as experienced by patients in a public hospital. To achieve this aim this study used quantitative, exploratory and descriptive research.

##### **3.2.1 Quantitative**

Quantitative research is a formal, objective and systematic process in which numerical data is used to obtain information about the world (Burns & Grove 2005:23). A quantitative approach is appropriate for this research because the aim of the study was to investigate patients' points of view on how BPP are implemented in the care of patients in a public hospital. This was determined by counting the responses given by respondents and presenting these numerically.

The following characteristics of quantitative research, as described by Burns and Grove (2005:24) are of importance in this study:

- Quantitative research focuses on specific concepts, in this study the BPP as implemented in a provincial hospital in GP.



- Quantitative research uses structured interviews, questions and observations. In this study a questionnaire was used to collect data from hospitalised patients.
- Quantitative research uses numbers and statistics. Numerical and approved statistical procedures were appropriate in the collection and analysis of data in this study.

### **3.2.2 Exploratory**

According to Polit and Beck (2004:718) exploratory research is a study that explores the dimensions of a phenomenon. This study was exploratory as it intended to explore and document in full the implementation of BPP, as experienced by patients in selected hospital nursing units.

An exploratory approach is used when little or nothing is known about a phenomenon and is thus appropriate to this study since the implementation of BPP has not yet been investigated.

### **3.3.3 Descriptive**

This study was descriptive as it attempted to provide an accurate account of characteristics of the phenomenon (Burns & Grove 2005:44) The phenomenon under research is the implementation of BPP in a provincial hospital in GP. It was also appropriate to use a descriptive research design in this study since little is known about the phenomenon. For this reason description allowed the identification of shortfalls in the implementation of BPP.

## **3.3 POPULATION**

Population is a well defined set of individuals that has certain specified properties (LoBiondo – Wood & Haber 2006:261). This will be the entire set of individuals who meet sampling criteria. The accessible population in this study was the patients in a specific provincial hospital in the Ekurhuleni District GP. For this study the population namely

patients in a public hospital was chosen because all patients are entitled to be cared for in line with the stipulations of the BPP.

### **3.4 SAMPLE AND SAMPLING METHOD**

Sampling is a process of selecting a portion of the designated population to represent the entire population. A non-probability sampling method was used in this study. This means that not every element of the population had an opportunity to be included in the sample. Convenience sampling was used, since this is the use of the most readily accessible persons or objects as respondents in a study (LoBiondo-Wood & Haber 2006:263,265). The hospital has a capacity of five hundred in-patients. A sample of one hundred respondents was chosen from the identified wards, namely the medical, surgical and orthopedic wards. These are the wards in which patients are admitted for a number of days. It is assumed that patients who stay for at least three days will be able to share more information on the implementation of BPP as opposed to patients who are admitted on a short term.

The sampling and research was done during a week that was convenient for the researcher, research assistant and the unit managers of the identified wards. Patients who met the inclusion criteria and who was willing to participate was included as part of the sample. The process continued until the sample size of 100 was reached.

The inclusion criteria stated that patients should be adult male or female patients from the designated wards who are:

- 18 years and older,
- fully mentally orientated ,
- from all races,
- skilled in reading and writing,
- admitted to the ward for three or more days.

The inclusion of criteria on age and mental capacity aims to identify respondents who will be able to give meaningful responses to the questionnaire. All races are included as health care in SA is available to all citizens and representatives from all races will be included as respondents where possible. The criteria on being skilled to read and write was included to ensure that persons would be able to complete the questionnaires themselves. This criterion was no longer valid following the pre-testing of the questionnaire, (refer to 3.5.2) as the researcher and assistant completed the questionnaires.

### **3.5 DATA COLLECTION**

Data collection is the gathering of information to address a research problem (Polit & Beck 2004:716). In this study a questionnaire was used to collect data. According to Brink (1996:153), a questionnaire refers to a self report instrument where a respondent writes his or her answer in response to the printed questions.

#### **3.5.1 The questionnaire**

A new structured questionnaire was developed, based on different policy documents and the literature review. The instrument consisted of the following sections (Refer to Annexure E):

- Section A Acuity level of the patient
- Section B Demographic Information
- Section C Batho Pele Principles
- Section D Patients' Right Charter
- Section E Quality Assurance

The questionnaire includes open- and closed-ended questions. A statistician checked the design and format of the questionnaire to simplify the analysis of data. The supervisors of the study checked all questions for content validity.

### **3.5.2. Pre-testing**

Pre-testing is the collection of data prior to the research, sometimes called baseline data (Polit & Beck 2004:728). Pre-testing of the data collection instrument entails data collection from a small sample of the population but not the same group that will be part of the sample group. pre-test can also be explained as a trial run to test the usability, reliability and validity of the questionnaire that was conducted. Pre-testing was done with ten respondents to see if they understand the instructions and questions and to monitor the amount of time taken to complete the questions. These questionnaires were also given to the statistician. Problems identified were discussed with the supervisor and minor changes were made to the questionnaire. One significant problem that was discovered during the pre-testing was that only three respondents were able to elaborate on open-ended questions. This meant that valuable information was not recorded by the respondents as they did not respond to the open questions. It was therefore decided that instead of the questionnaires being completed by respondents, the researcher and the researcher assistant would complete the questionnaires on behalf of the respondents. The criterion that states that respondents should be literate and able to write therefore no longer applies.

## **3.6 DATA ANALYSIS**

According to Polit and Beck (2004:716) data analysis is the systematic organisation and synthesis of research data. The analysis of quantitative data was done with the assistance of a statistician. Descriptive statistics were used to analyse the data in this study. MS Excel data capturing were used. Findings were presented in tables and the graphical format was accompanied by the researcher's interpretations.

## **3.7 RELIABILITY AND VALIDITY**

Reliability and validity as research principles play an important role in determining the quality of research.

### **3.7.1 Reliability**

According to LoBiondo–Wood and Haber (2006:346), the reliability of a research instrument is defined as the extent to which the instrument yields the same results on repeated measures. Reliability in this study was enhanced by ensuring that respondents understood the questions by means of using simple language and well-formulated questions. Pre-testing of the instrument contributed to the reliability.

### **3.7.2 Validity**

According to Brink and Wood (1998:270) validity refers to the ability of an instrument to measure exactly what it is supposed to measure and nothing else. In order to ensure the validity of the instrument, the researcher considered the major reasons for developing it and the major functions the instrument serves, in other words the aims and objectives of the study. Simple language was used in the questionnaire to ensure that respondents understand the questions. Questions were formulated clearly and concise to assist the respondents in interpreting them easily (Refer to Annexure E).

- **Face validity**

According to Polit and Beck (2004:423), face validity refers to whether the instrument looks as though it is measuring the appropriate construct. In this study face validity was enhanced by including the concepts relevant to BPP as identified in the literature study in the questionnaire.

- **Content validity**

Content validity refers to an estimation of the adequacy with which a specific domain of content is sample (Brink & Wood 1998:271). It further refers to the content representativeness of the concept, in other words the completeness with which items cover the important areas of the domain they are attempting to represent (Brink & Wood 1998:271). According to Polit and Beck (2004:423) content validity concerns the degree to which an instrument has an appropriate sample of items for the construct being studied.

In this study content validity was ensured firstly by including all aspects relevant to BPP in the questions. Problems identified were discussed with the research supervisors and statistician and corrections and changes were made accordingly.

Another measure to ensure the validity was the pre-testing of the questionnaire. After pre-testing it was discovered that most respondents didn't elaborate on open-ended questions, leading to valuable content and information not being recorded. It was therefore decided that the researcher and a researcher assistant were to complete the questionnaires on behalf of respondents.

### **3.8 ETHICAL CONSIDERATIONS**

When humans are used as study participants, care must be exercised to ensure that the rights of those humans are protected (Polit & Beck 2004:141). Ethical principles that were considered in this study are permission for the study, informed consent, beneficence and respect for human dignity, anonymity and confidentiality.

#### **3.8.1 Permission for the study**

To proceed with this research permission was obtained from the Gauteng Department of Health (GDOH), where the research proposal evaluation form was signed by the provincial research committee. Consent was also obtained from the Ekurhuleni Health District (Region B) where the research clearance certificate was signed by the chairperson of the Ekurhuleni Health District ethics panel, research co-coordinator of Ekurhuleni Metropolitan Municipality and the research coordinator of GDOH as well as the nursing service managers of the hospital (Refer to Annexure A, B, C & D).

#### **3.8.2 Informed consent**

Informed consent means that participants have received adequate information regarding the research and are capable of comprehending the information (Polit & Beck 2004:151).

Thorough and clear explanations were given to respondents including the aim of the study and the method of data collection so that they would be fully informed about what they agreed to and were required to do. Respondents gave their written consent. A covering letter requesting patients to participate in the study is included (Refer to Annexure D).

### **3.8.3 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 questionnaire, 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).

### **3.8.4 Respect for human dignity**

The dignity of respondents was respected and protected throughout the study, as well as their right to self-determination and the right to full disclosure. The right to self-determination means that prospective participants have the right to decide voluntarily whether to participate in a study without risking any penalty or prejudicial treatment (Polit & Beck 2004:147). It also means that respondents have the right to ask questions, to refuse to give information, to ask for clarification or to terminate their participation at any stage during the research. This was explained to the respondents.

### **3.8.5 Anonymity**

This principle refers to the protection of participants in a study to such an extent that even the researcher cannot link individuals with the information provided (Polit & Beck 2004: 711). Respondents were assured that their identity would not be disclosed in the

questionnaire or report. They were informed that the numbering of questionnaires 001-100 was done to facilitate the analysis of data only.

### **3.8.6 Confidentiality**

Confidentiality was protected and promoted throughout the study. The respondents were assured that no unauthorised person would gain access to raw study data.(LoBiondo-Wood & Haber 2006:299).

## **3.9 SUMMARY**

This chapter discussed the research design and methodology by explaining the research process step by step. The next chapter contains the data analysis and interpretation.



## **CHAPTER 4**

### **DATA ANALYSIS, PRESENTATION AND INTERPRETATION**

#### **4.1 INTRODUCTION**

A quantitative, explorative and descriptive strategy for research was used in this study to identify how and whether BPP is implemented by investigating patients' experiences of the national health system. This chapter describes the analysis, presentation and interpretation of the research findings.

#### **4.2 DATA MANAGEMENT AND ANALYSIS**

Data was collected using a structured questionnaire schedule. A hundred questionnaires were completed by the researcher and the research assistant on behalf of the respondents. All questionnaires were completed with all questions answered. The questionnaire consisted of five sections.

Section A dealt with the acuity level of the patient and two items in the questionnaire covered this topic. Five items of the questionnaire dealt with the demographic information of each patient in Section B. The largest number of items in the questionnaire, namely 24 items in Section C, had to do with the Batho Pele Principles and whether these are implemented, according to the respondents. Eight questions covering the Patients' Rights Charter made up Section D of the questionnaire and the final ten items in Section E focused on quality assurance in the national health system.

Descriptive statistics were used to analyse data in this study. The SPSS computer software program was used in the analysis of the data. Data analysis of close-ended questions was done with the help of a statistician. The researcher analysed the open

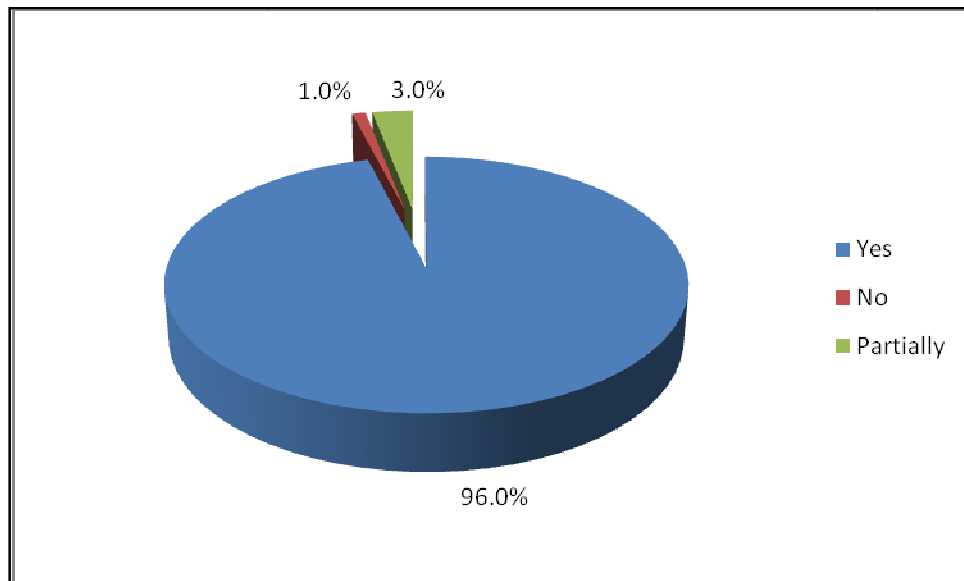
ended questions, which in most cases gave examples to expand on the preceding close-ended questions.

The analysis of data and interpretation of each item from the questionnaires will be discussed, with reference to the literature review where applicable.

### 4.3 SECTION A: ACUITY LEVEL OF THE PATIENT

#### Item A1: Dependence on assistance

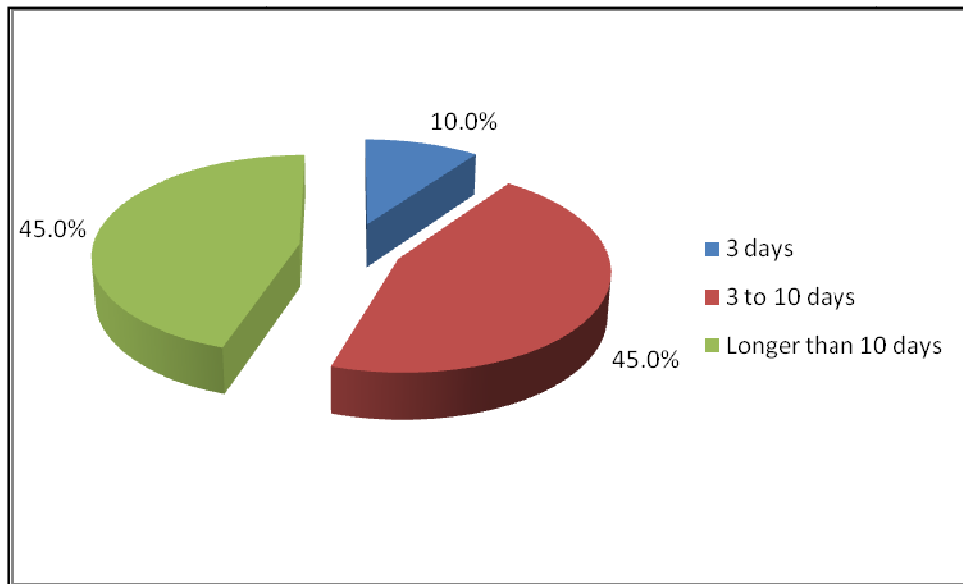
The majority of respondents, namely 96.0% (n=96), responded that they were able to feed themselves, while only 1.0% (n=1) of the respondents reported that they were unable to feed themselves. A few respondents 3.0% (n=3) indicated that they were partially able to feed themselves (Refer to Figure 4.1). This question was included because it is assumed that patients who are dependent on nurses for their basic needs such as feeding will be in a better position to reveal whether the BPP is indeed implemented.



**Figure 4.1 Dependence for assistance with basic needs (n=100)**

### Item A2: Stay in the ward

Ten percent (n=10) of the respondents reported that they had been in the ward for three days only, while 45.0% (n=45) indicated that they had been in the ward between three and ten days. Forty five percent 45.0% (n=45) answered that they were admitted to the wards more than ten days ago (Refer to Figure 4.2). This question was important to ask because the longer a patient stays in the hospital, the better they can report on their experiences and make a valuable input to the study.

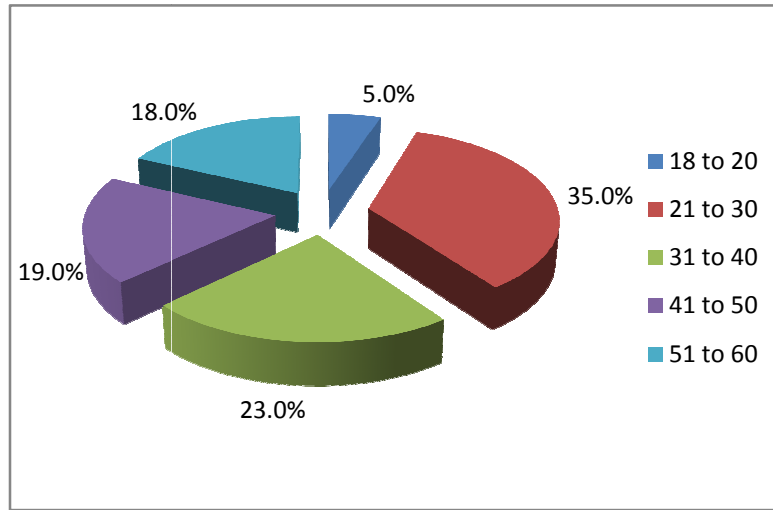


**Figure 4.2 Number of days admitted in the ward (n=100)**

## 4.4 SECTION B: DEMOGRAPHIC INFORMATION

### Item B3: Age

The ages of the respondents ranged from 18 to 60 years. Five percent (n=5) of the respondents were between the age of 18 to 20. Most of the respondents, 35.0% (n=35), fell in the age category of 21 to 30 years; 23.0% (n=23) were 31 to 40; 19.0% (n=19) were between 41 years to 50 years; and 18.0% (n=18) were aged between 51 years to 60 years (Refer to Figure 4.3). All the respondents were adults, having mature reasoning abilities and able to distinguish between right or wrong. They all had views or inputs on how to improve or complement the manner in which the health care services are currently rendered.



**Figure 4.3 Age of groups (n=100)**

#### **Item B4: Gender**

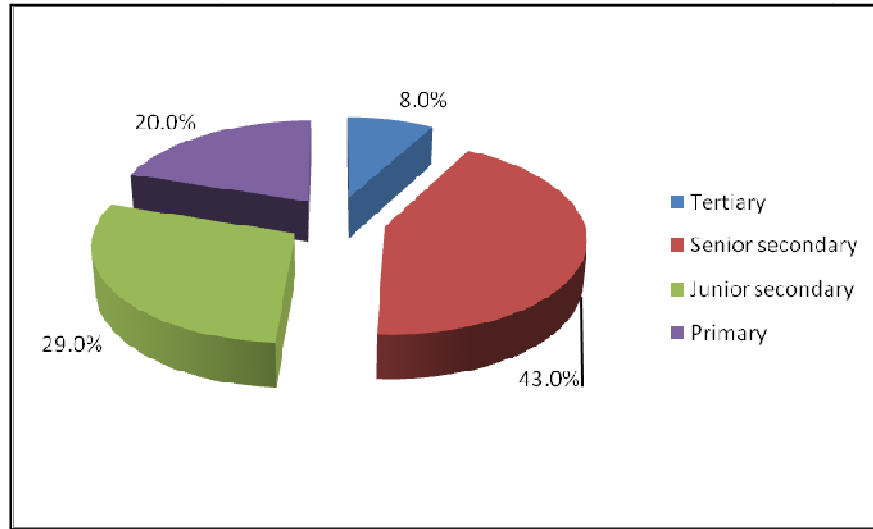
Sixty one percent (n=61) of the respondents fell in the category of male, while 39.0% (n=39) were females. Gender of respondents was important for this study, as it helped to identify views from both sexes, since males and females typically have different views and perceptions that may be of value.

#### **Item B5: Marital status**

The majority of respondents, 63.0% (n=63), were single, with 27.0% (n=27) married, 7.0% (n=7) divorced and 3.0% (n=3) widowed.

#### **Item B6: Educational level**

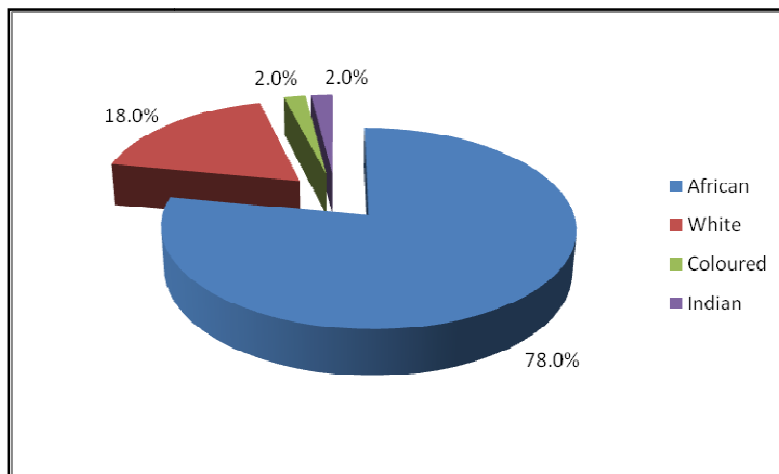
All the respondents had attended school, ranging from primary to tertiary level. Eight percent (n=8) had completed tertiary level; while most, 43.0% (n=43), of the respondents fell in the category of those who had attended the senior secondary level. Twenty nine percent (n=29) had completed junior secondary and 20.0% (n=20) of the respondents had completed only the primary school level. These findings are illustrated in Figure 4.4. From the statistics it can be concluded that all respondents were able to read the BPP and PRC displayed in the wards.



**Figure 4.4 Highest level of education completed (n=100)**

#### Item B7: Race

Respondents from different racial groups were involved in this study. The majority of respondents, 78.0% (n=78) were Africans while 18.0% (n=18) were whites. Only 2.0% (n=2) were coloured and 2.0% (n=2) were Indian. Before the transformation of the health care system whites and wealthy people predominantly received privileged health care and black people were deprived of the same quality health care (Refer to 1.2). This study shows a more balanced proportion of races receiving the same standard of health care.



**Figure 4.5 Representation of races (n=100)**

### Item B8: Place of residence

It was found that respondents admitted to this hospital came from all over Gauteng, Mpumalanga and North West Province. This information is important as the BPP should be implemented in all provinces of SA and the newspaper reports mentioned in the study as evidence of non-implementation reflect incidences all over the country. Although the aim of the study is not to compare or generalise the findings about the implementation of the BPP in different provinces, it may be assumed that similar problems exist in all the provinces (Refer to the newspaper reports in Annexure F).

## 4.5 SECTION C: BATHO PELE PRINCIPLES

### Item C9: Display of Batho Pele Principles Charts

Forty eight percent (n= 48) of the respondents reported that BPP charts were clearly displayed in the wards while the majority, 52.0% (n=52), reported that BPP charts were not clearly displayed. This finding is not in line with the requirements of the BPP “*Setting service standards*” which states that standards, of which BPP are one, should be displayed conspicuously (Refer to 2.6.2).

**Table 4.1 Batho Pele Principles charts clearly displayed in wards**

		Frequency	Percentage	Valid Percentage	Cumulative Percentage
Valid	Yes	48	48.0	48.0	48.0
	No	52	52.0	52.0	100.0
	Total	100	100.0	100.0	

### Item C10: Visibility of Batho Pele Principles Charts

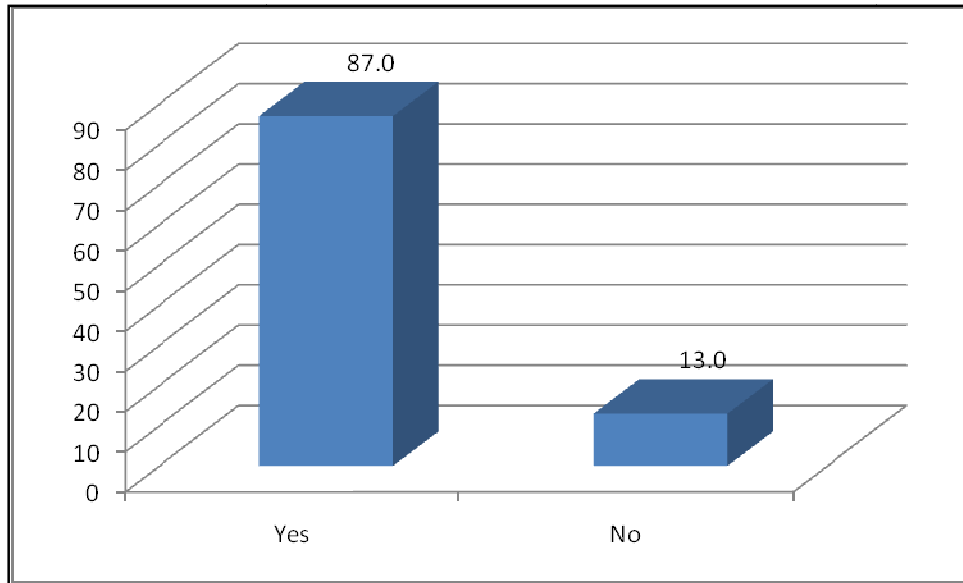
Forty four percent (n=44) of the respondents reported that Batho Pele charts were visible in the wards, while 56.0% (n=56) revealed that Batho Pele Principles charts were not visible in the wards (Refer to Table 4.2). Incorrect placement of BPP charts in the wards might have contributed to the majority of the respondents' response to the previous item (C9), because they might not have seen them even if they were displayed.

**Table 4.2 Batho Pele Principles Charts visible in wards**

		Frequency	Percentage	Valid Percentage	Cumulative Percentage
Valid	Yes	44	44.0	44.0	44.0
	No	56	56.0	56.0	100.0
	Total	100	100.0	100.0	

### Item C11: Informed on admittance

The majority of the respondents, namely 87.0% (n=87) revealed that they were informed by the doctor of their admittance to hospital. This finding is in line with the BPP of "*Providing more and better information*" which strongly emphasises that patients should be given full, accurate information about public health services they are entitled to receive (Refer to Section 2.6.5). However, 13.0% (n=13) reported that they were not informed by the doctor of their admittance to hospital. This response is not in line with the Policy on Quality in Health Care for South Africa which states that if a patient is well informed, he/she is able to participate actively in making decisions about their care, which can improve the effectiveness of care (Refer to Section 2.7.2).



**Figure 4.6 Informed by doctor of admittance to hospital (n=100)**

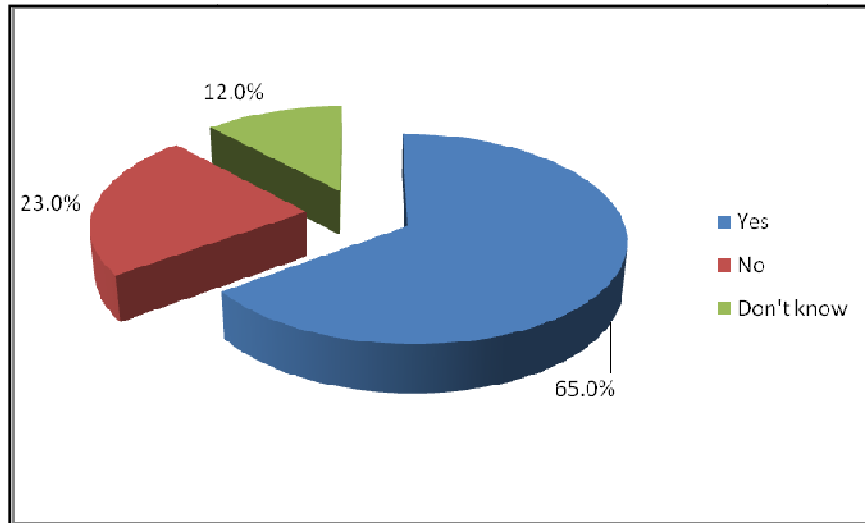
#### **Item C12: Equipment in the ward**

The majority of the respondents, namely 65.0% (n=65), were of the opinion that there is enough equipment in the ward for patient care, while 23.0% (n=23) responded that there is not enough equipment in the ward for patients and 12.0% (n=12) were not sure (Refer to Figure 4.7). Those respondents not satisfied, gave comments such as:

- waiting long for a bed in order to be admitted;
- shortage of ward accessories like walking aids and monkey chains;
- shortage of bed linen.

This finding is not in line with the BPP “*Value for money*” which entitles citizens to receive the best possible value for money (Refer to Section 2.6.8). A well managed nursing unit should provide the required resources for goal achievement (Refer to Section 2.8.1).

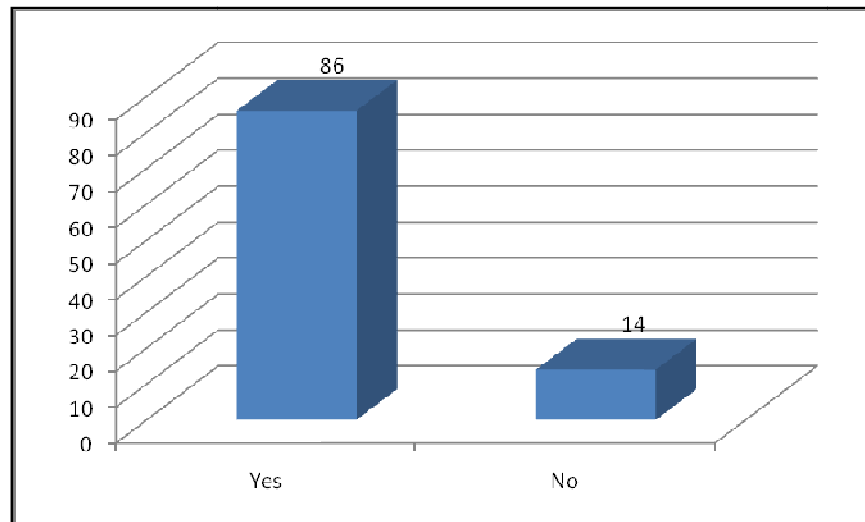




**Figure 4.7 Enough equipment in the ward for patient care (n=100)**

#### **Item C13: Procedures explained**

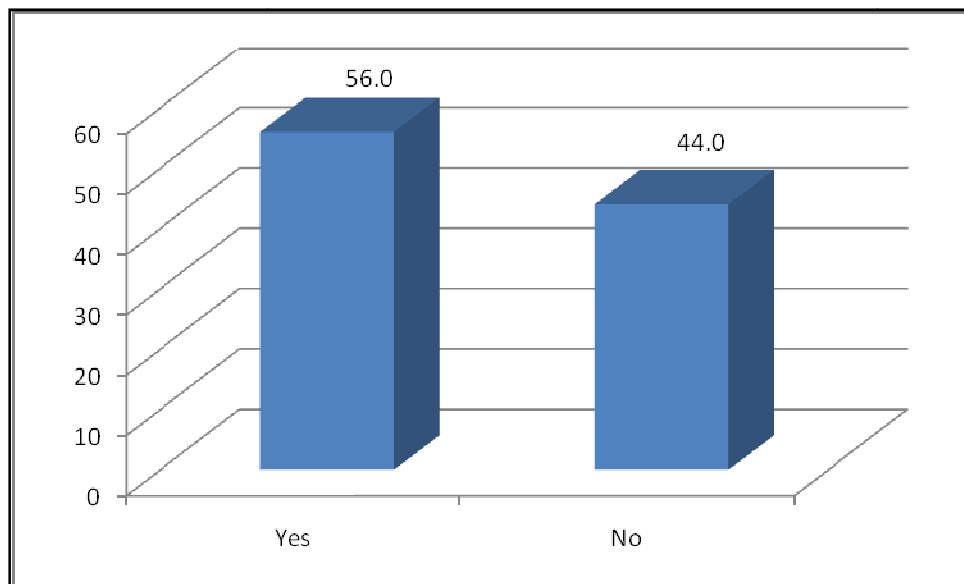
Eighty six percent (n=86) of respondents revealed that procedures were explained to them before they were executed. This finding is in line with the BPP of “*Providing more and better information*” which encourages the practice that citizens should be informed about care and treatment they will receive so that they are aware of what to expect (Refer to Section 2.6.5). Only 14.0% (n=14) of the respondents reported that procedures were not explained to them before they were executed (Refer to Figure 4.8).



**Figure 4.8 Procedures explained to respondents before executing (n=100)**

### Item C14: Daily routine of the ward

Fifty six percent (n=56) of respondents reported that they were informed about the daily routine of the ward as opposed to 44.0% (n=44) who were not. This response refers to two BPPs, namely “*Providing more and better information*” and “*Service standards*” (Refer to 2.6.5 and 2.6.2 respectively). Being aware of the ward routine will ensure that patients are in the ward during doctors’ rounds or for mealtimes. However, if 44% of patients are not informed about ward routines, patient care may be negatively affected.



**Figure 4.9 Informed about daily routine in the ward (n=100)**

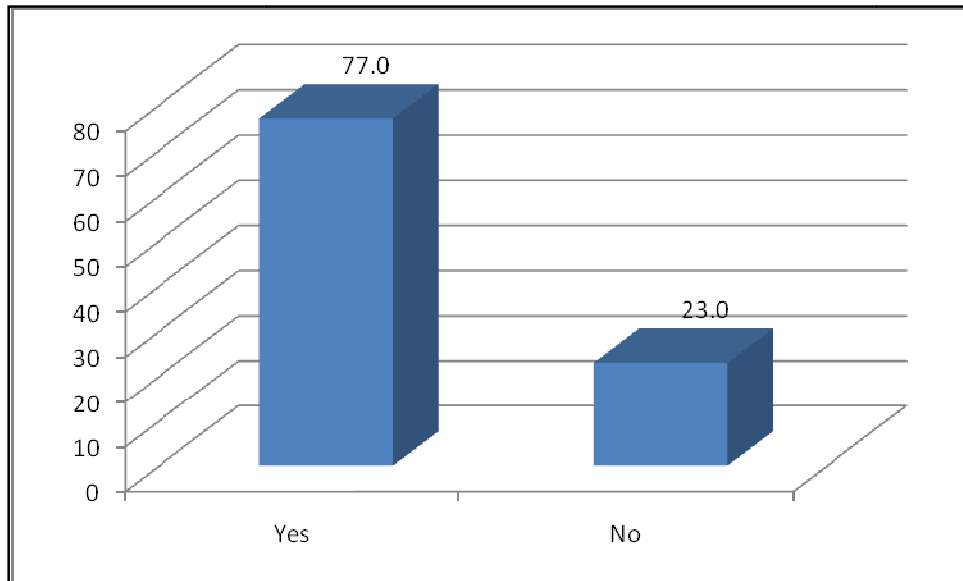
### Item C15: Use of the bathroom

The majority of the respondents, namely 77.0% (n=77), reported that they found it easy to use the bathroom. However, nearly a quarter, (23.0%; n=23), revealed that they did not find it easy to use the bathroom. Those respondents raised concerns such as:

- They were unable to walk properly without assistance and had to wait long periods for assistance from the nurses (Refer to Item C23, staff not helpful).
- Only one bathroom is available for 31 patients in the ward and therefore they had to queue (Refer to Item C12, enough equipment).

- Poor hygienic conditions of the bathrooms make it unpleasant and unsafe for use.
- The smell of smoke due to some of the patients smoking inside the bathrooms (Refer to “A safe and healthy environment “addressed in both the Bill of Rights and the PRC).

This response indicates that the following principles are not implemented properly yet: Batho Pele’s third principle of “Increasing access” (Refer to 2.6.3), the Bill of Rights under “Environment”, and PRC under “A healthy and safe environment” (Refer to 2.4 and 2.5), as well as “Improved access” as described in the Policy on Quality in Health Care for South Africa (Refer to 2.7.1). It is the responsibility of the unit manager to organise and control the unit effectively (Refer to 2.8.2 and 2.8.4).



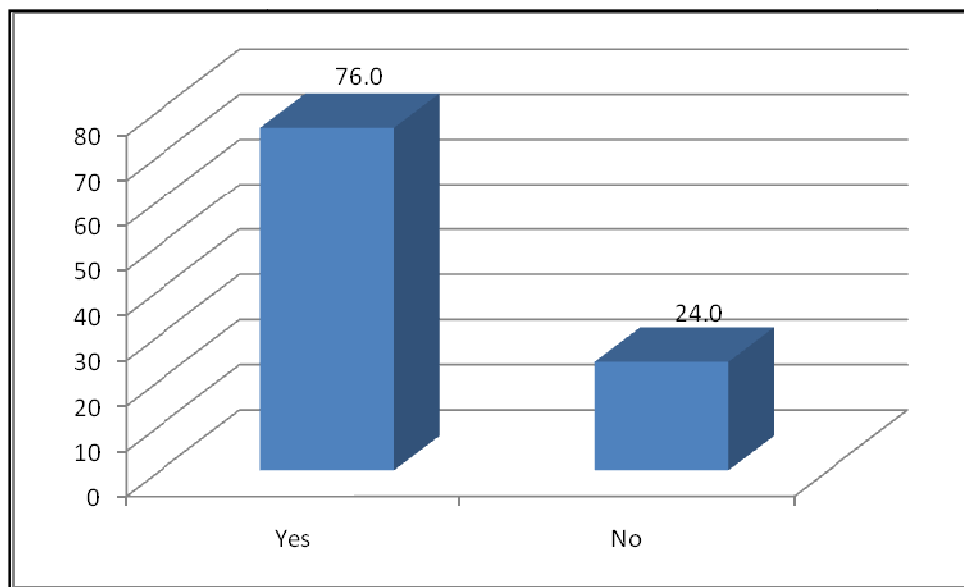
**Figure 4.10 Easiness to use bathroom (n=100)**

#### **Item C16: Ease of use of toilet**

The response to this question simulates the question on the use of the bathroom as the majority of respondents, 76.0% (n=76), revealed that they found it easy to use the toilet. The remaining 24.0% (n=24) of the respondents reported that they did not find it easy to use the toilet due to the following reasons:

- No bars in the toilet to hold onto
- Not enough space for the wheelchair inside the toilet.

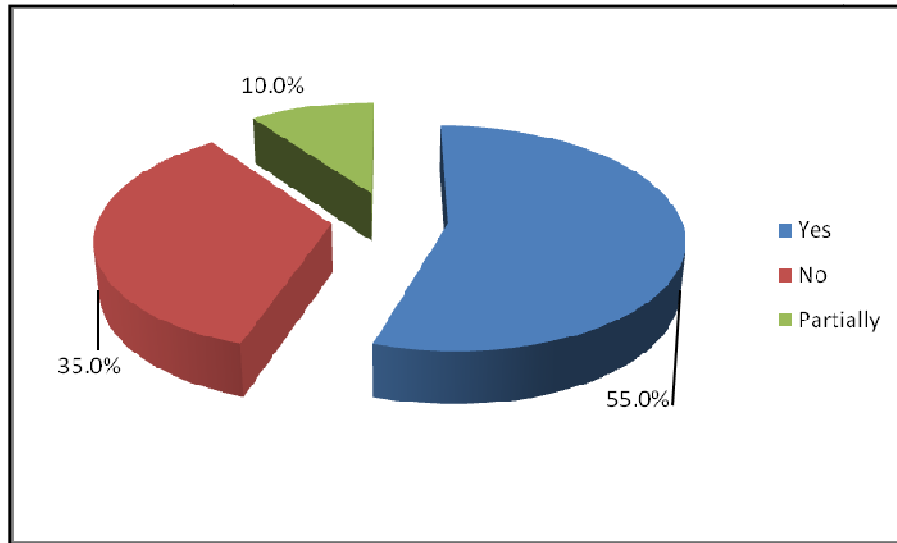
From this response it is apparent that some of the toilets do not have enough space for a wheelchair user, which is not in line with the accreditation programme and the BPP “*Access to health care*” that describes the availability of adequate resources with special provision for patients with disabilities (Refer to 2.6.3).



**Figure 4.11 Easiness to use toilet (n=100)**

#### **Item C17: Treatment offered**

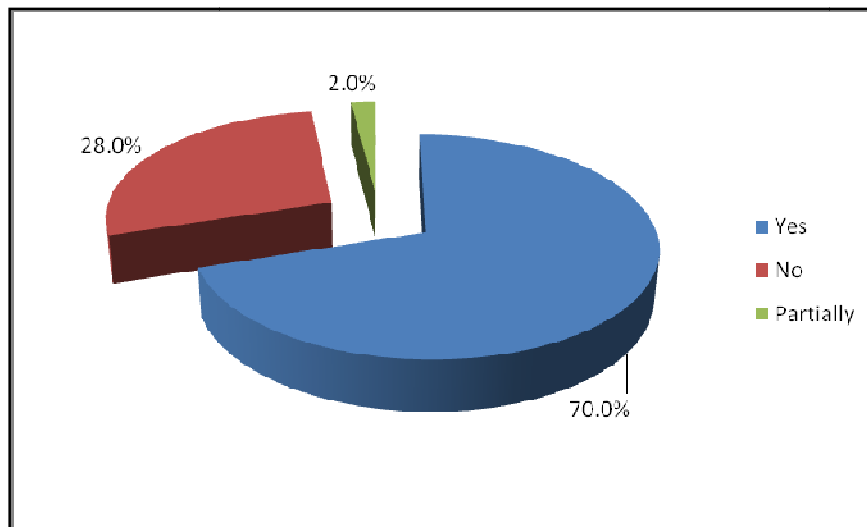
Fifty five percent (n=55) of the respondents reported that they did receive information about their treatment, which is in line with the BPP “*Providing more and better information*” (Refer to 2.6.5) and the Policy on Quality in health care “*Increasing patients’ participation*” (Refer to 2.7.2). Thirty five percent (n=35) indicated that they did not receive information and ten percent (n=10) were partially informed (Refer to Figure 4.12).



**Figure 4.12 Information about treatment received (n=100)**

#### **Item C18: Tests to be done**

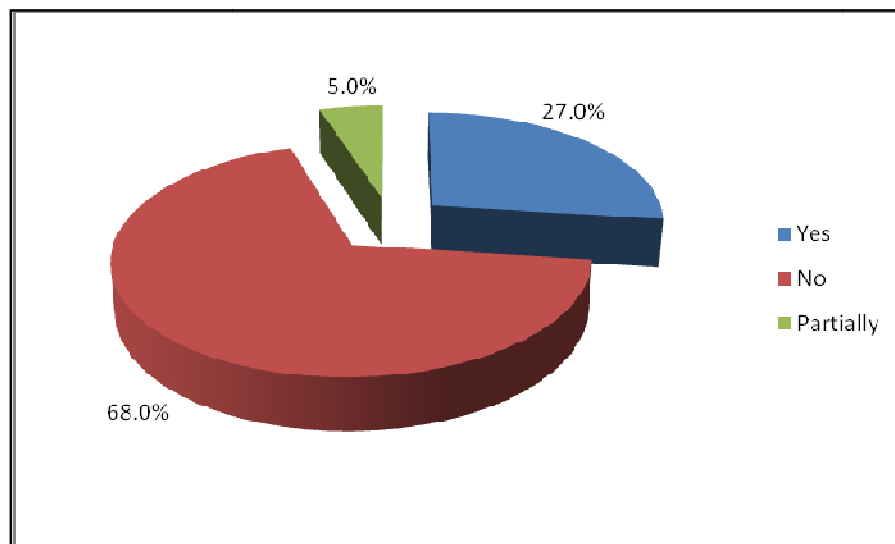
Seventy percent (n=70) of the respondents revealed that they were informed about the tests that were to be done by doctors in relation to their illnesses while 30.0% (n=30) reported they were not informed or partially informed (Refer to Figure 4.13). As with the previous item, this finding shows a violation of the BPP “*Providing information*” (Refer to section 2.6.5), the Bill of rights “*Access to information*” (Refer to Section 2.4) and PRC “*Participation in decision making*” and “*Informed consent*” (Refer to Section 2.5).



**Figure 4.13 Informed about tests done by doctors (n=100)**

### Item C19: Results of tests

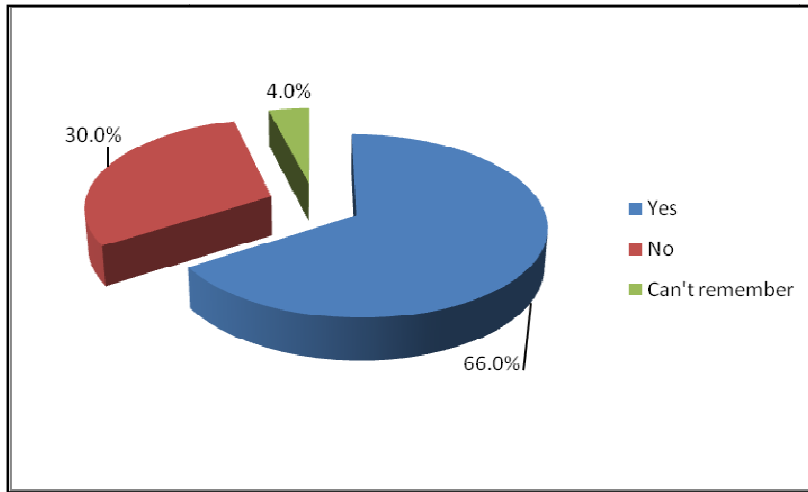
Twenty seven percent (n=27) of the respondents reported that they were informed about the results of tests done. The majority of the respondents, 68.0% (n=68), were not informed and 5.0%(n=5) were partially informed (Refer to Figure 4.14). The findings in items C17, C18 and C19 indicate that respondents are not consistent in their reporting.



**Figure 4.14 Informed about test results received (n=100)**

### Item C20: Visiting hours of the hospital

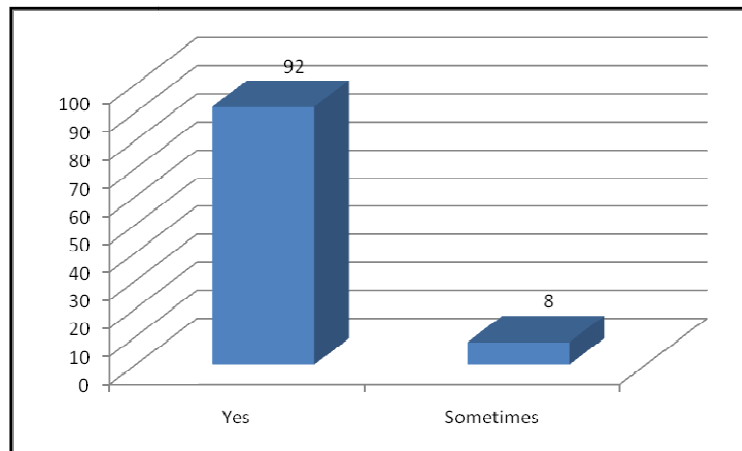
The research findings revealed that 66.0% (n=66) of the respondents were informed about the visiting hours of the hospital and 30.0% (n=30) were not informed. Four percent (n=4) of the respondents revealed that they couldn't remember (Refer to Figure 4.15). This is not in line with the BPP "Setting service standards" and "Providing more and better information" (Refer to 2.6.2 and 2.6.5).



**Figure 4.15 Informed about visiting hours of hospital (n=100)**

#### **Item C21: Language to address**

The finding reveals that the majority of respondents, 92.0% (n=92), indicated that staff members addressed them in a language they understood. The remaining 8.0% (n=8) of the respondents felt that they were not addressed in a language they understood. Communication in a language understood by the patient ensures their cooperation with treatment. The overall response in this question revealed that the BPP “*Ensuring courtesy*” and the Bill of Rights “*Human dignity*” (Refer to Sections 2.6.4 and 2.4 respectively) are well implemented.



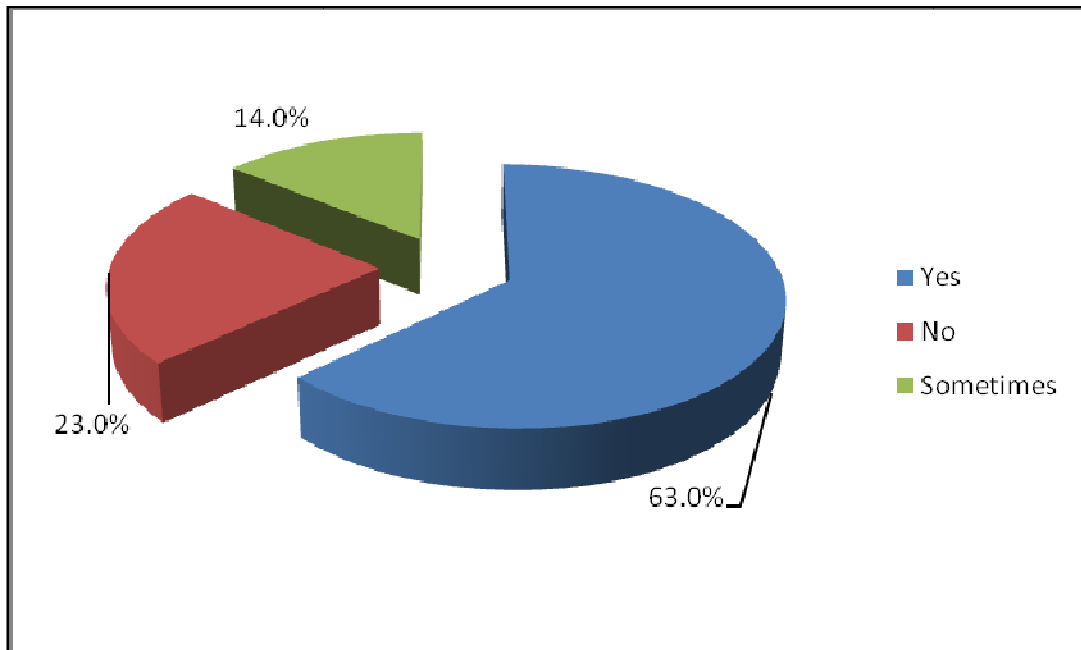
**Figure 4.16 Addressed in a language they understood (n=100)**

**Item C22: Friendliness of staff**

Sixty three percent (n=63) of the respondents reported that staff members were friendly while nearly a quarter (23.0%; n=23) indicated that staff members were not friendly and 14.0% (n=14) said that they were friendly sometimes (Refer to Figure 4.17). According to respondents, some of the staff members were:

- nasty;
- rude;
- short -tempered.

The issues of human dignity and courtesy as described in the BPP, the Bill of Rights and the PRC are violated in a significant number of cases and the unit manager should lead in a way to prevent this (Refer to Sections 2.4, 2.5.3, 2.6.4 and 2.8.3).

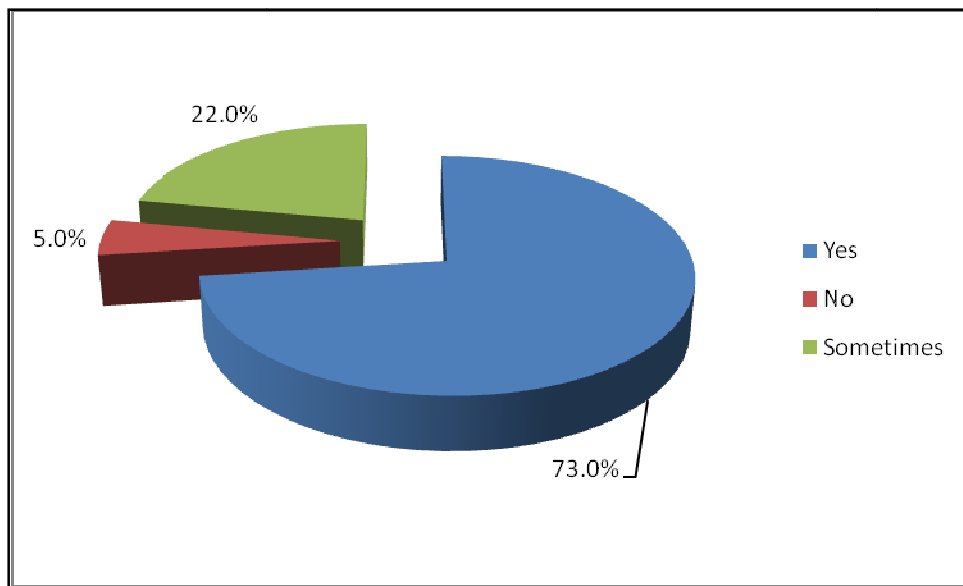


**Figure 4.17 Friendliness of staff members (n=100)**



### Item C23: Helpfulness of staff

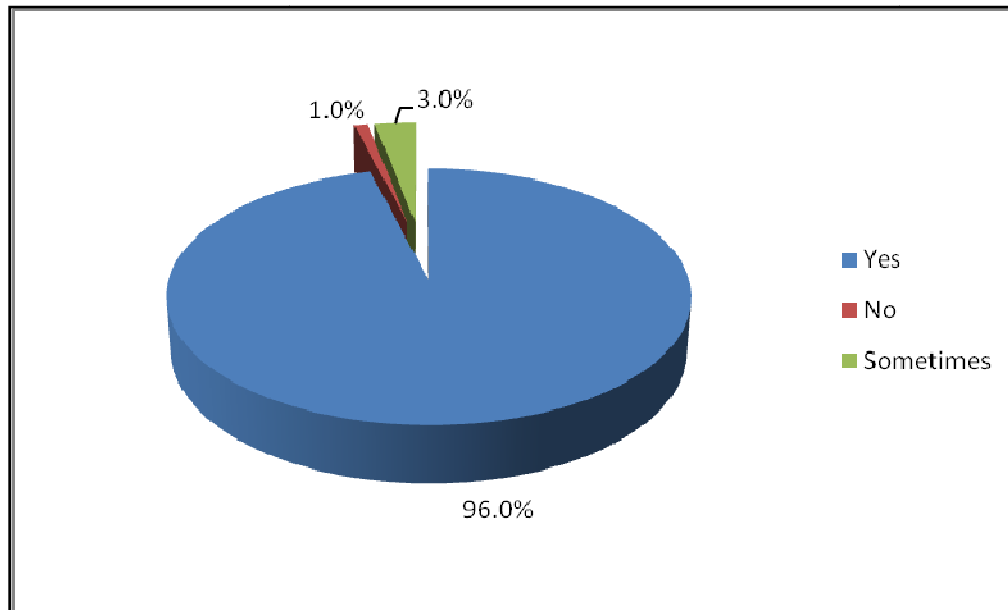
The majority of respondents, 73.0% (n=73), were of the opinion that staff members were helpful to them, but 5.0% (n=5) reported staff members were not and 22.0% (n=22) said that sometimes they were helpful and sometimes not (Refer to Figure 4.18). This response demonstrates the implementation of the BPP “*Ensuring courtesy*” (Refer to section 2.6.4) and correlates well with the previous item (C22).



**Figure 4.18 Helpfulness of staff members (n=100)**

### Item C24: Respect from cleaners

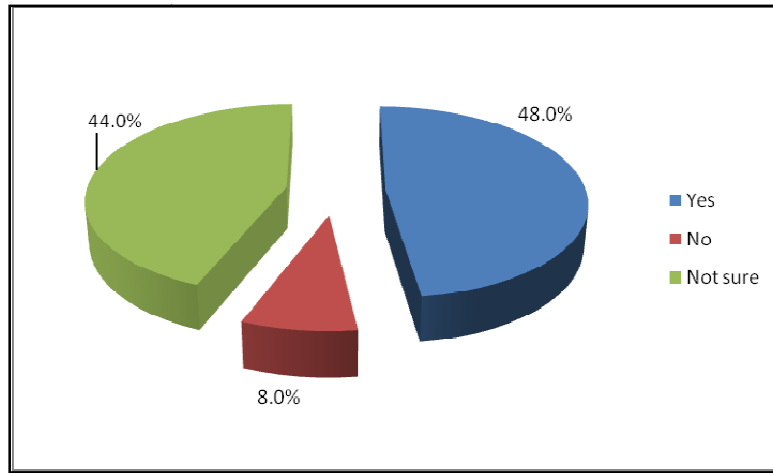
Data collected revealed that the majority of the respondents, 96.0% (n=96), were of the opinion that cleaners were respectful, but one respondent reported that cleaners were not respectful. A further three respondents indicated that sometimes cleaners were respectful to them. According to the response, it is apparent that cleaners do understand that patients in the hospitals are the customers of the health care services, thus they must “come first” as indicated in the third BPP “*Ensuring courtesy*” (Refer to 2.6.4). This question was of great importance in this study because in provincial hospitals cleaners are indirectly involved in the care of patients when serving meals and cleaning the wards.



**Figure 4.19 Cleaners respectful to patients (n=100)**

#### **Item C25: Information regarding illness**

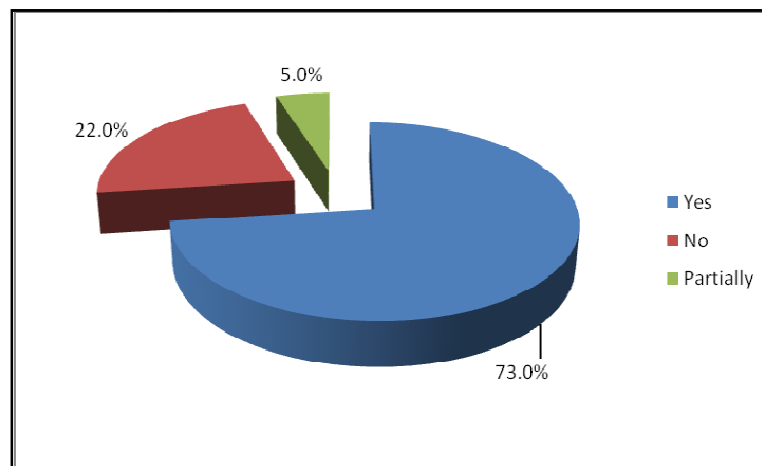
Forty eight percent (n=48) of the respondents reported that they did receive all the information they needed regarding their illness, while 8.0% (n=8) of the respondents did not receive the information and 44.0% (n=44) were not sure whether they received all the information they needed. This item shows that a large percentage of patients (52%) does not receive sufficient information about their illness. It correlates with Items C18 and C19 where 30% and 68% of patients respectively were not informed about tests done and results of tests. One should however, consider the education level of patients where the majority (92%) of respondents fell in the category of senior secondary, junior secondary and primary level (Refer to Item B6). Respondents may not remember or understand the information given to them.



**Figure 4.20 Information regarding their illness (n=100)**

#### **Item C26: The nature of illness explained**

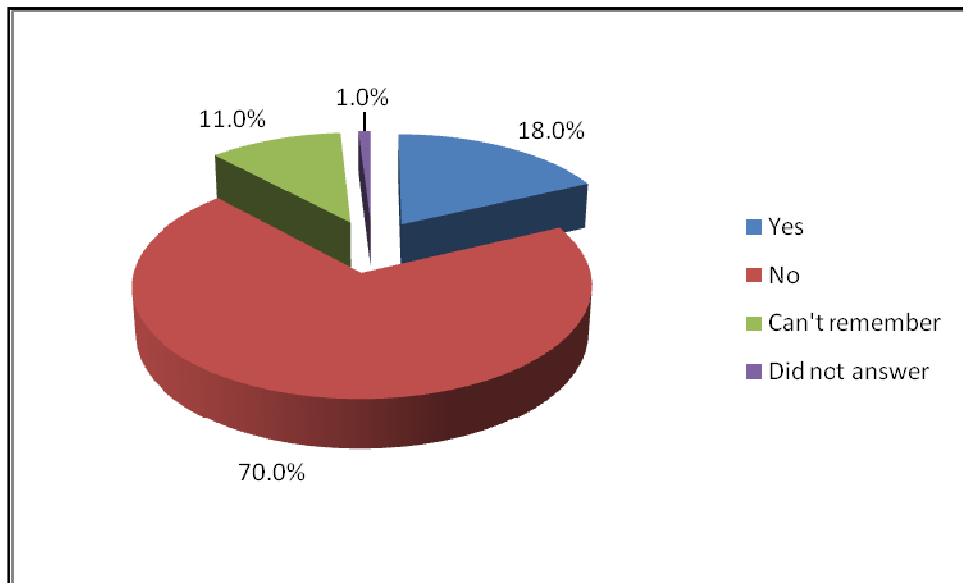
Seventy three (n=73) of the respondents reported that the nature of their illness was explained while the response of 22.0% (n=22) was negative and 5.0% (n=5) indicated that the doctor partially explained to them (Refer to Figure 4.21). The finding shows that in 27.0% of cases the BPP “*Providing more and better information*” and the issue of “*Access to information*” in the Bill of Rights and the PRC (Refer to Sections 2.4 and 2.3) are not implemented. The positive response of 73.0% of the respondents is in contrast with the finding of Item C17 where 45.0% of respondents did not receive any or full information on their treatment.



**Figure 4.21 Ward doctor explained the nature of illness in detail (n=100)**

### Item C27: Ward manager introduced

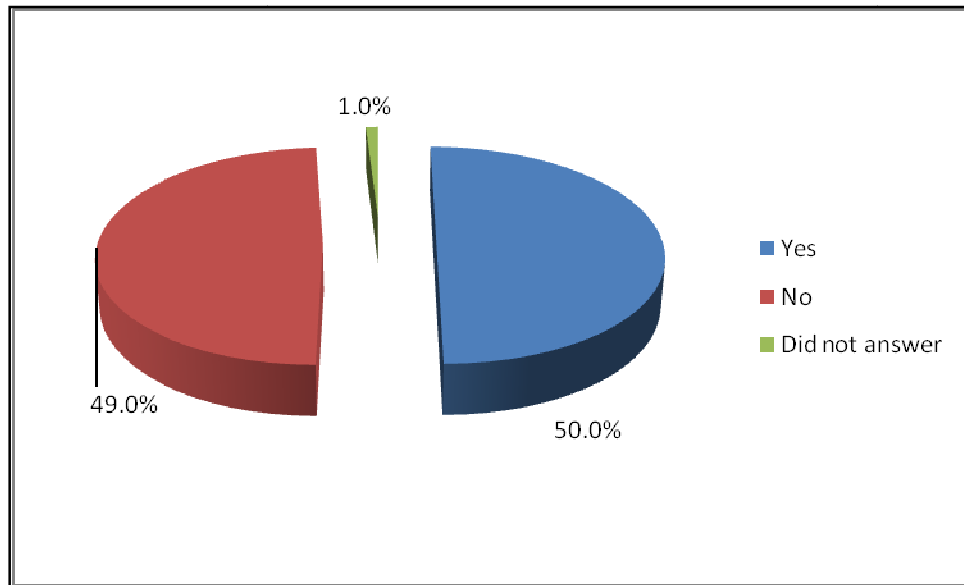
In 18.0% (n=18) of cases the respondents reported that the ward manager did introduce him/herself to them. The majority of respondents, 70.0% (n=70), indicated that the ward manager did not introduce him/herself to them. Of the respondents 11.0% (n=11) revealed that they couldn't remember whether the ward manager introduced him/herself or not. One respondent (1.0%; n=1) did not answer the question (Refer to Figure 4.22). The finding is not in line with the BPP of "Courtesy" and the PRC "To be treated by a named health care provider" (Refer to Sections 2.6.4 and 2.5.4 respectively). Unit managers should be role models for their staff (Refer to 2.8.3) and this response clearly illustrates the lack of role models in the nursing units.



**Figure 4.22 Ward manager introduced to respondents (n=100)**

### Item C28: Treating doctors introduced

The finding indicates that 50.0% (n=50) of the respondents were introduced to the doctors who were treating them in the ward while 49.0% (n=49) were not introduced. One respondent did not answer the question (1.0%; n=1). (Refer to Figure 4.23). This finding correlates with Item C27 where respondents also revealed that they were not introduced to the ward manager



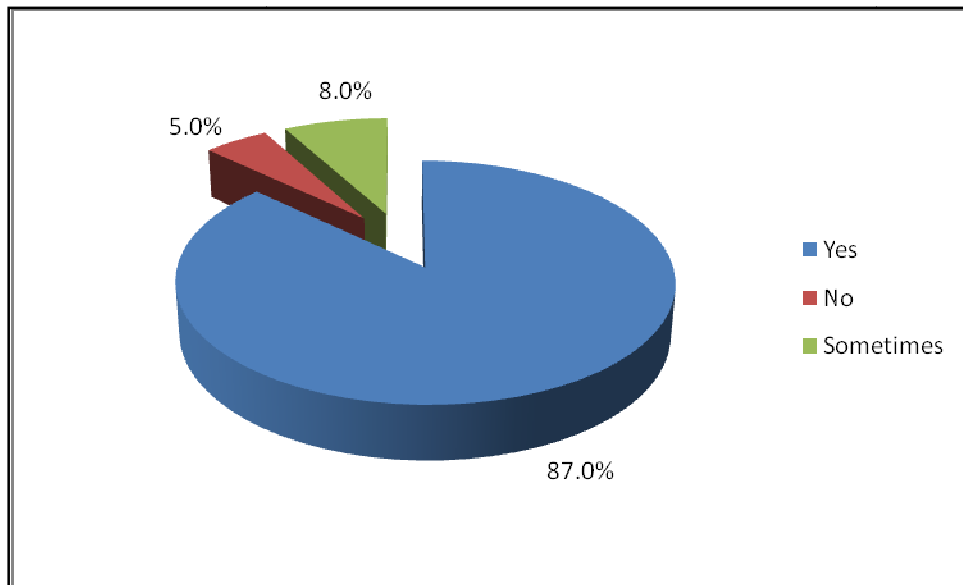
**Figure 4.23 Introduced to the doctors who were treating them (n=100)**

#### **Item C29: Respect from doctors**

The finding reveals that the majority of respondents, (87.0%; (n=87), were of the opinion that doctors treated them with respect in the ward and 5.0% (n=5) indicated that they were not treated respectfully. Another 8.0% (n=8) of the respondents reported that the doctor sometimes treated them with respect (Refer to Figure 4.24). Those who reported negatively raised concerns such as:

- doctor extremely rude;
- doctor shouted at them in front of other patients.

Although a small percentage, the 13.0% negative responses strengthened the view in Item C22 where it was revealed that staff members were not friendly, violating the obligation to courtesy, dignity and respect (Refer to Section 2.6.4).



**Figure 4.24 Doctors respectful to patients (n=100)**

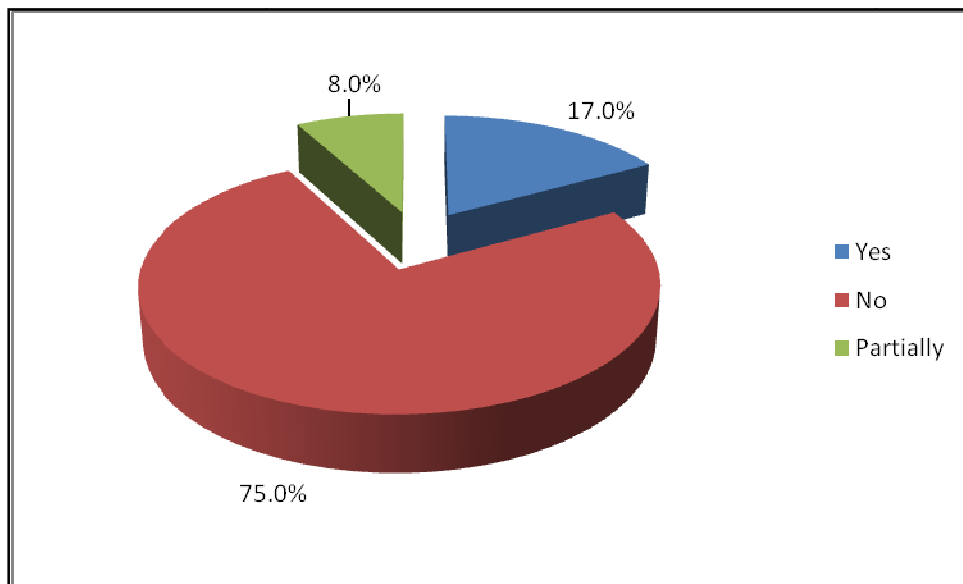
### **Item C30: Complaints about hospital care**

The finding reveals that the majority of respondents, 75.0% (n=75), had no complaints about hospital care, while 8.0% (n=8) had some complaints and 17.0% (n=17) had complaints on aspects such as staff, hygiene, nutrition, shortage of equipment and facilities, visiting hours and entertainment (Refer to Figure 4.27). Complaints were verbalised as follows:

- food served was not tasty;
- staff took their time when asked for help;
- no television for distraction in the ward;
- bathroom facilities are not adequate;
- shortage of pillows, bed linen and hospital attire.

It can be assumed that some of the 75.0% who did not complain, don't feel free to actively complain since there was a considerable percentage of complainants in other items, such as:

- Item C12, where 23.0% respondents reported a shortage of equipment and facilities for patient care;
- C15 &16 where the unhygienic bathrooms and toilets were mentioned;
- C18 & 19 where 30.0% and 68.0% respondents respectively reported insufficient information on treatment and information on their illness;
- C22 where 37.0% reported that staff is not always friendly;
- E43 where dirty wards, bathrooms, toilets, bedside lockers and the presence of cockroaches were reported;
- E45 where 34% were not satisfied with the food served.



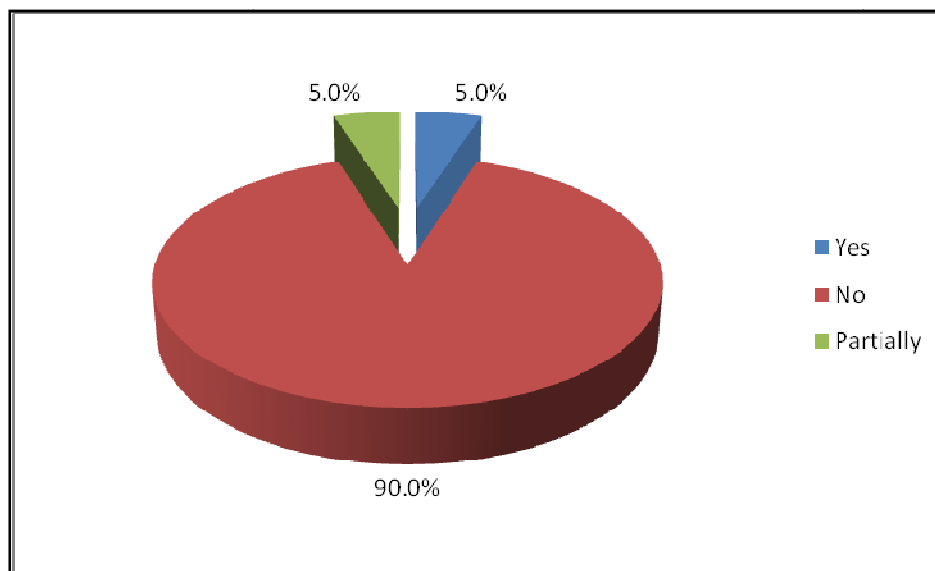
**Figure 4.25 Having complaints about hospital care (n=100)**

### **Item C31: Official complaints made**

The majority of the respondents, 90.0% (n=90), reported that they did not make any official complaint and 5.0% (n=5) of the respondents indicated that they had made official complaints. Some of these complaints were reported to matrons who promised to take the matter further. Only five percent (n=5) of the respondents indicated that they had partially

made official complaints, which can be taken as non-official complaints (Refer to Figure 4.26).

- Considering the negative responses found in other items, it is apparent that the respondents do have concerns or complaints but they might not have enough information or are afraid to come forward and make official complaints. This may also be attributed to the lower levels of education of the respondents thus they resorted to saying that they didn't have complaints. (Refer to Item B6). Examples to illustrate this reasoning include:
  - Item C12 – not enough equipment for patient care
  - Item C14 - not informed about the daily routine in the ward
  - Item C15 and C16 - difficulty in accessing the bathroom and toilet
  - Item C17 - not informed about treatment
  - Item C18 and 19 - not informed about the tests or test results.



**Figure 4.26 Official complaints made (n=100)**



### Item C32: Process to lodge a complaint

Less than a quarter, (21.0%; n=21), of the respondents reported that they knew how to make official complaints, while 67.0% (n=67) of respondents indicated that they didn't know and 12.0% (n=12) were not sure about how to lodge a complaint or make a suggestion. It is clear from the responses that they are not yet aware of the existing complaints system and the proper steps to follow, thus not aware of the BPP *"Remedying mistakes and failures/ redress"* (Refer to Section 2.6.7). If one refers to Item B6, the relatively low level of education indicated by respondents might have contributed to this response. Furthermore Item E50 reveals that only 13.0% of respondents confirmed the availability of complaint boxes in the ward.

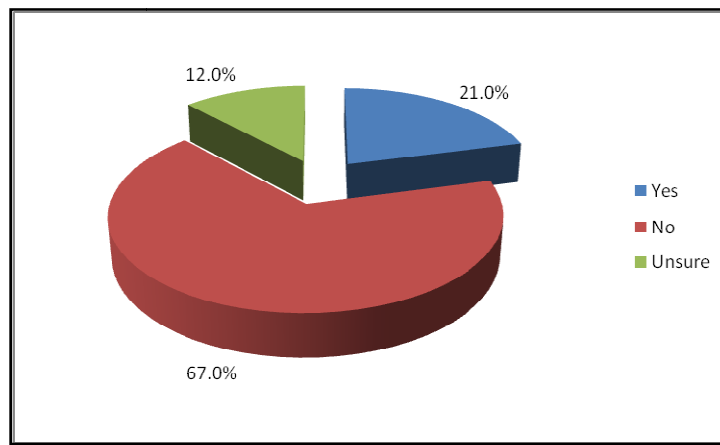


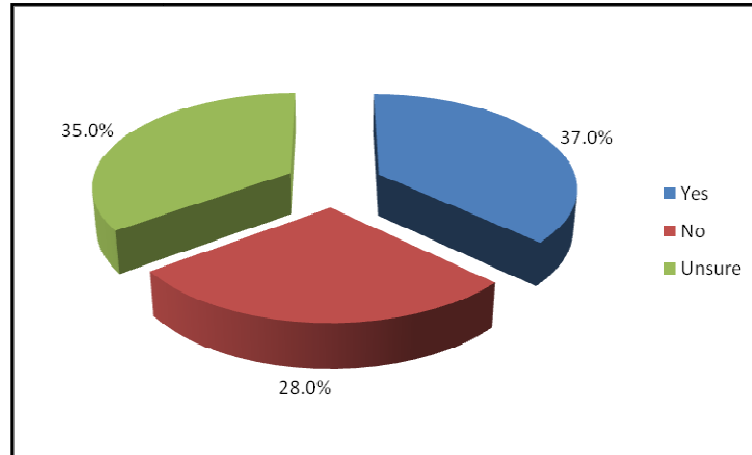
Figure 4.27 Knowing the process to make a complaint (n=100)

## 4.6 SECTION D: PATIENTS' RIGHTS CHARTER

### Item D33: Display of Patients' Rights Charter

Thirty seven percent, (n=37) of the respondents indicated that the PRC was clearly displayed in the ward, 28.0% (n=28) reported that it was not clearly displayed and 35.0% (n=35) revealed that they were not sure whether it was clearly displayed. The PRC is one of the documents that should be clearly displayed in all health care facilities (Refer to Sections 2.5 and 2.6.2). When this information is compared to the finding in Item C9, it is

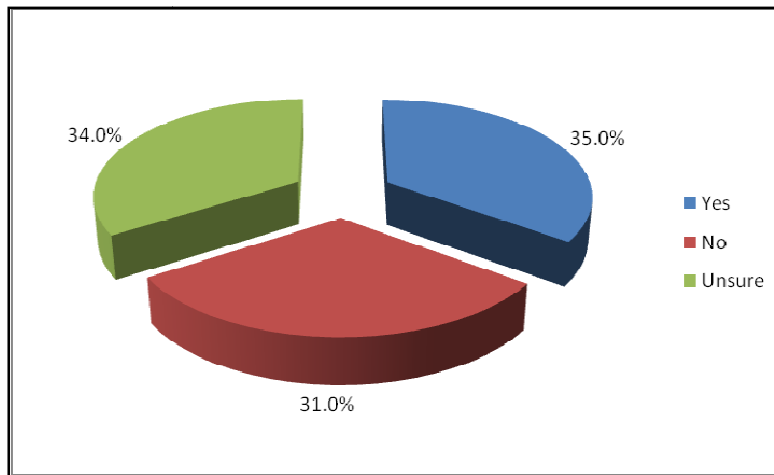
found that more respondents were aware of the PRC than the BPP, but the overall negative response is still too high and the issue needs to be addressed, for example charts must be large enough, easily noticeable and displayed in areas where patients access the units, such as the main entrance of the wards.



**Figure 4.28 Patients' Rights Charter clearly displayed in the ward (n=100)**

#### **Item D34: Display of patients' responsibilities**

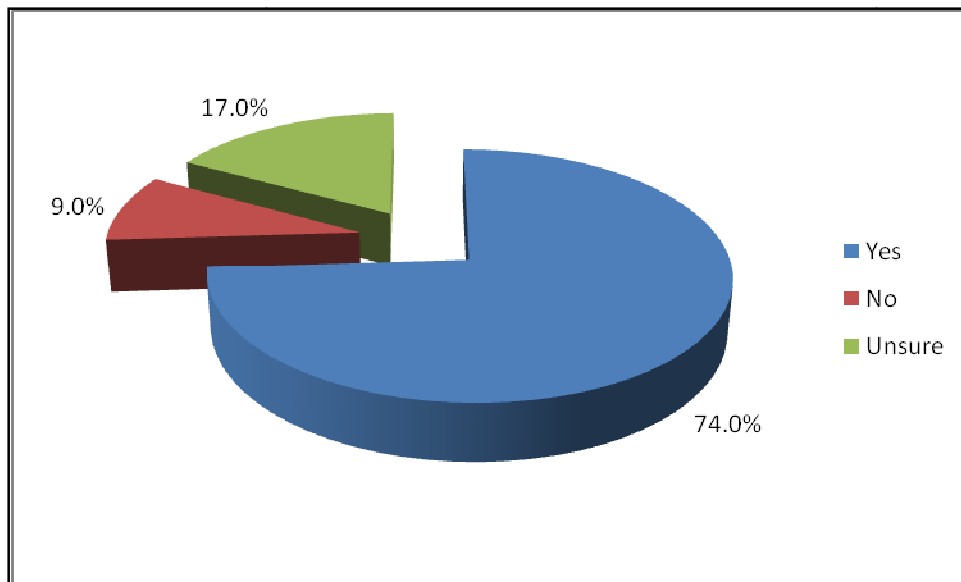
Thirty five percent (n=35) of the respondents reported that charts with patients' responsibilities were clearly displayed in the ward, while 31.0% (n=31) indicated that it was not clearly displayed and 34.0% (n=34) were not sure (Refer to Figure 4.29). There is a positive correlation between the findings of Items D33 and D34.



**Figure 4.29 Charts with patients' responsibilities clearly displayed in ward (n=100)**

#### **Item D35: Hospital security**

The finding indicates that the majority of respondents, 74.0% (n=74), reported that security in the hospital was adequate, 9.0% (n=9) felt that the hospital security was not adequate and 17.0% (n=17) were not sure (Refer to Figure 4.30). The safety and security of the patients is endorsed in the Bill of Rights and the PRC (Refer to Sections 2.4 and 2.5).



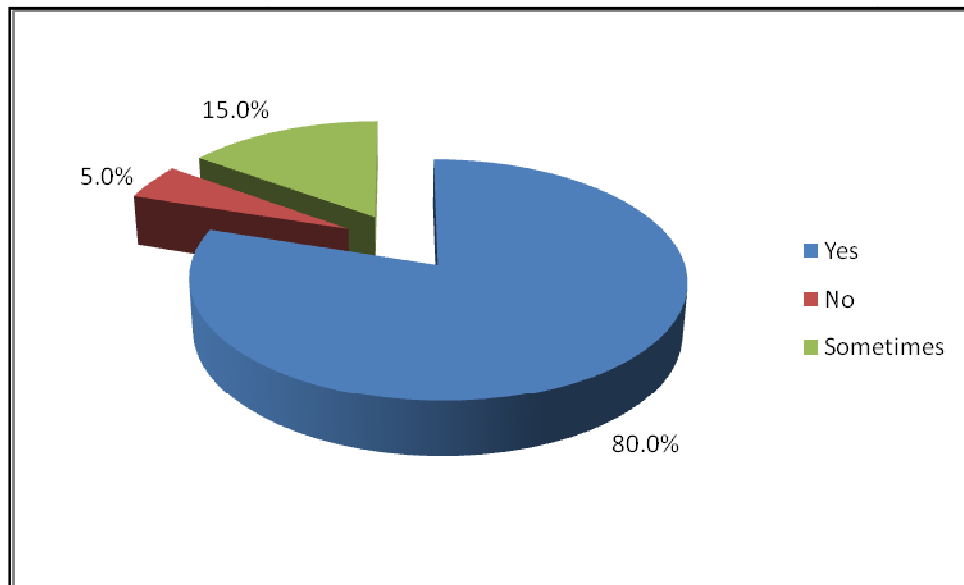
**Figure 4.30 Hospital security adequate (n=100)**

### Item D36: Hospital noise

The majority of the respondents, 80.0% (n=80), were of the opinion that the hospital environment was free from noise, while 15.0% (n=15) indicated that the hospital environment was sometimes free from noise and 5.0% (n=5) stated that the hospital was not free from noise (Refer to Figure 4.31). The respondents raised the following concerns:

- prison warders make noise;
- staff call each other at a distance and talk loudly;
- patients' radios are on high volume;
- trolleys are pushed in corridors with no consideration for patients.

The issues raised are relevant to the management of the nursing unit (refer to Section 2.8) since it should be addressed through quality control measures.



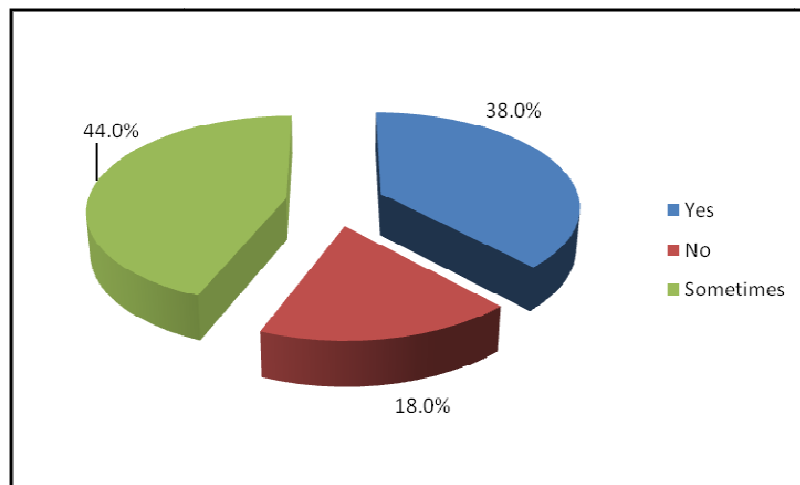
**Figure 4.31 Hospital environment free from noise (n=100)**

### Item D37: Involvement in decision making

Just over a third, (38.0%; n=38), of respondents indicated that they were involved in decision making about their own health matters, 44% (n=44) of the respondents revealed

that they were sometimes involved in decision making about matters related to their health and 18.0% (n=18) of the respondents felt that they were never involved in decision making with regard to health related matters (Refer to Figure 4.32). The following concerns were raised by the respondents for whom the right to participate in decision making did not realise (refer to Section 2.5):

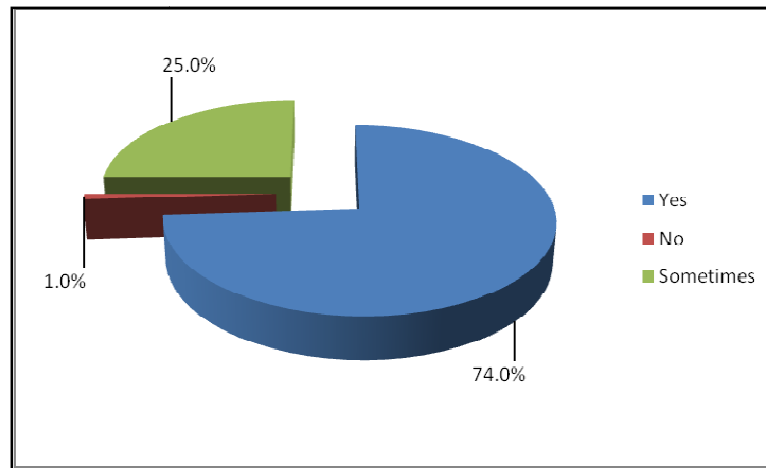
- When saying what you feel, no one takes it seriously.
- Patients are seldom asked for their opinion and just told what will be done.
- Staff only check the injured part and write notes in the file, then move to the next patient.
- Patients are not permitted to be involved in decision making in matters related to their health.
- Doctors discuss cases among themselves and do not involve patients.



**Figure 4.32 Involved in decision making about health related matters (n=100)**

#### **Item D38: Staff members' responses to patients' needs**

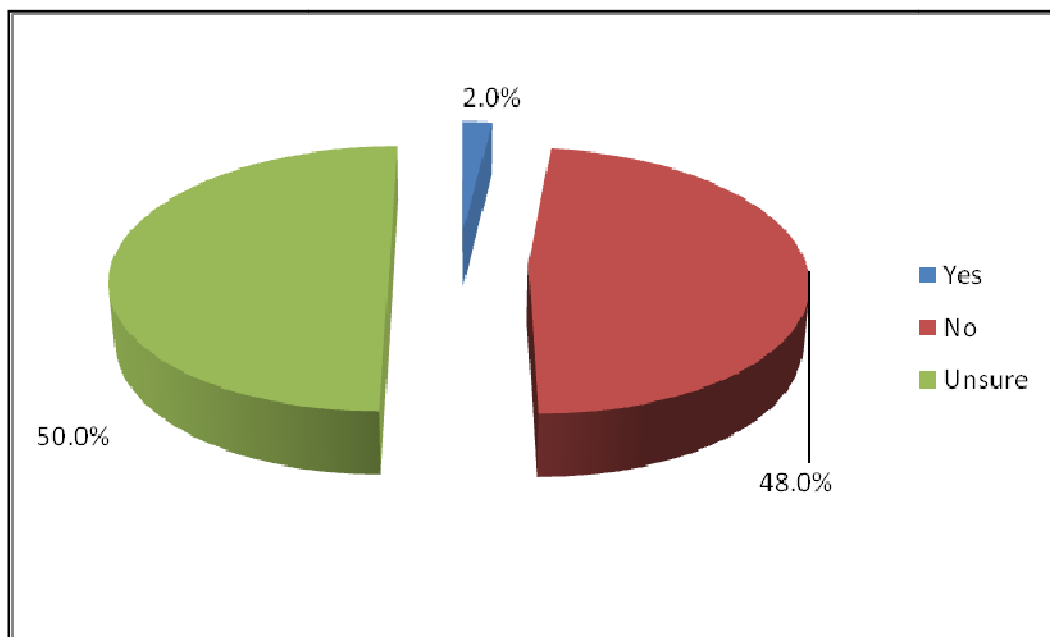
The finding revealed that the majority of the respondents, 74.0% (n=74), reported that staff members do listen to them when they make their needs known while one respondent felt that staff members did not listen to him and 25.0% (n=25) said staff members sometimes listen as illustrated in Figure 4.33.



**Figure 4.33 Staff members listen when patients make their needs known (n=100)**

**Item D39: Private rooms available**

Just 2.0% (n=2) respondents indicated that there was a room available to ensure privacy during conversations with the doctor or family while 48.0% (n=48) revealed that there was no room available and 50% (n=50) reported that they were unsure (Refer to Figure 4.34). When considering the number of days the respondents stayed in the ward as seen in Item A2, there was enough time to be introduced to such an area. If wards have private rooms available the majority of patients are unaware of the rooms and are seriously deprived of a component of the patients' right to "*Confidentiality and privacy*" (Refer to Section 2.5.5).



**Figure 4.34 Room available where patients can talk in private (n=100)**

### Item D40: Staff members' name tags

Fifty eight percent (n=58) of the respondents reported that they were treated by staff wearing name tags/badges. Only one respondent revealed that he was treated by staff members without identification. 41.0% (n=41) indicated that not all the staff members wore name badges (Refer to Figure 4.35). This response indicates that the majority of staff members wear identification when attending to patients. This is relevant to the sixth right from the PRC. *To be treated by a named health care provider*" (Refer to Section 2.4).

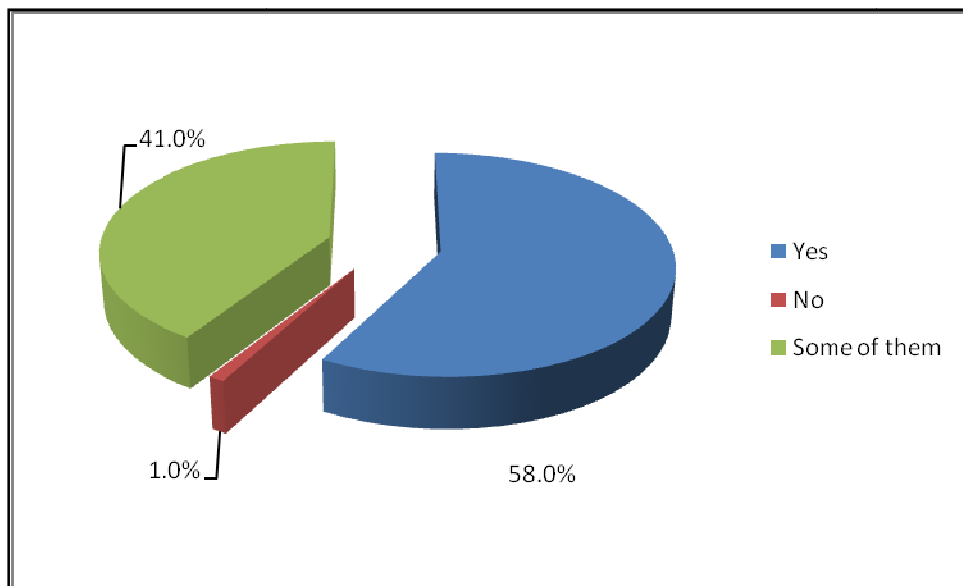


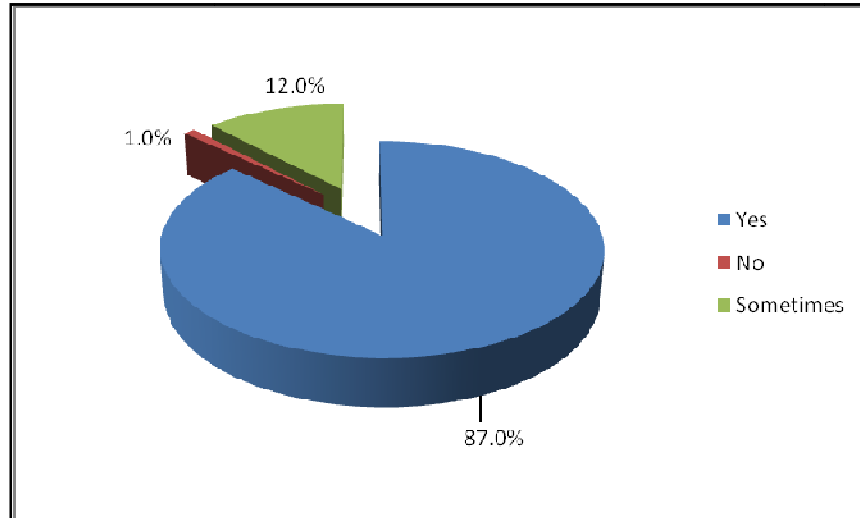
Figure 4.35 Staff members wear name tags (n=100)

## 4.7 SECTION E: QUALITY ASSURANCE

### Item E41: Dignity respected

The majority of respondents, 87.0% (n=87), were of the opinion that they were treated with dignity in the hospital. One respondent reported that some of the nursing staff treated him with dignity and others not and a further 12.0% (n=12) indicated that sometimes they were

treated with dignity (Refer to Figure 4.36). Human dignity is endorsed by the Bill of Rights, the PRC and the BPP (Refer to Sections 2.4, 2.5 and 2.6.4 respectively). This finding is inconsistent with the findings in Items C22 and C23 (friendliness and helpfulness from staff) and the validity of the answers can be questioned.

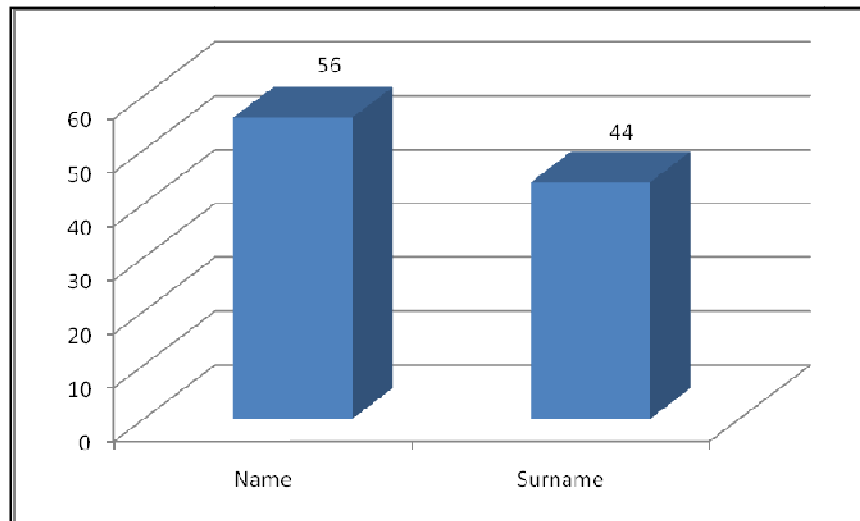


**Figure 4.36 Treated with dignity (n=100)**

#### **Item E42: Addressed by name or surname**

More than half of the respondents, (56.0 %; n=56), indicated that they were addressed by their names, while 44.0% (n=44) reported that they were addressed by their surnames. It is clear from the responses that patients were properly addressed by their names or surnames. No other unauthorised names were used like calling patients by a number or diagnosis (Refer to Figure 4.37).





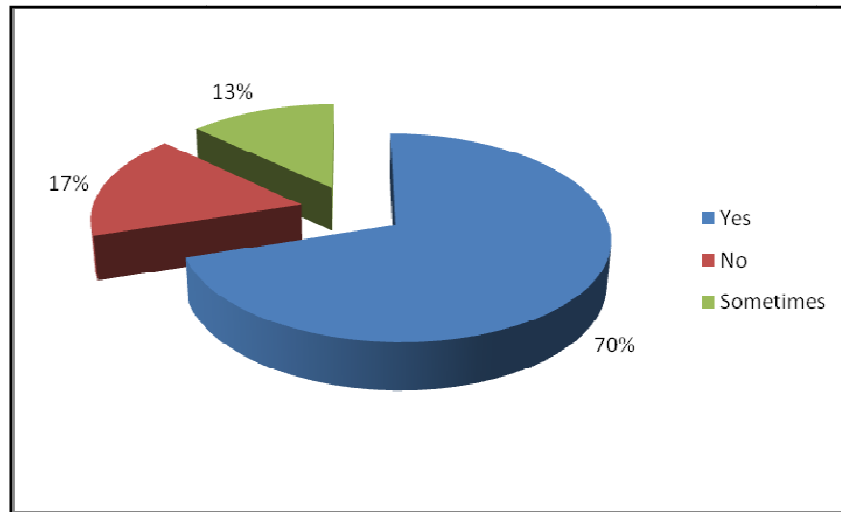
**Figure 4.37 Addressed by name or surname (n=100)**

### **Item E43: Ward hygiene**

Seventy percent (n=70) of the respondents revealed that they were satisfied with the cleanliness of the ward and 17.0% (n=17) reported that the ward was not clean, whereas 13.0% (n=13) reported that sometimes the ward was clean (Refer to Figure 4.38). The respondents reported the following comments which relate to responses to Items C15 and C16 that refer to bathrooms and toilets.

- Poor hygiene as the floors were dirty
- Dustbins overfull
- Lockers dirty
- Windows dirty
- Flies and cockroaches in the ward.

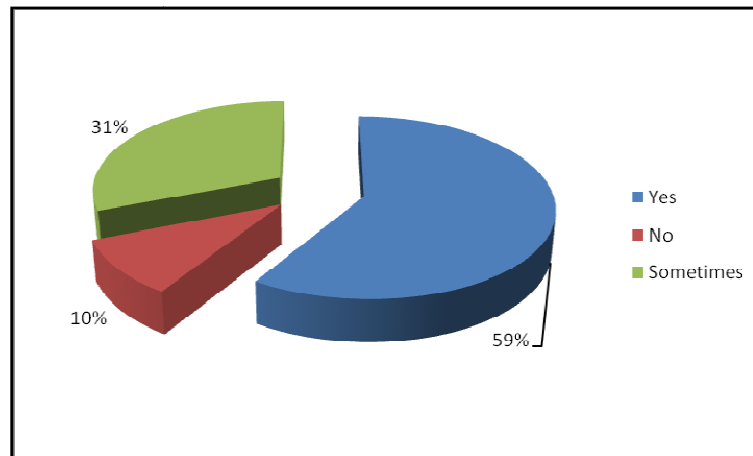
A negative response of 30.0% dissatisfaction reveals a violation of the first right of the PRC, namely *“To be treated in a healthy and safe environment”* (Refer to Section 2.5.1) and this response is unacceptably high. The issue of hygiene is addressed in the standard of cleanliness of the unit in the accreditation programme for hospitals. It is a reflection on the planning and control function of the unit manager. (Refer to Sections 2.8.1 and 2.8.4).



**Figure 4.38 Ward is clean (n=100)**

#### **Item E44: Supplies**

More than half of respondents (59.0%; n=59) reported that toilet paper was supplied at all times while 10.0% (n=10) of the respondents revealed that it was not available and a further 31.0% (n=31) said it was sometimes supplied (Refer to Figure 4.39). This response relates to management at unit level, where the unit manager is concerned with the allocation of the resources required for goal achievement (Refer to Section 2.8.2).



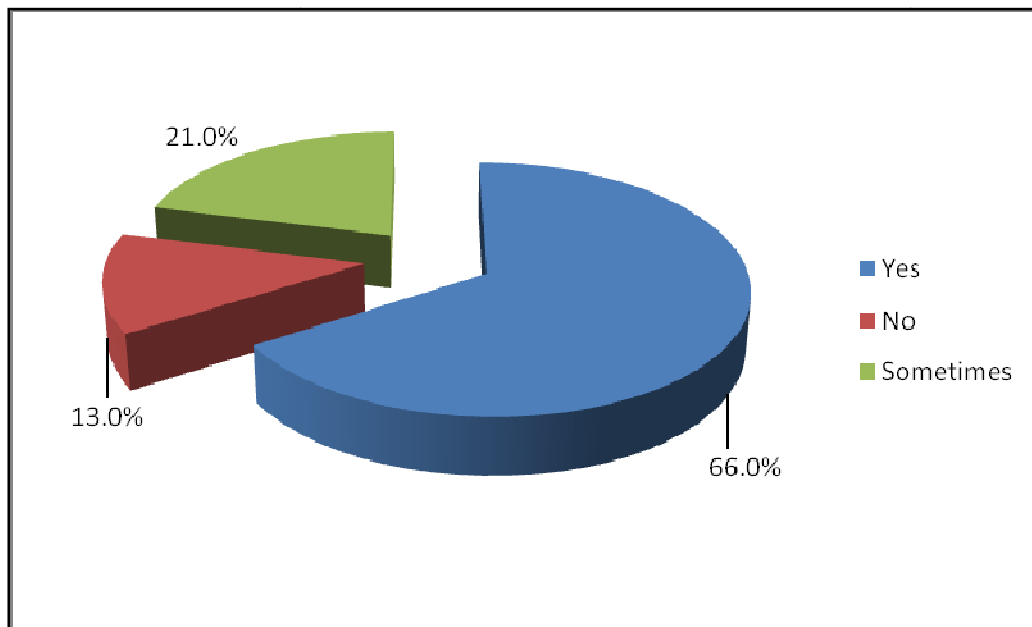
**Figure 4.39 Toilet paper is supplied (n=100)**

#### **Item E45: Food served**

The majority of respondents namely 66.0% (n=66) reported that they were satisfied with the food served and 13.0% (n=13) indicated that they were not satisfied while 21.0% (n=21) indicated that they were satisfied with the food sometimes (Refer to Figure 4.40). The 21% dissatisfied respondents made comments such as:

- Food is too little especially for male patients.
- Sometimes the food is tasteless with no salt added.
- Last meal is served at 16:00 and patients get hungry during the night.

This finding is related to the criteria on food service in the Guidelines and Monitoring Tools for Accreditation Programme for Hospitals (Gauteng Department of Health 2003:9).

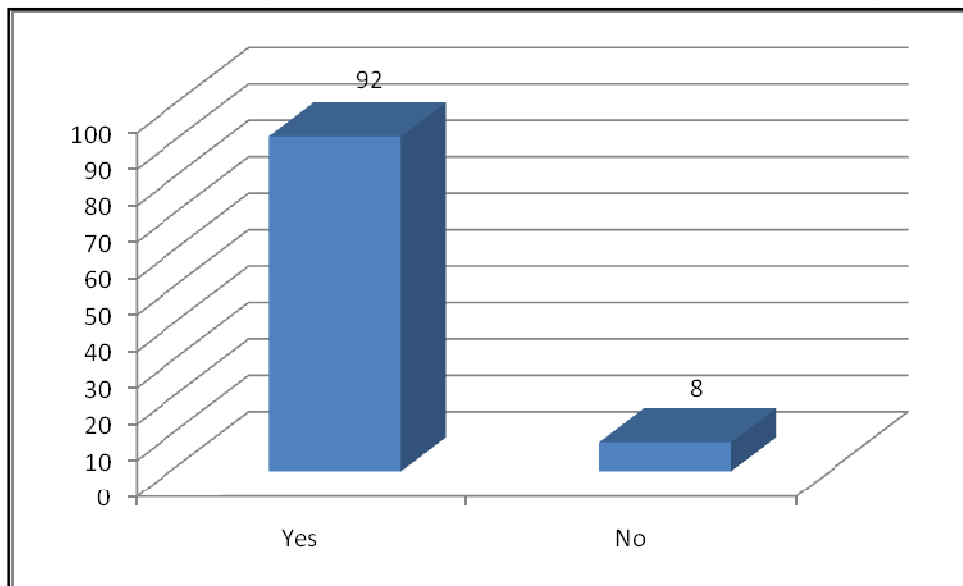


**Figure 4.40 Satisfied with the food served (n=100)**

### Item E46: Convenience of visiting times

The majority of the respondents, (92.0%; n=92), were of the opinion that visiting times were convenient in the hospital while only 8.0% (n=8) were not satisfied (Refer to Figure 4.41). Those respondents gave inputs such as:

- Visiting times should be longer over weekends due to shortage of public transport.
- Visiting times do not suit people who stay far away and should therefore be at least between 14:00 to 16:00.
- Visiting times should be from 10:00 or 12:00 to allow those who live far away to get public transport home.



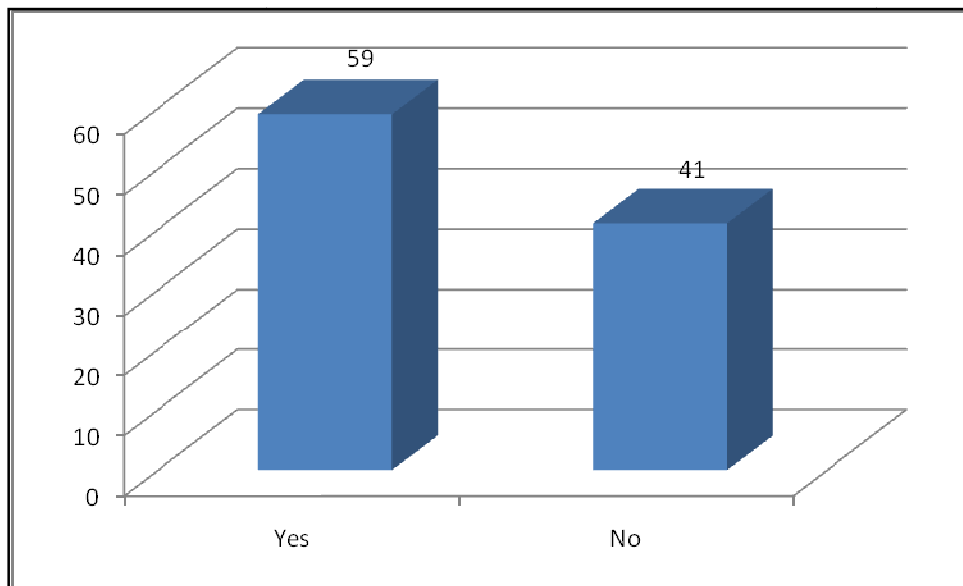
**Figure 4.41 Convenience of visiting times (n=100)**

### Item E47: Duration of visiting hours

Fifty nine percent (n=59) indicated that visiting hours were long enough while 41.0% (n=41) felt that it could be longer (Refer to Figure 4.42). These respondents made comments and inputs such as:

- Visiting time is not long enough especially for those who struggle with public transport.
- Visiting hours should be two hours in order to accommodate those who work and live far;
- Visiting hours should be one and a half hour instead of one hour.

Considering the relatively low educational level of the respondents (refer to Item B6), the response of 41.0% could be seen as a lack of understanding of hospital routine and the need for patients to have adequate rest and sleep.



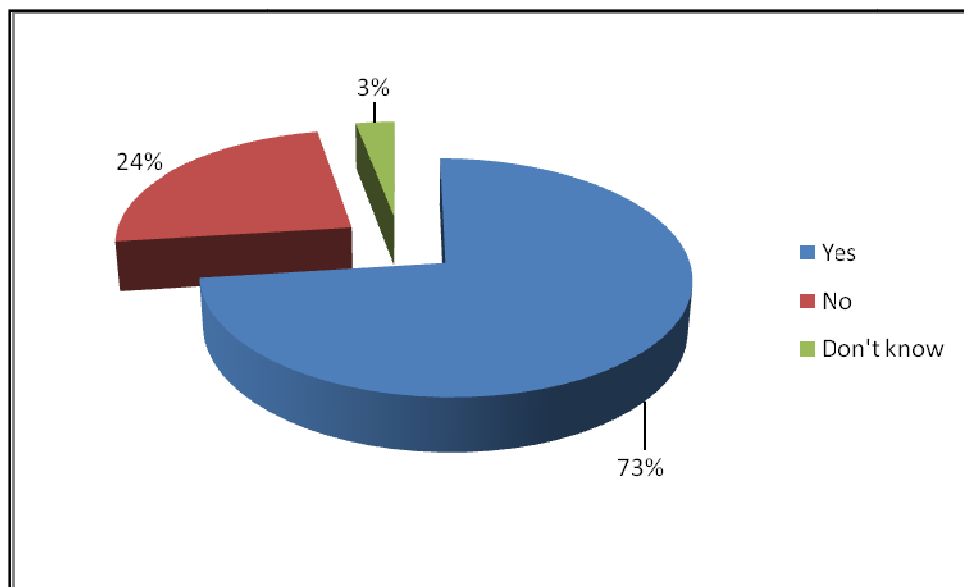
**Figure 4.42 Duration of visiting hours satisfactory (n=100)**

#### **Item E48: Bed linen**

Most of the respondents, 73.0% (n=73), indicated that their bed linen was changed daily and nearly a quarter (24.0%; n=24) said it was not changed. Only three respondents revealed that they didn't know whether their bed linen was changed daily. This response might be due to that they did not notice or they felt embarrassed to report that it was not changed daily (Refer to Figure 4.43). Some respondents made comments such as:

- Linen was only changed after four or five days.
- Linen was changed after four days.
- Linen was changed only if available.

This item is relevant to Standard Two *“Provision of linen and towels”* from the Guidelines and Monitoring Tools for Accreditation Programme which states that the amount and condition of the linen and towels contributes to the patient’s well-being and hygiene (Gauteng Department of Health 2003:10). The management function of the unit manager is relevant here (Refer to 2.8). The response is further not according to the BPP *“Getting the best value for money”*(refer to Section 2.6.8.), which states that public services should be provided economically and efficiently. The findings correlate with Item C12 where the respondents complained about the shortage of equipment.



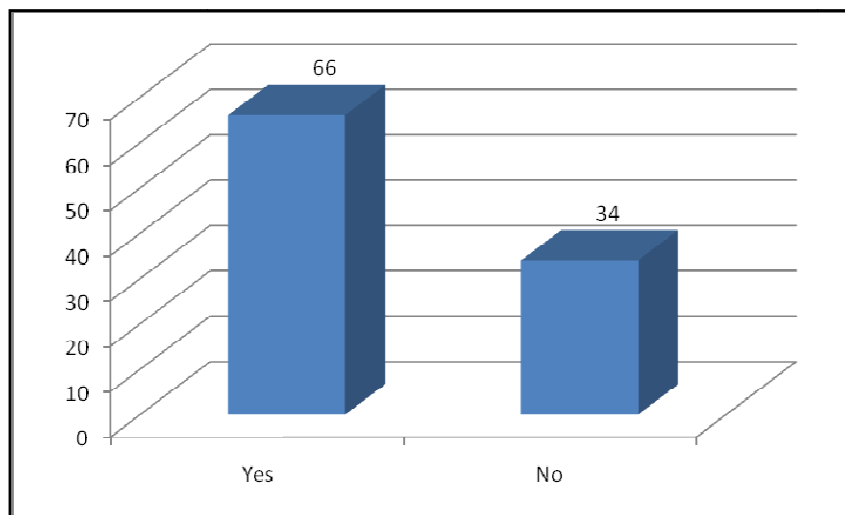
**Figure 4.43 Bed linen changed every day (n=100)**

#### **Item E49: Clean attire**

Sixty six percent (n=66) of the respondents indicated that they were given clean attire daily, while 34.0% (n=34) reported that clean attire was not given daily. Respondents raised concerns such as:

- Attire last changed two, three or four days back.
- They were told that their sizes (mainly big sizes) were not available.

These findings are not in line with the management process related to planning where the unit manager has the responsibility to ensure that the unit has enough resources, which includes bed linen and hospital attire. The issue also relates to the BPP “*Getting the best possible value for money*” (Refer to Section 2.6.8). Expecting patients to wear the wrong size of attire implies degrading of the individual and therefore violates the dignity of a person as described in the Bill of Rights and the PRC (Refer to Sections 2.4 and 2.5).



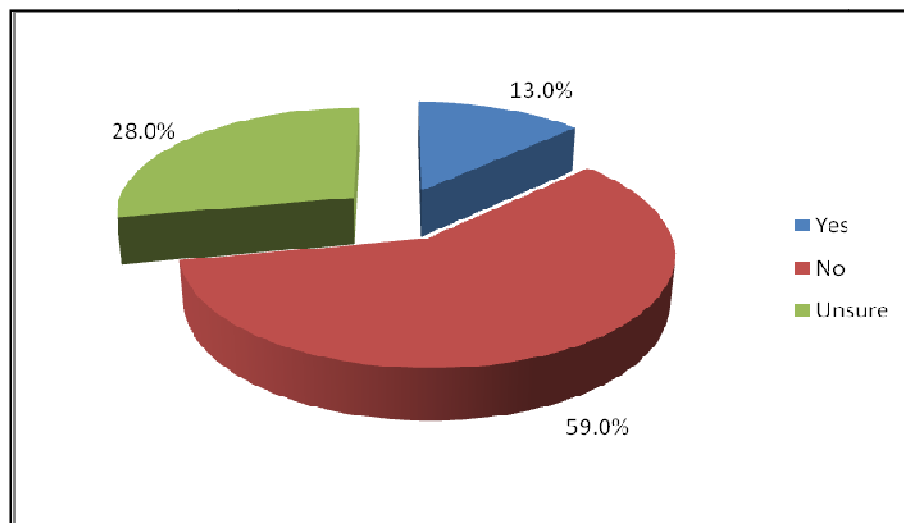
**Figure 4.44 Clean attire given daily (n=100)**

#### **Item E50: Complaint or suggestion box**

Thirteen percent (n=13) of the respondents indicated that they were aware of a complaint or suggestion box in the ward while 59.0% (n=59) reported that there was no such box. Another 28.0% (n=28) further revealed that they were unsure. These findings correlate well

with Items C31 and C32. where 90% of respondents indicate that they did not make any official complaints and 67% indicated that they did not know about the complaint system and procedure, especially with regard to the following issues:

- How to lay an official complaint
- How to lodge a complaint or make a suggestion
- Availability of the suggestion box in the ward.



**Figure 4.45 Complaint or suggestion box available in the ward (n=100)**

## 4.8 CONCLUSION

The analysed data were presented and described. The results revealed areas of concern as identified by the patients about how BPP was implemented, and their point of view assisted, in identifying shortfalls in the implementation of BPP. The research process is summarised and the conclusion of the research is discussed in chapter five.



## **CHAPTER 5**

### **SUMMARY, CONCLUSION AND RECOMMENDATIONS**

#### **5.1 INTRODUCTION**

This chapter concludes the study. It summarises the research design and methodology and interpretation of the research findings. Recommendations and the limitations of the study are described.

#### **5.2 RESEARCH DESIGN AND METHODOLOGY**

A quantitative, descriptive, explorative approach was used to identify problem areas in the implementation of the BPP as experienced by patients in a public hospital. A structured questionnaire was used to collect data. Questionnaires were completed by the researcher and a research assistant on behalf of the respondents. Data was analysed and presented through descriptive graphs and tables.

The objectives of the study were to:

- describe how patients experience the implementation of the Batho Pele Principles
- identify shortfalls in the implementation of the Batho Pele Principles as experienced by the patients.

#### **5.3 SUMMARY OF THE RESEARCH FINDINGS**

The findings are discussed according to the six BPP included in this study. In general it may appear that respondents are satisfied with the service standards, but closer observation reveals that significant high numbers of respondents are not satisfied with the implementation of BPP. Please note that in case of negative responses, the percentages referred to include the respondents who were not satisfied as well as those who were not satisfied at all times.

### **5.3.1 Setting of Service Standards**

Thirty five percent of respondents mentioned shortages of equipment e.g. beds and walking aids as well as shortages of stock such as bed linen and daily attire. Some of the respondents had to wear attire for as long as 3-4 days before receiving clean clothing. Forty one percent of respondents reported a shortage of toilet paper. Structural problems such as one bathroom for 30 patients were also mentioned (Refer to items C12, C15, E44, E48 and E49).

The majority of respondents (92%) were satisfied with the convenience of visiting hours but 41% of respondents indicated that visiting hours are not long enough to accommodate visitors from far away places or visitors with transport problems (Refer to Items E46 and E47).

The physical environment was investigated in terms of hygiene, security and noise. Thirty percent of respondents reported dirty wards and they commented on unhygienic bathrooms and toilets, dirty wards and bed lockers. Twenty six percent of respondents indicated that the hospital security was not adequate. Unfortunately this was a close ended question and the reasons for the response were not investigated. Twenty percent complained about the noise and mentioned staff, prison warders, radios, and trolleys as sources of noise (Refer to Items D35, D36 and E43).

Patients are admitted to health care facilities such as hospitals with the expectation that the authorities will provide the infrastructure, equipment and supplies to render the health care promised in the policy documents. The lack of stock identified in this study is not acceptable. Furthermore it is expected that the health services are managed in such a way as to facilitate health care delivery. The unit managers are accountable for the conduct of staff and the level of hygiene in the wards according to set standards. Performance has to be measured against standards and communicated annually.

### **5.3.2 The principle of increasing access**

This BPP and patient right stated in the PRC, addresses equal access to health care services, availability of resources and showing respect for human dignity. The latter will be discussed under 5.3.3.

When compared to South Africa's demographics, the demographic information of this study reveals a balanced proportion of the different races receiving the same standard of health care (Refer to item B7).

Unacceptable high incidences of shortages of stock and equipment were reported in 5.3.1. Hindered access to amenities such as bathrooms was reported by respondents (Refer to item C15). These and other similar problems cannot be resolved easily but should be provided for in the long-term architectural and strategic planning of the facilities.

The aspects hindering access to health care in order to comply with the service standards and access to health care are mostly on the operational level of management. Unit managers can address issues such as hygiene, professional conduct of staff and availability of stock by proper input in the budgeting process, planning and control.

### **5.3.3 The principle of ensuring courtesy**

Courtesy is underwritten by the Bill of Rights, the BPP and the PRC. Respondents revealed violations of their right to be treated with respect and human dignity. Thirty seven percent of respondents reported that staff is not always friendly and the conduct of staff in some cases was described as nasty, rude and short-tempered. Thirteen percent reported that doctors do not treat them with respect, some even shouting at them in front of the other patients. Contrary to the disrespectful conduct of professional staff, 96% of respondents reported that the cleaners treated them with respect (Refer to items C22, C24 and C29).

Courtesy is displayed in many ways and manifests in lay terms as good manners. In item E41 respondents were asked if they were treated with dignity and 87% responded positively and in item C21, 92% indicated that they were addressed in a language they understood. The validity of these responses is in question when responses to a number of other items are observed for example:

- Twenty seven percent of respondents said staff members were not always helpful (Refer to item C23).
- Eighteen percent of the respondents reported that the unit manager did not introduce her/himself to them (Refer to item C27).
- Forty nine percent reported that the doctors treating them did not introduce themselves (Refer to item C28).
- Twenty five percent of respondents said staff members do not always listen or respond to the needs of the patients (Refer to item D38).

Considering the relatively low educational level of the respondents (refer to item B6), the discrepancy may be attributed to respondents not understanding the meaning of courtesy/dignity. Respect for the dignity of people is an issue of interpersonal relations. The ideal is that every person will be raised from childhood to respect others. However, this attitude should also be instilled in health care providers through the process of professional socialization. The unit manager should ensure through role modeling and quality assurance that staff members treat patients with due respect.

#### **5.3.4 The principle of providing more and better information**

The primary documents that should inform patients about the obligation of health care providers and the rights of patients are the BPP and the PRC. This study revealed that both these documents were either not displayed noticeably or the respondents did not realise the importance of the documents. More than half of the respondents did not observe them (Refer to items C9, C10 and D33).

Respondents were well informed about visiting hours (Refer to item C20) and about procedures to be done on them (Refer to item C13). Nearly half of the respondents were not well informed about the daily ward routine (Refer to item C14).

Although 73% reported that their illness was explained to them, (Refer to item C26), this is contradicted by the 52% who said they did not receive all the information they needed and the 68% not informed about test results (Refer to items C25 and C19 respectively).

It seems that the general public needs to be informed and educated about their rights and the responsibilities of health care providers. Nurses and doctors must realise that information about their diagnosis, condition and treatment empowers patients to contribute to and participate in their health care. Furthermore sharing of information demonstrates respect for the dignity of patients.

### **5.3.5 The principle of remedying mistakes and failures/redress**

Issues, about which 30% or more of the respondents were definitely or partially unhappy or dissatisfied, include amongst others:

- Not enough equipment in the ward (Item C12)
- Not informed about the ward routine (Item C14)
- Not given information about treatment (Item C17)
- Staff members not friendly (Item C 22)
- Not introduced to the unit manager and doctor (Item C 27,28)
- Not involved in decision making (Item D 37)
- No room available for private consultation or conversation (Item D 39)
- Toilet paper not supplied (Item E44)
- Not satisfied with food (Item E 45)
- Clean attire not available (Item E 49)

Despite the above findings, 90% of respondents did not file official complaints (Refer to item C31). This may be because they are unaware of their right to complain, which

correlates with the fact that the PRC is not visible (Refer to item D33). Patients may be uninformed about the procedure to complain (Refer to item C32), or a third possible reason may be the absence of complaint/suggestion boxes in the wards (Refer to item E50).

The hospital and unit managers need to understand that complaints from patients serve to ensure patient satisfaction on the one hand and improvement of the quality of care on the other. Including the topic of complaints in the human resource development program will ensure that staff members are continuously on guard to avoid situations that can end in complaints.

### **5.3.6 Getting the best possible value for money**

The BPP document describes the implementation of this principle in terms of cost effective services within the departmental resource allocation. This means that budgets should be planned carefully and the use and utilization of resources needs to be controlled carefully. The document also describes the effect of good interpersonal relations and professional conduct, which do not require financial investment. The document states in this regard, "... a few hours each month of a senior manager's time spent talking to their customers – and the staff who serve them - may be worth hundreds of rands in research fees."

All the findings of this study point to the necessity of the implementation of the principle "*getting the best value for money*".

## **5.4 CONCLUSION OF THE RESEARCH**

The first objective of this study, namely to describe how patients experience the implementation of the Batho Pele Principles was met. The implementation of each of the six identified BPP was explored in terms of everyday situations in the three selected hospital nursing units. The discussion of the implementation of the principles was further complimented by inclusion of the Bill of Rights and the PRC.

The second objective of the study, namely to identify shortfalls in the implementation of the Batho Pele Principles as experienced by the patients was also met. The shortfalls that were identified in relation to this objective are in terms of hospital management, unit management and patient awareness. Each of these aspects will be discussed briefly.

- **Hospital management**

On the level of hospital management, insufficient planning and budgeting for capital expenditure such as equipment hinder the implementation of the BPP *“Increasing access”*. The fact that the BPP, PRC and complaint boxes are not placed conspicuously in the units and wards obstructs the implementation of the following BPPs: *“Setting of service standards”*, *“Providing more and better information”* and *“Remedying mistakes and failures/redress”*.

- **Unit management**

Ineffective planning, organising and control by the unit manager lead to ineffective implementation of the BPP *“Increasing access”*. This pertains to aspects such as stock supplies and ensuring a therapeutic environment. Inadequate dealings to measure performance of staff and poor leadership skills of unit managers resulting in below standard quality service hamper the implementation of the following BPPs: *“Increasing access”*, *“Providing more and better information”*, *“Ensuring courtesy”* and *“Getting the best possible value for money”*.

- **Patient awareness**

A lack of awareness and understanding of the BPP and the PRC by patients and the general public hinders the implementation of the BPP *“Remedying mistakes and failures/redress”*.

## 5.5 RECOMMENDATIONS

Recommendations are made in terms of research, management and education.

### **5.5.1 Research**

- A more extensive study should be done at the same hospital, including all the nursing units and other departments that deal directly with patients, such as radiology. This would give a clear picture of the implementation of the BPP with regard to the total health care delivery in the hospital.
- An improved questionnaire should include qualitative data that will reveal valuable information about the implementation of the BPP.
- The extensive study should be repeated at other hospitals in the district and province to ensure improvement of the implementation of the BPP.
- Research and scientific evidence should form the basis for evidence based clinical practice to secure a health care system in which the BPP are central.

### **5.5.2 Management**

- Problem areas identified in the research on the implementation of the BPP should be addressed and monitored on a continuous basis.
- All levels of management should ensure that quality assurance programs are implemented and the performance of all levels of health care staff should be measured and monitored.
- The leadership skills of managers should be developed to enable them to mobilise the human and material resources to meet the aims of quality programs.
- Managers should be role models of professional conduct for all levels of health care staff.

### **5.5.3 Education**

- The value of lifelong learning must be established at all hospitals.
- The implementation of the BPP and PRC should be an integral part of the human resource development program and care should be taken that all categories of staff gain from it.



- Strategies to ensure that patients are aware of and understand the BPP and the PRC should be planned, implemented and evaluated.

## **5.6 LIMITATIONS OF THE STUDY**

The study was conducted in a specific provincial hospital in the Ekurhuleni District in Gauteng Province and results about the implementation of the BPP cannot be generalised.

The respondents were selected from three nursing units in the hospital only. The inclusion of more nursing units and other departments such as Radiology and Dispensary may have given a more complete picture of the implementation of the BPP in the hospital.

A quantitative study approach was used as this was a study of limited scope only. A qualitative approach would have resulted in an in-depth exploration of patients' experiences.

More open ended questions would have supplied specific examples and details that could have been used to add to the description of the experiences of patients.

## **5.7 CONCLUSION**

This was a quantitative descriptive study on the implementation of the BPP in a public hospital. One hundred patients who were admitted for longer than three days were included in the study sample. Data was collected through questionnaires and analysed by means of descriptive statistics.

Study findings indicated that none of the BPP included in the research are implemented effectively. The shortfalls were identified as being inefficient management and a lack of knowledge about their rights in health care by patients.

The White Paper on Transforming Public Service Delivery (Batho Pele White Paper) number 1459 of 1997 provided a policy framework and implementation strategy for the

transformation of Public Service Delivery. The researcher found that no research on the success of the implementation, or lack thereof, has been done for ten years since the implementation of BPP in the health services. Numerous newspaper articles, reporting in detail about the complaints of patients with regard to health services prove that the BPP are not yet implemented effectively.

It is hoped that this small scale study will prompt hospital managements and Provincial and NDOH to initiate programmes, to ensure the implementation of the BPP and the delivery of quality health care to all citizens of South Africa.

This should be a matter of urgency, as the Batho Pele White Paper states:

“Improving the public service delivery is not a one-off exercise. It is an ongoing and dynamic process, because as standards are met, they must be progressively raised. This document marks only the first stage in that process. There is a great deal to do, and progress will sometimes be frustratingly slow; but the task is one of the most worthwhile and rewarding that the public service faces, and the need is urgent, so there is no time to lose.” (South Africa 1997: 30)

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