CHALLENGES EXPERIENCED BY PRIMARY HEALTH NURSES IN SUSTAINING IDEAL CLINIC STATUS POST IMPLEMENTATION IN ILEMBE DISTRICT, KWAZULU-NATAL

by

LEEANNA DUBRU-ODAYAR

submitted in accordance with the requirements for
the degree of

MASTER OF PUBLIC HEALTH

in the subject

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROFESSOR ZZ NKOSI

SEPTEMBER 2022

DECLARATION

Name: LEEANNA DUBRU-ODAYAR

Student number: 46723110

Degree: MASTERS IN PUBLIC HEALTH

Exact wording of the title of the dissertation as appearing on the electronic copy submitted for examination:

CHALLENGES EXPERIENCED BY PRIMARY HEALTH NURSES IN SUSTAINING IDEAL CLINIC STATUS POST IMPLEMENTATION IN ILEMBE DISTRICT, KWAZULU-NATAL

I declare that the above dissertation is my own work and that all the sources I have used or quoted have been indicated and acknowledged through complete references.

I further declare that I submitted the dissertation to originality-checking software, which falls within the accepted requirements for originality.

I further declare that I have not previously submitted this work, or part of it, for examination at Unisa for another qualification or at any other higher education institution.

(The dissertation will not be examined unless this statement has been submitted.)

_____ 19 JULY 2022_

SIGNATURE DATE

UNIVERSITY OF SOUTH AFRICA

KEY TERMS DESCRIBING THE TOPIC OF A DISSERTATION/THESIS

The Executive Committee of Senate decided that in order to assist the Library with retrieval of information, master's and doctoral students must list approximately ten key terms which describe the topic of the dissertation/thesis at the end of the summary of the dissertation/thesis.

If the dissertation/thesis is not written in English, the key terms in English must be listed at the end of the English summary.

The following is an example of key terms used for a thesis/dissertation:

Title of thesis/dissertation:

CHALLENGES EXPERIENCED BY PRIMARY HEALTH NURSES IN SUSTAINING IDEAL CLINIC STATUS POST IMPLEMENTATION IN ILEMBE DISTRICT, KWAZULU-NATAL

KEY TERMS:

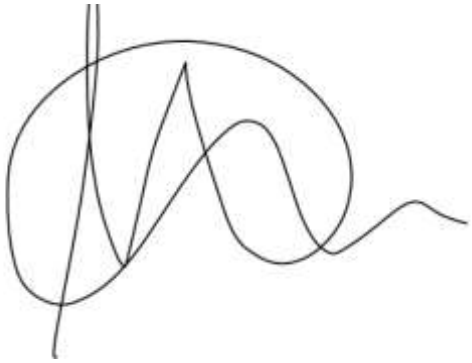
Challenges, Compliance, Ideal Clinic (ideal clinic), Ideal Clinic Realisation and Maintenance Programme (ICRM), National Health Insurance (NHI), Perception, Post Implementation, Quality Standards, Sustaining, Trends, Universal Health Coverage (UHC)

RESEARCHER ACKNOWLEDGEMENT

Hereby, I Leeanna Dubru-Odayar, ID number (8305160051087), in my personal capacity as a researcher, acknowledge that I am aware of and familiar with the stipulations and contents of the following:

- UNISA Research Policy
- UNISA Ethics Policy
- UNISA IP Policy

Furthermore, I shall conform to and abide by these policy requirements.



Signature: ……

Date: ...10 October 2022

ACKNOWLEDGEMENTS

Throughout the writing of this dissertation, I have received a tremendous amount of support and assistance.

I would first like to express my deepest thanks and appreciation to my supervisor, whom I greatly benefited from, Professor Zerish. Z. Nkosi, and fellow academic professors, whose expertise was invaluable. Your insightful feedback pushed me to sharpen my thinking and brought my work to a higher level.

I would like to express special thanks of gratitude to the Kwa-Zulu Natal Health Department and iLembe district offices for granting the permission needed to undertake this study.

In addition, this project would not have been possible without the encouragement from my parents, Mr C & KD Dubru and siblings Mary Ann, Joshua and Joel for their sympathetic ear and enormous support. You are always there for me.

Finally, I could not have completed this dissertation without the love, support and tolerance of my husband, Clinton Odayar, who provided emotional support in pursuing and completing this research. Without his encouragement, this dissertation would not have materialised. Also, the happy distractions of my two sweet baby girls, Jenna-Lee Peyton and McKenzie Leighton.

CHALLENGES EXPERIENCED BY PRIMARY HEALTH NURSES IN SUSTAINING IDEAL CLINIC STATUS POST IMPLEMENTATION IN ILEMBE DISTRICT, KWAZULU-NATAL

STUDENT NUMBER	**:**	46723110
STUDENT	**:**	LEEANNA DUBRU-ODAYAR
DEGREE	**:**	MASTER OF PUBLIC HEALTH
DEPARTMENT	**:**	HEALTH STUDIES, UNIVERSITY OF SOUTH AFRICA
SUPERVISOR	**:**	PROFESSOR ZERISH. Z. NKOSI

ABSTRACT

This study aimed to explore and gain more insight into the challenges experienced by primary healthcare (PHC) nurses in maintaining ideal clinic status, where previously achieved. Qualitative, phenomenological research was conducted to gain a perspective on challenges experienced by nurses. Data were collected through semi-structured in-depth interviews from the study sample of 13 clinical nurse practitioners from two clinics in the sub-district of Kwa-Dukuza. The findings revealed a non-maintenance or no improvement of Ideal Clinic (ideal clinic) status, with the current trend of working towards the ideal clinic assessment only at the time nearing the assessment, giving a false interpretation of the maintenance of the ideal clinic. This revealed several challenges experienced by PHC nurses, namely, the absence of vital resources, deficient emergency equipment and supplies, unsuitable infrastructure, substandard procurement processes and poor working conditions. Also, PHC clinics are far from fitting the description of an ideal clinic. Further investment is imperative in monitoring and evaluating the Ideal Clinic Realisation and Maintenance Programme (ICRM).

KEY CONCEPTS: Challenges, Ideal Clinic (ideal clinic), Ideal Clinic Realisation and Maintenance Programme (ICRM), Post Implementation, Sustaining, Trends

ACRONYMS

CPR	:	Cardiopulmonary Resuscitation
DENOSA	:	Democratic Nursing Organisation of South Africa
DOH	:	Department of Health
ICN	:	International Council of Nurses
ICRMP	:	Ideal Clinic Realisation and Maintenance Programme
KZN	:	Kwa-Zulu Natal
NDoH	:	National Department of Health
NHI	:	National Health Insurance
NSI	:	Non-Stock Items
PHC	:	Primary Health Care
PHCN	:	Primary Healthcare Nurses
RN	:	Registered Nurses
SDG	:	Sustainable Development Goal
SANC	:	South African Nursing Council
UHC	:	Universal Health Coverage
WHO	:	World Health Organisation

TABLE OF CONTENTS **PAGE NO**

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

National Health Insurance (NHI) is a dynamic intervention to pave the way to inclusive health care in South Africa (South Africa). Therefore, with guidance from the World Health Organisation (WHO) and benchmarking from first-world countries, South Africa is determined to implement the NHI. Currently, the South African Department of Health is adopting the Primary Health Care (PHC) approach, launching the Ideal Clinic Realisation and Maintenance Programme (ICRM) to improve the quality of health care provided in the public sector. This aims at ensuring to write off the disparities in the accessibility to health care. According to Hunter, Chandran, Tucker, Ravhengan, and Mokgalagad (2017:112), South Africa launched this ideal clinic programme in July 2013. However, public healthcare clinics are still grappling to maintain ideal clinic status achieved previously (NDoH, 2020).

This research aimed to explore the challenges experienced by PHC nurses in sustaining ideal clinic status post implementation in iLembe District, KwaZulu-Natal (KZN). By exploring their challenges, their perspectives provided purposive change strategies to maintain an ideal clinic status.

This chapter provides background to the study, including the problem statement, aim and objectives of the study, research questions, the significance of the study, definition of concepts, synopsis of research methodology, ethical principles, the scope of the study, and structure of the dissertation.

1.2 BACKGROUND INFORMATION ABOUT THE RESEARCH PROBLEM

1.2.1 The source of the research problem

According to the Health Care Index, health ministries and independent watchdogs in the health sector, South Africa has topped the African rankings in terms of health (Ebatamehi, 2020). This deems South Africa's healthcare system as the best in Africa. Although this implies a prestigious sentiment, Coovadia (2009:817) argued that South

Africa was riddled with colonialism and Apartheid. Now, 27 years after Apartheid, the healthcare system is still grappling with the challenges of transforming institutions. For example, promoting equity in accessibility to achieve Universal Health Coverage (UHC) as ascribed by the sustainable development goals.

Currently, the fragmented style of health care divides it into private and public health care. According to Maphumulo and Bhengu (2019:2), “the current public healthcare system overburdened with high nurse-patient ratios, lack of resources and inadequate infrastructure amounts to long waiting times, frustrated healthcare workers and occasionally substandard care”. Rispel (2016:18) added, “that 84% of the population, who carry a far greater burden of disease, depend on the under-resourced public sector”. This is opposed to the rest of the South Africans owing to their socioeconomic status, which can access private health care boasting the opposite of the current public healthcare system.

South Africa’s health care is advancing to the PHC approach. Therefore, together with NHI, a leading tool developed to elevate the public sector to bring it on par with the private institutions was the Ideal Clinic Monitoring System. This tool assists in improving the quality standards in the clinics, making it “IDEAL”. According to the National Department of Health (2020), an “ideal clinic” has good infrastructure, adequate staff, adequate medicine and supplies, good administrative processes, and sufficient bulk supplies. It uses applicable clinical policies, protocols, and guidelines and harnesses partner and stakeholder support. A well-devised checklist and manual, Ideal Clinic Realisation and Maintenance (ICRM), was developed to transform all PHC facilities by improving the deficiencies in standards of care and realigning the disparities in quality health care in South Africa. More specifically, a monitoring tool to ensure that quality standards are maintained and adhered to in PHC clinics. Although it launched in July 2013, Fryatt and Hunter (2016:24) argued that the ideal clinic’s actual commencement of implementation was in April 2015. Meanwhile, Operation Phakisa’s (2015:8) objective was to achieve the Ideal Clinic status for all clinics by 2018/19. Since its implementation, ideal clinic status was only attained in some clinics. The Department of Health (DOH, 2020) five-year review 2020 indicated that 93 clinics out of the 605 primary healthcare facilities had lost their status in four years, with only 19 maintaining their ideal clinic status. Thus, only 3% of the PHC facilities provide good quality health care.

According to Michel, Tediosi, Egger, et al. (2020:2), the services provided through government-funded institutions are largely unreliable, failing to provide a comprehensive PHC approach. Michel et al. (2020:2) also found quality problems in staff attitudes, waiting times, cleanliness, drug stock-outs, infection control, and safety and security of staff and patients. This is despite efforts to address these challenges and ongoing assessments of public sector facilities in the form of these ideal clinic assessments. Therefore, it was essential to explore and understand the challenges experienced by PHC nurses in articulating and maintaining the ideal clinic and quality standards programme post implementation to ensure that the NHI is executed fully.

1.2.2 Background to the research problem

Since its implementation in 2013, accredited ideal clinics have been failing to maintain their status, as described in the ideal clinic monitoring and evaluation software (2015/2016). According to this software, KZN had 603 PHC facilities, with only 24% classified as ideal, which is 141 clinics. Throughout South Africa, according to the five-year review by DOH (2020), 322 healthcare facilities were ideal in the 2015/2016 period. However, by 2020, the preliminary results revealed a downward trend in facilities remaining ideal clinics. Only 76 remained ideal in the 2019/2020 period. It revealed a 15% drop in South Africa, cumulatively.

The iLembe District, north of KZN, revealed the following downward trend in maintaining ideal clinic status:

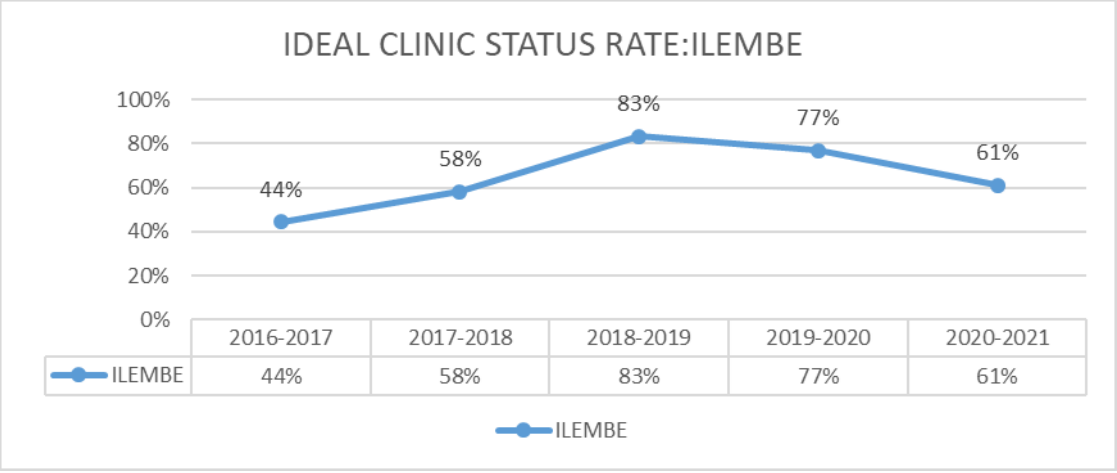


Figure 1.1: Ideal Clinic Status Rate: Extracted from KZN Annual Reports

In 2015/2016, the Ideal Clinic Programme was implemented using a phased approach with the objective of covering 100% of clinics and community health centres by 2020.

Although KZN had done well, the high failure rates resulted in unachieved vital elements. The two vital elements with the highest failure rate were the restoration of the emergency trolley after use (46%) and a well-equipped resuscitation room with basic functional equipment (40%), which could be addressed through active leadership and monitoring. Elements with the least failure rates were medicines, supplies and laboratory services (83%) and human resources (81%). (KZN Health Annual Report, 2017:46)

In 2017/2018, the second phase of implementation was added, namely 100% of status determinations (self-assessments). Poor-performing districts aimed to improve performance and strove to attain status, although no actual data were recorded. However, the annual report 2018/2019 revealed many challenges, from infrastructure to daily practices, with supervision identified as the main challenge in clinics regressing to ideal clinic status.

As the years progressed, the aggregated report for status determination (2021:1) revealed that 22 out of 36 clinics achieved ideal clinic status. In the sub-district of Kwa-Dukuza, out of the nine clinics, only one clinic achieved ideal clinic status for 2020. There are seven primary healthcare facilities in the sub-district of Kwa-Dukuza, which had only one clinic that maintained its status. Eight clinics lost their status, which is a cause for concern.

The results of this research and the transformation in standards of care will have a negative rebound impact on the roll out of NHI in South Africa. Therefore, describing the nurses' daily challenges will aid in improving the identified areas of concern. This study aimed to analyse the impact of the challenges and experiences faced by PHC nurses in maintaining IC status post implementation and how nurses perceive the challenges. This will, in turn, assist in maintaining and sustaining the ideal clinic statuses of all clinics.

1.3 RESEARCH PROBLEM

Currently, ICRM checklists are used as a quality healthcare standard marker, where regular assessments and evaluations have been done since its implementation. Downward trends were revealed in the majority of clinics throughout South Africa, especially in the iLembe District, KZN, in the five-year review by NDoH (2020). The

non-maintenance of ideal clinic status is a cause for concern. A 22% decline in the ideal clinic status rate was noted from 2018/2019 to 2020/2021 (KZN Annual Reports). Non-maintenance and non-sustainability of ideal clinic status render the quality of care provided to South Africans inefficient and ineffective. Therefore, identifying the nurses' challenges in maintaining IC status post implementation is vital, as this failure results in the inability to provide quality standards of care. Research by Hunter, Chandrani, Asmalli, Tucker, Ravhengani and Mokgalagadi (2017:115) explored the challenges in the implementation of IC. However, no research is documented on the post-implementation phase of IC, making this study unique.

1.4 AIM/PURPOSE OF THE STUDY

1.4.1 Research aim/purpose

This study aimed to explore and gain more insight into the nurse-related challenges experienced by primary healthcare nurses in maintaining ideal clinic status, where previously achieved, post implementation.

1.4.2 Research objectives

- Explore the challenges experienced by nurses in maintaining ideal clinic status.
- Explore nurses' perception of quality standards laid down in the ideal clinic.
- Describe their attitude toward achieving ideal clinic status.

1.4.3 Research questions

The following research questions were explored:

- What are the challenges experienced by PHC nurses in maintaining ideal clinic status?
- What are the factors affecting the maintenance of quality standards of care?
- What are the factors affecting nurses' attitudes toward the ideal clinic?

1.5 SIGNIFICANCE OF THE STUDY

South Africa's public healthcare system is largely fragmented, rendering inadequate health care to the majority. Ideal Clinic (IC) and ICRM have been redeeming quality for South Africa to fulfil the standard developmental goals of Universal Health Coverage (UHC). Since its implementation, research has been documented on the planning, progress and challenges in implementing an ideal clinic. However, no evidence has been documented since its implementation on the challenges faced in maintaining ideal clinic status, post implementation. With PHC nurses at the forefront as the drivers in providing quality health care, their challenges in maintenance of ideal clinic are quintessential in improving the quality standards. According to Rispel (2016:21), research conducted in Brazil has revealed that UHC reforms are more effective when careful attention is paid to health workforce challenges. The recommendations envisaged in this study can improve or implement strategies to curb non-adherence in maintaining ideal clinic status.

1.6 DEFINITION OF KEY TERMS

1.6.1 National Health Insurance (NHI)

According to NDoH (2017), NHI is a health financing system designed to pool funds and actively purchase services with these funds to provide universal access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their socioeconomic status.

1.6.2 Primary Health Care (PHC)

PHC is a whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs along the continuum of health promotion and disease prevention to treatment, rehabilitation and palliative (What is primary health care?, 2021).

1.6.3 Ideal Clinic (IC)

The NDoH (2020) defines an ideal clinic as a clinic with good infrastructure, adequate staff, adequate medicine and supplies, good administrative processes, and sufficient adequate bulk supplies.

1.6.4 Challenges

A challenge refers to a difficulty faced while trying to reach a goal/target (Mhagama, 2018, cited by Tuazon, Butiu, Natangcop, Lonzaga, & Lim, 2022:344).

1.6.5 Primary Healthcare Nurse (PHCN)

A primary healthcare nurse is a professional nurse with an additional qualification in Primary Care Nursing and is registered as such by the South African Nursing Council. This specialist provides direct care to patients with all types of illnesses and ailments, offering the first level of nursing care that patients receive. She/he is a registered nurse competent to independently render appropriate and skilled primary care services as first-line care (SANC, 2014).

1.7 THEORETICAL FOUNDATIONS OF THE STUDY

1.7.1 Research paradigm

A paradigm is a worldview, a general perspective on the complexities of the world (Polit & Beck, 2017:14). According to Lincoln and Guba (1985:308), as cited in Polit and Beck (2017:14), a paradigm comprises four elements: epistemology (the relation of the inquirer to those researched); ontology (what is the nature of reality); methodology (how is evidence best obtained); and axiology (what is the role of values in the inquiry).

The constructivist paradigm, also known as interpretive, underpinned this research. Honebein (1996:11-12), cited by Adom and Ankrah (2016:2), described the constructivism paradigm as an approach that asserts that people construct their own understanding and knowledge of the world through experiencing things and reflecting on those experiences. In relation to the purpose of the study, which was to gain more insight and an in-depth understanding of the PHC nurses' experiences, the

constructivist/interpretive paradigm was considered the most suitable paradigm, enabling the researcher to explore and interpret the experiences of PHC nurses.

1.8 RESEARCH METHODOLOGY AND RESEARCH DESIGN

For Creswell (2014:34), a research approach is a plan and procedure for research that describes the steps from broad assumptions to detailed methods of data collection, analysis and interpretation. Two types of research use different forms of collecting data: quantitative research, which deals with numbers and statistics, and qualitative research, which focuses on words and meaning.

According to Bhandari (2020), quantitative research is the process of collecting and analysing numerical data. It is often used to find patterns and averages, make predictions, test causal relationships, and generalise results to broader populations. Denzin and Lincoln (2005:2) cited by Aspers and Corte (2019:142) defines Qualitative research as a multimethod in focus, involving an interpretative, naturalistic approach to its subject matter. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them. The research approach most appropriate in the above paradigm is qualitative research. Qualitative research explores and understands the relationship between individuals and groups ascribing to a problem (Creswell 2014:32).

In this qualitative research approach, the researcher aimed to explore and gain an in-depth understanding of the challenges experienced by the nurses in an inductive style of in-depth probing. This probing style encouraged nurses to verbalise their challenges and experiences in not maintaining ideal clinic status, post implementation. Therefore, this research adopted an exploratory, inductive qualitative approach. Against this background, the researcher aimed to explore and describe the challenges faced by PHC nurses in maintaining ideal clinic status post implementation, which had no coverage and which will encourage the generation of new knowledge as the research questions are answered.

A research design describes how an investigator structures a research study to solve a research question. It is described as an organised plan detailing the study; thus, the

researchers' ways of collecting information on how the study will reach its conclusions and its limitations (Dagar 2019:36).

In this study, qualitative research design aimed to explore and describe the lived experiences in the challenges faced by PHC nurses in maintaining ideal clinic status post implementation in iLembe District, Kwa-Zulu Natal. Two PHC facilities were identified in iLembe District, with the selection criteria being that the ideal clinic had previously been implemented and had an ideal clinic status before. Purposive sampling was used to select the target population for the study, which included the following inclusion criteria: an RN with a specialisation in PHC who had worked in a PHC facility for more than six months. Years of experience and an additional qualification in PHC were the deciding factors.

The data collection tool selected for this study was a mix of structured and unstructured open questions via semi-structured interviews. Participants first responded to the biographical questions. Following this, they were asked to respond to questions such as "Describe your level of training or knowledge of an ideal clinic since its implementation", initiating the discussion. Thereafter the conversation proceeded to the main core questions, namely 1) As a PHC nurse, what are some of your experiences in maintaining ideal clinic status, and 2) Describe the challenges you face whilst maintaining an ideal clinic. To gain in-depth knowledge and understanding of their experiences, the researcher used prompting questions to clarify some responses. The exploratory interview sessions for each participant ranged from 45 to 60 minutes. The data analysis process followed the thematic analysis. This was guided by Braun and Clarke (2006:78) and revised by Caulfield (2021:3). All ethical principles and processes adhered to throughout the research study ensured integrity and rigour of the study against the five standards of trustworthiness (Lincoln and Guba 1985 as cited in Polit & Beck 2018:134).

All ethical considerations pertaining to the study were maintained throughout the research. The five principles of trustworthiness were adhered to in all areas, especially with data collection. The researcher did the data analysis.

1.9 SCOPE OF THE STUDY

This study was limited to two PHC clinics in the iLembe District, north of KZN. Only clinic nurse practitioners trained in post-basic PHC between the ages of 25 and 65 participated in the study.

1.10 STRUCTURE OF THE DISSERTATION

The research dissertation comprises the following chapters:

Chapter 1: Introduction and Background. The chapter also provided an overview of the study and its structure.

Chapter 2: Literature Review. This chapter structures the process and presents the findings of the existing literature related to the topic. It also highlights the gaps in the literature.

Chapter 3: Methodology. This chapter discusses the methodology, including the research design used in the study. It also highlights the ethical principles and measures followed in the study to ensure trustworthiness.

Chapter 4: This chapter presents the research results that emerged from analysing the data found in the participants' transcripts and field notes.

Chapter 5: This chapter discusses the findings, summaries and implications in relation to existing literature. It also presents the study's conclusion and recommendations for implementing strategies to curb the non-sustainability of ideal clinic status.

1.11 SUMMARY

This chapter served as an introduction and general orientation to the research study. The focus was on the background and problem statement. This chapter also included the research aims, objectives, and research questions and presented the significance of the study. Key concepts used were clearly defined, and the research methodology was described. The final section of this chapter displayed the structure and layout of the dissertation. Chapter 2 presents the process of literature reviewed relating to the study.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Chapter 1 comprised the introduction and the background of the study. It also provided an overview and the structure of the study. This chapter encompasses the literature pertinent to the research. According to Polit and Beck (2017:107), the primary purpose of a literature review is to summarise evidence on a topic; thus, summarising what is known and unknown. A literature review is a written synthesis and appraisal of the evidence of a research problem.

According to McCombes (2022), a literature review is a survey of scholarly sources on a specific topic. It provides an overview of current knowledge, identifying relevant theories, methods and gaps in the existing research. This literature review focused on critiquing articles about the implementation of the ideal clinic, challenges in the quality standards of healthcare in South Africa (SA) and the Ideal Clinic. Currently, no documented research on post implementation of the ideal clinic or the challenges experienced by nurses in maintaining the ideal clinic post implementation exists.

2.2 SEARCH STRATEGY

Pezaro (2017) defined a search strategy as a structured organisation of terms used to search a database. The search strategy method used for this research was according to the University of South Africa (Unisa) (5 August 2019) Library Guide. The steps used in a search strategy are:

- Conceptualise and Analyse the Research Topic
- Identify Keywords
- Formulate a search strategy using appropriate search techniques

According to Lui (2017:1463), a research topic is a subject or issue that a researcher is interested in when conducting research.

Once the researcher finalises the research topic, the topic must be divided into individual concepts, scrutinised and examined. The concepts identified in this study were translated into keywords to attain the most accurate and relevant information to develop a search strategy to help find appropriate literature. Some of the key terms identified and used to create this search included the following:

- Ideal Clinic (IC)
- Ideal Clinic Realisation and Maintenance Programme (ICRM)
- Challenges in implementation
- PHC facilities
- NHI
- Quality standards in healthcare
- Progress in the implementation of IC

A search technique called the Boolean Operator was used to connect these keywords effectively and have a more focused search. A Boolean Operator helps define the relationship between keywords or groups of keywords using AND, OR and NOT. This allows one to narrow or broaden the search and eliminate irrelevant hits (Unisa, 5 August 2019).

AND : Searches find all of the search terms.

OR : Searches find one term or the other.

NOT : Eliminates items that contain the specified term.

Therefore, using the above technique, the research articles were retrievable via electronic method or retrieved by acquiring assistance from library assistants. The researcher used Boolean Operators to refine the search.

The search strategy included the use of electronic databases:

- International Journal of Environmental Research and Public Health (PMC/PubMed Central)
- Sociology Index (SocIndex)
- Public/Publisher MEDLINE (PubMed)
- Strategic Advisory Group of Experts (SAGE)
- Bio-Medical Centre (BMC)

- South African Medical Journal (SAMJ)
- Global health reports
- South African Health Review (SAHR)
- African Journal of Primary Health Care and Family Medicine
- Curationis
- Research Gate

2.3 THE HEALTHCARE SYSTEM OF SOUTH AFRICA

South Africa's colourful history contributes to the disarray in the healthcare system. According to Coovadia, Jewkes, Barron, Sanders and McIntyre (2009:817), the current fragmented system stems from a historic past dating back to colonialism, Apartheid and post-apartheid. However, it still reflects the distinctive feature of inequity and inequality. The Public Health Amendment Act of 1897 separated health facilities racially and separated curative and preventative services. The segregation of races has been demolished in the current healthcare system of South Africa. However, it can still be described as dysfunctional, with a fragmented style of care divided into two tiers: state-funded health care and private sector funded by medical schemes and dependent on the people's affordability by a payment system. For Maphumulo and Bhengu (2019:1), the current public health system is not ideal for serving the majority of South Africans. Subsequently, the public health system is characterised by long waiting times, understaffing and questionable quality care compared to the efficient private sector, which boasts the best and many specialists. Providing quality health care for all should be non-negotiable. Maphumulo and Bhengu (2019:1) argued that, although the government of South Africa have embarked on quality improvement plans previously in trying to fulfil the constitutional obligation of providing quality health care, the desired effect of achieving a sustainable, long-lasting quality improvement system remains a challenge. Coovadia et al. (2009:817) asserted that the public health system has transformed into an integrated, comprehensive service catering to four concurrent epidemics. However, failures in leadership and stewardship and weak management have led to inadequate implementation of good policies. In December 2015, the African National Congress (ANC) government issued a White Paper on implementing NHI, a step towards achieving UHC in SA.

2.4 UNIVERSAL HEALTH COVERAGE

To improve the healthcare system, South Africa is realigning the variance in accessing health care by benchmarking a new system to ensure fair access for all. Currently, South Africa's health care is transforming towards the PHC-centred approach to attain UHC. This is a commitment to one of the seventeen Sustainable Development Goals (SDG) 3, "Good Health and Well-being". The Sustainable Developmental Goals (SDGs) Country Report - 2019 (South Africa, 2019) Target 3.8 aspires to ensure the health and well-being of all while aiming to achieve UHC and provide access to safe and effective medicines and vaccines for all.

UHC is defined as ensuring that all people have access to needed health services, including prevention, promotion, treatment, rehabilitation, and palliation of sufficient quality to be effective, efficient and free to all (Universal Health Coverage (UHC): What is UHC, 2019). It is a universal leading goal for health reform around the globe. In keeping with the UHC, South Africa adopted the ideal clinic assessments in a programme called the ICRMP to attain equal health care for all by realigning the disparities in the quality of health care and standards provided by the public system. The ICRMP served as a set of standards for the facility to adhere to in an attempt to improve the quality of care provided to its users.

2.5 NATIONAL HEALTH INSURANCE

According to Health Man (2017), the White Paper on National Health Insurance (NHI) defines NHI as a health financing system that is designed to pool funds to provide access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their socioeconomic status. NHI intends to ensure that health services do not result in financial hardship for individuals and their families. This will realign the disparity of accessibility of care by the majority owing to finances. Therefore, NHI will aim to transform the financing of health care in pursuit of financial risk protection by eliminating fragmentation, ensuring technical and allocative efficiencies in how funds are collected, pooled and used to purchase services, thus creating a unified health system that will move closer to the goal of UHC and SDG 2030 South Africa (Michel et al. 2020:1). In providing comprehensive healthcare services, the healthcare system is reorganising in the areas of strengthening PHC,

including PHC re-engineering, hospital services, and EMS, improving leadership and governance in the health system through reforms to the management and governance of clinics, districts and hospitals.

PHC has been labelled the “heartbeat of NHI”, according to former Health Minister Dr Aaron Motsoaledi, in an online article in the Council of Health Service Accreditation of South Africa (COHSASA) (17 October 2013). The first phase of NHI (2012-2017) piloted health services strengthening initiatives targeted at PHC. However, there have been reported flaws still existing in its implementation. The recent study by Murphy and Moosa (2021:1) on the views of public service managers on implementing NHI in primary care revealed that the managers viewed NHI as a social and moral imperative lacking clarity and insight in the NHI Bill as well as the associated implementation strategies. The respondents felt that national and provincial governments continue functioning in a detached and rigid top-down hierarchy.

2.6 PRIMARY HEALTH CARE (PHC)

According to the Alma Ata Declaration on Primary Health Care (WHO-UNICEF, 1978), PHC is essential health care based on practical, scientifically sound and socially acceptable methods and technology. It is universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

In South Africa, since 1994, health care has become free for all and freely accessible to all South Africans accessing it. With these newfound declarations, it was up to this new demographic government to maintain this commitment. Initiatives have been attempted for the improvement of PHC initiated by the NDoH. A timeline of the progress and initiatives since 1994 to improve PHC services is presented in Figure 1.2.

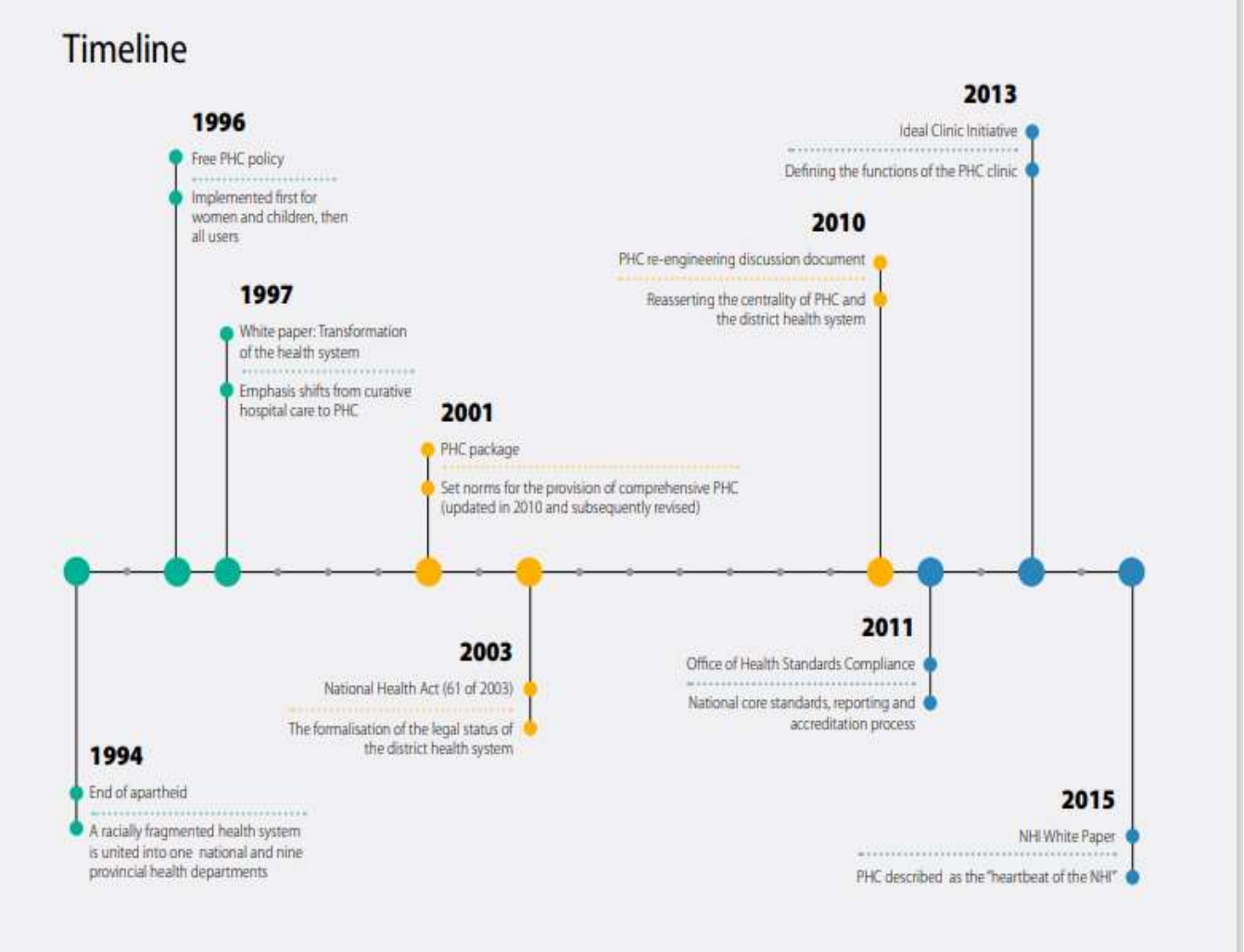


Figure 1.2. Timeline on the Health Care initiatives since 1994. Source: World Health Organisation (2017:5)

From 1996 to 1999, the health system was restructured, and the reconstruction and development plan was implemented. This included the amalgamation of 14 racially divided healthcare systems into one national health system, introducing the district health system and the PHC package. According to Draper and Louw (2007:6), students acknowledged that the state of health care in South Africa needed to change. However, their study revealed that the PHC approach was not workable in South Africa because of various obstacles to its implementation and success (e.g., disorganisation within the health system, a lack of infrastructure, finances and resources).

In need to improve services and with the new reconstruction and development programme, policy implementers and government stakeholders did not inform human resources about the free health care for maternal and child health. This subsequently resulted in an inundation of healthcare patients at the clinics. This attested to the

condition of a population increasingly reliant on the state for all basic services and necessities (Kautzky & Tollman 2008:23).

From 1999 to 2004, the PHC Re-engineering Strategy saw the influx of HIV and a subsequent increase in the mortality rate. The PHC Re-engineering Strategy was benchmarked from Brazil to strengthen PHC in South Africa. This new initiative aimed at integrated services with community care. The initiative ensured that health should go to the community and that health care should not be limited to healthcare facilities. This led to the introduction of ward-based outreach teams (WBOTs) comprising community health workers (CHWs) and a nurse team leader closely associated with the local PHC facility. The WBOTs and CHWs actively engage the community by profiling the household and addressing the health needs of the household itself. Naledi, Barron and Schneider (2011:17) deemed the PHC Re-engineering Strategy essential but not a sufficient condition to achieve improved health outcomes.

The latest strategy to improve PHC care in South Africa was the Ideal Clinic (ideal clinic) initiative. It began its implementation process in 2013 in phases in an attempt to improve health outcomes in a movement towards NHI. It aimed to make all clinics “ideal”, per the definition of the NDoH (2020), which defines an ideal clinic as a clinic with good infrastructure, adequate staff, adequate medicine and supplies, good administrative processes, and sufficient adequate bulk supplies. It uses applicable clinical policies, protocols and guidelines and harnesses partner and stakeholder support. A well-devised checklist and manual, ICRM, was developed to transform all PHC facilities by improving the deficiencies in standards of care and realigning the disparities in quality health care in South Africa. This monitoring tool ensures that quality standards are maintained and adhered to in PHC clinics.

In 1996, the NDoH formulated a health policy called “Restructuring the National Health System for Universal PHC”. This policy stated that a specialised group of registered nurses (PCNs), traditionally known as primary healthcare nurses (PHCNs), are expected to function independently as frontline providers of clinical PHC services within public health facilities (Magobe, Beukes and Müller 2010:2). These PHCNs are registered professional nurses with tertiary training in PHC, holding a postgraduate qualification in Clinical Nursing Science, Health Assessment, Treatment and Care, Regulation 48 (R48), referred to as PHC nurse in this study. These PHC nurses are

the providers of comprehensive health care. They are the drivers of all the new initiatives passed by the NDoH to ensure equitable, effective, accessible, and affordable health care for all. They have authorisations under the Nursing Act in terms of Section 58(1) (S), read in conjunction with Section 56 of the Nursing Act, 2005 (Act No. 33 of 2005), to prescribe drugs according to the standard treatment guidelines from Schedule 1 to 4. Therefore, in keeping with the above history of initiatives, their challenges and experiences in maintaining the ICRM programme are paramount to discovering shortfalls and improvements to sustain a prescribed programme.

2.7 IDEAL CLINIC REALISATION AND MAINTENANCE PROGRAMME (ICRMP)

Hunter, Chandran, Asmall, et al. (2017:111) stated that the ICRM programme was designed in response to the current deficiencies in the quality of primary healthcare services and to lay a strong foundation for the implementation of NHI.

Fryatt and Hunter (2015:24) described the ideal clinic initiative as an internal mechanism designed to respond to the current deficiencies and aimed at modifying existing systems to arrive at and maintain the desired clinic status. This programme also aimed to improve the South African health system's performance in managing priority infectious diseases such as Human Immune Virus (HIV), Tuberculosis (TB) and non-communicable diseases (e.g., diabetes and hypertension) (Onoya, 2021). Implementation of this health system strengthening intervention allows for quality PHC services rendered. It lays a strong foundation for the successful implementation of the NHI standards.

The NDoH conceptualised the ICRM programme in 2013. Operation Phakisa was launched in November 2014 to rapidly implement the Ideal Clinic Model across all PHC facilities, and in 2015, the ICRM programme was officially launched (DoH, 2018:4).

Operation Phakisa is a South African Government delivery programme initiated in 2014 to fast-track the implementation of the country's National Development Plan (NDP 2030) aimed at job creation, poverty alleviation and social equity (President Zuma, 15 October 2014). "Phakisa" means "hurry up" in Sesotho. This, used in all sectors in the South African departments, from environmental affairs to health, is regarded as a results-driven approach to achieving goals.

Stacey, Mirelman, Kreif, et al. (2020:1455) described the ICRMP as an innovative quality improvement policy rolled out in South Africa, which introduces a set of standards for facilities and a quality improvement process involving manuals, district-based support, and external assessment. According to Hunter et al. (2017:111), the NDoH seeks to turn South Africa's PHC facilities into "Ideal Clinics". An ideal clinic has a good infrastructure (i.e., physical condition and space, essential equipment, and information and communication tools), adequate staff, medicines and supplies, good administrative processes, and adequate bulk supplies. The ideal clinic uses applicable clinical policies, protocols and guidelines, as well as partner and stakeholder support, to ensure quality health services to the community (Hunter et al. 2017:111).

A recent study by Muthelo, Moradi, Phukubye, et al. (2021:7) revealed that the challenges toward the successful and effective implementation of the ideal clinic included poor implementation of the ideal clinic, as well as a lack of resources, essential drugs and equipment maintenance.

2.7.1 The ICRMP implementation reveals poor standards

According to WHO (2020), quality of care is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes. In other words, it refers to how an organisation meets its clients' needs and expectations. The WHO further states that quality health services should be:

- Effective – providing evidence-based healthcare services to those who need them.
- Safe – avoiding harm to people for whom the care is intended.
- People-centred – providing care that responds to individual preferences, needs and values.

According to the Merriam-Webster Dictionary, a standard is defined as something established by authority, custom, or general consent as a model, example, or point of reference for the standard of the reasonable person.

In South Africa, a 2012 audit revealed the poor state of public primary health care, including that 94% of primary care clinics reported not having all essential equipment (Health Systems Trust, 2013). This revealed that implementing quality standards for public facilities is flawed and does not meet the quality standards. Since its inception

in 2013/2014, various studies on the implementation process revealed that South Africa battled with non-compliance with quality standards. Some participants verbalised “that it was difficult to mentor new staff or provide in-service training, and it was difficult to ensure that they implement quality health standards due to the high staff-patient ratios”. Hunter et al. (2017:111) explored the ICRM project designed to improve the current deficiencies in the PHC approach, with 32 measurable subcomponents of quality for PHC clinics. In an initial assessment of the clinics in South Africa, 322 clinics were ideal out of 3477 PHC facilities. This amounts to a mere 9.26% of ideal clinics in South Africa. Thus, if the country is committed to UHC, ensuring that the ICRM implementation and transformation can occur is imperative. This can be a daunting but obtainable task. Maphumulo and Bhengu (2019:3) found that South Africa’s current public health care system is riddled with staff shortages and a lack of equipment, supplies, and infrastructure despite being accessed by the majority of the population.

The NDoH of the Republic of South Africa (RSA) (2007: I), as cited by Mogakwe, Ally and Magobe (2019:1), states that “the effort to comply with quality standards is not incidental; however, it is always the result of high intention, sincere effort, intelligent direction and skilful execution”. This is profound and should be the adage of all healthcare professionals who deliver lifesaving services. According to Muthathi, Levin and Rispel (2019:1), the unintended negative consequences of striving for ideal clinic status have created an illusion of quality standards.

The National Health Council gave a directive that all PHC facilities must be ideal within the next three years. A study by Muthelo et al. (2021:7) revealed that implementing the ideal clinic programme remains challenging in PHC facilities. Providing quality patient care seems unachievable.

2.7.2 Healthcare worker awareness and knowledge

According to the Oxford Dictionary, knowledge is facts, information and skills acquired through experience or education, the theoretical or practical understanding of a subject. With the dynamic nature of health care, especially in South Africa, PHC needs healthcare workers to be knowledgeable and up to date with all changes and new initiatives brought about by the NDoH. Nurses have an obligation to continue professional development (CPD).

Nettleton and Bray (2008:205-212) found that nurse mentoring, as a leading factor for quality improvement, is denigrated because of insufficient time and various workload commitments. Only 30.2% of HCWs reported that their knowledge of NHIS was in the form of in-service training through seminars and meetings (Oladimeji, Alabi & Adeniyi 2017:191). Thus, the knowledge of the objectives of the ICRM is essential to influence the sustenance of the programme positively.

Passchier (2017:837) argued that it is necessary to involve all stakeholders when attempting any reform, and vision and collaboration will require input and co-operation from multiple levels. Mabuza, Ogunbanjo, Hlabyago and Mogotsi (2018:101) found that after evaluating the HCW awareness of NHI, they had poor awareness of NHI objectives. This study is significant as it revealed a reason for the potential deterioration of ideal clinic status. Since the movement to PHC from the reconstruction and development programme to PHC re-engineering and now the ideal clinic programme, there seems to be a miscommunication among the various stakeholders who are the key figures in ensuring these programmes succeed. If HCWs have poor awareness, it shows a potential failure to maintain their status. Greater investment in the health workforce and special efforts to involve frontline workers are essential. This study also revealed a lack of involvement in the conceptualisation phase of ICRM. However, there was high participation in the implementation phase.

For Muthathi et al. (2019:9), nurses and midwives are at the heart of progress towards UHC in the SDGs as they play a crucial role in transforming health policies. The study indicated a need for greater investment in the workforce. Staff involvement can create ownership and have a positive impact (Muthathi et al. 2019:8).

No aspect of health care can eventually operate without the other. The quality of care provided to patients, the healthcare worker's knowledge and skill, and the standards of care all directly and indirectly influence each other. A study by Mlambo, Silén and McGrath (2021:1) found that nurses actively engage in CPD to maintain high standards of nursing care through competent practice.

2.7.3 Clinical performance

Clinical performance is the ability of healthcare workers to use their acquired knowledge and skill optimally in providing comprehensive health care to all patients.

Clinical performance and quality standards of care are often lacking in the public sector. Evidence from research by Stacey, Mirelman, Krief, et al. (2020:1543) on the facility standards and the quality of public sector primary care revealed that although there was improved performance in facility standards, there has been minimal improvement in clinical performance. This is a cause for concern, as increased accessibility equals increased healthcare utilisation but may not improve health outcomes. This implies that the health needs of the majority outweigh the capacity of health care provided (Acharya, Taylor, Masset, Satija, et al. 2013:260, as cited by Stacey et al., 2020:1543).

Many facets of the ideal clinic implementation process are patient-focused, having to improve accessibility and reduce the time spent in the healthcare facility. Egbujie, Grimwood, Mothibi-Wabafor, et al. (2018:311) evaluated the impact of the ideal clinic implementation on patient waiting time. They found that positive outcomes in reducing waiting times are achievable depending on the successful implementation of ICRM. Public transport and patient co-operation, community engagement, and patient education are major contributors to reducing waiting time. Some factors that may contribute to poor clinical performance include the workload faced by health service providers, training and motivation, and financial and non-financial incentives. All these are out of the control of the facility managers.

2.7.4 Non-maintenance of the ideal clinic

Since its implementation in 2015, South Africa still fails to maintain its ideal clinic status. According to South Africa's annual reports, South Africa has 2 100 PHC clinics. Since 2017, the performance of obtaining ideal clinic status has been monitored. However, despite the improvement since implementation, a decline is now evident. The decline in maintaining ideal clinics is of note to the country as a whole.

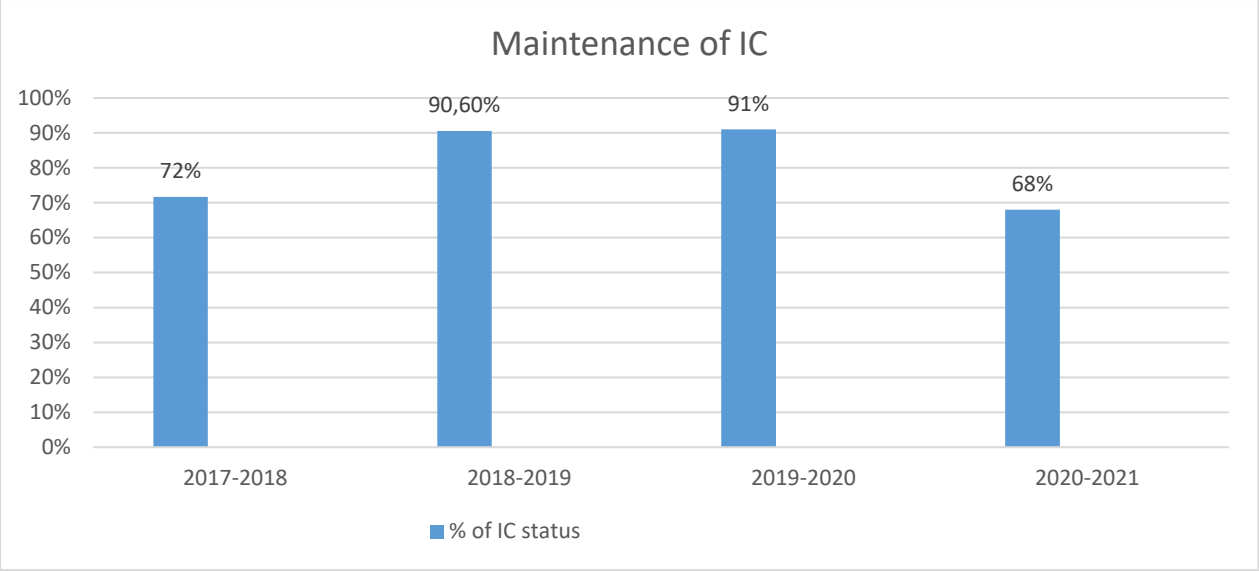


Figure 2.1: Maintenance of Ideal Clinic

The reasons for non-maintenance remain under-researched. Therefore, the nurses' challenges and experiences as drivers of PHC to ensure quality health care will highlight the main factors behind it.

2.8 CHALLENGES IN THE IMPLEMENTATION OF AN IDEAL CLINIC

Muthelo, Moradi, Phukubye, et al. (2021:1) asserted that implementing the ideal clinic programme remains a challenge in PHC facilities; therefore, providing quality patient care is not possible. In order to improve the identified gaps in the implementation of the ideal clinic programme, the NDoH in South Africa should consult with the end-users before and during the implementation to improve the quality of patient care. A lack of knowledge and training in the ideal clinic programme, poor infrastructure, the shortage of equipment, and inadequate provision of support by line managers were some of the challenges faced by professional nurses in implementing the ideal clinic, all resulting in poor-quality patient care.

2.9 LITERATURE GAPS

Since implementing the ideal clinic and ICRM, literature evaluating the progress and challenges in implementing the ideal clinic programme has emerged. This research dates back to 2017 and includes the following: evaluating the patients' experiences in an ideal clinic, the impact of 'Ideal Clinic' implementation on patient waiting time by Egbujie, Grimwood, Mothibi-Wabafor, Fatti, Tshabalala, Allie, Vilakazi and Oyebanji

(2018:311), evaluating the PHC managers in the implementation, and evaluating nurses experience in implementing ideal clinic in Limpopo Province, South Africa. Most research focused on patient satisfaction, the impact of ideal clinics on waiting time, and the effects of having ideal clinics on quality care.

There is currently no research post implementation of the ideal clinic, especially none conducted in KZN, about nurses' experiences and/or challenges in maintaining the ideal clinic status post implementation or identifying the challenges nurses experience while trying to maintain an ideal clinic status. Research has been documented on the planning, progress and challenges in implementing an ideal clinic. However, since its implementation, there has been no evidence documenting the challenges faced in maintaining ideal clinic status. Therefore, this research aimed to explore the challenges experienced by nurses in maintaining ideal clinic status, hoping that their perspective on their challenges will provide purposive change strategies to maintain ideal clinic status.

2.10 CONCLUSION

The literature review discussed the process of the healthcare system. It also explored the facets accountable for the progress of the healthcare system to a universal healthcare system that is equitable and of the highest standard. Since the implementation of ICRMP in 2013, SA has been reeling from the strains of poor implementation and therefore poses a threat to sustainability post implementation. This research identified the possible nurse-related challenges that hinder the progress of the UHC for all citizens in SA via the quality improvement strategy of the ICRM programme post implementation. The next chapter will discuss the process and methodology for data collection used in this study.

CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

This chapter describes the architectural design of the study, known as the research methodology. This study's research design, method, sampling, data collection methods and ethical considerations are described. This study aimed to explore and gain more insight into the nurse-related challenges experienced by primary healthcare nurses in maintaining ideal clinic status, where previously achieved and discover trends in compliance to ideal clinic status.

3.2 RESEARCH DESIGN

Polit and Beck (2017:743) defined a research design as the techniques used to structure a study and gather and analyse information systematically. This section discusses the research paradigm and approach. It also describes the research methodology in detail.

3.2.1 Research paradigm

A paradigm is a worldview, a general perspective on the complexities of the world (Polit & Beck, 2018:39). According to Lincoln and Guba (1985:308), as cited in Polit and Beck (2017:14), a paradigm comprises four elements: epistemology (the relation of the inquirer to those researched), ontology (what is the nature of reality), methodology (how is evidence best obtained), and axiology (what is the role of values in the inquiry). The constructivist paradigm, also known as interpretive, underpinned this research. Honebein (1996:11-12), cited by Adom and Ankrah (2016:2), described the constructivism paradigm as an approach that asserts that people construct their own understanding and knowledge of the world through experiencing things and reflecting on those experiences. In relation to the purpose of this study, which was to gain more insight and an in-depth understanding of the PHC nurses' experiences, the constructivist/interpretive paradigm was considered the most suitable. It tends to rely upon the "participants' views of the situation being studied" (Creswell, 2003:8), which enabled the researcher to explore and interpret the experiences of PHC nurses.

3.2.2 Research approach and design

According to Creswell (2014:34), a research approach is a plan and procedure for research that describes the steps from broad assumptions to detailed methods of data collection, analysis and interpretation. A research design describes how a researcher combines a research study to solve a research question or fulfil the research objectives. Hunter, McCallum and Howes (2019:2) suggests that “a qualitative exploratory design allows the researcher to explore a topic with limited coverage within the literature and allows the participants of the study to contribute to the development of new knowledge in that area”. In this study, the researcher’s objectives were to explore the challenges and experiences of nurses in maintaining ideal clinic status. The researcher also aimed to explore nurses’ perception of quality standards in an ideal clinic and describe their attitude toward achieving ideal clinic status. Furthermore, a research approach is an organised plan detailing the study, the researchers’ ways of collection, information on how the study will obtain its conclusions, and the limitations of the research (Dagar 2019:36).

3.3 RESEARCH METHOD

Polit and Beck (2017:743) described research methodology as “the techniques used to structure a study to gather and analyse information systematically”. The research approach most appropriate to the above paradigm is qualitative research. Qualitative research explores and understands the relationship between individuals and groups ascribing to a problem (Creswell 2014:32). In this qualitative research approach, the researcher aimed to explore and gain an in-depth understanding of the challenges experienced by the nurses in an inductive style of in-depth probing to encourage nurses to express their challenges and experiences in not maintaining ideal clinic status. Therefore, this research adopted an exploratory, inductive qualitative research approach.

3.3.1 Sampling

3.3.1.1 Setting

This study was conducted in iLembe District, in the sub-district of Kwa-Dukuza, situated north of KwaZulu-Natal. This district has seven PHC clinics and two

community health centres (CHC). The study occurred in two of the seven PHC facilities in the sub-district. According to the District Health Information System (DHIS, 2022), the two clinics chosen average a combined catchment population of 84 533, and have a headcount of approximately 6000 to 8000 per month. The common denominator for choosing these two sites was that they are high-volume sites that fit the definition of the ideal clinic and had lost their status or have not maintained or improved on their previously attained status. The choice of the number of clinics selected has its basis in accessibility and logistics (see the map of KZN and iLembe).

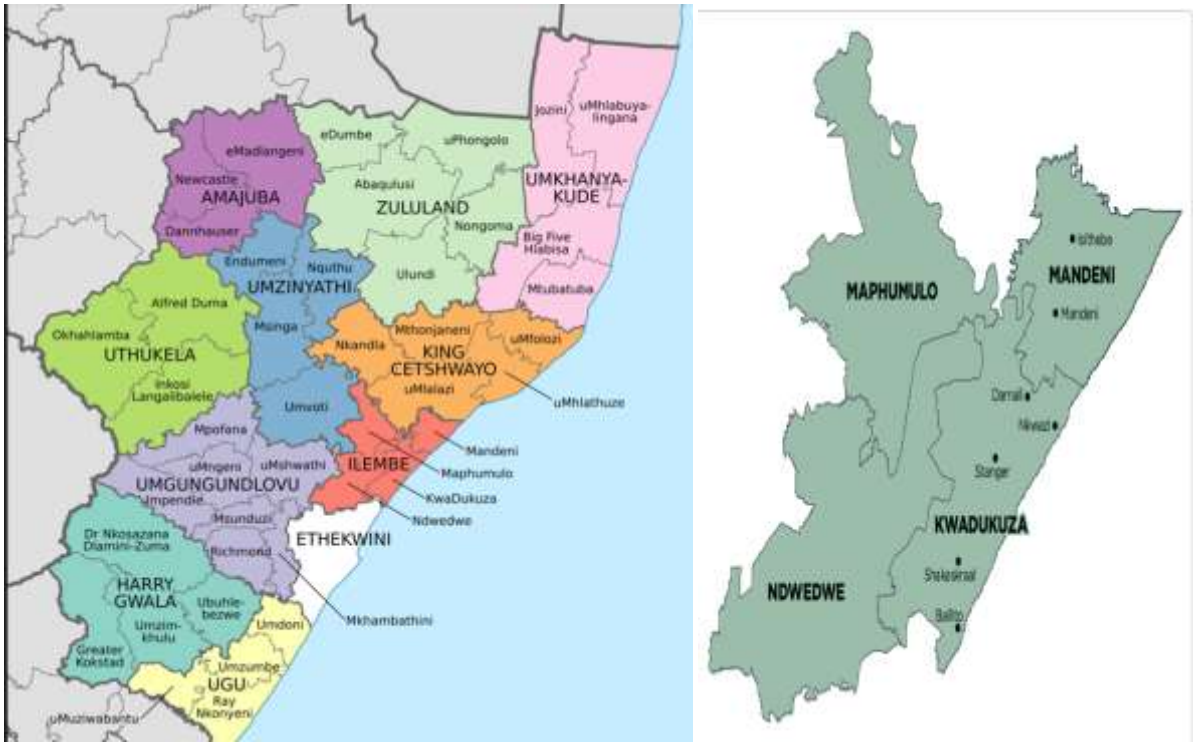


Figure 3.1: Map of KZN

3.3.1.2 Population

According to Polit and Beck (2017:249), the population is defined as the complete combination of cases in which the researcher is interested. South Africa's nursing component is differentiated into three categories of nurses: registered nurses, with/without speciality in PHC (RNs); enrolled nurses (ENs); and enrolled nursing auxiliary (ENAs). Each category has its own scope of practice (R2598) according to their level of education, guided by acts laid down by the South African Nursing Council (SANC) that are ascribed to RNs. RNs have three functions, dependent, independent

and interdependent, by which they practice professionally. Dependent function means that the nurse`s function is based on the law which authorises her practice, as well as on common law and relevant statutory laws in accordance with her acts and omissions. The interdependent function relates to the inter-relationship of the nurse with the patient and other members of the health team and independently. The independent function of the nurse has two dimensions. The first dimension relates to all those aspects inherent in nursing diagnosis, treatment and care that are the normal prerogatives of the nurse. The other dimension is concerned with how she carries out any of her duties as an RN, whether as an independent or interdependent function (Searle, 1982:20). In qualitative studies, a population is not chosen for the purpose of generalisability but rather to establish who are suitable to take part in the study (Polit & Beck 2017:491). Therefore, the study's target population were RNs trained with a speciality in PHC, having worked in a PHC setting since implementing an ideal clinic.

Inclusion criteria

Not all registered nurses were included in this study, as they did not fit the eligibility criteria. For Polit and Beck (2017:250), inclusion criteria are detailed characteristics of individuals selected for inclusion in the study. This study's inclusion criteria included:

- A registered nurse with a trained speciality certificate in PHC known as PHCNs;
- Employed in DOH since the implementation of the ideal clinic; and
- PHCNs actively involved in the process of implementation and or maintenance of the ideal clinic.

According to SANC competencies for Primary Care Nurse Specialists, PHCNs are professional nurses with additional qualifications in primary care nursing, providing direct care to patients with all types of illnesses and ailments. They can competently conduct a physical assessment, diagnose illnesses, and prescribe treatment (SANC, 2014). Based on the above, the researcher included PHCNs in this study.

Exclusion criteria

Exclusion criteria are not the opposite of inclusion criteria. Instead, they identify attributes that prevent a person from being included in a study (Gray et al., 2017). In this study, it was:

- Employed in DoH for less than six months.
- No training in the speciality of PHC.

In order to recruit participants, the researcher distributed information leaflets to all the PHCNs in both facilities. Contained in the leaflet was the purpose of the studies, the reasoning behind this research and the relevant ethical aspects. Thirteen PHCNs showed their interest in participating in the study. The final sample size was determined by data saturation. Data saturation refers to the point in the research process when no new information is discovered in data analysis, and this redundancy signals to researchers that data collection may cease (Faulkner & Trotter, 2017). All 13 PHCNs were interviewed; consent was obtained prior to the interviews.

3.3.1.3 Sample

Creswell (2012: 142) stated that a sample is a subgroup of the target population that the researcher plans to study to generalise the target population. According to Bhandari (2020:7), a population is an entire group from which the researcher draws conclusions. Each facility had all categories of nurses employed at their institution, as recognised by SANC. However, only registered nurses can specialise in PHC with formal training and education, thereafter identified as PHCNs. A sample is a specific group from which to collect data. The sample size is always less than the total size of the population. Purposive sampling is ‘used to select respondents that are most likely to yield appropriate and useful information’ (Kelly, 2010: 317 citied by Palinkas, Horwitz, Green, Wisdom, Duan, Hoagwood, (2015:4). A homogeneous purposive sample is one that is selected for having a shared characteristic or set of characteristics (Nikolopoulou, 2022), therefoe the choice of sampling. The sample size was initially considered 18 PHCNs employed in these two clinics or determined until data saturation was achieved.

Initially, Clinic A had 15 RNs, nine PHCNs, three general nurses with midwifery and three general nurses. The three general nurses worked on a contract basis to assist with the COVID-19 pandemic. At the time of data collection, one PHCN had since resigned, two PHCNs were on long-term sick leave, and one was on vacation leave. Only five PHCNs were interviewed.

Clinic B had 12 RNs, with nine PHCNs, one advanced midwife and two general nurses with midwifery. Eight PHCNs were interviewed at this facility, with one PHCN on vacation leave. Altogether, 13 PHCNs were interviewed.

3.3.2 Data Collection

Gray, Grove and Sutherland (2017:674) described data collection as a precise and systematic gathering of information for the purpose of the study process and of selecting subjects. The data collection instrument (see Annexure 6: Data Collection Instrument) that guided the data collection approach and the data collection process or method is discussed further in this section.

3.3.2.1 Data collection approach and method

Data collection tool

A semi-structured interview is a method that relies on asking questions within a predetermined framework. It can be a mix of structured and unstructured, unplanned questions (George, 2022). The interview guide developed by the researcher was a mix of open-ended questions allowing for flexibility. It was differentiated into three sections to fulfil the study objectives and answer the research topic. The first section of the interview guide comprised questions relating to the biographical data of the participant. The second section entailed the core questions related to the research question. The third section comprised open-ended probing questions. The questions and probes formed part of the interview schedule and acted as a guide to the study topic.

The researcher started the interview with simple questions focusing on biographical details from years of experience in the PHC setting and confirming their nurse category to establish rapport. Once the biographical data was obtained from each participant, the following core questions followed:

- Describe your level of training or knowledge of the ideal clinic since implementation.
- As a PHC nurse, what are some of your experiences in maintaining ideal clinic status?
- Describe the challenges that you face whilst maintaining an ideal clinic.

- After that, most of the questions emanated from the participants 'responses to the core questions, followed by probing questions:
- What do you think of an ideal clinic?
- Describe the reasons why you think an ideal clinic is a workable plan?
- Focus on your knowledge of the ideal clinic, and elaborate on the changes it has brought to the institution.

- What support structures do you have in place to assist you?

- Describe your role played in maintaining an ideal clinic.

- Prompts included, for example, "Please elaborate" and "What do you mean?" to encourage the participants to elaborate and give more information.

Prompting the participants further allowed them to share more with the researcher. The interview sessions for each participant ranged between 45 to 60 minutes and continued until their experiences, challenges and explanations were explored completely. Data saturation was reached after the 13th participant. Data saturation involves sampling until no new information is obtained and redundancy is achieved (Polit & Beck 2018:293).

Data collection approach and method

Data collection is a systematic process of gathering observations or measurements (Bhandari, 2020). The study aimed to explore and describe the lived experiences of the challenges faced by PHC nurses in maintaining ideal clinic status. In order to gain an in-depth understanding of the perceptions and opinions of the PHCNs, the data collection method was in-depth semi-structured exploratory interviews. This method allowed the researcher to gain individual perspectives, experiences, and the full nature of this research problem.

Before the data collection process, an email was sent to the Deputy Director of the iLembe District (Annexure 5: Permission From ILembe) to seek permission to collect data in two clinics in the district. Written permission was granted. Also, the researcher contacted the relevant clinics via the Operational Manager (OM) on suitable dates to access the facility to gather data.

The data collection took place over eight days, from 24 April to 6 May 2022. All prospective participants at the respective institutions were handed the participant information leaflets and invited to participate in the interviews. After they consented to participate, appointments were arranged according to their preference in date, time and venue for data collection, especially considering their comfort and safety due to COVID-19. All the participants preferred to have the interview at their respective places of employment as it prevented unnecessary travel expenses incurred by them. Also, they felt safe and at ease in the work environment. Although the interviews were conducted at the respective institutions, in consultation with the OM, service delivery was not compromised. The OM provided a conducive environment for conducting the interviews in an unused office.

Before the interviews commenced, the researcher explained all ethical aspects, such as confidentiality, respect and voluntary participation, to each participant, including the purpose and benefits of the study. The researcher advised that they could ask any questions for clarification purposes. The participants signed the consent forms when they were satisfied with all the information provided.

In order to ensure recording on the audio recording device, a test run of casual conversation was recorded with permission from the participants to make them feel comfortable and at ease. The audio recording was done after obtaining permission from the participants and described in the consent form. When the participants were comfortable, the researcher commenced with semi-structured interviews, beginning with biographical data such as age and educational standard.

3.3.2.3 Characteristics of the data collection instrument

DeJonckheere and Vaughn (2019:1) described semi-structured interviews as a data collection method that involves asking participants open-ended questions and following up with probing questions to explore their responses and the topic of interest. In qualitative research, semi-structured interviews are a blend of structured and unstructured interview questions to collect new data and explore participants' thoughts and beliefs about a particular topic. One of the characteristics of this data collection tool is a formal interview between the researcher and participants. The interview guide developed and utilised by the researcher used open-ended questions to discuss the topics in detail, enabling deep exploration of the participants' experiences, beliefs and

thoughts. Since it has both the elements of structured and unstructured interviews, the strengths of both research methods are present. This could benefit the interviews as they produce reliable, comparable data and offer the researcher the flexibility to ask follow-up questions. The advantage of having pre-set developed questions is that it helps the researcher to focus on the topic of interest and avoid distractions.

3.3.3 Data Analysis

For Dudovskiy (2018), narrative qualitative data analysis is a method involving the reformulation of stories presented by respondents, considering the different experiences of each respondent. In other words, narrative analysis is the researcher's revision of primary qualitative data. Data management in qualitative analysis is fulfilling certain tasks. Data analysis is collecting, cleaning and organising data. This is the ideology behind data analysis. Data analysis aims to discover, communicate, bring order and make sense of the data collected (Polit & Beck 2017:725). As described by Polit and Beck (2018:396), the researcher also used this sequential method:

- Transcription of data – it is the initial and most critical step followed by the researcher. In this study, the researcher transcribed the recorded interviews verbatim, writing down every word uttered by the participants. No transcriber was outsourced.
- Developing a category scheme – organising data into different smaller categories for retrieval and review later. This was achieved by repeatedly reading data for analysis.
- Coding of qualitative data – the process involves changing the data collected and summarising and representing it to give an account of the phenomena recorded.

Originally described by Braun and Clarke (2006:78) and revised by Caulfield (2021), thematic data analysis refers to the method of analysing qualitative data. It is applied to a set of texts, such as interview transcripts. By using thematic data analysis, the researcher closely examined the data to identify common themes (i.e., topics, ideas and patterns of meaning that come up repeatedly).

This research analysed the collected data using the thematic qualitative data analysis method with inductive coding. The process entailed the following:

- Familiarisation with the data. All the data were prepared and organised by transcribing the in-depth interviews with the participants verbatim. This took the researcher approximately 48-102 hours. All transcripts were collated for review and exploration of all the data.
- Coding. The researcher read the transcripts repeatedly to identify and highlight the interesting significant details the participants said. When the initial code creation occurred, those codes were reviewed, revised, or combined into themes. These themes were then presented in a cohesive manner. This allowed for a condensed overview of the main points that recurred throughout. Identifying patterns and developing themes align with the objectives of what the researcher attempts to find out.
- Reviewing the themes. In reviewing the themes, the researcher tried to ensure that the themes were useful and accurately represented the data. The researcher aimed to answer questions such as “Is there anything missing?” and “Can we improve on the themes?”
- Defining themes. This involved formulating exactly what was meant by each theme and figuring out how it helped to understand the data. Once the final list of themes was developed, a name was given, defined and described to each.
- Final analysis. The final analysis was produced by selecting extracts of the lived experiences of the registered nurses and narrating them back to the research question and the study objectives by summarising the themes and subthemes that emerged from data analysis. It also reflected the RN nurses’ experiences and challenges in maintaining ideal clinic status. After that, all analysis of data was written up in the results aspect of the research, addressing each theme separately.

3.4 RIGOUR OF THE STUDY: TRUSTWORTHINESS

The United States Department of Health and Human Services (2018) describes scientific rigour as the strict application of the scientific method to ensure unbiased and well-controlled experimental design, methodology, analysis, interpretation and reporting of results. According to Polit and Beck (2016:747), trustworthiness is the degree of confidence qualitative researchers use in their data collection and analysis. The five processes of trustworthiness are assessed by the criteria of credibility,

transferability, dependability, confirmability, and authenticity, the gold standard for trustworthiness according to Lincoln and Guba (1985) (Polit & Beck 2016:559).

3.4.1 Credibility

Lincoln and Guba (1985:1), as cited in Polit and Beck (2018:415), maintained that credibility refers to confidence in the truth-value of the data and interpretations thereof. Simply put, it means having confidence in the truth of data and interpretations of it, and qualitative researchers must strive to establish confidence in the data. Two aspects highlighted by Lincoln and Guba (1985): enhancing the believability of the findings and the steps taken to demonstrate credibility to external readers.

In this research, the researcher enhanced believability by thoroughly describing the data collection process, the study setting, the population used as study participants, and the prolonged engagement. This ensured integrity by investing time in data collection, thereby building the trust of the participants as well as enabling the researcher to have an in-depth understanding of the culture, language or views of the participants under study.

This research also enhanced credibility by transcribing audio recordings of all interview sessions verbatim. This ensured the proper capturing of participants' voices as proof of participants' data collection. The researcher coded and re-coded the transcripts to validate the themes that emerged from the data analysis.

3.4.2 Transferability

Transferability, analogous to generalisability, is the extent to which qualitative findings have applicability to other settings or groups (Polit & Beck, 2018:416). The aforementioned two aspects of trustworthiness are synonymous with internal validity in quantitative research. For Lincoln and Guba (1985), the researcher’s responsibility is to provide sufficient descriptive data so that readers can evaluate the applicability of the data to other contexts.

The transferability refers to a detailed description of the research methodology, a semi-structured interview by consented individuals using a prescribed interview guide to meet objectives.

3.4.3 Dependability

Dependability refers to the stability (reliability) of data over time and conditions (Polit & Beck, 2018:416). The question to answer is: Would the findings of the enquiry yield the same results if replicated? Dependability refers to consistent and stable evidence (Polit & Beck 2012:585).

An interview guide is used in an in-depth interview to answer objectives and research questions so that the results will be similar if the study is replicated. Dependability is achieved by describing the data collection method and the process of data analysis and interpretation. Dependability was ensured by keeping all data stored on a separate memory stick, password-protected and encrypted, for safekeeping and retrieval if needed.

3.4.4 Confirmability

Confirmability refers to objectivity, the potential for congruence between two or more independent people about the data's accuracy, relevance or meaning (Polit & Beck, 2018:416). It is the state of being objective in the results of the study and preventing bias in the participant's voice. Preventing bias in this research allowed the researcher to record all information from the participant verbatim, using the semi-structured interview guide. An independent coder who was not part of the study and did not know the study site was used to verify the coded data to ensure that the findings were based on the data collected.

3.4.5 Authenticity

Authenticity refers to the extent to which researchers fairly and faithfully show various realities. Authenticity emerges in a report when it conveys the feelings and tone of participants' lives as they live (Polit & Beck, 2018:416).

Ensuring authenticity entailed having experienced what the participant had experienced. It also implied presenting the results based on the responses provided in the in-depth interviews and the experiences of PHC nurses through audio recordings (verbatim quotations) of the interviews.

3.5 SUMMARY

This chapter highlighted the detailed account of the research design and method used to achieve the study's purposes and objectives. This research took on an exploratory, inductive qualitative research approach in order to gain insight into the challenges experienced by PHC nurses in maintaining ideal clinic status post implementation. An in-depth description of the research paradigm, the approach and sampling, and the details of the data collection instrument and data collection were provided. Measures to ensure trustworthiness and ethical principles were also described. Although the data analysis process outlined the results that emerged from the data, the next chapter will present the analysis.

CHAPTER 4

ANALYSIS, PRESENTATION AND DESCRIPTION OF THE RESEARCH FINDINGS

4.1 INTRODUCTION

This chapter presents the findings based on the data analysis of the research process described in Chapter 3. These findings are presented and described in relation to the purposes of the study. The main purpose was to explore and gain more insight into the nurse-related challenges experienced by primary healthcare nurses in maintaining ideal clinic status, where previously achieved and the effects on compliance to ideal clinic status. It also aimed at exploring nurses' perception of quality standards in an ideal clinic and their attitude toward achieving an ideal clinic. The objectives, which guided the study, were to:

- Explore the challenges and experiences of nurses in maintaining ideal clinic status.
- Explore nurses' perception of quality standards in the ideal clinic.
- Describe their attitude toward achieving ideal clinic status.

These objectives will be explored further in this chapter.

4.2 DATA MANAGEMENT AND ANALYSIS

According to Lucas (2022:1), qualitative data management and analysis aim to order, structure and give meaning to collected data. The data management process followed was initially transcription of data, followed by thematic analysis. Thematic analysis is a method for analysing qualitative data that entails searching across a data set to identify, analyse and report repeated patterns (Braun and Clarke 2006:78 revised by Caulfield 2021).

.

Figure 4.1: Thematic Analysis Data Process (source: Braun and Clarke 2006:78)

Data were collected using a qualitative approach and analysed via a thematic analysis process. The results were presented by first sharing the demographic details and then superordinating themes, further interpreting themes and subthemes. There was no co-coder used in the data analysis. The researcher opted to continue with this procedure without the assistance of a coder as a learning curve. However, a co-coder would have been asked to sign a confidentiality clause ensuring that the results of this study and data were not discussed on another platform and to protect the research participants.

4.2.1 Development and testing of the data collection instrument

The researcher developed the data collection instrument in the form of predetermined questions. The semi-structured, open-ended questions were developed per the purpose of the study to answer the research questions. The data collection instrument was pretested using a small convenience sample of respondents to provide feedback on the proposed questions. This sample of respondents was not part of the larger sample size of the study. The interview sessions were timed, and data was checked to see if it aligned with answering the research question. No changes were made to the original data collection tool.

4.3 RESEARCH RESULTS

The results depicted here are the actual results of the data collected. This was done in accordance with adherence to all applicable ethical considerations. The names of the participants and the research setting remained confidential. The researcher used

codes such as P001, P002, and P013 so the reader could not identify the participants. The verbatim quotations per the participant's interview transcripts were indented and written in italics after discussing each theme. Codes were used at the end of each quotation. The sequence of the unique codes was in the order of the interviews conducted. For example, the letter P represents a participant, followed by a specific number (P001). This specific number was given in the order of the given interview.

4.3.1 Biographical data

Eighteen Clinical Nurse Practitioners (PHCN) were identified in both healthcare facilities, and 13 out of 18 PHCNs interacted in semi-structured interviews. This indicated a response rate of 72.2%. All the PHCNs employed in both facilities had between one and 22 years of experience in a PHC setting. They were directly or indirectly exposed to Ideal Clinic. Table 4.1 shows the code and years of experience per PHC nurse. A PHCN refers to a registered nurse with an additional qualification in either a diploma or a degree in PHC (PHC).

Table 4.1: Summary of demographics

Participant	P001	P002	P003	P004	P005	P006	P007	P008	P009	P010	P011	P012	P013
Years of Experience	13yrs	1yrs	20yrs	20yrs	22yrs	18yrs	14yrs	13yrs	7yrs	10yrs	10yrs	15yrs	2yrs
Age	40yrs	47yrs	44yrs	45yrs	64yrs	55yrs	43yrs	45yrs	39yrs	46yrs	56yrs	59yrs	45yrs
Qualification	PHCN	PHCN	PHCN	PHCN	PHCN	PHCN	PHCN	PHCN	PHCN	PHCN	PHCN	PHCN	PHCN

Table 4.1 shows a trend of having seasoned PHCNs in the facility in terms of age. Approximately 53.8% of the participants were between 41 and 50 years, 23% were between 51 and 60, and 7.7% were aged between 61 and 65.

4.3.2 Themes and sub-themes emerged from the process of data analysis

The identified themes presented and described in the data analysis will be done with the support of the original verbatim quotations from the transcripts of the semi-structured interviews. This was done to provide evidence and a clear representation

of lived experiences of PHC nurses. According to Ritter (2000), superordinate themes represent a superior order or category within a classification system. A theme is a central topic, subject, or message within a narrative. Five superordinate themes emerged in this study. Table 4.2 illustrates the relationship between the superordinate themes and the themes and sub-themes.

Table 4.2: Themes and sub-themes

SUPERORDINATE THEMES	THEMES	SUB-THEMES
4.3.2.1 Challenges experienced by PHC nurses in maintaining ideal clinic	**4.3.2.1.1** Absence of vital resources	**4.3.2.1.1.1** Inadequate and under-skilled staff **4.3.2.1.1.2** Deficient emergency equipment and supplies **4.3.2.1.1.3** Unsuitable infrastructure
	4.3.2.1.2 Substandard procurement processes	**4.3.2.1.2.1** Stock outages **4.3.2.1.2.2** Financial constraints **4.3.2.1.2.3** Non-Stock Items (NSI)
	4.3.2.1.3 Poor working conditions	**4.3.2.1.3.1** Low morale **4.3.2.1.3.2** High workload/Burnout
4.3.2.2 Trends in compliance with the ideal clinic	**4.3.2.2.1** Preparation vs Maintenance **4.3.2.2.2** Actual trends: Non-compliance	**4.4.2.2.2.1** Borrowing of items **4.4.2.2.2.2** Dishonesty **4.4.2.2.2.3** Fictitious Results **4.4.2.2.2.4** Sourcing items privately

4.3.2.3 Insufficient Monitoring and Evaluation	**4.3.2.3.1** Discrepancies in assessments **4.3.2.3.2**Insufficient systems **4.3.2.3.3** Non-existent support systems	
4.3.2.4 Nurses' Attitudes to Quality Standards	**4.3.4.1** Level of training and knowledge in the ideal clinic **4.3.4.2** Quality vs Quantity	
4.3.2.5 Nurses' Perceptions of Ideal Clinic	**4.3.5.1** Positive perceptions **4.3.5.2** Negative perceptions **4.3.5.3** Recommendations by PHCNs	

4.3.2.1 Challenges experienced by PHC nurses in maintaining ideal clinic

This superordinate theme emerged from the core question that asked PHC nurses about their "challenges experienced in maintaining an ideal clinic". As discussed in Chapter 2, healthcare facilities, especially PHC facilities, showed a downward trend in maintaining ideal clinic status post implementation. Therefore, the challenges faced by PHC nurses as the forerunners of the PHC facilities sought exploration. This superordinate theme had the following themes and sub-themes:

- Absence of vital resources: Inadequate and under-skilled staff
  Deficient Emergency Equipment and Supplies
  Unsuitable Infrastructure
- Substandard procurement processes
- Poor working conditions

4.3.2.1.1 Absence of vital resources

Any resource which is capable of providing healthcare services is important. However, the three vital resources in health care are financial, human and material resources. They cannot work independently. They exist dependently. This theme included several sub-themes, which will be discussed next.

4.3.2.1.1.1 Inadequate and under-skilled staff

> *"But as the time goes by, all these things that we have put together fall out of place because we find that we are short-staffed and we do not have the time to maintain the clinic the way that it was supposed to be… we are short-staffed, and some staff are sick, and that adds to it."* (P005)

> *"While I'm here is just that we don't have enough resources. A human resource is a short-staff, and here, since I came here, there's no OM. We are having acting nurse as an OM. She don't have even time to do admin because always the clinic is [always] full. She used to see the patients."* (P008)

> *"This staff is a big problem for shortage of staff. We are failing even to do balancing to the department. So by that way, most of the things that they implement we failed to reach because of shortage of staff. But what I've noticed with overpopulation we do have a lot of clients while the staff is not enough. So by that way, we fail to do some of the procedures that we were supposed to. Because we don't balance."* (P012)

The possible reasons for inadequate staffing were discussed further with the participants. Some responded that there is no prompt filling of vacant posts and the possible high staff turnover.

> *"I think it is because of government. I don't know whether he is running short of money because some people are leaving, are leaving their post; they are resigning. Some have died. Because their posts are not filled in. In fact, they are frozen. So, we hear that is not enough funds for that. Maybe they will tell you wait for another financial year. When the new financial year comes, nothing happens. People keep on leaving so, which means the problem is with the top government."* (P011)

> *"Yeah, okay, I think. The reason for staff shortage is from this clinic. It's a turnaround. It seems it's high. It's high; people come and go. If there is a poor rewards, maybe? I'm not sure of that, but there isn't. That's usually, cause if the system it's not okay. The whole system. If it's not okay, it does cause turn around, and we don't have even operational manager. Can you imagine the*

clinic? The whole clinic just run for months without an operational manager." (P009)

Another aspect of inadequate staffing was the under-skilled staff at the facility. PHCNs are regarded as skilled resources to run the PHC facilities.

> *"The clinic, especially with qualifications, you can bring a number of staff, but they need to have a qualification for PHC because this is a PHC setting. So, when we have like other qualified nurses, their hands are tied. So, the clinical nurse practitioners or the PHC nurses end up getting burnt out because of under-skilled workers."* (P003)

> *"For this facility, we don't have the adequate staffing in terms of maintaining the ideal clinic because our staff have been sick, and some have left. We haven't been received, replaced with PHCNs. So you've got like junior sisters… they haven't been, haven't done PHC, so it becomes difficult for us to ensure that you know ideal clinic is maintained because we don't have the basic that's the staffing firstly…"* (P001)

> *"I can see. Hey, maybe the thing can say is the absence of operational manager. It's also a huge problem because operational manager is the one who oversees and the staff help."* (P009)

4.3.2.1.2 Deficient Emergency Equipment and Supplies

Equipment and supplies (medicines) also identify as another major resource that seems to be deficient. In order to provide comprehensive, efficient and quality care to the community, all equipment and supplies must be readily available at all times.

> *"There's a lot of times that we find we are short of equipment, we short of several things in the clinic, and we can't put it together to even pass the ideal clinic."* (P005)

> *"Some of the things first thing is the resources. We don't have. We don't have enough the resources to reach all the goals that they need us to achieve… Even to the medication as well, there is a time when we don't have some of the items."* (P012)

"Sometimes some of the drugs that are main drugs that will be out of stock." (P006)

More often than not, vital equipment was not available. Thus, by conducting a spot check or a random ideal clinic assessment, many clinics may find a non-compliant status or drop from gold to silver or bronze. As stated by P005, *"we can't put it together to even pass the ideal clinic."*

A probing question was asked to investigate why equipment and supplies were deficient and the contingency plans in place to acquire the equipment. There seems to be a need to comply with the ideal clinic assessments even if unable to procure items.

"Some equipment we borrowed from other facilities and some we bought it from the pharmacy. So it's like that". (P008)

"…but we don't have all that because even equipment is not sufficient in such a way that people, if we are for assessment with that assessment, you have to borrow some equipment so that it will look so that we will conform to the ideal". (P011)

"We don't have everything like we need. Like equipment sometimes. When during assessment, sometimes we borrow equipment from other clinics just to meet the target, which is not good because we returned them back when the assessment is done." (P002)

"It's not in a good place, it's equipment. You don't have the equipment. We don't know what to use. So it's really hard. I saw even the emergency trolley here. It's not like really for emergency. Because if they know there is no stock." (P013)

"Sometimes, if we're going to get assessed, we need to borrow the instrument for emergency trolley, all of all of those stuffs. you know, but ja." (P008)

"When we have an assessment, we buy it to make sure it's on the trolley. Like ET tubes and stuff like that. If we don't have it, if our stores on stock, then we go and look for it and buy it with our money." (P001)

Staff felt the need to comply or felt compelled to produce good results for the assessments instead of strategising for better processes and systems.

> *"Now we are having. I request one of the pharmacy manager. If she can help us with those instruments that we don't have, and she said I must send the list so that she can do a quote for us and how much for that stuff so that we can get. We can buy for us, so that just."* (P008)

4.4.2.1.3 Unsuitable infrastructure

Most participants indicated that the infrastructure was not the standard for the ideal clinic. This negatively impacts the care rendered to clients seen on a daily basis. The unsuitable infrastructure violates basic human rights, such as the need for privacy and confidentiality when attending the healthcare facility for both the patient and the nurses providing the care.

> *"Clinic infrastructure, the clinic as a whole, it's doesn't suit ideal clinic. It's a small clinic. It's a small clinic or sometimes nurses have to work in team. How you can provide the quality care when we are a team? You have seen your patient on your side, and the other nurses also busy with the patient on the other side."* (P009)

> *"…Some of the rooms we got, few rooms; some of the rooms we're working two PHCNs in one room. So, the privacy is not there. If we're working in one room, so there's a lot of things that we pick up. Confidentiality is not enough. To maintain a privacy is not enough. But we can't do nothing about those things because it's the structure that leads us to do that."* (P012)

> *"It's working place; it's not in a good place, it's equipment. You don't have the equipment. It's a chair where we're sitting we're not comfortably, it's the place where we are having our lunch, the kitchen. It's not a good place."* (P013)

4.3.2.1.2 Substandard procurement processes

Emerging from the deficient emergency equipment and supplies were the sub-standard procurement processes.

4.3.2.1.2.1 Frequent stock outages

On further probing into the reasons for deficient equipment, it became evident that the facilities experienced high stock shortages and delays in receipt of the equipment ordered timeously.

> *"There is a problem with ordering process. Cause sometimes we order it take long. They take long to deliver. Our main problem is out of stock is that the equipment is out of stock from where we order. We do order. The problem is that equipment or something what we order is out of stock, and then we have to order again and again, but it is out of stock."* (P002)

> *"When we order, they say it's out of stock, but when the items come to the district staff, they're not following up on the previous order that was out of stock. So we have to keep renewing the order, and we have to wait for the date for the to place the order."* (P004)

> *"All those things are not enough in the clinic. We just pressing saying we need this; we need this, but we still waiting for. Even the equipment at emergency room. There's a lot of things that we don't have. And we still putting the order always that we need to have this. We need to have this. We even think about now, to, to, to, to, to collect money as PHCNs to buy because always when they say assessment, we need to borrow to our to our colleagues. Because we don't have. Even the stores they don't have."* (P012)

Probing further into problems experienced with the stock outages, concurred that occasionally there is a problem with receiving stock from the order point to the outlying healthcare facilities.

> *"Because we don't have a specific driver to go and fetch stock. Sometimes we use the outreach teams. But she's always busy at the community. So it's very difficult, even without transport to fetch medication."* (P004)

Logistical failures interrupt quality care. This issue is beyond the control of the nurses. An intervention is needed with the relevant stakeholders, the operational manager from the institution as well as support structures of the facilities.

4.3.2.1.2.2 Financial constraints

Further probing gave rise to an impeding financial issue.

> *"I think it's a financial problem. Because our OMs, they say they try to order things, but they don't get them back, so maybe it's a financial thing. I'm not sure. Because we know what is expected and we make sure we try to have when we it an assessment day".* (P009)

> *"But I've noticed. Most of the things now, they've said they don't have enough, no budgets, so it's not easy to push. Because if, they've said there's no budget, then what to do? Because everything now is working because of money. If there is no money, nothing you can pressurise on because nothing can happen without money. If they say no budget, no budget. We will wait up until so far; then, we are waiting for that budget for now. We cross our fingers that may be our problem. Some of our problems will be solved."* (P012)

> *"That's the problem. Is where we struggle between because we don't have. We have to struggle. We have to. What can I say? Improvise. We have to improvise. Because there's nothing we can do if there's something we don't have, we have to try to what we can do for that time."* (P009)

4.3.2.1.2.3 Non-stock items (NSI)

A non-stock item is an item that is not stocked at the facility or store's department and is not readily available when required. An NSI application must be sent to a cash flow meeting to identify an adequate budget for that facility, acquire three quotations, and then obtain the item. This process can be lengthy and contributes to delays in obtaining medical equipment and resources.

> *"I remember one time. We were having the expired oropharyngeal tubes. Yeah, the OM did the NSI, but it came after the assessment, so with the oropharyngeal tubes, they are in the emergency trolley, and emergency trolley is a vital, so we ended up losing the status. That's the problem. That's the problem because we need these things, but they are not readily available. We have to do an NSI and the NSI is taking along a long too much time to come back."* (P007)

4.3.2.1.3 Poor working conditions

Another evident challenge is that the nurses do not work under conditions conducive to providing optimal care to clients. They cannot cope owing to the high workload or find themselves in situations where they experience low morale. They find themselves sacrificing lunch times in order to assist clients. They do not have appropriate places to take their breaks and no comfortable chairs. This negatively affects the staff and inadvertently causes a shortage of nurses.

4.3.2.1.3.1 Low morale

Morale is a feeling that a person experiences in relation to the work environment and their job. People live by emotion and always want a “feel good” experience to boost their morale. Happy emotional people project happiness in whatever they do, especially in their work environment. Maslow’s third hierarchy of needs, love and belonging, identified the workplace specifically. A nurse needs to feel appreciated and cared for, especially since their work requires always putting others first.

> *“We need to be praised when we've done good. We need to be criticised but to be praised first. You've done well, we thank you for that. You are working very hard. It's not that we don't see that you're working very hard, but how? If you guys try…So we're not getting any support. We're not getting any motivation. Therefore, we come and go. We come and clock at seven, I work, and then come time, I go. I don't even check what, what, what is it that as long as the patient had been finished at the facility, then I'm done. We need someone to come and say you know, what guys? Let's do it. We know you are working under pressure, but let's try. Let's try. Let's improve. Let's improve, guys. Let's get something.”* (P010)

> *“But with this shortage of staff, we end up drowning and with work and… even with the breaks the tea, tea breaks and lunch breaks. We are having only one break, tea breaks and lunch breaks. We're having only one break. Because there is no time. The clients are waiting for us”… “Because with ideal clinic and the work that we're doing every day. It's impossible for us that we are not coping as nurses. We are not coping, and nobody is concerned about our well-being?”* (P007)

4.3.2.1.3.2 High workload/Burnout

Nurses are subjected to high workloads, and their responsibilities exceed the capacity of what is realistic. High workloads above the norm cause concern due to determining the quality of care rendered to those clients under the nurse that is compelled to push beyond reasonable expectation.

> *"That we are working environment. I would say it's just not conducive. So, then you find that it's very hard to maintain the ideal clinic and the shortage of staff they say it's. It's not an excuse; that's what they tell us, but. Uh, according to what? Is this right? The ratio by right you must see about 35 patients per day. You'll find that a Clinical Nurse Practitioner sees more than 80. So what are you expecting from that person to that total number of patients, really? It's not doable. It's not. It's not practical at all because now, if you have to see 80 patients. You find that now you will be pushing their benches." (P010)*

> *"Hey, the burnout. The burnout, I think because we are working too hard. We are working too hard, long hours, number of clients that we attend so many targets. So we end up being exhausted. Then we feel burnout with the nurses are sick. They are off sick. They, nurses have to take leaves. So we end up being a skeleton at the workplace. So we end up failing. We end up failing to maintain the status. We end up failing to meet some of the targets."* (P007)

> *Like, like if there is a, what can I call this thing? We are working. From morning to afternoon with the clients. And are those things that needs to be. There are targets. Yes, that you must meet. The daily and the weekly targets, the clinic is very full, so there's no time to look out there, the things to sort out the problems, the challenges, and the, the problem is we don't have the resources."* (P008)

4.3.2.2 Trends identified in compliance with the ideal clinic

According to Waithe (2019:966, a trend is a general direction in which something is developing or changing. This theme emerged after participants were asked about their experiences maintaining ideal clinic status. The general direction was identified from the actual occurrences and experiences at the facility level.

4.3.2.2.1 Preparation vs Maintenance

Preparation is the action or process of preparing or being prepared for use or consideration (Waithe, 2019:702). Preparation is a management principle whereby people prepare for a final product or successful experience. Preparation means "a substance especially prepared" (Harper, 2022). Maintenance is the process of preserving a condition or situation or the state of being preserved (Simpson & Weiner, 2015). This sub-theme emerged from trying to identify if there was any maintenance of the already implemented ICRM.

> *"And, also, most of the time, things are just done for the assessment, and we don't follow up; we don't maintain the standards. And it's … it's not a true reflection when we have an assessment because we helter-skelter to sort things out according to the checklist, but the next day it falls off."* (P003)

> "*With the shortage of staff, we end up struggling, working even on weekends trying to to do whatever is needed for the assessment. When assessment is due, will end up working overtime. We're trying to fill the gaps that are there because by, according to my knowledge, I think we are supposed to maintain the ideal clinic. It mustn't be a problem when the assessment is coming, but with us, we end up running around when the assessment is coming. Because we are not prepared. It's not a continuity of doing things. We just do those things when we assessment approaching when we are done, then we continue with other things."* (P007)

> *"It's just that we do this only when we will have the ideal clinic, and then once the assessment is gone, then we just leave it like that."* (P010)

4.4.2.2 Actual trends in compliance

Since there is no evidence of non-compliance to the ICRM programmes and merely preparation for the ideal clinic assessments, certain trends were identified that assist the nurses in complying when there is an actual assessment. It can be asserted as a habit and trait as there is no innovation to procure items or strategy to prevent borrowing and buying items.

4.4.2.2.1 Borrowing of items

Borrowing refers to using or taking (something belonging to someone else) with the intention of returning it (Waite, 2019:97).

> *"I have experienced that ideal clinic, it's something that can improve is the health services, but the problem is we only prepare ourselves when we are about to be assessed. We have to make sure everything is in order for that particular day. After, we go back. "We are not doing well actually because we only prepare ourselves for that period, and we can borrow even in other clinics. Once the ideal assessment is over and people, they will take their own things back, what is there that gave me. It's not an ideal clinic as it's gonna be pictured. As we are in ideal clinic, while it is not."* (P009)

> *"It's very hard to maintain it because it hasn't changed. Because it's only changes for that specific day of assessment. Then it's gone back to square one; sometimes, stores are out of stock of items and things. So, we usually borrow to replenish, make sure that we have the items there."* (P001)

.

4.4.2.2.2 Dishonesty

For the Waithe (2019:254), dishonesty is act of not honest, trustworthy or sincere. Thus, non-compliance and the efforts used are dishonest to gain an advantage. It gives false hope to programme managers and the team responsible for rolling out this programme as it is a false sense of compliance and belief that the implementation is a workable strategy to improve the quality of care to the majority.

> *"The other problem that I've experienced is the cheating. With ideal clinic there is cheating because sometimes there is something that is needed we go and borrow it from other clinics. Then we come back with, with that to our clinic, but with the assessment; so it is not helping us because it's not meeting the idea of ideal clinic, so we end up getting a status, but we don't have the that maybe the guidelines, maybe the equipment or whatever that is needed. That is needed by the assessors."* (P007)

“So, we were like, running to things for them to make them know that we got thing, but we don't have. Because we don't have; so we want to cover that being for them for the moment. After then, it's going back to square one. But I think it's not supposed to be like that. If we don't have the thing, we don't have.” (P013)

The PHCNs are aware that these new ways to comply are wrong. However, they still continue to do the same. Subscribing to basic ethics in nursing is thus questionable. For Faubion (2022), the nursing ethical principle of fidelity is the one in question, revealed as remaining true to oneself and one’s profession to remain true to professional promises. As a PHCN, one is obligated to provide high-quality, competent, safe and efficient care to all. Cheating and borrowing items are the opposite of fulfilling the promise to provide high-quality care to patients.

4.4.2.2.3 Fictitious information

This theme surfaced when participants were probed about their experiences maintaining ideal clinic status. Participants verbalised that the ideal clinic status of facilities does not reflect the facility’s status. It gives a false representation of the maintenance of the ICRMP.

“If there is gonna be assessment, so we're gonna run like headless chicken to look for the stuff for the stock. To replace. Because if they know there is no stock. When we're not supposed to run to borrow the thing to pass, we supposed to have our own.” (P013)

“Now with these fake results, I can say its fake results, so I'm not with this imitation performances. It’s gives false hope for ideal clinic implementers.” (P009)

“This assessment doesn't make any difference. Because we go around, it's a fake thing because that's not the right thing. That's a fake thing because we go and try to impress. We like, we're not doing it, by the way, we do it just to impress them. That's all we. These were done; this was done, and this will be done.” (P010).

The participants affirmed that they are unhappy with having to borrow items for the day of the assessments only to revert to the “norm”.

4.4.2.2.4 Sourcing items privately

Healthcare workers are compelled or obligated to comply with the timeous assessment dates, even to the extent of purchasing items to prevent the negative outcomes in non-attainment of items procured. This indicates a failing system.

> *“So when we having an assessment, we need to, it needs to be seen on, in your facility. So that's when we, that's when I will help and buy, and then it’s there, it should stay there, then by, and if it should, it stays there until maybe it's used an emergency or you know. And then we need to start looking again. If we're lucky enough to get to replacement, if not, we have to buy one again.”* (P001)

These trends of borrowing, sourcing items privately, dishonesty and producing fictitious results do not truly reflect what is happening in the facilities. This gives rise to other problems that can be detrimental to the patient.

> *“Especially, let's say like we have an emergency. We borrow your stuff. We'll take your stuff back that got emergency now. We don't know what to use. So it's really hard. I saw even the emergency trolley here. It's not like really for emergency. So, and if we're doing, we practising that thing, we do it like regular. We're not gonna run if they said there is emergency.”* (P013)

> *“By right, emergency trolley should be checked every day for expiry dates for what is not there. What has been used because it needs to be replaced, but you'll find that that is not happening. No one is going there to check the emergency trolley. I, we should know that this this things that expired because we need to check it every day. But then you find that it's not happening.”* (P010)

On further probing, the interviewees had to elaborate on why they felt the need to develop these above trends.

> *“Practically, it's written in the paper, but practically, it's just not happening…They feel pressure because they wanna pass and get rid of it. They just wanna get the gold and get rid of it.”* (P010)

“Normally, when it's during the time of inspection, we try our best to put everything together so that we can score high marks.” (P005)

There is clearly minimal support for procuring items that are vital to the needs of the institution and the carer. Quality is the standard of how good something is as measured against other similar things (Waite, 2019:728). Perhaps the portfolio of the Operational Manager may require too much of one individual to cope with. The OM fulfils many roles and is ultimately responsible for all the facility's operations and the community it serves. Introducing a quality assurance manager to support healthcare facilities can prove beneficial to monitoring all interventions of the IC. In order for the ICRM programme to efficiently and effectively be maintained in primary healthcare facilities, change is imperative. Change management is a methodical, structured approach that enables healthcare organisations to transform workflows seamlessly (Gonzalez, 2022). Change is the driving force behind quality improvement. In order to prevent cheating, fake results and buying items as options to transform the facilities into maintaining IC status, a responsible person should be the catalyst for positive change.

4.4.3 Insufficient Monitoring and Evaluation

A Monitoring and Evaluation (M&E) programme assesses the performance of projects, institutions and programmes set up by governments, international organisations and NGOs. Its goal is to improve current and future management of outputs, outcomes and impact (United Nations Development Programme Evaluation Office, 2002). These sub-themes emerged after probing about the non-availability of equipment and having to purchase equipment just to “pass” the assessment. This probing aimed to identify any support systems or processes that are in place to assist in attaining vital equipment, despite poor working conditions.

“Everything can be achievable for ideal clinic. The only thing that need only just be motivated when we've been about to assessed. I think, if there can be somebody there a team that can monitor ongoing things can be fine for that. Or can be better. It can be monitoring, monitored continuously timeously.” (P009)

The comment above affirms that continuous monitoring is lacking. As nurses, they believe that the IC requirements are achievable, but assistance is required to reach the desired outcome. Lean management is an approach to managing an organisation

that supports the concept of continuous improvement; a long-term approach to work that systematically seeks to achieve small, incremental changes in processes to improve efficiency and quality (McLaughlin, 2022). Lean management could be a great strategy to assist continuously, as the manager would identify the risks in non-sustainment on an ongoing basis. Including an active quality assurance manager who is hands-on, supports the facilities, and is part of the district specialist teams would prove beneficial to improve the processes for attaining items and prevent staff from buying and borrowing “just to pass”.

4.4.3.1 Inefficient systems

Suppose the systems and processes are evaluated on an ongoing basis. In that case, it could alleviate the high workloads and the high turnover of staff.

> *“Things are not going well; we are just things are not organised.”* (P010)

> *“You know we have to check emergency trolley before you start on duty. You know everything is here. Once you have an emergency, you not running like headless chicken; you know you're looking for the thing, you know everything is here. And you're having like in-service training. Sometimes we having mock, we know how to handle the emergency not like if you have emergency now everybody he's screaming, you don't know what you're doing. You don't know who's writing, who's the timekeeper.”* (P013)

Basic nursing protocols and procedures seem to have been forgotten. In nursing training in the hospital environment, checking emergency trolleys is vital and requires twice daily checking. Mock drills on how to handle an emergency should be done regularly. However, this has become something of a pastime. Primary healthcare facilities are the focal point of the current health promotion initiative to achieve universal health coverage. Therefore, more efficient systems, protocols and procedures must be developed through active brainstorming sessions and group meetings to monitor and evaluate planned interventions.

4.4.3.2 Discrepancies in assessments

This emerged from asking participants to elaborate on their experience in maintaining an ideal clinic. In one clinic, they were “marked accurately” with no favouritism, while in the other facility, the assessment process seemed a little “different”.

> *“Even when they do assessment, we don't win because some of the things we don't have, and even the stores they don't have. So, but if they do assessment, they don't give us credit of this thing is not even at the stores they don't have. Why even, we mention that this we don't have? We do ordered, but we don't get because it's not the so. Give us hard time”… We don't have even to their stores. How can we have those things? Because it's not a thing that some of the things we say because we don't have, but they said we were supposed to have this as a clinic. But question is where we supposed to get this? If the stores they said they will, they don't have.”* (P012)

> *“The assessment that's being done at the clinic is not; it's very, it's not diplomatic; it's very biased, like the OM in a certain clinic will get favoured because they know her kind of thing. And they overlook important things. So ja, so, that's not a true reflection of how ideal clinic should be. And a lot of things are being overlooked because they are being assessed by their peers and their friends. It's just that it becomes a friendly thing. And the peers will actually not elaborate on the negative things that they found. They overlook it. So it's about okay; here, the ideal clinic, if something is missing or something is not done, it’s okay. Please do that. And they don't have a follow-up to check whether those things are done.”* (P003)

> *“… if we say we don't have this with even those assessors must also understand that okay, this and this is not there because this, as long as there is an evidence that this is not there, the OM did something to say she shouted for help that this is not. But some are unfair because as long as we have what is what we have. If it's written the Miggels force that we haven't got it so. Where are you gonna get it? I've ordered it. It's not there. I'm not getting it. Why do I have to fail for something that is not there that is beyond my control? Yes, some things doesn't make sense.”* (P010)

It is concerning when the assessors have different assessing skills for one facility over the other. Peer reviews must align with the office of health standards compliance assessment. Following favouritism and being biased in certain facilities over others shows a lack of professionalism and basic ethics. There needs to be a true reflection on how the clinics are managed and run on a daily basis. There should be some accountability for the processes for the non-attaining of vital items. The proof of attempts to acquire certain items must be documented and submitted. This will ensure that the programme managers for IC know where the discrepancies lie.

4.4.3.3 Non-existent support systems

The clinics in the sub-district of Kwa-Dukuza report to the iLembe Health District office. There are programme managers for all services provided at the facility. Suppose there is a quality assurance officer or perhaps more than one to assist the seven clinics in the district. In that case, they could assist in procurement processes and act as a middleman to continuously support all the facilities.

> *"Currently, we don't have any support system because during the inspection, that's the only time that we're rushing and looking for stuff, and we don't have special people to come and support us. We just know that there's a date given to us for ideal clinic, and then we start rushing to go and see what we can put together, and that's how it functions. But if there's someone coming from time to time to help us, to assist us, to prep us and to teach us then, and we have more assistance from the top with regards to clinic."* (P005)

> *"The only support structure we have with each other or the manager, the operational manager. When it comes to the district or supervisors, the support is none, it's nil. It's only when the time of assessment that they do behave as if the support but there's no support."* (P003)

> *"We are not getting the support from our district. There are programmes. But those programmes, you hardly see a coordinator coming to the facility and find out how are you doing, what makes you, not, you know, to get gold or whatsoever, even if you have failed that ideal clinic, you will never see a coordinator for that specific programme. Coming to you and check. Which of course, that is why we sometimes not improving."* (P010)

"If I can say poor monitoring, they only come for assessment. After assessment, there is no monitoring after that. They just come for that assessment; after assessment, like they should come and check and review after how things went after that. I haven't seen it. In my experience, to re-evaluate. I haven't seen." (P009)

Post-evaluation ad-hoc meetings are needed to discuss the results and way forward in achieving the desired outcome of an IC status for a health facility. Nursing staff need to participate in these meetings to implement workable strategies to reach the goal. M&E for ideal clinic post assessments must be in the form of quality improvement plans. This should be done in comparison with the findings of the assessment and the OM drawing up improvement strategies with a workable timeline.

"..And that thing of poor monitoring after they've been assessed if there is no chance for them to come back for evaluation. People, they implement things they should evaluate, timeously to check. With how things work." (P009)

"We failed to maintain the quality improvement plan. We know what is supposed to be done. We know what is expected from us. We try to maintain it, but we can't. We are failing, yeah. It's too much." (P007)

4.3.4 Nurses' Attitude to Quality Standards in the ideal clinic

4.3.4.1 Level of training and knowledge in the ideal clinic

The initial question following the biographical data was to describe their level of training or knowledge of the ideal clinic since implementation. Unfortunately, no formal training in the ideal clinic was reported by any of the 13 participants. A few excerpts from participants' transcripts described their attainment of knowledge of the ideal clinic as:

"*Okay, so there was no training involved in ideal clinic. I joined this facility in 2015, and uhm, that's when I was exposed to ideal clinic here. For me, it was just an announcement, and we were told that we're going to be assessed, and we were given out guidelines. And each staff member was asked to participate in, you know, either do, for example, the emergency trolley or the different aspects of that contents."* (P001)

“No training specifically. It was just that when it was during the inspection. There were questions, and we just worked according to the questions, but we didn't have special training.” (P005)

“Okay, I was never trained for ideal clinic, but uhh from the meetings, from the interviews I underwent when I was applying for the post.” (P011)

Empowered, knowledgeable individuals who understand why new things are implemented will adopt it because they see the importance of including a particular programme.

“So it's a bit difficult. We don't know who is, what ideal Clinic is helping? Is it helping the clients? Is it helping us as nurses? It's helping the Department of Health. We don't know exactly. Who is being helped by this ideal clinic? It’s just that we know that we have. To comply, that's it.” (P010)

“Staff lack of knowledge on those things that should be done now and again. To let the people know, to be educated what is expected of them.” (P011)

Participants are aware that they need training and workshops. They believe that it can equip them.

“All the staff must be aware if we're talking about ideal clinic. What is ideal clinic? What were we supposed to do… there is no one groom all the staff to be alert what? What step? Now? We are jumping on with trying to be. All the clinics must be its ideal. Clinic must be ideal, but at the same time, there's no training. The, does for is all the staff to know what is ideal clinic because they're supposed to define the word what is ideal clinic? Then?” (P012)

4.3.4.2 Quality vs quantity

Improving the quality and the standard of care is the epitome of an ideal clinic. As the ICRM strategy was developed to improve the quality of healthcare services, it is evident that PHCNs face many challenges, especially with large numbers of patients accessing the facilities. The pull towards quantity outweighs the necessity of quality.

"… and that's one of the factors hindering maintenance of ideal clinic because the nurses are overburdened and they just, we just want to push the crowd. We don't, we don't, what I must say Ideal clinic is the last thought when you're pushing the crowd." (P003)

"I think the reason that stops us is, 'Is there pressure when the bench is full?' And then, you will have to put your patient on your bed and do the full assessment heads to toe. It can take you time to do that. And then we are thinking about those patients who've been full in the bench; you are trying to push the bench instead of doing. The actually quality care. I think it's the pressure… We don't have enough staff, where we have to make sure we provide the equality service; if we are burn out with a lot of patient, it's difficult to do to provide quality care. You just doing it quantity. You have to do quality" (P008)

This overlaps with the shortage of skilled staff in the facilities. Therefore, nurses gravitate towards quantity care instead of quality care.

4.3.5 Nurses' Perception of the ideal clinic

This question aimed at understanding what PHC nurses perceived the ICRM programme to be and elaborating on whether it was a workable plan. A majority of the PHCNs (85%) believe in the affirmative that an ideal clinic is a workable plan if all the aspects or criteria of an ideal clinic are achieved. The Oxford Dictionary defines perception as the way in which something is understood or interpreted.

4.3.5.1 Positive perceptions

"I think it's a good thing because it can make our facility to perform. A quality service to our community. Give quality nursing care. If we, if we have the enough staff, enough resources, medicine equipment." (P008)

"Ideal clinic was a good idea. I can say beside the fact that there are certain challenges like the shortage of staff, as I mentioned before, shortage of equipment and infrastructure, which is not in the level of not in the good condition, I can say that." (P002)

"I think that it is an excellent programme in the sense that it will be no injustice with regards to health care. It's such a positive thing to improve services. The clinic is anything but ideal, and it's far from actually reaching the ideal clinic status." (P003)

PHCNs believe and perceive the ideal clinic as a plan to improve the quality of care for all. However, many technicalities to achieving IC status are beyond their control.

4.3.5.2 Negative perceptions

Even though 85% of the PHCNs believe it is a workable plan, 100% perceive it as a failure for now, while 7.7% of the PHCNs believe that the ideal clinic has brought no change or improvement and is not workable.

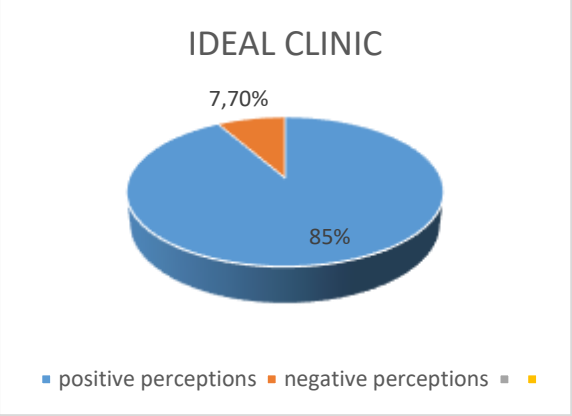


Figure 4.2: Perceptions of PHCN

"To me, it's not effective. Because, as I've said, we don't have the items that is required by ideal clinic. So it's unable, we are unable to maintain it. So I don't think it's effective." (P004)

"I can't say no is not can work, but according to the long list they've got. It's not easily to be practical. It's easy to mention everything while I'm sitting here, but when I'm there, still supposed to do daily basis, some of the things left behind." (P012)

All of the drivers of PHC indicate that it is a failure for now, although it has elements that can cause positive change. Higher intervention is needed to ensure all resources are available to achieve IC. The PHCNs asserted they are unable to maintain IC status due to the unavailability of resources.

4.3.5.3 Recommendations by the PHCNs

This theme emerged by probing PHCNs into describing their thoughts about IC. They verbalised what is needed to achieve the maintenance of IC. The people at the ground level who need to make things work face challenges and need to be heard.

> *"We shouldn't be assessed for ideal clinic to say we've passed or we didn't. We need support about the ideal clinic. Ideal clinic should be there; they must but they must stop this thing of coming for assessment. Because it's not making any difference they need, we need a support from them before they say, okay, we are doing this. They must work. They must work with the coordinator, that programme coordinator must come to the facility, work, and see how. Things are being done if we can get support, we won't even need; we need to be assessed. I don't see why we are we being assessed because the compliance… We need workshops. We need workshops. We need someone to motivate us. We definitely need workshops. I don't know how this can be done, but we need the motivation. We need their workshops. We need to be supported. We need to be supported. Someone must support us*." (P010)

> *"I think if we can have a quality nurse for a PN from PHC for the sub-districts, a quality nurse who can support all of the facilities. Maybe we can do better. Yes, if they can come before the assessment and check. How are we going to? Be assessed and check the things that we have that we don't have. It can help us a lot."* (P008)

4.4 OVERVIEW OF THE RESEARCH FINDINGS

The research findings revealed the challenges experienced by PHC nurses in maintaining ideal clinic status post implementation. This is in keeping with the main research purpose. Five superordinate themes emerged from the data analysis:

- Challenges experienced by PHC nurses in maintaining an ideal clinic.
- Trends identified in compliance with the ideal clinic.
- Insufficient Monitoring and Evaluation.
- Nurses' attitudes towards quality standards.
- Nurses' perception of the ideal clinic.

4.5 SUMMARY

Chapter 4 analysed the lived experiences of PHC nurses and categorised them into five superordinate themes, which emerged from the data analysis. Relevant quotations from participants' interviews were utilised to support the relevant themes. Chapter 5 discusses the findings, recommendations, limitations and conclusion of the study. The results of the study will also be highlighted.

CHAPTER 5

DISCUSSION, CONCLUSIONS, LIMITATIONS, AND RECOMMENDATIONS

5.1 INTRODUCTION

Chapter 4 described and presented the research findings of the study. This chapter aims to state the answer to the main research objectives, fulfil the aim and purposes of this study, and provide recommendations for future work. This chapter also aims to show the new knowledge contributed by this research to the existing body of knowledge. Furthermore, an interpretation of the research findings and limitations of this research are discussed.

5.2 RESEARCH DESIGN AND METHOD

A phenomenological qualitative research design aimed at exploring and describing the lived experiences in the challenges faced by PHC nurses in maintaining ideal clinic status post implementation in iLembe District, Kwa-Zulu Natal, was used to answer the following research questions:

- What are the challenges experienced by PHC nurses in maintaining ideal clinic status?
- What are the factors affecting the maintenance of quality standards of care?
- What are the factors affecting nurses' attitudes toward the ideal clinic?
- What improvements will enhance the maintaining of ideal clinic status?

5.3 ETHICAL CONSIDERATIONS

Ethics refers to a method of inquiry that helps people to understand the morality of human behaviour, the practices or beliefs of a certain group and the expected standards of moral behaviour of a particular group as described in the group’s formal code of professional ethics (Sasmita, 2019). For Bhasin (2020), ethical considerations are a collection of principles and values that follows when involved with humans. The need for ethical guidelines is to protect the rights of human beings. The ethical principles encompassed in the data collection are the principle of beneficence, respect

for human dignity and the principles of justice. The following principles are discussed in accordance with Polit and Beck (2018:134).

5.3.1 Beneficence

The principle of beneficence is a fundamental ethical principle imposed on researchers that seek to maximise benefits for study participants and prevent or minimise harm (Polit & Beck 2018:134).

Freedom from harm and discomfort

The researcher ensured freedom from physical discomfort, boredom, fatigue, and psychological or emotional distress at all times and ensured that only questions relevant to the study were asked.

Right to Protection from Exploitation

The research setting was a healthcare institution, and the participants were healthcare workers. However, they were reassured that their participation in the research and any information provided would not be used against them.

5.3.2 Respect for human dignity

This principle explores two facets: the right to self-determination and the right to full disclosure on which informed consent is based.

The right to self-determination

The right to self-determination means that prospective participants have the right to decide voluntarily whether they wish to participate in the study, terminate their participation, refuse to give information, and ask for clarification.

Confidentiality

Allen (2017:227) refers to confidentiality as separating or modifying any personal, identifying information provided by participants from the data. This ethical principle fits more aptly into qualitative research as opposed to anonymity, which is described as collecting data without obtaining any personal, identifying information.

Before collecting data, a research proposal to conduct the study was presented to the Unisa Research Ethics Committee for ethical clearance. Approval was granted (see Annexure 1: Ethical Clearance).

The letter of application for permission to conduct research (see Annexure 4: Request to Deputy Director) at the iLembe District, together with proof of the ethical clearance (Annexure 1: Ethical Clearance), was submitted, received and permission to conduct the study was granted (see Annexure 5: Permission from ILembe). After participants read and understood the information letter and signed the consent form, they were required to write their names, surnames and signatures on the consent forms. Only the researcher kept copies of the consent forms. Confidentiality in this study was maintained by securing the transcripts and interview sessions through safekeeping on a memory stick and stored in the researcher's safe. There was restricted access to identifying information, and no personal information from the individuals was shared with management. The institutions were identifiable using code names: Clinic A and Clinic B. The researcher ensured that any identifying information in the consent forms would be protected and destroyed as quickly as feasible.

The right to full disclosure (Informed consent)

According to Polit and Beck (2018:139), informed consent is described as participants having full disclosure about the study. This implies that they understand all the information and have the power of free choice, enabling them to voluntarily consent to or decline participation. Prior to recruiting the study participants, the purpose of the study, benefits and potential risks were explained to the participants, including all relevant information. The participants were reassured that they could withdraw from the study or stop participating at any given time (see Appendix 6: Information Leaflet).

5.3.3 Principle of Justice

Justice refers to the right to the fair distribution of the benefits and burdens of the respondent in a study (Burns & Grove 2011:107). This principle has two different aspects: the right to fair treatment and the right to privacy.

The right to fair treatment

In ensuring fair treatment, in this research, the selection of participants was on a research requirements basis. The researcher respected participants who opted out of participating and belonging to different cultural backgrounds. They were non-prejudiced during the course of data collection. Inclusion and exclusion criteria were used for eligibility in the study fairness, and equity, fairness and non-discriminatory selection of participants were honoured.

The right to privacy

Data collection was ensured in a non-intrusive way, and privacy was maintained throughout the study. This principle overlaps with the principle of confidentiality, and all relevant confidentiality procedures were adhered to strictly.

5.3 SUMMARY AND INTERPRETATION OF THE RESEARCH FINDINGS

A discussion of the results of the data collected presented in the previous chapter is described in the following sections. This discussion is in relation to the highlights of the thematic superordinate categories, themes and sub-themes that emerged from data analysis.

5.3.1 Demographic data

The demographic data related to this study was the age, gender and years of experience of the participants.

5.3.1.1 Age

The ages of the PHCNs ranged from 39 to 64 years. According to statistics from the South African Nursing Council (SANC) (2019), the current age demographics of registered nurses and midwives skew towards older practitioners, with less than a third under the age of 40. Furthermore, SANC (2019) statistics show that 27% of registered nurses are in their 50s, 26% in their 40s, and only 21% in their 30s.

The age relation to this study indicates an ageing community of nurses entering and remaining within the primary healthcare facilities. This contributes to the shortage of staff and delays in filling vacant posts. As a country moving towards the PHC-centred approach, and with high nurse-patient ratios (1:80) currently in the facilities, the workload versus ageing nurses could negatively impact service delivery and result in long waiting times.

5.3.1.2 Years of Experience

According to the Oxford Dictionary, experience means knowledge or skill gained over time. The years of experience of PHC nurses were identified to determine their

exposure to the ICRM programme and to determine if the exposure was pre and post implementation of the ICRM programme. The majority of the PHCNs have more than ten years of experience in a PHC setting, proving that many have lived through years in PHC and, therefore, were ideal participants for this research.

- 1-5 years : 2
- 6-10 years : 1
- Above 10 years : 10

The majority of PHC nurses have more than ten years of experience, which benefits the quality of healthcare services offered due to experience and improved skills.

5.3.2 Challenges experienced by PHC nurses in maintaining ideal clinic

This superordinate theme is discussed, together with the sub-themes and themes derived from this theme's analysis. The PHC nurses faced difficulties in attaining the goal of this discussion. To briefly discuss the findings and describe their relevance, the definition of the ideal clinic will be further unpacked in relation to the challenges experienced by PHC nurses.

5.3.2.1 Absence of vital resources

According to the NDoH (2016:11), an ideal clinic has good infrastructure, adequate staff, adequate medicine and supplies, good administrative processes, and sufficient bulk supplies. It uses applicable clinical policies, protocols and guidelines and harnesses partner and stakeholder support. One of the themes that emerged from the sub-theme of the data collected was the absence of vital resources. As the definition implies, an ideal clinic should have the following vital resources in order to be an ideal clinic:

- good infrastructure
- adequate staff
- adequate medicine and supplies
- sufficient bulk supplies

Findings presented and compared with the data collected in this research post implementation revealed that all the data presented in Chapter 4 are antonyms to all

the aforementioned vital aspects described in the definition of an ideal clinic. In a study conducted by Hunter et al. (2017:117), the progress and challenges in implementing the ideal clinic in South Africa were investigated. There were three main challenges, namely, poor infrastructure, inadequate staffing and poor supply chain systems in the implementation stages, implying that national and provincial Departments of Health must address these three challenges to improve the scale-up rate. Five years post the implementation of ICRM, these challenges are still at the forefront of implementing the ICRM programme, thereby implying a non-maintenance of ideal clinic status post implementation.

According to Muthathi, Muradi, Phukubye, et al. (2021:7), the challenges related to the available treatment and resources identified are barriers to effectively implementing the ideal clinic. These challenges were the inadequate supply of essential drugs during emergency care services, shortage of stationery and staff shortage. If these are challenges identified in the implementation phase of the ideal clinic, this reveals that these challenges still persist post implementation and clearly cannot be overcome in the maintenance of the ideal clinic status.

Muthathi et al. (2019:1) found the shortage of human resources and equipment as a major challenge. They recommended greater investment in the healthcare workforce and the provision of adequate resources. Their research study aligned with the finding of this subordinate theme.

5.3.1.2.1 Inadequate and under-skilled staff

As described in Chapter 3, Clinic A had three PHCNs out of the facility for more than one year. Two were on long-term sick leave, and one was transferred. This post lay vacant and is yet to be filled. In Clinic B, the facility has been without an OM since November 2021. This indicates the shortage of vital human resources. Even though Clinic A and Clinic B have 15 and 12 RNs, respectively, they still have only nine PHCNs per facility. These staff members must be utilised to provide a comprehensive care package, considering the PHCNs' need for vacation leave (booked or casual) as well as sick leave and operating daily, Sunday to Saturday, from 07H00 to 18H00. Human resources are considered one of the essential resources which are needed to provide quality care. The ongoing battle of inadequate human resources remains a crisis in South Africa. Maphumulo and Bhengu (2019:2) described it as a major

weakness in SA's health systems. Many reasons were attributed to shortages of nurses. However, this is not limited to Africa as a continent or South Africa. This is a global problem. Meetings with the World Health Organisation (WHO) and the International Council of Nurses (ICN) released a report on the "State of World Nursing" indicating that for every country to avoid crisis levels in terms of a severe shortage of nurses by 2030, each country must increase the intake of its nursing production yearly by at least 8%. If not, the world will likely experience a global shortage of 10 million nurses by 2030. It is now up to the individual countries to come up with strategies to improve the intake of nurses.

The "Ritshidze", which means "Saving Our Lives", is a community-led monitoring system in South Africa developed by people living with HIV/AIDS and activists to hold the South African government and aid agencies accountable for improving the HIV and TB service delivery. The State of Health KwaZulu-Natal report (2021:16) showed that the healthcare facilities in KZN perform the worst at filling open vacancies, reporting the highest proportion of Registered Nurses (RN). Data collected revealed that out of 95 facilities, 60 responded to having the most understaffed category, namely the RNs. This challenge worsens as staff retire and are not replaced.

In an online article in the Mail & Guardian (1 June 2021), Teranji opined, "employing more nurses can reduce total health costs". This coincides with the data found in this research in identifying budget cuts as another aspect that contributes largely to insufficient staffing. The author interviewed a spokesperson from the Democratic Nursing Organisation of South Africa (DENOSA), one of the trade unions representing nurses in South Africa. The contributions in the Mail & Guardian (1 June 2021) by Delihlazo were as follows: Posts are "frozen" and qualified nurses are sitting at home without work, the number of nurses in the country's healthcare system is extremely low, and the vacancy rate is very high. He also maintained that previously funded positions no longer exist as government reduced the so-called bloated public sector wage bill.

Having RN without this speciality causes a strain on experienced clinicians. Notably, there was a trend in redeploying contract workers employed in DoH at the peak of the COVID-19 pandemic to the local clinics. This was evident in Clinic A. Three contract workers were general RNs with no specialisation in PHC or midwifery and had no

knowledge and experience of the comprehensive care package rendered in the PHC facilities. During COVID-19, some nursing staff were employed as contract workers across all provinces. The retention of “contract COVID-19 nurses” in KZN, especially iLembe District, revealed vast shortages of nurses in KZN. “There are more qualified nurses who could be employed, but budget cuts and possible bureaucracy have prevented this” (Mail & Guardian (1 Jun 2021) by Alperstein).

The primary healthcare clinics provide comprehensive, specialised services to the different clientele visiting the facility on a daily basis. However, if clients require their chronic treatment and at the same time are unwell or require a contraceptive method, that nurse would provide a holistic package of care to that patient. The patient does not follow other queues. Therefore PHCNs are skilled and experienced individuals responsible for the following:

- Conducting physical assessments, diagnosing illnesses, prescribing treatment, and providing direct referrals for further treatment if applicable. They also provide specific care to specific groups of people.
- Women’s health (basic antenatal care, post-natal care, providing contraception methods, pap smears)
- Child care services (Expanded Programme for Immunisation and Integrated Management of Childhood Illnesses)
- Youth-friendly services (12-25 years)
- Men’s health [males who have sex with males (MSM), Medical Male Circumcision (MMC)]
- Safe conception and fertility
- HIV/AIDS programme (PreP, PEP, NIMART)
- Non-Communicable Diseases
- Tuberculosis (TB) diagnosis and management programme
- Sexually transmitted diseases (STI) diagnosis and management
- Outreach services
- School health services

These are all specialised programmes and require specialised formal training, including the PHC course. Currently, until the finalisation of this thesis, one of the clinics had five general nurses working in this PHC facility, providing care to the

community without formal training in any of the above specialities, let alone the programme of ICRM and NHI. These nurses were employed specifically for COVID-19. PHCNs are now faced with the task of on-the-job training for general professional nurses whilst trying to cope with the provision of safe, efficient and effective care to clients.

In addition, an operational manager is a person responsible for the smooth running of the institution and the driving force to ensure the maintenance of the ICRMP. No OM in an institution burdens the nurses and adds unduly pressure on the senior nurses to act as an OM without compensation. This lack of staff and unskilled staff contributes to non-compliance with ICRMP.

According to South Africa's 2030 Human Resources for Health Strategy, there will likely be a shortage of about 34 000 registered nurses needed in PHC by 2025 if nothing substantial is done.

5.3.1.2.2 Deficient emergency equipment and supplies

Medical equipment and supplies have been a long-term contributor to declining quality standards. Not only are the PHC facilities experiencing a lack of medical and emergency supplies, but also the hospitals in the public sector. These equipment and medical supplies are tools for nurses to provide quality, comprehensive care. Failure to have these on hand creates a negative perception of the nursing profession.

The annual reports for KZN 2015/2016 revealed that the high failure rates of ideal clinic assessments are attributed to unachieved vital elements. The two vital elements with the highest failure rate were the restoration of the emergency trolley after use (46%) and a well-equipped resuscitation room with basic functional equipment (40%). As the years progress and throughout the years, researchers found that the emergency equipment and unavailability of equipment still plague healthcare services.

Moyimane, Matlala and Kekana (2017:1) found a critical shortage of medical equipment at the healthcare facility, specifically the unavailability of equipment, low quality and poor maintenance. This negatively impacts nursing care, the nursing profession and the hospital.

This implies that resuscitation trolleys across all healthcare facilities, PHC facilities and hospitals are not prioritised and well maintained. Higher intervention is essential to provide essential medical emergency equipment and supplies in all healthcare facilities. This will promote optimal care provided to all patients accessing the healthcare facilities across the province.

5.3.1.2.3 Unsuitable infrastructure

The infrastructure of a healthcare facility is also a vital aspect of an ideal clinic. The Merriam-Webster Dictionary (1996) defines infrastructure as the system of public works of a country, state, or region and also as the resources (such as personnel, buildings, or equipment) required for an activity. In this context, the reference is made to physical buildings. In the past ten years, only one clinic in the sub-district of Kwa-Dukuza underwent renovation. To date, the other six clinics reside in infrastructure that has never been improved in proportion to the patients to whom it provides care. The communities and services provided need to be expanded. However, the building and spacing prove inadequate for the comprehensive services and programmes it renders to the community. State of Health KwaZulu-Natal (2021:16) concurs that the healthcare facilities in eThekwini are still not ideal, with 16% of facilities in “bad condition” and 88% requiring added space.

According to Matlala, Malema, Bopape and Mphekgwana (2021:7), almost the same number of professional nurses, 71 (46%) and 70 (45%), respectively, indicated that the infrastructure of the clinic is suitable and not suitable to render quality healthcare services. For Hunter et al. (2017:117), Operation Phakisa was meant to develop plans or a standard blueprint for constructing new proposed facilities in 2015. Ndoh was in the process of completing schedules for PHC facilities that may need major refurbishments or need to be refilled. However, Ritshidze (2021:16) found that 88% of facilities in eThekwini still require space.

The buildings currently are not user-friendly to healthcare providers and healthcare users. Plans proposed previously to refurbish facilities seem non-existent since 2015 in this regard. This confers with data collected in this research that the infrastructure is not suitable for an ideal clinic.

Unsuitable infrastructure is beyond the control of the PHCN and the operational manager. Basic necessities such as chairs for staff remain a problem, inadvertently causing a lack of staff due to high absenteeism and sick leave. If nurses are not comfortable for the majority of their day, it will negatively affect staff shortages as six out of the nine-hour day requires them to sit and consult with patients. Staff wellness should be a priority. Consulting with other staff members and their clients infringes on the patient's right to dignity, privacy and respect. Quality assurance aims to care for the carer (the nurse) as well as the patients. However, it seems that providing quality care remains a challenge.

5.3.2.2 Substandard procurement processes

Procurement involves every activity involved in obtaining the goods and services a company needs to support its daily operations, including sourcing, negotiating terms, purchasing items, receiving and inspecting goods where necessary and keeping records of all the steps in the process (Jenkins, 2021). These superordinate themes are subdivided into three different aspects, namely:

- Stock outage
- Financial constraints
- Non-Stock Items (NSI)

These three sub-themes inter-relate with one another, thus discussed together. After a lengthy search, no evidence of research regarding out-of-stock emergency equipment was found to the researcher's knowledge. Research by Hwang, Shroufi, Gils, Steele, Grimsrud, and Boulle (2019:1) indicated that South Africa experiences a high prevalence of stock-outs across all nine provinces. This is evidenced by differences in the provincial ability to prevent, mitigate and cope with the medicine stock-outs. The researcher deduces the conclusion that the healthcare facility experiences a shortage of emergency equipment and follows the protocol of ordering the item in question. At the supply chain office, that item becomes "out of stock" and labelled an NSI owing to the high cost. As noted in this research, the process of ordering stock seems to be lengthy, with high waiting times in receipt of items. The PHC nurses asserted that even though scheduled dates are given to all facilities to

ascribe to, a loophole of stock receipt to the ordering facility remains, resulting in delays or no stock of items. Poor communication between the facilities and the supply chain department, which supports the facility, was identified as the barrier to attaining these items as well as the transportation to and from the depot. In the interim, healthcare providers improvised to compensate for items not available with negative effects.

Some issues arose: there are no drivers to deliver the stock timeously, and neither is there a designated driver assigned per clinic. They occasionally use the outreach services linked to the institution. However, that also poses a challenge, as they also have their itinerary and often cannot be of assistance.

Muthathi et al. (2019:8) asserted that most PHC facility managers reported that, on some occasions, they had no option but to buy out of pocket or borrow equipment required for the ICRM programme, thus improvising to have the required item. Furthermore, some participants, who had improvised using laminated material to provide signage in the PHC facility, mentioned regretting the improvisation as this led to a lack of proper signage in the facility by the responsible department.

The PHC nurses believe that the district is experiencing financial constraints. Therefore, there is a non-availability of items, especially those considered NSIs. The majority of the emergency equipment qualifies as NSIs. There is a lengthy application process for these items, attending a joint cash flow meeting and identifying the need for the item versus the finances for acquiring the item. Clearly, the financial and budget cuts impede equipment acquisition because the department is experiencing financial constraints. This is now evident as a new development in attaining medical supplies and emergency equipment procurement.

Malakoane, Heunis, Chikobvu, Kigozi, and Kruger (2020:9) found that challenges identified by stakeholders included insufficient health system financing, increasing costs, financial unsustainability and lack of financial autonomy. Muthathi et al. (2020:311) stated that when discussing with a group of operational managers, most participants believed they had no power to influence procurement processes and turnaround times. These participants also believed that their decision-making powers for the provision of equipment for vital elements were limited since the delivery of orders depended on the supply chain department. Some reported problems in relation

to supply chain management included delays, delivery of wrong orders after a very long waiting period and lack of feedback on the progress of procurement. Some participants thought there was great urgency for the facilities to comply with the requirements of the ICRM programme but less urgency for those in authority to deliver the resources to support the programme.

Moyiyane et al. (2017:2) argued as follows: “Management, leadership, and governance structures need strengthening to ensure that procurement and maintenance plans for medical equipment are developed and implemented”. Matlala et al. (2020:7) stated that most professional nurses, specifically 116 (75%), reported that the maintenance plan of the medical equipment is not regularly monitored. Furthermore, 94 (61%) of the professional nurses reported not having enough medical equipment in the clinics.

The process of acquiring equipment remains a challenge. The turnaround to replenish these items is a lengthy one. It requires in-depth understanding and more research into the time frames for procuring an NSI emergency stock item. A more time-friendly process needs development and more intense monitoring and evaluation.

5.3.2.3 Poor working conditions

The fragmented health system attributes to the public sector being riddled with poor working conditions. The poor finance system and the lack of resources and vital equipment create an unpleasant work environment for the nurses. This contributes to the low morale of the nurses currently employed in the public sector. Consequently, many opt to leave the public sector for better conditions, whilst others face poor working conditions.

Two sub-themes emerged from the above superordinate theme:

- Low morale
- High Burnout/workload

The high burnout and increased workload are a rebound effect of the inadequate human resources that plague the public sector. This inadvertently causes low morale among the PHC nurses. These two sub-themes are discussed in unison.

According to SANC, in 2020, there was one nurse for every 213 patients in the country, in both the private and public sectors, and by the end of 2020, South Africa had a total of 280 231 nurses (Strydom 2021).

According to Delihlazo (2019), provinces have a “silent moratorium” on the non-filling of vacant posts. This leads to work overload and staff burnout, depression and anxiety among overworked healthcare workers.

Jeranji (2021) lamented that “nurses are overburdened due to increased workloads, contributing to negligence, high absenteeism and low staff morale”. These results in sub-optimal care rendered to patients and high litigation rates, which affect the meagre budget currently allocated to the health sector. Evidently, nurses “are not respected and appreciated for the work they do”.

As much as there are strategies to improve patient care, the Batho Pele principles also cater for staff in the principle of “encouraging innovation and rewarding excellence”. This principle also encourages nurses to be recognised and rewarded for going the extra mile in patient care or exceeding the requirements. When staff are happy and feel appreciated, it motivates them to do their best.

Strydom (2021) highlighted that South Africa has one of the world's lowest nurse-to-patient ratios and that by 2025 more than 16 000 additional nurses will be required. According to SANC’s (2020) Population per Qualified Nurse in KZN, the patient ratio for registered nurses is 325:1. This concurs with the data collected in this research on high patient volumes and the compromise to quality service delivery. Much research investigated the burnout and workload among ICU nurses, but the high workload and burnout experienced by the PHC were investigated minimally. The high patient workload inadvertently affects the quality of care offered to patients seeking healthcare.

Pérez-Francisco, Duarte-Clíments, del Rosario-Melián, et al. (2020:2) found that overlaps identify the problem of nursing overload, affecting health/burnout, decreasing the quality of care, and affecting patients’ safety. The increased workload affects nurses, manifesting in burnout in the light of absenteeism.

Matlala et al. (2021:7) found that the majority of professional nurses are overwhelmed by the workload. South Africa has over 4 200 public health facilities, and the number

of people per clinic averages around 13 718, exceeding WHO guidelines of 10 000 per clinic.

A report by DoH (2014), cited by Matlala et al. (2021:07) in the North West, revealed that some clinics provide a 24-hour service and approximately 300 patients visited the clinic per day with the clinic day shift consisting of five professional nurses, which resulted in one nurse attending to approximately 60 patients (1:60), therefore exceeding the national norm of 1:40 nurse to patient ratio. This concurs with common practise to date as one participant reported a workload of a PHCN as 1:80. The study found that the majority of the professional nurses, 129 (83.6%), were overwhelmed by the workload.

Matlala et al. (2021:5) further revealed that clinics operating for eight hours daily had a higher required number of professional nurses with specialisation to enhance the provision of quality healthcare services compared to clinics operating 12 hours daily. Working long hours affects the quality of care rendered to patients, as it causes nurses to be less productive, distracts their attention and deteriorates physical and mental health and has the risk of occupational injury caused by fatigue. All these negative effects of long working hours threaten the quality of healthcare services rendered to patients.

For Ritter (2000), burnout is a state of becoming extremely tired or sick. Nursing is a more mental kind of occupation compared to other occupations that merely require physical effort. Mental exhaustion and psychological stress can affect the activities of daily living for the person in question, especially for the person they are caring for. This can give rise to an increased incidence of patient safety incidents and adverse events. If a PHCN providing a comprehensive care package to the patient has a ratio of 1:80, the quality of care becomes questionable. All these issues affecting personnel inadvertently affect the patient, which contributes to negative attitudes of staff as well as high waiting times of patients. Nurses need support to assist them in perfecting the new quality strategies implemented. There need to be interventions in place to “care for the carer”. The “carer” refers to the nurse. A nurse’s well-being is paramount as a driver of the ICRM programme. It is of note that there is a difference between a “manager” and a “leader”. A manager is a person who gets people to do their job. A leader has people following them and is a few steps ahead of them in terms of

innovation and knowledge. Operational managers should become leaders with a self-sufficient team to provide efficient and effective superior-quality care.

The improved services of the employee assistance programme can be beneficial to assist staff to cope with these conditions. Improved intersectoral collaboration with other stakeholders, even from private enterprises, occasionally heed the call to provide comfort to others.

5.3.3 Trends in compliance in the ideal clinic

In this development of the superordinate theme, the researcher wished to identify the actual occurrence when it came to ICRM and the maintenance of the ideal clinic status once achieved. Therefore, the sub-theme of *Preparation vs Maintenance* and *Actual trends* emerged.

5.3.3.1 Preparation vs Maintenance

It is incomprehensible that preparation occurs with no maintenance. For Harper (2022), preparation is a management principle. It has become a priority for operational managers to prepare in anticipation of the assessment date for the ICRM programme evaluation. Once the assessment is over, no maintenance strategies are implemented to prepare for the assessment. They are not monitored until the next appointment date. Greater investment is imperative in the operational managers to better facilitate the maintenance of the ICRM programme. A course in lean management may prove effective.

There is no research evaluating the maintenance of ideal clinic status post implementation. This study is the first research evaluating post implementation. The study revealed that there is no ongoing maintenance or improvement of the ideal clinic status. Oxford Dictionary defines maintenance as the process of preserving a condition or situation or the state of being preserved. In essence, it describes the opposite of the current situation where the ideal clinic status or improvement is not preserved. It is a preparation for an assessment, similar to hosting an event. However, after the assessment, no action is taken. Despite the strategies identified and implemented to

prepare for an assessment, they revert to how they were before evaluation. Therefore, there is no maintenance of the ideal clinic, just preparation for the assessment day.

The DoH (2020) five-year review 2020 revealed that 93 out of the 605 primary healthcare facilities lost their status in four years, and only 19 maintained their ideal clinic status. For 2019/2020, 76 healthcare facilities remained, revealing a 15% drop rate in South Africa. The above could be the reason behind the non-maintenance of ideal clinic status. Participants reported that these are owing to several inadequacies plaguing the public sector, as mentioned in superordinate themes 1 and 2, namely *Challenges experienced by PHC nurses in maintaining ideal clinic status* and *Substandard procurement processes*.

5.3.3.2 Actual trends of non-compliance

This study revealed several trends mentioned by healthcare workers and operational managers in an attempt to “pass” the assessment and gain status. Due to emergency equipment stock outages, nurses need to be compliant and “pass”. Even though the term “borrowing” was used, no one returned some of the “borrowed” items.

Muthathi et al. (2019:8) found that pressure and urgency to be compliant sometimes led to ‘faked’ compliance. It is of note that these adopted practices are giving false hope to IC implementers. The implementers rely on the drivers of this programme to execute their responsibilities efficiently, safely and effectively to improve the country's overall status. Even though it should not be common practice, it is believed that they feel that it is their obligation to fulfil the assessment requirements. The majority of PHC facility managers reported that, on some occasions, they had no option but to buy out of pocket or borrow the equipment required. Delays led managers to buy items from their own pockets sometimes. Even though there are managers at the facilities, the budget is controlled at the district office level. Thus, if there is “no budget” to procure items, they will not be attained. “Crossing of fingers” in hope and “improvising” now appear as the coping mechanisms for the nurses as everything requires money. Therefore, purchasing “out of pocket” to appear compliant is a reality. By adopting these trends, they have provided a false sense of progress to the quality of health care and ultimately to achieving the Universal Health Care coverage goal for all in South Africa.

Most respondents believed achieving ‘ideal clinic status’ was strenuous, frustrating and a burden. The pressure and urgency to be compliant sometimes lead to ‘faked’ compliance (Muthathi et al. 2019:8). False compliance continues to result in gaps in care; even when health facilities receive high ratings, the experience of patients does not bear this out. The cost of failing to address this is high (Sparks, 2021). The major shortage of vital resources causes nurses to adopt these habits to comply.

Purchasing equipment out of pocket should not become a norm. Relevant stakeholders and support structures should be implemented to assist facilities requiring higher intervention. Borrowing items for the emergency trolley is unacceptable as the emergency trolley is a vital part of the ICRM assessment. An item not visible on the emergency trolley is non-compliant, which equates to failure. If this is a common occurrence, one would question what happens between the assessments when an actual patient requires emergency assistance. The consequences of litigation from possible patient safety incidence can be costly. This goes against all the interventions put ahead by the DoH to curb the very same. Since the initial implementation of the ideal clinic and as reviewed in various literature, the upkeep of items in the emergency trolley remains a challenge.

5.3.4 Insufficient Monitoring and Evaluation (M&E)

Monitoring refers to the actual checking process on the progress made against the ICRM programme, which is the standard. Evaluation is the actual monitoring of the data obtained in monitoring. In this superordinate theme, three sub-themes emerged:

- Discrepancies in assessments
- Insufficient systems
- Non-existent support systems

The M&E in the NDoH on quality of care through ICRM assessments follow the method of peer reviews. Peers refer to other operational managers and quality managers in the same field (i.e., fellow nurses) within the local area conducting the assessments. This comes with both positive and negative implications that give rise to discrepancies and false standards of care.

Key role players in monitoring, evaluation, and quality assurance in the district health team meant to support and assist facilities in achieving IC status and maintaining quality standards need to be revisited. It is of note that the facilities require tremendous support in order to achieve Ideal status and thus comply with NHI.

This study emerged with clinics being penalised for non-availability and non-compliance that were out of their control. Also, others were favoured due to peer reviewers' "likes" and "friendships" with the manager. Muthathi et al. (2019:1) found that some managers reported being penalised for areas beyond their control and were expected to deliver without resources from the national and/or provincial level.

This study revealed inefficient systems and poor support structures in place to assist them when things are out of their control. Post ideal clinic assessment, when the quality improvement plans are developed, there is no plan or system to improve client services. This research revealed an inefficient replenishment and checking of the vital emergency trolley. Initial research found inaccuracies in equipping the emergency trolley. To date, there are still insufficient emergency items. This proves that the systems and processes are flawed.

Basic nursing protocols and procedures are not executed. In nursing training in the hospital environment, checking emergency trolleys is vital and requires twice daily checking. Mock drills on how to handle an emergency are regularly performed. This has now become a pastime. Primary healthcare facilities are the focal point of the current health promotion initiative to achieve universal health coverage. Thus, more efficient systems, protocols, and procedures must be developed by active brainstorming sessions and group meetings to monitor and evaluate planned interventions. Extracts from the KZN Annual Reports (2015-2016) showed that the high failure rates are attributed to vital elements being unachieved. The two vital elements with the highest failure rate were the restoration of the emergency trolley after use (46%) and a well-equipped resuscitation room with basic functional equipment (40%). This revealed a concern and belief that could be addressed through active leadership and monitoring. Mogakwe, Ally and Magobe (2020:3) found that the participants lack support from senior management, as they do not understand and/or attempt to resolve the challenges that participants face.

Moseadeghrad and Chipeta, cited by Mogakwe et al. (2020:4), stated that a non-supportive management team affects compliance with quality standards and that inadequate support challenges staff morale. Furthermore, healthcare managers stated that they have no one to turn to when they experience challenges providing quality healthcare and need support.

For Michel et al. (2020:2), leadership and governance challenges remain prevalent in the various levels of the public sector, implying that managers' knowledge and skills are still very inadequate. Rispel (2016:18), as cited by DoH (2017), discovered fault lines in the health sector that have negative consequences for patients, policy implementation and health professionals. These fault lines include:

- Tolerance and ineptitude, and leadership
- Management and governance failures
- Lack of a fully functional district health system

Healthcare providers on the front line and at the bottom of the hierarchy suffer as they face an unsupportive management environment, staff shortages and health system deficiencies. They found it difficult to uphold their professional code of ethics and provide good quality care.

5.3.5 Nurses' Attitude to Quality Standards

Compliance with quality standards is non-negotiable when providing health care. The DoH has tried many avenues to improve the provided quality health care and correct health care disparities, especially for the majority accessing the public health system. The ICRM is the latest programme designed to provide efficient and quality health standards for nurses to ascribe to and to provide for those accessing health care. When healthcare workers are knowledgeable in providing quality health care, they become proficient. From this theme, two sub-themes emerged, which will be discussed next.

5.3.4.1 Level of training and knowledge in the ideal clinic

The researcher sought to understand the participants' knowledge of the ideal clinic and how they acquired that knowledge. This study revealed that no participant had

formal training on the ICRM programme, and whatever knowledge gained was via assessments or going for interviews. Mabuza, Ogunbanjo, Hlabyago, and Mogotsi (2018:101) found that the potential deterioration of ideal clinic status could be attributed to the HCW's poor awareness, showing a potential failure to maintain status. When there is a lack of knowledge, staff will resist as they do not see the value of the changes. The lack of knowledge and training is evident as participants are unaware of the actual reason for the ICRM programme.

If healthcare workers are not in line with the goals and plans of the DoH, the implementation of new strategies to achieve targets will be received with resistance. The education and ultimate reasoning behind the ICRM/NHI/SDGs/UHC are vital so that the healthcare workers are in line with achieving the goals of the DoH. Notably, the lack of knowledge on a certain subject can bring about a minimal interest towards it. This study revealed that no PHCN had any formal training on ICRM/NHI and that the method of attaining knowledge was through preparation for an interview or when the assessments were conducted. Training on new initiatives is lacking. Perhaps the methods behind the training need re-evaluation. Training needs and learning have to be on a continuous basis; this is part of the job description of a quality assurance officer. Health care is dynamic and ever-changing. Therefore, continuous training is imperative to achieving NHI/ICRMP/IC/UHC.

Oladimeji, Alabi and Adeniyi (2017:191) found that only 30.2% of HCWs verbalised that their knowledge of National Health Insurance (NHI) was in the form of in-service training (e.g., seminars and meetings). Some participants revealed that they lacked knowledge and insight into the ideal clinic programme, while the other professional nurses described unclear roles to play during the programme. The only person with knowledge of implementation was the operational manager, who received guidance from the South African manual documents of ideal clinic components regarding the programme's implementation. These documents included information about the administration and integrated clinical services management (ICSM), with sub-elements regarding commitment to ideal clinic implementation.

For Mogakwe et al. (2020:5), another reason for non-compliance with quality standards was the loss of skilled nurses. Many nurses leave for better working conditions, while others retire or are no longer fit to work due to medical reasons.

These staff members are not replaced; if replaced, their replacements are not skilled. There is a major gap between the staff needed to ensure high-quality services and the staff present each day in the facilities (Ritshidze-State of Health KwaZulu-Natal 2021:16). This study's participants voiced a need for workshops and in-service training as they believe that it can equip them to provide optimum quality health care.

5.3.4.2 Quality vs quantity

The Oxford Dictionary defines quality as the standard of something measured against other things of a similar kind; the degree of excellence of something. The Oxford Dictionary defines quantity as the amount or number of a material or abstract thing not usually estimated by spatial measurement.

This study revealed that nurses know that they need to provide quality services. However, circumstances and challenges are preventing them from providing it.

Nkabinde et al. (2021:234) found that nurses are hurrying when attending to patients. This is in response to the shortage of nurses and the increased workload. Manyisa and Van Aswegen (2017:36) reported that the lack of administrative equipment and skilled professionals adversely affects the quality of care offered in health institutions.

This study confirmed that the lack of vital resources (human/financial/equipment and supplies) and the increased workload of nurses force them to see the number (quantity) of patients sitting on the bench instead of the quality care that is non-negotiable. According to Stacey, Mirelman, Kreif, et al. (2020:1555), improving the quality of care is challenged by constraints on limited public financial resources, restricted human resources and capacity for training, poor infrastructure and systems based on historical investment, and significant need for healthcare arising from poverty-related disease burdens.

Matlala et al. (2021:1) stated that "despite the effort and interventions put in place by the Department of Health with regard to the ICRM in response to the current deficiencies in the quality of PHC services, and to lay a strong foundation for the implementation of NHI, the quality of healthcare services is still hindered by several factors such as overwhelmed by the workload, the attitude of the staff and cleanliness in the work environment, poor infrastructure and lack of equipment as perceived by the professional nurses".

A previous study by Tuten (2012), cited by Matlala et al. (2021:7), reported that professional nurses constantly overwhelmed by patient numbers could only endanger patients because of the more likely mistakes to happen once nurses have consulted beyond a certain number of patients.

5.3.5 Nurses' Perception of Ideal Clinic

The Oxford Dictionary defines perception as the way in which something is understood or interpreted. The perception of nurses of the ICRM programme is imperative because they are the drivers of PHC. For this programme to be effective, their perception of it needs to be positive. The negative perception gives rise to resistance and non-compliance. Three sub-themes emerged from this superordinate theme:

- Positive perceptions
- Negative perceptions
- Recommendations by PHCNs

In this study, 85% of the participants reflected on the ICRM as a positive strategy for improving care. This accounts for the majority and implies that they fully understand and interpret that the ICRM programme will improve quality standards of care. The minority perceived it negatively, owing to not seeing any positive change in this regard or lack of knowledge in the ideal clinic.

PHCNs identify with the positive that comes with maintaining and sustaining the ICRM programme. However, due to challenges out of their control, they have adopted a perception of looking good on paper only to receive the green light. This poses a threat to the rollout of the ICRM programme. The level of knowledge of the healthcare workers, including the operational manager, on the sustainable development goals in universal health coverage and the effort of the DoH to comply and achieve a universal, comprehensive, safe, efficient and effective healthcare system for all in South Africa is questionable. Borrowing items for vital aspects of the IC assessment only to return it shows they are oblivious to the greater good outcome of the DoH's health care plans for the country.

Muthelo et al. (2021:4) reported that professional nurses perceive the ideal clinic as a programme that benefits and improves the standard of primary healthcare services. The participants described a negative experience of the programme related to the

knowledge gap and a lack of training in implementing the ideal clinic programme as some of the experiences they faced (Muthelo et al. 2021:4).

Participants believe there should not be ongoing assessments but rather ongoing support to maintain ideal clinic status and one person (e.g., a qualified nurse) to provide support. During the implementation process, regular evaluation and consultation would be beneficial.

Muthelo et al. (2021:5) added that a lack of involvement of professional nurses in implementing the ideal clinic programme resulted in a negative attitude and behaviour. However, practical orientation should enforce positive behaviour when implementing the ideal clinic programme. Orientation should make the professional nurses feel more secure, enhancing the ideal clinic programme's enjoyment.

5.4 RECOMMENDATIONS

The recommendations provided resulted from the findings of this research that aims to allow for the smooth running of clinics in the maintenance of ideal clinic status. The following recommendations provided are in relation to the subordinate theme identified in the data analysis process: What improvements will enhance maintaining the ideal clinic status?

5.4.1 Nursing Management Responsibility

- Existing nurse policies should be reviewed and strengthened in collaboration and coordination with the district health services, procurement and supply chain department. An efficient and effective system, together with the development of standard operating procedures (SOPs), must be established to attain emergency equipment and supplies timeously.
- Leaders and managers to facilitate a more conducive environment for staff are needed. Develop strategies to decrease the high workload of PHCNs in order to provide a quality standard of care to all who access health care. This can be done through work studies on role responsibilities, the scope of practice, and motivation for more PHCNs.

- Establish staff wellness programmes to assist in improving morale and motivate nurses.

5.4.2. Nursing Education

- Inclusion of the SDGs, UHC, NHI and ICRM integrated into the curriculum of Nurse Training in order to facilitate compliance to ICRM and inclusion of lean management for training nurse managers to have trained upcoming senior managers to ensure effective management practices.

5.4.3 Health Service responsibility and In-service education

- Facilitate an enriching ICRM training and development programme for all employed staff. Also, ensure all staff entering DoH will promote acceptance to the smooth maintenance of sustaining an ideal clinic status.
- Lean management is an approach to managing an organisation that supports the concept of continuous improvement; a long-term approach to work that systematically seeks to achieve small, incremental changes in processes to improve efficiency and quality (McLaughlin, 2022). Provide lean management training/workshops by accredited institutions for all current operational managers and district supervisors to assist in maintaining ideal clinic status.
- PDSA cycles were originally known as the Shewhart cycle, "Plan, Do, Check, Act", and were later modified by Edwards Deming to PDSA cycles. This is a model for quality improvement that has been adopted by healthcare. Research documented by Knudsen, Laursen, Johnsen, Bartels, Ehlers and Mainz, J (2019:1) concurs that of the 120 Quality Improvement projects included, almost all reported improvement (98%). A team needs to be set up to implement a Plan-Do-Study-Act (PDSA) model. This model is a change model initiative to achieve desired outcomes. First, plan an intervention that can assist. Second, implement the intervention. Third, monitor or study the intervention to identify if the desired outcome is achieved. And finally, act by either retaining the intervention or removing the intervention.
- Employ a systems manager, to improve inefficient systems

5.4.4 Governing authorities

- Include healthcare professionals and multidisciplinary health teams on the ground level for when new strategies are developed.

5.4.3 Further research

Further research can be done on the identified challenges:

- A similar study researching the operational manager's (OM) experiences in maintaining an ideal clinic is needed to gain a managerial perspective of the challenges experienced. Including a focus group discussion with the Oms could be valuable as it could generate reasons for non-compliance to the ICRM programme.
- The level of knowledge and perspective of another category of nurses and support staff should be sought to identify their contribution to maintaining the ideal clinic.
- Replication of this study in other provinces` ideal clinics could be beneficial.
- Patient satisfaction surveys at ideal clinics could provide insight into patients' views of the quality of care they receive at ideal clinics.
- Determining patient ratios for delivering services in PHC clinics to address staff shortages.

5.5 CONTRIBUTIONS OF THE STUDY

According to the researcher's knowledge, this is one of the first studies to explore the challenges of PHC nurses in maintaining ideal clinic status post implementation. Nurses' experiences as the drivers of PHC are imperative to evaluate the accurate maintenance of the ICRM programme. This study revealed that since implementation and now with the maintenance of an ideal clinic, PHC clinics are failing to meet requirements. To date, there is still improper infrastructure, inadequate staff, inadequate medicine and supplies, poor administrative processes, and insufficient adequate bulk supplies, the opposite of the definition of an IC.

Since this topic has not been researched before, the researcher believes it will indicate where South Africa, specifically the two clinics in KZN that formed part of the study, are in maintaining ideal clinic status. In keeping with the purpose of this study which was to explore and gain more insight into the nurse-related challenges experienced in maintaining ideal clinic status, where previously achieved, this research revealed that there is a non-maintenance or no improvement of ideal clinic status. The current trend of working towards the ideal clinic assessment occurs only at the time nearing the assessment, giving a false interpretation of the maintenance of the ideal clinic. This highlighted several challenges experienced by PHC nurses. PHC clinics are far from fitting the description of an ideal clinic. Further investment is imperative in the monitoring and evaluation of the ICRM programme. This study revealed the non-compliance towards maintaining ideal clinic status, allowing policy implementers to improve management of the programme and quality assurers to rectify the shortcomings.

5.6 LIMITATIONS OF THE STUDY

The sample was exclusive to registered nurses with a specialisation in PHC. Other categories of nurses, namely general registered nurses, enrolled nurses, nursing auxiliaries, and support staff, could have been included in the study. The input of the operational managers could have proved effective, and the challenges they experienced on a management level could have been explored.

The ICRM programme is a new concept and has been adopted by only two countries to date, namely South Africa and Malaysia; therefore, data was limited.

5.7 CONCLUDING REMARKS

The challenges PHC staff experienced in maintaining ideal clinic status post implementation were examined in this study. The objectives were to:

- Explore the challenges and experiences of nurses in maintaining ideal clinic status.
- Explore nurses' perception of quality standards laid down in the ideal clinic.

- Describe their attitude toward achieving ideal clinic status.

The researcher can conclude that many difficulties prevent the maintenance of an ideal clinic status. Also, change management is vital to reach the goal of Universal Health Care for all and distinguish the fragmented inequality of health provided to all in South Africa. Non-compliance with the ICRM programme is out of the nurses' control.

Perception in a change process could be vital to organisational behaviour. Nurses are fully aware of the quality standards of care, and most nurses have a positive attitude towards the ideal clinic. However, they lack support to fulfil the challenges they face.

A better strategy to equip operational managers to become innovative and charismatic leaders is also an imperative driving factor that should not be ignored. Strengthening management, leadership and governance structures is important to ensure that procurement and maintenance plans for medical equipment are developed and implemented. All PHCNs revealed that the high workload and burnout are rife. Notably, all facets of the ICRM programme were inadequately implemented (i.e., the appointment system). If clients were appropriately managed according to an appointment system, it could lessen the burden.

REFERENCES

Acharya, A., Vellakkal, S., Taylor, F., Masset, E., Satija, A., Burke, M. & Ebrahim, S., (2013). The Impact of Health Insurance Schemes for the Informal Sector in Low- and Middle-Income Countries: A Systematic Review. *The World Bank Research Observer*, 28(2), pp.236-266.

Alperstein, M. (2021). Available at: https://mg.co.za/health/2021-06-01-employing-more-nurses-can-reduce-total-health-costs/.

Adom. D, Yeboah. A & Attah. K. A. (2016). Constructivism Philosophical Paradigm: Implication for Research, Teaching and Learning. *Global Journal of Arts Humanities and Social Sciences,* 4(10):1-9.

Allen, M. (2017). *Encyclopaedia of Communication Research Methods.* The SAGE (4). Thousand Oaks, CA: SAGE Publications, Inc. From:

https://dx.doi.org/10.4135/9781483381411 [Accessed 26 Aug 2022].

Aspers, P., Corte, U. What is Qualitative in Qualitative Research. (2019). *Qual Sociol* 42:139–160. From:

https://doi.org/10.1007/s11133-019-9413-7 [Accessed 15 February 2023]

Bramer WM, de Jonge GB, Rethlefsen ML, Mast F., & Kleijnen J. (2018). A systematic approach to searching: an efficient and complete method to develop literature searches. *Journal of the Medical Library Association*.106 (4):531-541

Bhandari, P., (2020). What Is Quantitative Research? | Definition, Uses and Methods. From: https://www.scribbr.com/methodology/quantitative-research [accessed 28 August 2021]

Bhagwandeen, R. (2021). Personal Interview. 29 March 2021, iLembe District office.

Brown R, Feller L, Benedict L. (2010) Reframing nursing education: The quality and safety education for nurse's initiative. *Teaching and Learning in Nursing*. (5):115-118

Braun, V. & Clarke, V. (2006) Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3 (2). pp. 77-101. From: http://eprints.uwe.ac.uk/11735 [accessed 28 August 2021].

Bhasin, H. (2020). What are Ethical Considerations in Research? From: https://www.marketing91.com/ethical-considerations/ [accessed 24 September 2021]

Creswell, J. W. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches* (second Ed.). Thousand Oaks, CA: Sage.

Creswell, J. W. (2012). *Qualitative inquiry & research design: Choosing among five approaches* (4th Ed.). Thousand Oaks, CA: Sage.

Creswell, J. W. (2014). *Research Design: Qualitative, Quantitative and Mixed Methods Approaches* (fourth Ed.). Thousand Oaks, CA: Sage.

Coovadia, H. Jewkes, R. Barron. P, Saunders. D., & McIntyre, D. (2009). The health and health system of South Africa: historical roots of current public health challenges. *Lancet.* (374): 817–34

Dagar, S. (2019). *Instant notes on Research Methods*. (First Edition). *The researcher's paradise*. New Delhi.

Delihlazo, S. (2021). Available at: https://mg.co.za/health/2021-06-01-employing-more-nurses-can-reduce-total-health-costs/.

Dudovskiy, J., (2018). Positivism - Research Methodology. Research Methodology. From: https://research-methodology.net/research-philosophy/positivism. [Accessed 28 January 2021]

DeJonckheere M & Vaughn LM. (2019). Semi structured interviewing in primary care research: a balance of relationship and rigour. *Family Medicine and Community Health*

Department of Health. (2014). Report on a service delivery inspection of the district hospital and clinics regarding the availability of medicines and medical equipment and the role of health district offices in the Department of Health North West province. From: http://www.pmg-assets.s3-website-en-west-1.

Department of Health (2018) Ideal Hospital Realisation and Maintenance Framework Manual. From:

https://www.idealhealthfacility.org.za/App/Document/Download/17.

Draper, C.E & Louw. G. (2007). Primary health care in the South African context – medical students\' perspectives *South African Family Practice*. 49 (10): 6-11

Ebatamehi, E. Top 10 Countries with Improved Healthcare System in Africa (2020). The African Exponent. [Accessed 16/07/21]

Egbujie, B.A., Grimwood, A., Mothibi-Wabafor, EC., Fatti, G., Tshabalala. A.M.E.T., Allie, S., Vilakazi. G. & Oyebanji. O. (2018) Impact of "Ideal Clinic "Implementation on patient waiting time in Primary health care clinics In Kwa Zulu Natal Province, South Africa: A before-and-after evaluation. *South African Medical Journal*, (108):311-317.

Fryatt, R & Hunter, J. (2016) The Ideal Clinic in South Africa: Planning for implementation, *South African Health Review*. (18):23-33.

Faulkner, S. and Trotter, S., (2017). Competencies for Primary Care Nurse Specialist Competencies. [Online] Sanc.co.za. From: <https://www.sanc.co.za/wp-content/uploads/2020/06/SANC-Competencies-Primary-Care-Nurse-Specialist.pdf> [Accessed 29 August 2022].

Faubion. D. (2022). Fidelity in Nursing- What is it, Whyis it important & Examples. Nursingprocess.org. http://www.nursingprocess.org/fidelitu-in-nursing.html. (Acessed: 8 November 2022)

Gray, J.R., Grove, S.K. & Sutherland, S. (2017). *The Practice of Nursing Research. Appraisal, Synthesis, and Generation of Evidence*. 8th Edition. Minneapolis: Elsevier.

Gafoor, K.A (2012). Considerations in the Measurement of Awareness. Paper for National Level Seminar on Emerging Trends in Education; Department of Education, University of Calicut, Kerala, India

George, T., (2022). Semi-Structured Interview | Definition, Guide & Examples. [Online] scribbr. From: <https://www.scribbr.com/methodology/semi-structured-interview/> [Accessed 2 August 2022].

Gonzalez, C. (2022). Exploring the Importance of Change Management in Healthcare. [Online] From: https://www.onpage.com/exploring-the-importance-of-change-management-in-healthcare/ [Accessed 9 November 2022]

Government Gazette 39506, Government Notice (2015) *White Paper on National Health Insurance*. From: https://www.gov.za/sites/default/files/gcis_document/201512/39506

Harper, D., (2022). Preparation. In: *Online Etymology Dictionary*. [Online] From: <https://www.etymonline.com/word/preparation> [Accessed 14 August 2022].

HealthMan (2017) National Health Insurance (NHI) White Paper (2017) Summary.

Honebein, P.C. (1996). Seven goals for the design of constructivist learning environments. From: https://www.semanticscholar.org/paper/Seven-goals-for-the-design-of-constructivist Honebein/ed9339452692b7ea41d184f007bfabc485474b7a [accessed 5 June 2021]

Hunter, J.R., Chandrani, T.M., Asmalli, S., Tucker, J., Ravhengani, N. M., & Mokgalagadi, Y. (2017). The Ideal Clinic in South Africa: Progress and challenges in implementation. *South African Health Review,* (20):111-124

Hunter, D., McCallum, J. and Howes, D. (2019). Defining Exploratory-Descriptive

Qualitative (EDQ) research and considering its application to healthcare. *Journal of*

Nursing and Health Care, 4(1),

Hwang, B., Shroufi, A., Gils, T., Steele, S.J., Grimsrud, A. & Boulle, A., (2019), 'Stock-outs of antiretroviral and tuberculosis medicines in South Africa: A national cross-sectional survey', PLoS One 14(3), e0212405. https://doi.org/10.1371/journal.pone.0212405

Jenkins, A., (2021). What Is Procurement? Types, Processes & Technology. Oracle Netsuite, [online] From:

https://www.netsuite.com/portal/resource/articles/accounting/procurement.shtml

[Accessed 24 August 2022].

Jeranji, T. (2021). Employing more nurses can reduce total health costs, VOLUME 397, ISSUE 10288, P1905-1913, May 22, 2021

Kautzky, K., & Tollman, S.M. (2008). A perspective on Primary Health Care in South Africa: Primary Health Care in context. *South African Health Review*, 2008, 17-30.

Kelly S. (2010) Qualitative interviewing techniques and styles. In: Bourgeault I, Dingwall R, de Vries R. (eds) The Sage Handbook of Qualitative Methods in Health Research, Thousand Oaks: *Sage Publications*.

Knudsen, S. V, Laursen, H. V. B., Johnsen, S. P, Bartels, P. D, Ehlers, L. H and Mainz,J (2019) Can quality improvement improve the quality of care? A systematic review of reported effects and methodological rigor in plan-do-study-act projects*. BMC Health Serv Res* 19, 683

https://doi.org/10.1186/s12913-019-4482-6

KZN HEALTH online. [s.a]. *KZN Annual Report. 2015-2016*: From: https://www.idealhealthfacility.org.za/ (accessed 12 March 2021)

KZN HEALTH online. [s.a]. *KZN Annual Report. 2016-2017*: From https://www.idealhealthfacility.org.za/ (accessed 12 March 2021)

KZN HEALTH online. [s.a.] *KZN Annual Report. 2017-2018*: From https://www.idealhealthfacility.org.za/ (accessed 12 March 2021)

KZN HEALTH online [s.a.] *KZN Annual Report. 2019-2020*: From https://www.idealhealthfacility.org.za/ [accessed 12 March 2021]

Libguides.unisa.ac.za. (2022). LibGuides: Formulate an Effective Search Strategy: Formulate a search strategy using appropriate search techniques. [Online] Available at: <https://libguides.unisa.ac.za/c.php?g=725948&p=5181744>

[Accessed 2 August 2022].

Lincoln, YS. & Guba, EG. (1985). *Naturalistic Inquiry*. Newbury Park, CA: Sage Publications.

Lui, X. (2017). Research Topic, Definition of. The SAGE Encyclopedia of Communication Research Methods, pp.1463-1465.

Lucas, K., (2022). Steps in Qualitative Data Management & Analysis. chron., [online] Available at: <https://smallbusiness.chron.com/steps-qualitative-data-management-analysis-72987.htm> [Accessed 9 August 2022].

Mabuza, L.H., Ogunbanjo, G.A., Hlabyago. K.E. & Mogotsi. M. (2018). Awareness of Health Care Practitioners about the National Health Insurance in Tshwane District, South Africa. *The Open Public Health Journal.* (11): 93-103.

Malakoane, B., Heunis, J.C., Chikobvu, P., Kigozi, N.G. and Kruger, W.H., (2020). Public health system challenges in the Free State, South Africa: a situation appraisal to inform health system strengthening. *BMC Health Services Research*, 20(1), pp.1-14.

Manyisa, Z. M, van Aswegen, E. J. (2017). Factors affecting working conditions in public hospitals: A literature review. *International Journal of Africa Nursing Sciences*. (6):28-38.

Maphumulo, W.T. & Bhengu, B.R., (2019), 'Challenges of quality improvement in the healthcare of South Africa post-apartheid: A critical review', *Curationis* 42(1):94-102

Matlala NT, Malema RN, Bopape MA, & Mphekgwana PM. (2021). The perceptions of professional nurses regarding factors affecting the provision of quality health care services at selected rural public clinics in the Capricorn district, Limpopo Province. *African Journal of Primary Health Care and Family Medicine*.13 (1), a2830. From: https://doi.org/10.4102/phcfm.v13i1.2830

McHugh MD, Aiken LH, Sloane DM, Windsor C, Douglas C, and Yates P. (2021). Effects of nurse-to-patient ratio legislation on nurse staffing and patient mortality, readmissions, and length of stay: a prospective study in a panel of hospitals. *Lancet*.

Mhagama and definition of challenges (2018).

Michel J., Tediosi, F., Egger. M, Barnighausen, T., McIntyre, D, Tanner, M., & Evans, D. (2020) Universal health coverage financing in South Africa: Wishes vs reality. *Journal of Global Health Reports. (4) From*: http: doi:10.29392/001c.13509

Mlambo, M., Silén, C. & McGrath, C. (2021). Lifelong learning and nurses' continuing professional development: A metasynthesis of the literature. *BioMed Central Nursing*. 20, 62. https://doi.org/10.1186/s12912-021-00579-2

Mogakwe, L.J, Ally, H. & Magobe, N.B.D. (2019) "Recommendations to facilitate managers" compliance with quality health standards at primary health care clinics. *Curationis.*42 (1), a1984.

Mogakwe, L.J, Ally, H. & Magobe, N.B.D., (2020) Reasons for non-compliance with quality standards at primary healthcare clinics in Ekurhuleni, *South Africa African Journal of Primary Health Care & Family Medicine.* (12) a2179

Moyimane, M.B, Matlala, S.F & Kekana, M.P. (2017). Experiences of nurses on the critical shortage of medical equipment at a rural district hospital in South Africa: a qualitative study. *Pan African Medical Journal*. 28:100. From: https://www.panafrican-med-journal.com/content/article/28/100/full

McCombes, S., (2022). How to Write a Literature Review | Guide, Examples, & Templates. [online] Scribbr. From: <https://www.scribbr.com/dissertation/literature-review/> [Accessed 12 August 2022].

Moreno-Serra, R., Peter, C. (2012) Does progress towards universal health coverage improve Population health. *Lancet*: 917-923.

Muthathi, I.S., Levin. J., & Rispel, L.C. (2019) Decision space and participation of primary health care facility managers in the Ideal Clinic Realisation and Maintenance Programme In two provinces. *Health Policy and planning*. (35): 302-312.

Muthathi, I., & Rispel, L.C. (2020). Policy context, coherence, and disjuncture in the implementation of the Ideal Clinic Realisation and Maintenance programme in the Gauteng and Mpumalanga provinces of South Africa. *Health Research Policy Systems*. 18, 55 1-15

Muthelo, L. Moradi, F. Phukubye, T.A.; Mbombi, M.O. Malema, R.N. & Mabila, L.N. (2021). Implementing the Ideal Clinic Program at Selected Primary Health care facilities in South Africa. *International Journal of Environmental Research and Public Health.* 18, 7762.

Murphy, S.D., & Moosa, S. (2021). The views of public service managers on the implementation of National Health Insurance in primary care: A case of Johannesburg Health District, Gauteng Province, Republic of South Africa. *BioMed Central.* 21, 969 https://doi.org/10.1186/s12913-021-06990-4

Magobe, N.B.D., Beukes, S. & Müller, A. (2010). Reasons for students' poor clinical competencies in the Primary Health Care: Clinical nursing, diagnosis treatment and care programme. *Health SA Gesundheit* 15(1)

Merriam-Webster (1996) Definition of infrastructure. Springfield, Massachusetts: Encyclopaedia Britannica, Inc. From: https://www.merriam-webster.com/dictionary/infrastructure.

Naledi. T, Barroni. P & Schneider. H. (2011) Primary Health Care in SA since 1994 and implications of the new vision for PHC Re-engineering. *South African Health Review*.17-28.

National Department of Health. (2020). A National Report of ICRM Programme 5-year Review. The National 5-Year Ideal Clinic Realisation and Maintenance Programme Review and Quality Assurance Workshop. Johannesburg: NDoH.

National Department of Health Online. [s.a]. Ideal Clinic South Africa: What is an Ideal Clinic? From: https://www.idealhealthfacility.org.za/ (accessed 6 February 2021).

Nkabinde, N.P, Bopape, M. A, Mothiba, T.M & Mphekgwana, P.M. (2021). Patients' Satisfaction with Services Offered by Nurses at a Selected Ideal Clinic in Ehlanzeni District, Mpumalanga Province, South Africa. *The Open Nursing Journal,* (15) 229-235.

Nettleton P., & Bray, L. (2008). Current mentorship schemes might be doing our students a disservice. *Nurse Education in Practice*. (8)205–212.

Noordien, I. (2020). The Challenges of Male Nurses, Yiba. Available at: https://yiba.co.za/the-challenges-of-male-nurses/(Accessed: August 22, 2022).

Nikolopoulou, K., (2022). What Is Purposive Sampling? | Definition & Examples. [Online]

Available at: https://www.scribbr.com/methodology/purposive-sampling/

[Accessed 9 November 2022].

Oladimeji, O., Alabi, A., & Adeniyi, V. (2017). Awareness, Knowledge and Perception of the National Health Insurance Scheme (NHIS) among Health Professionals in Mthatha General Hospital, Eastern Cape, South Africa. *The Open Public Health Journal*. (10):187-194.

Onoya, D. (2021) “Ideal Clinic Realisation and Maintenance program in South Africa,” 17 September. From: https://www.heroza.org/?p=4350.

Passchier. R.V. (2017). Exploring the barriers to implementing National Health Insurance in South Africa: The people`s perspective. *South African Medical Journal*. (10):836-838.

Palinkas L.A, Horwitz S.M, Green C.A, Wisdom, J. P, Duan, N, Hoagwood, K. (2015) Purposeful sampling for qualitative data collection and analysis in mixed method implementation research. Administration and Policy in Mental Health and Mental Health Services Research 42(5): 533–544.

Polit, D.F. and Beck, C.T. (2017). Nursing Research: Generating and Assessing Evidence for Nursing Practice. 10th Edition, Wolters Kluwer Health, Philadelphia

Pezaro, S., 2017. Developing your literature search strategy in five easy steps. [Blog] The Academic Midwife',

From:<https://sallypezaro.wordpress.com/2017/10/23/developing-your-literature-search-strategy-in-5-easy-steps/> [Accessed 13 August 2022].

Pérez-Francisco DH, Duarte-Clíments G, Del Rosario-Melián JM, Gómez-Salgado J, Romero-Martín M, & Sánchez-Gómez MB. (2020). Influence of Workload on Primary Care Nurses' Health and Burnout, Patients' Safety, and Quality of Care: Integrative Review. *Healthcare (Basel).* 8(1):1-14

Rajan, D. (2017). Negative impacts of long working hours: A comparative study among nurses. *MedCrave Online Journal of Applied Bionics and Biomechanics*. 1(2):60–67. From: https://doi.org/10.15406/mojabb.2017.01.00010

Rajeswaran, L, Cox. M, Moeng. S., & Tsima, B.M. (2018). Assessment of nurses' cardiopulmonary resuscitation knowledge and skills within three district hospitals in Botswana. *African Journal of Primary Health Care & Family Medicine.* 10(1), a1633. From: https://doi.org/10.4102/phcfm.v10i1.1633

Rispel. L. (2016). Analysing the progress and fault lines of health sector transformation in South Africa. *South African Health Review*, 17-24.

Ritter, R.M. (2014). *Trend in the Oxford Dictionary for Writers and Editors*, 2nd Ed. Oxford University Press.

SANC (South African Nursing Council). *Provincial of nursing manpower versus the population of the Republic of South Africa*. (2019).

From: https://www.sanc.co.za/wp-content/uploads/2020/09/Stats-2019-1-

Sasmita, S. (2019) "Ethical Aspects of Health Research." From: https://slideplayer.com/slide/15346490/

Siti. R.A, (2018). Ethical Considerations in Qualitative Study. *International Journal of Care Scholars* (2)31:33

Stein, R. (2015) Republic of South Africa Operation Phakisa Ideal Clinic Realisation and Maintenance Final Lab Report May 2015. From: https://www.idealhealthfacility.org.za/App/Document/Download/83.

Searle, C. (1982). The dependent, independent and interdependent functions of the nurse practitioner - a legal and ethical perspective. *Curationis*, 5(4), 19-23. doi:https://doi.org/10.4102/curationis.v5i4.444

Simpson, J. and Weiner, E. (2015). Maintenance. In: oxford dictionary, 3rd ed. Oxford University Press.

Sparks, R. (2021). Amidst the pandemic, health facility quality ratings give a false sense of security. Spotlight. From: https://www.spotlightnsp.co.za/2021/06/30/opinion-amidst-the-pandemic-

health-facility-quality-ratings-give-a-false-sense-of-security/. (Accessed 27 August 2022)

Stacey, N., Mirelman, A., Kreif, N., Suhrcke, M., Hofman, K. & Edoka, I. (2021). Facility standards and the quality of public sector primary care: Evidence from South Africa's "Ideal Clinics" program. *Health Economics*, 30(7), pp.1543-1558.

Sustainable Developmental Goals (SDGs) Country Report - 2019 South Africa (2019). From: http://www.statssa.gov.za/MDG/SDGs_Country_Report_2019_South_Africa.pdf

Saunders, M., Lewis, P. & Thornhill, A. (2012) "Research Methods for Business Students" 6th edition, Pearson Education Limited

Strydom, N. (2021) Study confirms necessity for minimum nurse-to patient ratio, Solidarity. Available at: https://solidariteit.co.za/en/health-care-nearing-crisis-due-to-shortage-of-nursing-staff/ (Accessed: August 28, 2022).

Tandwa, L.A. & Dha, A. (2020). Public Engagement in the development of the National Health Insurance: A study involving patients from a central hospital in South Africa. *BioMed Central Public Health*. (20):1191.

Tuazon. RJC, Butiu. JC, Natangcop. SFC, Lonzaga. JML, & Lim. MKA. (2022). Solo on and Off Duty: Challenges of Selected Solo Parent Employees in Call Center Companies and the Implication of Republic Act 8972. *International Journal of Research and Innovation in Social Science (IJRISS)* (VI) (III) 343-350

Tuten, T. (2012). Reducing nurse burnout: A win-win situation. From: http://www.m.huffpost.com.us/us/emtry.1916350

Universal Teacher. [u.s.a]. Definition of Research Design: From: http://universalteacher.com (28 September 2021).

Voight, E. (2021). Staff shortages and long waiting times plague KZN health, 16th November 2021.from: https://www.spotlightnsp.co.za/2021/11/16/staff-shortages-and-long-waiting-times-plague-kzn-health-report-finds/ [Accessed 27 July 2022]

Waite, M. (2019). Oxford South African Pocket Dictionary:Oxford University Press

World Health Organisation. (2006) *Quality of care: A process for making strategic choices in health systems*. Geneva: WHO Press;.

What is primary health care? (2021) World Health Organisation. From: https://www.who.int/news-room/fact-sheets/detail/primary-health-care (Accessed: 8 August 2022).

Universal Health Coverage: What is UHC? (2021) World Health Organisation. From: https://www.who.int/news-room/fact-sheets/detail/primary-health-care (Accessed: 8 August 2022).

United States Department of Health and Human Services (2018) Enhancing Reproducibility through Rigor and Transparency, National Institutes of Health (NIH) Central Resources for Grants and Funding Information. From: https://grants.nih.gov/policy/reproducibility/index.htm (Accessed: August 5, 2022).

United Nations Development Programme Evaluation Office (2002) Handbook on Monitoring and Evaluating for Results. Available at: United Nations development programme evaluation office - Handbook on Monitoring and Evaluating for Results. http://web.undp.org/evaluation/documents/handbook/me-handbook.

Zhu, J., (2022). Division for sustainable development goals. [Online] United Nations. Available at: <https://www.un.org/en/desa/sustainable-development-goals-report-2019> [Accessed 20 July 2022].

ANNEXURE 1: UNISA ETHICAL CLEARANCE

UNISA university of south africa

COLLEGE OF HUMAN SCIENCES RESEARCH ETHICS REVIEW COMMITTEE

29 November 2021

NHREC Registration # :
Rec-240816-052
CREC Reference # :
46723110_CREC_CHS_2021

Dear Leeanna Dubru-Odayar

Decision:
Ethics Approval from 29 November 2021 to 29 November 2024

Researcher(s): Name: Leeanna Dubru-Odayar
Contact details: 46723110@mylife.unisa.ac.za
Supervisor(s): Name: Prof ZZ Nkosi
Contact details: 0124296758

Title: Challenges experienced by primary health nurses in sustaining ideal clinic status post implementation in Ilembe District, Kwazulu-Natal

Degree Purpose: MA

Thank you for the application for research ethics clearance by the Unisa College of Human Science Ethics Committee. Ethics approval is granted for three years.

The ***low risk application*** *was reviewed by* College of Human Sciences Research Ethics Committee, in compliance with the Unisa Policy on Research Ethics and the Standard Operating Procedure on Research Ethics Risk Assessment.

The proposed research may now commence with the provisions that:

1. The researcher(s) will ensure that the research project adheres to the values and principles expressed in the UNISA Policy on Research Ethics.
2. Any adverse circumstance arising in the undertaking of the research project that is relevant to the ethicality of the study should be communicated in writing to the College Ethics Review Committee.
3. The researcher(s) will conduct the study according to the methods and procedures set out in the approved application.
4. Any changes that can affect the study-related risks for the research participants, particularly in terms of assurances made with regards to the protection of participants' privacy and the

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

confidentiality of the data, should be reported to the Committee in writing, accompanied by a progress report.

5. The researcher will ensure that the research project adheres to any applicable national legislation, professional codes of conduct, institutional guidelines and scientific standards relevant to the specific field of study. Adherence to the following South African legislation is important, if applicable: Protection of Personal Information Act, no 4 of 2013; Children's act no 38 of 2005 and the National Health Act, no 61 of 2003.
6. Only de-identified research data may be used for secondary research purposes in future on condition that the research objectives are similar to those of the original research. Secondary use of identifiable human research data require additional ethics clearance.
7. No fieldwork activities may continue after the expiry date **(29 November 2024).** Submission of a completed research ethics progress report will constitute an application for renewal of Ethics Research Committee approval.

Note:

*The reference number **46723110_CREC_CHS_2021** should be clearly indicated on all forms of communication with the intended research participants, as well as with the Committee.*

Yours sincerely,

Signature: pp

Prof. KB Khan
CHS Research Ethics Committee Chairperson
Email: khankb@unisa.ac.za
Tel: (012) 429 8210

Signature: PP

Prof K. Masemola
Exécutive Dean: CHS
E-mail: masemk@unisa.ac.za
Tel: (012) 429 2298

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

ANNEXURE 2: REQUEST TO CLINIC X

Mrs Leeanna Odayar
University of South Africa
College of Human Sciences
12 January 2022

The Operational Manager
Clinic X

Dear Madam

Request to conduct a research study

My name is Leeanna Odayar. I am a student registered at UNISA for the Master of Public Health program under the supervision of Professor Zerish. Z Nkosi.

This study is aimed at exploring and gaining more insight into the challenges experienced by primary health care nurses in maintaining ideal clinic status, where previously achieved. I hereby seek permission to carry out a research study titled:

CHALLENGES EXPERIENCED BY PRIMARY HEALTH NURSES IN SUSTAINING IDEAL CLINIC STATUS POST IMPLEMENTATION IN ILEMBE DISTRICT, KWAZULU-NATAL

If you have any further questions/concerns or queries related to the study you might contact the researcher:

Cell phone 0845825421

Email: leedubru@gmail.com or my supervisor email: nkosizz@unisa.ac.za

Your consent will be highly appreciated

Yours faithfully

Leeanna Dubru-Odayar

ANNEXURE 3: REQUEST TO CLINIC B

Mrs Leeanna Odayar
University of South Africa
College of Human Sciences
12 January 2022

The Operational Manager
Clinic B

Dear Madam

Request to conduct a research study

My name is Leeanna Odayar. I am a student registered at UNISA for the Master of Public Health program under the supervision of Professor Zerish. Z Nkosi.

This study is aimed at exploring and gaining more insight into the challenges experienced by primary health care nurses in maintaining ideal clinic status, where previously achieved. I hereby seek permission to carry out a research study titled:

CHALLENGES EXPERIENCED BY PRIMARY HEALTH NURSES IN SUSTAINING IDEAL CLINIC STATUS POST IMPLEMENTATION IN ILEMBE DISTRICT, KWAZULU-NATAL

If you have any further questions/concerns or queries related to the study you might contact the researcher:

Cell phone 0845825421

Email: leedubru@gmail.com or my supervisor email: nkosizz@unisa.ac.za

Your consent will be highly appreciated

Yours faithfully

Leeanna Dubru-Odayar

ANNEXURE 4: REQUEST TO DEPUTY DIRECTOR

UNISA university of south africa

REQUEST FOR PERMISSION TO CONDUCT THE STUDY

Request for permission to conduct research at iLembe, Kwa Dukuza sub district.

"CHALLENGES EXPERIENCED BY PRIMARY HEALTH NURSES IN SUSTAINING IDEAL CLINIC STATUS POST IMPLEMENTATION IN ILEMBE DISTRICT, KWAZULU-NATAL"

10 November 2021

The District Director
ILembe Health District Offices
1 King Shaka Street, King Shaka Centre
Second floor
032 4373500 or 076 790 3939
melanie.venter@kznhealth.gov.za

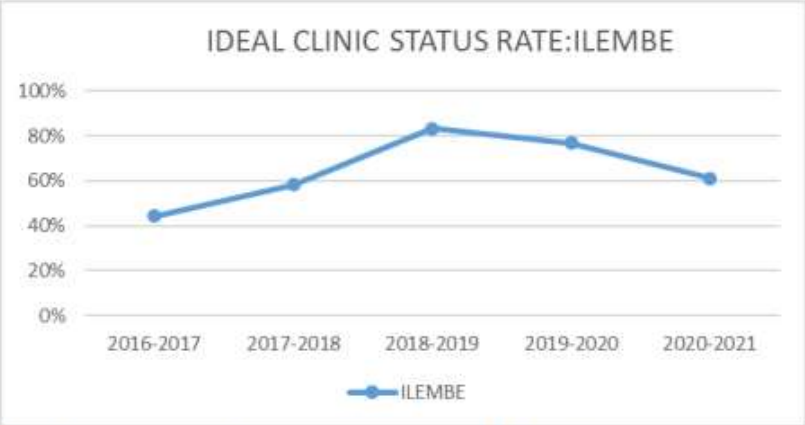
Dear Ms. Thembilihle Maphalala

I, Leeanna Odayar am doing research with Professor Z.Z Nkosi, a Deputy Executive Dean in the Department of Human Sciences, towards a Master's in Public Health at the University of South Africa. We are inviting you to participate in a study entitled "CHALLENGES EXPERIENCED BY PRIMARY HEALTH NURSES IN SUSTAINING IDEAL CLINIC STATUS POST IMPLEMENTATION IN ILEMBE DISTRICT, KWAZULU-NATAL"

The aim of the study is to explore and understand the challenges experienced by PHC nurses, in articulating and maintaining the ideal clinic and quality standards programme post implementation in order to ensure NHI fully executed.

Your district, has been selected because currently in the iLembe district, majority of the clinics are not maintaining ideal clinic status and quality standards as per KZN Annual reports.

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za



Year	iLembe
2020-2021	61.1%
2019-2020	76.8%
2018-2019	83.3%
2017-2018	58.3%
2016-2017	44.4%

Ideal Clinic Status Rate: Extracted from KZN Annual Reports

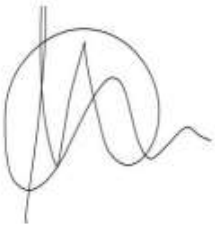
The study will entail the research engaging with primary health care nurses by means of semi structured interview questions centring on a core question.

The benefits of this study are to identify challenges and recommend interventions to assist nurses in maintaining ideal clinic status. Hearing the voices of the core of an institution, their thoughts and concerns regarding the challenges faced on daily basis in maintaining this newfound change innovation can bring positive change to maintaining ideal clinic status.

Potential risk are that it may involves some risk of the minor discomforts in the form of anxiety and fear that encountered in daily life. Being in this study would not pose risk to your safety or wellbeing.

Feedback procedure will entail after completion of the study, I undertake to provide the KZN Department of Health and the iLembe district office with a bound copy of the full research report

Yours Sincerely,



Leeanna Dubru-Odayar

University of South Africa
Preller Street, Muckleneuk Ridge, City of Tshwane
PO Box 392 UNISA 0003 South Africa
Telephone: +27 12 429 3111 Facsimile: +27 12 429 4150
www.unisa.ac.za

ANNEXURE 5: PERMISSION FROM ILEMBE

KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

DIRECTORATE:
DISTRICT DIRECTORS OFFICE

Ilembe Health District Office: 1 King Shaka Street, King Shaka Centre
2nd and 3rd Floor, KwaDukuza, 4449
Tel: 032 437 3500 Fax: 032 552 1878 Email: Thembelihle.maphalala@kznhealth.gov.za
www.kznhealth.gov.za

Date: 21ST January 2022
Mrs. L Odayar

RE: PERMISSION to complete research at the clinics

I have pleasure in informing you that permission has been granted to you by ILEMBE DISTRICT to conduct research in the following clinics: ILembe, Kwa Dukuza sub district. Ballito Clinic and Shakaskraal Clinic

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to this observation.
2. Please ensure this office is informed before you commence your observation.
3. ILEMBE district will not provide any resources for this observation.
4. You will be expected to provide feedback on your findings to ILEMBE DISTRICT.
5. You are required to contact this office regarding dates for providing feedback when the observation has been completed.

Thank you

Ms T.E Maphalala
Director: District Health Services
ILembe District

21/01/2022
Date

ANNEXURE 6: DATA COLLECTION INSTRUMENT

Semi Structured Interview Questions

Biographical Data

1. Years of experience in PHC setting
2. Category of nurse

Core Question

1. Describe your level of training or knowledge of ideal clinic since implementation
2. As a PHC nurse, what are some of your experiences in maintaining ideal clinic status
3. Describe the challenges that you face whilst maintaining ideal clinic

Probing Questions

1. What do you think of ideal clinic?
2. Describe, the reasons why, you think ideal clinic is a workable plan?
3. Focus on your knowledge of ideal clinic, elaborate on the changes it has brought to the institution
4. What support structures do you have in place to assist you
5. Describe your role played in maintaining ideal clinic
6. Please feel free to share any information on the ideal clinic

ANNEXURE 7: INFORMATION LEAFLET

PARTICIPANT'S INFORMATION SHEET

Dear Prospective Participants

My name is Leeanna-Dubru Odayar, and I am studying towards a master's degree in Public Health (MPH) at the University of South Africa (UNISA) together with my supervisor, Professor Z.Z Nkosi, we would like to invite you to participate in a study entitled CHALLENGES EXPERIENCED BY PRIMARY HEALTH NURSES IN MAINTAINING IDEAL CLINIC STATUS

The ideal clinic tool developed to improve deficiencies in standards of care and realign the disparities in public health care. The reason for this study is to explore and gain more insight into challenges experienced by nurses in maintaining ideal clinic status. Discovering trends in compliance to ideal clinic status interventions assists in developing recommendations to render high quality care to all patients accessing it.

Previously since implementation in 2013, clinics have achieved ideal clinic status however, majority of the clinics are not maintaining ideal clinic status and quality standards. The ideal clinic programme commenced in 2013 and rolled out to all provinces in SA by 2015.

The study is involving an in-depth interview with nurses of all categories. This should take approximately 15 to 30 minutes. For this, a secluded room identified to ensure confidentiality and thus, minimize any discomfort and harm to you, the participant including any physical, psychological, or emotional distress.

The tape and transcript (typed document of verbal conversation during the interview) will not be audible or seen by anyone else other than the researcher and the research supervisor. No personal information, such as names (your name or institution you belong to) will be used in the report or the transcripts.

Participation is voluntary and there will be no benefit taken away from you for non-participation. You are under no obligation to consent to participation. If, you decide to take part, this information sheet is yours to keep, and you will sign a written consent form.

The researcher and the research supervisor will be the only people that will access this, and it will be confidential. The transcripts and audiotapes will be kept in a safe place for the duration of 5 years then, destroyed.

Findings of this study will assist Department of health to assist in ensuring that strategies established to curb challenges experienced by nurses, thus ensuring quality standards maintained always in using ideal clinic tool.

You will sign a confidentiality agreement. This submitted to the Research Ethics Review Committee. After the report, the transcripts (interview) will be stored in a safe place. Your responses reviewed by people responsible for making sure that research is done properly, including the transcriber, external coder, and members of the Research Ethics Review Committee. Responses that identified by you will be available only to people working on the study unless you give permission for other people to see the records.

There is a probability that the report of this study submitted for publication, but your name will not be identifiable. Hard copies of your responses stored by the researcher for a period of five years in a locked cupboard/filing cabinet for future research or academic purposes; electronic information will be stored on a password protected computer. Future use of the stored data will be subject to further Research Ethics review and approval if applicable. All hard copies of the interview sessions will be shredded. This study has received written approval from the Research Ethics Review Committee of the Post Graduate Degree committee, UNISA. A copy of the approval letter is obtainable from the researcher if you so wish.

Participants in this study will receive no incentives or gifts.

If you would like to be informed of the final research findings, please contact Leeanna Dubru-Odayar on 0845825421 or @ leedubru@gmail.com

The findings are accessible once the study is completed. Should you require any further information or want to contact the researcher about any aspect of this study, please contact Professor Z.Z Nkosi on 021 429 6758 or nkosizz@unisa.ac.za.

Should you have concerns about the way in which the research conducted, you may contact Professor Z.Z Nkosi.

Thank you for taking time to read this information sheet and for participating in this study.

Thank you

(Signature)

Leeanna Dubru-Odayar

ANNEXURE 8: CONSENT FORM

INFORMED CONSENT TO PARTICIPATE IN THIS STUDY

I, ..., currently employed at....., confirm that the person asking my consent to take part in this research has told me about the nature, procedure, potential benefits, and anticipated inconvenience of participation.

I have read and understood the study as explained in the information sheet.

I have sufficient opportunity to ask questions and am prepared to participate in the study.

I understand that my participation is voluntary and that he/she is free to withdraw from the study at any time.

I am aware that the findings of this study processed into a research report, journal publications and/or conference proceedings, but that my participation kept confidential unless otherwise specified.

I agree to the recording of the semi-structured interview

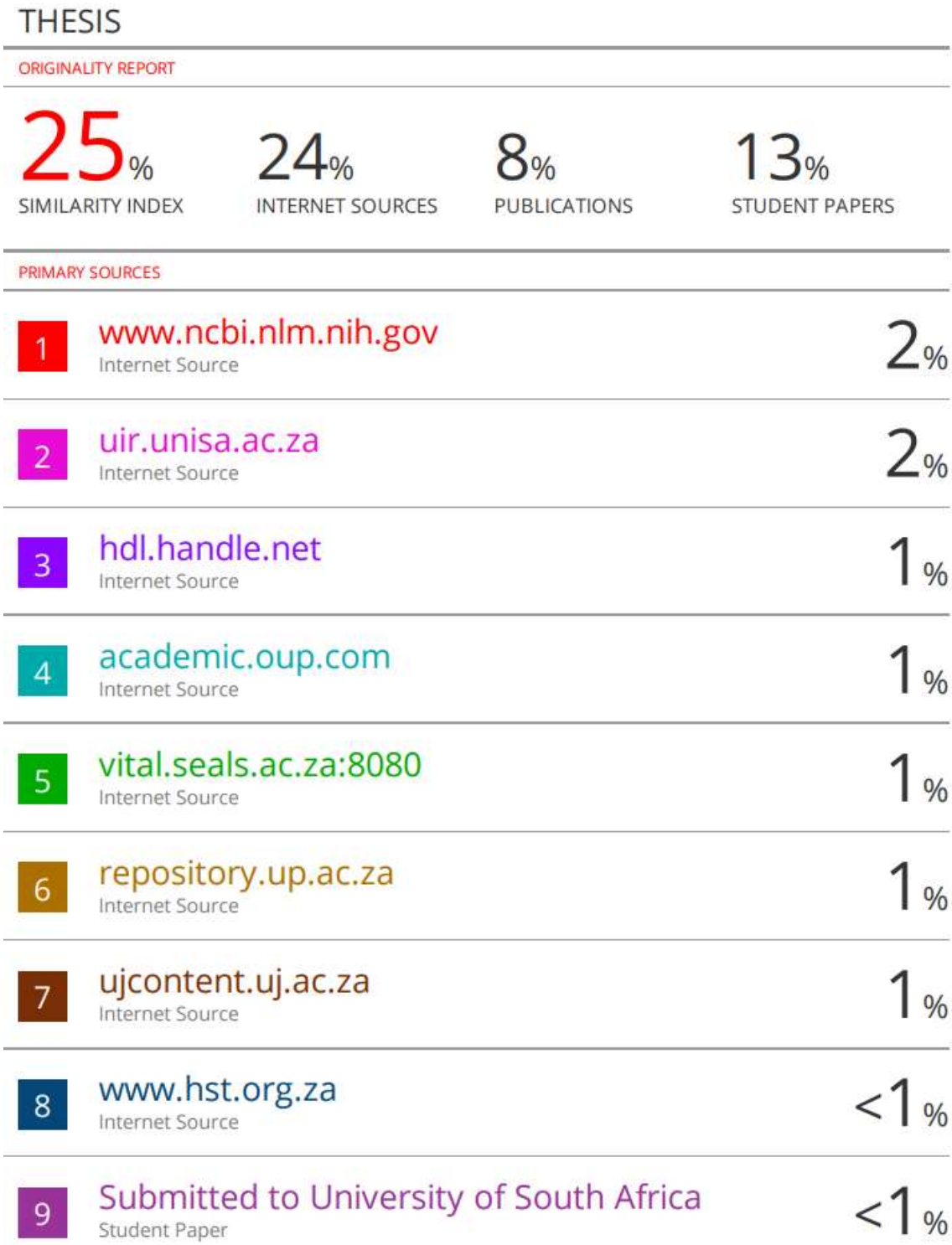
I have received a signed copy of the informed consent agreement.

Name & Surname..... (Please print)

Signature..... Date.....

Researcher's Name & Surname..... (Please print)

ANNEXURE 9: TURN-IT-IN REPORT



THESIS

ORIGINALITY REPORT

25%	24%	8%	13%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

1	www.ncbi.nlm.nih.gov Internet Source	2%
2	uir.unisa.ac.za Internet Source	2%
3	hdl.handle.net Internet Source	1%
4	academic.oup.com Internet Source	1%
5	vital.seals.ac.za:8080 Internet Source	1%
6	repository.up.ac.za Internet Source	1%
7	ujcontent.uj.ac.za Internet Source	1%
8	www.hst.org.za Internet Source	<1%
9	Submitted to University of South Africa Student Paper	<1%

ANNEXURE 10: LANGUAGE EDITOR CERTIFICATE

LANGUAGE PRACTITIONER: Anneke-Jean Diesel

BA Communication Science (Corporate and Marketing Communications)*
BA Hons Communication Science (Corporate and Marketing Communications)*
* Cum Laude

17A Innes Avenue
Waverley, Bloemfontein

Tel: 084 244 8961
annekedenobili@gmail.com

February 2023

DECLARATION

I, Anneke-Jean Diesel, hereby declare that I did the language editing of the dissertation of LEEANNA DUBRU-ODAYAR, titled *CHALLENGES EXPERIENCED BY PRIMARY HEALTH NURSES IN SUSTAINING IDEAL CLINIC STATUS POST IMPLEMENTATION IN ILEMBE DISTRICT, KWAZULU-NATAL*. This dissertation is submitted in accordance with the requirements for the degree of MASTER OF PUBLIC HEALTH at the University of South Africa. All the suggested changes, including the implementation thereof, were left to the discretion of the student.

Please note:

The language editing did not include reference editing/checking or formatting. Also, the editor will not be held accountable for any later additions or changes to the document that the editor did not edit, nor if the student rejects/ignores any of the changes, suggestions or queries, which he/she is free to do. It remains the student's responsibility to ensure that the similarity index is according to the University's regulations. The editor can also not be held responsible for errors in the content of the document or whether or not the student passes or fails. It is the student's responsibility to review the edited document before submitting it for evaluation.

Sincerely

SATI Registration #: 1003466

ANNEXURE 11: EXAMPLE OF TRANSCRIPT

Uhm Welcome to err interview. Thank you for participating err in this interview session, according to your participant information sheet, uhm we are doing a research on the challenges experienced by primary health care nurses in maintaining ideal clinic status and so just a few questions and a small discussion on that. Please feel free to stop when ever you want to or pause or whatever, please feel free okay. So im just gonna start with a little bit of biographical data like whats your years of experience in a healthcare setting

Uhm err almost 20 years

And you are now what category of nurse are you now

Clinical Nurse Practitioner, professional nurse

Okay, so can you describe your level of training or knowledge of ideal clinic since its implement implementation so implementation started in 2013? So what's your level of training? Or Knowledge on ideal clinic

Ideal clinic is Basically, according to me is like bringing all hospitals and on par bringing all hospitals on par where you have like all services that are rendered in the sense that you will have enough of staff, equipment, cleanliness of the hospital and clinics and what I said staff and resources should be we should have all the resources available and staff manpower.

So what sort of training had to do you in terms of ideal clinic?

There was no training with regards to ideal clinic but when we have an assessment, that's when we get familiar with the requirements for ideal clinic.

As a primary health care nurse, what are some of your experiences in maintaining clinic status?

Negative or positive, negative and positive.

Can you elaborate?

So the negatives are with maintaining the ideal clinic. First and foremost, it starts at the gate the waiting time. The waiting time is, it's a very long waiting time sometimes the waiting time is like about five hours. But according to ideal clinic and our clinic. The

waiting time should be at least between two and three hours. But we find that our patients are coming what you call in are waiting for like five hours. Also.

Can I just ask? What, what are some of the reasons you believe that patients are waiting that long?

Lack of manpower? One of one of the main reasons lack of manpower and the filing system. We don't have a very efficient filing system. So that's also were the problem is because if the patient comes to reception, the patient has to spend a long time looking at the reception because the clerk has to look for files, and that ends up increasing the waiting time. And as I said manpower in the sense that sometimes it's only one person working in the department, so they have to take their lunch and teas and the department will be left unattended and that's why the waiting time is increased.

So you go back to the experiences you mentioned negative and positive. So can you elaborate on that?

The positives, I would say that the operational manager or would I say that the supervisors they be trying the level best to like to improve the standard of care in the clinics by supplying us with equipment and supplying equipment and trying to get manpower, more manpower but it's trying is not like it's not something that's forcefully done is the do but it's trying to do trying to improve on that. So for me that would be a positive.

What other experiences do you have in maintaining?

Like just say, a for attitude of the staff. We get like we get disciplined if our attitude is not right towards the patient. Infection Control. Actually in this institution, there is no infection control, it's failing. So, that should be one of the factors for ideal clinic and lack of resources. More it should be more forceful in ordering resources and getting our resources because most of the time it's about budget and lack of manpower. The clinic especially with qualifications, you can bring a number of staff but they need to have a qualification as for PHC because this is a PHC setting. So when we have like other qualified nurses, their hands are tied. So the clinical nurse practitioners or the PHC nurse has info up getting burnt out because of underskilled workers. We don't have enough of workshops and training. It's lacking in this district. That is why knowledge is so so poor in the sense that people don't read the guidelines that affects it. They don't read the guidelines. They not they're very resistant to improving the knowledge or getting information. And also, most of the time, things are just done for the assessment and we don't follow up we don't maintain the standards. And it's a it's

not a true reflection when we have an assessment because we we helter skelter to sort things out according to the checklist, but the next day it falls off

So you mentioned that infection control is failing in this clinic. What what are some of the reasons why?

Firstly, we don't have an infection control rep. We don't have enough of workshops. The Cleaners especially don't have enough knowledge and they're not willing to learn. They're not willing to gain the knowledge. We don't, So knowledge to staff in the sense that at least once a month we should be doing some in service with regards to infection control, but we don't do that. It's been long, maybe a year plus that infection control is in service has stopped

What makes you think, what are some of the reasons in your opinion the reasons why

The reasons why have been service or you don't because it's infection contro in this clinic is seen as as unimportant like it's not important. It just basically as long as the floors are clean everything else doesn't matter.

What kind of plan do you have in place to sort of remedy these things that you have seen or you have noticed?

The thing is, infection control is failing like as I said, about a year or two because of workshops and in services. So with regards to a plan, there's no plan or such with infection control. There's no plan for workshops. There's no plan for teaching the cleaners, there's no plans for getting a rep. There is no plan. It's basically you on your own you have to read the guidelines or get the knowledge on your own. But as far as I know, there's no plan currently in this clinic for infection control and to improve

Why do you think staff are resistant in gaining more knowledge? What do you think are some of the reasons?

So one of the reasons is that staff are lazy. Staff are lazy (so sorry to interrupt, can I take those documents). So one of the reasons is that staff are lazy, another factor is they are different categories of nurses. So if you are say category one, category two and category three. So the PNs are category one and category two and three is the staff nurses and enas. So they refuse to to gain knowledge because they feel that according to their scope they have to do like their hands on time with regards to certain things. So they just want to do what they want within their scope. So they don't plan to like broaden their knowledge with regards to that another thing is, with regards to knowledge, we lack the guidelines, because our government has stopped making

hardcopy guidelines, so it's more cheap, you noe have to use them downloaded. We have downloaded on our phones and most of the people don't have access to data. And so that's also another issue because previously we used to have hard copies of guidance where you can refer to immediately when you when you have a problem, but right now there's no hardcopy guidelines. So that's also another issue. And if there are guidelines, it's older, it's not updated. So that's one of the reasons why our knowledge is not broadened. And the I think also another reason is that the patient to nurse ratio is there's a big difference the nurses are over budget as I spoke about categories and the categories and level of qualifications. And that's one of the factors hindering maintainance of ideal clini because the nurses are overburdened and they just we just want to push the crowd. We don't we don't what I must say Ideal clinic is the last thought when you're pushing the crowd.

So, I think you've covered in terms of your experiences yourself. Yourself maintaining the clinic status and the challenges that you guys face. What do you think of this idea of this program that is implemented and that we trying to maintain? What do you think of it?

I think that it is an excellent program in the sense that it will be no injustice with regards to health care. Everyone will get the same health, same level of care. So because South Africa has a lot of people living below the breadline, and government clinics, clinics and hospitals the waiting times are very very long and if we have if we maintain either clinics status, those factors would improve. what else And one of the things with regards to why the ideal clinic is why I feel that the ideal clinic is it's a good thing is that we at least like the infection control and all our things that we lagging will get improved

If you focus on your knowledge on the ideal clinic, what can you elaborate on the changes it has brought to this institution? The ideal clinic

The changes in the sense that we are getting more manpower resources are getting our resources as improved. So, that is also the manpower and the resources are the two main factors which are trying to improve for ideal clinic and what else, there is nothing else. The clinic is anything but ideal and it's far from actually reaching the ideal training status. So we are still at ground level and the resources and manpower are starting to come in so

Elaborate on that, we are far from ideal clinic

Ideal clinic has a checklist 123456 whatever and according to the checklist, we tick no boxes. We tick no boxes in the sense that we only get prepared for Ideal clinic assessment. And I feel that the assessment that's being done at the clinic is not it's very it's not a diplomatic it's very biased like I feel like like the OM in a certain clinic will get favored because they know her kind of thing. And they overlook important things. So ja, so that's not a true reflection of how ideal clinic should be. And a lot of things are being overlooked because they are being assessed by their peers and their friends. So there's not a true reflection of how ideal clinic should be

So in your experience, what have you noticed when, when staff when being assessed by peers

It's just that it becomes a friendly thing. And the peers will actually not elaborate on the negative things that they found. The overlook it. So it's about okay, here the idea clinic if something is missing or something is done, done, okay. Please do that. And they don't have a follow up to check whether those things are done.

What support structures do you guys have in place to assist you to maintain ideal clinic

The only support structure we have with each other or the manager the operational manager. When it comes to the district or supervisors the support is is none it's nil its only when the time of assessment that they do behave as if the support but there's no support

Okay, your role can you describe your role played in maintaining ideal clinic status

My role play is that I make sure that documentation is done properly. I make sure that I work fast. So the waiting time for the patient as will decrease. I Make sure that the environment that I'm working is is clean and neat. I make sure that I have the correct bins in my room or in the department that I'm working we make sure that our attitude, my attitude towards the patient is not. It's not rude. We make sure that we do everything the patient requires.

Thank you I think we're almost at the end of our interview. But any information please feel free to share any other information that you think you could have missed out or whatever on your challenges or your experiences with ideal clinic maintaining the ideal clinic status.

Ideal clinics status the challenges I think it is it's resistance from staff. It's resistance in the sense that they don't want to be overworked. They feel like they have to continue and maintaining status they feel that it is beyond them. Because they feel that it's they

feel burdened. So that's one of the challenges and as I said the knowledge lack of knowledge and why and actually the different definition of ideal clinic I think many of us, many of us are failing to even know what the definition of ideal clinic, I think if we can we make some attempt to know what is an ideal clinic is actually going to be such a good thing. It's such a positive thing to improve services. So it starts there the basic ground level. If they knew what is deal clinic and what is the purpose of ideal clinic then we would then maintain the status. But if staff are not resistant to even know the definition of ideal clinic. And even like even managers are doing ideal clinic. It becomes all about them. Right and so the staff are not learning because I feel like a checklist. The complete checklist should be given to each staff to have a look at it. So we know what is required is not about it's not about just the supervisors just it's not just about the operational manager working on it in her office. I feel that we should work as a team that's one of the challenges it becomes one person's project. So the others others. The others don't know. What is ideal clinic what's expected? It becomes an operational manager's project.

Ok if there is nothing more to add, I think we have come to the end of it. Thank you