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INTRODUCTION TO
# Health Services Management
FOR THE UNIT MANAGER

4
FOURTH EDITION

Booyens ▪ Jooste ▪ Sibiya

INTRODUCTION TO

# Health Services Management

FOR THE UNIT MANAGER

## FOURTH EDITION

**Susanne Booyens** (Originating author)

Updating editors:
**Karien Jooste and Nokuthula Sibiya**

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# Preface

Like the previous editions, this revised and updated fourth edition of *Introduction to Health Services Management* describes the functions and environments of the first-level health service manager, that is, the nurse in charge of a nursing unit in a hospital, community healthcare clinic or other healthcare facility.

Several authors with different areas of expertise have contributed to this book, with the result that it addresses all the aspects of first-line management in the health sector and brings different voices and perspectives to the various topics.

The arrangement of the chapters follows these elements of healthcare management – planning (the first four chapters), organising (chapters 5–7), staffing (chapters 8 and 9) and control (the last two chapters).

It is hoped that this book will serve its purpose, namely, to contribute to a thorough understanding of the scope and functions of first-level health service managers in South Africa's various healthcare facilities.

**Karien Jooste and Nokuthula Sibiya**
*Updating Editors*

2015

# 1

# Introduction to Nursing Management Processes

K Jooste and P Bimray

## Chapter outcomes

After studying this chapter, you should be able to:
- explain the evolution of the different management theories;
- describe the basic management process and principles;
- discuss leading versus management in a health service unit;
- recognise the importance of management competencies in an organisation;
- describe the millennium goals, for importance in a health organisation;
- explain management ethics in the context of a healthcare unit.

## 1.1 Introduction

The past two decades have seen significant changes in healthcare services. These changes are mainly due to various political, socioeconomic, demographic, technical and epidemiological factors. In South Africa, healthcare services are further hampered because of the burden of disease, an aging nursing population, inadequate resources and ineffective management systems. The survival and reconstruction of the healthcare service depend on appropriately qualified and developed managers and personnel who continually update their knowledge and skills and adequate healthcare structures (Booyens, 1995:4).

Management in the healthcare context refers to the processes of planning, organisation, staffing, leading and control, in a healthcare facility or organisation. These are important functions for a unit manager, in order to achieve the predetermined organisational goals as productively as possible and according to the highest standards (Jooste, 2010:78). Henri Fayol was an engineer and administrative theorist who, in 1925, identified management functions. He investigated how productivity could be improved from the top management down to the subordinates to focus on the job and tasks (Clark, 2009:33).

The nursing manager is responsible and accountable for the management of the nursing unit, at the operational level, within a legal and professional-ethical context.

Nursing unit management is a component of healthcare service management. The management of a nursing unit takes place within the context of the healthcare service's vision, mission, goals, values and strategic plan (Muller, 2009:95–101).

## 1.2 Management theories

The different management theories are a point of departure in understanding the management principles that a nursing manager should follow to organise a health unit successfully. These theories are often divided into three groups to facilitate understanding and interpretation:

- classical theories
- humanistic school of thought
- modern, or contemporary, approaches.

### 1.2.1 Classical theories of organisation

The main exponents of these theories of organisation are Fayol, Taylor and Weber.

### *Henry Fayol*

Henry Fayol (1841–1925) is considered the father of the classical school of thought. He listed the following principles of management:

- *Division of work*: specialisation occurs when an organisation is growing and division of work promotes productivity and control.

- *Authority and responsibility*: authority should be accompanied by responsibility. Managers in healthcare services have the right to give orders, but should accept the effects or consequences of giving orders.

- *Unity of command*: an employee has a direct supervisor from whom he or she receives orders to avoid confusion and promote clear instructions.

- *Unity of direction*: there should be only one person in charge of a group of similar activities.

- *Subordination of individuals' interests to general interests*: the goals and activities of the organisation or unit always come first.

- *Remuneration of personnel*: as far as possible, a fair salary that satisfies both employer and employee should be paid.

- *Centralisation and centrality*: power and authority are concentrated at the upper levels of the organisation; however, employees at the lower levels should be granted enough authority to perform their jobs.

- *Scalar chain*: an unbroken chain of authority and communication should extend from the highest to the lowest level in an organisation.

- *Order*: there is a given place for everyone and everyone must be in place.

- *Equity*: all employees in an institution should be treated alike. No favours should be given to anybody.

- *Employee discipline*: the employer has the right to discipline employees if they do not comply with the organisation's rules, but everybody should be treated equally.

- *Stability of job tenure for personnel*: a characteristic of a prosperous institution is a stable workforce. Healthcare professionals should be given continuity of employment in order to build expertise.

- *Encourage initiative*: individuals should have the opportunity to exercise initiative at every level of the organisation, within the limits of respect for authority and discipline.

- *Esprit de corps*: teamwork and harmonious interpersonal relations are important in an organisation for productivity and effectiveness (Pettinger, 2002:12; Lewis, Goodman & Fandt, 2004:52).

Fayol emphasised that these principles must be flexible and would vary between different organisational situations. Some of these principles (subordinates using their own initiative, team spirit and good interpersonal relations) still have value and are applicable in modern organisations. Fayol was also responsible for dividing management into management functions, namely planning, organising, commanding, co-ordination and control (Marquis & Huston, 2003:7).

## Frederick Taylor

Frederick Taylor (1856–1915) laid the foundation for the scientific school of thought regarding the management of organisations. He believed that productivity could be increased by applying the scientific methods of observation, measurement and experimental comparison to the work situation. His focus areas were task performance, supervision and motivation.

### Task performance

The performance of employees should be observed by time and motion studies undertaken to identify the best way of performing a task. This could lead to several basic expectations of management, namely:

- development of work standards for performing each job in the best way
- selecting employees to fit the specific job
- training employees in the standard methods
- supporting employees by planning their work for them.

### Supervision

One supervisor cannot be an expert at all the tasks to be supervised. Specialisation takes place by appointing functional level supervisors with managerial responsibilities to a certain group of subordinates to supervise them. A professional nurse supervising a paediatric unit cannot be expected to be equally effective if suddenly put in charge of a geriatric unit.

### Motivation

Money can be used to motivate employees to increased productivity. When they attain a certain standard, they should receive a certain wage. When exceeding

these standards, they should receive more than the standard wage. However, if an employee produces less, the rate of pay should drop. This principle is not applied strictly in the health services, although some organisations use the merit rating system to motivate employees to higher productivity (Lewis et al, 2004:49–51).

Today, it is understood that money is not the only motivator. Although Taylor's approach has merit, it is more appropriate to factory production than to healthcare delivery. The biggest problem with his approach is that it is not holistic; every task performed is seen in isolation of another task. Taylor's focus on task performance emphasised the importance of physical facilities. Optimum conditions of lighting, workplace layout, comfort of the employees, and the necessary tools and equipment should be supplied for the employees to succeed in their jobs. Equipment that is out-dated or not in a satisfactory working condition may result in employee stress, burnout and absenteeism.

## *Max Weber*

Max Weber (1864–1920) regarded bureaucracy as the best way to organise a complex organisation. Characteristics of bureaucratic management are the following:

- *Rules and procedures*: these are seen as formal guidelines, controlling the behaviour of employees on the job. They ensure uniformity of procedures, stability and co-ordination of employees' efforts. In healthcare organisations, policy and procedure manuals direct formal guidelines.

- *Impartiality*: managers' objectivity and fairness is needed when evaluating employees, for instance, when doing merit rating.

- *Division of labour*: duties are divided into simpler and more specialised tasks, enabling more efficient use of personnel.

- *Employee selection and promotion*: emphasis is placed on technical competence by hiring people with certain skills and knowledge to carry out specific aspects of the total work of the organisation. Employees are promoted on the basis of their job performance.

- *Hierarchical structure*: most healthcare organisations operate according to a hierarchical structure that resembles a pyramid. Power and authority increase at every level. The nursing service managers are at the top of this pyramid (healthcare service), and the student nurses and nursing auxiliaries are at the bottom.

- *Lifelong career commitment*: both employee and employer view themselves as being committed to each other throughout the employee's working life. Job security is guaranteed as long as the employee stays sufficiently qualified for the post. In nursing, this can no longer be regarded as a strong commitment, as can be seen from current career mobility trends among nurses.

- *Authority structure*: the system is tied together by an authority structure; decisions are made at the 'top'. People high up in the hierarchy make decisions and expect people on the lower levels to implement them.

- *Rationality*: the organisation's objectives should be achieved using the most efficient means (Hellriegel, Jackson, Slocum, Staude & Associates, 2004:50–52; Lewis et al, 2004:53).

Weber considered bureaucracy to be highly efficient in dealing with changing circumstances, but it has proved to be too rigid and clumsy for the rapid changes in modern society. This approach became extremely unpopular for the following reasons:

- rigid rules and red tape leave little room for individual freedom and creativity, resulting in poorly-motivated employees
- slow decision-making processes
- incompatibility with changing technology
- incompatibility with professional values (Hellriegel et al, 2004:53).

Roussel, Swansburg and Swansburg (2006:115) mention that bureaucracy inhibits professionalism in nursing.

## 1.2.2 Humanistic (behavioural) school of thought

During the first decades of the 20th century, managers became more aware of human behaviour and its impact on employees' actions (Lewis et al, 2004:56). The major contributors to this school of thought are Mary Parker Follett, Elton Mayo, Douglas McGregor and Chester Barnard. This school of thought recognised that the goals and needs of employees may differ from those of the organisation. By including employees in decision making and planning and by acknowledging their needs, a more co-operative milieu in the organisation may be created.

### *Mary Parker Follett*

Follett emphasised the employees' contribution to the problem-solving process (the people closest to action are able to make the best decisions) and the dynamics of management. She recognised persons as 'a collection of beliefs, emotions, and feelings' (Hellriegel et al, 2004:59). She valued the vital role co-ordination plays in effective management, and developed the following principles to encourage co-ordination:

- When people responsible for decision making are in direct contact with each other, co-ordination is best achieved.

- Co-ordination should be established during the first phases of planning and implementing projects.

- All factors in a situation should be addressed by co-ordination.

- To co-ordinate is a continuous process (Hellriegel et al, 2004:59).

## *Chester Barnard*

Organisations are viewed as social systems by Barnard. The main functions of managers are viewed as continuous communication with employees, motivating them to work hard in order to achieve the objectives of the organisation and communication with role players outside the organisation, like investors and suppliers upon whom the organisation depends (Hellriegel et al, 2004:60).

## *Elton Mayo*

The famous Hawthorne studies were initiated by Elton Mayo (1880–1949). Mayo thought it incorrect to believe that a well-designed task and sufficiently high wages would always motivate employees. Sympathetic supervision is viewed as a further reinforcement to motivation. Mayo's work is important because he emphasised that the employee should be viewed as a whole person and not just as a worker. The employer should also pay attention to the worker's attitudes, hopes, fears and personal problems. The employer should acknowledge informal groups of employees and try to obtain the co-operation of employees in an effort to achieve the goals of the organisation (Tappen, 2001:32).

The following are basic assumptions of the behavioural school of thought:

- The social needs of employees play an important role in motivating them. Their relationships with the persons they associate with give them a sense of identity.

- The social influences of fellow employees, rather than financial incentives and rules of management, tend to make employees more responsive.

- Employees are more receptive to managers who help them satisfy their own personal needs.

- The organisation's efficiency can be improved when managers co-ordinate work with the participation of subordinates (Hellriegel et al, 2004:61).

Health service managers should understand the informal and formal structures of healthcare organisations. They should foster group cohesion, loyalty and participation in decision making in order to reduce resistance to necessary changes.

## 1.2.3 Contemporary approaches to organisation

The period of modern organisation theories started in the 1960s. These theories consist of different approaches to organisation, namely, the systems approach, the contingency approach, Ouchi's Theory Z, the excellence movement, total quality management (TQM), participative management and the learning organisation.

**FEEDBACK**

| Inputs from the environment | Transformation or processing of inputs | Outputs to the environment |
|---|---|---|
| • Financial<br>• Human<br>• Physical<br>• Information | *Manufacturing and operational systems*<br>• Technology<br>• Expertise<br>• Information<br>*Managing process*<br>• Planning<br>• Organising<br>• Leading<br>• Controlling | • Products<br>• Services<br>• Job opportunities |
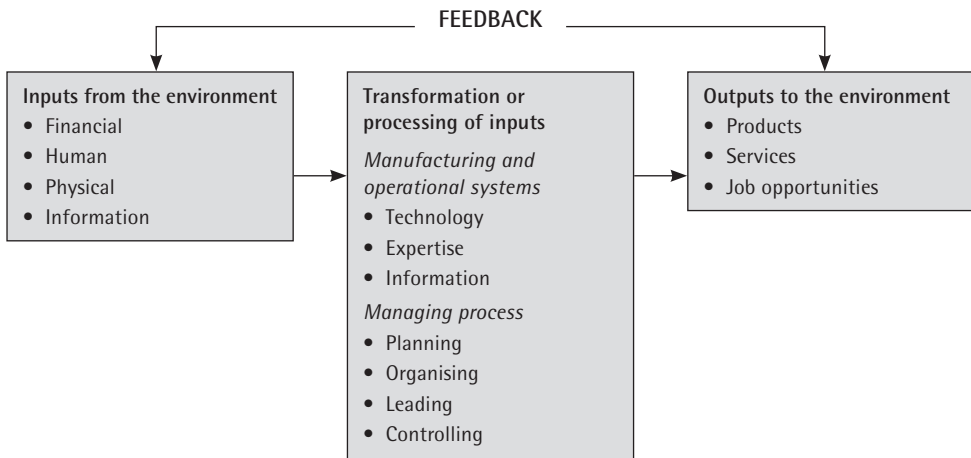
**Figure 1.1**: A systems perspective of an organisation

Source: Smit and Cronjé (2002:62)

## The systems approach

The systems approach aims to solve problems by looking at the relationships between the system's input, throughputs, output and environment (see Figure 1.1). The input comprises the physical, human, material, financial and informational resources (Hellriegel et al, 2004:62). Smit and Cronjé (2002:46) believe that the single purpose of the interrelationships is for all parts to remain in equilibrium. Any activity in one part of the system will influence other parts of the system. The healthcare organisation is regarded as an open system because it is dependent on the environment in which it functions, while the environment is also reliant on the system. Specific interaction between the system and the environment takes place (Smit & Cronjé, 2002:62).

The healthcare system is greatly exposed to the effect of changes in its environment. Aspects in the environment that influence the healthcare system are, among others, the economy of the country, political stability and legislation, natural and man-made disasters, the educational system and technology.

In a healthcare organisation the input may be the training of healthcare employees, the building of hospitals and clinics and the provision of equipment and supplies. The throughput is the process or action by means of which the system converts the input into the product or service (output).

The input may be an immunisation programme to prevent the outbreak of diseases, or the surgical or medical treatment of a patient in hospital. The output is the service or product that is the result of the input and throughput. In the health service this product may be a drop in the outbreak of contagious diseases or the level of patient satisfaction with the care given.

To operate effectively, there must be feedback to provide information on the status and performance of the system. This is why it is important to keep accurate statistics and conduct patient satisfaction surveys. Future planning should be done in accordance with the feedback received.

In this approach, management has a wider perspective of the organisation as a whole than that of the employee working at grass roots level.

## The contingency (situational) approach

During the 1960s, managers became aware that there is not only one best approach to management. The contingency approach tries to integrate the ideas of the different schools of organisational thinking. In a particular situation management will decide which school's principles should be applied (Lewis et al, 2004:62). Healthcare organisations are unique with respect to the type of product and services they offer. Every health service has its own particular environment and patients they serve. One would, therefore, expect to see different management approaches even in the same hospital. To take an example, in an intensive care unit, where highly specialised employees take responsibility for the specific patients assigned to them, the environment can be more unstructured. In a paediatric unit, however, where the supervisors work with more junior healthcare professionals, the approach may have to be more structured, indicating the lines of authority between junior and senior staff.

The uniqueness of management situations, however, should not be overemphasised (Smit & Cronjé, 2002:47–8). Criticism of the contingency approach is that it seems to ignore the fact that there are universal principles of organisation that are valid in every situation. This approach can be explained as follows. In a management situation the characteristics of the situation are called contingencies. These contingencies are the external environment of the organisation (changes, complexity), the capabilities of the organisation (strengths and weaknesses), managers and employees (their values, goals, skills and attitudes) and the technology used in the organisation. Managers should approach the situation by assessing the above-mentioned contingencies and then decide which approach is most likely to bring the best results.

## Theory Z

Theory Z, developed by Ouchi in the 1980s, aims to integrate the best management approaches from American and Japanese organisations alike. Important factors are the following:

- *Long-term employment*: Employees move around in an organisation, rather than between organisations. They become less specialised, but more valuable to the organisation. They understand the functioning of the different departments within an organisation better, resulting in better communication and co-ordination between the departments.

- *Slower promotion*: Rapid promotion prevents the development of close relationships, while slower promotion allows time to make a comprehensive assessment of the employee.

- *Group decision making* based on qualitative and quantitative data. Problem solving by means of quality circles forms an integral part of this theory. The manager and employees meet on a weekly basis to solve problems related to

work, or discuss methods that can be used to improve work processes and outcomes. Communication between management and employees is thus improved through frequent interaction. Some hospitals have quality circles in place, assisting in solving problems in units and in the hospital itself.

- *Indirect supervision*: Employees are familiar with the values, goals and philosophies of the organisation and do not need to be told what to do.

- *Holistic concern*: Both the employees' and the organisation's welfare are considered through the values of trust, fair treatment, commitment and loyalty (Tappen, 2001:38–9).

## The quantitative school

According to the quantitative school of management thinking, management is a system of mathematical models and processes. Pioneers in the Total Quality Management (TQM) arena are Joseph Juran, Philip Crosby and W. Edward Deming. The principles of this movement are described in Chapter 16, Quality Improvement in Health Services.

- *The key focus is decision making*: Managers routinely need to solve problems and make decisions. Problems are solved and decisions made using mathematical techniques like break-even analysis, capital budgeting, linear programming, queuing theory and probability theory.

- *Measurable criteria*: Before managers make a decision, they should weigh different alternatives against each other, making use of measurable criteria, such as profit, cost, return on investment and output rate.

- *Quantitative model*: The impact of each alternative is simulated by means of mathematical symbols, equations and formulas to represent properties and relationships.

- *Computerisation*: In view of these characteristics, it comes as no surprise that computers play an integral role in the problem-solving process, as it is costly and time-consuming to do these equations with pen and paper.

This approach should be seen more as an aid to management than as a school in its own right.

## The excellence movement and total quality management

Total quality management (TQM) is a continual process requiring the involvement of every employee in an organisation. By receiving constant feedback from customers, any problems encountered are dealt with in a preventive or proactive way (Marquis & Huston, 2003:453).

## Participative management

A decentralised structure, where decision making takes place at lower levels of the organisation, is ideal for the participative management approach. Characteristics of this approach are the following:

- *Trust*: Managers display trust in employees at a lower level and allow them to accomplish assignments without interference. Managers receive feedback by means of periodic reports from the employees.

- *Commitment*: Managers show their commitment to the organisation by their visibility and regular contact with the employees, for example area managers doing a daily round in hospital wards. Employees' roles in decision making motivate them.

- *Goals and objectives*: At regular performance appraisal interviews, the manager and employee decide together on performance goals for the employee.

Further characteristics of this school of thought, as identified by Hellriegel et al (2004:64) and Lewis et al (2004:60), are as follows:

- *Autonomy* is typical of the behaviour of professionals, where they are trusted by their managers to make decisions in their field of expertise.

- *Roles of the managers*: Managers delegate authority to their subordinates; this requires good interpersonal skills and conceptual abilities.

- *Communication*: Good communication is required in participative management, where employees and managers talk freely to each other, thus omitting the 'middle person'. This also saves time.

Advantages of participative management are improved morale, job satisfaction, productivity and enhanced teamwork. Disadvantages of this management style are that it is sometimes difficult to establish who is responsible for which task, as well as changing existing policies and procedures (Roussel et al, 2006:135–41).

## The learning organisation

Learning organisations, according to Senge (1990) in Stinson, Pearson & Lucas (2006:309):

> 'are places where people continually expand their capacity to create the results they truly desire where new and extensive patterns of thinking are nurtured, where collective aspiration is set free and where people are "continually learning how to learn together."'

### Senge's five disciplines of a learning organisation

The views of Senge, which he terms 'the five disciplines of the learning organisation', are summarised as follows:

1. *Systems thinking*: This means to see inter-relationships rather than linear cause–effect change, to see processes instead of static events, to think in context, and to value the effect of actions on other parts of the system.

2. *Personal mastery*: Develop personal proficiency and mastery in key areas and focus one's energy.

3. *Mental models*: Be aware of unconscious generalisation and assumptions that limit our views and actions on incidents in the organisation.

4. *Shared vision*: Building a shared vision for the organisation that involves genuine commitment, rather than compliance, will enable people to excel and learn.

5. *Team learning*: Identify patterns of interaction that undermine learning so that the team can engage in discussion and think together in a productive way.

(Adapted from Stinson et al, 2006:309; Goding, 2006:117)

Stinson et al (2006:309) suggest that learning organisations should value and recognise the need for lifelong learning and allow protected time for learning activities. A learning culture can be established through developing strong teams, and through socialising and learning activities. Stinson et al (2006:309) further suggest that it is necessary to be open to feedback and ideas from others, to be able to learn from mistakes, and to develop self-awareness.

## 1.3 The management process

The nursing unit is part of the entire healthcare service. Nursing unit management is therefore the achievement of the nursing unit's objectives through applying the management activities of planning, organising, staffing, directing and controlling. This management process is presented in the form of a cycle (see Figure 1.2).



**Figure 1.2**: The management process circle

### 1.3.1 Planning

One of the duties of a professional nurse is to involve nurses in planning. The scope of practice for registered nurses (Reg. R. 2598, Act 33 of 2005 as amended) makes it clear that nurses are responsible for establishing, maintaining and executing the nursing regimen to promote the physical and mental health of a patient (South African Nursing Council). Planning may be defined as deciding in

advance: what to do; who is to do it; when to do it and where to do it. Planning involves choosing from alternatives, which implies that it is a proactive and deliberate process (Marquis & Huston 2003:55). Muller (2009:101–102) on the other hand talks about a purposeful assessment of what should be achieved and how it will be achieved as a requirement of the planning process (Table 1.1).

Table 1.1: Different dimensions of planning

| Marquis & Huston (2003) | Muller (2009) |
|---|---|
| • What to do? | • What do we want to achieve? |
| • Who is to do it? | • How are we going to achieve it? |
| • When to do it? | • How are we going to determine whether or not we were successful? |
| • Where to do it? | |

Planning is the first management activity, and refers to the intentions of the unit manager and other healthcare professionals. The planning activity requires that the unit manager and healthcare professionals formulate a vision of the unit, as well as giving guidance or direction to nurses in the unit. A thorough needs assessment is an important phase in the planning process, especially in view of:

• the objectives to be achieved
• the activities or strategies which are necessary to achieve these objectives
• the resources (personnel, funds, equipment, supplies and time) (Muller, 2009:102).

Assessment is always followed by a plan of action, implementing the plan of action and an evaluation strategy. The evaluation strategy describes how the success of the goal achievement will be measured.

## Strategic planning

The strategic planning process is as follows:

• The mission of the organisation is formulated.
• The external and internal environments are analysed.
• Objectives are set.
• Strategies are devised.
• Action plans are drawn up for achieving the objectives in terms of the mission statement.

The plans are implemented and progress is monitored and evaluated. The results are then fed back into the system at stage 1 of the five-stage model (Figure 1.2). The strategic planning exercise is costly and it results in raised expectations regarding the solving of organisational problems. Success requires the commitment of top management. All the stages of the strategic planning process must be worked

through. The process must be applied on an ongoing basis, with strategic thinking being promoted among all personnel. Each manager and healthcare professional should understand that the onus is on each individual to do the work according to plan, in order to bring about the planned changes in the organisation. Without such commitment, nothing will change.

The Strategic Human Resource (SHR) plan is driven by the objectives of an organisation or healthcare institution. It is referred to as a management tool developed to deal with change. In Figure 1.3, a five-stage model of the strategic human resource planning process is illustrated. It is an example of a structured and comprehensive approach to, for example, human resource planning.

Investigating → Forecasting → Action planning → Implementing → Monitoring

**Figure 1.3**: The strategic process as applied to human resources

The process is applied at three levels in the organisation or healthcare institution:

- the strategic or top management level
- the division or middle management level
- the operational or functional level.

### 1.3.2 Organising

Organising in the nursing unit refers to the orderly structuring of functions or responsibilities in order to ensure the smooth running of activities which involves the establishment of order in the unit – the work should be organised and divided in a logical manner to facilitate quality, efficiency and effectiveness (Muller, 2009:103,118).

### *Organisational structure*

Organising follows planning. In the organising phase, relationships are defined, procedures are outlined, equipment is readied and tasks are assigned. Organising involves establishing a formal structure to co-ordinate and utilise resources to accomplish unit objectives. Organisational structure refers to the way in which a group is formed, its lines of communication and its means for channelling authority and making decisions (Marquis & Huston, 2003:153; Jooste, 2010:80). Each organisation has a formal and informal organisational structure. Formal structure provides a framework for defining managerial authority, responsibility and accountability. Informal structure is generally social in nature, with blurred or shifting lines of authority and accountability. In each organisation, there must be an awareness that informal authority and lines of communication do exist, even when they are never formally acknowledged (Marquis & Huston, 2003:154).

A vertical or hierarchical division of jobs or posts indicates the order of rank and direction for responsibility and accountability of the job levels and the employees

in each job (Figure 1.4). This division takes place in order to indicate the number of posts that are filled in the nursing unit or service on the same job or post level.

| |
|---|
| Chief professional nurse |
| Senior professional nurse |
| Professional nurse |
| Enrolled nurse |
| Auxilliary nurse |
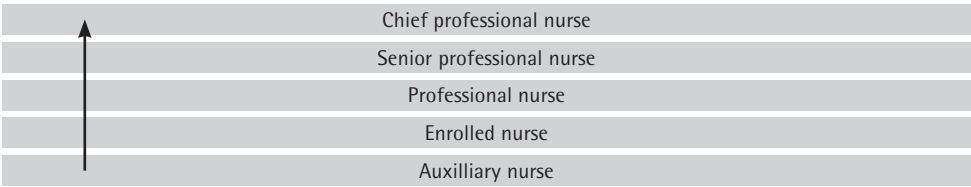
**Figure 1.4**: Vertical division of positions or post levels in a nursing service

Horizontal division of labour takes place in order to indicate the number of posts that are filled in the nursing unit on the same post level. Two or more senior professional nurses, who are on the same job level, can therefore be employed in the same unit (Figure 1.5). Usually there is more than one professional nurse, as well as several staff nurses and auxiliary nurses in the same unit. This division of post levels in the organogram is important, as it indicates the relationship of authority between personnel.

| Senior professional nurse | ⟷ | Senior professional nurse | ⟷ | Senior professional nurse |
|---|---|---|---|---|
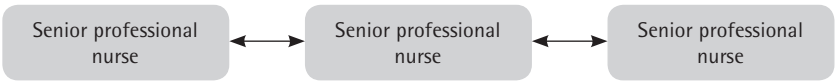
**Figure 1.5**: Horizontal division of a post level of an enrolled nurse in a nursing unit

First- and middle-level managers have their greatest influence on the organising phase of the management process at unit or departmental level. At this level, managers organise how work is to be done. At unit level, managers have control over the organisational climate and how patient care delivery is organised. However, for any healthcare delivery system to be effective and successful, top-level managers should influence a supporting philosophy and adequate resources (Marquis & Huston, 2003:208).

## 1.3.3 Staffing

Staffing is the third phase in the management process. In this phase, managers recruit, select, appoint, orientate and promote personnel development, and conduct performance development to accomplish the goals and objectives of the organisation or unit. Ensuring adequate numbers of skilled healthcare professionals to accomplish organisational goals is an important management function. Staffing, or personnel management, is an essential part of the unit manager's function. The goal of staffing is to optimise human capital performance in a healthcare organisation or unit. To get the right people to do the job effectively, unit managers must ensure that staffing follows an orderly, systematic process which is based on a sound rationale (Jooste, 2010:162). It is fundamental that healthcare organisations provide adequate numbers of competent healthcare

professionals. Adequate staffing is key to improving the quality of patient care, to decrease burnout among healthcare professionals, and to keep nurses employed in settings where they are needed (Aiken, Clarke & Sloan, 2002; Clark, 2009:328).

## 1.3.4 Directing

Directing refers to the unit manager's leadership responsibilities, namely to give direction and to ensure that the goals and objectives are achieved in the unit. It includes a facilitation function in which the unit manager exercises leadership in the undertaking, supervision, motivation and empowerment of group members or subordinates (Muller, 2009:104). Directing healthcare professionals includes motivating, managing conflict, delegating tasks, communicating, monitoring and collaborating. Directing ensures that healthcare professionals work towards specific goals and objectives; it also ensures that employees understand what the organisational plans are. The unit manager guides the team by training and instructing them what to do, when to do it and how to do it, and at the same time influencing others (Clark, 2009:35).

Unit managers are responsible for supervision and monitoring of goal achievement by using their influence to motivate and achieve the goals, as well as implementing change (Jooste, 2010:78). Muller (2009:151) describes directing as an enabling management activity, aimed at achieving the objectives of the nursing unit. Harmony in the nursing unit is one of the principles which should be facilitated by the unit manager. Directing is also related to teamwork, motivation and dealing with conflict. As part of directing, unit managers should take part in the following:

- maintaining a high staff morale
- providing education and training programmes to maintain healthcare professionals' competencies
- facilitating effective communication and interpersonal skills
- organising human resource utilisation
- mentoring healthcare professionals
- inspiring trust and promoting teamwork in the organisation
- assisting employees with career management (Jooste, 2010:83).

## 1.3.5 Controlling and evaluation

Controlling ensures that activities are aligned with set standards, that policies are adhered to, and that employees comply with them while they perform their tasks. Without control, management of the organisation or unit becomes disorganised and the achievement of unit goals is disrupted (Jooste, 2010:87). Controlling helps keep the team on course by using performance appraisals, financial accountability, quality control, legal and ethical approaches, and professional and collegial control. As part of the controlling function, special attention should be given to quality control in a unit, performance appraisal and development of healthcare professionals, creating a growth-producing work environment through discipline, and monitoring employees with special needs.

By putting control mechanisms in place, the unit manager helps keep the team on course by removing obstacles or by finding an alternative if the present system is not working.

The process of controlling involves:
- establishing standards for measuring work performance
- measuring performance and comparing it with standards
- identifying the reasons for the discrepancy between standards and performance
- taking corrective action to ensure that goals are attained (Clark, 2009:35).

## 1.4 Management versus leadership

Management and leadership are two interdependent factors and are often used interchangeably. An individual may be a great leader, but not a manager; however, the roles often overlap. The best-case scenario would be for a person to have the best characteristics of both.

### 1.4.1 The difference between management and leadership

Despite the similarities in meaning, there are, however, distinct differences between the two concepts.

### *Planning and vision*

Managers are more dependent on systems, while leaders rely more on people. Managers tend to focus their planning on short-term objectives, that is the day-to-day issues or problems, how to react to immediate pressures and events, and how to get a task done; leaders, on the other hand, will concentrate more on planning for, and envisioning the future with long-term strategies. Leaders communicate a vision that will have an enduring effect and which will move the organisation in new directions.

### *Roles*

Managers lean strongly towards an implementing role, but leaders rather assume a guiding and more influential role. Generally, the manager has an expectation to be 'served' by their subordinates, whereas the leader fulfils their role by serving others.

### *Goals*

Leaders are actively engaged in goal-directed attitudes, as they strive to formulate goals to bring about change and a different future within the organisation. Managers, due to an impersonal and passive attitude, will mostly react to goals as the need arises, or when there is pressure to bring about change.

## Risk taking

Their need for survival within the organisation causes managers to shy away from taking too many risks, and rather rely on management tools such as planning and budgeting. In contrast, leaders are prepared to take real risks because they believe in the people within their organisation and strive to motivate their followers by making their work more purposeful.

## Attitude

Leaders value commitment and relationships with others and tend to communicate and empathise more easily with employees. Managers are more emotionally detached from their employees and would rather just focus on the task at hand.

## Motivation of employees

Managers often use threats and rewards to motivate their subordinates. They use power and control strategies such as enforcing policy, mandates and contracts, and only derive a sense of self when acting like a gatekeeper. Due to their strong self-identity, leaders are able to motivate others by emphasising the employees' sense of purpose and by sharing power to gain the trust of their employees.

## Change

Regarding future prospects, leaders affect organisational or structural changes by changing the way people think about potential inventions and improvements. Leaders are more innovative, imaginative and broad-thinking than managers; they use their instinctive, rather than their logical, thinking and are even prepared to created disorder to create progress. Managers are more cautious and are inclined to prefer the status quo, and will rather make smaller functional changes when necessary. They are more rational and systematic when choosing goals, objectives and processes, and will rather interpret established policy, procedures and mandates (Booyens, 1995:403).

## 1.4.2 The importance of management competencies in an organisation

Unit managers continue to play a critically important role in the success of healthcare organisations, since they represent and provide leadership to the largest group of employees in any healthcare organisation (Mathena, 2002:141). In addition, world-wide changes in the healthcare environment over the past decades are also challenging unit managers to deal with managerial issues such as financial constraints, nursing shortages, high turnover rates, and increasing demands for nursing services; it is clearly demanding for unit managers to cope with such managerial issues and competently lead nursing organisations at the highest level of excellence (Kang et al, 2012:939). Even though competencies such as effective staffing strategies, performance evaluation, delegation and problem solving are important, effective communication was identified as the

most important skill for unit managers (Mathena, 2002:138). Unit managers can positively influence others if they are able to deliver the message in such a way that the listener will hear it (Contino, 2004:57).

The American Organisation of Nurse Executives (2014) defines nurse management functions as including management of care delivery, personnel development, management of human, fiscal and other resources, strategic planning, compliance with regulatory and professional standards and fostering of interdisciplinary, collaborative relationships. The fact that unit managers perform at different levels in the healthcare organisation, from first-line patient care manager, to middle manager, to executive manager, results in their roles being developmental, and built upon knowledge and skills.

Swansburg and Swansburg (1999:43–44) allude to some of the following important competencies:

- *Financial management skills*: an ability to prepare and defend budgetary expenses involving unit personnel, supplies, and even managing scarce and expensive resources for performance.

- *Communication skills*: an ability to communicate and to promote effective communication among healthcare professionals and others, including presentation skills.

- *Knowledge of internal factors* related to purpose, tasks, people, technology and structure, as well as knowledge of external factors such as socio-political and economic issues and technology.

- An ability to provide *professional development opportunities*, to empower staff and to provide a climate in which personnel clearly recognise that they are pursuing meaningful and worthwhile goals through their own efforts.

- A commitment to maintain *self-development.*

Managerial competencies form the building blocks of success of any organisation, by helping it to achieve its vision and mission. Managerial competencies include the following major areas as identified by Krajčovičová and Čambál (2012:75).

- *Skill*: the abilities that were acquired through practice, for example budgeting (financial skills) and presentations (verbal skills).

- *Knowledge*: the understanding that was acquired through learning. In order to perform, a manager needs, for example, knowledge of policies and procedures for staffing.

- *Personal characteristics*: the inner attributes which are brought to the profession or position. Knowledge and skills are built and developed on this foundation.

- *Behaviour*: observable demonstration of competency, skill, knowledge and personal attributes. Behaviour can therefore be observed, taught, learned and measured.

### 1.4.3 The role of management in achieving the Millennium Development Goals (MDGs)

The Millennium Development Goals (MDGs) are:

- Eradicate extreme poverty and hunger.
- Achieve universal primary education.
- Promote gender equality and empower women.
- Reduce child mortality.
- Improve maternal health.
- Combat HIV/AIDS, malaria and other diseases.
- Ensure environmental sustainability.
- Develop a global partnership for development.

Achieving the MDGs for health requires scaling up of health service delivery. This entails an increased number of competent managers and healthcare professionals, an essential resource for ensuring that priority healthcare needs are met and resources are used effectively (Egger & Ollier, 2007). Nursing management and leadership must be strengthened in the following ways:

- There must be *adequate numbers of competent managers and healthcare professionals* at all levels of the health system. This should be ensured by a balance between, for example, bringing in new healthcare professionals with innovative perspectives, and retaining sufficient experienced healthcare professionals and managers with institutional past knowledge.

- *Professional development and capacity building* must take place continuously; professionals must be responsible for their own competencies (knowledge, skills, attitudes and values).

- *Functional management support systems*, such as systems to monitor finances, healthcare professionals, information, supplies, etc, must be improved.

- A more *supportive and enabling work environment* must be established, with clear expectations and set rules under which managers work. This includes the relationship with local government and other role players.

- *Supervision and performance management* should be improved, with incentives for improving performance.

## 1.5 Management ethics in the context of a healthcare unit

Ethics is the science relating to moral actions and is concerned with motives and attitudes and the relationships of these attitudes to the good of the individual. Ethics has to do with actions we wish people would take, not actions they must take (Yoder-Wise, 2007:50). Healthcare reform poses a concern for health practitioners, especially for those in management positions. Mohr (1996) in Yoder-

Wise (1999:52), is of the opinion that there is great concern that ethical healthcare will prevail, because of the way in which patients are enrolled and the uncertain future of healthcare delivery in a managed care system. Issues that continue to be ethical concerns for nurses include the patient's refusal of healthcare, issues surrounding death and dying, nurses' ability to be patient advocates, and the ability to perform competent, quality nursing care in a system that rewards only cost-saving measures and that staffs fewer and fewer professional nurses.

## 1.5.1 Deontological theory

Deontological theory derives norms and rules from the duties human beings owe to one another by virtue of commitments made and roles assumed. The strength of this theory is its emphasis on human dignity. In the nursing unit, unit managers are likely to base their decisions on their duties, but also on professional rules, values and religious beliefs which are regarded as important. Morality plays a big role in decision making, where the unit manager aims to do the best thing, telling the truth and by keeping their oaths and promises. In the nursing unit, where ethical decision making is required in situations involving healthcare professionals and subordinates, the unit manager considers what is viewed as right or wrong in that specific situation, as well as their views of humankind and acting in the interest of the healthcare professionals (Jooste, 2010:29).

## 1.5.2 Utilitarianism

Teleological theories, also referred to as utilitarianism, derive norms or rules for conduct from the consequences of actions. What makes the action right or wrong, is its utility. The utilitarian applies a scientific analysis of the advantages and disadvantages for the patient, family or practitioner. In this case, when a unit manager is confronted with an ethical dilemma in the nursing unit, all the options available will be taken into account. The unit manager then makes a decision based on the one which has the greatest advantage for the larger number of people (Jooste, 2010:29).

## 1.5.3 Aspects of ethics

Aspects of ethics to be considered are autonomy, beneficence, non-maleficence, veracity, justice, fidelity and respect for others.

### *Autonomy*

Autonomy refers to the unit manager's right to exercise his or her own judgement and critical thinking in professional decisions, addressing personal freedom and the right to choose. As an independent practitioner, the unit manager exercises freedom of choice to facilitate the care and protection of the patient in the nursing unit. Making autonomous decisions allows the unit manager to ensure that healthcare professionals provide quality nursing care (Jooste, 2010:29).

## Beneficence

Beneficence is the action that one takes to promote good. It often requires the unit manager to make personal sacrifices, for example by being used therapeutically for the betterment of the healthcare professionals in the nursing unit. The unit manager should be willing to sometimes accommodate subordinates' personal requests in order to build morale and ensure that full co-operation is received from the staff (Jooste, 2010:29).

## Non-maleficence

Non-maleficence is the duty to not inflict harm. The unit manager has a duty to protect healthcare professionals from any harm which might be caused by unsafe conditions in the nursing unit. Unit managers are responsible for effectively implementing policies and procedures regarding safe working procedures and safety precautions. The unit manager should ensure that the healthcare professional is familiar with the latest protocols in healthcare provision. Healthcare professionals should be encouraged to be lifelong learners in order to grow personally and professionally.

## Veracity

Unit managers are expected to be open and transparent with the healthcare professionals in a nursing unit. To be truthful to the staff means that the unit manager should at all times be honest and not deceive the staff, or act with insincere motives. The unit manager must be accessible, frank and easy to talk to. Mistakes made by any healthcare professional in the nursing unit must be reported, irrespective of consequences (Muller, 2009:63).

## Justice

Justice means to be fair, and the unit manager should treat all healthcare professionals equally, without discrimination or favouring of any member of staff. To be fair, the unit manager should understand the benefit of having knowledge and skills, and use these to the advantage of everyone working in a nursing unit, according to their needs and without discrimination (Jooste, 2010:29). Paternalism allows one to make decisions for another, and is often seen as an undesirable or negative action.

## Fidelity

Commitments to remain faithful relate to maintaining confidentiality of information and keeping promises. The unit manager should exercise caution and apply critical judgement skills to distinguish between the legitimacy of a promise, and the legal and professional responsibility of his or her duties as a leader in a nursing unit (Muller, 2009:63).

## *Respect for others*

This principle acknowledges the right of the individual to make decisions and to live by these decisions. Unit managers positively reinforce this principle in their daily actions with employees, patients and peers because they serve as role models for staff members and others in the institution (Yoder-Wise, 2007:52). Ethical theories and principles are important because they form the essential base of knowledge from which to proceed to treat others with respect.

## 1.6 Summary

The purpose of management is to achieve the goals or objectives and performance indicators of the healthcare service, and to make a positive impact on health indicators. Management is therefore defined as a process whereby human, financial, physical and information resources are employed in order to achieve the goals and objectives of the healthcare organisation. In managing a healthcare service or unit, cognisance should be taken of the different principles of management theories, the difference between management and leadership, ethics in managing health services, the competencies needed by a unit manager and the differed components of the management process.

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# External Factors Influencing Health Services Management

MC Bezuidenhout

## Chapter Outcomes

After studying this chapter, you should be able to:
- describe the systems approach to managing a healthcare unit;
- discuss certain external factors influencing health services management.

## 2.1 Introduction

Society is composed of various systems that form part of the social system. The health system is one of the systems within the greater social system. The different systems, such as the economic, educational, political and health systems, interact and influence one another in many ways. The healthcare industry is an open system, which means that it is affected by many external factors. In the quest to deliver optimal patient care, healthcare services must know about the factors that impact on healthcare provision.

It is inevitable that communities and services should interact in one way or another, whether it concerns health, education, economics, transport or any other service. The various communities that form a nation are unique and expect the different services to address their specific needs. Healthcare organisations and services, therefore, should function in close co-operation with the leaders and institutions of society.

A good understanding of the health system's external environment will contribute to its success. There are, however, differences in complexity, susceptibility to change and competitiveness in the external environment for different healthcare facilities (Shortell & Kaluzny, 2006:17). These differences pose a challenge to the healthcare services manager striving to function optimally within the set parameters and with the available resources.

This chapter examines the following external factors that influence the health system, namely:
- globalisation
- statutory, political and legal factors
- demographic factors
- social factors
- economic factors
- technological advances
- professional regulation.

## 2.2 The healthcare system

The systems approach is an important tool in both the planning and control functions of management. A system can be described as a set of goals and elements that interact to achieve a specific goal. Gillies (1989:71) defines a system as a logical and orderly arrangement of parts in an ongoing process; it consists of interconnected and interrelated subsystems, each of which has its own objective that contributes positively towards the goals of the larger system.

The systems approach to management aims to ensure a balance between the different interrelated parts. Altering one part would affect the other parts, therefore management should view the organisation as a whole entity and foresee the effect of their decisions on the other parts of the organisation.
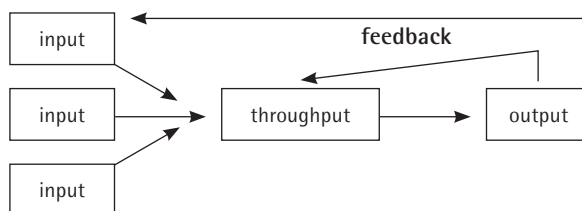


**Figure 2.1:** Elements of a system

The basic elements of a system are threefold – input, throughput and output – interconnected by a feedback loop (refer to Figure 2.1).

- *Input* is the energiser and operating material of the system. It includes factors such as facilities; human resources (and their qualifications, experience, attitude, loyalty, management style and philosophy); equipment and supplies; information; money and raw material; and patients (their ailments, culture, age and income). Inputs are strongly influenced by the environment in which they exist and function.

- *Throughput* is the conversion of inputs into the products and services needed to achieve the goals of the organisation. Throughputs in healthcare services include actions, activities, interactions, treatment and care.

- *Output* is the result of the throughput process. Outputs can be either satisfactory or unsatisfactory in terms of the healthcare result for the patient or organisation.

- *Feedback* is the means of communicating successes or errors in the system and the need for correction based on the measurement of outputs.

The healthcare system is an open system strongly influenced by the environment in which it functions. For example, shortages of funds or human resources have a strong influence on patient care. Similarly, the disease profile of epidemics such as HIV/AIDS and tuberculosis can impact heavily on available resources and facilities.

Healthcare organisations such as hospitals, day centres, clinics, hospices and other health-related institutions function as subsystems within the health system. The external factors influencing the health system originate in the social system as a whole and are produced by the other systems. The health system, in turn, is part of the environment of the other systems.
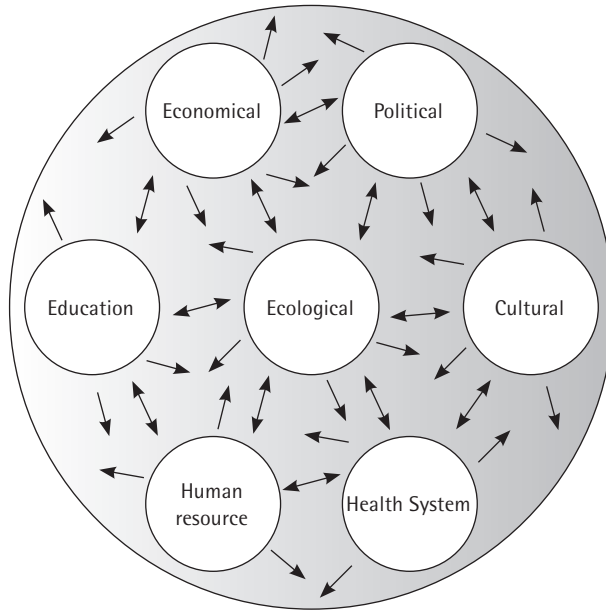


**Figure 2.2:** The social system encompasses a number of other systems

Figure 2.2 indicates the external environment of all systems. Note that each system is also influenced by the other systems. The factors that are the source of these influences must be studied in order to understand their effect on the system, in particular their effect on the health system.

Professionals in healthcare services management should understand the environment within which their service operates. The external factors must be identified and analysed in order to determine how the health service will be influenced and how the effects should be managed.

## 2.3 Globalisation

According to Nikitin and Elliott (in Al-Rodhan, 2006:3):

'globalization involves economic integration; the transfer of policies across borders; the transmission of knowledge; cultural stability; the reproduction, relations, and discourses of power; it is a global process, a concept, a revolution, and an establishment of the global market free from sociopolitical control.'

Globalisation is the flow of information, goods, capital and people across political and economic boundaries (Daulaire, 1999 in Walt, 2000:1). Lee (2000 in Walt, 2000:1) defines globalisation as the process of closer interaction of human activity across a range of spheres, including the economic, social, political and cultural spheres, experienced along three dimensions: spatial, temporal and cognitive. Our perceptions of physical space have changed: different means of travel have made the world feel smaller as people travel more frequently.

Our perceptions of time have changed: the communications revolution has heightened our expectations of rapid turnaround. Anyone who has experience of the Internet and emails knows that responses are expected immediately. This puts more pressure on all managers as large volumes of emails are received every day with fewer people relying on postal systems. Equally important is the cell phone, which has made communication possible in many ways across different time zones.

The spread of ideas, cultures and values is about much more than the worldwide availability of Japanese cameras, Finnish mobile phones, Asian clothes, Colombian coffee and the like. It also concerns the transfer of culture and political ideas, resulting in the neo-liberalism of the 1980s, which, in turn, fostered the health systems reform movement.

Globalisation can be characterised by five themes which are interdependent although often conflicting. Their effect on healthcare is briefly summarised according to the views of Walt (2000:1–4).

## 2.3.1 Economic transformation, financial volatility, marginalisation and labour insecurity

There is increasingly fluid investment across borders, such as foreign investment to open and manage private hospitals and clinics. The investors are not always healthcare-orientated, and the way that they measure outcomes may differ from the norms or standards used in the traditional healthcare sector.

Another technique for penetrating foreign markets is through managed-care services that combine management and insurance. Such investments carry the danger of creating two-tier health systems, movement of healthcare professionals from the public sector, inequitable access to healthcare and undermining of the national health system.

The mobility of human resources across borders has created many opportunities for new employment possibilities. South Africa has a dire shortage of all categories of healthcare professionals, especially doctors, but also dentists, nurses, physiotherapists, occupational therapists and paramedics. According to Grobbelaar (2013), South Africa has a shortage of 80 000 healthcare professionals, posing serious challenges for the delivery of quality healthcare in the public sector. This has led to the development of new categories of healthcare professionals, such as clinical associates.

Clinical associates are required to earn a Bachelor of Clinical Medical Practice degree at an accredited university in order to qualify for registration with the Health Professions Council of South Africa. During their problem-based training, these students gain hands-on clinical skills to prepare them for their participation in district-level healthcare teams. Their functions include:

- obtaining patient histories
- performing physical examinations
- ordering diagnostic or therapeutic procedures
- interpreting findings and diagnosing common emergency conditions
- developing and implementing a treatment plan
- monitoring the efficacy of therapeutic interventions
- assisting with surgeries
- providing patient education and counselling
- making appropriate referrals for specialised care (AIHA, 2011).

## 2.3.2 New trade regimes in which there are winners and losers

Trade is probably the most highly contested international arena and includes trade-related aspects of intellectual property. Of particular interest here is the licensing of medicines. Of great concern is the compulsory licensing for reasons of public interest, without permission from the patent holder, in order to produce drugs more cheaply. South Africa, which followed this route, has come under huge pressure to repeal its draft medicines law, which would allow compulsory licensing and parallel import of drugs for HIV/AIDS.

The deregulation of trade has exacerbated environmental deterioration and increased the non-accidental injuries being perpetrated on the planet. An example is the increase in air pollution which will have both short-term effects on respiratory disorders, and much longer-term effects on the ecosystem (McMichael & Haines, 1997 in Walt, 2000:2).

## 2.3.3 The electronic revolution – those who have access to information and those who do not

Electronic communications offer extraordinary opportunities; even in remote areas, it is now possible to connect to the Internet via cell phone. However, to benefit from this, people need to have access to reliable electricity, cell phones, computers, training and education. E-commerce – a common model for the sale of pharmaceuticals through the Internet – has implications such as loss of revenue for governments and all those selling to the public; this creates further disadvantages for those unable to access cheaper medicines. It also raises serious questions about regulation, drug resistance and drug abuse.

Telemedicine – the practice of medical care using interactive audio-visual data communications – includes medical care delivery, consultations, diagnosis and treatment, as well as education and the transfer of medical data (Mandil, 1998 in Walt, 2000:2). Telemedicine is another area likely to grow with improved

communications. This mode of treatment raises a number of ethical and regulatory issues, such as the patient's privacy, recognition of the qualifications of providers, legal liabilities and payment for services.

## 2.3.4 Health inequalities due to a growing poverty gap

According to Walt (2000:3), 20% of the world's population lives in absolute poverty, with an income of less than $1 per day. Almost half the people on the planet survive on less than $2 a day. Those living in absolute poverty are five times more likely to die before the age of five.

The United Nations Food and Agriculture Organization estimates that:

> '… nearly 870 million people of the 7.1 billion people in the world, or one in eight, were suffering from chronic undernourishment in 2010–2012. Almost all the hungry people, 852 million, live in developing countries, representing 15 percent of the population of developing countries. There are 16 million people undernourished in developed countries (FAO 2012). The number of hungry grew in Africa over the period, from 175 million to 239 million, with nearly 20 million added in the last few years. Nearly one in four are hungry. And in sub-Saharan Africa, the modest progress achieved in recent years up to 2007 was reversed, with hunger rising 2 percent per year since then.' (World Hunger Education Service, 2013).

In many countries, health systems have deteriorated; access to healthcare is poor and its quality low, and drugs and supplies are not available. As public health systems have broken down, the spread of infectious diseases has become more alarming, affecting the poor disproportionately. The emergence and re-emergence of infectious diseases such as polio, have risen over the past decade, partly because of drug resistance, new diseases such as HIV/AIDS, poor management and people's increasing mobility. While the responses of the rich world are often understood in terms of new threats to the health of their own populations, they have nevertheless drawn attention to problems that have never been absent from low- and middle-income countries.

## 2.3.5 New forms of governance and the proliferation of non–state role players

The entry of the corporate sector into the health domain reiterates how much the healthcare landscape has changed. Until the late 1970s, there was minimal collaboration between private and public sectors and relationships were often abrasive. Today, however, there is a great convergence towards partnerships between the public and private sectors. Governments are contracting private companies to undertake tasks that used to be the responsibility of the public sector, such as laundry and cleaning services; they have also contracted private hospitals and clinics to provide certain diagnostic or medical services on their behalf. Similarly, pharmaceutical companies form partnerships with government

by donating drugs to counter specific diseases such as malaria, river blindness and trachoma.

Globalisation, consequently, is both an opportunity and a threat and can have a positive and/or negative impact on the health environment and the management of healthcare services.

# 2.4 Statutory, political and legal factors

In addition to the Constitution, a number of legislative measures have been developed to govern and regulate the provision of healthcare in South Africa.

## 2.4.1 The Constitution

The Constitution of the Republic of South Africa, 1996 makes provision for nine provinces. The legislative authority of a province ' … shall have the power to make laws for the province in accordance with this Constitution' (section 125). Provision is made for the establishment and status of local government and traditional authorities in the Constitution (sections 174 and 181).

It is important to note that local government functions, inter alia, as follows:

> 'A local government shall, to the extent determined in any applicable law, make provision for access by all persons residing within its area of jurisdiction to water, sanitation, transportation facilities, electricity, primary health services, education, housing and security within a safe and healthy environment, provided that such services and amenities can be rendered in a sustainable manner and are financially and physically practicable.' (section 175(3))

Chapter 3 of the Constitution deals with fundamental human rights. It addresses, among many other things, equality; dignity; freedom and security of the individual; servitude and forced labour; privacy; religion; freedom of expression; citizens' rights and political rights; access to court information and justice; economic activity; labour relations; language, culture and education.

## 2.4.2 Acts

Healthcare professionals are governed by a number of laws and ethical rules. The laws are found in the Constitution, statutes, the common law and the ethical codes of the profession. Healthcare services managers are obliged to ensure that optimal healthcare is delivered within legislative parameters. If the delivery of healthcare does not meet the required standards, medico-legal risks will occur that could be detrimental to the patient, healthcare professional and the organisation. Officials in healthcare services management cannot function in isolation. They must execute their duties according to legislation at national and provincial level, as well as according to their local authorities' by-laws. The healthcare professional must always bear in mind that the patient is a citizen who is entitled to certain rights.

The following is a list of Acts relevant to healthcare professionals. Note that the list also includes Acts which regulate the management of human resources. The list is in alphabetical order for ease of reference.

- Basic Conditions of Service Act 75 of 1997

- Children's Act 38 of 2005

- Chiropractors, Homeopaths and Allied Health Service Professions Second Amendment Act 50 of 2000

- Choice on Termination of Pregnancy Amendment Act 92 of 1996

- Compensation for Occupational Injuries and Diseases Act 130 of 1993 (COID Act)

- Domestic Violence Act 116 of 1998

- Employment Equity Act 55 of 1998

- Hazardous Substances Act 15 of 1973

- Human Tissue Act 65 of 1983

- Labour Relations Act 66 of 1995

- Medical Schemes Act 131 of 1998

- Medical, Dental and Supplementary Health Services Professions Amendment Act 1 of 1998

- Medicines and Related Substances Control Amendment Act 90 of 1997

- Mental Healthcare Act 69 of 2001

- National Health Act 61 of 2003

- Nursing Act 33 of 2005

- Occupational Health and Safety Act 85 of 1993

- Older Persons Act 13 of 2006

- Pharmacy Act 53 of 1974

- Skills Development Act 97 of 1998

- Skills Development Levies Act 9 of 1999

- South African Medicines and Medical Devices Regulatory Authority Act 132 of 1998

- Sterilization Act 44 of 1998

- Tobacco Products Control Amendment Act 12 of 1999

- Traditional Health Practitioners Act 35 of 2004.

### 2.4.3 Regulations

As the supreme guardian of its citizens, the state has a duty to ensure public welfare. In order to guarantee a safe level of healthcare, the government regulates nursing and other healthcare professions by maintaining standards of education and practice. Regulations and policies are developed from the different Acts to serve as prescriptions and guidelines to regulate and control the practice of healthcare professionals. The aim of this regulation and control is to protect the public against unauthorised, unqualified and improper practice and conduct by healthcare professionals.

Chapter 7 of the National Health Act of 2003 mandates the Minister of Health, advised by the National Health Council, to develop and manage human resources in the national health system. This led to the development of the National Human Resource Plan for Health in 2006. This plan identifies human resources planning and development needs as a key priority area in healthcare (DoH, 2006:iii). The Nursing Charter was developed in 2004, with the aim of aligning nursing practices with changes in the national health policy and the legislative framework (South African Nursing Council, 2004:2).

### 2.4.4 Department of Health

The National Department of Health is the governing department for health-related services and issues and plays a directive role in this regard. Table 2.1 lists the six programmes which inform the department's activities.

**Table 2.1:** Programmes of the Department of Health

| Programmes of the Department of Health guiding its functions |
| --- |
| Programme 1: Administration |
| Programme 2: Strategic health programmes |
| Programme 3: Health planning and monitoring |
| Programme 4: Human resource management and development |
| Programme 5: Health services |
| Programme 6: International relations, health trade and health product regulation |

Source: Department of Health (2011:15–18)

The National Department of Health's priorities for 2009 to 2014 are known as The 10 Point Plan. These priorities are intended to assist the country in meeting the Millennium Development Goals (MDGs) and monitoring improvements in the healthcare system.

1. Provide strategic leadership and creation of a social compact for better health outcomes.

2. Implement a National Health Insurance for South Africa.

3. Improve the quality of health services.

4.  Overhaul the healthcare system and improve its management.

5.  Improve human resources planning, development and management.

6.  Revitalise physical infrastructure.

7.  Accelerate the implementation of the HIV and AIDS and Sexually Transmitted Infections National Strategic Plan and the increased focus on tuberculosis (TB) and other communicable diseases.

8.  Mass mobilisation for better health for the population.

9.  Review drug policy.

10. Strengthen research and development. (HST, n.d.)

## 2.4.5 Health reform and transformation

The transformation of the South African healthcare system has been an ongoing, protracted process. The drive, direction and significant markers of this reform were broadly spelled out in the Reconstruction and Development Programme (RDP) of 1994, which subsequently became the government's framework for reform. The goals of health reform since 1994 have been to:

*   Unify the fragmented health services into a comprehensive and integrated National Health System (NHS).

*   Reduce the disparities and inequities in service delivery and health outcomes.

*   Extend access to an improved health service.

These goals are systematically being converted into more detailed strategies of transformation and restructuring, specified in numerous White Papers, policy documents and legislation. All sectors of the health system have been significantly affected by these new policies and legislation.

In support of the RDP, the broad parameters indicating the fundamental reform of the healthcare system are contained in the National Health Plan for South Africa of 1994, which briefly relates to the following issues:

*   Every person has the right to achieve optimal health and the right to be treated with dignity and respect.

*   The primary healthcare (PHC) approach is emphasised, with promotive, preventive, rehabilitative and curative care provided by the most appropriate PHC service.

*   The primary healthcare approach is to be based on full community participation within the framework of the decentralised district health system.

*   An inter-sectoral approach is applied to health, health problems and solutions, enlisting the collaboration of sectors, such as education, employment, water, sanitation and housing as key determinants of health.

- The creation of a single, comprehensive, equitable and integrated National Health System that would determine priorities, guidelines and standards for healthcare.

- Organisationally, the NHS would be structured to function at national, provincial and district or community levels.

- The NHS would be funded through general tax revenue. Promotional and preventive services in the public sector would be free, while free healthcare was introduced for specific patient groups, such as pregnant women and children under the age of six.

- The development of priority health programmes for vulnerable groups, such as mother and child, nutrition, mental health, control of communicable diseases and violence.

- The training and reorientation of existing healthcare professionals, training of new cadres and the redistribution of healthcare professionals.

- The systematic collection and analysis of appropriate data on health by means of a comprehensive health information system (Van Rensburg, 2004:114–15).

Most of these determinants have been implemented at a functional level, which has seriously affected the healthcare professionals, especially nurses and doctors, as there has been very little, if any, adjustment to the staff establishments and the provision of equipment and supplies to deal with the increased patient load that has resulted.

## 2.4.6 Patients' rights

The Patients' Rights Charter was adopted by the Department of Health as a means of realising patients' constitutional rights of access to quality healthcare. It attempts to balance patients' rights with their responsibility to take care of their own health and well-being.

The charter indicates that patients have the right to:
- access healthcare, receive timely emergency care, treatment and rehabilitation, provision for their special needs and to be cared for by healthcare practitioners who are courteous, empathetic and tolerant
- the choice of health service provider or healthcare facility for treatment
- the provision of health information in a language understood by the patient
- referral for a second opinion
- complain about the healthcare service that they receive.

In addition, patients have a number of responsibilities that need to be fulfilled, namely:
- taking care of one's own health
- proper utilisation of the healthcare system without abusing it

- complying with the prescribed treatment or rehabilitation procedures
- enquiring about the costs of treatment and/or rehabilitation and arranging for payment
- advising healthcare professionals about their wishes with regard to death (Van Rensburg, 2004:119–20).

## 2.5 Demographic factors

In terms of demographic factors, the population and health profile are briefly discussed in the following sections.

### 2.5.1 Population

Changes in the demographic variables of a country's population, such as size, age, growth, structure and distribution have implications for the health of people and the environment. The impact of these demographic variables on the environment is greatly determined by the population's lifestyle and behaviour. An example is the living conditions of the poor, who are often concentrated in urban areas with high-density populations – frequently the breeding grounds for infectious diseases and social misconduct.

The HIV/Aids epidemic currently dominates the demographic features and trends of our country. According to Van Rensburg (2004:173–81), the following current and projected trends of the South African population are relevant for healthcare professionals.

*Slowdown in population increase and (possible) decline in population size*

This is mainly due to the impact of the HIV/AIDS epidemic, but can also be attributed to a decline in fertility rates.

*Rapidly declining population growth rates and fertility rates*

The worldwide decline in fertility rates can be attributed to increases in literacy and educational levels, particularly among women, as well as an increase in the use of contraceptives and improved accessibility to reproductive healthcare.

*Declining birth rates and increasing death rates*

Declining birth rates are caused by modernisation, urbanisation and personal aspirations for a better lifestyle. The crude birth rate in a population is dependent upon the gender, age, structure and fertility pattern of that population. Crude birth rates of all population groups in South Africa have declined significantly during the past 20 years and this trend is expected to continue in the next decades. Part of the reason is the fact that HIV/AIDS targets people in their reproductive years. This is confirmed by the Allianze Initiative (2010): 'nowhere on Earth has the disease spread more widely than in sub-Saharan Africa. Roughly 68 percent of

all adults in the world who have HIV/AIDS live in this part of Africa; 60 percent of them are women.' Increasing death rates are expected over the next decade or two as a result of HIV/Aids.

## Changing age structures and ageing of some population sectors

In South Africa, almost one-third (28.97%) of the population is currently aged 14 years or younger. According to the 2011 census, 'over 5.6 million South Africans are under the age of four, while 4.8 million children are aged five to nine, and close to 4.6 million are between the ages of 10 and 14' (Blaine, 2012).

Throughout the world, however, the ageing of populations is a growing challenge. Ever-growing ageing populations strain public resources and many developing countries are not able to meet the housing, health and financial needs of the elderly.

## Rapid decline in life expectancy until 2016, followed by a slight increase

Life expectancy is particularly threatened by AIDS, due to the deaths of infants, children and young people. However, Muhwava, Herbst and Newell (2013:6), recently reported that life expectancy has shown a great improvement in South Africa, even in the rural populations, since the introduction of antiretroviral treatment (ART) in 2004.

## Changing migration patterns and population distribution

Migration across borders and within countries creates difficulties for health policy and healthcare provision. Migrant populations often require specialist treatment for unfamiliar conditions. The large numbers involved, as with illegal immigrants, pose a challenge to demographic and epidemiological assumptions about the local populations and subsequent service provision.

## 2.5.2 Health profile

Healthcare in a country should aim to address the health needs of the population. A study of the health profile of the population will indicate its healthcare needs. Healthcare services managers should be knowledgeable about the health profile, not only of the national population in the country, but also specifically of their regions and communities. The information obtained from epidemiology, vital statistics and health statistics forms the basis of planning in healthcare services.

## Health statistics

Vital or population statistics and health statistics are studied together to identify trends. Statistics commonly associated with the assessment of the health status of the population include those displayed in Figure 2.3 overleaf:

| | | | |
|---|---|---|---|
| **Crude birth rate** | = | $\dfrac{\text{Number of live births in a calendar year}}{\text{Estimated mid-year population}}$ | × 1 000 |
| **Crude death rate** | = | $\dfrac{\text{Number of deaths in a calendar year}}{\text{Estimated mid-year population}}$ | × 1 000 |
| **Neonatal death rate** | = | $\dfrac{\text{Number of deaths of infants during the first four weeks of life in a calendar year}}{\text{Number of live births in that year}}$ | × 1 000 |
| **Infant mortality rate** | = | $\dfrac{\text{Number of deaths of infants during the first year of life in a calendar year}}{\text{Number of live births in that year}}$ | × 1 000 |

Source: De Haan (1993:32)

**Figure 2.3:** Statistics used in assessing the health of the population

The use of statistics in a healthcare organisation enables planners of health services to:

- identify areas of concern for present and future planning and programme development in order to provide a comprehensive healthcare service
- utilise allocated financial resources judiciously
- assist in the planning for healthcare professionals and to allocate personnel effectively so that available knowledge and expertise are used to the best advantage
- identify areas for research
- evaluate existing healthcare programmes.

## *Main causes of mortality*

The main causes of mortality indicate which diseases have the greatest effect on a population's health. Some of the principal causes of death in South Africa are briefly touched on in this section.

## HIV/AIDS

The HIV/AIDS pandemic is the single most important global health issue. It currently affects 28 million Africans (Sanders in www.choike.org/nuevo_eng/ Informes/990.html).

Shell (2000:50) describes the virus as one 'that has no human understanding, and its diabolically engineered and dynamically changing genetic code is programmed with a single purpose: to attack and take over vulnerable human immune systems'. HIV (human immunodeficiency virus) is one of a family of retroviruses that enters the bloodstream and attacks the body's immune system, compromising its ability to fight infections. As the immune system weakens, a

clinical point is reached where the condition is diagnosed as AIDS (acquired immune deficiency syndrome). From this point onwards, numerous opportunistic infections can invade the body, which has little resistance, ultimately resulting in death (Womensnet).

AVERT reports on the 22nd National Antenatal Sentinel HIV and Syphilis Prevalence Survey of 2011, in which 36 000 women attending 1 445 antenatal clinics across all nine provinces were surveyed; it was found that 29.5% of pregnant women between the ages of 15 and 49 were living with HIV in 2011. Until 1998, South Africa had one of the fastest expanding HIV populations in the world, but since 2006 the prevalence among pregnant women has remained relatively stable. Different surveys may produce different figures due to using different processes or populations. Avert's national estimates were derived by comparing the HIV prevalence figures of all recent South African surveys.

'Based on a wide range of data including the household and antenatal studies, UNAIDS estimated that HIV prevalence was 17.3% among 15–49 year olds at the end of 2011. Their low and high estimates were 16.6% and 18.1% respectively. According to their own estimate of total population, this implies that around 5.6 million South Africans were living with HIV at the end of 2011, including 460,000 children under 15 years old.'

Since HIV is primarily sexually transmitted, the peak ages for infection are people in their teens and early twenties, with the peak ages of AIDS deaths 10 years later. With antiretroviral drug treatment, HIV-positive people can maintain their health and often lead relatively normal lives. The availability and use of ART has increased survival among HIV-infected individuals. According to the Human Sciences Research Council (HSRC, 2014), the 2012 South African National HIV Prevalence, Incidence and Behaviour Survey found 'that over 2 million people were on ART by mid-2012, suggesting that the country is on its way towards universal access to treatment. This significant increase of ART exposure in the country has had a major impact on the survival of people living with HIV.'

The South African AIDS Council (SANAC) consists of representatives from government, civil society and the private sector and aims to present a combined response to the affliction of HIV, TB and STIs in South Africa. According to SANAC, the National Strategic Plan (NSP) 2012–2016 is South Africa's third master plan outlining the country's planned response for the next five years to prevent and treat HIV and AIDS, TB and STIs, which pose a serious threat to the health of a large portion of the South African population. This NSP seeks to improve on the achievements of the previous NSP (2007–2011), which considerably increased the antiretroviral treatment programme and aimed to decrease the number of new HIV infections.

According to the SANAC, the goals of the 2012–2016 NSP are in line with UNAIDS's vision and are formulated as follows:

'1. To reduce new HIV infections by at least half (50%), using a combination of available and new prevention methods.

2. To ensure that 80% of all people who need antiretroviral treatment (ART) receive it, and ensure that 70% of the recipients recover and remain alive and on treatment five years after initiation of ART.

3. To reduce by half (50%) the number of new TB infections and deaths caused by TB.

4. To ensure an enabling and accessible legal framework that protects and promotes human rights in order to support the implementation of the NSP.

5. Lastly, to reduce self-reported stigma related to HIV and TB by 50%'.

## Tuberculosis

The incidence of tuberculosis (TB) is closely related to socio-economic factors in South Africa. Housing, unemployment and poor nutrition play an important role in the lives of those who suffer from this disease. It is also the most common opportunistic infection and the largest killer of people living with HIV/AIDS in South Africa.

According to TB Facts.org, South Africa has one of the highest TB disease burdens in the world, with an estimated 450 000 active cases of TB in 2013. Of these 450 000 cases, 73% were also HIV-positive. The TB epidemic in South Africa is likely to be further exacerbated in the years to come because of HIV/AIDS, which makes sufferers more vulnerable to infection with TB. Multidrug-resistant TB (MDR-TB), which is largely caused by non-adherence to drug regimens or inappropriate drug regimens, is further exacerbating the epidemic.

As a result of these facts, the HIV/AIDS and STD Directorate has strengthened its ties with TB programmes at national, provincial, regional, district and community levels (DoH, 2000:14).

The main aim of the National TB Control Programme is to detect 70% of cases, cure 85% of new TB infections, have a treatment success rate of more than 85%, and to prevent the spread of TB and the development of resistant strains of TB through the implementation of the Directly Observed Treatment Short-course (DOTS) strategy (DoH, 2009:11).

## Malaria

At present, an estimated 40% of the world's population is at risk of malaria, especially those living in the world's poorest, developing countries in Africa, Asia and South America. Malaria is a major cause of morbidity in Africa, constituting 10% of the continent's overall death burden. Approximately 90% of all malaria cases and 90 to 95% of malaria-related deaths occur in sub-Saharan Africa (Van Rensburg, 2004:257). According to Health24 (2013), malaria kills 1.2 million people worldwide annually. In South Africa, 2 267 cases of malaria were reported during January 2012 with 16 deaths and a month later, 968 cases were reported resulting in 10 deaths.

Malaria has life-threatening consequences if it remains untreated. Children who survive malaria infection are often burdened by learning disabilities or brain

damage and pregnant women and their unborn babies are particularly vulnerable to malaria infection, which causes peri-natal mortality, maternal anaemia and low birth weight (Van Rensburg, 2004:257).

Because the malaria parasites are showing a resistance to the treatment and eradication measures normally used, the use of DDT in certain areas had to be reintroduced and, increasingly, a second line of malaria drugs needs to be administered (DoH, 2000:17–19). In controlling the spread and consequences of acquiring malaria, a multidisciplinary approach needs to be activated, which incorporates environmental factors such as temperature and humidity, social factors such as migration patterns, economic aspects which affect the quality of housing and protection as well as political collaboration and co-operation.

## 2.6 Social factors

The term social environment in a health context refers to people's living conditions, such as poverty or overcrowding, and to the norms, values and attitudes that reflect a particular social and cultural context (Cockerham, 1995 in Van Rensburg, 2004:204).

### 2.6.1 Poverty

In the 2011 census, the South African population was calculated at 51.7 million, of which 41.4% were living below the poverty line. This means that some 21.4 million people are officially classified as poor. There is, however, a positive trend in the decline of poverty levels since 1994, when the poverty level was 59.3%, and 58.2% in 2000 (Transforamtionaudit.org, 2012). Women are significantly affected by socio-economic factors, such as unemployment and illiteracy, which have a profound impact on their empowerment and their ability to take responsibility for their own reproductive health behaviour (Van Rensburg, 2004:205–207).

With poverty affecting such a large proportion of the population, widespread food insecurity, and related malnutrition is present in many households. Furthermore, with an unemployment rate between 25–30% it is difficult for many people to access healthcare services due to transportation costs (Poverty. org, 2013). A lack of access to basic services, such as electricity, drinking water, refuse removal and proper sanitation is directly related to high prevalence rates of preventable diseases, such as diarrhoea, TB and other respiratory diseases. Poverty, unemployment and inequalities are associated with stunted growth and high levels of child and infant mortality and teenage pregnancies (Van Rensburg, 2004:209).

### 2.6.2 Trauma and injuries

Trauma refers to both psychological and physical damage that results from an injury. Trauma can be classified as unintentional, such as traffic collisions, falls or any other unpredictable and uncontrollable event, such as weather disasters; it can also be intentional, which includes deliberate gunshot wounds, stabbing and assaults. Further classifications of trauma are self-inflicted or personal

injuries, encompassing attempted and successful suicide, work-related injuries or personal behaviour, which includes non-fatal attacks, assaults and murder.

Van Rensburg (2004:261) is of the opinion that trauma and injuries should feature prominently in any exploration of South Africa's health profile for the following reasons.

• Violence is a troubling feature of society. Many intentional injuries are inflicted by violent attacks from strangers or as a result of domestic violence.

• Injuries affect productivity negatively due to work days lost, disabilities and health consequences caused by injuries.

• The causes of injuries need to be addressed so that the number of injuries and fatalities can be reduced, thereby lessening the burden on healthcare providers.

## 2.6.3 Lifestyle

Lifestyle disorders are mostly the result of long-term unhealthy habits in lifestyle, such as unhealthy diet, tobacco use, excessive alcohol intake, drug abuse and stress. The prevalence of chronic lifestyle diseases is often ascribed to obesity and the less active lifestyle of urban populations.

Lifestyle diseases can affect any age group, but it is particularly during adulthood and old age that the risk of developing chronic diseases increases drastically. Hypertension, stroke, ischaemic heart disease, diabetes and chronic bronchitis are particularly prevalent in the ageing population. A factor leading to a higher prevalence of such diseases is the rise in life expectancy: as people live longer, they are more likely to develop degenerative diseases.

# 2.7 Economic factors

The economy of a country has a profound influence on its healthcare services. On the one hand, the financial means available to treat the poorer portion of the population with public funds usually determines the quality and the quantity of the services that can be offered. On the other hand, the richer portion of a population, while at times enjoying 'better' services because they are insured for their healthcare by medical aid schemes, has to fund part of the bill. This is not only to fund their own healthcare, but also that of the poorer communities, for example by paying exorbitant prices for their prescribed medicines.

The Department of Health has been planning for the implementation of the National Health Insurance (NHI), a financing scheme which will ensure that all citizens of the country receive essential healthcare, regardless of their employment status or their ability to make a financial contribution. The intended NHI is not meant to do away with private healthcare providers or private medical schemes, but the premise is that all employed citizens will have to make a contribution to the NHI.

In order to ensure that the quality of service delivery within the public sector is on par with that offered by private healthcare providers, the Department of Health prescribes the following three mechanisms to take effect.

- A radical improvement in the quality of services in the public health facilities, requiring massive investments for the improvement of healthcare infrastructure, such as buildings and equipment.

- Certain basic core standards must be complied with in all healthcare institutions. To ensure adherence to standards, an independent 'watchdog' body, called the Office of Health Standards Compliance, will be established by an Act of Parliament.

- A radical change to healthcare management will have to take place within the public healthcare system, in line with point 4 of the Department of Health's 10 Point Plan (overhauling the healthcare system and improving its management). Regulations will include measures to standardise hospital care across the country and to ensure that managers of different categories of hospitals have specific skills, competencies and appropriate qualifications.

South Africa devotes considerable financial and other resources to healthcare. According to Van Rensburg (2004:378), the levels of healthcare expenditure far exceed those in most middle-income countries and are indeed comparable to those in some high-income countries. However, the health services provide poor value for money, given that South Africa's health status indicators are considerably worse than many other middle-income countries.

It has been evident for some time that the major challenge facing the health services is not a lack of resources, considering the combined resources of the public and private sectors, but the need to utilise existing resources more efficiently and equitably. This improved utilisation and distribution of resources is necessary not only in each sector, but also between the public and private sectors (Van Rensburg, 2004:378).

## 2.7.1 Sources of finance for the health sector

There are four main sources of finance for health:

- Government is the largest contributor to healthcare.

- Healthcare-funding households are the second largest source of funds for healthcare. Households pay contributions to medical schemes or pay directly for services provided by health workers and facilities, and for pharmaceuticals.

- Employers are the third major source of funds. Employers fund healthcare for their employees either directly by providing healthcare services, or indirectly by contributing to different forms of private health insurance on behalf of their employees.

- Donors and non-governmental organisations are the fourth source of healthcare funds (Van Rensburg, 2004:380–382).

In a quest to meet the health needs of the population, the Department of Health is guiding provinces on the design and implementation of suitable partnerships, with the aim of:

- establishing purchasing services, such as contracts with private providers for clinical services
- outsourcing support services, such as catering, laundry and security
- entering into joint ventures, where the two sectors (public and private) may provide a particular service jointly or share expensive technology (DoH, 2000:40–42).

## 2.8 Technological advancement

Technological advancements have had a major impact on healthcare provision. Not only have recent technological developments led to earlier diagnosis, more effective treatment and the preservation of life for longer periods, but technological advances have also changed the way healthcare can be provided.

Scientists today are able to work together in person or via tele-medicine or e-mail to find treatments and cures for diseases. The Internet has accelerated access to scientific information: electronic journals are available to scientists across the world, enabling the use of evidence-based medicine to diagnose, treat and rehabilitate their patients (Shisana, 2005:7).

These are some examples of how technology has improved healthcare:

- The Internet has become a major source of medical information and consultation.
- Healthcare facilities are reaching patients regardless of where they may be by using social media. This enhances communication between patients and healthcare professionals such as by providing health education, reminders about appointments and providing results of tests.
- Better treatment and less suffering is possible by means of modern, safe and user-friendly equipment.
- Patient care and worker efficiency is improved by connecting all members of the multidisciplinary healthcare team with one another as well as with the patient with greater ease and time efficiency.
- Doctors are easier to reach and able to provide a faster, more accurate diagnosis and treatment due to data management and immediate availability of test results and X-rays.
- Online databases can accurately provide statistics, compare results and predict medical trends.
- Patients can be guided to improve their well-being and health by using the different mobile apps which provide information on, for instance, staying active, sleeping better, eating more healthily, and so forth.

- Tele-medicine provides medical assistance and consultations in areas where resources and infrastructure are limited or inaccessible.

- Remote monitoring tools allow people to be monitored in their homes, reducing costs and visits to the physician, simultaneously allowing greater independence for the patient.

- The electronic health record integrates different platforms such as medical, nursing, pharmacy, dietetics and accounting inputs (Krueger, 2010; Jayanthi, 2014).

## 2.9 Professional regulation

In South Africa, a statutory body, the South African Nursing Council (SANC), regulates the training and practice of nursing by means of the previous Nursing Act 50 of 1987 and the most recently promulgated Act, the Nursing Act 33 of 2005. From the Nursing Act, regulations have been developed for all matters relating to the functioning of the SANC, the minimum requirements for the education and training of the different categories of nurses and for safeguarding the public. Two important regulations in this regard pertain to the scope of practice of nurses and their acts and omissions.

Ethical codes play an important role in the management and practice of nursing care. Medical ethics and human rights are linked. Indirect links are evident in the concerns of healthcare professionals to improve the health and lives of individuals and of society and to treat all patients with respect. Direct links include recent declarations to respect human rights and an increasing discourse about rights within bioethics.

According to Van Rensburg (2004:570), there are several ways in which healthcare professionals can protect human rights:

- by commitment to high ideals in medicine (through aspirations and exhortation)
- through greater understanding of the content of ethics and human rights (via education and knowledge)
- by knowing about and using international statutes and laws (following due process)
- by enlisting assistance from national and international medical and nursing associations (through strategy and networking)
- through human rights commissions and other NGOs, such as Amnesty International (requires action).

A sound understanding of ethical codes is paramount if healthcare services managers are to be prepared to deal with the many ethical dilemmas that are present in the healthcare field. It is imperative that nurses of all categories be trained, educated and socialised in the principles and requirements of professional conduct, ethical behavior and respect for every patient, regardless of the patient's condition, temperament or inclination. Professional nurses should

accept their responsibility to model the professional conduct expected of them by the statutory body and the nursing profession.

## 2.10 Summary

The factors that have a profound influence on healthcare services are dynamic in nature. The healthcare administrator, healthcare services manager and, indeed, all healthcare practitioners, need to be not only extremely adaptable to the ever-changing health problems of their patients, but also to the external factors affecting their service delivery. These include globalisation; statutory, political and legal factors; demographic changes; social and economic factors; technological advancements and professional regulatory issues.

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# Managing Policy and Procedures

MC Bezuidenhout

## Chapter Outcomes

After studying this chapter, you should be able to:

- explain the origins, purpose and considerations in policy formulation;
- outline the different policies utilised in the healthcare services;
- discuss the use of procedure and other manuals in healthcare services;
- describe the format and use of the circular and memo in health services.

## 3.1 Introduction

Health policy creates the context within which healthcare should be practised. Therefore, health professionals are both dependent on health policy and affect health policy by means of the services they deliver and by direct lobbying. Policies and procedures are means of accomplishing goals and objectives. Policies explain how goals will be achieved and serve as guides that define the general course and scope of activities permissible for goal accomplishment.

Manuals are basically guides to action as they contain sets of policies and/ or procedures. Together with memoranda and circulars, they serve as a means of written communication to convey information across the entire organisation. Policies, procedures, rules and regulations are the standing plans of the organisation. Standing plans or protocols are fixed in both nature and content and are used repeatedly. They apply until reviewed and modified or abandoned. While hospitals and healthcare professionals seldom use the terms rules or regulations, they frequently develop and maintain policies and procedures that incorporate the rules and regulations imposed by government or other authorities.

## 3.2 Policy considerations

### 3.2.1 The purpose of policy

Policies exist to ensure consistency in the interpretation and the execution of expected actions pertaining to a specific matter. A policy sets a definite course of action for taking decisions and is based on accepted well-defined norms and standards. Norms and standards articulate what should be done, who is served and what services are required, thus creating consistency, enabling specific expectations and regulating practice (Illinois Department of Health Services, 2014).

Reasons for having a written policy of a health service's views and attitudes vary, from providing legal protection to the service and its employees, to fostering a more productive work environment. Policies serve as a means by which authority can be delegated and serve as a basis for future decisions and actions.

They help to co-ordinate plans, control performance and ensure consistency of action by increasing the probability that different managers will make similar decisions when independently facing similar situations (Marriner-Tomey, 2008).

This uniformity should make all healthcare professionals aware that an equitable set of standards governs major aspects of their working lives. Consequently, morale is increased when healthcare professionals perceive that they are being treated equally. Reaves (1992:2) reiterates that if policies are well laid out, patients will sense this through their interaction with members of the health service. The fostering of understanding, good feelings and compassion, derived from an awareness that treatment is fair and from the respect of peers, is the best way to promote the quality of work life and the aims of a health service.

A written policy provides for a uniform response from all healthcare professionals. As with many other areas in our daily lives, organisational policy is affected by local, regional and state laws designed to curb abuses.

It is therefore essential for every health services manager to be familiar with state guidelines concerning, for instance, conditions of employment, labour legislation and compensation so that health service policy complies with these requirements.

Copedia.com affirms that, 'policies and procedures prescribe how an entity will function and be administered, they are the rules and methods of conducting business. Internal controls refer to the processes that help ensure efficiency of operations, including the safeguarding of assets, achievement of goals, the reliability of information, reporting, and compliance with laws and regulations. These elements, combined with a clear vision and a defined strategic plan, form the framework of strong general management, proper governance, and a successful enterprise'.

According to Reaves (1992:1–2), Beach (1991:35–6) and Rousell, Swansburg and Swansburg (2009), policies serve the following purposes:

- The primary purpose of policies is to further the objectives of the health service. When a policy statement is formulated, it usually sets out how a specific goal or objective should be accomplished. This should be in a manner consistent with the philosophy of the health service and conducive to active participation and acceptance by employees.

- Policies also prevent temporary problems from becoming permanent, as guidelines are set for handling such matters.

- Some policies serve to protect the health service by stating a desire to comply with laws. Others provide protection for the organisation by gaining the endorsement of employees to act in the best interests of the organisation as part of their psychological contract with the employer.

- Formulating policies requires management to give deep thought to the basic needs of both the organisation and the employees. Management must examine its basic convictions, as well as give full consideration to prevailing practice in other similar organisations.

- Established policies ensure consistent treatment of all healthcare professionals throughout the organisation. Favouritism and discrimination are thereby minimised. Uniformity of policies prevents conflict and promotes fairness.

- Continuity of action is assured even though senior management may change. The tenure of office of any manager is finite, but the organisation continues. Policies, therefore, promote continuity and stability.

- Policies serve as a standard of performance. Actual results can be compared with the policy to determine how well the members of the organisation are performing.

- Sound policies help to build employee enthusiasm and loyalty. This is especially true where the policies reflect established principles of good faith, fair play and justice, and where they help people to grow within the organisation.

- Policies promote consistency of action and stability, for example in disciplinary matters. In the absence of a stated policy, one manager could terminate an employee's employment, while another manager might give counsel or a written warning for the same act.

- A policy ensures that similar problems do not have to be addressed repeatedly.

- Policies conserve time by setting standards. They provide guidance from senior management to lower-level managers and, in so doing, thus speed up decision-making processes.

The primary value of a written policy is thus that it ensures uniformity in response to similar situations by different employees. In ensuring uniformity, standardisation takes place.

## Standardisation

Standardisation is the process of developing uniform practices that should be followed when work is done – it thus creates a certain level of conformity. Standards exist 'primarily to provide a reliable and accepted basis on which common expectations can be shared regarding specific characteristics of a product or service or process. Standards are drafted in the expectation that those who use them will be appropriately experienced, qualified and equipped to do so, that they will apply them conscientiously and, where necessary, take sound advice by others qualified to provide it' (BSI Standards Publication, 2011:10).

Standardisation can be applied to work processes such as admission and discharge procedures, or to work outputs which specify the end product. Policy states the expected performance and the skills and knowledge, which enables healthcare professionals to perform their tasks in any given situation (Shortell & Kaluzny, 2006:242–243).

## *Benchmarking*

Where standardisation aims at setting standards which will ensure uniformity and a specific level of quality, benchmarking seeks to compare an organisation's processes, practices and products against the world's best. The purpose is to make the organisation better at delivering a certain product or service. Benchmarking thus aims at continuous improvement of current practices in order to enhance the end product or service delivered.

## 3.2.2 Characteristics of effective policy

Policies should be comprehensive in scope, stable, but flexible, so that they can be applied to different situations that are not so diverse that they require a separate set of policies. Consistency in the development, interpretation and implementation of policy is important, since inconsistency introduces uncertainty and contributes to a feeling of bias, preferential treatment and unfairness. Policies should, therefore, be in a clear written format and understandable to all concerned.

## 3.2.3 Ways of stating policy

Policies can be implied or expressed. Implied policies are not directly voiced or written, but are established by patterns of decisions and behaviour. Thus courteous treatment to patients may be implied rather than expressed (Marriner-Tomey, 2008). Expressed policies may be either oral or written. Oral policies are more flexible and can be easily adjusted to changing circumstances. Oral policies are, therefore, less desirable than written ones because they may not be known to all healthcare professionals and consistent implementation is difficult and not frequently achieved.

The process of writing policies reveals discrepancies and omissions and makes management think critically about the policy, thereby contributing to its clarity. Once written, they are readily available to all in the same form; their meaning cannot be changed by word of mouth; misunderstandings can be referred to the written word; the chance of misinterpretation is reduced; policy statements can be sent to all affected by them; they can be referred to whoever wishes to check the content, and they can be used for orientation purposes (Marriner-Tomey, 2008).

Written policies indicate the integrity of the organisation's intention and generate confidence in management. Only when policies are committed to writing can they be equally communicated to all employees; this implies that policies should be read and understood by all. To ensure the latter, a mechanism should be devised whereby employees sign as an indication that they have read each policy statement.

In large organisations containing decentralised and dispersed sections, written policies are a necessity. For instance, written personnel policies will ensure reasonably consistent treatment throughout the service on such matters as pay, promotion, transfer, lay-off, pension rights, insurance benefits, training

opportunities and grievance handling. A disadvantage of written policies is the reluctance to revise them when they become outdated. Managers should review policies periodically. If this does not happen, personnel can appeal for a revision.

## 3.2.4 Origins of policies

Policies can develop or be initiated in several ways and, depending on their origins, are termed originated, appealed or imposed policies.

- *Originated or internal policies* are usually developed by senior management to guide subordinates in their functions and tasks. Marriner-Tomey (2008) is of the opinion that strategy for originated policy flows from the goals of the organisation, as defined by senior management. They may be broad in scope, allowing staff associates to develop supplementary policies, or may be well defined with little room for misinterpretation. All decisions made by lower-level managers should implement and support the broader policy defined by senior management.

- When a staff member does not know how to solve a problem, disagrees with a previous decision, or otherwise wants a particular question reviewed, the staff member appeals to management for a decision. As these non-routine requests are taken up the hierarchy and decisions are made, precedents known as *appealed policy* develop and these precedents guide future managerial actions (Marriner-Tomey, 2008). Policies developed from such appeals (non-routine requests) are likely to be incomplete, unco-ordinated and unclear, as they are often seen in isolation. Rousell et al (2009) note that, where policy is lacking on a specific matter, employees often make decisions and act on their own without any comment or action by their supervisors. They thus set a precedent for the behaviour of others. Sometimes managers dislike facing issues until forced to do so and consequently delay policy making until precedents have been set.

- *Imposed or external policies* are thrust on an organisation by external forces, such as government or labour unions. The overall policy statement on health services in the Republic of South Africa is contained in the National Health Act 61 of 2003. Other Acts of Parliament provide policies regarding specific aspects of health matters, such as the Mental Health Care Act 17 of 2002, the Nursing Act 33 of 2005, the Medical Schemes Act 131 of 1998 and Choice on Termination of Pregnancy Amendment Act 38 of 2004. From these, regulations are formulated and delegated downward as a guideline for policy formation and employee behaviour.

For the healthcare services manager, it is therefore essential to have a policy manual containing all the appropriate legislation, regulations, as well as the rules of the organisation where he/she is working. The South African Nursing Council (SANC), the controlling body that serves to safeguard the position of the patient in all health services in the country, has a function in setting standards for performance. Utilising the Nursing Act 33 of 2005, SANC promulgates certain

regulations that are specific and regulatory to the practice of nursing and the specific professional responsibilities of the nurse. Two regulations that control the activities of the nurse and that need to be considered in the development of policies and procedures are Regulation 2598 on the scope of practice and Regulation 387 on the acts and omissions of the practising nurse.

The policies of the organisation must conform to local, regional and state laws. Labour law, collective bargaining and union contracts (recognition agreements) would, for instance, direct labour policy (Bezuidenhout, Garbers & Potgieter, 2007:19), while professional and social groups, such as nurses' associations, ethical codes, religious organisations, schools and charitable organisations, have an influence in forming policy.

## 3.2.5 Compiling policy

When policies are compiled, the purpose, philosophy, goals and objectives of the organisation serve as a guide. Policy making is a part of the planning function of senior management. The development of policy can be initiated anywhere in an organisation and should involve healthcare professionals who will be affected by the policy. Although any supervisor may set a policy, it must not conflict with one enforced by a higher authority; a policy may also be made by a manager only for the area over which he or she has jurisdiction.

When a policy statement is drafted, it may often contain an expression of philosophy and principle. According to Beach (1991:35), it is necessary to separate the expression of principle from the policy statement, as he indicates in the following examples.

> The following is a statement of principle with regard to the health and safety of healthcare professionals:
>
> > 'It is the intention of the health service to provide a safe and a healthful working environment.'
>
> It can be seen that such a statement is broad and general, whilst a policy statement is more specific and to the point. It commits management to a definite course of action, as shown in the following statement example:
>
> > 'Our policy is to institute every practical method for engineering safety into our processes and equipment, to provide protective clothing where necessary, to train employees in safe operating procedures, and to vigorously enforce established safety rules. Our policy is to provide a healthful plant by giving adequate attention to cleanliness, temperature, ventilation, light, and sanitation.'

A policy does not spell out the detailed steps by which it is to be implemented. A procedure provides the method for carrying out a policy. A policy should be stated in terms broad enough for it to be applicable to varying situations. Lower-level managers (ie first- and second-level) who apply a policy must be allowed some discretion in carrying it out – a rigid, excessively detailed policy

statement may result in an injustice if supervisors are not granted some latitude. Swansburg (1993:168) emphasises that an excessive imposition of policies is frequently perceived by professionals as authoritative and bureaucratic. Administrative directions in any form, including policies, should be kept to a minimum. They should be pertinent, concise, comprehensive and state their underlying reasons. When policies are written to cover every possible situation, they stifle independent thought and action.

## Principles for policy content

When determining the content and meaning of policies, it is important to consider the following five principles:

- past experience in the organisation
- prevailing practice in other services in the community and throughout the nation with regard to health services
- the attitude and philosophy of the board of directors and senior management
- the attitude and philosophy of middle- and lower-management
- the knowledge and experience gained from handling problems on a day-to-day basis (Erasmus, Swanepoel, Schenk, Van der Westhuizen & Wessels, 2005:276).

## 3.2.6 Types of policies required

Policy manuals allow the professional nurse and other practitioners in charge of a unit to conduct the affairs of the unit according to the overall policies of the organisation. This gives the health services manager something against which to check actions and serves as a guide to healthcare professionals in the unit when uncertainty arises. As previously stated, policies can be categorised in many different ways; the following discussion will focus on examples of the ways in which policy is derived and organised to facilitate easy utilisation and control. Policy derived from the following authorities will be dealt with:

- directives from the highest authority, such as the state, province or local authority
- directives from the department of the medical superintendent or managing director
- directives from the office of the chief nursing service manager
- directives or special instructions from the professional nurse in charge of a unit, ward or clinic.

## Directives from the state, province or local authority

In the public sector, the Public Service Act 103 of 1994 as amended, regulates all matters pertaining to the administration of the public service, such as the organisation of the public service, staff employment and termination as well as the obligations, rights and privileges of employees. From these topics, regulations are derived which find their application in practice through the relevant policies.

In order to demonstrate how public service personnel policy is affected by laws and regulations from the different levels of governmental authority, the following aspects must be considered. In South Africa, the conditions of service of state employees are regulated, first, by general conditions of service and, secondly, by occupational specific conditions of service. The Public Service Act 103 of 1994 empowers the State President to promulgate Public Service Regulations for the detailed regulation of conditions of service of employees in the service of the state. The general conditions of service are thus regulated jointly by the Public Service Act, the Basic Conditions of Employment Act, and the Public Service Regulations.

Organisational policy statements are usually available in written format in the form of manuals. The policy manual presents, in writing, what is expected at each level of management. It is clear that very specific guidelines are given in the policy statement regarding all aspects related to a specific topic.

## Directives from the managing director (medical superintendent)

In the private sector, health services may be part of a group, such as Medi-Clinic or Life Health Groups, or may be individual hospitals managed by independent management teams. These services are also bound by the applicable health legislation, as in the case of the public service, but their interpretation of the legislation and policy formulation may be less standardised than in the public service.

As an example, policy could be divided into two main areas, namely hospital policy and ward or unit policy, relating to the whole organisation and the wards or units respectively. Policies on working hours and asset control would be considered hospital policies, whereas waste management, pharmacy dispensing and handling of patient clothing and valuables fall under ward or unit policies.

## Directives from the office of the chief nursing service manager

Specific policies included in the hospital policy manual may vary in length and scope, depending on the topic. Aspects included under this heading could, for instance, be concerned with etiquette and the responsibilities of accompanying doctors on ward rounds, patient admission and discharge, and incident reporting.

## Directives or special instructions from the professional nurse in charge of the unit or clinic

Unit policy manuals contain policies applicable to all units, wards and clinics in general, but may also contain policy specifically related to the services rendered by a particular unit. Unit manuals are often devised to cater for the specific needs of the patients and the doctors who treat their patients in a certain unit. In addition to the hospital manual, the unit manual could, for example, explain and give directives regarding the nursing care of a certain doctor's patients in respect of orthopaedic surgery. Content could focus on positioning, movement, exercise, braces and ambulation. In a paediatric ward, emphasis could be on the handling, bathing, clothing, feeding and support of small dependent children.

### 3.2.7 Communicating policies

For statements of policy to be effective, they must be communicated throughout the organisation.

All members of management, including supervisors, are concerned with the content and meaning of policies because they have to interpret and apply them. Policies should not only be distributed to healthcare professionals, but training sessions should also be conducted to teach managers at all levels how to handle problems and deal with the newly enunciated policy. It is very important that all relevant people sign a statement that they have read a specific policy.

The most common way of informing non-supervisory employees of policy statements is by means of the policy manual. To achieve real understanding, however, this should be followed up with an oral explanation and interpretation by first-level supervisors. A policy is worthwhile only when it is carried out on a day-to-day basis.

Many organisations publish and disseminate their policies to supervisors and managers by means of policy manuals. These manuals are often in loose-leaf form to facilitate the insertion of new or changed policies. The manuals may also contain procedures on the implementation of policies.

## 3.3 Procedure manuals

Procedures stipulate the actions, processes, methods, and routine and specific conduct required to comply with policies. Procedures are normally related to policies, but may simply be an instruction sheet on how to do something, for example the procedure for changing the ink cartridge on a printer or how to complete a procurement requisition.

A procedural manual provides guidelines to ensure adherence to consistent, recognised standards of nursing practice. Smit and Cronjé (2002:94) define a procedure as a short-range statement of technique to be used in realising an institutional objective. A procedure explains how a policy must be carried out and supplies a more specific guide to action. Procedures help to achieve a high degree of regularity by enumerating the chronological sequence of steps in a process. Procedures are intra- or interdepartmental and consequently do not always affect an entire organisation to the extent that policy statements do.

Nursing procedures are usually contained in a nursing procedure manual, which is standard for units and departments within a hospital or community health service. A nursing procedure is an established and uniform method of performing nursing activities and provides specific information for those performing the procedure.

### 3.3.1 The purpose of procedures

Procedures are used for communication, understanding, standardisation, and co-ordination. They are referred to for review when an employee has not done the procedure for some time. They are used to teach and evaluate students and

new employees, to conduct auditing of nursing care, to orientate new employees and to update employees in developing technologies. Procedures contain the written instructions for performing activities taught at college, encompassing the principles and standards set for achieving safe and quality nursing care. They provide a means, therefore, of combining theory and practice in a practical guideline for performance.

Patient care procedures should inform, teach and reduce errors. They should cover the methodology for new equipment (and for changing equipment) and relate this to patient care practices. They should stipulate where to order, call for or send for something, how to perform tasks and why.

Procedure manuals are utilised at the functional level by professional nurses, nursing students and clinical teachers. Procedures guide new healthcare professionals, maintain standards, serve as a means of evaluating the performance of activities and ensure the safe care of the patient.

## 3.3.2 Development of procedures

The chief criteria for the format of procedures in nursing service manuals is simplicity and practicality. Writing procedures demands a consistent format that covers the definition, purpose, materials needed and how to locate, requisition, and dispose of them; steps in the procedure; expected results; precautions and appropriate charting. There is no best format, but in all cases, a procedure should be simple to follow.

Procedures are updated by a committee of professional nurses representing those who use them, relate to them and contribute theoretical insights. Each step in the procedure should be stated and should relate logically to the other steps. A balance between flexibility and stability should be maintained. Procedures should be reviewed and revised as necessary and should be dated to indicate the time of the most recent review. Procedure standards written for students in an education institution would be simplified, contain more detail and be more explanatory than those written for competent, trained staff.

## 3.3.3 Advantages and disadvantages of procedures

The major advantages of procedures are that they:

- *Conserve management effort*. Procedures state the preferred method of performing an activity, thus eliminating the need for multiple explanations by the supervisor.

- *Facilitate delegation of authority*. As procedures are an explanation of how policy should be achieved, authority for their performance can be delegated to middle- and first-level managers (eg zonal managers and ward or clinic supervisors).

- *Lead to more efficient methods of operation*. Efficiency can be achieved as the step-by-step actions and instructions are defined for a specific activity.

- *Permit significant economy in personnel utilisation.* The implementation of procedures is usually allocated to specific categories of staff, thus ensuring that the best qualified person performs the activity.

- *Facilitate control* by utilising the set procedure as a means to evaluate the method, standards and safety of the execution of the procedure.

- *Aid in co-ordination of activities.* Procedures stipulate the prerequisites, environment and sequence of events to take place when a specific activity must be performed. They ensure, therefore, that operations are coordinated in the immediate environment of the activity, as well as in the broader sense of ward or clinic management.

- *Can result in time and labour savings.* People know what is expected of them when a good procedure manual is available and is understood by all. Such a manual enables them to continue with their tasks without delay and explanation.

- *Increase productivity and reduce costs.* In the development of procedures, research goes into the planning and determination of every step to be performed. All aspects have been well thought through, ensuring that the best method, means and personnel will be utilised in the performance of the activity.

Disadvantages of procedures include the following:

- They do not always encourage participative management (Swansburg, 1993:171). They provide the accepted means of achieving a goal and do not allow for individual discretion and decision making.

- Procedure manuals may restrict clinical freedom and become a recipe book for nursing, negating the patient's individual needs. This is often the case when procedures are not based on the application of principles.

- They may omit extra dimensions of care that allow total consideration of the patient (Horne & Cowan, 1992:43–44). This is possible when procedures are based on explicit actions instead of principles.

### 3.3.4 Performing nursing procedures

The term 'nursing procedure' covers a wide range of activities, from injections, administering medication, bed-bathing, carrying out diagnostic tests and feeding, to wound dressing, suctioning a tracheostomy, defibrillating, suturing a wound and many more. Professional nurses in charge of the unit or clinic must be able to perform these procedures correctly and have the responsibility to ascertain which of their personnel are capable of competently performing those procedures which are part of the work of the specific unit or clinic. They must also see to it that those not yet proficient in the required skills are given instruction and afforded the opportunity of supervised practice with regard to the specific procedures.

As with policy manuals, the procedure manual should be easily accessible and well organised, with a table of contents and page numbers. It should be easy to replace each procedure with a later revision. The following criteria will facilitate the utilisation of a procedure manual:

- A code system should be used to enable the reader to find the related policy and procedure statement.

- All policies, procedures and directives should be dated and signed by the executive officer.

- The most common terminology used in the institution and/or department should be applied.

- The purpose of the procedure and a brief description of the directive should appear at the top of the document and be followed by actions to be taken.

- Manuals can be divided into clear sections and subsections, each having its own page references, which should appear in the outline of the contents of the manual. A cross-indexing system facilitates location of material. Nursing procedures may be organised under major headings, such as the care of patients with circulatory, gastrointestinal, neurological, cardiopulmonary, cardiovascular, eye, throat and orthopaedic conditions.

- Manuals should contain loose-leaf pages so that procedures can be readily removed or added to the section.

- A plan should be developed and maintained for the periodic review and updating of the manual's contents.

## 3.4 Other manuals

Policy, procedure and unit manuals are only three types of manuals that can be developed for use in hospitals or other healthcare institutions. Depending on the size of the institution, there may be a number of policy manuals available for the following purposes, such as:

- *human resource management*: job evaluation, staffing structures and establishments, recruiting, selection and appointment, induction, orientation, training and development, performance appraisal, promotion criteria and termination

- *labour relations*: trade unions, recognition agreements, collective bargaining and negotiation, grievances, discipline and dispute resolution

- *safety and disaster management*: environmental safety, preparedness for disasters, disaster training and reporting, safety committees, monitoring and evaluation, occupational health

- *nutrition and food services*: procurement, storage, dietary plans, preparation of food and cleanliness and hygiene of kitchen facilities

- *pharmacy*: dispensing license, procurement of stock, storage, dispensing processes, control measures

- *domestic matters*: cleanliness and maintenance of facilities, laundry, waste management
- *professional practice*: SANC regulations and registration, dress code and distinguishing devices, professional conduct, scope of practice, acts and omissions, responsibility and accountability, and advocacy role
- *patient procedures*: procedures performed on patients such as wound dressing, administering blood transfusion, preparing for theatre
- *infection prevention and control*: monitoring and evaluation, reporting, handling outbreaks, training and preventative measures
- *quality management*: risk management, quality improvement, quality assurance and total quality management.

The value of policy and procedure manuals cannot be overemphasised. They may be used for procedure demonstrations, group learning sessions, orientation of new staff, reference and at meetings.

## 3.5 Rules and regulations

Most relevant rules and regulations are included in policy and procedure manuals. They describe what can or cannot be done under specified circumstances and form part of the imposed or external guidelines that are passed down from various sources of authority. Rules and regulations permit no variations and must be strictly adhered to in order to avoid disciplinary action. It is important to keep in mind the regulations formulated by the South African Nursing Council as a guideline for effecting safe patient care.

## 3.6 Circulars

Circulars are a type of correspondence used in public services. They are sent out by the head office (usually seated at provincial or regional level) to bring standing orders or changes in policy to the attention of branches or services under their jurisdiction. They contain policy matters and long-term regulations and instructions. There are several types of circulars, namely, general, staff, advertisement and community service circulars and standing orders. All circulars are included in the policy manual as they serve as a source of reference.

There is a difference between a circular and a circular minute. The latter contains a short-term instruction applicable to a particular situation at a specific point in time. It usually refers to a specific issue and may be discarded as soon as it has been noted, for example, as an addendum to an advertisement of vacant positions or the implementation of a new public holiday. Internal circulars deal with matters related to the institution itself.

# 3.7 Memoranda

Memo is the singular, abbreviated form of memorandum, while memos are the plural shortening of memoranda. The term comes from the word memory. Memoranda are a means of communicating between departments within an organisation. As the format is usually simple and standardised, a memorandum allows fast and effective communication with a large number of healthcare professionals. Due to the advances in technology enhancing ways and means of communication, most organisations now make use of e-mails to distribute information to specific groups or all the staff of an institution.

## 3.7.1 Memo characteristics

Despite differences in length and content, most memos have features in common.

### Distribution

A letter is usually reserved for external use, for customers and clients, whereas a memo generally stays in-house and is read by co-workers, supervisors and executives. Letters may be read by only one person, while memos may be read by many people who know the sender or may know of him or her.

### Format

A memorandum may vary in length, but is usually a one-page document. Many offices use a standardised format that contains the following particulars:

- To:
- From:
- Date:
- Subject:

The standardised format makes compiling and organising a memorandum easy. The format may also expedite distribution, as the address is often positioned so that it is left exposed during folding, thus eliminating the need for an envelope.

### Content

It is essential to state the purpose of the communication in the first paragraph and preferably in the first sentence of the memo. Do not make it difficult for the reader to find out what the point of the memo is. Principles involved in the writing of memoranda are the following:

- They should be brief: only the essential information should be given.

- The contents should clearly indicate who, what, when, where, how and why.

- All points should be listed in logical order.

- Separate memoranda should be prepared for different subjects, as this facilitates filing.

- Simple language should be used.

- A copy of each memorandum should be kept on file in the unit. This file should be properly indexed.

Having explained the legal documents that enable, facilitate and guide the actions of employees in ultimately reaching the goals of the organisation, an illustration of the different components and their relationships is given in Figure 3.1.
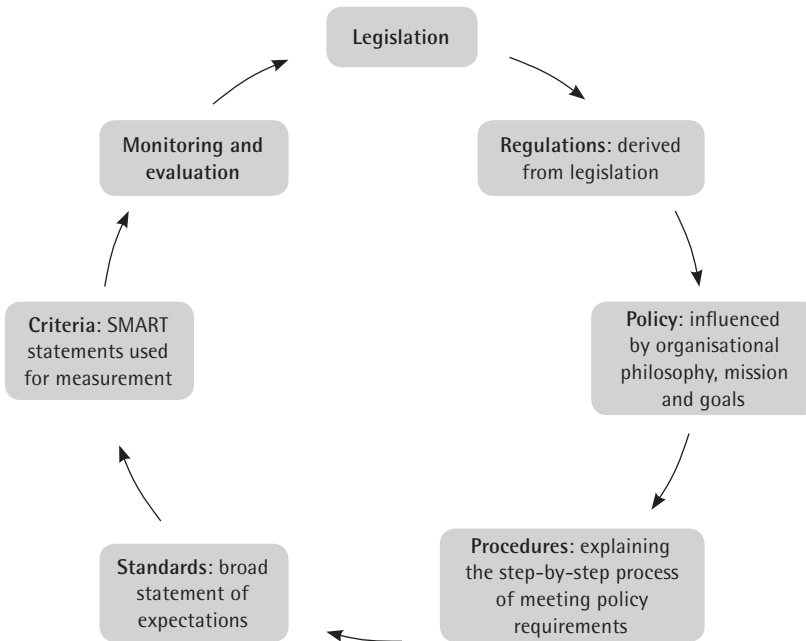


**Figure 3.1:** Progression of guiding documents to abide by legislative stipulations

Legislation is promulgated by government from which various regulations are developed to guide practice. Within sectors, organisations, departments and units, the applicable regulations are used to formulate policy statements, taking cognisance of the organisational philosophy, mission and goals. As policy statements inform employees of what should be done, procedures explain the process of how the policy focus/goal should be achieved. To ensure that procedures are performed at a certain level of proficiency, standards and criteria are set by which performance and outcomes of specific indicators can be monitored and evaluated.

## 3.8 Responsibility of the professional nurse for policy and procedures

Policy and procedures are laid down by the employing organisation to protect the patients, healthcare professionals and the organisation. It is essential that the

unit manager should bring the policy and procedure manuals (copies of which should be available in all wards and departments) to the attention of healthcare professionals, especially those new to the ward. The unit manager must also ensure that all nurses comply with these guidelines. Alterations or additions to the manuals must be conveyed to everyone (Matthews & Whelan, 1993:244).

It is the unit manager's responsibility to bring to the attention of their superiors any difficulties in implementing a specific policy. A great deal of policy-making comes from senior management and the unit manager must abide by decisions such as which cases are to be admitted to the unit; what form of general record keeping will be implemented and where records will be stored; the arrangements regarding the ordering of equipment and supplies; channels of communication; in-service education policy; and the basic allocation of personnel.

As first-level managers, senior professional nurses are a vital link between the heads of the organisation and the nurses and other subordinates. As such, nurses are responsible for maintaining good working relationships, discipline, efficient work methods and procedures that ensure that safe, humane, understanding and efficient care is given. To their subordinates, the unit managers are often the only tangible link with those higher up the chain of command. Mellish and Wannenburg (1992:202) see them as the interpreters of policy, the instructors of nursing skills and techniques, the purveyors of knowledge, the judges of efficiency, the experts who can solve problems connected with the work of the unit, the spokespersons who convey views and requests to those in higher authority, and friends to whom staff can turn for help and guidance when experiencing difficulties.

## 3.9 Summary

Senior management initiates policies and procedures for the express purpose of guiding managers and subordinates in the daily operations of the organisation. Policies are guides that stem from the goals of the institution, while procedures indicate by means of a process how the policies should be implemented.

It is recommended that policy statements should be in writing and available to all members of staff. They indicate not only what is expected from the staff, but also what kind of treatment staff can expect from management. Only when policies are committed to writing can they be consistently communicated.

Statements of policy and procedures are contained in loose-leaf manuals, enabling easy replacement when necessary. Professional nurses have specific responsibilities as leaders to ensure that subordinates are familiar with the content and implications of policy, procedures and the applicable rules and regulations. These documents aim to create uniformity in operations throughout the organisation and ensure that similar methods are used to resolve similar problems.

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# 4

# Foundations of Planning in Unit Management

F Smith and F Khan

## Chapter Outcomes

After studying this chapter, you should be able to:
- discuss statements of vision, mission and philosophy in health services;
- write clear and meaningful objectives and goals that will result in actions;
- distinguish between the various decision-making models;
- list the types of plans and the steps in a project plan;
- describe the benefits of planning;
- explain the importance of aligning plans to organisational policy.

## 4.1 Introduction

Planning is one of the fundamental skills of modern life. We all practise it to a greater or lesser extent. Planning helps determine the direction of an organisation over the short, medium and long terms, matching its resources to a changing environment, and in particular, to its markets, customers and clients, so as to meet their expectations. Planning is a systematic process, envisioning the desired future and translating this vision into broadly defined goals or objectives and a sequence of steps to achieve them.

## 4.2 The importance of planning

Planning analyses competitive opportunities and threats, as well as the strengths and weaknesses of an organisation. It then determines how to address the issues and compete effectively in the business environment. It also identifies clear objectives that direct behavior and action. Planning provides the vison and mission, the specific strategy and clear objectives to all levels of staff within the organisation (Mintzberg, 1973 in Lamond, 2004).

## 4.3 The benefits of planning

According to Kotler, Armstrong and Tait (2010:26), planning has the following benefits:

- *Direction is established in management*: The planning process forces managers to think strategically and about the future. Strategic planning requires that an assessment is done and that the organisation chooses a direction to follow.

- *Planning defines the business*: Planning develops a mission statement and identifies the business of the organisation, including its markets and products.

Annual plans also give an indication of the objectives, action programmes, budgets, control and marketing strategies of an organisation.

- *Communication and teamwork are improved*: Plans should be communicated to all employees at all levels. This will improve their morale and consequently teamwork within the organisation. Organisational efforts can thus be better co-ordinated.

- *Planning develops personnel*: A successful plan includes the employees who will implement it. This may motivate employees to improve their performance.

- *Planning helps to measure performance*: In the plan, details are set out about action plans, persons responsible for the execution of these plans, and completion time; these details can be used in performance appraisals.

- *Planning improves profitability*: More efficient use of resources, higher productivity and better morale will increase the profitability of an organisation.

- *Planning helps to manage change and is future directed*: An organisation that undertakes effective planning can adapt more quickly to environmental changes and is better prepared for sudden developments.

- *Planning ensures that management keeps abreast of advances in technology*: New, technologically advanced projects require money and time, therefore planning plays a critical role in their success.

## 4.4 Vision, mission and philosophy

Planning should be aligned to the vision, mission and the philosophy of the organisation, which should in turn form the cornerstone and building blocks of any organisation.

According to Ehrat (1994:37), the philosophy of a service is the amalgamation of its vision, mission and value statements. These statements describe the service conceptually. In other words, they describe the specific context in which the service functions. Information is also included regarding the organisation's desired future, its intentions and beliefs. The vision statement is the most abstract form of these statements, the mission statement somewhat less abstract and the value statement (also called the 'philosophy') is the least abstract.

### 4.4.1 Vision statement

According to Nagy, Fawcett, Berkowitz and Schultz (2013), your vision is your dream. It is what the organisation believes are the ideal conditions for the community it serves; how things would look if the issues important to you were completely, perfectly addressed. By developing a vision statement or statements, the organisation clarifies its beliefs and governing principles, first for itself, and then for the greater community (Nagy et al, 2013). An example of a vision statement of a private healthcare organisation in South Africa could be: to be a world-class provider of excellent healthcare services for all.

## 4.4.2 Mission statement

According to Nagy et al (2013), the next step is to ground the vision in practical terms. This step in the action planning process involves developing a mission statement. An organisation's mission statement describes what the group is going to do and why it is going to do that. Mission statements are similar to vision statements in that they also look at the big picture. However, they are more concrete and more 'action-oriented' than vision statements.

The vision statement should inspire people to dream; the mission statement should inspire them to action (Nagy et al, 2013). The mission statement might refer to a goal, such as providing access to healthcare for everyone. And, while they do not go into a lot of detail, they start to hint – very broadly – at how the organisation might fix these problems or reach these goals (Nagy et al, 2013). An example of an effective mission statement could be: upholding mother and child health through a widespread family and community programme.

## 4.4.3 Philosophy (Value statement)

A philosophy is a guide or framework for action. The most crucial step in developing a philosophy is to identify the basic phenomena, or pillars, of the discipline (Salsberry, 1994:13). In the context of healthcare, the philosophy essentially states the values and beliefs held by the healthcare professionas about the nature of the work required to achieve the mission of the organisation. It states what we believe nursing management and practice are, and sets the stage for developing goals to realise these beliefs (Yoder-Wise, 1995:169).

Mission statements and a philosophy can be helpful only if they direct nursing care. Each nursing unit should use the organisation's philosophy to develop its own unit philosophy. Each professional nurse should have a personal nursing philosophy which corresponds with the organisational philosophy (Marquis & Huston, 1998:61).
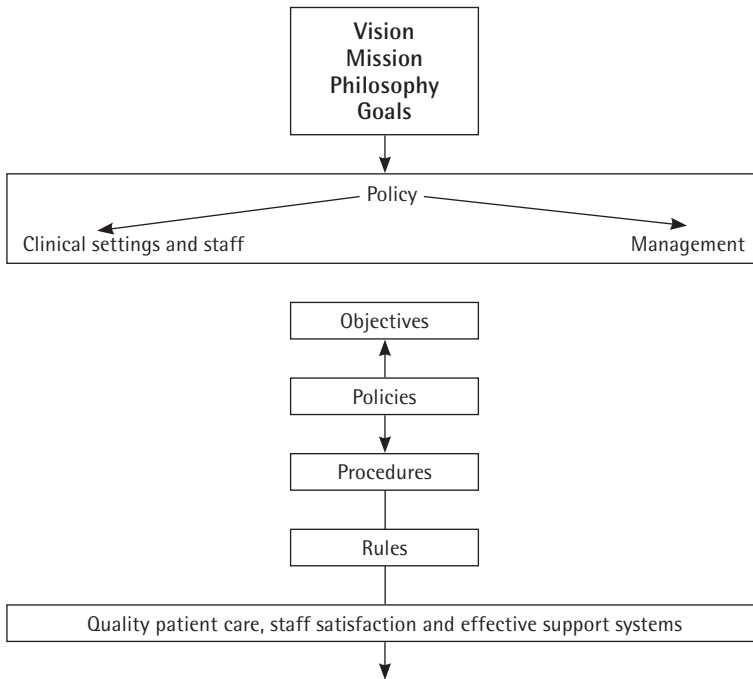
**Figure 4.1:** The management hierarchy

Source: Adapted from Marquis & Huston (1998:60)

## 4.5 Goals and objectives

Creating meaningful business goals is an important activity in every organisation. Properly created goals should cascade from the organisation's strategic plan, business unit goals and/or from departmental goals. Typically, as goals flow downward they move from a broader focus to an individual's specific accountabilities. Correctly established goals provide a roadmap for organisational success and move the organisation and its workforce toward meaningful accomplishments. Typically, goals form the basis of professional and management employees' performance reviews.

Objectives, like the mission statements and the philosophy, must be functional and useful. Objectives should be used to evaluate nursing care and healthcare professionals' performance, plan educational programmes, estimate staffing requirements and order equipment and supplies. Objectives are the standards against which the performance of the healthcare service can be measured. They are the basis for work and task assignment in nursing. Objectives make nursing tasks clear and unambiguous, with measurable results (Swansburg 1993:34–37).

### 4.5.1 Writing SMART goals

The acronym, SMART, is a guide for writing meaningful goals. Goals should be specific, measurable, attainable, realistic and time-based.

## Specific

Goals need to be specific to help focus and define the overall effort and tasks involved. To develop specific goals, they should answer the following questions:

- Who is involved?

- What needs to be accomplished?

- Where will it be accomplished?

- When should it be accomplished?

- What conditions need to be met?

## Measurable

Goals need to have concrete ways for measuring progress and evaluating performance. This helps to keep the plan on track and reach set targets. Different points or milestones may be included, where progress should be measured. By successfully reaching progress points, a cycle is created that provides added motivation to maintain efforts toward reaching the final goal.

## Attainable

Goals need to stretch and challenge current capabilities, but they must be attainable although not necessarily easy. Goals that are perceived to be unreachable will lead to frustration. If goals seem overwhelming, they can become more manageable if broken into attainable steps.

## Realistic

Unrealistic goals will lead to negative experience and frustration. Often, personal and situational factors influence the ability to reach objectives. To ensure that an objective can be achieved, these factors should be considered. Goals that involve steep learning curves should also be avoided, unless there is adequate time to come up to speed. The bar should be set high enough for satisfying outcomes and to encourage a positive cycle of achievement.

## Time-based

Starting and end points should be written into every objective. Day-to-day crises and other priorities will supersede goals without timelines or schedules. Deadlines create a powerful and necessary sense of urgency to take action. Goals with long time spans should be broken down into attainable steps with progress checkpoints.

# 4.6 Decision making

Nurses are involved in complex decision making, in a range of environments and for a variety of purposes. The decisions that nurses make in their daily practice include those related to: ethical and legal dilemmas; time management and priorities; clinical interventions and their effectiveness; unit or facility policies

and protocols; communication; role relationships among healthcare professionals; delegation among nurses and to other healthcare providers; expansions to scopes of practice; safe staffing levels; and service organisation, delivery and management.

The guiding principle for all decision making in nursing, irrespective of its nature and purpose, is to achieve the best health outcomes for the patients. Decision making can be regarded as the process resulting in the selection of a course of action among several alternative scenarios. In a healthcare organisation, members of the management team and multidisciplinary healthcare professionals usually engage in group decision making to ensure the best clinical outcomes for the patients.

## 4.6.1 Stages of group decision making

According to Fisher (2014), there are four stages that should be involved in all group decision making. These stages, sometimes called phases, are important for the decision-making process to begin.

- *Orientation stage*: This is when members meet for the first time and start to get to know each other.

- *Conflict stage*: Once group members become familiar with each other, disputes, little fights and arguments occur often. Group members eventually work it out.

- *Emergence stage*: The group begins to clear up vague opinions by talking about them.

- *Reinforcement stage*: Members finally make a decision, while justifying that it was the right decision.

## 4.6.2 Examples of decision–making models

### Rational model

Consists of a structured four-step sequence:

1. Identify the problem.

2. Generate alternative solutions.

3. Select a solution.

4. Implement and evaluate the solution.

### Group decision–making model

This model assumes that:

- Groups can accumulate more knowledge and facts.

- Groups have a broader perspective and consider more alternative solutions.

- Individuals who participate in decisions are more satisfied with the decision and more likely to support it.

## Clinical decision-making models

Nurses make clinical decisions each day while planning and delivering care. They use the knowledge and skills they have gained through previous education and expertise in practice. Three examples of clinical decision-making models are:

- the information-processing model, which uses a scientific hypothetic-deductive, quantitative approach
- the intuitive-humanistic model, which focuses on intuition and how the knowledge gained from nursing experience enriches the clinical decision-making process
- the clinical-decision model, which uses both hypothetic-deductive and pattern recognition.

Critical pathways could be used as a technique in clinical decision making. Clinical decisions made by nurses commonly relate to choosing and implementing nursing interventions, evaluating their effectiveness and communicating with patients, families and colleagues about the interventions. Effective clinical decisions, which result in health improvements for patients, are the product of complex decision-making processes that take account of available evidence, the context of care and available resources, patient preference and clinical expertise.

# 4.7 The planning process

Planning is essential for the efficient operation of any healthcare organisation. However, plans must be flexible enough to successfully adapt to an ever-changing healthcare environment. South Africa is faced with transforming all aspects of its healthcare system and practices. For instance, various changes have been proposed to the scopes of practice for nurses, as well as the criteria for re-registration. Changes are also taking place to the framework of nursing education.

# 4.8 Types of plans

Plans are made at all levels in an organisation. Everyone will be affected by plans that are made by others.

## 4.8.1 Strategic (corporate) plans

Strategic, or corporate, plans form the basis for everything that the whole organisation wants to achieve during a specific period. They are usually long-term plans, ranging from a minimum of one year to five years ahead. Many organisations annually revise and update their strategic plans for the coming years. They add a further year in place of the one just passed, and revise the plans for the present year according to changing circumstances in the business environment.

According to Peel (1993:45), most organisations involve only senior managers in corporate planning, but an increasing number involve managers at every management level. Some organisations use the bottom-up strategy, whereby a plan evolves from the inputs of all units and departments in the organisation.

There are numerous definitions of strategic planning. According to Kotler and Armstrong (2012), strategic planning involves a process of developing and maintaining a strategic fit that is aligned to the organisation's goals and capabilities and its changing marketing opportunities.

According to these authors, a strategic plan also involves adapting the organisation in order to take advantage of all opportunities in its ever-changing environment. A strategic plan's foundation lies in a clear mission, the supporting objectives, a thorough business portfolio and co-ordinated functional strategies (Kotler & Armstrong, 2012).

Nolan, Goodstein and Pfeiffer (1993:118) define strategic planning as 'the process by which the guiding members of an organisation envision the organisation's future and develop the necessary procedures and operations to achieve that future.' In the vision of the future are the direction and energy required to help the organisation achieve its strategic goals.

## 4.8.2 Business plans

Some smaller organisations produce a business plan for all their activities. This type of plan is effectively a corporate plan under another name. In larger organisations, business plans are drawn up for new products or special projects (Peel, 1993:45). The purpose of a business plan is to provide information to investors and decision makers regarding internal and external aspects that influence the organisation. These plans also provide information on motivation and the performance of the organisation (Swansburg, 2011:54).

## 4.8.3 Operational plans

Operational planning means the day-to-day and month-by-month planning by the managers in every unit or department of a health service. This is the type of planning that is done most often. The planning horizon is how far managers can sensibly plan. According to Peel (1993:46), it depends on factors like the routine of operations performed and the nature of the services required by the patients. Planning for services that consist of a small number of major and specialised assignments is very different to planning for a large number of similar jobs.

Plans may be handed over from upper management or from other departments, but when a department accepts a plan, the manager also accepts the responsibility for implementing it. It is therefore necessary that the manager, when accepting a plan, should ensure that it is properly constructed and achievable. The objectives should be attainable, otherwise nothing is gained by accepting a plan. If a manager does not feel positive about an accepted plan, reservations should be clearly stated on record to prevent any misunderstandings.

## 4.8.4 Project plans

According to Peel (1993:46), projects are activities that are not fulfilled every day in an organisation and are more or less self-contained. The same author also describes these plans as instruments of change. According to Larson and Larson (2004) there is a six-step approach that can be followed to creating a project plan.

### Step 1: Explain the project plan to key stakeholders and discuss its key components

The project plan is a dynamic set of documents that can be expected to change over the life of the project. Like a road map, it provides the direction for the project. A common misconception is that the plan equates to the project timeline; the project timeline is only one of the components of the project plan. The project plan is the major work product from the entire planning process, so it contains all the planning documents.

### Step 2: Define roles and responsibilities

It is important for the project manager to get clarity and agreement on what work needs to be done, by whom, as well as which decisions each stakeholder should make.

### Step 3: Develop a scope statement

The scope statement is arguably the most important document in the project plan. It is used to get common agreement among the stakeholders about the project definition. The scope statement should include:

- the business need and business problem
- project objectives, stating what will occur within the project to solve the business problem
- benefits of completing the project, as well as the project justification
- project scope, stated as which deliverables will be included or excluded from the project
- key milestones, the approach and other components as dictated by the size and nature of the project.

### Step 4: Develop the project baselines

The scope baseline includes all the deliverables produced on the project, and therefore identifies all the work to be done. These deliverables should include:

- schedule and cost baselines
- an estimate of how many hours it will take to complete each task
- an estimated cost of each task, using an average hourly rate for each resource
- a schedule which combines all the tasks and estimates in a calendar: it shows by chosen time period (week, month, quarter or year) which resource is doing which tasks, how much time each task is expected to take, and when each task is scheduled to begin and end.

## *Step 5: Create baseline management plans*

Once the scope, schedule and cost baselines have been established, create the steps the team will take to manage variances to these plans. Not all new requests will result in changes to the scope, schedule or budget, but a process is needed to study all new requests to determine their impact on the project.

## *Step 6: Communicate*

One important aspect of the project plan is the communications plan. This document states such things as:

- who requires which reports, how often, in what format, and using what media
- how issues will be escalated and when
- where project information will be stored and who can access it
- what new risks have surfaced and what the risk response will include.

Developing a clear project plan takes time. The project manager will probably be tempted to skip the planning and jump straight into execution (Larson & Larson, 2004). However, the traveller who plans the route before beginning a journey ultimately reaches the intended destination more quickly and more easily than the disorganised traveller, who often gets lost along the way (Larson & Larson, 2004).

## 4.9 Summary

Ever-increasing demands on health services managers oblige them to plan effectively in order to keep up with current changes in South Africa's health services. Health services managers should understand why planning is important, as well as the benefits that planning gives health services.

Planning should be based on the vision, mission, philosophy, goals and objectives of a specific organisation. The planning process, the components and elements of a plan, and the different types of planning are essential management guidelines, as are the factors affecting the success of a plan and the reasons why managers resist planning. Strategic planning sets the stage for all other planning and involves looking into the future.

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# 5

# Principles of Organisation in the Health Services

JH Roos

## Chapter Outcomes

After studying this chapter, you should be able to:

- describe the basic elements of organisational structure;
- recognise the importance of the informal structure in an organisation;
- identify factors influencing centralisation and decentralisation;
- identify factors influencing the organisational design;
- discuss the organisation of time in a health services unit;
- describe the organisation of staff members in a health services unit;
- explain the different methods of assigning nursing staff to patient care;
- list the organisation of the physical environment that should receive attention.

## 5.1 Introduction

'Organizing is the grouping of activities for the purpose of achieving objectives, the assignment of such groupings to a manager with authority for supervising each group, and the means of co-ordinating appropriate activities horizontally and vertically with other units that are responsible for accomplishing organizational objectives' (Roussel, 2013:217).

To achieve the objectives of an organisation, the available resources need to be organised. These resources are human, physical, financial and information-related.

## 5.2 The importance of organisation in the health services

Even the best designed plans of health services managers are meaningless if they are incapable of implementing them through good organisation. It is important to organise because of the following factors:

- *Work analysis*: organisation leads to the analysis of the work that must be done and the resources available. If the organisation wants to excel in the delivery of quality patient care, it is crucial to appoint an experienced health professional as a quality control officer.

- *Allocation of responsibilities*: employees will know for which tasks they are responsible, for example, every nurse should have a written job description.

- *Accountability*: this means that employees will be liable for the positive as well as negative outcomes of the tasks for which they are responsible.

- *Clear channels of communication*: information is distributed through the correct channels at all levels of the organisation.

- *Productive utilisation of resources*: by grouping patients with the same illness together, effective use is made of human resources and expensive technical equipment.

- *Division of work*: related activities and tasks of individual employees are grouped together in specialised departments. This may include different outpatients departments or dividing staff activities into specified units, for example eye or diabetes clinics.

- *Co-ordination of activities*: there are various activities taking place in the environment of the patient. Without a mechanism for the proper co-ordination of these activities, for example, the administration of medicine and ward rounds, quality of care cannot be attained.

- *Prevention of duplication*: organisation prevents overlapping and duplication of activities in a service. It is expensive to repeat the same laboratory test because of a lack of organisation.

- *Clear lines of authority*: employees know to whom they must report (Nickels, McHugh & McHugh, 2011:205; Smit, Cronjé, Brevis & Vrba, 2011:218).

## 5.3 The organisational structure

The formal system of working relationships that separates and integrates tasks is known as the organisational structure. It provides a framework for allocating responsibility, authority, accountability and delegation to various posts.

The organisational structure of healthcare organisations, whether a clinic or a hospital, is usually based on one of three structural forms, namely bureaucracy, matrix or project teams (Huber, 2006:237). This formal structure is usually portrayed on an organisational chart.

An organisational structure is necessary for the following reasons:
- people and resources must be allocated to tasks
- responsibilities have to be clarified through job descriptions and lines of authority
- employees must know what is expected of them through the establishment of rules, regulations, performance standards and procedures
- decision making and problem solving become easy.

The organisational structure of health organisations, like any other organisations, can be divided into four elements, namely specialisation, standardisation, co-ordination and authority.

## 5.3.1 Specialisation

Specialisation occurs where specialised tasks are identified in an organisation and assigned to groups or individuals who are appropriately trained.

Growing organisations are forced to specialise because of the following factors:

- Individual expertise is enhanced by the repetition of tasks.

- Transfer time can be reduced as it becomes unnecessary for a person to carry out more than one task.

- Specialised equipment is better maintained and utilised when operated by only one person.

- Training costs are reduced because only one worker is trained for each component of a particular task (Cronjé & Motlatla, 2000:141).

A consequence of specialisation is the formation of different sections. The work is subdivided horizontally and formally assigned to different sections, a process called departmentalisation. It is important to understand that, while some organisations may have only one form of departmentalisation, complex organisations, like healthcare services, may use different forms of departmentalisation at various levels of the organisation. These different forms of departmentalisation are discussed below.

### *Functional departmentalisation*

Most hospitals use functional departmentalisation. Functions are grouped according to the field of specialisation, for example, medical, surgical and intensive care units.

The advantages of functional departmentalisation are the following:

- It promotes skills specialisation, for example, nurses working in a family planning clinic become experts in that specific field.

- It reduces duplication of services and co-ordination problems within the functional area. Everyone working in that specific department knows who is responsible for certain services and co-ordination problems are thus reduced.

- Career development within a department is enhanced. The nurses working in one department have an idea how to develop themselves for promotion in that department.

- Superiors and subordinates share some common skills. This makes supervision and decision making easier.

- High-quality technical problem solving is promoted.

- It tends to be economical if it is operating effectively. Less specialised equipment is needed.

The disadvantages of functional departmentalisation are the following:

- Routine tasks are emphasised. This may prove to be demotivating to nurses and make them feel bored.

- Communication between different departments is reduced, consequently decision making becomes slower.

- Conflict over product priorities may be created. This is especially true when a budget is prepared for the nursing department and every department wants its fair share. The healthcare budget is usually restricted and it should be decided how much of the budget will go for family planning and how much will go for immunisation in primary healthcare.

- It can make duty hour scheduling difficult across various departments. It is often the case that nurses are unwilling to lend a hand in another department because they do not regard it as their work.

- The focus is on departmental, rather than organisational, issues.

- Managers are developed to be experts in narrow fields (Hellriegel, Jackson, Slocum, Staude & Associates, 2004:205; French, Rayner, Rees & Rumbles, 2008:348).

## *Geographical or area departmentalisation*

Area departmentalisation is a method commonly used by organisations when operating in different geographical areas. The health service, for instance, has similar clinics countrywide. 'The idea is to focus attention on the needs of the individual customer' (French et al, 2008:348). The advantages of area departmentalisation are the following:

- Equipment in use is all located in one place.

- Managers develop expertise in solving problems particular to that area.

- Managers know the problems experienced by the customers in a specific area.

- This method is suited to multinational organisations.

The disadvantages of area departmentalisation are the following:

- All functions are duplicated for every level in all departments.

- Conflict may arise between the objectives of the departments and the objectives of the organisation.

- Extensive rules and regulations may be required to co-ordinate and ensure uniformity of quality among departments.

- It does not foster employees' knowledge of problems in other departments (Hellriegel et al, 2004:207).

## *Product or service departmentalisation (divisional structures)*

When an organisation grows, the weaknesses of functional departmentalisation often become apparent. This may give rise to product or service departmentalisation, which is a structure of self-contained units, each able to design and produce its own goods or services. In healthcare services, for instance, some hospitals offer their services to a specific group of customers, for example, a hospital for eye diseases, a clinic for patients with heart problems or an orthopaedic hospital.

The advantages of product or service departmentalisation are that it:

- can accommodate fast changes in product or service

- allows for greater product or service visibility

- fosters a concern for customers' demands

- clearly defines responsibilities

- recognises the need for interdepartmental co-operation

- develops managers who can think across functional lines.

The disadvantages of product or service departmentalisation are that it:

- may not use skills and resources effectively

- does not foster co-ordination of activities across product or service lines

- fosters politics in resource allocation

- restricts problem solving to a single product or service

- limits career mobility for personnel outside their product or service line

- increases administrative costs because each section has its own function (Hellriegel et al, 2004:208).

Client departmentalisation is when an organisation focuses on only a specific segment of the market or group of consumers. It has the same advantages and disadvantages as product departmentalisation. In the healthcare services, for instance, hospitals may offer a service to a specific group of patients, such as female patients or children.

## 5.3.2 Standardisation

Standardisation is the process whereby an organisation develops procedures to ensure that employees perform their work in a uniform and consistent manner. When procedures are carefully planned and followed, labour and time are saved, equipment and supplies used economically and individuals protected from bodily harm and potential hazards. Procedure manuals, job descriptions and rules and regulations are examples of methods to enhance this process (Hellriegel et al, 2004:202). This also means standardisation of supplies and equipment.

The unit manager makes sure that procedures go smoothly through teaching and supervision. Every nursing unit should have a procedure and policy manual that the nurse can consult when in doubt. Examples of these are written job descriptions and rules and regulations. Every organisation should, for instance, have a standardised grievance procedure and every employee, irrespective of the department in which he or she works, should follow this procedure whenever he or she wishes to bring grievances to the attention of higher authorities.

The healthcare professionals should feel free to approach the unit manager with suggestions that may improve the service. If the unit manager gives them the necessary credit for their ideas, it will motivate further proactive thinking. It is important that procedures and methods are revised on a regular basis to incorporate the latest technology and scientific knowledge.

## 5.3.3 Co-ordination

Co-ordination is the process of integration of all the activities of the different employees and departments. This is a difficult process, especially in large organisations. Bureaucratic organisations try to overcome this by strict adherence to the rules and regulations of the organisation. Co-ordination requires knowledge of the functions and problems of the different departments. It is usually one of the main functions of the unit manager to integrate all the efforts of the various care providers. This requires an understanding of the role and functions of the various departments, and of diplomacy and effective communication channels. If nursing units experience problems with the delivery of supplies from the stores, it is important that the different parties consult with each other and that there is co-ordination between the efforts of the different role players.

Effective communication within an organisation forms the key to the co-ordination of activities in an organisation. Communication will be discussed in more detail in Chapter 9 of this book. It is however important to understand the role of organisational communication in the management of an organisation. Smit et al (2011:414) refer to the flow of communication in an organisation in four directions, namely downwards, upwards, horizontally and laterally.

### *Downward communication*

Downward communication flows from top management through the hierarchy to the subordinates, consisting of the goals, strategies and policies. Sullivan and Garland (2010:99) see this type of communication as often being directive. Before passing on information to the lower levels, the information is 'likely to be filtered, modified or halted at each level' (Smit et al, 2011:414). Delegation takes place through a process of downward communication. This time-consuming activity between managers and subordinates is necessary as managers need to clarify and support subordinates on what is expected from them.

## Upward communication

Upward communication is seen as a process where communication flows from the lower level of the hierarchy to top-level management. The subordinate at the lower level could inform the top level with important information regarding their patients as well as the needs experienced by the subordinates. Middle management should ensure that the information from the lower level reaches top management accurately and completely. Upward communication facilitates problem solving and decision making in the organisation (Sullivan & Garland, 2010:100).

## Horizontal communication

'Horizontal communication occurs between people on the same level of the hierarchy' (Smit et al, 2011:415). Though formal, this type of communication does not follow the chain of command principle. Through regular meetings between representatives of the various departments, interdepartmental co-ordination is improved.

## Lateral communication

Lateral communication is intended to provide information, co-ordination and assistance to people at different levels of the hierarchy. Managers at different levels have knowledge of the communication taking place and approve and encourage it. They understand the necessity of this type of communication to exchange accurate communication between role players functioning at the different levels of the hierarchy (Smit et al, 2011:415).

Communication and co-ordination are closely linked to the organisational principles summarised in the following sections.

## The unity of command principle

Each employee should be responsible to and receive orders from only one supervisor to minimise confusion when making decisions (Nickels et al, 2011:205). Uncertainty about whose instructions should be followed could lead to serious productivity and interpersonal problems. It is only in the case of matrix organisations that this rule is intentionally violated in order to benefit from functional and product departmentalisation.

## The scalar principle (chain of command)

An unbroken chain of command links every worker in an organisation with his or her supervisor. There is no overlapping in delegation: when a person on the lower level wants information from higher levels, the communication must go through his or her immediate supervisor. Strict adherence to this principle can waste time and money and is frustrating. To overcome this frustration, informal relationships across departmental lines often develop to solve problems and facilitate communication within the organisation.

## *The span of control principle*

The span of control principle stipulates that a person should be a supervisor of a group that he or she can effectively supervise in terms of numbers, functions and geography (Roussel, 2013:220). Fewer employees are supervised by one supervisor with a narrow span of control which will lead to a tall, centralised organisational structure (see Figure 5.1), while when more employees are supervised, the span of control becomes wider, leading to a flat, decentralised structure (see Figure 5.2) (Smit et al, 2011:221; Sullivan & Garland, 2010:38).
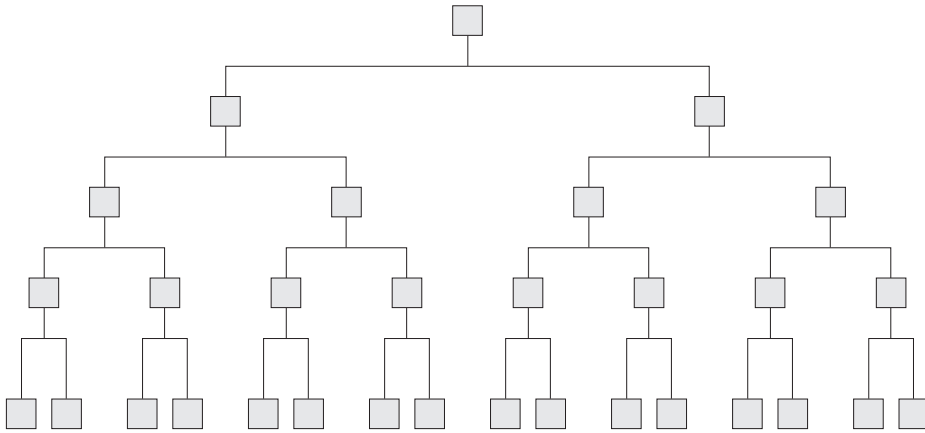
**Figure 5.1**: A tall span of control
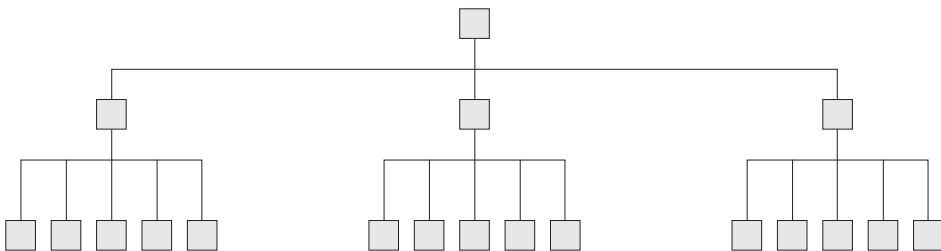
**Figure 5.2**: A flat span of control

Factors that affect the span of control are the following:

- *The competence of both supervisor and worker*: In nursing, a first-year student is more in need of guidance than a student nurse in his or her third year.

- *The physical division of subordinates*: The similarities or dissimilarities of supervised tasks and the degree of interaction between the departments that are supervised affect the span of control. The greater the required interaction, the narrower the span of control.

- *The extent to which the manager must carry out non-managerial work*: If the manager is involved in technical work, there is less time for supervision and the span of control should be narrower.
- *The types of tasks being supervised*: Similar jobs demand a wider span of control than less similar jobs.
- *Incidence of problems in the supervisor's department*: If the manager experiences problems in the department, closer supervision with a narrow span of control is recommended.
- *Extent of standardised, objective rules and procedures in the organisation*: The span of control can be wider when the procedures in the department are standardised and routine, for example, taking temperatures twice daily.
- *The degree of physical dispersion of tasks*: When the nursing station, for instance, is located within sight, the person in charge can supervise more nurses than when the nursing station is out of sight.
- *The degree of interaction required between supervisor and worker*: Where less interaction is required, the potential span of control is wider (French et al, 2008:345).

### 5.3.4 Responsibility, accountability, authority and delegation

Responsibility refers to the managers' duty to attain the goals and objectives of the organisation. This is done through a process of organising, while accountability 'is the evaluation of how well individuals meet their responsibility' (Smit et al, 2011:223). Responsibility is the obligation or commitment of a manager or subordinate to carry out an assignment according to the received instructions.

Authority is the power given to someone to make decisions and take actions, 'the right to act' (Sullivan & Garland, 2010:117; Smit et al, 2011:224). The extent to which an organisation is centralised or decentralised affects the way that authority is distributed. In highly centralised organisations, decisions are made mainly by top management. These decisions are then handed down to lower management to be implemented. In decentralised organisations, greater initial decision-making responsibility is given to lower management. Authority always implies responsibility and accountability. Authority is the right of an employee to organise resources and make decisions to complete delegated tasks successfully. For instance, a nurse at a clinic should have the authority to order an ambulance to take a patient to the hospital when he or she believes it is necessary.

Delegation is an important element of authority. It can be seen as the process by which managers assign authority and responsibility to subordinates (Smit et al, 2011:236).

### Principles of delegation

The manager has to establish objectives and standards with the help of the subordinate who will perform the task. The manager remains answerable after he or she has delegated a task and is still responsible for inspecting, supervising and ensuring the correct performance of the task.

The delegated work and authority must suit the person to whom it is delegated. The subordinate must understand the nature of the delegated responsibility and authority involved and be willing to accept it and be prepared to carry it out. The subordinate must feel involved by being kept informed and by being assisted to improve skills and abilities. The subordinate must feel responsible for carrying out the task to completion.

Training should be provided to build the strengths and overcome the weaknesses of subordinates. Managers should supervise the performance regularly and compare it with the agreed standards. The subordinate must receive recognition for the assignment carried out.

Factors that might prevent delegates from accepting the delegated tasks could be the following:

• A perception of themselves as 'incapable or overburdened' could result in unwillingness to accept the delegated task (Sullivan & Garland, 2010:125).

• An unclear job description could inhibit employees from understanding what the delegated task expects of them (Smit et al, 2011:238).

Chapter 14 provides an in-depth coverage of the topic of delegation.

## 5.3.5 Centralisation and decentralisation of authority

Centralisation involves a high degree of authority at the top; decentralisation involves a high degree of delegated authority to the lower levels of management. No organisation is completely centralised or decentralised: organisations differ only in the degree to which they are centralised or decentralised.

Factors that affect the decision to centralise or decentralise are the following:

• *External environment*: A complex environment with a high level of uncertainty will have a greater tendency to decentralise.

• *The history of the organisation*: When an organisation's corporate culture is one of centralisation, then centralisation of decision making will be practised.

• *The nature of the decision*: High-risk decisions with lots of money at stake will usually require centralised decision making.

• *The organisation's strategy*: Large organisations developing new products and favouring diversification will make use of decentralised structures, while organisations which tend to be more conventional in nature tend to be centralised.

• *Skills and availability of lower-level managers*: Depending on the decision-making skills of the lower–level managers, top management decides to centralise or not. For successful decentralisation, lower-level managers need skilled and knowledgeable decision-making skills.

- *The size and growth rate of the organisation*: Large and complex organisations have a greater need for decentralisation, as managers will have an increased burden of decision making (Smit et al, 2011:226).

Advantages of decentralisation are:

- In a decentralised environment the workload of top management is reduced. This allows them time to develop organisational plans and strategies.
- The employees at lower levels feel more empowered, experiencing better job satisfaction.
- Subordinates' morale and initiative increase and they feel part of the organisation.
- Subordinates are closer to the action; this knowledge may help them make better and faster decisions. This fits well in fast-changing environments, such as healthcare organisations.
- A healthy achievement-orientated atmosphere is created among managers when they receive feedback on their performance on a regular basis (Nickels et al, 2011:209; Smit et al, 2011:228).

Disadvantages of decentralisation:

- There might be a reduction in the efficiency of service delivery.
- There is an increase in the complexity of the distribution system, requiring more co-ordination.
- The image of the organisation is reduced (Nickels et al, 2011:209).
- There is a feeling of loss of control, defeating the integration of sub-units.
- Duplication of tasks might happen, for instance, patients' files might be duplicated.
- Management requires more costly and intensive training and development to allow them to fulfil tasks delegated to them.
- Top managers will always remain accountable for attaining the goals of the organisation and need to receive frequent feedback. Planning and reporting methods, therefore, need to be more sophisticated than when centralisation exists (Smit et al, 2011:228).

Advantages of centralisation are the following:

- Top management has greater control in the organisation.
- Task implementation is done with more efficiency.
- The distribution and co-ordination system in the organisation is simplified.
- The image of the organisation is stronger (Nickels et al, 2011:209).
- It is cost effective because special services are grouped together.

- Management is made easier for managers, because managers need to be experts in only a concentrated range of skills.

Disadvantages of centralisation:

- There seems to be a lack in the responsiveness to the needs of the clients.

- Employees at all levels feel less empowered.

- There appears to be high levels of conflict in the organisation.

- The morale of employees is lowered (Nickels et al, 2011:209).

- When the organisation becomes larger and more complex, the hierarchical arrangements can become cumbersome.

- Because decisions must be made by higher-level managers, the organisation is relatively slow to adapt to change (Roussel, 2013:483).

## 5.3.6 Line and staff authority

Within the organisation, there are two types of authority, namely line and staff authority. Line authority can be seen as authority, assignment of work and supervision of employees delegated down the line of command. It flows according to the scalar principle through the chain of command. The managers in the line are directly responsible for achieving the aims of the organisation.

Staff authority is an indirect and supplementary authority, applying specialised knowledge to a particular field. Staff authority function is usually to support, advise and recommend. An example of this is unit managers who are seen as line managers and finance officers who are considered as staff managers where 'line managers do not report to staff managers' (Finkler, Jones & Kovner, 2013:43). Staff authority usually flows directly to top management, which then exercises line authority to apply the recommendations made by the staff authority.

### *Line and healthcare professional conflicts*

There are often conflicts of authority between line and healthcare professional departments. The reasons may be the following:

- *Personal characteristics*: Healthcare professional employees, in general, are younger, better educated and more concerned with their personal appearance than line employees. Line managers are orientated to advancement in their organisation and healthcare professional managers are more orientated towards advancement in their profession. Line managers tend to be loyal to their organisation, while healthcare professional managers tend to be loyal to their profession.

- *Informal command authority*: Healthcare professional departments are usually located higher in the organisational hierarchy and top management tends to ask them to analyse reports on line departments. This informal authority may dismay line managers.

In order to reduce these conflicting situations, it is usually recommended that healthcare professional and line managers are brought together to discuss their conflicts, keeping in mind the broad organisational goal. This often results in a constructive resolution of the conflict.

## 5.3.7 Adhocracy

Adhocracy refers to teams or workforces that are formed to fulfil a specific task, which are dissolved once the task is completed. It is described by Nel, Werner, Poisat, Sono, du Plessis, Ngalo, van Hoek and Botha (2011:146) as 'highly open and decentralized'. Experts belonging to interdisciplinary teams are given the opportunity to work as a team on a specific project to its completion. 'Power co-ordination and control are constantly shifting' (Sullivan & Garland, 2010:43). For example when arranging a conference, the conference committee consists of a team that compiles the programme and reviews the abstracts, a team that does the registration for conference attendees, an IT support team to assist with the presentations and a logistic team for arrangement of venues and catering.

## 5.3.8 The matrix organisational structure

The matrix organisational structure is based on multiple authority and support systems. There are two lines of authority. The functional departmental authority line runs vertically, while the project authority line runs horizontally (see Figure 5.3). The functional departments, therefore, are represented in columns, the project teams form the rows.

Every matrix has three unique sets of relationships, namely:
- the top manager, who heads the service and balances the dual lines of authority
- project managers, who share subordinates from a variety of departments
- subordinates, who report to two different managers (departmental head and project manager) (Hellriegel et al, 2004:232).

A matrix organisation can be described as a combination of functional and product structures, aiming to capture the advantages of both and minimising their disadvantages. Generally, this structure makes better use of the available human resources and tends to be more flexible and adapt better to changes in the environment; however, the principle of unity of command is violated as the employee needs to report to two supervisors (Smit et al, 2011:228).
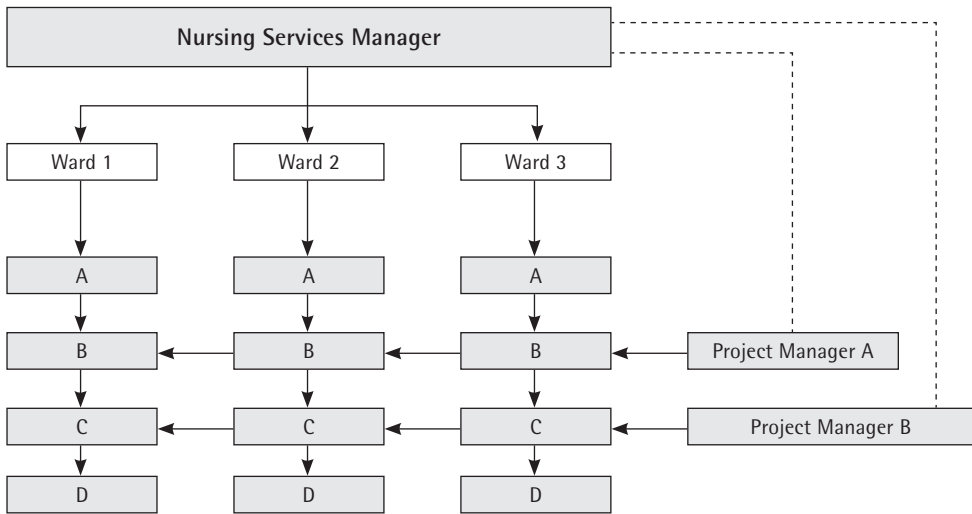
**Figure 5.3**: The matrix organisation

Every ward has a departmental head (professional nurse in charge called 'A' in the figure). Every ward has subordinates, 'B', 'C' and 'D'. Project manager 'A' is the project leader of the audit project in that hospital and subordinates 'B' from every unit work with the project manager on that project. Project manager 'B' is the project leader of the infection control project in that hospital and subordinates 'C' from every unit work with him or her on that project.

The matrix organisation requires flexibility and co-operation at all levels. Managers and subordinates alike may need special training to learn new skills, such as how to resolve conflicts effectively.

It is a complicated structure; hence, organisations should use it only when there is strong competition from other firms to provide multiple innovative products. In this case, the co-ordination of production and the technical expertise necessary to develop the product are of equal importance.

This type of structure is also used when changes in the environment necessitate the processing of large amounts of information by the managers. Communication of important information throughout the organisation can be facilitated by co-ordination of the service (product) with the technical expertise available.

A matrix organisation is used when the organisation needs to use its resources efficiently, but is unable to allocate separate facilities for each product or service. Personnel are shifted from one area to another, according to the needs of the various product or service lines.

The advantages of matrix departmentalisation are the following:

- Managers are given flexibility in assigning people to projects.

- Interdisciplinary co-operation is encouraged.

- The managerial, human and conceptual skills of project managers are developed.

- Employees are permitted to learn new skills in different areas.

- Specialised knowledge is made available to all projects.

The disadvantages of matrix departmentalisation are the following:

- Matrix managers have to be capable of maintaining a balance between functional and product interests.

- Good interpersonal skills are required.

- Negotiation rather than managerial skills may be rewarded.

- Employees receive orders from two managers, which may be frustrating (Hellriegel et al, 2004:233).

## 5.3.9 Organisational charts

The structure of an organisation is often displayed visually in the form of an organisational chart (see Figure 5.4) indicating the relationships and communication channels. The organisational chart usually gives an overview of the following elements:

- It indicates the range of tasks within an organisation. These tasks or responsibilities are linked to a position and title. This position and title, which also broadly describe the responsibility (for example, nursing services manager – patient care) are enclosed in a box.

- Each subdivision of the organisation is represented by a different box, indicating the responsibilities or function of the employee(s). The relative status of that position within the organisation may be indicated by the distance of the job title from the top of the chart. It also identifies the responsibility of that subsection.

- The level in the management hierarchy is indicated. Employees reporting to the same supervisors are on the same management level.

- Solid lines represent line functions, while staff functions are indicated by a dotted line (Roussel, 2013:223).
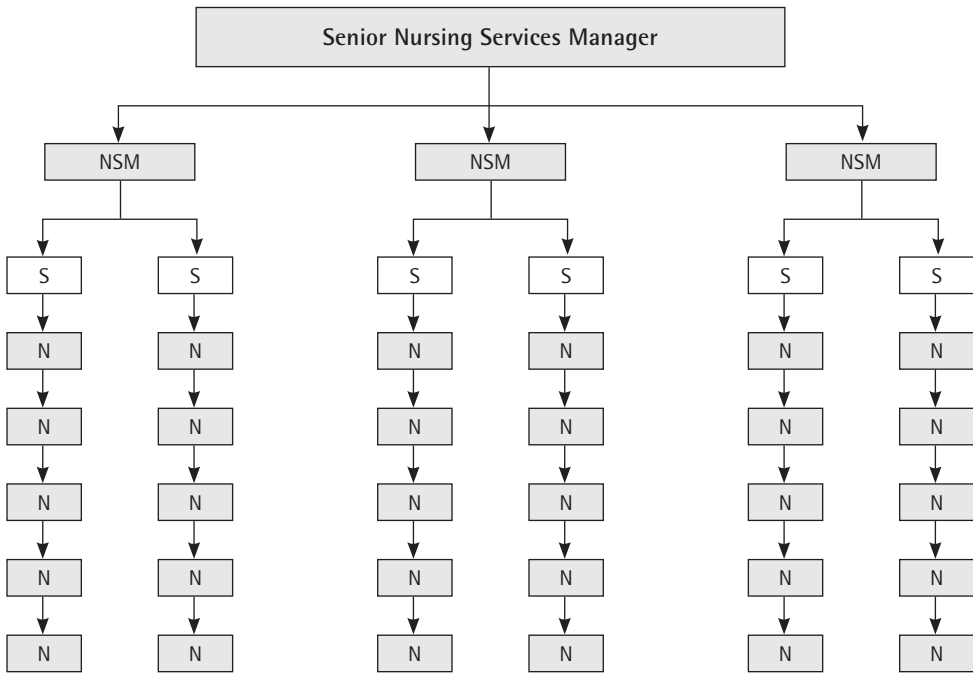
**Figure 5.4**: An organisational chart of the nursing services in a hospital

*NSM = Nursing Services Manager; S = Sister in charge of a unit; N = Nurse working in a unit*

The advantages of an organisational chart are the following:

- It assists in the orientation of new workers by showing how the organisation fits together and indicating how specialised tasks relate to the whole organisation.
- It indicates clearly the lines of authority – who reports to whom.
- Helps managers in charge of healthcare units with organisational planning.
- Assists managers to detect potential duplication of tasks.
- The organisational chart facilitates communication.
- It assists managers in the implementation of organisational changes.

The disadvantages of an organisational chart are that:

- It does not indicate informal channels of communication, responsibility and authority, without which an organisation cannot function.
- It can become outdated quickly as the organisation develops.
- It confuses authority with status (Roussel, 2013:224).

## 5.3.10 The informal organisation

Managers of a health service must ensure that they do not overlook the important informal organisation that exists in every organisation. Through regular interaction between workers, social relationships are established. These interpersonal relationships are not defined by the formal organisational structure. Sound relationships can support the formal structure and management should keep this in mind.

The informal organisation has the following advantages:

- It provides a sense of belonging, safety and acceptance and thus open and friendly discussions take place.

- Employees develop feelings of personal integrity, self-respect and choice.

- If used correctly, communications can be distributed in an accurate and informal way.

- An informal organisation provides opportunities for social interaction and a source of practical information for managerial decision making, thus developing future leaders (Roussel, 2013:278).

# 5.4 Factors influencing the organisational design

The organisational structure should be developed in such a way that it will promote the strategies and plans of management. It is important that managers should give attention to the following factors that may have an influence on organisational design.

- *The organisational environment*: In a stable environment where there are few changes in the product and technology, the functional structure is suitable because there is not a great need for co-ordination between departments. In a turbulent environment where changes take place on a regular basis and new products appear daily, departmentalisation according to product is appropriate.

- *The technologically dominated environment*: In a technologically dominated environment, more levels of management and technical specialisation are needed.

- *The relationship between strategy and structure*: Changes in the strategy or mission of an organisation will give rise to changes in the organisational structure.

- *The size of the organisation*: An increase in the size of an organisation creates greater specialisation and more departments, as well as more levels of management.

- *Healthcare professionals employed*: The competence, experience and attitudes of staff influence management's decisions regarding how organising should take place. Some managers may also have a preference for a particular organisational structure.

- *Organisational culture*: This refers to the beliefs and values of the people in an organisation. The success with which tasks are implemented depends to a large extent on the organisation's culture (Cronjé & Motlatla, 2000:150).

## 5.5 Organisation in a health service unit

Managers in charge of healthcare units have to organise the day-to-day running of their units to co-ordinate the patient care activities in a cost-effective manner, without compromising the quality of patient care and patient satisfaction.

The first step in organising people, materials and time involves deciding which activities must be performed to achieve the organisation's objectives, what stock will be required, what equipment and healthcare professionals will be employed, and over what period the activities will take place.

Tappen (2001:226) identifies the following factors that need consideration when organising a healthcare unit:

- *Priorities*: When organising the daily routine in a unit, the most important and urgent matters would receive attention first, before attending to less important issues. The preparation of an emergency theatre case is usually given priority over routine procedures, like completing the diet list from the dietary service.

- *Allocation of scarce resources*: Allocating scarce resources without lowering the quality of healthcare is a big challenge for any health professional.

- *Timing and sequence*: Some tasks must first be finished before the next one can be started, for instance, before patients receive preoperative medication, they should first have signed consent for the operation.

- *Deadlines*: There are fixed times enforced on health professionals which they should adhere to, for instance writing three-monthly reports or submission of the annual budget before a specific time.

- *Organisational goals*: The goals of the organisation should be considered when organising the routine for the healthcare unit.

- *Skills mix of healthcare professionals*: When assigning tasks to healthcare professionals, their experience and scope of practice should be taken into consideration.

- *Characteristics of the work*: Some tasks in a healthcare unit require highly technical skills and precise timing, such as the administration of intravenous medications, while other tasks are more flexible, like patient education.

The organisational responsibilities of the manager in charge of the unit include the organisation of time, personnel, environment, equipment and supplies.

## 5.5.1 Organisation of time

Successful time management is often said to be a result of organising skills (Sarp, Yarpuzlu & Mostame, 2005:228). The manager in charge of a unit uses time effectively by organising patients and their nursing care according to the patients' needs. This is done by organising the healthcare team and delegating tasks and responsibilities, planning duty rosters and acquiring the necessary stock and equipment for the unit and ensuring their effective use.

Routines are necessary to organise time effectively. Waterworth (2003:435) refers to Strauss and Corbin (2007), who regard routines as 'habituated ways of responding to occurrences in everyday life'. Routine is about completing activities within a certain time frame and sequence (Waterworth, 2003:435). The harmonisation of the different routines of personnel is critical for the establishment of continuity in complex organisations.

By following routines, healthcare professionals, equipment and supplies are utilised economically. Routines ensure the standardisation of equipment, supplies and work procedures. They underpin the development of safe standards of patient care and orderliness in the unit and assist the organisation and allocation of duties throughout the working day. Routines also reduce the chances of error, promote increased efficiency and remove ambiguity and confusion. They should not, however, be inflexible. Times will inevitably occur when routine activities have to be suspended and the experienced healthcare professional should be able to make this decision at the right time and under the appropriate circumstances.

In most healthcare units there are internal routines. These relate to the storage of linen and supplies, housekeeping and clerical duties, times when particular tasks must be performed, such as the control of dressing rooms, checking emergency trolleys, the collection of specimens, the removal of soiled linen and refuse, the care of thermometers, arrangements for washing patients and performing treatments and routines for most procedures.

When the routines of the day are planned, they should revolve around the patients' needs, rather than the needs of the nursing or medical staff. Many factors, such as the policies of the organisation, services, co-ordination with other departments or healthcare workers, medication times and the turnover of patients, admission and discharge days influence the routine of a healthcare unit.

The patients' individual needs should be given priority (comfort, pressure care, fluid balance, preparation for special tests, discharge planning and listening to the patients), rather than the routine itself of bathing, bed-making and 'getting everything done'.

Checklists are important tools that managers can use to ensure that routine tasks are completed on time. Examples of checklists that are used in healthcare units include checking emergency trolleys and oxygen cylinders, checking the records of administration of dependence-producing drugs and routine procedures, such as taking patients' temperature and blood pressure.

Setting priorities is another method used by managers to organise time, as the process of prioritisation helps to determine which activities are most important

and thereby provides a structure for ordering activities. Interruptions, however, can unsettle priorities. Waterworth (2003:437) indicates that, although these 'interruptions to nurses' work can be accepted and taken for granted', team members should support priorities set and should provide time protection for fellow team members when they are busy with urgent matters.

## 5.5.2 Organisation of nursing staff for patient care

The *raison d'être* of healthcare organisations is to offer care to the patients. This can be done by means of various methods of allocating nurses to patients.

Nursing care assignments involve the allocation of professional duties to nursing staff within the unit according to their experience and scope of practice. If the assignments are performed correctly, improved patient care is the outcome, the healthcare professionals are used more effectively and economically, the work is better distributed and the healthcare professionals more satisfied. Where the assigning of duties is handled incorrectly (eg when duties are delegated to subordinates who are incompetent) the consequences can involve a poor distribution of workload, lowered morale and even lawsuits.

In making assignments the following principles should be noted:

- The assignment of tasks and responsibilities should be in writing and personally prepared by the manager in charge. Ambiguities should be avoided and assignments should be specific.
- Sound nursing care assignments should ensure that all work areas are covered.
- Healthcare professionals should be allocated so that adequate cover of the unit is available at all times.
- Contingencies for emergencies must be provided for (eg the need for healthcare professionals on duty to control haemorrhage or to deal with unconsciousness, respiratory failure or cardiac arrest).
- In preparing nursing assignments, the manager must bear in mind the central policy of the nursing service department.
- Supervision provided must be adequate.

There are different nursing care delivery systems or methods to assign nursing staff to patient care. According to Huber (2006:315), the goals for successful patient care delivery include 'high quality and low cost'. The methods that are used are functional, case assignment, team nursing, primary nursing and modular nursing.

Nursing case management and disease management are two further types of arrangements for the management of patient care used in managed care settings.

## The functional method

Nurses are assigned specific duties and functions for all patients receiving care in the unit. Examples of these might be the allocation of patient washing to one or more nurses, while making beds, dressings, handing out medicines, taking blood pressures and temperatures are allocated to other nurses. This method allows duties requiring greater responsibility to be given to more experienced healthcare professionals, while lower categories of nursing staff are allocated to less demanding functions. Generally, neither patients nor nurses are satisfied with this method of rendering care.

The main advantage of this method is its efficiency in getting the work done with as few healthcare professionals as possible. Staff members are competent to do specific tasks. This method is useful in times of disasters and emergencies.

The main disadvantages are that patient care becomes fragmented, as this method lacks holistic care; there is little flexibility to meet patients' individual needs and nurses often tend to experience this method as a number of essential, but boring, routines and tasks that must be completed. Furthermore, the needs and symptoms of the patient might be overlooked. (Booyens & Bezuidenhout, 2013:222; Whitehead, Weiss & Tappen, 2010:127).

## Case assignment (total patient care)

In the case assignment method, one nurse takes the responsibility of the total nursing care of one or more patients (Sullivan, 2012:32). Its use is based on a patient's need for continuous care and observation for a period of time. The method is well suited to intensive care nursing, to the nursing of unconscious patients, to patients in the immediate post-operative phase and to the care of patients who are being barrier-nursed. It is also appropriate for private duty nursing and community healthcare.

The main advantages are the care providers' accountability for care given, easier identification of patient status and the increased personal satisfaction of nurses. Co-ordination of functions and communication between healthcare professionals responsible for nursing care and the patient, family and other health professionals is good (Sullivan, 2012:32).

The main disadvantages are the high personnel cost (Booyens & Bezuidenhout, 2013:223) and the fact that 'the' highly qualified professional nurses are used to do basic nursing care, which could be done by student nurses or nursing auxiliaries.

## Team nursing

Team nursing has been defined as 'the assignment of a group of clients to a small group of workers under the direction of a team leader' (Huber, 2006:322). It is a modification of the case assignment method and consists of a team comprising a professional nurse and a support group of less qualified nurses, which may include student nurses. The team provides complete nursing care to all the patients allocated to them. The size of the team varies according to the state of health of the patients, the nursing staff available and the time of day or

shift. More teams are used in morning shifts than on evening or night shifts. Functional assignment takes place within each team, with duties being allocated according to the ability and training of different members of the team (Booyens & Bezuidenhout, 2013:223). The team leader takes the level of expertise into account when assigning functions to team members (Huber, 2006:322).

The advantages are the increase in communication between team members and the full use that is made of each team member's abilities, which increases job satisfaction and morale. Patient satisfaction increases as patients perceive this method as more personalised and holistic (Booyens & Bezuidenhout, 2013:224).

The disadvantages are that more nursing staff are needed, which increases costs; staff absenteeism and leave cause teams to break up; the team leader requires good leadership skills, otherwise problems arise and the physical layout of units may not be conducive to team nursing.

## *Primary nursing*

Primary nursing is a systematic way of organising the nursing care on the unit in order to provide individualised, comprehensive, co-ordinated and continuous patient-centred care. A professional nurse is assigned to each patient and the total care of any one patient is the responsibility of only one nurse, instead of the whole nursing team. Known as the primary nurse, this nurse is then responsible for assessing, planning and evaluating nursing care for his/her patients and for overseeing the implementation of that care. She or he is responsible for the patients on an on-going basis from admission to discharge and delegates responsibility to other associate nurses when not present. The primary nurse is also responsible for communication with other members of the health team and involves the patient and the patient's family in the total healthcare process. Primary nurses have accountability, authority and autonomy for the care of their primary patients and their families (Sullivan, 2012:33). It does not mean that the primary nurse takes care of the patient 24 hours a day; the primary nurse is accountable for supervising and delegating the nursing care of the patients under her or his care.

The advantages of primary nursing are:

- It provides satisfaction for patients, doctors and nurses. Patients receive individualised, comprehensive, continuous patient care and primary nurses derive more satisfaction from providing this care.
- There is greater autonomy and accountability for primary nurses, as they work as individual practitioners in their own right.
- Decentralisation of decision making, authority and responsibility (Sullivan, 2012:33).

The disadvantages of primary nursing are:

- It can be stressful for primary nurses and lead to burnout (Huber, 2006:323).
- A greater number of professional nurses than ancillary nurses are needed, making nursing care costly (Booyens & Bezuidenhout, 2013:225).

Primary healthcare and primary nursing should not be confused with one another. Primary healthcare refers to first-level healthcare given to an individual by a member of the healthcare team. It includes the assessment, diagnosis and treatment of the patient, in addition to preventive, promotive, rehabilitative and maintenance care.

## Modular nursing

The main characteristic of modular nursing is that nursing staff are assigned to patients according to the geography or layout of the unit (Kelly, 2012:358). Their tasks are to co-ordinate and provide comprehensive care. Elements of both team and primary nursing form part of modular nursing. The size of the modules and the number of patients in them may vary. In large modules, nursing staff work together; in small modules, they work independently. A module consisting of eight to twelve patients is nursed by a team of approximately two to three nurses. Each module has a leader, a professional nurse whose responsibilities include giving and receiving reports at changeover and offering help to (and receiving it from) the leader of the next module. Auxiliary nurses are assigned to the modules where the need is greatest. The nurse in charge co-ordinates and supervises the activities on the unit and makes patient care assignments (Booyens & Bezuidenhout, 2013:226).

The advantages of modular nursing are that it provides better communication and co-operation among healthcare professionals on the unit (Booyens & Bezuidenhout, 2013:226) and that nursing productivity (ie time spent in direct nursing care and communication) is better than any of the other two methods alone.

Kelly (2012:359) describes communication in this model as complex and the shared responsibility and accountability can cause confusion. This model requires good supervisory and delegation skills from the charge nurse.

## Combined methods

The most realistic approach seems to be a combination of functional, team and primary nursing. With this approach individualisation of the patient is achieved, while the economic advantages of the other methods are retained. When the process takes place in an environment where staff shortages are present, it has proved to be the most effective approach.

## Nursing case management

According to Yoder-Wise (2011:259), this method originated in the 1980s when 'acute care hospitals began to be reimbursed based upon a certain diagnosis, nursing case management became a popular and effective method to manage shortened lengths of stay for patients co-ordinating healthcare by planning, facilitating and evaluating interventions across levels of care to achieve measurable cost and quality outcomes'. In hospitals case managers are assigned a patient based on the case manager's specialisation area. The patient will have a specific 'care MAP' (multidisciplinary action plan) or critical path based on an appropriate diagnosis-related group (DRG) category. For example, there will be a

case manager who co-ordinates the care of all asthma patients in the hospital. The case manager will implement the care plan and communicate with all nurses, doctors and other healthcare providers. The team of healthcare providers will work together to reduce the length of the patient's stay in the hospital. Critical paths serve as tools to case managers to achieve patients' outcomes and provide a framework of what to expect each day of hospitalisation. The care MAPs are combinations of the nursing care plans and critical paths. They provide a written system with the daily needs of the patient and family, followed by all healthcare providers to change practices, increase efficiency, facilitate outcomes and reduce cost (Yoder-Wise, 2007:252–253).

The advantages of nursing case management are:

- It provides well co-ordinated care for patients with complex healthcare problems.
- Outcomes can be improved.
- Length of patients' hospitalisation may decrease.
- Efficient use is made of the different services.
- Nurses experience a sense of satisfaction, as patients receive high-quality, co-ordinated care (Yoder-Wise, 2011:261).

The disadvantages of nursing case management are:

- Financial barriers are experienced, as nursing case management is a revenue-protecting, not a revenue-generating activity.
- Some nursing case managers experience a lack of administrative and information support.
- Education and preparation of nursing case managers are not firmly established; there seem to be insufficient nurses trained in this specialist field.
- There is a concern that 'the art of nursing' may disappear, with patients moving quickly through the hospital (Yoder-Wise, 2007:258–259).

In South Africa, this model is implemented at some private hospitals. Huber (2006:323) describes case management as the fastest-growing form of the new care delivery models, as it is linked to managed care.

## *Disease management*

This model of care co-ordinates the communication and healthcare interventions of people suffering from chronic diseases, like asthma, diabetes, arthritis, cardiovascular diseases and congestive heart failure (Kelly, 2012:60). Disease management focuses on wellness – living well with a chronic illness with the aim of preventing complications and empowering patients to improve their own well-being (Yoder-Wise, 2011:262). This model exists most of the time at medical aid schemes, whose aim is to keep patients with chronic diseases out of hospital as long as possible.

### 5.5.3 Organisation of non-nursing personnel

Although the main responsibility of managers lies in the organisation of nursing personnel, they must also organise non-nursing personnel in their units. If non-nursing personnel are utilised well, nursing personnel can use their time more efficiently for nursing duties.

#### Unit clerk (ward secretary)

The introduction of unit/ward clerks or secretaries has helped to ease the workload of the healthcare professionals, especially with regard to the large amount of paperwork that is required in modern hospitals and clinics.

The duties of the ward clerk include answering telephones; conveying messages to patients and unit and medical staff; ordering supplies, such as special diets, linen, central sterile supplies, cleaning materials and newspapers; arranging for the repair of broken or damaged equipment and condemning irreparable equipment; drawing up charts for new patients and sending completed charts and their supporting documents to the record section and updating certain information on the computer, such as admissions and discharges.

Unit clerks should not, under any circumstances, take orders from medical staff and transmit them to the nursing staff. They may not chart routine patient observations or treatment: this is the responsibility of nurses themselves and it may not be delegated to clerks.

#### General assistants

Housekeeping staff make a major contribution to the care of the physical environment. Housekeeping services no longer fall directly under the control of the professional nurse in charge of the unit; however, nurses must liaise with housekeeping services to ensure that the unit is cleaned whenever necessary. Housekeeping duties include: sweeping and mopping floors; dusting; cleaning basins, toilets and bathrooms; washing walls; vacuuming; polishing furniture; cleaning windows; changing curtains; replacing toilet paper, towels and soap; emptying dustbins and removing articles for incineration.

Except for cleaning medicine cupboards, which remains the responsibility of the nurse, cleaning all other storage facilities and general ward equipment can be carried out by housekeeping staff.

#### Voluntary workers

Voluntary workers can provide an invaluable service for patients and nursing staff. They can perform such tasks as running errands for patients, reading to them and assisting them with letter writing. Voluntary workers can assist the nursing staff with clerical work and perform duties similar to those of the ward clerk. The manager in charge of the unit must be aware of organisations in the community that provide services so that voluntary workers can continue to provide support to patients even when they have been discharged.

## 5.5.4 Organisation of the environment

The manager (the professional nurse in charge of the unit) is responsible for ensuring that the environment of the unit is conducive to the patients' welfare and suitable for healthcare professionals to work in. The most important environmental factors to be considered are outlined in the following sections.

### Safety of patients, staff members and visitors

Special caution should be taken to prevent medico-legal hazards in the health-care unit. Prevention of slippery floors, unprotected windows, broken steps, faulty electrical equipment, unlocked medicine cupboards and bathrooms left open in children's wards are some aspects that need particular attention from the unit manager. Staff should be orientated and receive regular in-service education on the prevention of cross-infection and handling of blood products. Faulty equipment should be reported immediately, such as non-functional lights, call bells, leaking taps and lifts. Health facilities usually have a contract with a company specialising in fire equipment that oversees the equipment. This does not, however, take away the responsibility of the health services manager for monitoring the servicing of the extinguishers, as indicated on them, in such a way that patients and personnel are not exposed to any danger.

Policies should be in place to address issues, such as an early warning system in case of a fire and all personnel should know exactly where the fire extinguishers are, how to use them and the evacuation procedures for patients and staff. These policies should be part of a monthly on-the-spot teaching strategy.

### Plumbing

Clean running water is a costly resource that must be used sparingly. Leaking taps and toilets must be reported so that they can be repaired. During rounds, the health services manager should note if all baths and basins have plugs provided that are fixed. A watchful eye should be kept for the first signs of a blocked drain or toilet as it can impact on infection control and patients' comfort. A proactive approach would be to introduce a monthly pre-determined dosage of a solvent for clearing drains and toilets.

### Cleanliness

The general cleanliness and hygiene of hospital wards and especially of the toilets and bathrooms are extremely important to patients. When an environment is soiled and untidy, it affects the morale of the nursing personnel negatively (Roos, 2000:111). Bins must be emptied and wiped or sprayed; bathtubs should be checked for cleanliness; sluice rooms (also sometimes referred to as dirty utility rooms) and toilets checked that there are no unflushed bedpans and urinals. Other sources of infection, such as soiled linen and dressings must also be handled according to the set policy. Where a kitchen is in use for a unit, special attention should be given that refrigerators are defrosted regularly, that kettles and urns are descaled and that sinks and cupboards are kept clean to prevent pests.

## Quietness

Most hospitals deliver a 24-hour service and are seldom quiet places. Noise is a source of serious irritation to patients. Unnecessary noise levels should be eliminated from the environment, such as banging doors and equipment, clattering dishes or other equipment, radio noise and shouting or raised voices by staff. Even the buzzing of a fluorescent light or the noise emanating from lift doors irritates patients. Culture also plays an important aspect in this issue: some patients find it difficult to adapt to the louder discussions of nurses, patients and visitors who belong to other cultural groups (Roos, 2000:113).

## Privacy

According to Bäck and Wikblad (1998:940), privacy is a basic human need. Patients' privacy should be respected. They should not be disturbed when they wish to rest or be alone and should not be attended by too many staff at one time. Curtains should be drawn or screens used when performing procedures on the patients. The distance between beds should be controlled to avoid overcrowding. Very sick patients should be nursed in private or semi-private wards. Where possible, genders should not be mixed to avoid embarrassment.

## Temperature

The temperature of the environment should be as comfortable as possible. The manager of the unit should be aware of the factors influencing temperature, such as prevailing climatic conditions outside the building, the ventilation system, the number of people inside the room, the function each person performs and the equipment used in these areas.

## Humidity

The humidity should be maintained within acceptable limits. If an area is too dry, which may be the case if artificial heating is used, patients with respiratory conditions could have problems with breathing. Nursing staff should be aware that bacterial growth is encouraged in hot, humid areas.

## Ventilation

If a unit is air-conditioned, the mechanism must be kept in working order. In units without air-conditioning, windows should be open or shut for the comfort of patients and staff. Drafts should be avoided and smells eliminated through adequate ventilation.

## Lighting

Lighting should not be irritating to patients and staff should have sufficient light in which to do their work. Glare should be avoided where possible through correct positioning of patients or the use of blinds or curtains. Lighting should be sufficient at night so that staff and patients can see where they are going and

what they are doing. The health services manager should preferably delegate the responsibility of ensuring that all lights are in working order to the ward clerk who can, when necessary, complete the relevant requisition forms. Electricity is a resource that is often wasted and staff members should be made aware that lights are to be switched off when there is sufficient natural light.

## 5.6 Summary

Organisational specialisation occurs as the organisation gets more complicated. Through standardisation, procedures are always performed in a uniform and consistent manner.

Co-ordination is the process of integrating the various activities of different employees and departments. Authority is the decision-making power in an organisation. Line and staff functions are different methods of assigning authority in an organisation.

An organisational chart is a visual display of the organisational structure. In every organisation there also exists an informal organisation that may strengthen or weaken relations.

The organisation of a unit involves numerous activities, ranging from the organisation of temporal and physical aspects of nursing to those of patients and personnel. The manager of a unit works in a dynamic healthcare environment. Routines and checklists can assist in the effective management of their units.

The various methods of assigning nursing staff to patients have been discussed, their advantages and disadvantages explained.

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# Financial Management

A Marx

## Chapter Outcomes

After studying this chapter, you should be able to:

- implement the budgeting process in order to effectively utilise equipment, facilities and supplies;
- identify expenses in a nursing unit;
- distinguish between direct and indirect costs;
- briefly outline how a budget can contribute to quality care;
- draft an income statement;
- apply remuneration systems in your unit.

## 6.1 Introduction

Healthcare services are businesses and should be managed as such. As part of their responsibilities, managers have the task of planning for and controlling resources. The purpose of this chapter is to provide the necessary knowledge needed to manage the unit's stock, staff and budgets. Unit managers should also be able to determine the value of equipment that needs to be used in their departments. According to Thompson and Martin (2005:214), financial management also includes controlling costs in order to be able to make a profit and adding value to products and services. This goal can only be achieved when healthcare professionals are cost conscious and managers supervise the utilisation of resources.

## 6.2 Budgets

A budget is a detailed plan for the acquisition and use of financial and other resources over a specific period of time. It represents a plan for the future, expressed in formal, quantitative terms (Garrison & Noreen in Lotz, Lourens & Marx, 2006:19). Various types of budgets are in use, but for the purpose of healthcare services the focus will be on fixed and flexible budgets.

A fixed budget is geared to only one level of activity and the actual results are compared to the budgeted costs at the original activity level. It includes items such as materials, administrative costs and labour budgets.

A flexible budget, on the other hand, is geared towards a range of activities and is dynamic rather than static in nature. Actual results are not compared against the budgeted costs, as is the case with fixed budgets, and the manager can draw up a new budget in the event of an activity change.

The fixed budget given in Example 6.1 has an activity level and budgeted costs based on 200 patients (indicated in the second column, 'Budget'), but the actual

costs are based on an activity level of 150 patients (indicated in first column, 'Actual') and are thus favourable, as indicated in the third column (Variance). If the budget were a flexible one, the costs for the indirect materials and the electricity would have been adjusted for the changed level of activity, with the result that there would be no 'favourable funds' at the end.

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### Example 6.1: The difference between a fixed and a flexible budget

AMA-Clinic has budgeted for bed occupancy of 200 patients for the month of May. The variable overheads budget has been set for the level of activity as follows:

| Budgeted bed occupancy of patients | 200 |
|---|---|
| **Budgeted variable overheads costs** | |
| Indirect materials | R2 000 |
| Electricity | R   500 |
| **Total** | **R2 500** |

If the bed occupancy of 200 patients does not materialise and only 150 patients are hospitalised for the given month, the fixed budget approach will be shown as follows:

| | Actual | Budget | Variance |
|---|---|---|---|
| **Bed occupancy** | 150 | 200 | 50 U |
| **Variable overheads costs (R)** | | | |
| Indirect materials | 1 500 | 2 000 | 500 F |
| Electricity | 350 | 500 | 150 F |
| **Total** | **1 850** | **2 500** | **650 F** |

*U = Unfavourable*          *F = Favourable*

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## 6.2.1 Budgeting for effective utilisation of equipment, facilities and supplies

To ensure that the necessary facilities, equipment and supplies are available, budgeting should be done annually. Planning the budget usually starts several months before the end of the financial or fiscal year (a one-year period that generally does not coincide with the calendar year). Incremental budgeting, displaying the previous year's expenditures and the inflation rate, is the method that is generally used.

Inputs from the health services managers are essential to develop an effective budget, as nursing staff are the main users of resources in units. The budgeting committee, comprising the heads of departments, the superintendent/hospital

manager, the secretary and/or the board of directors, draws up the final budget. The budget is also reviewed regularly (usually monthly) by a committee to avoid deficits or surplus funds at the end of the fiscal year. Large deviations from the use of the budgeted allocations should be examined for possible causes. Items are budgeted for in capital and operational budgets.

## 6.2.2 Computerised budgeting

Today, budget preparation is usually done using computer programs developed specifically for this purpose. Spreadsheets and data applicable to the budget can be an important source of information in preparing the budget more accurately. The government service currently utilises an electronic purchasing system. Healthcare professionals are able to get particulars, such as the current list of tenders, prices of articles, code numbers in the case of existing items in use, and the format in which the request for purchasing is to be submitted, by simply logging onto their computer terminals.

## 6.2.3 Capex versus Opex budgets

In general, budgeting is divided into capital budgets and operational budgets. Capex (capital expenditure) is a health service expense incurred to create future benefit (have a lifespan beyond the tax year). The hospital might buy new assets, machinery, or equipment, or it might upgrade existing facilities so their value as an asset increases.

Expenditures required for the day-to-day functioning of the business, like wages, utilities, maintenance and repairs and telephone bills, fall under the category of Opex (operational expenditure). Opex is the money the business spends in order to turn inventory into throughput (Diffen, 2015). Operational budgets are used for short-term planning.

### *Capital budgets*

The capital expenditure budget provides for the purchase of major equipment, such as a computed axial tomography (CAT) scanner, or physical changes to the institution requiring large sums of money.

The replacement of fixed equipment and equipment exceeding a certain price margin also falls into the capital budget. The capital budget should also provide for depreciation of equipment (see Example 6.4). A special form is used to request items on the capital budget. Depending on the policy of the private institution concerned, health services managers, in consultation with medical specialists, can motivate for specialised equipment required in a particular area, after obtaining three quotations. Suppliers are, as a rule, asked to come and demonstrate the equipment and provide information on maintenance, guarantees and availability.

The capital budget is composed of a long-term planning component and a short-term budgeting component. The long-term component usually outlines future replacement and expansions that will exceed one year, for example, a medical resonance (MR) machine. The short-term component includes purchases

that fall within the annual budget cycle, such as hospital beds (Marquis & Huston, 2006:226). The capital budget usually sets a base amount for the purchase of new equipment. If this set amount is exceeded, what is requested is deemed to fall within the capital budget. This set base amount varies from institution to institution.

Expendable equipment is ordered on a regular basis, while non-expendable equipment will be ordered for a special purpose or as a replacement when it has broken or is worn out. While supplies are ordered on the basis of the average number of patients in the unit, equipment can be ordered according to the maximum number of patients admissible to the unit. Decisions can be made to increase or reduce the equipment budget based on projected patient days and revenues (Roussel, Swansburg & Swansburg, 2006:286).

## Operational budgets

The operational, or operating, budget includes estimates for expenses related to staffing, as well as for expenses related to supplies, smaller equipment and direct expenses for consumables, such as water and electricity. Daily expenses, like maintenance and repairs, or medical and surgical supplies and utilities, are also included in the operational budget. The expenses in this budget may fluctuate according to the volume of services that must be rendered in the institution. Purchasing and distribution of supplies is a key area in containing costs, as nursing staff use a large amount of supplies.

The operational budget consists of budgets for materials, labour, overheads, sales (expected revenue), marketing costs and administrative costs.

- *Materials budget*: In health services, materials requirements are projected on patient statistics and are thus used as a basis for identifying costs (Lotz et al, 2006:81).

- *Labour budget*: This is usually the largest component of the operating budget, accounting for two-thirds of the total operating expenses. It includes salary expenses.

- *Overheads budget*: This consists of the various budgets of all cost items that do not fall under direct materials or direct labour, for example maintenance, rent, insurance, electricity, etc.

- *Sales budget (expected revenue budget)*: This figure forms the basis of most budgets. It must be as reliable and accurate as possible. The manager must be realistic when preparing the sales forecast and should take into consideration both internal and external factors. Internal factors may include the last nine months' sales and the capacity of the hospital or unit. External factors include government policy (for example, free medical services) and economic trends.

- *Marketing costs budget*: This budget includes expenses associated with marketing such as the salaries, bonuses and commissions of the sales staff. For the purposes of control, fixed and variable costs must be kept separate from each other, as with overheads costs (Faul et al in Lotz et al, 2006:82).

- *Administrative costs budget*: This represents only an estimate of the expenditure concerning the formulation of the policy, leadership and administration of the organisation.

*Income statement* is a document that reflects the results of the institution's business and financial transactions during an entire financial year or other shorter period.

*Budgeting for salaries* is usually done separately by the department responsible for human resources. In some institutions, however, a special staffing budget is used to include all staffing requirements. An example is a private institution where each unit is allocated an amount of money according to the number of patients, their acuity level and diagnoses. The unit's manager can then appoint staff within these budgetary limits.

## 6.3 Overhead costs

When determining the price of a service provided, overhead costs must be included with the direct materials and the direct labour. The assignment of overheads to a service is often a difficult task because of the following:

- Overheads costs are indirect costs, which means that they are difficult or impossible to allocate to a particular service.

- Overheads costs can be fixed or variable and may consist of many different items, such as telephone costs, which consist of a fixed amount (line rental) and variable costs (the number of calls made).

- A large portion of overheads is usually fixed and remains relatively constant.

In order to overcome the indirect nature of overheads, one can assign overhead costs to a service using an allocation base. This is a measure of activity, such as direct labour hours, direct materials use or bed occupancy. Direct costs are those for activities or services that benefit specific projects, eg salaries for the projects staff, as well as materials needed for specific projects. These activities are easily traced to projects and their costs are usually charged to the projects on an item-to-item basis. Indirect costs are for the activities or services that benefit one project and are often difficult to trace, for example, it could be difficult to trace how the activities of the director benefit a specific project.

### 6.3.1 Budgeted overheads versus applied overheads

Budgeted overheads are a scientific forecast of the overheads for a future period. Applied overheads are the amount of overheads applied to the service during the period in which it is rendered. The latter are calculated according to a predetermined rate based on the budgeted overheads. Applied overheads represent the amount of overheads recovered during the year and brought into account in determining the cost price and total service price.

When calculating the predetermined overhead rate it is necessary to find a suitable allocation basis upon which this rate can be based. The following can be considered as suitable allocation bases:

- bed occupancy
- labour hour basis
- labour cost basis
- materials cost basis
- a combination of the above.

The formula for the calculation of the predetermined overheads rate is as follows:

$$\text{Allocation rate} \quad = \quad \frac{\text{Budgeted service overheads}}{\text{Suitable basis}}$$

---

### Example 6.2: Hospital XYZ general ward budget

|  | Total | Per patient (client) |
|---|---|---|
| Budgeted number of patients | 1 000 | |
| Budgeted direct materials cost | R15 000 | R15 |
| Budgeted direct labour cost | R20 000 | R20 |
| Budgeted overheads | | |
|   Fixed               R8 000 | | |
|   Variable          R4 000 | R12 000 | |
| Budgeted direct labour hours | 4 000 | 4 |

---

### Example 6.3: Calculate overheads

Referring to Example 6.2, calculate the predetermined overheads rate according to each of the bases mentioned.

## *Bed occupancy*

$$\text{Allocation rate} \quad = \quad \frac{\text{Budgeted overheads}}{\text{Budgeted number of patients}}$$

$$= \quad \frac{\text{R12 000}}{\text{1 000}}$$

$$= \quad \textbf{R12 per patient}$$

For each patient during the year, R12 of overheads is allocated to the service process in the general ward. As soon as 1 000 patients have been taken up in the ward, the total budgeted overheads will have been recovered.

## Labour hours basis

Allocation rate    =    $\dfrac{\text{R12 000}}{\text{4 000}}$

=    **R3 per labour hour**

Overheads are allocated at a rate of R3 per labour hour. Four labour hours are expended on one patient, therefore R12 per patient is recovered.

## Labour cost basis

Allocation rate    =    $\dfrac{\text{Budgeted overheads}}{\text{Budgeted labour cost}}$

=    $\dfrac{\text{R12 000}}{\text{R20 000}}$

=    **60% of labour costs**

The rate is usually expressed as a percentage of direct labour costs. This is a simple method of allocating overheads.

## Calculation of the service cost per patient

| | |
|---|---|
| Direct materials | R15 |
| Direct labour | R20 |
| Applied overheads | R12 |
| **Total service cost    =** | **R47** |

## Materials cost basis

Allocation rate    =    $\dfrac{\text{Budgeted overheads}}{\text{Budgeted materials cost}}$

=    $\dfrac{\text{R12 000}}{\text{R15 000}}$

=    **80% of materials costs**

## 6.3.2 Service overheads

The most important cost items found under service overheads are depreciation of machinery and equipment, maintenance of equipment and buildings, indirect materials and indirect labour.

Depreciation is an important overheads expense item. Fixed assets are used up or worn out after a time, so the asset's value is reduced each year. The amount by which the fixed asset's value decreases is called depreciation.

The two methods commonly used to calculate depreciation are the reducing balance method and the straight line method. In the reducing balance method, depreciation is calculated annually on the book value. In the straight line method, a fixed amount, calculated on the cost price, is written off.

---

### Example 6.4: Calculating depreciation

| Cost of equipment: | R10 000 |
| --- | --- |
| Date purchased: | September 1 2014 |
| Depreciation: | 20% per annum |
| Financial year end: | February 28 2016 |

| | | Reducing balance method (R) | Straight line method (R) |
| --- | --- | --- | --- |
| 1/9/14 | Cost | 10 000 | 10 000 |
| 28/2/15 | Depreciation at 20% for 6 months | 1 000 | 1 000 |
| 1/3/15 | Book value | 9 000 | 9 000 |
| 28/2/16 | Depreciation @ 20% for 1 year 20% of R9 000 (book value) 20% of R10 000 (cost) (fixed amount) | 1 800 | 2 000 |
| 1/3/16 | Book value | 7 200 | 7 000 |

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Source: Adapted from Lotz et al (2006:69–70)

## 6.4 Purchasing, receipt and issuing of stock

The health services manager's financial responsibilities include the unenviable task of managing the misuse, overstocking and theft of supplies and the disciplinary steps associated with these. Examples of such stock are medical supplies, medications, stationery and cleaning materials. Supplies, or stock, are divided into two classes – direct and indirect materials. Direct materials can be traced and form an integral part of the product or service. Indirect materials are small items, such as plasters. The latter can be traced to the service rendered to a patient, but at great expense and inconvenience.

The task of carrying the optimum stock levels (Q) lies firmly in the health services manager's hands and it is important that the establishment and management of the level of stock in the organisation are done effectively in order to meet the demand. Quantities to be purchased are influenced by cost factors

as well as demand. Inventory-keeping is an important method of checking the status of stock and functions as a control measure to reduce the amount of stock held as much as is feasible.

The manager should keep in mind inventory carrying costs and inventory ordering costs when deciding what to order and purchase. The organisation's carrying costs (C) include both direct and indirect costs and include the following:
• rent, electricity, security, maintenance, administrative and management costs
• inventory investment interest
• insurance on the inventory
• loss of profit.

When calculating carrying costs, the following should be kept in mind:
• Is there a definite and constant demand? If so, orders should be placed and filled immediately – shortages cannot be tolerated, as this will affect patient care negatively.
• Ordering costs (O), which are paid when an order is placed, should understandably be kept as low as possible. It should be understood how these ordering costs are made up, namely, administrative costs for handling the order; records to be kept; cost of the process for finalising it; delivery costs.

## 6.5 Remuneration systems

The remuneration that an employee receives depends on the type of work that is performed, the degree of skill required, the quality of the employee's work, as well as supply and demand. According to Faul et al in Lotz et al (2006:54), methods to remunerate employees can be grouped into three categories, namely the fixed salary method, hourly wages and piecework payments.

### 6.5.1 Fixed salary method

An employee receives a fixed salary irrespective of the quantity of the work done or the time it takes. This form of compensation is found in administrative, nursing care and supervisory functions and has the disadvantage that it bears no relation to the employee's output or the number of hours worked (Lotz et al, 2006:55).

### 6.5.2 Hourly wages

The worker is remunerated in accordance with the number of hours worked. The disadvantage of this method is that it also does not keep pace with the employee's output, but has the advantage in that it pays only for the number of hours that the employee is present. This system also supplements the payment by a higher rate per hour for working hours in excess of the normal working week (overtime). It is normally at a premium of 50% to 100% above the normal hourly

rate. This premium will then be assigned as overheads to the service, as it cannot be directly traced to a service itself.

## 6.5.3 Piecework

The person is paid for the actual work that is done and not according to the time it takes. This method can be used only where an employee's output can be determined precisely. It is advantageous to the employer, who pays only for the piece of work that is delivered. A variation of the basic piecework principle is to set a daily target level of activity and the employee is then paid a higher rate per section for those units completed in excess of the target. It is necessary consequently to inspect the work to assess whether the minimum quality requirements are met.

## 6.5.4 Payroll

When all the timekeeping records have been prepared, the wages or salaries can be computed. This computation appears on a payroll that lists all employees and shows details relating to their payment. The preparation of the payroll is divided into two parts – computation of gross wages and computation of net wages.

### Computation of gross wages

Gross salary is the amount of money paid after adding all benefits and allowances and before deducting any tax. The net salary is therefore derived at after the employee's deductions are subtracted from the gross salary. Mandatory deductions from a salary include pension, unemployment insurance and taxes. Optional deductions may include medical aid and car or travel allowances (Net CV, 2015).

The gross wages of each employee are computed with reference to the following documents: clock cards, piecework tickets and the employee's record card.

- Clock cards are required for day rate and premium bonus workers and to compute overtime and minimum guaranteed wages for pieceworkers.

- Piecework tickets are forms that record the production of each pieceworker.

- The employee's record card is the document recording remuneration details of the individual employee, eg holidays taken, PAYE number and deductions such as medical aid and pension contributions.

### Computation of net wages

From each employee's gross pay, all statutory deductions are made, such as income tax, unemployment insurance contributions (UIF) and voluntary deductions (such as housing payments, recreational club contributions). The balance is the employee's net pay. Different computer programs exist for the computation of gross and net wages. To illustrate the principles involved in the computation of gross and net wages, work through the following example.

## Example 6.5: Calculating employees' remuneration

ZXC Hospital provides the following information on the time tickets of workers for the week ending April 25.

| Name | Job | Basic rate | Hours worked Normal | Hours worked Overtime |
|------|-----|-----------|--------|----------|
| B Mokele | Administrator | R20 | 40 | 5 |
| M Venter | Senior nurse | R30 | 40 | 3 |
| M Williams | Nursing manager | R35 | 40 | 2 |

**Notes**

- Overtime is remunerated at time and a half of the normal rate. Overtime payments are not subject to pension contribution.

- Managers receive only a basic rate for overtime and no overtime premium.

- The following are deducted from gross wages: income tax (10%), pension (6%) and medical aid (R30 per person).

- Pension is exempted from income tax and the employer contributes a further 6% to pension and a further R50 for medical aid.

**Required**

1. Prepare a payroll with all the detailed information regarding gross wages, deductions and net wages.

2. Analyse the labour costs into direct and indirect labour costs.

**Solutions**

1. Payroll

| Name | Normal hourly rate | Overtime hourly rate | Normal | Overtime | Total |
|------|-------------------|---------------------|--------|----------|-------|
| B Mokele | R20 | R30 | 40 | 5 | 45 |
| M Venter | R30 | R45 | 40 | 3 | 43 |
| M Williams | R35 | R35 | 40 | 2 | 42 |

| Remuneration | | Overtime | | Deductions | | | | |
|---|---|---|---|---|---|---|---|---|
| Name | Normal | Basic | | Gross | Pension | PAYE | Med Aid | Net |
| B Mokele | 800 | 100 | 50 | 950 | 48 | 90.20 | 30 | 781.80 |
| M Venter | 1 200 | 90 | 45 | 1 335 | 72 | 126.30 | 30 | 1 106.70 |
| M Williams | 1 400 | 70 | | 1 470 | 84 | 138.60 | 30 | 1 217.40 |
| | **3400** | **260** | **95** | **3 755** | **204** | **355.10** | **90** | **3 105.90** |

2. Payroll

| Name | Job | Direct labour R | Indirect labour R | R |
|---|---|---|---|---|
| B Mokele | | 900 | | 50 |
| M Venter | Senior nurse | 1 290 | | 45 |
| M Williams | Unit manager | | 1 470 | |
| Pension contribution by employer | | | 204 | |
| Medical aid contribution by employer (3 × R50) | | | 150 | |

## Cost to company (CTC)

This is the total amount that an employer is prepared to pay for the employee and includes all costs associated with employment, including benefits. This means the gross salary plus the employer's contributions.

## 6.6 The budgeting process

A fiscal year exists for financial purposes and can start at any point in the calendar. The budget is done annually and in relation to the organisation's fiscal year.

According to Booyens (1997:194–195), the following steps are applicable in the budgeting process:

1. Gather information and draw up plans.

2. Reassess the organisation's mission, goals and objectives.

3. Establish measurable financial objectives.

4. Review proposed budget plan and guidelines.

5. Formulation of the unit's goals.

6. Estimate future staffing needs.

7. Estimate future supply needs.

8. Estimate capital equipment needs.

9. Prepare the budget proposal and submit for approval.

10. Implement and monitor the budget.

## 6.6.1 Gather information and make plans

This is step 1 of the budgeting process. Senior management carries out an environmental assessment that includes an appraisal of the changing health needs of the population it serves, economic factors, such as inflation, interest rates, unemployment and different funding patterns (from government and medical funds).

Changing health needs may include HIV/AIDS and TB. Economic factors include inflation and fluctuating interest rates that affect the funding patterns upon which the organisation depends. These are factors that increase the financial burden of healthcare. Unemployment affects the healthcare budget as seeking work has been one of the biggest factors influencing the patient numbers in the public sector's hospitals, outpatient clinics and others (Booyens, 1997:22).

## 6.6.2 Reassess mission, goals and objectives

This is the second step of the budgeting process. In this phase, goals and objectives are reassessed. Programmes are prioritised so that resources can be allocated to those programmes that will assist the organisation in achieving its goals and objectives.

The missions, goals and objectives of healthcare organisations ultimately refer to supplying care to persons in need. These standards are ultimately transferred into fiscal standards and used for the functions of the organisation.

## 6.6.3 Establish measurable financial objectives

During the third step of the budgeting process, measurable financial objectives that the organisation wants to achieve must be stated, for example, a reduction of 5% in the supply costs for the next financial year. Assumptions regarding salary increases, inflationary factors and volume projections should also be determined.

Furthermore, organisations are responsible for the payment of salaries. This is a contentious issue that can make or break an organisation, as contented staff contribute to its effectiveness. Needless to say, salaries are connected to inflation and increases in the cost of living. Salaries play a significant role in the future projections regarding volume, which is the responsibility of the financial staff in the organisation.

## 6.6.4 Review proposed budget plan and guidelines

This is step 4 of the budgeting process. The health services manager receives a general budget plan as well as other relevant information from the financial officer of the organisation. This information contains the budgetary timetable, historical data for each of the units, worksheets, forecast information and specific instructions on how to prepare the budget.

## 6.6.5 Formulate the unit's goals

During step 5 of the budgeting process, the objectives and goals for the organisation must be thoroughly reviewed. Swansburg (in Booyens, 1997:44) states that objectives are concrete statements of the goals that health services managers seek to accomplish: they are action commitments through which the mission will be achieved and the philosophy or beliefs sustained. They are stated in terms of results to be achieved and focus on the production of healthcare services to patients.

## 6.6.6 Estimate future staffing needs

This is step 6 of the budgeting process. The number and categories of nursing personnel must be determined, based on the objectives set, any possible new activities and patient workload (Lotz et al, 2006:66–69). The manpower or staffing budget is applicable in this phase (Booyens, 1997:189–191).

A number of calculations are made to estimate future personnel requirements and the associated costs:

1.  Patient acuity levels must be determined by making use of a patient classification system.
2.  The average daily census or number of in-patients for each acuity level must be determined. These averages are arrived at by collecting data for at least six to twelve months.
3.  The average daily number of patients per acuity level is then multiplied by 365 in order to arrive at the number of annual patient days per level.
4.  The total number of days for each acuity level is then multiplied by the established hours of care per day for each acuity level; this gives the annual required hours of care per acuity. The totals for each acuity level are then added up, to get the total number of nursing care hours needed in a unit for a year.
5.  The total number of nursing care hours (4 above) is then divided by the number of hours that nursing staff work in a year, for example 40 hours x 52 weeks = 2 080 hours per year.
6.  No nurse, however, works the full 2 080 hours per year, due to holidays and sick leave. The total unproductive time (holidays and sick leave) must also be calculated for the number of nurses calculated (5 above). Additional staff numbers will have to be added.

7. In this step, the staffing mix is determined, for example, how many registered nurses, student nurses and auxiliary nurses are needed. The total number of nurses required (6 above) must be borne in mind.

8. In the last step, the staff turnover experienced in the unit per year can be calculated. The number of additional healthdcare professionals needed to make up for the expected loss can be budgeted for.

## 6.6.7 Estimate future supply needs

This is step 7 of the budgeting process. Based on the objectives set and the anticipated patient workload, the materials and provisions required and their costs must be determined (materials budget). The projected patient statistics are used as a basis for identifying supply requirements. The health services manager must determine the types of supplies that will be needed, as well as the amount of each type and then translate the requirements into rands. The estimation of the required costs is done in the following sequence:

1. The year-to-date report of expenditure for at least the past eight to nine months must be reviewed in order to determine the supply and utilisation of provisions.

2. Future needs must be determined. The health services manager must consider whether new health programmes will be implemented, whether new procedures (medical and nursing) will be used, and whether the number of patients treated is likely to increase or decrease and, if so, to what extent (eg 20% increase or 30% decrease). The different types of patients to be served will obviously determine the supplies required.

3. The inflation rate must be considered and incorporated into the budget projections.

4. The budgetary estimates for each type of supply must be filled in on the prescribed documentation of the health institution (Booyens, 1997:191–192).

## 6.6.8 Estimate capital equipment needs

The formulated objectives also dictate the acquisition of capital equipment items (step 8). It is important to note that the acquisition of equipment, for example, a new monitoring machine, will also affect the staffing and materials needs.

Very expensive equipment, such as X-ray machines and MRI scanners are termed major capital items and are budgeted for in a separate budget, the capital expenditure budget (Capex). The reason for the separate budget is because of the high costs involved, which can increase the costs of providing patient care; it may then be too costly for patients to seek the needed healthcare. Capital expenditure costs are subtracted from the income or revenue generated by the institution and this affects the profit earned by the organisation.

Organisations normally allocate a fixed amount of money for capital expenditure each year. Competition between the different departments, to

purchase an expensive machine or improve the building, can be stiff; therefore, the motivation or justification for these expenses must be complete and well documented.

A thorough analysis is done before a request for expensive equipment can be made. The following questions are asked:

- Is any equipment currently not in use?
- Will any new services be offered in the future that will require different or new equipment?
- Does the current equipment break down easily? If so, how often?
- What is the cost of repairs?
- Is there a decrease in nurses' productivity because of poorly functioning equipment or a lack of equipment?
- Does the current equipment provide inaccurate information that leads to incorrect interventions?
- Would new equipment improve patient care?
- Would new equipment improve patient safety?
- Would new equipment lead to shorter hospital stays?
- Would new equipment improve or lower the organisation's operational costs?

Once a decision has been taken to apply for funding for a new piece of equipment, the following questions should be asked:

- What is the initial purchase price?
- What are the installation costs?
- What are the maintenance costs?
- What are the labour costs? Would extra staff be needed to maintain or operate the machine?
- How much training would the existing staff need in order to operate the machine correctly?
- What would the regular service and repair costs be?

When identifying equipment costs, it should also be determined whether there are additional charges for special features. When this is the case, the extra features should be evaluated to determine whether or not they are necessary or desirable.

Once the costs and possible revenues have been determined, a simple break-even analysis will tell at what point in the future the item of equipment will have paid for itself and will be able to generate a profit. It is always a good idea to test a new product before a decision is made to buy it. This is not always possible,

but must be done if at all possible. Aspects to evaluate are price, convenience of use, performance, availability and whether improved patient care will result (Booyens, 1997:192–193).

### 6.6.9 Prepare the budget proposal and submit it for approval

During step 9, the required worksheets and other forms are completed and submitted to the appropriate person for approval, depending on the institution's policy.

### 6.6.10 Implement and monitor the budget

This final and ongoing phase of the budgeting process relates to the control function of management. Management should ensure strict adherence to the budget and take the appropriate steps in the case of variances.

According to Booyens (1997:197–198), to manage costs effectively, health services managers must understand the reasons for managing costs. These could be the following:

- Costs determine how many nursing staff members will be hired and how much they will be paid.
- Costs determine the quality and quantity of supplies and equipment available.
- Costs determine whether a service can be rendered or not.

A budget focuses on improving the quality of care or on expanding access to quality healthcare. This can be seen in expenses allocated to, for example:
- support for a wide array of lifesaving healthcare services in communities
- promoting quality hospitals and nursing home facilities
- restructuring of healthcare facilities such as hospitals, clinics and nursing homes
- funding for women's and family health initiatives
- a programme to help seniors to afford their prescription medications
- creating a provincial or national electronic medical record system (Majority Press, 2014).

## 6.7 The purpose of financial statements

The purpose of financial statements is to observe how the institution spent income and what the current financial position is. The financial manager must know the principles of financial management in order to manage the institution's financial affairs, preserve its assets and maintain its liquidity and solvency (Lovemore & Brummer, 2003:3). Lovemore and Brummer (2003:7–8) explain that the task of financial management is to monitor the institution's financial position, namely by analysing the financial position and managing the assets and financial structure.

### 6.7.1 Analysing the financial position

Analysing entails investigating the institution's financial position to ensure soundness (eg liquidity, or the ability to meet payments of short-term debts) and profitability. It also entails strategic planning to solve problems regarding liquidity and profitability.

### 6.7.2 Managing the asset structure

Managing the asset structure entails ensuring the availability of funds and equipment for day-to-day functioning. It also refers to ensuring that no over-capitalisation takes place from hoarding unnecessary equipment and excess stocks of supplies. The financial manager has the responsibility of balancing the optimum ratio of utilisation between fixed (long-term) and current (short-term) assets.

- Short-term finance (also called working capital) is needed for the gap between getting paid and paying the suppliers and for the payment of overheads costs.
- Medium to long-term finance, ranging between three and ten years, depends on the life expectancy of machinery, equipment and building structures, among other things. The loan term should match or be shorter than that of the life expectancy of the items (Stokes & Wilson, 2006:399–400).

### 6.7.3 Managing the financial structure

Managing the financial structure entails striking a balance between the share-holders' funds, the long-term and short-term loans and accommodating the financial risks in the specific industry. Shareholders' funds are a safe, long-term financial structure. Long-term debt is safer than short-term debt due to the longer period of repayment. The management of the available funds at the most favourable interest rates and payment conditions will ensure liquidity and profitability.

## 6.8 Financial statements

Reading a financial statement should give the reader an impression of the financial performance of the company. Financial statements consist of the following: the income statement, the cash flow statement and the balance sheet.

Financial statements are used by a variety of users, for example:
- shareholders, to check up on their investments
- management, to help the planning and control of the activities to reach the objectives as set
- creditors, to keep a eye on their investment
- labour unions use financial statements as a basis for wage negotiations
- investment analysts for investment purposes
- SARS representatives, to check taxes paid
- credit bureaus for credit ratings.

## 6.8.1 Income statement

The income statement is an accounting document that shows the results of an organisation's activities over a period of time (usually a year), whereas the balance sheet shows the financial state of affairs on a specific day, normally the last day of the financial period. This statement shows the money (revenue) coming into the organisation for services rendered and the money leaving the organisation in the form of expenses (Booyens in Lotz et al, 2006:82–83). It includes income due but not yet received, expenses owed but not yet paid, and expenses such as depreciation which are deducted from the gross profit but do not go through the organisation's bank account.

The income statement is divided into three parts. The first part reflects total income from sales, less all operating, administration and marketing costs. The second part reflects how rewards are dispensed in the form of interest, taxes and dividends. Finally, the income statement reflects the amount of net income (if any) that is to be retained in the business for major uses, such as paying off long-term loans and expanding operations (Lovemore & Brummer, 2003:2). The income statement is seen as incomplete if not accompanied by a balance sheet (see section 6.8.2 below).

Items reflected on the income statement:
- sales
- direct costs (the costs of the services or goods that are sold)
- indirect costs (operating costs)
- notes on the wages
- depreciation
- operating profit on earnings before tax and interest was deducted
- interest
- income tax
- earnings after tax and interest and the payment of dividends.

### *Understanding the income statement*

The income statement is one of three financial statements – the others being the balance sheet and the cash flow statement. The income statement summarises the company's revenue and expenses, quarterly and annually, for a specific fiscal year (see Example 6.6 below).

## Example 6.6: Example of an income statement

| Typical Business, Inc. | |
| --- | --- |
| **Income Statement** | |
| **For year ended December 31, 2016** | |
| Sales revenue | R  26 000 000 |
| Cost of goods sold | R  14 300 000 |
| **Gross margin** | **R11 700 000** |
| Selling, general, and administrative expenses | R    8 700 000 |
| Operating earnings | R    3 000 000 |
| Interest expense | R       400 000 |
| Earnings before income tax | R    2 600 000 |
| Income tax expense | R       910 000 |
| **Net income** | **R  1 690 000** |

To read this income statement it is important to keep the following in mind:

- *Heading*: Identifies the business, the financial statement title, and the time period summarised by the statement.

- *Body*: The financial report is designed to be read from the top line (sales revenue) and to proceed down to the bottom line (net income). Each line down in the income statement involves the deduction of an expense. The following is how it is usually presented:

  - *Minus signs are missing*: Minus signs are very seldom used to indicate deductions in front of expense amounts. Sometimes, brackets are put around a deduction to signal that it is a negative amount.

  - *Your eye is drawn to the bottom line*: It emphasises the final profit by putting a double underline under it or placing it in bold type.

  - *Profit is not usually called profit*: The bottom line is often called net income. Businesses use other terms as well, for example, net earnings or just earnings.

  - *You don't get details about sales revenue*: The sales revenue amount in an income statement is the combined total of all sales during the time period; you will not be able to tell how many different sales were made, or how many customers the company sold products to, or how the sales were distributed over the period.

- ▪ *Gross margin matters*: The costs of the goods sold is what it cost the company to buy or develop products to sell to customers, the sales revenue of which is reported on the sales revenue line. The sales revenue of goods sold less the cost of goods sold gives the gross margin (also called gross profit). The gross margin is the profit before expenses are deducted.

- ▪ *Operating costs are lumped together*: Here we have a wide variety of costs of operating the business and sales, including labour costs, insurance premiums, advertising and any legal costs.

## 6.8.2 Cash flow statement

The cash flow statement is a document indicating how cash has flowed into and out of the business during the year or any other given period (Lovemore & Brummer, 2003:2). It only shows money actually received and actually spent.

## 6.8.3 Balance sheet

The balance sheet is a summary of how much money was spent and the manner in which it was spent. It is an annual financial statement showing assets, debt and investments (Swart, 2003:199). According to Lovemore and Brummer (2003:2), the balance sheet reflects an organisation's financial and business affairs on a particular day – usually the last day of the financial year – by showing its assets and liabilities, both long and short term. Since the liabilities represent the total funds used to finance the assets, the total asset value must equal or balance with the total of the liabilities.

### Assets

- *Current assets* are those that can be turned into cash within a year of the date of the balance sheet, eg cash on hand (a positive bank balance) and inventory. These assets change as business takes place.

- *Fixed assets* are also called non-current assets. These assets are retained for longer than the accounting period. Examples are property, land, equipment and vehicles. Fixed assets are devalued annually by depreciation.

### Liabilities and net worth

- *Net worth* consists of the institution's assets less its liabilities.

- *Current liabilities* include money owing, for example to medical supply firms and drug distributors.

- *Long-term liabilities* are debts owed by the institution for longer than a year after the date of their appearance on the balance sheet (eg the mortgage owed on land and buildings).

## 6.8.4 Budgeted balance sheet

This is a financial document stating the financial position of an organisation at a specific point in time. It shows what the organisation owns (assets), compared to what it owes (liabilities).

## 6.9 Summary

The need for and value of the budgeting process in health services management has been dealt with at length in this chapter, showing the different steps followed in order to arrive at the final financial requirements of the institution. The difference between fixed and flexible budgets has been illustrated by means of relevant examples. Other examples have been used to explain how to compute the estimated costs needed for supplies, equipment, labour and overheads. Finally, how to calculate the various remuneration systems for staff has been shown using examples.

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# 7

# Organising Facilities, Equipment and Supplies

A du Rand

## Chapter Outcomes

After studying this chapter, you should be able to:

- outline the role of budgeting in the effective utilisation of equipment, facilities and supplies;
- explain staff responsibilities to ensure that the equipment needed for the service is available and in working order;
- describe the responsibilities of providing sufficient and appropriate supplies for the rendering of safe patient care;
- list the important principles in supply chain management;
- describe the role of the health services manager to ensure adequate equipment and supplies in a disaster situation.

## 7.1 Introduction

Nursing staff in the units are at the point of output where care is being rendered and, as they control a large portion of the resources allocated for healthcare, it is their responsibility to help the service be cost effective. Each healthcare professional should, therefore, be cost conscious and carefully supervise and control the utilisation of resources.

## 7.2 Environmental control

The physical environment in which healthcare is rendered has an effect on the patients, healthcare professionals, equipment and supplies. Any obstacle that prevents healthcare professionals from practising effectively should be eliminated. The physical environment in which care is rendered is just as important for cost-effective care as the quality of the care itself. Facilities should, therefore, be kept in good condition. Paintwork should receive attention at regular intervals. Dust, temperature, humidity and dirt are variables affecting the environment, which, in turn, has an influence on the equipment and supplies used in the unit. Healthcare professionals should see to it that the environment in which they are delivering nursing care, as well as all equipment that they use, are kept free of dust and dirt. The correct temperature and humidity should be maintained under all circumstances.

## 7.3 Organising facilities

Facilities refer to aspects of the building structure. Health services managers can contribute to a safe and effective environment by looking at features in the unit that they can control. Areas that need repair and maintenance, for example, peeling paint, broken tiles, taps and windows, must be reported on the correct forms and sent to the responsible department. An example of forms used in the maintenance of facilities and equipment is shown in Figure 7.1. These forms may vary from one service to another.

Safety committees in the institution are responsible for inspecting facilities for any irregularities and checking that repairs are done as soon as possible. The maintenance of, and changes to, facilities in general falls within the capital budget. The capital budget gives an overview of the requirements concerning the purchase of land, buildings, facilities or equipment that would result in future economic gain or in an increase of services and/or quality rendered. Only minor repairs are covered by the operational budget, which is designed to cater for day-to-day operational costs.

### 7.3.1 Extensions or renovations to facilities

Motivations for extensions or renovations to existing facilities should be directed through the correct channels. When budgeting for the following fiscal year, a motivation is written by the budgeting committee, which presents it to the authorities. Requests for extensions or renovations could come from either the top authority or the health workers at the bottom level. Often, the government or the directors of the institution identify a need and appoint a committee to investigate the possibilities of implementing the plan.

It could also be that the patients or healthcare professionals become aware that existing facilities are not meeting their requirements. A request would then be lodged with the authorities, together with the necessary motivation.

UNIVERSAL HOSPITAL
REPAIR REQUISITION

Department.................................................. Tel...............................................................

Date...................................................

Section...................................................... Tel...............................................................

Date...................................................

Block ...................................................... Floor..........................................................

Room...................................................

| EMERGENCY | URGENT | AS SOON AS POSSIBLE |
|---|---|---|

Please carry out the following work:
Only one item per request

..............................................................................................................................
..............................................................................................................................
..............................................................................................................................
..............................................................................................................................
..............................................................................................................................
..............................................................................................................................
..............................................................................................................................

Reported by

...............................................................

The equipment will be available for repairs from

...............................................................
to ............................................................

Requesting official


...............................................................


Authorised on behalf of Medical Superintendent

...............................................................

**Figure 7.1**: Example of an order form for repairs and maintenance

Health services managers play a major role in planning extensions. A member of the nursing staff should serve on the multidisciplinary team planning extensions to a facility or planning a new healthcare facility. In general, the nursing staff should have knowledge of the planning policy of the authority responsible for the institution. The completed structure must be functional and the plans flexible. The nursing staff member serving on the planning team should be able to study architectural plans so that his or her input ensures a facility that is effective and takes the nursing staff's needs into account. For example, the facility's design, spaces for visitors, areas for waiting rooms and the surface finishes are all areas that should be of concern to the nursing staff.

## 7.3.2 Maintenance of facilities

The authorities also have a policy concerning the maintenance of facilities. An example could be that all exterior paintwork must be repainted every five years and interior paintwork every three years. Plans for the maintenance of new or renovated facilities, buildings and major equipment must be made more than a year in advance. Requisitions for minor works and renovations are also applied for on a prescribed form.

Items included under minor works and renovations might be, for example, the replacement of a washbasin or floor covering. Details must be provided of the service to be rendered and a sketch of the work area is required. The nature of the required service and its location should be clearly indicated and a full motivation given. The works department as a rule usually checks the work to be done to give an indication of the costs involved. The budgeting committee on which the health services manager serves will review this annual requisition for minor works before presenting it to the authorities for approval. After the budget has been approved, the institution receives the amount granted and then decides which minor works can be afforded. Minor repairs are done by approved contractors according to priority.

For smaller works, such as replacing electrical bulbs or clearing blocked drains, a works order is submitted to the directorate of works. The workshop then completes the job and hands it over to the health worker in charge of the unit, who should check that it has been done satisfactorily. The same form as shown in Figure 7.1 can be used. The expenses related to smaller works are covered by the operational budget.

## 7.4 Organising equipment

Equipment comprises a large portion of a health service's budget. Quality care can only be rendered if there is sufficient equipment of high quality to meet the needs of the patients and to improve the health workers' productivity. Clear policy regarding the standard allocation of equipment to a unit should be available. Equipment can be divided into the following categories:

- Fixed equipment, which is built into the facility structure (ie walls and floors), for example overhead lights, suction mountings, cascade oxygen and sinks, sterilisers and lockers.

- Loose equipment, which is not part of the structure and is moveable. Movable items can be categorised as:

  - Non-expendable: part of the capital budget, for example stretchers, wheelchairs and examining tables.

  - Expendable: consumable items, such as instruments, bedpans and urinals.

The capital budget is composed of a long-term planning component and a short-term budgeting component. The long-term component usually outlines future replacement and expansions that will exceed one year, for example, a medical resonance (MR) machine. The short-term component includes purchases that fall within the annual budget cycle, such as hospital beds (Marquis & Huston, 2006:226). The capital budget usually sets a base amount for the purchase of new equipment. If this set amount is exceeded, what is requested is deemed to fall within the capital budget.

Expendable equipment is ordered on a regular basis, while non-expendable equipment will be ordered for a special purpose or as a replacement when it has broken or is worn out. While supplies are ordered on the basis of the average number of patients in the unit, equipment can be ordered according to the maximum number of patients admissible to the unit. Decisions can be made to increase or reduce the equipment budget based on projected patient days and revenues (Roussel, 2006:286).

## 7.4.1 Acquiring equipment

The application for equipment is done initially during the budgeting for a fiscal year. A specified form is used for purchasing articles or apparatus (eg ventilators) over and above the fixed head office limit for the institution concerned. An example of an application form is shown in Figure 7.2. A clear, objective motivation for purchasing the required article is needed, as well as the names of suppliers concerned, the tender item number, price details, maintenance and installation costs and guarantee period.

If this piece of new equipment is a replacement of an item that was disposed of, a form indicating this (form for the application for disposal of assets – see Figure 7.3) must also be completed.

Another form, which is used to apply for the replenishment of disposed assets (ie any broken or outdated item that can no longer be used), also accompanies the application form as shown in Figure 7.2. An example of this is depicted in Figure 7.4. Requisitions for items below the fixed limit are also submitted on prescribed forms. An example of such a form is shown in Figure 7.5. All the details mentioned above also apply to these items. Additional points to remember are type and compatibility with existing equipment, safety, training healthcare professionals to use the equipment, as well as existing contracts.

The budgeting committee reviews the requisitions and compiles a list of priorities, which is forwarded to head office for approval. The provincial authority decides on the amounts to be granted for a particular fiscal year. Once the institution receives the amount granted, a decision is made about which

expensive articles (that exceed the fixed limit) will be purchased. As a rule, three quotations are obtained before deciding from which firm or tender to buy. Health services managers are notified of the requisitions that cannot be provided in the fiscal year. Requisitions that have been turned down may then be submitted the following year.

| APPLICATION FOR NEW REPLACMENT EQUIPMENT | | | | |
|---|---|---|---|---|
| | | | Section................................. | |
| 1. Replacement of equipment | No | Yes | If yes, Please fill in 1.1, 1.2, 1.3 and 2 | |
| 1.1 Description of item | | | | |
| | | | | |
| | | | | |
| | | | | |
| 1.2 Tender item number | | | Supplier | |
| 1.3 Price | | | | |
| 2 New equipment (ignore 1) | | | | |
| 2.1 Description of item | | | | |
| | | | | |
| | | | | |
| | | | | |
| 2.2 Tender item number | | | Supplier | |
| 2.3 Price | | | | |
| 2.4 Complete motivation for product, please | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| 3. Motivator signature | | | Date | |
| 4. Approval of management | | | Yes | No |
| 5. Purchase authorised | | | Yes | No |
| Manner | | | Disposal | Additional |
| | | | Date | |
| 6. Place of inventory | | | Yes | No |
| Mark with section code | | | Yes | No |
| | | | | |
| SENIOR MEDICAL SUPERINTENDENT | | | | |

**Figure 7.2**: A typical application form for replacing or purchasing new equipment

**APPLICATION FOR DISPOSAL OF ASSETS**

A.   Asset Controller

I, the undersigned would like to apply for the disposal of the following items as reflected on Asset

Record..............................................(Technical Report attached if applicable)

| ICN Number | Description of item | Quantity |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Signature of

A:      ................................................  Name..............................................  Date ........................................


B.   Cost Centre Manager (person approving the disposal)
The disposal of the item is recommended / not recommended. (See attached technical report)

Signature of

B:      ................................................  Name..............................................  Date ........................................


C.   LOGIS System Controller
The application for disposal is approved / not approved.

Signature of

C:      ................................................  Name..............................................  Date ........................................


D.   Asset Clerk
The transaction has been done as per attached LOG 4. New Asset Control reports have been printed and signed.

Signature of

D:      ................................................  Name..............................................  Date ........................................

Balance ..............................................  Adjustment No. ............................


E.   LOGIS Official Verifier
The transaction has been done in accordance with the prescripts.

Signature of

E:      ................................................  Name..............................................  Date ........................................

**Figure 7.3**: Example of a form for the application for disposal of assets

BALANCE ADJUSTMENTS

FOR STOCKTAKING PURPOSES THE LOG MUST BE COMPLETED SEPARATELY FOR CONFIRMED SURPLUSES AND SHORTAGES

PAGE 0

DOCUMENT DATE:

C C Y Y M M D D
0

CHIEF USER NO:

CHIEF USER NAME:

INVENTORY/PERSONNEL NO:

FROM ICN · DESCRIPTION · QUANTITY

TO ICN · DESCRIPTION · QUANTITY

FROM – TO ONLY

SUSPENSE TYPE: disCrepancy/disPosal/From-To

REASON CODE:
01-Surplus 03-Redundance 05-Unserviceable
02-Shortage 04-Outdated/Obsolete 06-Damaged 09-From-To

ADJUSTMENT TYPE:
1-Stock 3-Livestock
2-Equipment 4-Slight shortage/Surplus

BALANCE TO CHANGE: Stock/Inventory (SA)

ICN:

ITEM DESCRIPTION · QUANTITY · FINANCIAL CODES · JOURNAL · DOCUMENT NO.

REVERSAL: (BARV)
REVERSAL: (BARV)

Note for serialised, batch and face value items, complete a log 6 / 7 / 8

REMARKS / MOTIVATION:

SIGNATURES:

1. COMPILER: DATE:
1. AUTHORISED: DATE:
3. BACP-ENTERED DATE:
4. VERIFIED DATE: SIGNATURE: DATE:

**Figure 7.4**: Example of a form for balancing adjustments

## 7.4.2 Using equipment

When using equipment, the following principles apply:

- The equipment must be used for the purpose that it was intended for. Standardising equipment is common practice in health facilities as it contributes to negotiating a good price when purchasing a follow-up service and maintenance for a negotiated period. Standardisation also facilitates in-service training.

- When agency nursing personnel are utilised, the health services manager must ensure that they are also taught about the use of the equipment, as they may not be familiar with all the equipment.

- If healthcare professionals are not taught how to use equipment properly, they tend to improvise, which can lead to inefficient and dangerous practices.

- The equipment must be kept clean. The importance of using clean equipment cannot be emphasised enough; this is essential for rendering safe care.

- Equipment must be cleaned according to the instructions supplied, as non-compliance can contribute to the problem of cross-infection.

- In some cases, it may be necessary for equipment to undergo special cleaning methods, which requires it to be sent to a specific department specialising in cleaning equipment after use. There must be clear instructions as to how this should be done, as non-adherence may damage the equipment.

- The equipment must be maintained so that it is ready for use and in the right place. It must be kept in mind that health workers have the responsibility to attend to equipment vigilantly, even though there may be a service contract for its maintenance.

The health services manager must emphasise to all staff that having the necessary equipment to render the necessary care requires that they should immediately report any piece of equipment that is broken or damaged. The prescribed procedure must then be followed so that it can be sent for repair. If such equipment is essential, arrangements need to be made for replacement while the repairs are being carried out. The relevant requisition forms will be completed for the repairs. A follow-up inspection should also be made to see that the equipment is returned to the unit in a reasonable time. Should the equipment be irreparable, the institutional policy will be followed for its replacement. A special record is kept on equipment sent for repairs. The name and the code of the instrument are recorded, the date and to whom it was sent for repair.

The storage of equipment is dependent on the availability of space and the extent to which it must be readily available. For example, life-saving equipment cannot be locked away, whereas other equipment should be locked away for safekeeping. The best safeguard against loss and misuse of equipment is an awareness to treat all property carefully. Making equipment inaccessible to healthcare professionals undermines their sense of responsibility, so careful consideration should be given as to how and where the equipment is stored so that it is in the right place and accessible when needed.

**REQUEST / REQUISITIONING FORM**    PAGE ☐☐☐ OF ☐☐☐

Normal Request: ☐

Petty Cash Request: ☐

Petty Cash Voucher: P T ☐☐☐☐☐

Petty Cash Voucher: Y Y Y Y M M D D
Date: ☐☐☐☐☐☐☐

Requisitioning Institution: ................................

Chief User No: ☐☐☐

or

Store No: ☐☐☐☐☐☐☐

Functionary /
Chief User / Store Name: ................................

Functionary
(Unique): ☐☐☐☐☐☐☐☐

Request or
Reference No: ☐☐☐☐☐☐☐

Requisition No: R Q ☐☐☐☐☐

    Y Y Y Y M M D D

Requisition Date: ☐☐☐☐☐☐☐

Job / Project /
Animal No: ☐☐☐☐☐☐☐☐

**Requisition Chief User / Functionary**

Street: ...............................

Suburb: ...............................

City: ...............................

Country: ...............................

Code: ...............................

| ICN | Item Description | U | Request Quantity | Approved Quantity | Increase in Capacity | Replacement Quantity | Inventory / Personnel No. | Financial Codes |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |
| | | | | | | | | |

Remarks / Motivation: ..........................................................................................................

Signatures:   1. Functionary    Date    3. Chief user    Date    5. RQAT-verified   Date

         2. Chief user clerk    Date    4. RQCP-entered    Date

**Figure 7.5**: Example of an order form for requisitions

## 7.4.3 Stock control

The control of equipment is usually performed by keeping an inventory. Close co-operation between the acquisitions department and the health services manager is necessary to ensure that the inventory is up to date. This will ensure that when stock taking is done by the relevant support services all equipment can be accounted for. It is not the duty of nursing staff to do the stocktaking – they should only be involved in the case of specialised medical equipment. A computerised system for taking inventory and control over the use of equipment is normally used. All equipment must have a code number that should be entered into the computer as soon as it is delivered to the unit. A printout can be sent to the unit at regular intervals to compile an inventory on what is in the unit.

The local authorities provide a computer printout to the health services clinic on a monthly basis, which records items that have been purchased, costs involved and the amount of money left over for those specific items. Health services managers must control this carefully, as overspending is not allowed. Money not used by the end of the financial year goes back into the budget.

All new items should first be checked by a standardisation committee before being put to use in the units. The item should be evaluated and reported. Factors to consider are cost, safety, availability, maintenance and cleaning.

Supervision of equipment includes checking all equipment received in the unit for completeness and working order. It should then be placed on the inventory list. When a unit borrows equipment from another unit, it should be entered into a borrowing book. The date, time, name of unit and equipment borrowed should be entered and space provided for the signature and date returned. The equipment on the emergency trolley should be checked daily and after it has been used. A special record is kept of the date, time and by whom it was checked.

## 7.4.4 Condemning of equipment

Equipment that can no longer be used in the unit must be condemned and, where necessary, replaced. The institution's policy with regard to condemning must be made known to all healthcare professionals. Minor equipment falling under the operational budget is often replaced on a monthly basis (refer to Figure 7.6), but the policy can differ from one institution to another: a more desirable method is to replace articles when needed. This, however, can result in the stores being continually contacted by healthcare professionals who need replacements. In some private institutions a report is written weekly on the condition of all equipment and facilities in the unit. In accordance with this report equipment is then either repaired or replaced.

As a rule, equipment that falls under the capital budget (those items that cost more than a predetermined amount and have a certain life expectancy) must be evaluated the year before the expected replacement to establish whether replacement is necessary. A motivation for replacement must be written and at least three tenders put out. Breakable items (eg cups and glasses) and other smaller items are condemned usually on a monthly basis. A requisition form is used when reordering items, indicating whether they are general items, replacements, shortages or smaller items. An example of such a form is shown in Figure 7.5.

Requisition for the repair of surgical instruments, apparatus and anaesthetic apparatus should be done on a prescribed form, as shown in Figure 7.1.

### Expired, damaged and poor quality items

It is important to reduce waste caused by expiry and to maintain the quality of the product given to patients. After a medicine has reached its expiry date, or when a product is of poor quality or damaged, its effectiveness may be reduced. Expired medicines should NOT be used at all. Identify items which are

short-dated or overstocked but still within their expiry date, and return these items to the pharmacy in a timely manner. Count the stock that must be returned and record the transaction on the necessary forms and record all information on the stock cards (date, time, name of witness, manner of removal). Place the stock in the ward stock box and lock the box. The cost of expired and damaged medicines must be calculated and the reasons for expiry or damage investigated (Schellack & Meyer, 2010).

# 7.5 Organising supplies

The items needed to operate a nursing unit include medical-surgical supplies, pharmacy items, linen and housekeeping supplies. The organisation of supplies differs from that of equipment because supplies are influenced by changes in volume. Changes in supply requirements and their consumption can result from changes in the patient mix, the type of patient, procedures or the use of a new piece of equipment. Given that these changes in volume cannot be projected accurately and, consequently, the amounts of supplies needed cannot be determined accurately, systems need to be put in place that provide for fluctuations in volume. Different types of supplies require different systems. The systems usually require that the level of usage first be identified in terms of the minimum and maximum amounts used in a specified time frame. What this particular period of time is depends on whether the supplies are ordered on a daily, weekly or monthly basis.

To determine these levels it is necessary to analyse the statistics of the unit for a period of at least six months. The statistics to be reviewed include the bed occupancy rate and the volumes of the different items ordered. From this information it should be possible to ascertain the minimum and maximum amounts of the items used. This analysis can be provided by the stores/warehouse where the supplies are obtained, as they usually have computerised records at hand. Once these levels are known, the appropriate system can be determined for the different supplies; this depends on whether the supplies are ordered on a daily, weekly or monthly basis, or whether the stores/warehouse come to the unit to top up the supplies to the determined level.

Minimum level or safety stock level is the level of inventory, below which the stock of materials in a unit should not fall. If the stock goes below minimum level, there is a possibility that the nursing care may be interrupted due to shortage of materials. In other words, the minimum level represents the minimum quantity of the stock that should be held at all times in the unit.

## 7.5.1 Calculation of minimum level of safety stock

The minimum level could be determined by using the following formula:

---

Minimum Level = Reorder level – (Normal consumption × Normal reorder point)

### *Example*

Reorder period = 8 to 12 days

Daily consumption = 400 to 600 units

Minimum level = ?

### *Solution*

Minimum level = Reorder level – (Normal consumption × Normal reorder point)

= 7200 – (500 × 10)

= 2 200 units

### *Notes*

Reorder level = Maximum consumption × Maximum reorder point

= 600 × 12 = 7 200 units

Normal consumption = (Maximum consumption + Minimum consumption) ÷ 2

= (600 + 400) ÷ 2

= 1 000 ÷ 2

= 500 units

Normal reorder period = (Maximum reorder period + Minimum reorder period) ÷ 2

= (12 + 8) ÷ 2

= 10 days

---

Source: Accounting–management (2015)

## 7.5.2 Daily, weekly and monthly supply orders

Each institution has its own particular ordering procedure and paperwork for this purpose.

The actual ordering need not be done by a nurse unless it is of a special nature: it can be delegated to a ward clerk or another designated person in the unit. This person, however, needs to be trained so that he or she understands the principle of ordering according to the minimum–maximum levels.

The ultimate responsibility for ordering remains with the health services manager and it is, therefore, wise to do spot checks to ensure that there is no over- or under-stocking of supplies.

## 7.5.3 The topping-up system

This system saves time and energy: the stores visit the unit on set days to top up supplies so that they meet the predetermined levels. The use of this system can be influenced by the physical layout of the facility; if accessibility to the storage area is limited, the topping-up system may not be the best option.

If such a system is used it is important that control is exercised over the delivery of supplies to ensure that what is recorded corresponds with the actual amounts received; this should be delegated to a person other than a nursing staff member. Irrespective of the system used, the health services manager should regularly review the levels, as patients' needs and the mix of patients are not static and adjustments need to be made accordingly.

The responsibility for daily, weekly and monthly ordering of medicines, dressing items and other consumables depends on the system in use. If a topping-up system is used, orders will only be placed for special medication or items that are not on the regular stock of the unit. Ordering will be placed with the suppliers or the institution's stores, depending on the item ordered. Items, like tea, coffee, medications, surgical dressings and batteries will be kept in the store. When these items are ordered from the store, the order list should indicate the item and code number.

In private institutions, these supplies are topped up according to the unit stock changes. Each patient's list of stock used is sent on a daily basis, or in accordance with the institution's policy, to the dispensary, which issues the unit with the stock that has been used. Figure 7.6 shows an example of such a form. Most institutions use a computer system to record the use of stock. Each item is given a code and a price is noted. The number of items used is entered and the patient's account is charged accordingly. The patient's prescription chart is sent to the pharmacy to dispense the medication. Each patient's medication is provided in a separate container with the patient's name and number and is charged to the patient's account. This medication is kept in the medicine trolley and given to the patient as prescribed. Should the patient be discharged, any medicine left over should be given to the patient to take home or sent back to the dispensary, according to the doctor's orders.

Health clinics are given permission to keep certain medications up to schedule 4. This depends on the type of service that is being rendered and whether a medical officer is available. The following are examples of clinics' medication supplies:

- a clinic providing for immunisation will have all the necessary vaccines
- all the medication needed for the protocol for the treatment of tuberculosis will be available for TB patients
- a family planning clinic will have the necessary contraceptives
- a primary healthcare clinic will issue medications as required, and
- a clinic dealing with sexually transmitted diseases will have the necessary medication.

Special permission is required to enable the dispensing of medication.

**UNIVERSAL HOSPITAL DISPENSARY**
**UNIT STOCK CHARGES**

Patient's Sticker

| CODE | DESCRIPTION | DATE | | CODE | DESCRIPTION | DATE | |
|---|---|---|---|---|---|---|---|
| | AMPOULES | | | | SUNDRIES | | |
| 1001 | Pethidine | | | 8001 | Band Aid | | |
| 1002 | Heparin | | | 8002 | Gloves | | |
| 1003 | Ampicillin | | | 8003 | Ribbon Gauze | | |
| | ORAL LIQUIDS | | | 8004 | Safety Pin | | |
| 2001 | Amphogel | | | 8005 | Nappies | | |
| 2002 | Cough Mix / ml | | | | EXTERNAL LIQUIDS | | |
| 2003 | Valoran Drop | | | 0001 | Eusol / ml | | |
| | ORAL TABLETS | | | 0002 | Spirits / ml | | |
| 3001 | Codis | | | 0003 | T.B. CO / ml | | |
| 3002 | Isordil | | | | INHALANTS | | |
| 3003 | Valium | | | 0100 | Bisolvin / ml | | |
| | OINTMENTS | | | 0101 | Berotex / ml | | |
| 4001 | Betadine | | | | OTHER | | |
| 4002 | Reparil | | | 0201 | Electrodes | | |
| | SUPPOSITORIES | | | 0202 | ECG Paper | | |
| 5001 | Voltaren | | | | MATERNITY | | |
| 5002 | Glycerin | | | 0301 | Gloves | | |
| | SYRINGES | | | 0302 | Olive Oil | | |
| 6001 | 1 ml | | | 0303 | Sanipad | | |
| 6002 | 2 ml | | | 0304 | Prostin Tab | | |
| 6003 | Needles | | | | SUTURES | | |
| | PRE + POST OP | | | 0401 | Chroom | | |
| 7001 | Prep Tray | | | 0402 | Polisyn | | |
| 7002 | E.N.T. Tray | | | 0403 | Vicril | | |

**Figure 7.6**: A typical unit stock charges form

## 7.5.4 Storage and control of supplies

All supplies should be stored in accordance with the organisation's policy. All healthcare professionals working in the unit must know exactly where to find the items. Each category of supplies should be kept separately, for example, medicines should be kept in a separate area from food and cleaning materials. The cupboards must be locked and the key kept where it is accessible to healthcare professionals

only. Items that have an expiry date must be carefully noted and special attention given to this matter when supplies are used. Make sure that items are stored in such a way that materials nearing their expiry date are used first.

Cupboards must be cleaned at regular intervals. The temperature under which storage should take place must be noted and adhered to. The areas where supplies are kept should be free of rodents and insects.

Medicines and blood products requiring cold storage should be stored in a fridge allocated for medicines only. The temperature required should be checked. The medicine fridge should be locked and the key kept where only healthcare professionals have access to it.

## 7.5.5 Using supplies

Supplies should be used for the purpose for which they were intended, for example, vacolitres should be marked with an appropriate sticker and not a plaster. Waste must be reduced by using only the right amount of material, for example, cotton wool, antiseptic or cleaning materials. Dressing packs from the central sterilising department should be made up to provide for smaller and bigger dressings. Special bins should be provided for injection needles and syringes: these bins are disposable and when full, sealed and incinerated. This prevents healthcare professionals from being pricked by used needles and eliminates unwanted waste.

## 7.5.6 Linen supplies

The linen room should be kept locked at all times to prevent any unauthorised persons entering it. Standard supplies are determined for the type and amount of linen for a unit according to the number of beds, the types of patient, bed occupancy and discipline (eg paediatric, geriatric, surgical etc) and patient turnover. Standards are also determined for the coverage of weekends and public holidays. Laundry services are often outsourced to private companies if they can provide a more cost-effective service than the institution itself. This also contributes to the quality of the supplies, as no torn or damaged linen is received. The laundry services have their own staffing component who are responsible for the collection and delivery of linen.

Although the nursing personnel are not directly involved in the provision of clean linen and the removal of soiled linen, they must have clarity on the principles applicable. Care should be taken not to have too many blankets stored, as they can be damaged by fish moths if they are not used regularly and, in a financial sense, represent 'dead' capital.

The health services manager should ensure that a stepladder is available to reach higher shelves and cupboards so that none of the personnel, linen service and nursing staff are exposed to any danger when packing or collecting linen.

From time to time it happens that pillows become soiled, therefore the health services manager should, if necessary, arrange for their covers to be replaced or to have them covered with protective material. This can be included in the responsibilities of the linen service personnel.

A safe environment for the patient has to be created; therefore, it is also necessary that attention be given to the curtains around the patients' beds. They are easily contaminated and an arrangement should be made with the linen service staff to have them washed on a regular basis. As they cannot all be done at the same time, a schedule should be drawn up so that they are all washed, for example, every six months. Single incidents of contamination can be attended to on an ad hoc basis.

There should be a clear policy on the handling of all contaminated linen so that no healthcare professional is exposed to danger. The input of the infection control nurse is important, as the policy regarding the handling of soiled linen must be practical enough to be implemented in all areas. All healthcare professionals must receive in-service education on the policy and the health services manager should emphasise adherence to it when she or he is doing rounds.

## 7.5.7 General principles regarding the storage and control of supplies

All supplies need to be used for the purpose that they were acquired and in the most cost-effective manner. In many health facilities, the architectural layout often dictates where supplies are stored, but a principle derived from industrial engineering, which designs methods and procedures for doing work more efficiently, can be applied. Store items together that are used together. This assists healthcare professionals in knowing where different items can be found and eliminates the danger of using the wrong item. General principles that are applicable are the following:

- Supplies that have an expiry date must be stored in such a way that those with the earliest expiry date will be used first. On expiry, they must be returned to the pharmacy.

- Medications and blood products that have to be refrigerated must be kept in a separate fridge from the one used in the kitchen. The regulation of the temperature is of vital importance here and must be checked on a daily basis. It is also necessary to ensure that there is no buildup of ice; defrosting must be done to prevent this. During defrosting it must be ensured that the medications are kept at the required temperature so as not to break the cold chain. The kitchen fridge can be used during defrosting, but only for this short period.

- Certain storage places will need to be locked, like the medicine cupboard. All nursing staff should know where the keys are kept so that no unauthorised access is allowed and the safekeeping of poisonous substances and solutions is ensured.

- The policy of the specific institution regarding the disposal of sharp items (injection or suturing needles, scalpel blades) must be made known to all concerned. The health services manager should also ensure that it is carried out meticulously.

- The post-HIV exposure prophylaxis (PEP) guidelines must be available and known to all in the unit.

## 7.6 Evaluation of new equipment and products

It is necessary for unit managers and nursing personnel in charge of units to be aware of and evaluate new products and equipment on the market. Different nursing units should be asked to test new products to let as many nurses as possible feel that they have a say in selecting the equipment and supplies that they are asked to use. Nursing staff should be made to understand that testing new equipment and supplies is not intended to burden their workload because the purchasing staff cannot make the necessary decisions. They should rather see it as an essential input from them regarding the institution's finances. It is essential to link the use and purchase of healthcare technology with the nursing staff providing the patient care (Spitzer-Lehmann, 1994:477).

All nurses should play a role in research, although they may not be conducting the research themselves. Testing new equipment and supplies generates knowledge and provides new methods or ideas to improve the nursing care and offers nurses the chance to participate actively in their evaluation, which is closely related to research. Evaluation is a systematic means to determine the effect of a technique, programme or intervention (Doheny, Cook & Stopper, 1997:219). It should be decided whether other departments outside the nursing department should also test new products. Collaboration with other departments is necessary to establish an effective system for selection.

Policy should be formulated to assist in the evaluation of products. The purchasing department should be aware of all products received for evaluation, as they can provide input regarding the availability of funds and how to go about ordering supplies. A sufficient number of items should be tested. Guidelines on how it is to be used should accompany the new item to ensure that it is used according to the manufacturer's instructions. An evaluation form should be compiled or used to ensure that a record can be kept of items evaluated. The report should include recommendations and reports on findings. The trial period should be stipulated and feedback given to all units on the outcome of the tests.

The availability and maintenance of an item are important factors: it is necessary to ascertain whether or not a new item can be readily obtained and, in the case of equipment, whether or not it can be serviced regularly and repaired quickly should it break down. Attention should be given to the cost involved, taking the warranty and maintenance into consideration.

In some private institutions, special units are given permission to test new products required by medical specialists. This would imply that medical staff should also be involved in the evaluation and should, therefore, also complete an evaluation form. Figure 7.7 is an example of an evaluation form that can be used in nursing units when evaluating new products.

**EVALUATING NEW PRODUCTS**

Name of product: _____

Estimated cost of product: _____

Is the product available locally?_____

What is the warranty period of the product? _____

Is provision made for maintenance of the product?_____

Trial period: _____

Unit where it is being tested: _____

*Please complete this form after having evaluated the listed item. Make sure that you have become fully aware of the correct procedure to follow in using the item, before evaluation is done. Return the form at the end of the trial period to the head of department.*

**Report on findings**

1.  The product is an improvement on the one we are using at present.

                Agree_____ Disagree _____

2.  Give a reason for your response to the above statement.

    _____

    _____

3.  The product
    a) ensures improved patient care.        Agree_____ Disagree _____

    b) contributes towards productivity.     Agree_____ Disagree _____

    c) offers easier procedure.            Agree_____ Disagree _____

4.  The instructions on how to use the product are clear.   Agree_____ Disagree _____

5.  The equipment is easy to operate.       Agree_____ Disagree _____

6.  The equipment is easy to clean.         Agree_____ Disagree _____

7.  The product meets the expectations set out by the manufacturers.

                Agree_____ Disagree _____

8.  The product can be easily stored.       Agree_____ Disagree _____

9.  Recommendations: _____

    _____

    _____

10. Comments:_____

    _____

    _____

    _____

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

**Figure 7.7**: Evaluation form for new products

## 7.6.1 Purchasing equipment and supplies

Health services managers need to be aware of new equipment and products that are available. Having a good interpersonal relationship with the staff of the acquisitions department is of value, as they usually have the latest catalogues. Rowland and Rowland (1980:193–194) suggest the following guidelines for purchasing equipment:

- Equipment follows function, but needs in health institutions change drastically. Consider whether the equipment will be able to be modified, added to or easily replaced.
- Look for equipment that will cease to function before it malfunctions dangerously.
- Try to determine the lifecycle cost by taking into account original cost, operational cost, maintenance cost, modernisation potential and durability.
- Consider the efficiency and effectiveness.
- Bear in mind the availability of parts and service/maintenance.
- Evaluate it before purchase; visit another facility that has the same item.
- Can it easily be cleaned?
- Is training of personnel included in the cost?
- Is the space sufficient to house the equipment?
- Does it comply with national regulations/codes?

The health services manager can play an important role in acquiring cost-effective equipment, as knowledge of these points will create the opportunity to identify functional and safe equipment.

It is necessary to liaise with the engineering department in the case of equipment that needs to be professionally installed to ensure that the installation costs are included in the estimate (Spitzer-Lehmann, 1994:486).

Depending on the institution's policy, all representatives from companies should report to the purchasing department, hospital manager or unit manager before visiting the different units to obtain permission to display their products. Before new products are ordered, it may be necessary to have them approved by a standardisation committee. A purchase order number is necessary to order any item and purchase orders must be filled in accurately (Spitzer-Lehmann, 1994:487).

## 7.7 Principles of supply chain management

The supply chain management systems should be integrated with the critical business and clinical functions within a healthcare service, by employing best practices. Certain overall principles to follow in supply chain management are:

- To ensure that billing is accurate and complete.
- To ensure that rebates are captured (Dudas, 2010/2011).

- IT systems should support maximum flexibility putting the emphasis on barcoding to streamline processes.

- Try to manage the utilisation of an item at the floor level, at the point where the user – the nurse, is basically documenting the use of that item.

- Nurses should take a hard look at their own utilisation patterns of items to reduce stock on the shelves and thus overall reduction in the inventory sitting on the floor.

- Nurses should have a strong value analysis process and use the best, most efficient and most effective products (McNickle, 2012). Product evaluation, selection and supplier relations management are essential.

- Understand why a supply chain strategic plan is essential and know how to communicate with senior executives about supply chain performance.

## 7.8 Summary

The health services manager has an important role to play in the control and supervision of facilities, equipment and supplies to ensure cost-effectiveness. Evaluating new equipment and products plays an important role in determining cost-effectiveness. The most cost-effective approach in organising resources is the 'bottom-up' approach, where healthcare professionals in the unit are involved in the budgeting and control of resources. This way, supervisors and subordinates alike have a thorough understanding of the needs of the department. Managers at lower levels can provide input to substantiate the proposals for supplies and, at the same time, be more motivated to accept the budget. The morale and satisfaction of healthcare professionals improve if they feel that they have actively participated in making decisions that affect their service.

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# 8

# Human Resources Management

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## Chapter Outcomes

After studying this chapter, you should be able to:

- recruit and retain staff, interview, select and place successful candidates based on established job descriptions;
- select appropriate activities to be included in the induction and orientation programmes;
- implement a succession plan;
- establish staffing standards and scheduling for staff;
- discuss absenteeism and the steps that can be taken to reduce it;
- describe cultural diversity factors that may be a source of conflict;
- discuss the creation of a culturally sensitive environment through management and leadership skills;
- describe culture competency skills to resolve conflict in a cultural diverse work environment;
- discuss types, causes, managing and resolving conflict in the work environment;
- describe how effective industrial relations can be maintained by use of the grievance procedure, disciplinary processes and disciplinary counselling to deal with unsatisfactory employee behaviour.

## 8.1 Introduction

Human resources (HR) management is the most important and challenging function of management because the outcomes of a unit or organisation depend largely on the staff. The main concern when examining a healthcare organisation's staffing efficiency is to determine how the manager recruits, selects, places, inducts, orientates and retains healthcare professionals to accomplish the goals of the organisation. This chapter discusses employee selection, interviews, succession plans, job descriptions, performance management, employee wellness programmes, absenteeism, staff motivation, cultural diversity in the work place, conflict management and industrial relations.

Staffing and scheduling are major components of nursing management, so the nursing division needs a practical, written philosophy that guides staffing and scheduling activities; this philosophy should preferably be acceptable to the healthcare professionals. Absenteeism is one of the major factors that impacts negatively on the productivity of a unit or organisation, as the goals of the institution cannot be reached if healthcare professionals are not on duty to perform their tasks and responsibilities.

South Africa's multicultural environment poses a challenge for the health services manager, as healthcare professionals of different cultures have to work

harder to form a team, owing to their numerous differences in values, norms and behaviours. Conflict is inherent in all human relationships and can therefore serve as a change agent. Conflict can, however, have a severely demoralising impact on the affected parties if it is not dealt with appropriately. Healthy industrial relations can be promoted by effectively implementing procedures such as performance appraisals, or by managing undesirable behaviour through counselling or positive discipline of employees.

## 8.2 Recruitment and retention

Recruitment is the process of actively seeking out or attracting applicants for existing positions, which is an ongoing process. For an organisation to achieve its goals and objectives, it needs to attract applicants of a suitable quality. Wise nurse leaders do well by surrounding themselves with other nurses of ability, motivation and wisdom. Although non-monetary conditions of service are important for the successful recruitment and retention of quality performers, it is essential to offer a fair, competitive wage and benefits (Marquis & Huston, 2011:329–330).

Recruitment is expensive because of the cost of advertising for and interviewing temporary replacements for lost employees, lost productivity and the cost of training time to bring new employees to the desired level of efficiencies and competencies. One of the best ways to maintain an adequate pool of staff is by word of mouth.

There is, however, a link between recruitment and retention: the closer the fit between what the nurse is seeking in employment, and what the organisation offers, the greater the chance that the nurse will be retained (Marquis & Huston, 2011:329–330). Retention is the best way to ensure adequate staffing in the long term. Excessive turnover is undesirable and expensive, as it reduces the institution's ability to provide excellent patient care. However, some turnover may be desirable as it provides an opportunity to hire people with fresh ideas and positive contributions.

### 8.2.1 Employment selection interview

Marquis and Huston (2011:331) define an interview as a verbal interaction between individuals for a particular purpose. It is conceived as purposeful conversation. A selection interview is conducted before employment and is utilised to collect and share information about the applicant. The interview is frequently accepted as the foundation for hiring, despite its well-known limitations in terms of reliability and validity (Marquis & Huston, 2011:331).

According to Rigolosi (2013:329), the hiring interview is often used to:
- ascertain whether the applicant has the required behaviours to occupy the position to be filled
- sell the job to the applicant
- describe fully to the applicant what the job entails

- ensure that the applicant's career, enthusiasm and commitment fits the position
- answer questions from the applicant.

Marquis and Huston (2011:331) add that the selection interview is conducted to:
- seek to obtain enough information to determine the applicant's suitability for the position
- allow the applicant to obtain adequate information to make an intelligent decision about accepting the job, should it be offered
- present the institution in a positive light so that regardless of the interview's results, the applicant should have respect for the organisation.

The present selection process demands that interviews be conducted by a panel of interviewers. The interview panel should be aware of policies and legal implications on the type of questions asked in an interview, because legal action is possible for unlawful employment practices. Interview questions should not include asking about marital status, children, race, sexual orientation, financial or credit status, national origin or religion. Nurse leaders involved with recruitment and selection processes need to work closely and consistently with personnel departments to make sure that they operate according to current regulations. Updated policies, protocols, guidelines and procedures in this regard must be readily available (Marquis & Huston, 2011:337; Rigolosi, 2013:329).

## 8.2.2 Selection

Selection is defined by Marquis and Huston (2011:340) as a process of choosing from among applicants the most suitable candidate for a particular position. It takes place after applicants have been recruited, completed their applications and been screened. Screening or pre-interviewing involves verifying the applicant's submitted qualifications and work history and conducting reference checks. According to Marquis and Huston (2011:340–342), the selection process is as follows:

1. Screen applications: verify qualifications and conduct reference checks.

2. Conduct employment interviews.

3. Applicants undergo physical examinations (if appropriate).

4. The employer makes the selection.

5. Notify applicants.

A decision to hire is made based on a good match between the applicant's qualifications and the job requirements or organisation's expectations. The following aspects should be considered to determine that match: educational requirements and the applicant's credentials, the outcome of reference checks, results of pre- or post-employment testing, and physical examination, if this is appropriate.

### Educational requirements

The candidate's academic and professional credentials should be checked to determine if they are a match for the job requirements. Nursing experience can be substituted for some preferred academic qualifications to avoid losing applicants who would benefit the organisation.

### Reference checks

It is important that the candidate's academic qualifications are verified to ascertain if the applicant is qualified for the position. References should be requested and employment history and work experience be verified. A position should not be offered until information provided by the applicant has been verified and references have been checked. Companies exist that specialise in this. This exercise has potential for disputes later on and should therefore be done meticulously.

### Pre- or post-employment testing

Very few healthcare organisations do pre-employment testing because of lawsuits resulting from improper interpretation and implementation of recruitment policies and labour law stipulations on equal employment opportunities. Some healthcare organisations may use post-employment tests to determine learning or skills needs for the future development of the service.

### Physical examination

Only applicants who have been selected for hire may be required to have a physical examination. An examination is often required for selection as a record of the physical condition of the applicant at the time of hiring. The exercise might form part of the medical pre-employment surveillance. This helps the organisation to be aware of the candidate's health needs, possible impact on attendance at work, the candidate's placement and rotation needs, as well as any future claims on the organisation's health insurance. This stage may also be used to introduce the prospective employee to the employee wellness programme.

### Making the selection

The same standards must be used to evaluate all applicants. The final selection must be based on established criteria and not on the value judgements or personal preferences of the interviewer. Both external and internal applicants should be interviewed in the same way; however, some organisations may give priority to existing employees. Organisations should follow their own policies and guidelines on transfers, promotions and retirement.

The selection process should be as objective as possible due to far-reaching consequences of such decisions (Marquis & Huston, 2011:340–342; Roussel, 2013:319–320).

## *Finalising the selection*

Once a final selection has been made, the pre-employment process should be closed as follows:

- All applicants who were invited for the selection process should be thanked for applying and informed when they will be notified about the outcome of the process.

- Applicants who were not offered a position should be notified, with reasons where appropriate (for example insufficient education, work experience or high competition from other candidates).

- Successful applicants must be informed in writing, including details such as salary, working conditions and benefits.

- Successful applicants should be requested to confirm in writing their intention to accept the offer.

- Applicants who accept the job offer should be informed of pre-employment procedures and the date to report for work.

## 8.2.3 Placement

Many positions within a unit require different skills and abilities. Appropriate placement is important for the success of the organisation and that of the new employee. Faulty placement may lead to reduced organisational efficiency and effectiveness, increased attrition, threats to organisational integrity and image, as well as frustration for all those involved. However, proper placement brings organisational gains such as personal growth, maximises productivity, provides a motivating climate for employees and increases the probability of the organisation meeting its goals and objectives (Marquis & Huston, 2011:340–344). Aspects to be considered when placement is done include organisational needs, as well as purpose and objectives; the employee's preferences, health, skills and job description. The placements should not be different from the advertised key performance areas (KPAs).

## 8.2.4 Induction

Induction is a planned process of providing guided adjustment of a new employee to an organisation and work environment (Marquis & Huston, 2011:346–347). It takes place after a candidate has been selected but before the candidate assumes a job role and may be included with orientation activities. This process occurs to educate and inform a new employee about the organisation, the job requirements as well as personnel policies and procedures.

Information on working conditions, institutional recognition of good performance, wellness programmes and recreation facilities should be communicated to employees during the induction process. This information may be compiled into a handbook, file or placed on a website developed by the personnel department. Unit managers should be familiar with the content of this handbook or website and make input into its development. Employees

might not read all the information in the handbook at once, but may use it later for reference. The information must be followed up with discussions between the new recruits and various people such as the first level manager, personnel managers and staff development personnel (Marquis & Huston, 2011:346–347).

## 8.2.5 Staff orientation

Following placement and induction, staff members are orientated. Staff orientation is a planned introduction of employees into their workplace, the jobs they are required to perform and to their co-workers. In some healthcare organisations, this may be done concurrently with induction which may need to be well planned and co-ordinated to achieve pre-set goals. Induction provides the employee with general information about the organisation but orientation activities are more specific to the position. Both induction and orientation activities seeks to help employees by providing them with information that will smooth their transition into the new work setting and healthcare team (Marquis & Huston, 2011:347–348).

New employees are orientated to the unit policy and procedure manuals, training and development opportunities, organisational vision and mission, performance management and development strategy (PMDS), the generic standards of patient care, the national core standards of care, the department's six priority areas, leave and other benefits, ethics of care and professional behaviour. During the orientation process, new employees should be encouraged to be active through asking questions whenever they do not understand and appropriate mentors should be assigned to them (Marquis & Huston, 2011:347; Roussel, 2013:786).

### *Responsibilities for orientation*

Organisations usually have varied orientation programmes, but the first phase may be a first-day orientation conducted by the hospital's personnel department. This may include a tour of the hospital. The second phase of orientation would take place in the staff development department, and the third phase would be the individual orientation in the unit.

- *Personnel or human resources (HR) department*: Performs salary and payroll functions, insurance forms, physical examinations, tour of the organisation, labour management and union relationships with management and benefits plan.

- *Staff development department*: Distributes and reviews the handbook on working conditions and discusses the organisation's vision, mission statement, philosophy and objectives. The staff development department also discusses the history of the organisation, its organisational structure, fire and safety programmes, disaster care plan, available educational and training programmes and selected procedures and policies.

- *Individual unit*: Establishes a feeling of belonging, acceptance and sociali-sation. A tour of the unit would be conducted and the incumbent introduced

to all healthcare professionals and multidisciplinary team members. The unit would also review unit-specific policies that differ from the general organisational policies, the unit scheduling and work assignments. (Booyens, 2008:214–215).

## 8.2.6 Succession planning

Succession planning is a process for identifying and developing internal people with the potential to fill leadership positions in an organisation. Marquis and Huston (2011:243) define succession planning as a planned system of training and developing people so that they acquire the skills, insights, attitudes and values needed to manage people and their work effectively within an organisation. Furthermore, succession planning increases the availability of experienced and capable employees who are prepared to assume these roles as the positions become available. Through the succession planning process, employees with potential are identified and their knowledge, skills, and abilities developed to prepare them for advancement or promotion into more challenging roles. If succession planning is pursued, nurse leaders will ensure that these employees are developed to fill roles in middle and senior management.

Healthcare organisations may lose key employees through resignations, retirement or deaths. Nurse leaders need to train and develop healthcare professionals with potential so that these employees are equipped and ready to fill new roles as needed. This helps to ensure that the next generation of nurses is in place and ready to take over when necessary.

Because many nurses feel that they lack the knowledge and experience necessary to become a manager, this development process is particularly important and can help the nurse overcome her or his lack of confidence (Fitzpatrick, 2003:143; Marquis & Huston, 2011:243).

Research indicates that clear objectives are critical to establishing an effective succession plan. These objectives tend to be core to many or most organisations that have well-established practices; therefore:

• identify those with the potential to assume greater responsibility in the organisation

• provide critical development experiences to those who can move into key roles

• engage the leadership in supporting the development of high-potential leaders

• build a data base that can be used to make better staffing decisions for key jobs.

In other organisations these additional objectives may be embedded in the succession plans:

• Improve employee commitment and retention.

- Meet the career developmental needs and expectations of existing employees, as many of them feel that they lack the knowledge, skills, insight, experience and attitude necessary to become mangers (Marquis & Huston, 2011:253).

It is understood that replacement planning for key roles is the heart of succession planning. In contrast, replacement planning is focused on identifying specific back-up candidates for given senior management positions. A 'talent mindset' must be part of the leadership culture for these practices to be effective (Marquis & Huston, 2011:244).

Unit managers function at different levels of management, which helps the leadership to identify, develop and retain talent. Today's healthcare organisations are facing higher demands because of the many changes in the national healthcare system, combined with the retirement of many experienced nurse managers, contributing to a widening talent gap. Huston (2008:907) suggests that the skill sets needed by leader managers by the year 2020 will be even more complex and that organisations must begin now to create management development programmes to prepare the next generation of leader managers. Planting seeds of leadership excellence and management in staff members makes the succession plan a natural progression (Huston, 2008:906).

## 8.3 Job descriptions

A job description is defined by Muller, Bezuidenhout and Jooste (2011:264) as a written record of the principal duties and scope of responsibility for a particular job, and the required employee characteristics. Job descriptions are useful standards for guidance in establishing performance standards, performance appraisal and compensating factors (Muller et al, 2011:264).

The scope of practice provides a basis for developing job descriptions for the different nursing categories. Nursing categories in South Africa are defined in the Nursing Act 33 of 2005 as registered nurse, midwife, enrolled midwife, enrolled nurse and enrolled nursing assistant. The scope of practice directs nurses to assess their patients' needs, develop a care plan, implement the planned nursing care regimen, and evaluate and record the results of that care. This regulation provides broad guidelines which allow the expansion and development of the nurses' role in order to keep pace with technological advances in the healthcare field (Young, Van Niekerk & Mogotlane, 2004).

### 8.3.1 Uses of job description

Job descriptions are used:

- to assist with recruitment, selection, placement and induction
- to determine the content of orientation programmes
- to facilitate salary and wage administration and to determine appropriate level of employee compensation
- to provide information for job evaluation

- to provide guidance on behaviours to be measured in employee evaluation and performance appraisal
- to provide a basis for human resource planning
- as a legal document in times of litigation concerning the assignment of duties, or to substantiate claims for sex, age or race discrimination
- during times of strikes and disputes to decide which worker category should be included in the bargaining unit
- to help avoid duplication and overlap of duties of different categories by pointing where jobs interact, complement and supplement
- to contribute to maintaining the order of relationships that is to exist between employer, supervisor and employees (Muller et al, 2011:264–265).

## 8.3.2 Constructing a job description

Job descriptions should be written according to a standardised format. Each job description should include information on the job title, job code, a summary statement, reporting relationships, function, span of responsibility, tasks, resources, methods, job context, performance standards and employee requirements (Muller et al, 2011:265).

### Job title

Each job should be referred to by a single title, as is designated in the current Nursing Act 33 of 2005 (as Amended). The ideal title is brief and indicates the role to be played by an incumbent in that position. It describes the job range of responsibility and suggests the job's skill and hierarchical placement, for example, head nurse.

### Summary statement

The summary statement is a brief one-sentence statement of the job's purpose. An example of a summary statement of the head nurse could be: 'Directs, supervises and co-ordinates the planning, implementation, evaluation and recording of patient care provided by registered nurses in a unit.' The summary conveys an overall impression of the job's nature and scope. It should include a clear statement of responsibilities or KPAs and give an indication of the percentage of time devoted to each of them.

### Reporting relationships

Reporting relationships need to be clarified to place the job in relation to the organisation's organogram by indicating the position of the supervisor to whom the incumbent reports (Muller et al, 2011:265).

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## Job description example

Name of Hospital

**Identifying information**

    Position code: NU-0025

    Position title: Head nurse

    Department: Surgery

    Immediate supervisor: Divisional director

**Summary statement**

    Has a 24-hour, 7-day responsibility for managing personnel and material resources in the surgical unit to facilitate patient care, education of nurses, employee development and nursing research.

**Responsibilities**

    Responsibilities stated in terms of the elements of the nursing process and related activities.

**Job prerequisites**

    Nursing diploma or degree, relevant certification, two years' experience in surgical unit and one year's experience as a team leader or nursing care manager.

**Working conditions**

    Type of patients nursed, heterogeneous mixture of healthcare givers, physical environment in the unit.

**Job context**

    Includes the physical, emotional and psychological contexts in which the job is performed.

Source: Muller et al (2011:266)

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## 8.3.3 Job specifications

Job specifications are the personal qualities that an employee must possess to execute the job satisfactorily. This may include descriptions of knowledge, experience, skills, attitudes, energy, emotional intelligence and temperament (Muller et al, 2011:264).

Writing job descriptions enables managers to logically explain a job's duties, responsibilities and the working conditions so that an uninformed outsider can easily follow and understand the purpose and significance of the job.

## 8.4 Staffing standards and scheduling of staff

Scheduling staff or planning the duty roster is one of the unit manager's less satisfying duties. It is indeed difficult to get the balance right between covering the ward adequately and satisfying the staff's duty-hour preferences.

Shift work is classified as an occupational source of stress. Nevertheless, in a nursing unit, where patients are cared for 24 hours a day, seven days a week, it is inevitable that the nursing staff must work on a shift basis.

### 8.4.1 Compiling the schedule

Schedules are usually compiled for a predetermined block of time based on organisational policies and protocols, which could be weekly, biweekly or monthly. The unit schedule may be prepared in a decentralised fashion by unit leaders through a staff self-scheduling method (Yoder-Wise, 2011:286). Staff self-scheduling is defined by Kelly (2012:354) as a process of scheduling done by the unit staff themselves, which has the potential to promote staff autonomy and to increase staff accountability. Although the personal needs of staff are met, scheduling must be balanced with the unit's patient care needs to be successful. Scheduling may also be centralised, that is, executed by personnel in the central nursing office. Both approaches have their pros and cons.

Organisations have various mechanisms for staff to request days off and to know when the final schedule will be posted. Most organisations have written policies and procedures that must be followed to ensure compliance with labour law. These policies and procedures provide guidelines in making scheduling decisions that will be viewed as fair and equitable by all staff members (Yoder-Wise, 2011:286).

### 8.4.2 Variables to be considered when planning a unit schedule

There are a number of variables to be considered when developing a unit schedule plan, including the type of patients and acuity levels, the number of patients, the experience of the staff, support available to the staff and their duty-hour preferences (Kelly, 2012:350).

According to Yoder-Wise (2011:285–286), it is the task of the unit manager to see that the on- or off-duties of the nursing staff are arranged in such a manner that:

- Sufficient staff are available for patient care to be rendered for the whole 24-hour period.

- Provision is made for times of high intensity of work, for example, operation days and admission days.

- An equitable distribution of staff is available throughout the working week.

- There is an equitable distribution between senior and junior staff members, taking into account periods where more or fewer senior staff are needed.

- Sufficient staff are provided for periods when teaching or meetings are to take place, for example, during orientation and in-service education sessions, staff meetings and meetings with other members of the multidisciplinary team.

- Staff members' requests are accommodated as far as possible, taking into account patient care needs.

- Resting times for staff members are distributed in such a way that staff do not become chronically overworked.

- A trained nurse is in charge of each shift, as far as possible.

- Some form of continuity is provided, especially when the most senior staff members are returning after days off or from holidays.

- The coverage for weekends and public holidays is worked out, keeping in mind the expected workload, in order to achieve a cost-effective utilisation of staff.

- Days off are spaced together if possible and half days should follow on from each other, for example, an afternoon off followed by a morning off.

- Set days and duty hours for part-time staff are taken into account.

The duty roster must be planned well in advance, for example, at least five to seven days beforehand, in order to allow individual staff members time for arrangements for their personal and social obligations. A duty roster should preferably be available one month to two weeks prior to its inception; every staff member is allowed at least one weekend off per month.

The task of the unit manager regarding effective scheduling of the staff members assigned to a unit varies from time to time and from institution to institution. It is not easy to schedule staff's working hours in such a way that the unit is covered adequately and the preferences of all staff members are accommodated. There is a fairly wide variety of scheduling patterns that are used in different nursing units and healthcare services to ensure patient safety, some of which include flexi-time patterns and part-time employees.

According to Zhang, Unruh, Liu and Thomas (2006:76–80), minimum staffing is considered to be a measure below which quality is unacceptable, but above which quality continues to improve at the same rate as additional staffing. Such an approach to minimum nurse staffing looks at the staffing–quality relationship in absolute terms, and overlooks efficiency considerations of additional staffing.

Unit managers need to look at the minimum nurse staffing thresholds necessary to achieve both quality and efficiency in healthcare organisations. This efficiency-oriented concept identifies the staffing threshold at which the growth rate of the organisation's quality decreases — the starting point of the decline of a quality return on additional investment in staffing. The efficiency-oriented minimum nurse staffing is critical because it represents a joint point where quality and efficiency meet (Zhang et al, 2006:80).

### 8.4.3 Scheduling patterns

A 40-hour working week is the norm for full-time nursing staff in South African health services. The general hospital wards in South Africa and the comprehensive health services clinics usually work a mixture of six-hour, twelve-hour and eight-hour shifts in order to make up a forty-hour working week. Night staff usually work twelve-hour shifts, for example, seven nights on, seven nights off, or four nights on and three nights off, or three nights on and four nights off.

In the private health clinics, hospitals and services, a variety of duty hours are worked. When these hours are added, they should total 160 hours over a four-week period. Part-time nurses' working hours per week are often predetermined and their working shifts fixed, with the result that, when a duty roster is planned, the shifts worked by these staff members are filled in before the other duty hours can be added.

### 8.4.4 Hours per shift

There is a wide variety of hours per shift with which unit managers in different settings experiment, in order to satisfy their staff and unit needs. Although the eight-hour shift pattern is still used, the twelve-hour shift has become popular in South African health services. In this shift, a nurse can work three twelve-hour shifts per week and have four days off as a full-time employee. There are only two handoff reports per twenty-four hours in this shift. (A handoff report occurs when a nurse caring for a group of patients reports off to the nurse on an oncoming shift.)

Unit managers tend to tolerate this working pattern because the staff is satisfied with the working hours. The cost savings made from reduced absenteeism, sick-leave and reduced turnover are a powerful reason for allowing nurses to work shifts that cause as little disruption to their personal lives as possible. When implementing these schedules, it is also important to assess what the effect will be on the continuity of care for patients. Units must, however, shorten patient lengths of stay. When implementing scheduling plans, whether eight-hour shifts, twelve-hour shifts or other schedules, unit managers must ensure that there are always staff members scheduled who are familiar with the patients and the events that transpired previously (Kelly, 2012:351).

### 8.4.5 Flexi–time and part–time

Flexi-time schedules and part-time work, both on day duty and on night duty, have become a popular way of accommodating nurses' family lives. In some hospitals, the weekend night shifts are only worked by part-time nurses, while the permanent staff enjoy free weekends.

Part-time nurses can make a substantial contribution to a nursing service if they are orientated properly, kept up to date and if they are not moved frequently from one unit to another. A hospital or health service can only absorb a certain percentage of these part-time nurses, although there are institutions that rely on part-time staff for at least 50% of their staffing needs. It is worthwhile analysing

the work in every nursing unit at least annually to ascertain whether a greater proportion of part-time workers could be profitably employed. The prerequisites for the effective utilisation of part-time nurses are that they should:

- receive a proper orientation of the unit and of the health service
- be included in staff development programmes
- not be moved from unit to unit, but remain as a stable factor in the unit of their choice.

## *Advantages of flexi-time work schedules*

Flexi-time means that employees may come and go off duty as they please, within certain guidelines encompassing a set number of minimum hours at work, core days and good record keeping. Flexi-time has several advantages:

- Employees are able to adjust their working hours to suit their personal needs, with the result that when they arrive at work, they can concentrate more effectively on their work. This way, they don't need five or ten minutes every now and then for attending to personal matters.
- It has been shown statistically that absenteeism can be reduced by as much as 25% and productivity improved by 5% by introducing flexi-time.
- It has been found that, when people start work at different times of the day, no time is lost in discussing personal matters with others on the same shift.
- Flexi-time users often plan their working times to avoid travelling during peak traffic hours, with the result that they are more relaxed when they come on duty and can start working productively immediately (Kelly, 2012:352–353).

## *Controlling the flexi-time system*

According to Booyens (2008:187–188), there are a number of guidelines used in controlling the flexi-time system:

- *Core time* is the predetermined number of hours during which all staff assigned to a shift should be on duty.
- *Choice time* is the number of hours, excluding core time, during which an employee is either on or off duty, according to his or her needs and in accordance with the agreement reached with the employer.
- *Flexi-time* is the system in which a work day is divided into core time and choice time, and where the employee is allowed to begin and end the working day according to the hours most suitable to him or her, within certain predetermined limits.
- *Work day* is the total period, made up of core time plus choice time, during which the employee will be on duty and for which credit will be earned.
- *Credit* refers to the agreed upon number of hours that an employee may accumulate in a four-week period in excess of the total working hours, which may be carried forward to the next four-week period.

- *Debit* refers to the agreed number of hours by which an employee may be short in a four-week period and which have to be made up in the following four-week period.

## Steps in compiling a duty roster for a week

A duty roster does not happen by itself and a haphazard approach to its formulation may cause a lot of frustration due to the many corrections that will have to be made. The following steps are, therefore, recommended.

*Step 1:* Write down the names of the staff members in order of seniority on the duty roster form.

*Step 2:* Fill in the dates of the week at the top of the form.

*Step 3:* Note in pencil the days and the hours for special activities that must be taken into account, for example, orientation periods for new staff members, monthly sister's meeting, in-service education sessions, admission days, operation days, etc.

*Step 4:* Fill in the fixed duty hours and days off of the part-time staff and any other predetermined duty hours of staff.

*Step 5:* Consult the off-duty request book and fill in the requests for days off. Mark these with an asterisk as a reminder that, when a shuffling of days off becomes necessary, these should not be changed without prior consultation with the particular staff member.

*Step 6:* Consult the previous week's duty roster and fill in two days off (resting days) for each staff member.

   Where possible, the days off should be consecutive.

   Each staff member should have at least one weekend off per month.

   Days off should be reasonably spaced, taking into account the previous week's days off.

   Count the number of staff, multiply the number by 2 and divide the total by 7 to find out how many off-duty days must be planned for each day of the week. Use this as a general guideline for spacing the staff's off-duty days.

*Step 7:* Fill in the duty hours according to the institution's shift hours to ensure coverage, allow for the workload and take into consideration special activities.

*Step 8:* If it is not possible to grant all the requests of the nursing staff, the matter must be discussed with the particular staff members involved and an agreed alternative entered into the plan with their consent.

*Step 9:* Add the number of staff members on each shift and, if changes are necessary, they must now be made. It is important to remember that there must be a balance between senior and junior staff on each shift, there must be a senior nurse on duty to take charge and that the trained nurses must be evenly balanced (Matthews & Whelan, 1993:129).

*Step 10:* The completed duty roster must usually be signed by the area supervisor and then displayed for all the nursing staff to see.

## 8.5 Performance management

Performance management (PM) is a broad term described as a technology or science embedded in application methods for managing both behaviour and results, which are two critical elements of what is known as performance (Armstrong & Baron, 2005). Later, the definition was modified to acknowledge PM as a process by which organisations align their resources, systems and employees to strategic objectives and priorities to get better or optimum results and good performance (Muller et al, 2011:353–354). Performance management is viewed as an ongoing process of managing employees' performance by employing strategies such as ongoing coaching, setting goals together with employees, and providing them with leadership training (Marquis & Huston, 2011:585). PM includes activities which ensure that goals are consistently met in an effective and efficient way.

Literature shows that some experts in human resources management suggest that the annual performance appraisal should be eliminated and replaced by ongoing PM (Muller et al, 2011:353–354). Instead of the annual performance appraisal, the manager puts efforts into ongoing coaching, mutual goal setting and leadership training of subordinates. This method requires that the manager has regular meetings with the employee and spends scheduled face-to-face time discussing their roles in order to achieve annual organisational strategic goals.

Performance management is used most often in the workplace or where people interact with their environments. All employees are expected to reconcile personal goals with organisational goals and increase the productivity and profitability of an organisation using this process. Performance management is applied by organisations or a single department or unit inside an organisation, as well as by individual employees. Benefits may include a fair, equitable, consistent and rigorous approach to PM and continuous attention by management to employee performance and development to build a sustained culture of excellence (Armstrong & Baron, 2005).

### 8.5.1 Aspects of performance management

Performance management involves:

- planning work and setting expectations
- continuous monitoring
- developing the capacity to perform
- summarising the rating performance
- rewarding good performance.

### *Planning work and setting expectations*

Planning in PM means setting performance expectations and goals towards which individuals or groups channel their efforts. In an effective organisation, work is planned in advance. Getting employees involved in the planning process will help them understand the goals of the organisation, what needs to be done, why it needs to be done, and how well it should be done. This is closely related to the

management by objectives (MBO) method popularised by Peter Drucker in 1954 (Marquis & Huston, 2011:302), during which performance goals are established jointly between the manager and the employee.

The regulatory requirements for planning employees' performance include establishing the standards of their performance appraisal plans. Performance standards should be understandable, verifiable, equitable, measurable and achievable. Employees are then held responsible and accountable as individuals for work assignments and delegated duties. Employee performance plans should be flexible so that they can be adjusted for changing programme objectives, work requirements and crisis situations. When used effectively, these plans can be beneficial working documents that are discussed between the manager and employee, and not merely paperwork that is filed in a drawer and seen only when rating of records is required (Ivancevich, 2010:252; Rousell, 2013:653).

## Continuous monitoring

Monitoring means consistently evaluating performance against established standards and providing ongoing feedback to employees and work groups on their progress toward reaching their goals. In an effective organisation, assignments, projects and delegated duties are monitored continuously.

Monitoring performance includes conducting progress reviews with employees where their performance is compared against established standards. Ongoing monitoring provides the opportunity to check how well employees are meeting predetermined objectives and making changes to unrealistic or problematic standards. Monitoring performance continually helps both parties to identify unacceptable performance at any time during the appraisal period and gives the opportunity for assistance to address substandard performance rather than wait until the end of the period when summary rating levels are due (Ivancevich, 2010:252).

## Developing the capacity to perform

Development in this context means increasing the capacity to perform through training, learning new skills or higher levels of responsibility and improving work processes. In an effective organisation, employees' development needs are identified, evaluated and addressed. Carrying out the processes of performance management provides an excellent opportunity to identify these development needs. During the planning and monitoring of work, deficiencies in performance become evident and can be addressed. Providing employees with training and development opportunities encourages good performance, strengthens job-related skills and competencies and helps employees keep up with changes in the workplace, such as new technology. Areas for improving good performance also stand out, and action can be taken to help successful employees improve even further (Ivancevich, 2010:253).

## *Summarising rating performance*

Rating means evaluating employee or group performance against standards in an employee's performance plan and assigning a summary evaluation of quality, standard or performance record. From time to time, organisations find it useful to summarise employee performance because they need to know who their best performers are. This can be helpful for looking at and comparing performance over time or between various employees.

Within the context of formal performance appraisal requirements, the rating of record is assigned according to procedures included in the organisation's appraisal programme. It is based on work performed during an entire appraisal period. Although group performance may have an impact on an employee's summary rating, a rating of record is assigned only to an individual's achievement of own objectives and not to a group (Milkovich& Newman, 2005:264).

## *Rewarding good performance*

Rewarding good performance, according to Milkovich and Newman (2005:263), means recognising employees individually and as members of groups for their performance and acknowledging their contributions to the organisation's achievement of goals. A basic principle of effective performance management is that all behaviour is controlled by its consequences. Those consequences can be formal or informal and both positive and negative. In an effective organisation, rewards are used well to motivate staff for improved performance.

Good performance should be recognised without waiting for formal awards to be solicited. It should be an ongoing part of day-to-day experience. A lot of the actions that reward good performance, such as saying thank you, do not require formal structures. However, more formal rewards for a variety of contributions can take forms such as cash, bonus, time off and many non-monetary items (Milkovich & Newman, 2005:263).

# 8.6 Employee wellness programmes

An employee wellness programme is a plan implemented at some institutions, designed to care for the health of employees, lower staff costs and improve productivity. Some organisations have on-site gyms, staff education sessions and carefully selected food choices in staff canteens.

Some of the benefits of an effective employee wellness programme include reduced costs of absenteeism related to illness, greater productivity and improved staff morale.

# 8.7 Absenteeism

Absenteeism is defined by Booyens (2008:189) as any time away from work. In order to ensure that the required number of employees in the desired categories and skills mix report for duty each day, the health services manager must regulate employee hiring, allocation and attendance. When designing jobs and managing

employee activities, an effective manager should maintain a work environment that is attractive enough to retain productive employees and disciplined enough to remove unproductive employees. The institution's productivity and profitability will suffer unless every manager reduces employee absenteeism and turnover to manageable levels.

## 8.7.1 Types of absenteeism

There are two types of absenteeism, based on the work of Booyens (2008:189), it is namely unavoidable (legitimate) and voluntary (illegitimate) absenteeism. The cause may be legitimate, such as illness or a crisis at home, or it could be feigned, meaning that it is reported as legitimate, but is in reality just an excuse not to come to work. High absenteeism may also be a symptom of other problems, such as job dissatisfaction, tension at work and low morale. Irrespective of the reason, absenteeism remains a costly and disruptive problem facing managers. There are numerous causes of absenteeism, such as:

- family responsibilities
- holding down two jobs
- chronic illness
- long commuting distances
- low self-esteem and confidence
- low morale and demotivation
- strained work relationships
- conflict with colleagues
- monotonous job tasks
- insufficient job autonomy
- burnout
- alcohol and drug abuse (Booyens, 2008:189).

## 8.7.2 Effects of absenteeism

According to Booyens (2008:361), absenteeism can be a major problem for organisations. As pressure increases on the budgets and for competitiveness, more attention needs to be given to reducing workplace absenteeism and its costs. A high rate of absenteeism is costly in terms of institutional expenditure and staff morale. When a person is absent, it affects the workflow as it requires schedules to be modified, or it means the work does not get done. Alternatively, a substitute person must be employed, which is not only costly, but also carries risks associated with hiring someone who may be unfamiliar with the work environment and routines of the unit or division.

Studies have shown that individual needs, relationships with co-workers and supervisors, working conditions, work policies and compensation affect the extent to which an individual is gratified or fulfilled in his or her work. A satisfied employee tends to be absent less often than a dissatisfied employee

(Muller et al, 2011:338). A dissatisfied employee may be absent often and may experience stress, which disrupts co-workers. The key concern of organisations is to minimise feigned absenteeism and reduce legitimate absences.

### 8.7.3 Calculating absenteeism

Common methods used to quantify absenteeism are the time lost percentage and absence frequency rate. According to Booyens (2008:190), these figures are calculated as follows:

| | |
|---|---|
| **Time lost percentage** $=$ $\dfrac{\text{Number of days lost}}{\text{Number of potential work days}}$ | $\times\,100 =$ percentage of time lost |
| **Absence frequency rate** $=$ $\dfrac{\text{Total episodes of absence per year}}{\text{Average number of employees for the year}}$ | $\times\,100 =$ yearly absence frequency rate |

In order to take the appropriate action based on solid statistics, the unit manager can calculate the percentage of time lost due to employees who absent themselves frequently from their work commitments. It is a fact that approximately 20% of employees are responsible for 80% of an institution's absenteeism. Absenteeism can be classified in terms of amount, frequency and pattern of time loss. Some employees may have frequent short-term absences. Others demonstrate predictably higher rates of absenteeism in conjunction with weekends, holidays, vacation periods or pay days.

### 8.7.4 Methods of reducing absenteeism

Several methods have been used to combat absenteeism, with varying degrees of success. Booyens (2008:191) suggests the following actions:

- Keep accurate records of employee attendance and calculate absenteeism rates at regular intervals to identify each employee's pattern of attendance.

- Any employee with excessive absences should be counselled by his or her supervisor to discover the causes and eliminate them where possible.

- The manager should establish a formal call-in procedure that requires an employee to speak directly to the immediate supervisor when reporting that he or she will be absent from work.

- The supervisor should be required to document the telephone call in writing and the employee should be required to report to the supervisor on returning to work and sign the telephone call record.

- Require employees to submit a doctor's certificate documenting the medical basis for one-, two- and three-day absences. The Basic Conditions of Employment Act 75 of 1997 states that an employee has to produce a medical certificate from a person registered by a professional council in order to get

paid sick leave. The decision to disclose an illness, however, lies with the employee (Nel, Swanepoel, Kirsten, Erasmus & Tsabadi, 2005:321).

- An occupational health nurse could be assigned to contact each employee who missed work because of illness. The nurse should be responsible for assessing the employee's health needs, making a nursing diagnosis, providing nursing care, giving health teaching and securing medical attention if needed.

- Provide free health-promotion programmes or healthcare to employees by means of a local occupational health clinic, so that those who are unable to pay for a doctor's visit or have to wait days for an appointment can be assisted immediately.

- A safety and accident-prevention programme can reduce absenteeism by reducing the number and severity of work-related injuries.

- Managers should improve those aspects of the work environment and work design that are known to reduce employees' work motivation.

- Allowing participation in decision making and autonomy improves work morale and employees' self-esteem.

- Managers should acknowledge strained relationships in the work environment and constructively work towards resolving conflict and serious differences.

- Introducing flexible work hours and staffing schedules will reduce absenteeism because employees can more easily arrange time off for personal commitments and make more satisfactory arrangements for the care of dependents.

- Provide on-site day care and sick day facilities for children of hospital employees.

- When all else fails, disciplinary action should be taken. Effective discipline requires that tardiness and absenteeism be documented and counselling should take place as the first step to progressive disciplinary action.

Since high staff turnover and absenteeism have been linked to job dissatisfaction – and both are costly to the organisation – managers should seek to create work environments that promote employee job satisfaction. Certain organisational processes, such as shared governance, participative management, quality circles and professional autonomy are known to promote job satisfaction and could, therefore, help reduce levels of absenteeism.

## 8.8 Cultural diversity in the workplace

Multicultural diversity is a fact of life in today's organisations (Daft, 2005:313). Today, healthcare organisations welcome cultural differences as a result of significant changes in the political world, society in general and in the workforce itself. Healthcare workers may find themselves working with people of a culture that is entirely new and unfamiliar to them. At times, they may find themselves to be part of the mainstream culture, at others, part of the minority culture,

which is generally more uncomfortable and often a source of stress. Monareng (in Jooste, 2009:188) points out that people prefer to work with people of the same race, gender, ethnic group and education.

It is vital for those in management and leadership positions to acquire multicultural leadership skills in order to create a work environment that is sensitive to different cultures. Monareng (in Jooste, 2009:188–189) laments that never before has there been such a need for culturally sensitive managers and leaders to deal with the challenges that prevent organisations achieving high levels of awareness and appreciation of cultural diversity.

## 8.8.1 What is cultural diversity?

The term 'cultural diversity' refers to the differences between people along dimensions such as – among others – age, race, ethnicity, religion, gender and home language. Cultural diversity is an acceptance of the unique customs, norms, patterns of behaviour, world views and traditions of many groups of people (Jooste, 2009:186).

Cultural diversity is said to include both primary and secondary dimensions. Primary dimensions are inborn differences that have an impact throughout one's life, such as race, age, sexual orientation, gender, ethnicity and mental and physical abilities. These dimensions are core elements through which people shape their self-image and world view. Secondary dimensions can be acquired or changed throughout one's lifetime. They tend to affect a person's self-definition, world view and how the person is viewed by others. Secondary dimensions also include home language, income, education, work experience, geographical location, marital status and communication style (Daft, 2005:558; Jooste, 2009:187).

It is important to remember that cultural diversity includes everyone, not only racial or ethnic minorities. The culture and climate within the work environment should be such that each healthcare professional's culture has equal value and importance. According to Marriner-Tomey (2000:160), cultural diversity can affect an individual's values, attitudes, perceptions of self, of others, quality of performance and opportunities in the workplace.

### The implications of cultural diversity in the workplace

Cultural differences in an organisation affect the internal leadership and cannot be ignored. Culture forms the backdrop for the ways in which people think, feel, speak and act, particularly in the workplace. Individuals who belong to the same cultural group are not necessarily the same even though they share common traits and agree upon certain values (Booyens, 2008:200).

## 8.8.2 Cultural factors

Cultural differences manifest themselves through factors such as time orientation, authority, physical space and religion, among others (Booyens, 2008:197–198).

## Attitudes towards time

People from urban cultures tend to follow rigid time schedules, while those from rural cultures tend to be less concerned with timekeeping. This can lead to conflicts and negative attitudes or stereotyping. Research about cultural factors and the implementation of ergonomics in developing countries found that time was the most significant factor, among factors such as language, communication, religious beliefs, education and ethnicity values (Strydom, 2000:iii).

Arriving on duty late or regular absenteeism from work, citing the reason as a different time orientation to that of the mainstream values, are unacceptable practices for most organisations. Colleagues from a Western cultural orientation who are punctual may find it difficult to accept the perpetual lateness of colleagues who may belong to an African cultural orientation, where time is viewed to be flexible and inexact. Adherence to organisational policies regarding duty times and absenteeism should be observed to minimise these irregularities (Booyens, 2008:197).

## Authority

Cultural differences may also impact the advancement to higher positions or opportunities for promotions and status symbols. Minority leaders often struggle to delegate authority and responsibilities to people who show them little respect. Those who are part of the majority culture should show respect and consideration for others who belong to the minority cultural groups.

## Physical space

In some cultures, the physical size of an employee's workspace is a status symbol, for example, the size or location of an office; in other cultures, location or space may not be significant.

## Religion

Religion is the means by which humans express their spirituality in a framework of beliefs, values and attitudes, often actively pursued in rituals, religious practices and reading sacred texts. It includes philosophical attitudes towards life (Booyens, 2008:198). Religious practices that may create problems include opening business meetings with a prayer or praying for patients and reading sacred texts as part of patient care. Opening meetings with prayer often makes some people feel extremely uncomfortable and saying prayers for patients is generally delegated to religious leaders or agents. Some healthcare professionals regard religion as a private matter and may feel uncomfortable to experience it at work (Monareng, 2013:1).

## 8.8.3 The need for an awareness of cultural diversity

There has been a dramatic change in the composition of the workforce and patients in the South African healthcare context in terms of national origin as well as age, race, gender, sexual orientation and mental and physical ability. It

has become imperative for organisations to recruit a wider range of staff members whose brain power and culturally diverse ideas meet the needs of culturally diverse patients. Attitudes towards cultural differences are gradually changing. The labour pool is also becoming more diverse. Healthcare professionals who come from different geographic locations, ethnic groups, race and religions work together in both public and private institutions. Women are taking up more senior positions than before and immigrants are entering the workforce in great numbers as more skilled South African trained nurses are leaving the country (Diller, 2007:9–10). The advent of the HIV/AIDS epidemic, which can affect the physical or mental ability of current or potential employees, compounds the scene.

Culture plays an important role in determining the conditions of service for healthcare professionals, retaining them in their jobs and in improving the quality of patient care services provided. Strydom (2000:iv) is of the opinion that more than one cultural group in an organisation produces a rich environment, with different viewpoints and, if understood, can increase productivity.

## 8.8.4 Benefits of a culturally diverse workforce

The benefits of cultural diversity are not automatic and working with, or relating to, people who are different from oneself can be very difficult and frustrating. However, a willingness to change and being more open to cultures other than one's own are benefits that can be derived from experiencing cultural diversity under the guidance of strong, culturally sensitive leadership (Booyens, 2008:198–199).

Consider the following points:

- When organisations support cultural diversity, people feel valued for what they can bring to the organisation and this leads to higher morale.
- Relationships among healthcare professionals may improve as they develop skills to understand and accept cultural differences (Booyens, 2008:198). The general rule is to treat others as you want them to treat you. This view is in line with the values of different faiths. It is hence necessary to develop a spirit of good neighbourliness in spite of diversities.
- The presence of people with different cultural values develops and increases organisational flexibility.
- Organisations can attract and retain the best available human talent if all cultural groups are targeted.
- The quality of management can improve if the different viewpoints are managed productively.
- Productivity can be enhanced if cultural differences are managed well.
- A contribution to social responsibility can be made.

In organisations where cultural diversity is used to bring forth a broader base for decision making and problem solving, effectiveness and innovation may be enhanced (Marriner-Tomey, 2000:268).

## 8.8.5 Challenges to achieving a high level of cultural diversity awareness

Leaders need to be prepared and empowered to deal with multiculturalism in a positive way. Increased cultural diversity can lead to tensions, lowered work performance, 'we' and 'you' attitudes and, consequently, lowered morale.

Valuing cultural diversity in the workplace and enabling all healthcare professionals to develop their potential is not easy to achieve. Many leaders relate to people in an organisation as if everyone shares similar values, beliefs, motivations and attitudes about work and life in general. It is an assumption that is faulty even when dealing with people of the same cultural background (Booyens, 2008:198–200; Jooste, 2009:188). Below are some of the challenges as outlined by Tjale and De Villiers (2004:210–213).

### Ethnocentrism

This is the belief that one's culture and subculture are inherently superior to others – a tendency of many people. Booyens (2008:199) adds that ethnocentric viewpoints combined with a standard set of cultural assumptions and practices create a number of challenges for minority employees and leaders, which can lead to conflict.

### Stereotypes and prejudices

Stereotypes and prejudices are mentioned by Booyens (2008:199) as two of the biggest challenges and obstacles in providing equal opportunities for women and minorities at work. Stereotyping implies that people belonging to the same group, race or gender are all the same in terms of nature, values and capabilities. Prejudice can be defined as the tendency to view people who are different from the mainstream culture as deficient. Prejudice is an assumption that minorities are inherently inferior, less competent at their jobs and less suitable for leadership positions. Prejudice is the most serious challenge to valuing cultural diversity in the workplace.

### Opportunities for advancement

Opportunities for advancement in organisations favour people who fit well into the mainstream culture.

### Viewing cultural difference as a deficiency or incompetence

Yoder-Wise (2007:155) laments the fact that women and minorities in the workplace – no matter how many academic degrees they have, how many hours they work, how well they dress or express themselves or how much effort and enthusiasm they invest – are never perceived as being the 'right' employees. This is especially so if the standard of quality is based on being white, black, male or female. This issue is often difficult to handle and leads to much conflict in the workplace. The offending parties are not always intentionally racist or sexist: such attitudes are deeply rooted in our society and organisations. Many affected

healthcare professionals feel extremely uncomfortable with the prevailing attitudes and do not know how to deal with or change them (Booyens, 2008:197).

## Cultural racism

According to Booyens (2008:200), cultural racism in the workplace often shows up in many subtle ways, such as a disregard or disrespect for co-workers or leaders who are culturally different. Such groups often struggle with biculturalism.

## Biculturalism

Biculturalism is defined by Hooijberg and DeTomaso (1996) as the sociocultural skills and attitudes used by racial minorities as they move back and forth between the dominant culture and their own ethnic or racial culture. Minorities in general feel less accepted in their organisations, perceive themselves to have less ability and discretion in their jobs, receive lower ratings on their performance and experience lower job satisfaction than their co-workers of the mainstream culture (Daft, 2005:312).

## Communication difficulties

Difficulties in communicating may derive from language, an inferiority complex or fear of ridicule, leading to misunderstandings, conflict and anxiety for leaders, healthcare professionals and patients alike (Karsten, 2006:6).

## 8.8.6 The role of management and leadership in building a culturally sensitive environment

Leaders in organisations may experience enormous challenges in relation to healthcare professionals who are from different cultures. The following management/leadership practices, as suggested by Marriner-Tomey (2000:268–269), can help organisations to accommodate and support cultural diversity more positively:

- Have a broad knowledge and understanding of the primary and secondary dimensions of diversity and an awareness of multicultural issues. Put such knowledge into practice by showing respect for people with cultural differences.

- Be willing and open to change for the better.

- Be open to all opinions and accessible to all workers across cultures.

- Recognise and value cultural diversity. Organisational leaders should be aware that each person can bring value and strengths to the workplace, based on their own unique combination of diverse characteristics.

- Learn how people of different cultures live, as well as their needs and challenges.

- Create organisational environments that support creative thinking and sharing of diverse views and ideas.

- Advocate cultural diversity awareness training as part of the HR development programme. This, according to Marriner-Tomey (2000:268), will help healthcare professionals become aware of their own cultural boundaries, prejudices and stereotypes so that they can learn to work together successfully. It will also assist healthcare professionals to build cultural awareness, control discrimination and reduce prejudice.

- Clearly written policies, equal support and fair allocation of resources for all employees can help reduce the risk of reverse discrimination, which occurs when a person of a particular ethnic group is chosen over someone else who has better credentials (Marriner-Tomey, 2000:268).

- Plummer (2003:287) is of the opinion that, for healthcare leaders to succeed, they should acknowledge and value cultural differences and understand how diversity affects organisational operations and outcomes, such as finances, productivity, work morale and quality of patient care.

Leaders need to do some introspection regarding their own view of cultural differences and change their leadership style, if necessary, to adapt to a model that is inclusive of all cultures. Cross, Basron, Dennis and Isaacs (1989), as cited by Diller (2007:18), suggest ways of improving the following basic skill areas necessary for effective cross-cultural management and leadership.

## *Awareness and acceptance of differences*

This is the first step in developing an awareness of the ways in which cultures differ and realising that these differences may affect working processes and relations. Cultural differences exist in values, styles of communication, modes of thinking, perceptions of time and the meaning of health. It is very difficult to accept cultural ways and values that are at odds with one's own norms. Somehow, what eventually emerges after creating awareness is the broadening of a perspective that acknowledges the co-existence of differing realities that do not require comparison or judgement. All exist in their own right and are different. These differences need to be valued for the richness in perspective and complexity they offer.

## *Self-awareness*

It is not easy to be aware of and appreciate the culture of others if one is out of touch with one's own cultural background. Self-awareness involves understanding how culture impacts on human behaviour. Cross et al (1989), as cited by Diller (2007:14), state that 'people never acknowledge how their day to day behaviours are shaped by cultural norms and values and to what extent they are reinforced by families, peers, friends and social institutions … '. The skill of self-awareness requires sufficient self-knowledge about one's cultural limits, potential areas of conflict and tension with specific groups or how to accommodate them. Pretorius (2002:iii), in the findings of his thesis, indicates that social work practitioners are not clear whether their cultural, ethnic or language backgrounds have an influence on their work. One of the recommendations in this study is that

education programmes should continuously stress the importance of cultural diversity and the development of skills so as to deliver culturally competent services in the workplace.

## Dynamics of differences

When two individuals from different cultures work together, there is a strong likelihood that, sooner or later, they will miscommunicate by misinterpreting or misjudging the behaviour of the other. Parties in such situations should be aware of the dynamics of differences, which involves knowing what can go wrong and how to set it right. These may be due to previous experiences with members of the other group or the nature of current racial politics between groups.

## Knowledge of others' culture

Cross et al (1989), as cited by Diller (2007:18), believe that it is critical for leaders to familiarise themselves with the subculture of healthcare professionals who are different, so that behaviour may be understood from its own cultural context. Interpreting the behaviour of someone who is culturally different without considering the context or the impact of ethnocentricity can be fraught with danger. Many serious mistakes can be avoided if only leaders would take the time to analyse behaviour or motivation by considering what it might mean within the context of that group. Leaders may not be able to know all the ways of cultures and subcultures; making an effort, however, to identify the required information and consulting cultural experts will help them.

## Adaptation of skills

The fifth skill area involves adapting and adjusting one's management and leadership style to accommodate cultural differences. Other aspects would be to deal with racism, resolving conflicts and clarifying issues of ethnic identity.

This approach, according to Diller (2007:19), will help organisations to survive and prosper in an increasingly diverse world. Thomas and Davis (in Karsten, 2006:70) argue that despite the availability of cultural awareness training programmes, practices, diversity consultants and policies, many organisations still lack guidance regarding best practices on cultural diversity management and leadership. The persistent, escalating costs of defending organisations against allegations of sexual harassment and discrimination and the subsequent settlement costs demonstrate that organisations are still struggling with issues of diversity and inclusion. Common best practices emerged across the theme of culture-sensitive leadership. Cultural differences can cause serious problems in the workplace if ignored. Many organisations are aware of this but take too long to respond or do something about it. All healthcare professionals want to be accommodated and their own cultures and background accepted. Monareng (in Jooste, 2009:198) asserts that healthcare organisations particularly should manage the myths, prejudices and stereotypes regarding minorities in the workplace. The effort and commitment of all involved are needed to transform organisations into truly multicultural organisations. As the popularity of cultural

diversity is growing, there is hope that more research and cultural best practices will occur across all areas of organisational life, as they affect every area of an increasingly diverse workforce (Thomas & Davis in Karsten, 2006:81).

# 8.9 Conflict

Conflict is part of everyday life. A conflict exists when two or more parties (individuals, groups or organisations) differ over facts, opinions, beliefs, feelings, drives, needs, desires, goals, methods and values. In fact, virtually anything can be the source of conflict (Bach & Ellis, 2011:57). Conflict is more likely to arise as a response to an individual perception or understanding of a situation. It produces a feeling of tension and people wish to do something to relieve the discomfort that results from this tension (Bach & Ellis, 2011:57). Daft (2005:410) defines conflict as a hostile or antagonistic interaction in which one party attempts to thwart the intentions or goals of another. Smit and Cronjé (2002:381) define it as an interaction of interdependent people who perceive opposition of goals, aims and values and who see the other party as potentially interfering with the realisation of these goals.

For any organisation to be effective and efficient in achieving its goals, the people in the organisation need to have a shared vision of what they are trying to achieve, as well as clear objectives for each department, unit, team and individual. Ways of recognising and resolving conflict among people should be formalised so that conflict does not become so serious that co-operation is impossible or that it leads to violence. For all team leaders and unit managers, no skill is more important than managing the conflicts that will invariably arise. Conflict management is the process of planning to avoid conflict where possible and organising to resolve conflict when it does happen as rapidly and smoothly as possible (Bach & Ellis, 2011:57).

## 8.9.1 Types of conflict

According to Booyens (2008:192–193), conflict can be divided into four types and each requires different methods of resolution.

### Intrapersonal conflict

Conflict may be intrapersonal (within the person) as a result of having to make a choice between two things of generally equal value, when one is not living according to one's own values and norms, when values and perspectives are threatened, due to discomfort from fear of the unknown, or due to lack of fulfilment.

### Interpersonal conflict

Interpersonal conflict arises between two individuals. This is the most frequent type, as people constantly interact and are likely to differ over opinions, goals and values.

## *Intergroup conflict*

Intergroup conflicts can occur between groups. Regardless of the size of the groups involved, intergroup conflicts have certain predictable consequences. Within each group, cohesiveness increases, members become more task oriented collectively and less concerned with individual needs. Group leadership tends to become more autocratic and the groups are highly structured so that a unified front will be presented to the opposition

## *Personal–group conflict*

Conflicts between an individual and a group occur when the individual is at odds with the group. An example could be a nurse who does not do or submit expected work when it is due and thus affects the performance of the rest of the group. (Booyens, 2008:192–193).

## 8.9.2 Causes of conflict at work

Competition usually brings out the best in people, as they strive to be at the top of their field, be it sport, community affairs, politics or work. When competition becomes unfriendly or bitter, however, a conflict situation may arise and this can bring out the worst in people. Causes or sources of conflict are many and manifold; the most common as postulated by Booyens (2008:193), however, are the following:

- *Scarcity of resources*, such as finance, equipment, facilities, information and supplies, resulting in stress.
- *Lack of clarity in roles and responsibilities*, resulting in uncertainties with regard to responsibilities, performance and accountability.
- *Personality clashes* due to different attitudes, values and perceptions, where strong personal natures do not match.
- *Unclear task responsibilities* pertaining to who does what and when.
- *Poor or unclear communication*, resulting in personnel not being informed about decisions and/or actions and being taken by surprise.
- *Poor or inadequate organisational structures*, such as unclear lines of authority and communication.
- *Lack of teamwork* due to disagreements between team members and unclear goals.
- *Leadership problems*, including lack of leadership or inconsistent, overbearing or uninformed leadership.
- *Inconsistent treatment of employees* during which favouritism, harshness and unfairness is evident and experienced.
- *Bullying, harassment and abuse* are noted to be among the major causes of conflict in the workplace. Bullying can take many forms such as staff bullying other staff, staff bullying patients, patients bullying staff and relatives and

visitors bullying staff. Gossiping about other employees, spreading false rumours and ridiculing another as well as being constantly rude and abusive all constitute bullying behaviour (Bach & Ellis, 2011:62).

The conflict situation becomes a problem when it:
- hampers productivity
- lowers morale and leads to despondency and a feeling of helplessness
- causes further, continued conflict
- causes inappropriate behaviours (Booyens, 2008:193–194).

### 8.9.3 Managing and resolving conflict

Conflict is not necessarily always bad, as it can lead to change and renewal, but it is important to manage every conflict situation in order to resolve issues causing discomfort and strained relations. One of the reasons that conflict management is important is that conflict may negatively influence the experiences of staff, patients and their families. Every nurse needs to try to prevent or resolve conflict. Much conflict can be prevented or reduced by practising open communication, trust and accountability. Nurse leaders need to think of treating nurses as people first and staff second, which can lead to increased levels of trust and reduce the potential for conflict (Bach & Ellis, 2011:58, 63).

A number of variables will affect the course and management of conflict. These include the personal characteristics of the parties involved; their values, beliefs, goals and resources; the previous relations between the parties, such as trust, respect and degree of attachment and the nature of the problem that has created the conflict (its size, complexity and significance must be considered). The environment, or setting, will determine the type of interaction; the audience who observe the conflict situation can aid or hinder its resolution. The strategies and tactics used by the parties will determine the outcome and, finally, the consequences of the conflict for both parties must be determined (Booyens, 2008:195).

### 8.9.4 Key managerial actions to minimise conflict

Booyens (2008:194) suggests the following proactive interventions by management to reduce the possibility of conflict situations arising:

- *Regularly review job descriptions*: Make sure to get the incumbents' inputs, state them in writing and date each revision. Ensure that job roles do not conflict and that no tasks are unallocated.

- *Intentionally build relationships with all subordinates*: Meet at least once a month with each healthcare professional; ask about accomplishments, challenges, performance needs and related issues.

- *Get regular, written status reports*: Include accomplishments, current issues and needs from management, as well as plans for upcoming events and periods.

- *Conduct basic training about interpersonal communications and relations, conflict management and delegation.*

- *Develop procedures for routine tasks and include healthcare professionals' input*: Have team members write procedures when possible and appropriate. Seek other healthcare professionals' review of the procedures, then distribute the procedures and train subordinates about them.

- *Hold regular management meetings:* During monthly meetings, new initiatives can be communicated and the status of current programmes discussed.

- *Consider an anonymous suggestion box*: This allows healthcare professionals to make suggestions about problem areas or good ideas that they may have to improve the functionality of the unit.

## 8.9.5 Ways to deal with conflict

There is no best way or style to deal with conflict; each method has its own strengths and limitations (Rigolosi, 2013:207). The type of approach to use to resolve conflict depends on the specific conflict situation and the parties involved. There are, however, a number of recognised conflict-resolution styles that serve to guide the approach. The leader in the conflict situation should adopt the best approach for handling the conflict by choosing the style needed to manage the situation effectively. The choice of an approach also depends on the nature of the conflict, who is involved, where it is taking place and whether the conflict is physical or verbal in nature.

Daft (2005:411–413) and Bach and Ellis (2011:64–65) propose that the way an individual approaches conflict is measured along two dimensions, namely assertiveness and co-operation, and explains the different styles as follows:

- *The avoiding or dodging style*, which reflects neither assertiveness nor co-operativeness. Avoidance is a technique whereby the leader avoids or dodges resolving the conflict, which is rarely effective. This style is appropriate only when an issue is trivial, when there is no chance of winning, when delay is needed to cool off or gather more information, when a disruption would be costly, or if the leader is too busy to deal with the issue.

- *The competing style*, which reflects assertiveness to get one's own way, should be used when quick, decisive action is vital on important issues or unpopular actions, such as during emergencies or when instituting urgent cost-cutting measures. A manager or leader recognises that competition can escalate some conflicts or may become physical in nature.

- *The compromising style* reflects a moderate amount of both assertiveness and co-operativeness. It is appropriate when the goals on both sides are equally important, when opponents have equal power and both sides want to split the difference, or when people need to arrive at a temporary or expedient solution under pressure of time. This approach can speed up the process of resolving a conflict.

- *The accommodating style* reflects a high degree of co-operativeness, which works best when people realise that they are wrong, when an issue is more important to others than oneself, when building 'social credits' that will be valuable in future situations, or when maintaining cohesiveness is especially important. However, Bach and Ellis (2011:65) argue that some people may see this approach as a sign of weakness and take advantage.

- *The collaborative style* reveals a high degree of both assertiveness and co-operativeness. This style enables both parties to win, although it may require substantial dialogue and negotiation. It provides a win–win solution. The collaborative style is important when both sets of concerns are too important to be compromised, when insights from different people need to be merged into an overall solution, or when commitment from both sides is needed for consensus.

Each approach can be successful, depending on the specific situation and the parties involved. It is worth mentioning that labour-related conflict resulting in disputes is usually dealt with by means of collective bargaining and negotiation, which includes the processes of conciliation, mediation and arbitration (Bach & Ellis, 2011:64–65; Booyens, 2008:195; Daft, 2005:411–413).

## 8.10 Industrial relations

South Africa's labour legislation is among the most progressive in the world, providing for institutions to settle disputes and ensure fairness in the workplace. Industrial relations (IR) encompass all aspects of the employment relationship between an employer and its unionised employees. It is also called labour relations or employee relations, although the latter term could signify relationships between an employer and its non-unionised employees. One of the most important ways of maintaining good labour relations is by establishing a formal grievance procedure (Muller et al, 2011:402).

### 8.10.1 Grievance procedure

A grievance procedure is defined by Muller et al (2011:402) as a formal expression of individual or collective employee dissatisfaction in respect of the application or lack of application of managerial policies, actions, customs or practices. A grievance pertains to any dissatisfaction with regard to matters which are directly related to the employment relationship. The formal (written) complaint moves from one level of authority to the next higher level. At the beginning of the employment relationship, the employer is expected to inform the employee about the grievance procedure and whom to contact to seek guidance on the resolution of a grievance related to work.

The purpose of the grievance procedure is to allow an employee or employees to bring to the attention of management any dissatisfaction or feeling of injustice which may exist in respect of the workplace. The institution will attempt to

resolve the grievance in a manner which is acceptable to both the employee(s) concerned and the institution. Preventing grievances is important to maintain a calm and productive environment (Muller et al, 2011:402–403).

## 8.10.2 Discipline

Unit managers can control their subordinates' behaviour by implementing the formal disciplinary process or procedures. They have the right to discipline subordinates by virtue of their position. The organisation's code of conduct and guidelines should be included in the employee handbook (Muller et al, 2011:403–404).

### *Employee code of conduct*

Employees need to be made aware of the organisation's rules and regulations with regard to employee behaviour at work. Behaviour rules should be well written in a clear and understandable language and appear in the handbook given to employees during induction. The code of conduct should be discussed between the unit supervisor and the new employee to explain the rationale for each rule. The following are examples of behaviours that require disciplinary action to be taken:

- absent from scheduled duty assignment without the manager's approval
- physical or verbal abuse of a patient, visitors or other employees
- giving confidential information about patients or the organisation to unauthorised persons
- use of patient's property or personal use of the organisation's property
- insubordination to authorised authority
- sleeping during duty hours
- coming on duty or being on duty under the influence of alcohol or unpre-scribed drugs
- carrying a weapon while on the organisation's premises (Muller et al, 2011:409).

### *Principles of effective discipline*

The purpose of imposing discipline should be to correct an incumbent on an undesirable behaviour, as an aversive conditioning and not as punishment.

- Discipline should be administered promptly, privately, thoughtfully, considerately and consistently.
- For severe offences, discipline should be progressive and be preceded by counselling.
  - At a first time incidence of breaking the rule or misconduct, take the incumbent for a friendly, informal talk privately and review the code of conduct together.

- On the second occasion of the violation of the conduct, the manager should give the nurse a verbal reprimand. This is a reminder that, should this behaviour be repeated, it will lead to steps of progressive discipline which may lead to suspension or termination of employment.

- If the nurse persists with the undesirable behaviour, the unit manager should administer a written warning and one copy must be filed in the incumbent's file. The written reprimand must include a clear description of the unacceptable behaviour and an explanation of consequences to be expected if the behaviour is repeated.

- If the nurse continues with the undesirable behaviour after all the steps of counselling and reprimands, the nurse should be suspended for several days or weeks.

- Finally, if efforts to correct, mould and improve the nurses' behaviour are unsuccessful, the nurse should be discharged (Muller et al, 2011:406–407).

- Before a verbal or written reprimand, suspension or even discharge is imposed, the manager should investigate the incident thoroughly to make sure that the organisation's rule or regulation has indeed been broken. The nurse must be informed of the rule, be made to realise that she/he violated the rule and that there were no extenuating circumstances.

- Most employees comply with behaviour codes when undesirable behaviours are clearly described and unpleasant consequences are well described (loss of pay, privileges, position or suspension leading to discharge) and administered quickly, equitably and unemotionally to all offenders (Muller et al, 2011:402–403).

Disciplinary action may be ineffective due to methodological weaknesses or procedural omissions by the manager. Methodological weakness may be due to lack of interviewing skills or improper documentation of the disciplinary interview. Procedural weaknesses may result from the failure to apply discipline in a timely fashion or the process not being followed correctly (Muller et al, 2011:402–403).

## Disciplinary counselling

A disciplinary counselling session is a meeting between a supervisor and an employee. It may focus on a specific workplace incident, or may be the result of a performance appraisal. The counselling process may be initiated and executed by the supervisor when an employee's behaviour is observed to be a violation of the code of conduct. A particular aspect of the employee's performance or conduct may have been identified by the supervisor as undesirable and requiring attention. It is an opportunity for face-to-face communication between the supervisor and the employee and is conducted in private. It is often intended to have a constructive goal of providing feedback to the employee to correct the problem or give a friendly verbal warning for performance or misconduct problems (Yoder-Wise, 2007:510).

Counselling shares the same goal of improving performance and/or stopping inappropriate workplace behaviours. With counselling, however, the meeting between the supervisor and the employee takes on a different feel. In such meetings the supervisor attempts to understand and identify the issues contributing to the performance or behavioural problem. Accordingly, in a counselling meeting, the supervisor is focused on listening, verifying their understanding of the problem and engaging in problem solving with the employee. The supervisor and the employee leave the counselling meeting with a corrective plan in mind. Counselling is letting the employee know that the supervisor takes the issue seriously and wants to help them get past it. At the same time, the message is clear from the supervisor – the employee's performance must improve, undesirable behaviours must change or more serious steps will have to be taken (Yoder-Wise, 2007:510).

Counselling is therefore an important supervisory skill, required as often as any other interaction facing the supervisor. It is a necessary step preceding disciplinary action.

## Disciplinary conference

It is a challenging role for managers to discipline a subordinate. It is also damaging to the employee's self-esteem to receive criticism from an authority figure. A disciplinary conference makes both the manager and the employee feel anxious. Some institutions send the employee a letter before the disciplinary conference which informs the employee of the hearing, the date, venue and time. It also explains the reason for the hearing and the reasons for the manager's concerns. An employee is given the choice to be accompanied by a representative, who may be a union member or co-worker.

To reduce anxiety, disciplinary conferences should be short, simple and to the point. To guide the discussion, the manager should begin with a clear statement of the broken rule, describe the corrective actions expected of the employee, specify the time allowed to remedy the shortcoming, and mention further disciplinary action if the prescribed behaviour changes do not occur. The manager should maintain objectivity when discussing the violated rule and the proposed disciplinary action. The manager should aim for success in the exchange, keeping the conversation focused and controlled. The disciplinary interview should be recorded in detail as a basis for later steps in progressive discipline, should it be necessary.

The manager should send a letter to the employee immediately after the conference, documenting the interview content, including: the employee's rule violation, reasons for the manager's concern, behavioural changes expected of the employee, plan of action for effecting the desired behaviour change, comments made by the employee about the problem, and consequences if the undesired behaviour persists. A copy of the letter documenting the disciplinary interview should be kept in the employee's file to assess the subsequent behaviour change, to determine the need for later discipline and to provide evidence during subsequent grievance or arbitration proceedings (Muller et al, 2011:402–409).

## *Errors in discipline*

Proper disciplinary action needs to be taken as soon as possible following an error of omission or commission by an employee. Some managers are reluctant to criticise a subordinate's behaviour or performance and may be unable to deal with hostility from their subordinates. This makes them avoid, delay or dilute discipline, with serious consequences for productivity. Grievances about the employee's behaviour pile up unattended until issues blow up between the employee and the manager. Sometimes criticism is administered in such a way that the employee does not recognise it as discipline. Issues may be generalised rather than dealt with specifically. Discipline may be applied unfairly because of the halo effect or erroneous interpretation of circumstances. Failure to follow the disciplinary process fairly results in unfair, inappropriate or ineffective disciplinary actions (Muller et al, 2011:410).

In the interests of justice, the manager must ensure that the disciplinary action is suitable to the offence. The purpose of discipline is to improve performance. To be effective, discipline must be applied consistently. If managers fail to act when needed, ie at the time of the violation, they will lose credibility; other employees may also lose trust in the manager and the team will be demoralised.

The unit manager may also be positive and use a violation as a teaching opportunity. In a situation that is progressive, the manager must refer the matter to those in more senior levels of management for more serious decisions of discipline. The human resources department is available for consultation at any step of the performance improvement counselling or disciplinary process, and should always be consulted before disciplinary action is taken or employment terminated (Yoder-Wise, 2007:509–510).

## 8.11 Summary

Successful recruiting and an adequate workforce depend on many factors. Productivity – the unit of nursing output – must include quality care indicators that can be observed and measured. In this regard, management has a responsibility to supply adequate numbers of competent staff. Staffing and scheduling are major components of nursing management. Access to training and research, appropriate technologies and the promotion of evidence-based practice are also prerequisites for improving productivity. For health services managers to accomplish work through employees, those employees must be present in the workplace at assigned times. Employee absenteeism through health or other reasons constitutes a significant loss of human resources. A manager who reduces subordinates' absenteeism can increase staffing levels in the unit without spending additional personnel funds. Interventions and strategies that increase employee loyalty to the primary work group enhance employees' motivation and job satisfaction.

Multicultural diversity is an ever-increasing feature of modern organisations and may also lead to conflict situations. Since conflict is an inevitable part of the human condition, managers must learn to manage it effectively. Various approaches to conflict management have been presented and should be

appropriately applied to ensure that the work unit is not fraught with tension and disagreements. Managers need to develop skills to resolve industrial disputes quickly and effectively, restoring the workforce's productivity. Managers must work closely with the HR department for guidance when making decisions on the more complex HR issues based on industrial labour law.

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## *Annexure A*

**DUTY ROSTER**

Hospital: **Nightingale**                                            Week ending: **12 March 2008**

| NAMES | SUN | MON | TUES | WED | THUR | FRI | SAT | HOURS WORKED |
|---|---|---|---|---|---|---|---|---|
| | 6 | 7 | 8 | 9 | 10 | 11 | 12 | |
| Senior nurses | R | 13–19 | 07–19 | 07–13 | 07–19 | 07–19 | R | 40 |
| Nurse 1 | 07–13 | 07–13 | 07–19 | R | 07–19 | R | 13–19 | 40 |
| Nurse 2 | 13–19 | 07–19 | 07–13 | 07–19 | 07–13 | R | R | 40 |
| Nurse 3 | R | 13–19 | 07–13 | 07–19 | R | 07–19 | 07–13 | 40 |
| Nurse 4 | R | 07–19 | 07–13 | 07–13 | 07–19 | 07–13 | R | 40 |
| Student nurses | R | R | 07–19 | 07–13 | 07–13 | 07–19 | 13–19 | 40 |
| Enrolled nurse 1 | 07–13 | 07–19 | 07–13 | R | R | 07–19 | 07–13 | 40 |
| Enrolled nurse 2 | R | R | 13–19 | 07–13 | 07–19 | 07–19 | 07–13 | 40 |
| St enrolled nurse 1 | 13–19 | 07–19 | 07–13 | 07–19 | 13–19 | R | R | 40 |
| St enrolled nurse 2 | R | R | 07–13 | 07–19 | 07–19 | 07–13 | 13–19 | 40 |
| St enrolled nurse 3 | 07–19 | 07–13 | 07–19 | 07–13 | R | R | 07–13 | 40 |
| St enrolled nurse 4 | R | 07–19 | 07–19 | 07–19 | 07–13 | R | R | 40 |
| Number of staff on duty | | | | | | | | |
| 07–13 | 3 | 7 | 11 | 10 | 8 | 7 | 4 | |
| 13–19 | 2 | 7 | 6 | 5 | 6 | 4 | 3 | |
| | 07–18 | 07–18 | 07–13 | 09–18 | 07–13 | R | R | 40 |
| General assistants | R | R | 09–18 | 07–13 | 12–18 | 07–18 | 07–18 | 40 |

1 Femal Surgical

Sister in charge of ward .....................................................................

## Annexure B

<div align="center">

**DUTY ROSTER**

</div>

Hospital: **General Section: Policlinic**  Week ending: **19–04–2008**

| NAMES | SUN | MON | TUES | WED | THUR | FRI | SAT | HOURS WORKED |
|---|---|---|---|---|---|---|---|---|
| | **13** | **14** | **15** | **16** | **17** | **18** | **19** | |
| SENA | | 07–00 | 07–00 | 07–00 | 07–00 | 07–00 | | |
| Y. Monyani | R | 16–00 | 16–00 | 16–00 | 16–00 | 13–00 | R | 40 |
| ENA | | 07–00 | 07–00 | 07–00 | 07–00 | 07–00 | | |
| Z. Zolwini | R | 16–00 | 16–00 | 16–00 | 16–00 | 13–00 | R | 40 |
| SRRENA | | 07–00 | 07–00 | 07–00 | 07–00 | 07–00 | | |
| J. Motau | R | 16–00 | 16–00 | 16–00 | 16–00 | 13–00 | R | 40 |
| SENA | | | 07–00 | 07–00 | 07–00 | 07–00 | 07–00 | |
| K. Vezi | R | R | 16–00 | 16–00 | 16–00 | 16–00 | 13–00 | 40 |
| ENA | | 07–00 | 07–00 | 07–00 | 07–00 | 07–00 | | |
| P.P. Myoli | R | 16–00 | 16–00 | 16–00 | 16–00 | 13–00 | R | 40 |
| PENA | | 07–00 | 07–00 | 07–00 | | 07–00 | 07–00 | |
| S. Thlati | R | 16–00 | 16–00 | 16–00 | R | 16–00 | 13–00 | 40 |
| ENA | | 07–00 | 07–00 | 07–00 | | 07–00 | 07–00 | |
| L. Tlhazi | R | 16–00 | 16–00 | 16–00 | R | 16–00 | 13–00 | 40 |
| ENA | | | 07–00 | 07–00 | 07–00 | 07–00 | 07–00 | |
| S. Mbeli | R | R | 16–00 | 16–00 | 16–00 | 16–00 | 13–00 | 40 |
| ENA | | 07–00 | 07–00 | 07–00 | 07–00 | 07–00 | | |
| A.C. Xaba | R | 16–00 | 16–00 | 16–00 | 16–00 | 13–00 | R | 40 |
| ENA | | 07–00 | | 07–00 | 07–00 | 07–00 | 07–00 | |
| K. Jijana | R | 16–00 | R | 16–00 | 16–00 | 16–00 | 13–00 | 40 |
| Ward Helper | | 07–00 | 07–00 | 07–00 | 07–00 | 07–00 | | |
| D. Mafuya | R | 16–00 | 16–00 | 16–00 | 16–00 | 13–00 | R | 40 |
| Ward Helper | | 07–00 | 07–00 | 07–00 | 07–00 | 07–00 | | |
| E. Kambule | R | 16–00 | 16–00 | 16–00 | 16–00 | 13–00 | R | 40 |
| NUMBER OF | | 10 | 11 | 12 | 10 | 12 | 5 | 480 |
| PERSONS ON DUTY | | 10 | 11 | 12 | 10 | 5 | – | HOURS |

*(Fictitious names used)*

Sister in charge of ward.......................................................................

## *Annexure C*

**DUTY ROSTER**

Hospital: **Labour Ward – Comprehensive Healthcare Clinic**      Week ending: **26–08–2008**

| NAMES | SUN | MON | TUES | WED | THUR | FRI | SAT | HOURS WORKED |
|---|---|---|---|---|---|---|---|---|
| | 20 | 21 | 22 | 23 | 24 | 25 | 26 | |
| SPN<br>H. Shandu | R | R | 07 / 19 | 07 / 13 | 07 / 19 | 07 / 12 | 13 / 19 | 40 |
| PN<br>J. Khosa | R | R | 07 / 19 | 07 / 13 | 07 / 19 | 07 / 12 | 13 / 19 | 40 |
| PN<br>B. Maseko | R | R | 07 / 19 | 07 / 13 | 07 / 19 | 07 / 12 | 13 / 19 | 40 |
| ENA<br>A.N. Diale | R | R | 07 / 19 | 07 / 13 | 07 / 19 | 07 / 12 | 13 / 19 | 40 |
| SPN<br>D. Chiloa | 13 / 19 | 07 / 19 | 07 / 12 | R | R | 07 / 19 | 07 / 13 | 40 |
| SPN<br>H. Iyambo | R | 07 / 19 | 07 / 12 | R | R | 07 / 19 | 07 / 13 | 40 |
| PN<br>N. Xaba | 07 / 13 | 07 / 19 | 07 / 12 | R | R | 07 / 19 | 07 / 13 | 40 |
| ENA<br>M. Tyolo | 07 / 13 | 07 / 19 | 07 / 12 | R | R | 07 / 19 | 07 / 13 | 40 |
| SPN<br>D. Mbeli | 07 / 19 | 07 / 16 | 07 / 16 | 07 / 19 | 07 / 12 | R | R | 40 |
| PN<br>T. Lediga | R | 07 / 19 | 07 / 16 | 07 / 19 | 07 / 12 | R | R | 40 |
| PN<br>S. Tlhasi | 07 / 19 | 07 / 13 | 07 / 13 | 07 / 19 | 07 / 12 | R | R | 41 |
| ENA<br>A. Mafuya | 13 / 19 | 07 / 16 | 07 / 16 | 07 / 19 | 07 / 12 | R | R | 40 |
| WH<br>L. Zondi | R | R[4] | 07 / 16 | R[4] | 07 / 16 | 07 / 16 | R | 40 |
| NUMBER OF PERSONS ON DUTY | | | | | | | | |

*(Fictitious names used)*

Sister in charge of ward ......................................................................

## *Annexure D*

Example of 12-hour shifts on day duty and calculation of hours worked.

**DUTY ROSTER – NURSING SERVICE**

Hospital: ............................................................ Ward:.................................................................

Week ending: **1 September 2008**

| NAMES | SUN | MON | TUES | WED | THUR | FRI | SAT | HOURS WORKED |
|---|---|---|---|---|---|---|---|---|
| C. Mda | D | 06h45–19h00 | 06h45–19h00 | D | D | 06h45–19h00 | 06h45–19h00 | 49 |
| D. Spangeberg | 06h45–19h00 | D | D | 06h45–19h00 | 06h45–19h00 | D | D | 34 ¼ |
| A. Colebrander | 06h45–19h00 | D | D | 06h45–19h00 | 06h45–19h00 | D | D | 34 ¼ |
| W. Joshua | D | 06h45–19h00 | 06h45–19h00 | D | D | 06h45–19h00 | 06h45–19h00 | 45 ¾ |

Week ending: **1 September 2008**

| NAMES | SUN | MON | TUES | WED | THUR | FRI | SAT | HOURS WORKED |
|---|---|---|---|---|---|---|---|---|
| C. Mda | 06h45–19h00 | D | D | 06h45–19h00 | 06h45–19h00 | D | D | 34 ¼ |
| D. Spangeberg | D | 06h45–19h00 | 06h45–19h00 | D | D | 06h45–19h00 | 06h45–19h00 | 45 ¾ |
| A. Colebrander | D | 06h45–19h00 | 06h45–19h00 | D | D | 06h45–19h00 | 06h45–19h00 | 45 ¾ |
| W. Joshua | 06h45–19h00 | D | D | 06h45–19h00 | 06h45–19h00 | D | D | 34 ¼ |

# 9

# People Management

MN Sibiya

## Chapter Outcomes

After studying this chapter, you should be able to:
- identify important principles in people management;
- explain the principles of effective communication in a multidisciplinary team;
- describe the factors that contribute to team effectiveness;
- discuss the nurse's advocacy role;
- explain the concept of role modeling in the healthcare environment;
- describe the steps in problem-solving and decision-making processes;
- describe strategies for planning and running successful meetings;
- describe the meaning of resilience among healthcare professionals.

## 9.1 Introduction

When managing the people within an organisation, the focus should be on optimising each person's input. To achieve this, consistent policies and practices should be in place to allow for the appropriate training and development of healthcare professionals. These policies and practices should encourage each healthcare professional to work as a partner to achieve the organisation's vision. In their people-management role, effective unit managers attract quality candidates, drive performance, engagement and retention, and play a key role in maximising their subordinates' contribution to the organisation.

Poor communication and difficult relationships with their direct manager are often the reasons healthcare professionals quit their jobs. Good communication plays an important role in the organisation's effective functioning. Unit managers should therefore pay particular attention to their own communication and communication within the team.

## 9.2 Core principles of managing people

Kelloway (2004:5) identifies the following three goals for effective people management. Ensure that employees:
- have the ability to do the job
- are motivated to use their ability to improve their job performance
- have the opportunity to contribute to the growth and development of the organisation.

In order to achieve these three goals, Kelloway (2004:5) identifies four elements of effective human resources. He uses the mnemonic, HTML.

**H**ire the best (individuals with the right skills, abilities and competencies).

**T**reat them well and fairly.

**M**anage performance: evaluate individual performance in an organisational context.

Provide **L**eadership (transformational leadership).

No matter how long one has been managing people, it can be tricky. Below are some guidelines that can assist managers.

- *Be enthusiastic*: If you show a positive attitude, people are more likely to work with you to find a solution to any problem that arises.

- *Trust*: The best way to gain your subordinates' trust is to be consistent; always act in the same way and do what you say you are going to do. Show your subordinates that you trust their abilities. Never repeat anything said in confidence.

- *Listen*: Team members are motivated when their managers listen to them. Be careful not to interrupt others or be judgemental of what they say.

- *Do not judge unfairly*: Learn to make the best possible decision with the information you have at the time. Rather than responding immediately, reflect on what the person said by summarising the essence of the message. This will avoid misunderstandings and give you time to think about your response.

- *Warmth*: Be considerate to your team members and show empathy if there is a need.

- *Delegate*: Recognise the talents and skills that your team members have and delegate. Trust your members with various roles.

- *Learn*: Learn new things that will help you improve your leadership style. Talk to others, listen and find out new ideas that will improve your leadership style.

- *Set goals*: Great managers set goals, not only for their team, but also for themselves. Identify financial and personal goals, keep track of them and review them periodically.

- *Lead by example*: Do not ask your team members to do something you would not be prepared to do yourself.

- *Be tough but fair*: As a manager, you cannot be popular all the time. There are times when you have to make tough decisions that will not be liked by your team. Take time to explain your reasoning.

Probably the most important people-management task unit managers must fulfil is bringing out the best in their subordinates. Developing healthcare professionals' potential should be recognised as key to successful service delivery. When a healthcare professional's talents are not channeled correctly, their behavior can seriously compromise the organisation's success. A dissatisfied or unfulfilled

employee can adopt one of several negative roles, such as procrastinator, martyr, gossip, manipulator, backstabber, narcissist, 'deer in the headlights', curmudgeon, bully or predator.

## 9.3 Types of communication

The purpose of communication is to inquire, inform, persuade, entertain, request and investigate. The two main types of communication are verbal and non-verbal.

### 9.3.1 Verbal communication

Verbal communication is associated with spoken words and is vitally important in the healthcare context. Members of the multidisciplinary healthcare team communicate verbally with one another and with patients. This could be during history-taking, management, handing over of reports, etc. A breakdown in communication could lead to poor management of the patient and have serious consequences.

### 9.3.2 Non–verbal communication

Non-verbal communication consists of all forms of communication that do not involve spoken words. In the healthcare setting, non-verbal communication is important when assessing a patient's condition. There is a lot that a nurse can read by observing the patient's non-verbal communication, for example grimacing can indicate severe pain.

## 9.4 Principles and the purpose of communication

The principles of communication can be summarised as follows:

• Communication is a process.

• Communication is not linear, but circular.

• Communication is complex.

• Communication is irreversible.

• Communication involves the total personality (Booyens, 1998:274).

## 9.5 Multidisciplinary teamwork

Multidisciplinary teamwork involves more than just members of different professions working together. Putting people together in groups representing many disciplines does not necessarily guarantee the development of a shared understanding (Clark, 1993). It entails a shared purpose.

The terms 'multidisciplinary' and 'interdisciplinary' are often used interchangeably. According to Pirrie et al (1998), the distinction between 'inter-' and 'multi-' is based on three dimensions, namely numerical, territorial and epistemological.

The question is 'How many professions must be present before a team is truly multiprofessional? It is often argued that the difference between 'inter-' and 'multi-' is largely numerical. 'Inter-' appears to involve two professions only but becomes 'multi-' if more than two professions are involved. Pirrie et al (1998) state that 'multi-' describes activities which:

- bring more than two groups together
- focus on complementary procedures and perspectives
- provide opportunities to learn about each other
- are motivated by a desire to focus on the clients' needs
- develop participants' understanding of their separate but inter-related roles as members of a team.

For a team to be effective, note the following points:

- Planning should be guided by the team's needs.
- Leadership should be democratic and participative.
- Communication must be frequent and effective between team members.

## 9.6 Factors that contribute to team effectiveness

An effective unit manager should be aware of certain factors that can enhance and improve teamwork:

- Teamwork represents a set of values that encourages behaviours such as listening and responding co-operatively to points of view expressed by others, giving others the benefit of doubt, and providing support to those who need it.
- A team is created and energised by significant and demanding performance challenges.
- A team outperforms individuals acting alone.
- A team is flexible and responsive to changing events and demands.
- A successful team invests much time and effort exploring, shaping and agreeing on a purpose that belongs to them, both collectively and individually (Katzenbach & Smith in Armstrong, 2008:61).

## 9.7 Barriers to effective teamwork

The findings of a study conducted by Atwal and Caldwell (2006) identified three factors that hinder teamwork:

- *Different perceptions of teamwork*: Healthcare professionals often have different perceptions of the meaning of multidisciplinary teamwork. Improve the understanding of teamwork by educating healthcare professionals about concepts such as collaboration.

- *Different levels of skills*: In order for teams to work effectively, the members must be able to collaborate. Assertiveness and confidence are regarded as essential skills to function as a team member. Atwal and Caldwell (2006:364) showed that some nurses did not always feel equipped with the necessary skills to function as a team and suggested that such skills are only present in expert nurses.

- *The dominance of medical power that influences interaction in teams*: Atwal and Caldwell (2006:363) further revealed that some nurses do not always regard themselves as having equal status and/or power in a team. As a result, they might not always voice an opinion.

## 9.8 Team development and performance

The following is a list of team-building tips:

- Establish urgency and direction.
- Select members, based on skills and skills potential, who are good at working with others but still capable of taking their own line when necessary.
- Pay particular attention to first meetings and actions.
- Set targets to be achieved by the team members.
- Assess people's performance not only on the results they achieve, but also on their ability to work in a team. Recognise people who have been good team players.
- Recognise team performance with praise and rewards for the team as a whole.
- Build team spirit by engaging in outside-of-work activities.
- Hold team meetings to review performance, focusing on team processes as well as outputs.
- Provide learning and development opportunities so that team members can become multiskilled, or at least improve the level of their existing skills.
- Make use of any learning activities provided by the organisation that focus on teamwork (Armstrong, 2008:65).

### 9.8.1 Assessment of team performance

The performance of teams should be assessed in terms of their output and results, and the quality of team processes that have contributed to those results. Output criteria include the achievement of team goals, patient satisfaction and the quantity and quality of work. Team processes include:

- participation, collaboration and collective effort
- conflict resolution
- joint decision making, planning and goal setting
- interpersonal relations, interdependence and adaptability.

## 9.8.2 Review of team performance

Team-building efforts will be supported if regular team-performance reviews are conducted. The purpose of the review meeting is to assess feedback and control information on joint achievements against objectives, and to discuss any issues concerning teamwork. The checklist below may be helpful.

*Checklist for analysing team performance*

1. How effective are we at achieving team goals together?

2. How well do we work together between units?

3. Does everyone contribute in the different units?

4. How effectively is the team led?

5. How good are we at analysing problems in our units and making decisions?

6. How good are we at initiating action?

7. Do we concentrate sufficiently on the priority issues? Do we focus on the same priorities?

8. Do we waste time on irrelevancies?

9. To what extent can team members speak their minds without being squashed by others?

10. Is there any conflict? Is it openly expressed? Is it about issues rather than personalities?

# 9.9 Advocacy for patient and healthcare professionals' rights

Advocacy is broadly defined as the process of defending, pleading the cause of, promoting the rights of, or attempting to change systems on behalf of an individual or group in pursuit of their fundamental rights. Nurses comprise the largest professional group within healthcare and are trusted by the public. All nurses should become involved in developing processes to advocate for the realistic changes that meet the needs of both patients and healthcare professionals (Tomajan, 2012). This is an extremely important role for nurses, who plan the patient's path through the health system. Nurses must be supported to advocate for patients' rights for universal accessibility to safe, quality healthcare.

Modern nursing is complex, ever-changing and multifocused. The workplace stress falls squarely on the shoulders of nurses at the point of care. Many nurses work in environments where they have much responsibility but little real power to influence how healthcare is delivered. They do not have opportunities to exercise organisational power as they frequently lack the necessary information, support and resources (Paliadelis, 2008).

## 9.10 Nurses as role models

The actions and interactions of nurses working in clinical settings are observed by patients, family members, students and other healthcare professionals. Often, these nurses are role models, potentially influencing the behaviour and attitudes of others in either positive or negative ways. Bandura (1965) argued that people generally adopt the standards exhibited by exemplary models. The term 'role model' was coined by Merton. He defined a role model as someone who sets a positive example and is worthy of imitation (Holton, 2004).

For nurses to be exemplary role models, they must have considerable professional knowledge and outstanding psychomotor, technical and inter-personal skills (Perry, 2009:39). Beyond this, to be truly outstanding role models, they must also be attentive to the little things. What they say and do, and the way they say things, are foundational to their success as role models.

## 9.11 Problem solving and decision making

A leader is expected to get the job done. To do so, he or she must learn to plan, analyse situations, identify and solve problems, make decisions and set realistic and attainable goals for the unit or organisation. Decision making and problem solving are basic ingredients of leadership. Making good decisions is important, not only for the unit manager, but also for the organisation. As a leader, the unit manager will make decisions that affect the morale and welfare of others.

Some decisions, such as when to hold a meeting, are simple and have little effect on others. Other decisions can be complex and may have a significant impact on many people. Making decisions can be complex because of the large number of factors that influence the decision-making process. Some factors are the unit manager's personal values, goals and priorities, or external factors such as cultural and organisational values. Therefore, having a problem-solving, decision-making process is a helpful tool.

### 9.11.1 Steps to solve problems and make decisions

As a leader, the unit manager needs to have logical thought processes that will ensure that key factors are considered. The following eight-step process can be used to solve problems and make sound decisions.

1. Identify the problem.
2. Gather information.
3. Determine the options.
4. Consider the consequences of each option.
5. Select the best option.
6. Draw up a plan.
7. Implement the plan.
8. Evaluate the results.

## Step 1: Identify the problem

Identify the real problem. Incorrect problem identification may lead to the wrong decision.

## Step 2: Gather information

Make sure the information is accurate by questioning its validity.

## Step 3: Determine the options

Look for as many options as possible to solve the problem. The more options that can be thought of, the more likely you are to find a solution to fit the situation. Conducting brainstorming sessions may be useful when it is difficult to find a course of action. Generally, there should be at least two or three possible options – more if the situation or time permits.

## Step 4: Consider the consequences of each option

The next step is to determine which course of action will best solve the problem. Think about the positive and negative outcomes of doing each option. Next, objectively and logically analyse the advantages and disadvantages of each option, comparing it to the advantages and disadvantages of the others.

## Step 5: Select the best option

Based on the positive and negative consequences of each alternative, select the best option. Try to identify a 'best' option that is logical and likely to succeed and that also 'feels' right according to your intuition, values and character.

## Step 6: Draw up a plan

List action steps showing how the decision will be implemented. Make a plan that includes who would do what, when, where, how and why. Be as specific as time permits, but do not leave out vital information. Include contingencies in your plan that address possible unexpected situations or actions. Develop these contingencies based on the assumptions made when the problem was identified and information was gathered.

## Step 7: Implement the plan

Once the decision and plan have been finalised, the plan must be put into action.

## Step 8: Evaluate the results

The last step of the process is to analyse the results or outcomes of the decision. This analysis will help determine the effectiveness of the decision-making process (Krehbiel, 2012).

## 9.12 Managing meetings

A meeting is essentially a gathering of two or more persons to collectively accomplish what one person cannot. A well-run meeting leads to positive results and increased productivity. However, not all meetings are really necessary. Before calling a meeting, the unit manager must check if there is a need for it. Given the cost of people's time, meetings are an expensive choice for getting things done. A meeting might be necessary to:

- Convey information to a group.
- Solicit information from a group.
- Share information as a group.
- Solve problems.
- Brainstorm ideas.
- Plan and set goals.
- Allow people to voice concerns and know that they have been heard.
- Move a project forward.
- Sell an idea, product or service.
- Network.
- Find out how changes under consideration will affect different parts of the organisation in order to modify plans accordingly.
- Take collective responsibility for a course of action.
- Celebrate successes.

## 9.12.1 Effective meetings

An effective meeting boils down to three things:

- It achieves the meeting's objective.
- It takes up a minimum amount of time.
- It leaves participants feeling that a sensible process has been followed.

Meetings are more productive if they are planned beforehand. Attendees will notice if meetings are well prepared. To ensure that meetings are effective, the following essential elements should be considered when planning the meeting:

- *Purpose*: Plan meetings with a purpose. Write down the purpose and objectives of the meeting.
- *Participants*: Invite only those people whose presence or input is necessary.
- *Location and time*: Select a meeting place that best matches the participants' needs, the objective and the meeting structure. Choosing a meeting time depends on the availability of participants and meeting facilities. Try to avoid meeting very early or very late in the day.

- *Agenda*: An agenda should be prepared and distributed to participants at least three days prior to the meeting day. An agenda is crucial because it clarifies the objectives. With clear objectives, the participants can come to the meeting well prepared and make an effective contribution. Clear objectives also provide direction and focus for discussion. The agenda must clearly outline the following:
  - the date of the meeting
  - the times it will start and end
  - the location of the meeting
  - a brief summary stating the purpose of the meeting
  - topics to be discussed.

Certain principles need to be followed to run effective meetings.

- *Begin on time and end on time*: Starting a meeting late shows a lack of respect and appreciation for those who made an effort to arrive on time. Ending on time is respectful of other people's busy schedules.

- *Use the agenda*: Review the agenda with the participants at the beginning of the meeting and ask them if any changes need to be made to the discussion content.

- *Manage interpersonal conflicts that may arise*: Make sure that everyone's viewpoint is heard and respected.

- *Control dominating individuals*: Make sure that each individual has a fair chance to express ideas and opinions. Do not allow one person to dominate the discussion.

- *Bring food*: Food energises and motivates people.

- *End on time and on a positive note*: For example, say: 'We have accomplished a lot today.' Do not forget to thank everyone for coming.

## 9.13 Developing resilience among healthcare professionals

All healthcare professionals face numerous stressors within their clinical practice, including time pressure, workload, multiple roles and emotional issues (McCann et al, 2013; Lim, Hepworth & Bogossian, 2011; Lambert et al, 2004). The following factors contribute to the occurrence of role stress among nurses:

- low job control
- high job demands
- low supportive work relationships
- concern about poor quality nursing care
- dealing with death and dying
- being moved between different patient care units within the organisation
- shortages of essential equipment

- excessive workload
- unco-operative family members and patients
- low organisational commitment
- poor relationships with supervisors, colleagues or doctors
- extended periods of time working on one specific unit
- managing family work responsibilities (Lambert et al, 2004).

Developing and fostering resilient individuals in the health profession is emerging as a way to reduce the negative and increase the positive outcomes of stress in nurses. Luthar, Cicchetti and Becker (2000) define resilience as the ability to maintain personal and professional well-being in the face of on-going work stress and adversity. The authors further explain resilience as a dynamic process which encompasses positive adaptation within the context of significant adversity. Literature shows that nurses use a number of positive coping strategies to manage their daily challenges, including problem-focused coping, taking time out, and giving and receiving support from co-workers (Lambert et al, 2004; Gillespie et al, 2009; Lim et al, 2011).

## 9.14 Summary

Effective teams require members who value each individual's contribution to the team. Unit managers should select and appoint great people who share their vision of the service to be rendered. Unit managers should provide clear direction and expectations and give their subordinates the opportunity to do the best they can do. An effective team leader is always available to support each person on the team, but also encourages autonomy, creativity and risk taking.

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# 10

# Leadership

K Jooste and E Ahanonu

## Chapter Outcomes

After studying this chapter, you should be able to:
- describe the important principles of leadership in a healthcare unit;
- distinguish between different leadership theories;
- describe the differences between different styles of leaders.

## 10.1 Introduction

Leadership is seen as a dynamic and interactive process that involves three dimensions, namely the leader, the followers and the context. Leadership is a process involving a relationship between those who aspire to lead and those who choose to follow. It includes the influence on the direction of a shared common goal (Valenzuela, 2008). A professional nurse can be viewed as a nurse leader when he or she is able to inspire and influence his or her patients and members of their families, and other healthcare professionals to achieve the goals that have been jointly agreed upon. An understanding of different leadership theories can aid in the thoughtful appreciation of leadership qualities and the identification of potential nurse leaders.

## 10.2 Leadership – an essential component in delivering healthcare

Leadership can be defined as the process through which a leader uses his or her power, authority and influence to stimulate followers to realise mutual goals (Jooste, 2009). It can also be described as a leader inspiring and influencing a group of people to achieve shared goals by using a set of leadership activities such as attentiveness, good interpersonal connections and decision making (Northouse, 2013).

Leadership abilities can be innate, acquired or learned. The exhibition of an individual's leadership abilities is also dependent on the given context or situation (Cherry & Jacob, 2014). In the view of Ryan, Haslam, Hersby and Bongiorno (2011), a person's capacity and competence to lead effectively and successfully is demonstrated given the right circumstances. Similarly, Hersey, Blanchard and Johnson (2013) advance that good leadership is a function of the leader and follower variables, as well as the facilitating dynamics present in the environment in which the leadership is taking place.

Professional nurses play an active role in providing safe, evidence-based, quality care for patients in today's multifaceted healthcare environment. To be able to carry out their duties and responsibilities professionally and successfully

in the clinical setting, professional nurses need certain qualities. These qualities include good communication skills, good social skills, commitment, cognitive abilities, emotional intelligence and empathy (Ealias & George, 2012; Mast, Jonas, Cronauer & Darioly, 2012).

It is important to note that a professional nurse may not necessarily occupy a position of authority (for example, unit manager or nurse supervisor) to be considered as a nurse leader. The reason for this is that the leadership role is clearly separate from the management role. Management encompasses the co-ordination of resources (human, materials and time) to achieve the goals of an organisation (Daft & Marcic, 2013); leadership, however, involves the process of motivating and influencing people to accomplish a common aim (Jooste, 2009). Nevertheless, it is advantageous for a unit manager to possess and demonstrate good leadership skills in the same way that a nurse leader should possess good management skills (Jooste, 2014:284).

## 10.3 Leadership theories

Leadership theories explain the qualities that distinguish individuals who can be categorised as leaders from those who are not leaders. There are eight main types of leadership theory: the Great Man theory, trait theory, situational theory, contingency theory, behavioural theory, participative theory, transactional theory and transformational theory.

### 10.3.1 The Great Man theory

The Great Man theory is one of the earliest leadership theories and emerged in the 1800s. It was made popular by Thomas Carlyle and assumes that a leader is different from the average person in terms of certain innate or inheritable qualities (Hoffman, Woehr, Maldagen-Youngjohn & Lyons, 2011). It is believed that, for a person to be a leader, that person must be from a particular 'breed', since leaders are those who have been destined by birth to lead, while every other person had to be led, a situation which cannot be altered (Baker, 2013).

### 10.3.2 Trait theory

The trait leadership theory is based on the Great Man Theory. The theory recognises that leaders possess certain innate personality, intellectual, social and physical traits which distinguish leaders from non-leaders. It also alleges that, even though leadership is contingent on the individual qualities and abilities of the leader, these leadership traits do not solely reside within the precincts of a specific group of persons (Colbert, Judge, Choi & Wang, 2012). According to this theory, it is alleged that great leaders are born and not made (Day & Zaccaro, 2007). Several models have been offered to explain the association of trait theory and leader effectiveness. These include the Leader Trait Emergence Effectiveness (LTEE) model (Judge, Piccolo & Kosalka, 2009) and the integrated model of leader traits, behaviours, and effectiveness (Derue, Nahrgang, Wellman & Humphrey, 2011).

While early researchers have criticised the trait leadership theory as being inadequate in foretelling a leader and for a lack of confirmation of the relationship between individual traits and leadership effectiveness, recent evidence authenticates this association (Day & Zaccaro, 2007). For instance, a quantitative study by Hoffman et al (2011) studied the relationship between individual differences and leader effectiveness, and reported that both trait-like and state-like individual differences are important predictors of effective leadership. Traits include self-confidence, motivation, energy, dominance, honesty/integrity, achievement, creativity, and charisma, while states include skills in the following areas: interpersonal relationships, written communication, oral communication, administrative/management, problem solving and decision making.

## 10.3.3 Situational theory

The basic assumption of the situational theory is that various circumstances require different styles of leadership, and that the best action to be taken by the leader is determined by a whole range of situational factors (Cherry & Jacob, 2014). Furthermore, it is assumed that there is no single preferred style of leadership that is suitable for every situation (Holt & Marques, 2012; Northouse, 2013). In the view of Ryan et al (2011), an individual's capability to lead effectively and successfully is demonstrated under the right situations. Thus, situational theory tends to focus on the behaviours that the leader should adopt, given a particular situation.

## 10.3.4 Contingency theory

The contingency theory of leadership takes a wider view on the situation in which leadership occurs and includes other contingent factors about leadership skills and variables in the situation. The theory hypothesises that the environment in which a leader functions determines the leader's effectiveness (Nandan, 2012). According to Hersey et al (2013), good leadership is a function of the enabling dynamics present in the environment in which the leadership is taking place, including the leader and follower variables.

An example of a contingency theory is Fiedler's (1967) contingency model. According to this model, leadership effectiveness is dependent upon the appropriate mix between the leadership style used by the leader in relating to followers, and the degree to which the circumstances influence the leader. The situational factors are defined in three dimensions: the relationship between the leader and the followers (levels of trust, respect and confidence), the task structure (the level to which assignments are organised) and position power (the authority of the leader in influencing variables such as employment, firing and promotion) (Nandan, 2012).

There are five forms of power, namely referent power, coercive power, expert power, legitimate power and reward power (Table 10.1 below).

**Table 10.1**: Forms of power

| Type of power | Characteristic |
|---|---|
| Referent power | Based on the respect that followers or subordinates have for a leader and as such they are able to identify with him or her |
| Coercive power | Emanates from the leader's use of force, threats and/or potential punishment to enforce actions |
| Expert power | This originates from the leader's possession of superior knowledge and skills |
| Legitimate power | Comes merely from the position of authority occupied by the leader |
| Reward power | Based on the leader's use of incentives to lure followers or subordinates to carry out assignments eg promotion, salary increments |

Source: Adapted from French and Raven (1960)

## 10.3.5 Behavioural theory

The behavioural theories do not agree that leadership traits are inborn or that situational factors determine leadership. Rather, they assume that effective leadership is based on definable, learnable behaviour (Lussier & Achua, 2015). Behavioural theories examine what leaders essentially do that makes them succeed in leadership. This implies that any individual can study the behaviours of successful leaders in order to emulate them and become successful at leadership (Northouse, 2013). Several researchers have also proposed the integration of trait and behavioural theories to understand how traits relate to leader effectiveness (Derue et al, 2011; Robbins, Judge, Odendaal & Roodt, 2009).

## 10.3.6 Participative theory

The participative theory of leadership is founded on 'democratic principles of connection, co-operation, inclusion, ownership, agreement, mutual benefit and support among leaders and followers in the interactional process of leadership' (Bass & Bass, 2008:461). This implies that leadership does not revolve around one single individual. Instead, every member of the team is involved with the process of accomplishing a shared goal (MBA Brief, 2014).

Participative leadership fosters the development of trust, commitment, positive relationships and a team spirit between the leader and the followers (Benoliel & Somech, 2014; Miao, Newman, Schwarz & Xu, 2013). A participative leader does not adopt an autocratic style of leadership; he or she instead involves followers, subordinates, peers, superiors and other stakeholders in the processes of decision making and problem solving (Tyssen, Wald & Spieth, 2013).

### *Team leadership*

This is a form of participative leadership which focuses on the essential practices in teams which motivate and influence the behaviours of individual team members to be proactive and work productively. Recent research has

acknowledged the importance of team leadership in helping members of the team to be active and efficient in the handling of both their personal and team goals (Liden & Antonakis, 2009).

The positive effects of team leadership include improved interpersonal relationships between team members, goal attainment, self-confidence and self-leadership by team members. Through self-leadership, individual effectiveness is enhanced by meeting the goals and objectives of the team. For instance, research has demonstrated that, when self-leading individuals progressively work together in a team, the team is highly creative and innovative (Curral & Marques-Quinteiro, 2009) and the team members exhibit high levels of co-operative behaviours, problem-solving ability and performance on their individual work assignments and tasks. Also, they are able to efficiently manage available resources for the attainment of individual and team goals. The following have been recognised as positive effects of team leadership on the self-leadership of team members: positive attitudes, enriched self-confidence and esteem, and constructive thinking (Konradt, Andreßen & Ellwart, 2009; Sonnentag & Volmer, 2009).

## 10.3.7 Transactional theory

Transactional theory is also referred to as a management theory. The underlying philosophy of this theory states that individuals are driven by reward and punishment and humans are largely looking for ways to take full advantage of satisfying experiences while reducing unsatisfying experiences (Piccolo, Bono, Heinitz, Rowold, Duehr & Judge, 2012). It is also assumed that social systems work best when there is a clear structure or chain of command. Structure refers to behaviours such as co-ordinating group members' actions, defining task roles and role relationships among group members, standards of task performance, and making sure that group members meet these standards. Likewise, transactional leaders state clearly what they anticipate regarding task performance and the rewards when the expectations are met (Derue et al, 2011). Examples of transactional theories include path–goal theory, Blake and Mouton's (1964) managerial grid and Fredrick Taylor's scientific management.

## 10.3.8 Transformational theory

This theory focuses on social transformation as the foundation for both specific and shared achievements in a healthcare setting. For instance, transformational leaders focus on communicating a shared vision, challenging assumptions, searching for diverse perspectives from members of their team and engaging in risk taking (Derue et al, 2011; Northouse, 2013).They are also known for their inspirational motivation, vision and inspiration, charisma, intellectual stimulation and individualised consideration for their followers or subordinates (Sherman, 2012). Some examples of transformational theories include: Burns' transformational leadership theory, Bass' transformational leadership theory and Kouzes and Posner's leadership participation inventory. Table 10.2 below shows the differences between the transformation leader and the transactional leader.

Table 10.2: The transformation leader versus the transactional leader

| Transformation leader | Transactional leader |
|---|---|
| • Achieves goals by inspiring vision and motivating followers. | • Achieves goals by enforcing procedures and roles. |
| • Advances a culture of collaboration. | • Develops a culture of command and control. |
| • Possesses a clear vision and strategic focus (has more of a long-term perspective eg commitment to staff coaching and development). | • Issues are viewed more on a short-term basis (immediate tasks or targets to be accomplished). |
| • Is focused on team building and collaboration. | • Focused on power and position. |
| • Operates an 'open door' policy which encourages followers to contribute to the process and organises regular one-on-one meetings with each individual follower or employee. | • Supports rigid structures and systems of communication. |
| • Shows genuine concern and respect. Positively utilises the strengths and weaknesses of followers in ways that bring out the best in individuals and teams. | • Rewards include incentives and compensation in the form of payment, and punishments include progressive discipline, including termination. |

Table 10.3: Summary of leadership theories and their merits and demerits

| Theory | Distinguishing features | Merits | Demerits |
|---|---|---|---|
| **Great Man** | Leaders are born not developed. | People with outstanding capabilities and personalities can be identified. | Limits leadership capabilities to a selected few. |
| **Trait** | Essential traits are required for leadership. | May be helpful in identifying potential leaders. | Traits vary from person to person and produce different behaviours. |
| **Situational** | The most appropriate action depends on the situational factors. | Rational and promotes compliance. | Insufficient emphasis on the capability of the leader. |
| **Contingency** | Environment determines the style of leadership suitable for a situation. | Encourages adaptability and creativity. | No leadership style is suitable for all situations. |
| **Behavioural** | Leaders can be made. | Leadership capability can be learnt. | May not encourage individuality and inventiveness. |

| Theory | Distinguishing features | Merits | Demerits |
|---|---|---|---|
| **Participative** | Mutual benefit and support. | Increases commitment and collaboration. | Decision making may be prolonged. |
| **Transactional** | Individuals are motivated by rewards and punishments. | Focuses on tactical issues. | Can create an unfriendly work environment. |
| **Transformational** | Motivation, shared vision and team-building to bring about a positive change. | Promotes positive work environment, reduces staff turnover. | May not be effective when employee lacks the requisite skills. |

# 10.4 Leadership styles

Style refers to a distinctive or characteristic manner of performance. It is seen as the exclusive privilege of the expert, an elegance and economy of effort to be sought by the novice leader.

## 10.4.1 Autocratic leadership

The leader is task-orientated and uses positional and personal power in an authoritarian manner. She retains all responsibility for goal setting and decision making. She motivates followers through praise, blame and reward (Marriner-Tomey, 1996).

## 10.4.2 Democratic leadership

Democratic leaders value the individual characteristics and abilities of each team member. They use personal and positional power and co-operative decision-making methods to draw out ideas from employees and motivate them to set their own plans and control their own practices (Marriner-Tomey, 1996).

## 10.4.3 Participative leadership

Participative leadership is a compromise between authoritarian and democratic styles. The leader presents her or his analysis of problems and a proposal for action to employees, inviting their criticism and comments.

## 10.4.4 Laissez–faire leadership

Leaders who adopt a laissez-faire style abdicate responsibility, leaving followers without direction, supervision or co-ordination. They allow their followers to plan, execute and evaluate their work in any way they like; there is no leadership here.

## 10.4.5 Servant leadership

According to Smith, Montagno and Kuzmenko (2004), servant leaders are attentive to the individual needs of their followers and are focused on their individual growth and development. Furthermore, servant leaders engage in self-reflection and are concerned about the success of every stakeholder in the organisation. Spears (2010) outlined the following as the characteristics common among servant leaders: listening, empathy, healing, awareness, persuasion, conceptualisation, foresight, stewardship, commitment to the growth of people and community building.

Servant leadership is an inspirational model of leadership which covers the moral protection of followers (Greenleaf, 1977; Brown & Treviño, 2006). This is because leaders who are considered servant leaders are typically selfless and can rise above self-interest to act in the best interests of their followers; these leaders are also genuinely concerned about their followers, precluding manipulative behaviours. By so doing, servant leaders are able to create and foster an environment in which their followers respond by engaging in supportive behaviours (Walumbwa, Hartnell & Oke, 2010).

Although servant leadership intersects with other views of leadership (for example charismatic, transformational and authentic leadership), servant leadership is a theoretically distinct concept in that servant leaders exhibit behaviours such as altruism and role modelling as well as stimulating communication (Brown & Treviño, 2006). Previous research has demonstrated a positive relationship between servant leadership and employee attitudes and behaviours. For example, a study conducted by Walumbwa et al (2010) to test the impact of servant leadership on employee attitudes and organisational behaviour reported that there was increased self-efficacy and commitment by the employees to their supervisor. Similarly, Takeuchi, Chen and Lepak (2009) reported that servant leadership behaviours produce a social context which affects followers' attitudes and behaviour positively, and that these leader behaviours in turn offer situational prompts by which the followers understand their environment. Walumbwa, Wu and Orwa (2008) suggest that a person is more likely to engage in supportive behaviours when they observe that they are being treated fairly by a servant leader. This is so because fair procedures signal to employees that they are valued and are seen to be important in the organisational setting.

## 10.5 Becoming a nurse leader

Becoming an effective and efficient nurse leader does not happen intuitively. Typically, the development of good leadership skills is a continuous and enduring process which occurs over a period of time. It also requires conscientiousness and diligence on the part of the professional nurse (Huber, 2014).

Day (2011) suggests that leadership skills can be nurtured through leadership development programmes. McCauley (2008) defines leadership development programmes as planned activities that aim to develop and nurture people's leadership skills and abilities. These programmes have been successfully used in many organisations, including healthcare settings, to develop and improve

the skills and competencies of team members and significantly increase team cohesion and productivity (Amagoh, 2009). In defining successful leadership, the circumstantial influences on leadership recognise the vital part played by operational processes and situational factors (Dinh, Lord, Gardner, Meuser, Liden & Hu, 2014).

A professional nurse acting as a nurse leader is in a unique position to transform the healthcare system and create opportunities for empowerment. As a leader, he or she also has the capacity to guide his or her professional colleagues through a co-operative leadership relationship (Tuckey, Bakker & Dollard, 2012).

### 10.5.1 Mentoring

One key avenue for fulfilling a leadership role is through mentorship. Mentorship can be defined as 'a relationship in which an individual nurtures in another professionally defined values, knowledge and skills which will ultimately result in a judgement being made regarding the mentee's competence' (Bailey-McHale & Hart, 2013:3).

Some of the distinguishing qualities of a good mentor are: being well-informed, knowledgeable, experienced, competent, friendly, caring, approachable, compassionate, empathic, trustworthy, collaborative, committed, loyal and supportive (Miner, Dowson & Devenish, 2012). Nurses should be aware that, to be good mentors, they should think strategically and focus on guiding and mentoring others towards achieving the goals and objectives of the team. According to Hoyt, Burnette and Innella (2012), people usually experience positive self-confidence in their leadership abilities when they have good mentors guiding and stirring them to likewise grow and develop into effective and efficient leaders.

## 10.6 Summary

All successful organisations have one thing in common – innovative leadership. The effective leader acknowledges followers as the primary source of organisational creativity, energy and value. The latter leads to a situation wherein colleagues and followers deliver their best performance. Leadership is about influencing yourself and others to move towards your dream, by using your position and power sources to achieve your vision.

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# 11

# Staff Development

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## Chapter Outcomes

After studying this chapter, you should be able to:
- explain the meaning of staff development;
- identify policies and legislation related to staff development;
- describe the purposes of staff development;
- identify the training needs of staff;
- identify healthcare professionals who can benefit from a staff development programme;
- describe the working environment necessary for learning to take place;
- compile a list of topics that would form the core content of an orientation programme;
- outline the need for and the way in which in-service education can become an everyday reality in health services;
- discuss the value of a programme aimed at developing the professional competencies of nursing staff;
- compile a professional development plan;
- explain the workplace skills plan.

## 11.1 Introduction

Healthcare institutions experience change in both the structure and processes of healthcare delivery. Nurses are expected to anticipate and respond to change regarding their career goals; this also maintains the viability of healthcare institutions (International Council of Nurses, 2006; Jakubik, Grossman, Daly-Parker, Gaffney, Strauss & Mars, 2004).

The nursing shortage continues to be a threat to the healthcare system. Unit managers can reduce the loss of nurses by addressing nurses' job satisfaction and their commitment to the organisation. Creating a culture of staff development in healthcare institutions is one way to combat skills shortages. Proenca and Shewchuck (1997) indicate that learning and career development opportunities are two important factors that influence the retention of new nurses. Retention of experienced and knowledgeable nurses is of critical importance for the success of healthcare institutions.

Staff development is one of the essential responsibilities of the health services manager. There are many definitions of the concept of staff development. Staff development is the systematic process of teaching, training and growth through which an individual acquires skills and knowledge and develops attitudes and perceptions (Jooste, 2011:253). Other concepts that are used interchangeably with the concept of staff development are induction, orientation, in-service education, mentoring, professional development and continuing professional development.

## 11.2 Definition of terms

It is important to distinguish between these concepts that are used interchangeably with staff development.

- *Induction*: Orientation of new employees in a new work environment.
- *Orientation*: Planned introduction of employees into their new workplace and the jobs they are required to perform (Marquis and Huston, 2011:347).
- *In-service education*: Education of an employee while he/she is doing the job or rendering a service to clients in an organisation. It is also referred to as staff in-service, on-the-job training or in-service. The term relates to healthcare professionals acquiring, maintaining or increasing their competencies. The educational sessions are generally short, presented informally and usually at the work site (Ridge, 2005:31).
- *Mentoring*: Formal relationship between a senior nurse and a junior nurse, directed toward the advancement and support of the junior nurse (Weng, Huang, Tsai, Chang, Lin & Lee, 2010).
- *Professional development*: Constant commitment to maintain specific skills levels and career paths (Lannon, 2007).
- *Continuing professional development*: Process of tracking and documenting the skills, knowledge and experience that is gained formally and informally, as one works beyond initial training.

## 11.3 Orientation

The overall goal of orientation is to ease the path of the new employee into the healthcare facility and into the unit or department where she or he will work. Making a good impression on the new employee will have a profound effect on the individual's professionalism, commitment to high standards and long-term productivity (Ridge, 2005:30). In order to get this message of the importance of good quality nursing across to the newcomer, the new employee must be approached in an adult way and the information presented should be meaningful. The message will be enhanced if the chief nursing officer, hospital directors, senior unit managers and heads of department with whom the nurse will come into frequent contact, are present during at least some stage of the orientation process. The use of adult learning principles sends a message to staff members that they also have a responsibility for their own learning and professional development (Ridge, 2005:30).

Effective orientation programmes should strike a balance between individualised plans directed at a staff member's particular needs and a standardised curriculum. It has been found that orientation programmes focusing on the development of critical thinking skills, patient-care management and the enhancement of self-esteem are directly related to higher retention levels among staff. Self-directed and self-designed programmes developed to enhance critical thinking skills, such as problem identification and reasoning to get solutions, are generally more effective than traditional lecture presentations (Ridge, 2005:30).

Core content includes, according to Ridge (2005:31), the following: a review of the specific act relating to the practice of the particular category of health worker, the scope of practice, job descriptions and information on how to gain access to resources and information in the specific health facility. The content should also include standards of care and practice, medication information and the availability of clinical staff.

Competency-based orientation programmes prove to be an effective way to orientate new employees to the job. A competency-based orientation programme focuses on the learner's ability to perform a task, rather than possessing the knowledge of how to do it. A competency-based orientation programme includes the use of adult learning principles together with an outcome-based evaluation (Whelan, 2006:201). Such a programme consists of competency statements, or in other words, the performance outcomes that can be demonstrated and the critical behaviours, or specific actions that must be completed in order to reach the competency statements (O'Shea, 2002 in Whelan, 2006:201).

The following three-phase, competency-based orientation programme, as described by Whelan (2006:201), is worth mentioning:

- *Phase 1*: A general hospital orientation, consisting of one day. On this day, a review is done of mandatory life safety issues as prescribed by the Occupational Health Safety Act and hospital accreditation authorities. Subjects covered during this phase include, among others, fire hazards and safety codes, infection control, electrical safety and the prevention of back injuries.

- *Phase 2*: During the second phase, employee-specific orientation is done. For instance, the nursing orientation is carried out relating to basic nursing policies and procedures, such as the administration of medication, blood transfusion and nursing documentation.

- *Phase 3*: This consists of orientation to the specific unit to which the new employee is assigned. The new employee works with a preceptor on the unit. An initial evaluation of the employee's skills is made and this is followed up by an orientation plan developed for the specific employee.

A newly qualified employee's orientation may last longer than that of an experienced healthcare professional. It is, however, worth the effort because when the unit manager is confident that staff can perform proficiently, they have time to do rounds more thoroughly and take note of any deficiencies in care. It is the manager's responsibility to identify educational and development needs.

## 11.3.1 Professional competence

Developing professional staff's competencies is viewed as an important part of maintaining a high-quality workforce that provides excellent care. In today's healthcare practices, patients are more acutely ill and have shorter lengths of stay in hospital than previously. Consequently, greater demands are placed on nurses and other healthcare professionals to demonstrate competence in caring

for increasingly complex patients in a healthcare environment that is continually changing (Whelan, 2006:198).

There are many definitions of competence. It is often defined as 'the individual's capacity or potential to perform his or her job' (Whelan, 2006:198). All workers should have a job description and the number of competencies that a worker should be able to demonstrate depends on that person's job description. The more skilled the job, the greater number of competencies it will require. Competencies are not only tasks that a person performs, but include elements such as knowledge, attitudes, values and self-image. It is, of course, much easier to measure technical competencies than friendliness or the ability to stay calm when criticised. Core competencies are different for every organisation: they are part of an organisation's unique composition and personality (Whelan, 2006:199).

A competency can be seen as something that has two parts, namely a definition statement and a list of skills and activities. The definition statement explains what the person has to be competent at, for example, putting up a blood transfusion safely. The list of skills for this statement would include such aspects as checking the patient's particulars against those written on the transfusion bottle, checking the patient's blood group against the blood group of the donor, and maintaining a continuous flow of blood at the correct rate.

In order to improve a person's competence, the existing level of skills must first be assessed. According to Whelan (2006:198), competency assessment is an ongoing process of initial development, maintenance of knowledge and skills, educational consultation, remedial teaching and redevelopment. Competence levels are viewed as extremely important for efficient patient care and, therefore, annual merit increases are dependent on the satisfactory completion of prescribed annual competencies at some healthcare facilities (Whelan, 2006:199–200).

The Joint Commission on the Accreditation of Hospitals (JCAHO) has formulated standards for quality care that focus on the '… actual performance of those functions and processes, both clinical and organisational, that most significantly affect patient care …' (Whelan, 2006:200). According to Whelan (2006:200), a competency-based development system was designed by Dr Del Bueno to assess an individual's competencies. This system consists of sets of videotapes that have scenarios of patient situations related to specific disease processes. The nurse has to view the tape, then document everything that she or he would do for the patient. The documentation is then reviewed and, from the scored results, an individualised orientation plan is developed for the nurse. Whelan (2006:200) explains that multiple practice skills and abilities can be assessed and validated with this system, including critical thinking, such as problem recognition; risk and problem management; differentiation of priority and urgency; interpersonal skills, such as resolution of conflicts, customer satisfaction, team building; and technical skills, such as the safe performance of procedures and effective use of equipment.

A competency-based orientation programme focuses on the learner's ability to perform a task, rather than a simple possession of the knowledge required to perform the task. As Whelan (2006:201) explains, '… a competency-based

orientation programme involves adult learning principles with an outcome-based plan of evaluation …' This integration of the necessary components of knowledge, attitude and skill clearly shows a nurse's competence to practise in the intended setting (Whelan, 2006:201).

## 11.4 In-service education

The term in-service education refers to regular educational sessions geared to the ongoing development of staff while they are performing their assigned nursing duties. It is also referred to as staff in-service, on-the-job training or in-service. It relates to healthcare professionals acquiring, maintaining or increasing their competencies. The educational sessions are generally short, presented informally and usually at the work site (Ridge, 2005:31). Content in these sessions usually includes, among others, demonstrations of new equipment by non-hospital presenters; demonstrations by experienced staff of the use of certain lesser-known equipment, such as certain ventilators; pharmaceutical representatives explaining the use of new products in the health field; nurse or hospital managers explaining and demonstrating new policies and procedures; the presentation of scientific findings related to clinical issues – for instance the latest research information regarding HIV/AIDS or tuberculosis.

Carlson (2004:50) gives the following advice for the preparation of successful in-service presentations:

- Draw up the outline for the session, including your purpose and objectives, your name, the session's title and the method of teaching to be used.

- Reserve the presentation room and the necessary audio-visual equipment well in advance.

- Practise setting up and running the equipment you are planning to use. Enlist a helper if necessary.

- Ensure that a record is kept in the files of your presentation for future use and reference.

- Advertise to get a maximum attendance: use emails, reminders at staff meetings and circulate eye-catching flyers at least two weeks in advance.

- Put up notices in high-traffic areas, such as restrooms, bulletin boards and staff lounges.

- Ensure adequate seating and sufficient copies of handouts are available. For a firm idea of numbers, invite staff to sign up for this session by a certain date.

- Create an environment conducive to learning by having arranged seating for everyone, good ventilation and a comfortable room temperature.

- Avoid holding such sessions on a Monday: potential attendees may be too busy to attend, getting things in order after the weekend (Carlson, 2004:50).

In-service education sessions serve as opportunities to share pertinent new information and to assess staff's specific competencies, thereby keeping staff on their toes and up to date. Assessment of the areas or topics where education is needed should be an ongoing activity. Postler-Slattery and Foley (2003:35) and Pinkerton (2006:50) state that the following topics, among others, were found relevant for in-service educational purposes: new medications, cultural competency, pain (its pharmacological and pathophysiological aspects), antibiotic resistance, intravenous therapy advances, management of type 2 diabetes, respiratory care, computer systems and the physical assessment of patients. In addition, the following topics could also be included: ethics regarding patient care and record keeping, basic emergency procedures and the identification of risks.

## 11.5 Policies and legislation related to staff development

Since 1994, government has passed several laws which regulate the employment relationship and skills development in particular. They are:

- Basic Conditions of Employment Act 75 of 1997

- Black Economic Empowerment Act 53 of 2003

- Employment Equity Act 55 of 1998

- Labour Relations Act 66 of 1995

- Nursing Act 33 of 2005

- Skills Development Levies Act 9 of 1999

- Skills Development Act 97 of 1998

- South African Qualifications Authority Act 58 of 1995

The Skills Development Act 97 of 1998 is the primary legislation that seeks to restructure the country's national education and training system. It is supported in law by the Skills Development Levies Act 9 of 1999. These Acts were promulgated to develop and improve the skills of the South African workforce. The purpose of the Skills Development Act is to:

- Provide a decision-making framework for co-ordinating and directing the skills development initiatives of the organisation.

- Provide a framework for implementing and monitoring the skills development plans for all departments/units in line with the departmental goals.

- Provide a framework for implementing the principles contained in the skills development legislation governing education, training and development to create an environment that is conducive to the utilisation of skills development opportunities.

## 11.6 Purposes of staff development

The purpose of a staff development programme could be to:

- enable the organisation to show commitment to developing its healthcare professionals
- encourage individuals to realise the need to improve their own and other individuals' performance
- show the institution's appreciation and recognition of the contribution made by their employees
- indicate that the healthcare organisation is committed to ensuring equality of opportunity in the development of all its healthcare professionals
- make employees aware that the healthcare organisation has a plan with clear aims and objectives, understood by all the healthcare professionals
- ensure that the development of individuals is in line with the aims and objectives of the healthcare organisation
- support the development of employees in order to improve the performance of individuals, teams and the healthcare organisation as a whole
- establish a culture of continuous improvement in the organisation (Pollitt, 2006 in Jooste, 2011:253).

## 11.7 Healthcare professionals who could benefit from a staff development programme

A staff development programme is usually designed to address the needs of different categories of healthcare professionals. The programme could benefit the following healthcare professionals:

- recently qualified healthcare professionals, to consolidate the competencies obtained during training
- newly appointed healthcare professionals
- healthcare professionals who have been away from the healthcare environment for a long period of time
- healthcare professionals who have the desire to update their skills and knowledge
- healthcare professionals whose professional role changes
- healthcare professionals who are transferred from one unit to another
- healthcare professionals who do not have an adequate educational background
- healthcare professionals whose responsibilities have increased.

## 11.8 Timing and core components of staff development programmes

Timing is important when scheduling professional development interventions (Mayes & Schott-Baer, 2010). Programmes must be scheduled at a time that will most likely benefit the nurses. The following components, as reported by Ridge (2005:31), form the cornerstone for effective staff development:

- An organisational culture that fosters ongoing learning for all levels of healthcare workers.

- Efficient orientation of new nurses, which offers, among others, an introduction to the vision, mission and values within the organisation.

- Valid and accurate assessment of competencies of healthcare workers. The programme should ensure that the gaps between the initial level of performance and the desired criteria of performance are identified and addressed.

- Sufficient and relevant opportunities for continuing education for staff members while working. This should meet the shifting needs of existing staff with respect to new diagnoses, procedures and technological advances.

- Preceptorships/mentorships providing a framework for the retention of new and existing staff members in a manner that fosters support, learning and effective clinical practice.

- Supporting the continuation of formal education of staff members by way of scholarships or other incentives.

## 11.9 Factors that influence ongoing development

Research has identified the following factors that influence healthcare workers' further development:

- The personal characteristics of practitioners influence their readiness to participate in learning activities, for example curiosity, readiness to know more about work-related issues and willingness to ask questions are noteworthy factors.

- Motivation to learn more comes to the fore when nurses and other healthcare personnel enter the workforce as qualified professionals and accept responsibility and accountability for patient care.

- The satisfaction of patients with the care rendered would appear to play an important role in motivating healthcare workers to develop themselves so as to render better patient care (Khomeiran, Yekta, Kiger & Ahmadi, 2006:69).

- In general, professional healthcare practitioners seem to seek learning because of intrinsic motivation, such as personal fulfilment, responsibility, achievement and a desire to improve their performance at work.

- Acquiring more theoretical knowledge is seen as important to enhance competency, especially if the theoretical knowledge is tailored to meet the real needs in practice (Khomeiran et al, 2006:69).

- The more experience a health practitioner has, the more he or she is motivated to gain further knowledge. From reflecting on their own experiences, practitioners develop competence. They also learn from listening to more experienced professionals' accounts of their own experiences and seeing them in action.

- The environment in which the practitioner functions, both in physical and emotional terms, is also extremely important (Khomeiran et al, 2006:70).

## 11.9.1 The teaching and learning environment

If a healthcare worker does not feel valued in the place, situation or area where he or she works, very little teaching or learning can take place, because they feel stressed and uncomfortable. Newly qualified nurses with limited experience often find themselves in charge of wards. In this situation, they suffer from self-criticism as they encounter negativity in their interactions with senior managers. In this sort of climate of ineffective communication, they are often confronted with unrealistic expectations and experience enormous stress (Manias, Aitken & Dunning, 2005:355). The staff shortages experienced in healthcare settings nowadays compound the issue, as there is no time to work alongside more experienced healthcare professionals. This, in turn, causes fewer opportunities for communication with colleagues during stressful and difficult situations (Manias et al, 2005:355).

An environment that fosters a good learning climate has the following characteristics:

- mutual respect between nurses and between nurses and other professional groups
- partnership
- support and trust
- value experienced by nursing staff from authorities and professional colleagues
- healthcare professionals are highly motivated among themselves and provide supportive relationships.

In such an environment, newly qualified nurses are nurtured, given appropriate support by a preceptor or mentor and receive guidance and constructive feedback on their performance. There is organisational support for discussions to take place and, as a consequence, the development of critical thinking skills is enhanced (Khomeiran et al, 2006:70). This, in turn, leads to the production of high-quality work content, which, in itself leads to motivation and satisfaction among nurses. According to Ridge (2005:29), today's organisations are required to be learning organisations. Leaders in health services management should embrace the concept of building an organisational culture of ongoing learning, where the environment is one in which staff feel free to report, for instance, variances in patient responses to medications or medication errors in the knowledge that action will be taken not at an individual level, but at senior management level to address risks.

## 11.9.2 Learning opportunities in healthcare settings

Students learn effectively if there is good integration of service, experience and training. The learning opportunities that become available in the work setting should, therefore, be utilised to the full (Stanley, 1998:239).

There are many opportunities for teaching and learning to take place in healthcare settings. Teaching can be done informally during ward rounds and shift handover reports. Ward rounds, whether conducted as routine doctors' rounds or teaching rounds, should be seen as learning opportunities. A structured ward round, where registered nurses can communicate formally with doctors about patients, is an excellent opportunity for learning to take place. Nurses can contribute actively by asking proactive questions, giving information about the current status of patients and making clinical judgements about patient care plans (Manias et al, 2005:359). Research indicates that nurses feel freer to contribute when medical ward rounds are structured or formal. Nurses know beforehand that a round is going to take place and can prepare for it in the sense that each patient's clinical records are put together and the questions they want to ask can be framed in advance. This way, they can also prepare the information that they wish to put forth and the recommendations about the patient care plan they want to make (Manias et al, 2005:361). Nurses also tend to be proactive in clinical settings that have structured ward rounds, as they can anticipate and formulate likely questions about their patients' medications (Manias et al, 2005:361). Formal sessions of ward rounds where a medical consultant not only teaches medical students, but also briefs other professionals about patients, should be included in a teaching programme of a speciality as often as possible (Stanley, 1998:241).

A further valuable learning opportunity in the work setting is the handover, or change of shift, report. According to Speas (2006:82), the change of shift report is regarded as a powerful arena of professional socialisation and communication. It is seen as important for building teams or promoting teamwork and has the potential to affect staff retention because it is a primary tool to enhance the quality of patient care. The inexperienced nurse is being shaped, taught and evaluated by more experienced nurses, as the report handover serves as a forum for accountability and responsibility for patient care (Speas, 2006:82). The importance of the handover report in quality patient care is obvious. If important information about patients and their care is omitted, the oncoming nurses' abilities to carry out their responsibilities effectively are hampered (Manias et al, 2005:360).

The following strategies are recommended by Speas (2006:83) to promote effective communication and improve relationships between shifts when report handover takes place:

• Guidelines should be drawn up by representative nurses from each shift on what should be in the patients' reports to be shared with oncoming staff.

• Make use of face-to-face reports for sharing information. As the patients' records are used, it helps to 'cue' what should be said and act as a double

check for the completion of documentation. Walking rounds, where the off-going nurse introduces the oncoming nurse(s) to the patient, promote supportive communication between staff.

- Promote listening skills by encouraging nurses that listening without agreeing is acceptable.

- Encourage staff members to participate in the education of their peers by giving case presentations. This method builds respect, promotes staff development and supports inter-shift communication.

## 11.10 Training needs analysis

A systematic analysis of training needs should be conducted, focusing on the following three areas:

- *Organisational analysis*: This involves examination of the environment, strategies and resources in order to determine where the emphasis of training should be.

- *Task analysis*: This involves reviewing job description and specifications to identify the activities performed in a particular job and the key skills required to perform these activities.

- *Person analysis*: This involves determining which employees require training and which do not.

## 11.11 Professional development plan

Each nurse should draw up a professional development plan to set their own professional development goals (Figure 11.1).

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**Your Personal Professional Development Plan**

Name ..................................................................................................... Date .........................................

Category ..................................................................................... Years of experience .............

Your goals.................................................................................................................................................

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Activities needed to reach your goals....................................................................................

.........................................................................................................................................................................

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**Figure 11.1**: Set professional goals

**Figure 11.2**: Own professional development plan

## 11.12 Continuing professional development (CPD)

The South African Nursing Council (SANC) is in the process of finalising the guidelines for a continuing professional development (CPD) system for nurses. CPD assists professionals to reflect, review and document their learning, and to develop and update their professional knowledge and skills.

### 11.12.1 Purpose of CPD

The reasons for introducing the CPD activities include the following:

• The knowledge, information and skills acquired by healthcare professionals as students and/or interns become obsolete with time.

• The acquisition of new knowledge and skills for any field is advancing constantly and this new knowledge is not easily communicated to healthcare professionals.

• In order to protect the welfare of the public, healthcare professionals are required to commit to lifelong learning and to keep abreast by improving their knowledge, skills and ethical attitudes.

## 11.12.2 Workplace skills plan

The national skills shortage is a major obstacle to economic growth, social development and sustainable employment growth in South Africa. The workplace skills plan (WSP) allows the government to project skills needs and use this information to identify skills shortages, critical skills in organisations and development requirements within the country (ETDP SETA, 2012). The WSP is a detailed document outlining training priorities. It enables the organisation to access grants in terms of the Skills Development Act. The WSP records information on employee profiles and planned training interventions (ETDP SETA, 2012).

## 11.13 Process flow for skills development

*Step 1*: Relevant line manager to identify the performance gaps for the job according to the competencies required.

*Step 2*: Relevant line manager to agree on the training interventions to address the performance gaps within the approved budget.

*Step 3*: Human resources officer to assist the line manager to compile the training plan and report.

*Step 4*: The quarterly skills report will be monitored against the skills plan on an on-going basis.

*Step 5*: All requisitions to be signed by the relevant line manager and verified against the training plan.

*Step 6*: Skills unit to capture skills needs and compile the institutional workplace skills plan and annual training report.

*Step 7*: Relevant line manager to assess the impact of training on performance by completing a post-training evaluation form.

## 11.14 Summary

There is a need to establish a culture of learning in healthcare so that the environment is one in which teaching and learning can take place. The need for general and specific orientation (where preceptors are used) and in-service education have been highlighted. A healthcare institution can only achieve quality nursing care by committed and loyal nurses, but these nurses need the necessary competencies and ongoing in-service education; should they wish to develop themselves further educationally they should be encouraged to do so.

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# 12

# Clinical Governance

R Schaefer

## Chapter Outcomes

After studying this chapter, you should be able to:

- implement the principles of clinical governance in a healthcare unit;
- advocate the use of evidenced-based practice;
- conduct root-cause analysis;
- implement plan, do, study and act (PDSA) cycles.

## 12.1 Introduction

Clinical governance is an institutional quality management system which aims to maintain and improve patient care in a holistic manner, throughout the healthcare facility. Managerial, organisational and clinical approaches are combined to improve the quality of service to the patient (Currie, Morrell & Scrivener, 2003:7; Buetow & Roland, 1999:184). Clinical governance involves every department in a healthcare institution and expects accountability from every person. Each department is regarded as an integral part of the whole. If one department fails, the whole system fails (Ka-yee, Lee, Lam, Lam, Leung, Man, Tang & Lo, 2014:133).

Clinical governance attempts to implement and maintain quality improvement measures, to implement evidence-based standardised care for all population groups, and to recognise and award achievements. Clinical governance advocates risk mitigation, evidence-based practice, education and training, clinical accountability, information management, quality improvement, strong leadership, patient involvement, and defining and monitoring standards (Roland & Baker, 1999:3). Many of these aspects of clinical governance have been covered in this book.

## 12.2 Core components of clinical governance

Clinical governance is made up of a number of components which, when implemented together, will enhance a comprehensive service where all individuals have responsibility and accountability for their contributions. The focus is on the quality of service provided to the patient (Buetow & Roland, 1999:188).

### 12.2.1 A personal and institutional learning culture

Each staff member should have an individual professional development plan which is based on their own, team and institutional needs (Stonehouse, 2013:96). The progress of the plan should be discussed during performance meetings with an aim to encourage life-long learning (Roland & Baker, 1999:19; Currie, Morrell & Scrivener, 2003:21).

## 12.2.2 Initiation, participation and implementation of research

Each unit should have a core research team which drives research and research implementation for improved patient care. The team works with the education department to access research pertinent to their patient profile and to conduct applied research in the unit. Patients, their families and the multidisciplinary team should all be involved in the research activities. All standards and changes must be based on empirical evidence, with the aim of improving the quality of the care rendered. Research with a view to standardisation is essential (Moyen, Camiré & Stelfox, 2008:209).

## 12.2.3 Gathering, analysing and using reliable data

Data is useless unless it is accurate and it is utilised to analyse a situation with a view to improvement. When collecting data ask: Why am I gathering the data? What will change because of the data? (Currie et al, 2003:12).

## 12.2.4 Effective resource management

The foundation of clinical governance is determining the number of staff members and the skills mix required, based on the patient and unit profile. Employing self-motivated staff members, who fit into the team and organisation and who are open to change, is important. The environment in which the staff members work must be conducive to healthcare delivery. The team is accountable and responsible for the management of the physical and financial resources (Currie et al, 2003:22).

A number of factors influence the manner in which staff members behave when at work. Some of these are the work environment, the team, individual circumstances, the tasks allocated, the patient allocation, as well as organisational and management factors. The work environment includes general management aspects such as staffing, skills mix, workload, etc. (Currie et al, 2003:13). Communication is the biggest factor influencing the manner in which teams perform. Others are the team structure, the consistency of the team members and the leadership of the team. Individuals are influenced by their attitude, health, knowledge, competence, experience and efforts to remain up to date with developments in healthcare.

## 12.2.5 Self and team accountability and responsibility

Effective individual and team work is at the core of patient care (Stonehouse, 2013:94). To be effective, the team must communicate well. Each team member has a responsibility to uphold the values of the organisation and reach the objectives of the unit. If problems of poor quality, competence or under-performance occur, these must be addressed at both an individual and team level.

So that there is no uncertainty about how a task should be carried out, all tasks should be governed by the organisational or unit policies and procedures. Personal and team accountability and responsibility for all actions and omissions must be enforced (O'Malley, 2013:28).

## 12.2.6 Integration of the client, patient and community in planning, implementation and evaluation of services

The core objective of any healthcare institution is service to the community. Therefore, before any planning or implementation can take place, the needs of the community must be known and understood. The best way to do this would be to communicate with the local community forum. If that is not possible, then elicit the opinion of patients on current services (Currie et al, 2003:9–10, 26; Stonehouse, 2013:96).

## 12.2.7 Standardised, improved care delivery at primary, secondary and tertiary levels

Clinical governance aims to provide inclusive, accessible, standardised care to all people in the community; to promote healthy lifestyles and prevent disease. Special attention is paid to people living with disabilities and/or chronic diseases, in order to assist them to reach their full potential. Situations which impede healthy living are addressed at local and national level eg housing, sanitation, drug abuse and violence.

## 12.2.8 Maintenance of privacy and confidentiality

Privacy ensures that patients' information is anonymous to protect them from harm. Confidentiality is the safe-guarding of information. The information is only shared with those who have a direct involvement with the patients' care. Confidentiality is one of the basic ethical guidelines of healthcare and may only be broken if it is in the patient's or society's best interests. Special attention should be paid to confidentiality when using case studies for teaching and when conducting research.

Patient documents and records must be kept in safe storage to prevent information becoming public. Record keeping is a crucial part of care and is the way in which professionals communicate with each other on the care rendered and the patient's response to this care. Therefore, records must be accurate, complete, concise, in a logical or chronological order, readable and signed in such a way that everyone can see who made the entry. The entries should be made in a colour which can be photocopied, eg black or blue, to enable the copying of records should the need arise eg for litigation. The records reflect the service, and thus the quality of the service should be obvious from reading the records. Records could be used as tools to demonstrate quality care or the lack thereof, and thus could be used as baseline information for quality programmes.

## 12.2.9 Continuous assessment and evaluation of performance: individual, team, institution

Performance and outcomes are the indicators of success. If these are not measured/audited, there will be no base line data and no empirical evidence of any improvement, or of poor service. The information will be anecdotal and

may not reflect the true level of service. For this reason all institutions should measure the performance of the individual, the team and the institution. This measurement will then form the baseline for the objectives set for the next period (Currie et al, 2003:26–27).

Assessment and evaluation could be formal or informal, but should include patient feedback, scrutiny of standards and of research conducted, reflection on the unit's objectives, self-assessment and peer assessment to be effective.

## 12.2.10 Proactive risk management

A risk in the healthcare environment can be one of many things and could involve a patient, a visitor or a staff member. Risks include such things as incorrect administration of medication, access to scheduled medication, patients falling out of bed, hospital-acquired infections, or a visitor slipping on a wet floor (Currie et al, 2003:15; Stonehouse, 2013:96). Risk management should form an integral part of staff assessment (Som, 2011:356).

Risk management aims to:
- identify risks
- manage risks proactively to reduce or eliminate potential harm
- evaluate the measures in place to reduce the risk
- learn from incidents and accidents
- implement these learnings with a view to reducing future risk (NHS Wales, 2001:16).

Good record keeping, standardised policies and procedures and audits will assist the staff members to identify and mitigate the risks in the unit.

Collier (2014:12) maintains that every staff member contributes to clinical governance by practicing self-regulation, aligning own development with that of the healthcare institution, setting standards, promoting evidence-based practice, working cost effectively, integrating theory and practice and by developing strong leadership qualities.

## 12.3 Clinical governance values

Clinical governance supports the Batho Pele principles by entitling each South African to coherent, transparent, efficient, effective, accountable and responsive care. Other values underpinning clinical governance are justice, empowerment, humanity and respect.

- *Justice* is acknowledging that a mistake has been made. The patient has the right to know what will be done about the mistake. Justice is not about blaming the mistake on any person, it is about taking responsibility to investigate each incident fully and giving feedback to the patient on the cause of the incident, and the actions put in place to prevent a similar occurrence.

- *Empowerment* is crucial to healthcare. Patients must be educated about their own healthcare needs, the solutions to these and the measures they can take to promote their own health and prevent recurrences of illness. The healthcare provider must teach patients to take control of their own health. The patient should be the leader of his/her healthcare, and should know when to seek medical assistance and where this assistance is available.

- *Humanity* is recognising that all people are unique beings who should not be discriminated against because of this uniqueness eg race, creed, gender, intelligence. Each person is regarded as being worthwhile and a valuable contributor to healthcare because of their uniqueness.

- *Respect* is demonstrating regard for everyone. Respect means to treat all persons as equal, with dignity and with equity.

In addition to the above values, healthcare institutions also expect their staff members to display and/or practise competence, caring, commitment, integrity, compassion, responsibility, confidentiality, a spirit of enquiry and patient advocacy.

## 12.4 Evidence–based practice

Evidence-based practice (EBP) is an analytical methodology that facilitates problem solving through critical thinking. EBP uses current empirical evidence and takes into account the patient and unit situation, the patient's preferences and the internal and external factors that impact on the various levels of care delivery (Staniland, 2007:30). If applied appropriately, EBP will lead to improved, dependable patient management, cost savings and increased job satisfaction. EBP includes all members of the multidisciplinary team. The time period between finding effective interventions and application should decrease as nurses increase their use of EBP (Rickbeil & Simones, 2012:55). EBP is measured by a clinical audit; reflection on the individual and team's performance and the level of accountability; mitigating risk; life-long learning; and a strong culture of quality supported by leadership.

Research is a component of professionalism. Every time 'something new' is tried, research is being conducted. In nursing, most of this 'trying out' is limited to the nurse's own experiences in the clinical facility;  the results are rarely recorded, which means that experiments cannot be duplicated. Therefore, evidence is anecdotal and anecdotal evidence is difficult to replicate because the process is not recorded.

Healthcare is moving from anecdotal practice to EBP. Therefore, all nursing care plans should be grounded in research that has been subject to the rigors of academic review, duplication, replication and ethical practice. EBP could be used to develop nursing care pathways based on the findings of research. This would enhance the quality of healthcare.

## 12.4.1 The process of evidence-based practice

The scope of this book does not allow for a full discussion on the process necessary to produce EBP. However, the following is a short description of the main aspects involved.

### *Gather evidence*

To implement EBP, demographic information should be collected, which includes the patient's emotional, social, spiritual and physical circumstances, as well as the abilities and circumstances of the family and significant others. In addition, information must be gathered about the healthcare team and its skill, motivation, capacity and readiness to implement new techniques.

The gathered information illustrates the current situation and highlights the shortfalls, potential problems and healthcare issues. Once these are identified, empirical evidence about the management of similar situations is sought.

### *Evaluate evidence*

The current empirical evidence on the topic is then evaluated for suitability, acceptability and possible implementation. If found to be suitable, the solution can be implemented and the results are recorded to add to the evidence.

Should the current evidence be found to be lacking, all those involved with the patient would propose a range of solutions. The usefulness, consequences and acceptability of each of the solutions is carefully determined. Records are kept of all the deliberations. Once the solutions have been determined these are explained to the patient and the healthcare team. The patient has the right to accept or refuse the solutions given. When all have been briefed and are in agreement, the solutions are implemented under supervision.

All actions, problems which arise, deviations from the solution decided upon and the effect of the solutions are carefully documented in such a way that the process can be repeated at a later stage.

After an agreed upon time period, the base line data from the patient is assessed against the results of the solution implemented. The solution is then adapted, discarded, or continued and re-evaluated after a given time period.

As mentioned, this is a very summarised version of the process of EBP. It would be advantageous to consult a book dedicated to this topic.

## 12.4.2 Benefits of evidence-based practice

A few of the benefits of EBP are enhanced patient safety, improvement in patient outcomes, and a decrease in negative incidents. EBP enhances the credibility of healthcare practice and expands the body of knowledge available.

Research has demonstrated that in an environment where EBP is applied, both staff and patient satisfaction are improved and costs are reduced due to fewer re-admissions. The use of up-to-date information increases the trust between healthcare providers and enhances the credibility of nursing. Nurses feel more

empowered to make decisions and accept greater accountability for their actions (Brody et al, 2012:28).

## 12.5 Patient pathways

When healthcare practice is based on EBP, the average patient's stay from admission to discharge can be planned. This plan is called a patient pathway or a clinical care pathway. The patient pathway is the expected journey the patient will follow to recovery. All nursing interventions are indicated throughout the recovery process. This pathway enables the nurse to provide acceptable and effective EBP interventions. An added advantage of the patient pathway is that record keeping can be reduced: when following a patient pathway, only deviations from the plan are recorded (National Council for the Professional Development of Nursing and Midwifery (NCPDNW), 2006:5).

The main objective of a patient pathway is to optimise health by ensuring fair access, rendering responsive and suitable care and improving quality by using EBP. A further objective is to make care as cost effective as possible (NCPDNW, 2006:7, 10).

### 12.5.1 Principles of patient pathways

The patient pathway is a diagnosis-specific written patient care plan which should accommodate the needs of all patients with the specific diagnosis, but with space to individualise the care. The methodology to set the pathway is the same as for EBP. The principles of patient pathways are:

- *Patient centricity*: The emphasis is on holistic and individualised patient care, without any discrimination.

- *Safety and quality*: The implementation of EBP enhances the patient's outcomes and supports improvements in quality.

- *Effectiveness and efficiency*: EBP encourages innovation and up-to-date management, thereby eliminating waste and reducing costs.

- *Timeliness*: As the care is standardised, delays and impediments in care delivery are reduced.

- *Justice*: Care is standardised and thus all patients receive the same level of care with no discrimination based on socio-economic status or other factors (Scottish Executive Health Department, 2007:5–9, 11; NCPDNW, 2006:10).

### 12.5.2 Advantages of patient pathways

Patient pathways enhance patient outcomes through standardised evidence-based care, but leave space for personalised care to ensure patient satisfaction with the level of care rendered by the whole multidisciplinary team (Fitzsimons & Wright, 2012:2, 11). Patient care is detailed from admission to discharge and is guided by empirical evidence and therefore can serve as a tool to evaluate the quality of care the patient received. Standardised care lends itself to cost

effectiveness and improved quality through the effective utilisation of all resources including human resources. Staff members are therefore more satisfied and the patient experiences the care as value for money (Fitzsimons & Wright, 2012:5; Scottish Executive Health Department, 2007:5; NCPDNW, 2006:10).

## 12.6 Adverse events

An adverse event is any actual or potential mistake in patient care, leading to injury. This could usually have been prevented if the correct organisational, institutional and unit standards were in place and followed. It includes both actions and failure to act. Nurses are regarded as patient advocates and should proactively identify and mitigate risks to the patient.

## 12.7 Error management

Errors are often blamed on staff members. The challenge is to look past the staff member and to find the true cause. The true cause is often found in the working environment, the systems within which the staff member works, or the circumstances surrounding the error. If the true cause is not identified, the error will recur and patients remain at risk. The process of identifying the true cause is called root cause analysis (Reason, 2000:768).

Reason divided errors into two types – active and latent errors. He defined active errors as those committed by staff members at the bedside due to noncompliance with procedures or negligence. He further classified active errors into slips, lapses and mistakes (Reason, 2000:769; Donaldson, 2000:ix, 21–22). Slips happen when one knows how to do something correctly, but unintentionally does it incorrectly. Lapses occur when one knows what to do, but forgets to do it. Mistakes occur when one does not have sufficient information of the treatment, care or situation due to distractions, absent-mindedness, lack of concentration, lack of insight, as well as wrong decisions, assumptions and judgments.

Latent errors are problems inherent in the healthcare system. These will happen again if the organisation does not change. These errors could be related to a decision made without realising that future complications may arise. Examples of latent errors are changing the skills mix; changing a process, eg pre-operative care document which does not include allergies; policies, eg administration of intravenous and intramuscular medication at the same time by the same person. Latent errors are difficult to detect.

Errors have also been classified as errors of omission and errors of commission. Errors of omission are when something which has been agreed upon or which is known to the person is not done, eg failure to render pressure care. Errors of commission happen when a task which is known to the person is done incorrectly, eg giving a medication via the wrong route.

## 12.7.1 Factors associated with healthcare errors

There are numerous factors associated with errors, some are related to communication and others to organisational factors.

### Communication

Verbal and written communication could be perceived and interpreted differently due to hearing, reading or transcribing problems.

- *Inadequate information flow*: Breakdowns occur when information is conveyed incorrectly, record keeping is lacking or information is not distributed to the correct people.

- *Individual factors*: Lack of knowledge of how to do something, failure to follow the available policy and procedure, too few staff members to do the work, absent-mindedness, feeling ill or tired, drug or alcohol abuse, stress and being busy with many activities at the same time.

- *Team factors*: Lack of co-operation and leadership in a group could lead to conflict, which detracts the attention of the staff from their work.

- *Patient factors*: Inadequate language to express their needs or to understand what the healthcare provider is explaining may lead to poor patient education and inadequate care. The patient's level of acceptance of his/her disease process may lead to the denial of symptoms or withdrawal from the caring process.

### Organisational factors

Several factors which could exist in the healthcare organisation contribute to the incidence of errors in care.

- Lack of induction and orientation, staff development and/or education and training could all lead to inadequate knowledge of the policies and procedures of the organisation.

- Inadequate staffing, inappropriate staffing and lack of supervision lead to staff being overwhelmed by the workload to such an extent that they become demotivated to complete even the tasks they could manage.

- Lack of or inadequate policies and procedures allow staff members to conduct activities in the way they want to, instead of doing them correctly.

- Lack of appropriate equipment and materials, or poor maintenance of equipment, lead to increased workload and problems.

- A culture of blame-and-shame discourages reporting of incidents and accidents. The under-reporting of incidents and accidents reduces the opportunities to learn from mistakes and causes the recurrence of these mistakes (Donaldson, 2000:viii, 21).

## 12.8 Root cause analysis (RCA)

To encourage root cause analysis (RCA), staff members must be open to acknowledging and reporting errors. Most errors do not cause patient injury or other damage. An in-depth investigation could prevent future problems by devising plans to mitigate future occurrences of the same problem. This way of investigating incidents is called root cause analysis. RCA should be done by the multidisciplinary team with no predetermined notions or defined conclusions.

### 12.8.1 Steps to conduct RCA

RCA is a logical process which follows a process of information gathering, information analysis and solution formulation.

### *Step 1: Gather information*

A variety of methods should be followed to gather the information. The research principle of triangulation should be followed to define the root cause. The staff members involved write the incident report and are interviewed as soon as possible to ensure the exact recollection of the incident. Follow-up clarifying interviews are then held. The interviewers seek answers to the questions about the incident: what, why, how, when and where. To probe further, the interviewers employ the 'five why' technique, by asking why until the response is such that there is no further information forthcoming (Vorley, 2008:7). The interviewers should not stress the staff and administrative factors, as this might lead to staff being unwilling to share further information.

The questions interviewers should ask are:

- What is the sequence of events?
- Which of the individual healthcare professional's characteristics played a role in this problem?
- What is it about the patient and the task that led to this problem?
- Which team factors contributed to the problem?
- Which institutional factors contributed to the problem?
- What are possible ways to prevent a further similar problem?
- What could we learn from this problem?

The interviewers should then scrutinise the policies and procedures of the organisation, including the unwritten rules.

### *Step 2: Analyse information*

The incident must be defined in detail to ensure the solutions are applicable (McDonald & Leyhane, 2005:28). Once the information is gathered, all involved should participate in the examination of the information. A barrier analysis

follows information analysis. Barriers are restraints such as policies and procedures, practices and technical features which should have prevented the incident. Observance of these controls is interrogated to determine why they failed.

Many tools are available to identify the causative factors:

- The fishbone is used to identify all the contributing reasons of the error and to interrogate each. The most probable causative factor is then identified and analysed further (Vorley, 2008:8).

- Process flow charts can demonstrate flaws in process flows, eg time delays, ineffective use of equipment, etc.

- Pareto or bar charts provide visual representation of the differences, eg staffing for a month or a week could be plotted to see the variances per day (Vorley, 2008:7).

- A histogram and scatter diagram provide a visual representation of the relationships between data.

### Step 3: Decide on a solution

Solutions can be found by using national and international benchmarks, investigating what other industries did when faced with the same problem, interrogating best-practice, etc.

Decision trees provide a model to determine the possible solutions with their possible consequences, both positive and negative. This provides direction for decision making. (Vorley, 2008:10). The possible solutions are brain-stormed and then explored for usefulness, cost-effectiveness, constraints, prerequisites and the processes required to implement the change.

## 12.9 Plan, do, study and act (PDSA) cycles

One way in which to introduce changes are plan, do, study and act (PDSA) cycles, also called Deming's cycles. PDSA-cycles are small problem-based research studies, conducted on a specific problem in a specific area. If the plan is successful in the specific area, the plan and the learning from it are implemented in other areas with the same problems. In other words, evidence-based care is implemented after piloting it using a controlled process (Karuppusami & Gandhinathan, 2007:7).

The aim of PDSA-cycles is to implement small changes in incremental phases in order to evaluate the effectiveness of each change. The change is planned, using all the data related to the problem, the change is implemented, and the results of the change are studied. If the results are positive, the PDSA-cycle is implemented in other areas where similar problems exist. If not, the intervention is changed, refined or discarded (Gorenflo & Moran, 2010:5).

### 12.9.1 Plan

During the planning phase, the principles of root cause analysis are used to determine the aim of the project, as well as the consequences, the causes and the solution to the problem. The resources needed, the assistance and involvement required, as well as the success parameters are determined. From this information, the specific objectives are compiled. All the measurements must be specific, attainable, realistic and must have an explicit deadline.

### 12.9.2 Do

To 'do' is to implement the plan. Before implementation, training in the measurements is required. The change process must be managed and staff must be motivated to implement the change fully. The staff members identify pitfalls, problems, as well as the expected and unexpected results.

### 12.9.3 Study

'Study' is to study and reflect on the results and evaluate them for efficacy. The success is measured against the results of the plan. The possible solutions to the problems experienced are investigated. The impact and success of the plan are evaluated.

### 12.9.4 Act

'Act' is to determine if the plan will be abandoned, grown, changed or expanded to other similar units. During this phase, the next problem is identified and a new cycle commences (Gorenflo & Moran, 2010:3–5).

## 12.10 Summary

Clinical governance should be the basis of all quality initiatives in any healthcare institution. By conducting root cause analysis and implementing PDSA-cycles, the quality of care will improve, staff satisfaction will increase and the credibility of the institution will be confirmed.

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# Customer Service and Corporate Governance

R Schaefer

## Chapter Outcomes

After studying this chapter, you should be able to:
- understand and implement a customer service culture in a healthcare unit;
- understand the responsibility of healthcare institutions towards the general public and the environment;
- implement a plan to mitigate the impact of healthcare on the environment;
- implement a plan to improve the life of the people in the area serviced by the healthcare facility.

## 13.1 Introduction

In public healthcare, the customer is the population of South Africa to whom care is given. Additional customers in private healthcare include the shareholders, the board, medical aids and other divisions in the organisation, eg the pharmacy.

Corporate governance refers to the way in which an institution is managed. Without strong governance and management, it seems unlikely that an institution could offer good customer service. Both of these aspects are therefore covered in this chapter.

## 13.2 Customer service

Customer service in healthcare is the collective actions that place the patients' welfare, comfort and security first, and which recognise that the patient is the leader of her/his healthcare journey. Patients measure service by using their senses, ie touch, smell, vision, taste and hearing. They might not have a direct influence on which healthcare facility they use, as this is often dictated by the type of medical cover and the physician consulted. Negative outcomes and complaints could, however, influence the physician and medical aid to move their patients to another hospital.

### 13.2.1 The Batho Pele principles

In an effort to improve the healthcare service delivered to the public in South Africa, the Batho Pele principles were published by the Mandela government during 1997. Batho Pele is about putting others first. The Batho Pele principles are a customer service pledge to every individual who accesses healthcare. These principles should underpin all the services delivered in both private and public healthcare facilities.

## Consultation

The patient is the customer and, as such, should be consulted on all matters concerning his/her health. No treatment or care programme may be implemented without the patient's informed consent.

## Service standards

Patients should have a choice of the service they want. Transparency in reporting of standards achieved in the healthcare institution would enable patients to select a facility based on these measures.

## Access

Access is about how accessible healthcare facilities and healthcare staff are to the patient. The attitude and demeanour of the staff could inhibit communication between the patient and the healthcare professional, and the patient would be unable to voice his or her needs. This would lead to a breakdown in service delivery.

## Courtesy

All patients should be treated with respect and dignity. Friendliness, helpfulness and courtesy must be shown to patients and their families at all times.

## Information

The patient must be fully informed of all treatments and care regimes before they are implemented. Patients must be aware of the costs involved and where free alternatives may be available. To prevent misunderstandings, the information must be given at the educational level of, and preferably in the language of, the patient.

## Openness and transparency

The service should be transparent regarding all activities, planned activities, budgets and strategy to empower the patients when they must make a decision. When a mistake is made, the patient should be informed of what went wrong, how it will be addressed and how it would be prevented in the future. If a patient is unhappy, he/she should be assisted to make a complaint in the correct manner to the correct person.

## Redress

Redress is about how complaints are managed. The patient is entitled to compensation if the service was not up to standard. Healthcare professionals must listen to complaints sympathetically and should apologise to the patient.

## Value for money

The patient is entitled to a cost-effective service. All waste, fraud and corruption should be reported and eliminated.

## Encouraging innovation and rewarding excellence

Healthcare professionals should be encouraged to look for ways in which to improve the service to the patient. Rewarding staff for service excellence would improve staff satisfaction, which in turn leads to improved patient satisfaction.

## Customer impact

Excellence in service delivery and implementation of all the Batho Pele principles enhances patient health, as the patient would receive planned and effective care. The patient is also empowered to manage his/her own health.

## Leadership and strategic direction

Management must be the enabler for the implementation of the Batho Pele principles. They should reward staff for implementing the principles and thus create a culture of excellence in service delivery.

## 13.2.2 Improving customer service

Patients often feel disempowered in a healthcare facility, due to the strangeness of the environment and the relative loss of control over their lives. This feeling could either be alleviated or aggravated by the service they receive from health-care professionals. Satisfied patients will trust the staff members who render good care, which increases the possibility of a positive outcome. One of the key aspects of customer service is a motivated, optimistic workforce with a culture of customer service excellence. Healthcare professionals must display a positive, caring attitude in all their interactions with patients and with each other.

Healthcare professionals must act promptly, listen attentively, be sympathetic and considerate, act with empathy, provide explanations and avoid medical terminology during their interactions with the patient. The language used when speaking to the patient must be at a level that he/she can understand; therefore, no medical jargon should be used. However, the tone of the conversation should not be such that the patient feels that he/she is regarded as mentally backward.

Patients value face-to-face interaction with healthcare professionals and appreciate care rendered with dignity and respect (Richins, 2002:558). Healthcare professionals should be honest, disciplined, creative and humble. They must be honest about their acts and omissions, be disciplined in performing their duties, creative to prevent or solve problems, recognise their knowledge deficits, put the patient first, and must investigate anything that seems outside of the ordinary. The patient should be appreciated as a holistic individual with individual needs. Patients must not feel neglected due to the work pressures of healthcare professionals (Richins, 2002:558). Waiting times are often the source of complaints. Ensure that the patient knows how long the waiting period is and,

if there is a delay, notify the patient of this timeously (Tea, Ellison & Feghali, 2008:233).

Most healthcare facilities have systems in place to measure customer satisfaction with a view to improving service. The measurements include customer service ratings, adverse incidents, clinical effectiveness, record keeping, productivity and cost effectiveness. The success of customer service is measureable in loyalty (returning), attitude (feeling safe, positive), effort (being prepared to change from medical aid or physician to come to the institution) and identification (sharing the same values).

Private healthcare derives value from customers because they provide profits that increase shareholder wealth and ensure increased investment. Public healthcare derives value from customers as they attract more private patients and can become more self-sufficient. Patients' willingness to pay for a service depends on their perceptions of the quality and value which they received.

The healthcare facility should have a response plan in place when patients complain, and empower employees to use customer recovery strategies before the patient realises the mistake or problem. For example, apologise for the delay in the operation before the patient realises that his operation time is delayed.

## 13.2.3 Service recovery

Service recovery is a strategy to recover the patient's immediate satisfaction and to improve the patient's trust in the healthcare facility. It is a strategy to minimise the harm caused by a service failure and a means to reinstate and validate relationships with patients (Bendall-Lyon & Powers, 2001:28).

Complaints are inevitable, but controllable if the patient is satisfied with how the complaint is managed and resolved. Dissatisfied patients do not necessarily complain, but they discuss their frustrations with their friends and family (Chueh, Wang & Liao, 2014:857), resulting in damage to the image of the healthcare institution. Therefore, patients should be encouraged to voice their unhappiness by making complaining easy, being an active listener, being empathetic, and asking patients about a specific service issue and by creating an organisational culture that values complaints as opportunities to improve the level of service. The patient must feel that he/she is heard, so speedy action is important (Bendall-Lyon & Powers, 2001:279).

Healthcare professionals should be empowered to manage complaints about service at the lowest possible level. They should be trained to take accountability, to apologise on behalf of the healthcare facility, to seek a speedy resolution, or if necessary to escalate the problem sooner rather than later (Bendall-Lyon & Powers, 2001:283).

Tracking and conducting root cause analysis (RCA) on complaints is important to ensure learning from recovery experiences with a view to improved service (Bendall-Lyon & Powers, 2001:285).

## 13.2.4 The multidisciplinary team as customers

Healthcare customers include both the users of healthcare as well as the members of the multidisciplinary team. Nurses are the co-ordinators of the patient's care; to enable the rest of the team to provide quality care, the nurse must keep the team up to date about the patient's condition and needs. Both written and verbal communication is essential. Inadequate information may lead to inappropriate requests or prescriptions for treatment.

Specific strategies have been developed to improve communication between the members of the multidisciplinary team. The SBAR (situation, background, assessment, recommendation) method is the most frequently implemented communication framework in the healthcare setting (Joffe et al, 2013:495). The purpose is to ensure that sufficient information is communicated for the members of the multidisciplinary team to make an informed decision regarding patient care, to stimulate critical thinking and to be solution focused.

To implement SBAR, ask the following questions:

- **S**ituation: What is happening now? What is my assessment of the situation and the patient? What has been done to try to solve the problem? What are we doing now? Is this working or not?

- **B**ackground: What are the circumstances leading up to this situation? Which of these indicators imply that the patient's condition will worsen?

- **A**ssessment: What do I think the problem is? What is my nursing diagnosis? Why do I need to involve the members of the multidisciplinary team?

- **R**ecommendation: What could we do to correct the problem? What do I suggest? (Joffe et al, 2013:495).

## 13.2.5 Customer service challenges

Nurses face numerous challenges while caring for patients. They need to empower their subordinates and themselves to manage difficult situations successfully.

One of the biggest challenges is that patients in general are becoming more informed about their health and demand quality care. The patient often knows more about his/her condition than the nurse does. This may give rise to conflict with the patient due to the patient's increased demands and the nurse's insecurity. Staff members should accept this and be prepared to take their lead from the patient. The patient may also be convinced of the worth of a treatment and may then either refuse alternate treatment or insist on a specific treatment. The patient has a right to refuse treatment. Manage this situation with tact and empathy; try to convince the patient of the worth of the treatment without diminishing his/her dignity.

Patients want feedback; they want to know the results of their tests and the way forward. Often, this information may only be given to the patient by another member of the multidisciplinary team. Ensure that, when the specific member of the team visits the patient, this information is shared with the patient. Go back to the patient and ask if he/she understood and explain further if needed.

Patients rate value in terms of time spent waiting and on communication received from the healthcare professionals. The better the patient understands the processes and procedures, the more satisfied he/she will be. Naturally, healthcare professionals should know and understand the needs of the patient (Chueh et al, 2014:858).

A golden rule is to never promise something to the patient that cannot be done; rather under-promise and over-deliver. For example, if you think you will be able to assist the patient in 10 minutes, tell him/her you will assist in 20 minutes.

## 13.2.6 The patient journey

The patient journey is a term used to describe the period from the first symptom to the time of resolution/health recovery or death. The question is: what can health-care professionals do to improve the patient journey? Patients have differing experiences of the same event, based on their expectations, their backgrounds, their personalities and their perceptions. Healthcare professionals should identify the causes of the problems patients experience, conduct a root cause analysis, and then implement policies and procedures to prevent the problem in future. Figure 13.1 explains the process of conducting a root cause analysis.
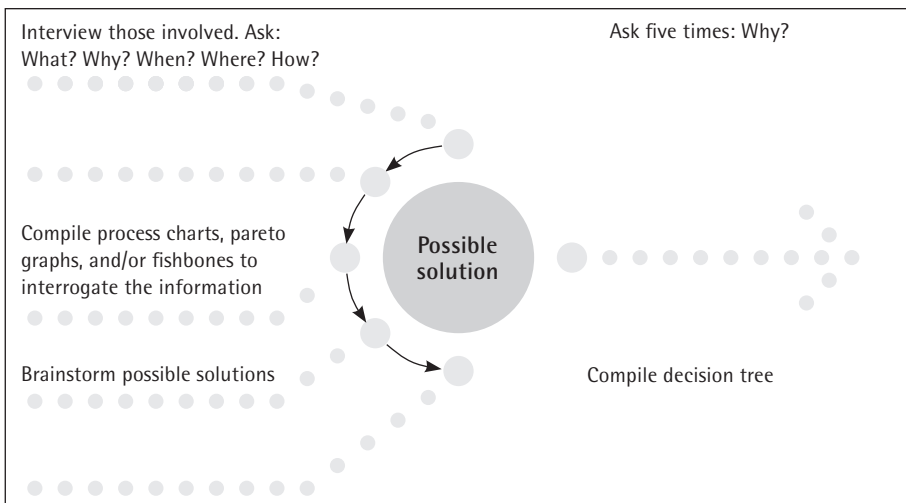


**Figure 13.1**: Root cause analysis

Improving the patient's experience is a complex task. The requirements are transformational leadership; a clear vision; desired values and behaviours embedded across the whole organisation; engaged staff, patients, families and carers; greater clinical engagement and professional empowerment; and a healing environment.

## 13.3 Corporate governance

As mentioned in the introduction to this chapter, corporate governance is about the way in which an institution is managed. It establishes a culture of transparency and accountability between management and stakeholders, protects the interests of stakeholders, and determines the division of power in the organisation (Muswaka, 2013:11). Governance of the institution is not only about how the internal processes are managed, but also about the responsibility of the institution to the environment and the population it serves. Thus, the environment and the catchment area of the institution become its customers.

The goal of corporate governance is to create value, improve performance and enhance sustainability and stakeholder confidence. If these primary aims are in place, decision making is facilitated and service to the patient is improved. Continuous monitoring and evaluation of the corporate objectives is essential to reach the goals of the healthcare institution.

During 1994, the government of the day appointed a committee to investigate elements of good corporate governance. Led by retired judge, ME King, the committee released the first King report in 1994, which set goals for all businesses to reach as indicators of good corporate governance. The committee's third report, known as King III, was released in September 2009. It set compulsory goals for healthcare and other institutions which have to be measured and reported on annually. King III is revolutionary in that it made South Africa the first country in the world where institutions have to report on what became known as the triple bottom line. This means that all institutions have to report to both their stakeholders and the government on their finances, their environmental impact and their social responsibility.

The concept of the triple bottom line was developed by John Elkington (Kosovic & Patel, 2013:8). It is believed that performing well in all three areas will ensure sustainability, not only for the institution, but also for the world at large (Kosovic & Patel, 2013:8–9). South Africa has adopted the 'comply or explain' approach, which means that, if an institution does not comply, it has to explain why it is not complying.

The King III report maintains that good governance is about intellectual honesty and not just sticking to the rules and regulations. This compels healthcare institutions to identify and understand their impact on the environment and on society and acknowledge their responsibilities towards these (Van Zyl, 2013:19). The healthcare institution then also serves the broader community of South Africa by addressing the social and environmental problems experienced in South Africa, for example transformation, human rights, human capital, access to healthcare, waste, etc (Van Zyl, 2013:23).

## 13.3.1 The basic elements of good governance

To ensure governance is applied throughout the organisation, the following elements must be in place:

### *Accountability*

The board and senior management are accountable for all the actions of the employees of the healthcare institution, the financial expenditure, the social impact and the environmental impact of the healthcare institution. The healthcare institution, in both the private and public sectors, has to report annually according to generally accepted accounting principles. Should there be discrepancies in its financial management, the healthcare institution has to declare the causes of these. External auditors monitor the financial activities and report irregularities to the board and senior management (Van Zyl, 2013:26; European Commission, 2004:19).

### *Participation*

The healthcare institution can and should participate in rectifying social issues such as the lack of transformation, the lack of education and the lack of access to healthcare. This can be done through learnerships, bursaries for studies, investing time and money in social outreach programmes, and implementing equity and transformation targets.

### *Predictability*

The board, senior management and employees must have a common goal and use the same policies and procedures, subject to legislative and regulatory requirements, throughout the organisation. This will ensure that decisions are made on a common understanding and will create consistency in behaviour and decision making (Nyanamba, 2013:250).

### *Transparency*

The healthcare institution must be transparent to all the stakeholders (employees, shareholders, patients, government, etc) with regards to all its policies and procedures and the financial reporting done. Information should be available to all who have an interest in the healthcare institution (Van Zyl, 2013:27; European Commission, 2004:19; Nyanamba, 2013:250).

### *Measures to combat corruption*

The board and senior management must create a programme where the employees can report any fraudulent behaviour. This programme should be anonymous to encourage reporting. The programme could also provide access to reporting abusive behaviours of management and employees (European Commission, 2004:23).

## *Legislative reform*

The board and senior management must ensure that they remain up to date with legislative changes and regulatory changes eg tax laws. They have to implement initiatives to ensure the healthcare institution and its employees function within these (European Commission, 2004:29).

## *Responsiveness*

The healthcare institution should remain responsive to changes in the economic environment, competitors and trends in the market place, as well as to social ills in the country. They cannot remain relevant if they ignore these forces (Nyanamba, 2013:251).

## *Consensus orientation*

The members of the board and senior management should reach consensus on decisions, based on what is in the best interests of the healthcare institution. Consistency is important. The interests of the individual members of the board and senior management should not influence decision making (Nyanamba, 2013:252).

## *Equity*

All of society should have equal access to employment in healthcare institutions, based on their qualifications, past experience, potential and cultural fit with the healthcare institution. Equity policies should encourage transformation, the employment of people with disabilities and prevent discrimination of any sort (Van Zyl, 2013:31; European Commission, 2004:18).

## *Effectiveness and efficiency*

Processes and institutions should produce results that meet the needs of the patients. Efficient use of resources will lead to cost-effective healthcare delivery and will broaden the access to healthcare facilities (Nyanamba, 2013:251).

## 13.3.2 The principles underpinning corporate governance

- The institution must take an ethical approach to all policies, procedures and decisions. Healthcare institutions should report all ethical breeches and dilemmas to the board and senior management.

- Balanced objectives are essential so that the pay-off between quality, quantity and finance is considered when the budget is drafted and forecasts are made.

- There must be equal concern for all stakeholders, even if some may seem more important than others.

Governance, objectives and strategies within a healthcare institution must be compatible, and there must be agreement with the expectations of interested parties.

## 13.4 Summary

In the healthcare environment, the patient is the customer and it is the patient's needs that should be considered first in every interaction. There are numerous challenges in providing good customer care and improving the patient journey. However, if the healthcare professional communicates with patients and their families with courtesy, respect and helpfulness, this can go a long way to improve the patient's time in the healthcare institution.

Corporate governance refers to the way in which an organisation is managed and in line with the King III Report, each institution must report on the triple bottom line of finances, social responsibility and environmental impact, whilst maintaining transparent and ethical practises.

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# 14

# Delegation and Supervision

P Ntamane

## Chapter Outcomes

After studying this chapter, you should be able to:
- define delegation in the context of a healthcare unit;
- describe the principles which guide professional nurses when delegating tasks;
- describe the barriers to delegation of tasks in the unit;
- define the concept 'supervision';
- analyse the supervisor's critical role in the unit;
- describe effective supervision skills;
- discuss supervision as a control instrument in unit management.

## 14.1 Introduction

When professional nurses do not effectively delegate to others, the quality of patient care can be compromised and valuable resources can be mismanaged. Delegation is the process of transferring authority and the responsibility for an activity or a task from one individual (the delegator) to another (the delegate), while accountability for an outcome is retained by the person delegating. It is a complex professional skill, requiring sophisticated clinical judgement and final accountability for patients' care.

## 14.2 The concept of delegation

In the healthcare context, delegation can be defined as achieving performance of care outcomes for which you are accountable and responsible, sharing activities with other individuals who have the appropriate ability, and responsibility and authority to accomplish the work (Yoder-Wise, 2011). In the delegation process, accountability rests in the decision to delegate, while responsibility rests in the performance of the task.

In an organisation or a healthcare unit, a professional nurse delegates a task to a subordinate, but the ultimate responsibility or accountability for the outcome remains with the professional nurse. Accountability cannot be shared; therefore, if the task has been delegated and it is not done correctly, the delegator takes the blame (Jooste, 2010:57). This does not, however, mean that the person delegated to perform a task does not have some degree of responsibility for their actions. Careful selection and understanding of subordinates and the provision of supervision minimises adverse events and possible legal liabilities – both for the patients and for the organisation.

When delegating, the delegated role needs to be clearly defined. Consider the following questions:

- Is your communication clear? Does the subordinate understood what is required?
- Is the task within the subordinate's scope of practice?
- Is the task within the subordinate's job description?
- When will the task be assessed?

## 14.3 When to delegate

The professional nurse needs to realise that not all tasks can be delegated. To determine when delegation is most appropriate, there are five key areas that need to be explored:

- Is this person the right person for the task? Is there someone else who can complete the task?
- Does the task provide an opportunity for the subordinate to grow and develop skills?
- How long will the task take to be completed? Will it require a handover before completion?
- Is there enough time to delegate the job effectively? There should be time for adequate training if necessary, for questions and answers, for opportunities to check progress, and for rework if required.
- Is this a task that should delegated, or is it a task that needs the delegator's attention?

## 14.4 Effective delegation

Delegation creates resources for managers and gives subordinates a chance to grow, which is why supervision should be done to monitor overall progress. Koloroutis (2004:136) identified guidelines for implementing this critical skill:

- Delegation requires that the professional nurse makes decisions based on patient needs, the complexity of the work, the competency of the individual accepting the delegation, and the time taken to do the work.
- Delegation requires that information regarding an individual patient be shared. Specific expectations must be defined and any adaptations of the work to suit the patient must be clarified. The delegator must provide guidance and support.
- Delegation requires that the professional nurse accepts ultimate accountability for the process and outcomes of care.

In addition, the delegator should remember that the subordinate is part of the delegation process and her/his input is important. Remember that the delegator cannot delegate her or his own accountability, because the task remains the responsibility of the delegator; the subordinate is accountable to the delegator.

The delegator should be prepared to revoke the delegated task, if things do not work out as planned. There could be several reasons for this, including inappropriate delegation or the subordinate failing to perform for some reason. Therefore, the delegator has the responsibility to revisit the decision but should never rescind without cause. A suggestion is to establish checkpoint expectations or supervisory periods. The delegator has a right to reasonable monitoring of progress, as she or he remains accountable for the delegated task. The delegator and the subordinate should agree on mutually acceptable checkpoints and stick to them, for example asking for status updates within agreeable time frames. However, some adhoc monitoring periods should not be ruled out completely.

Remember also to delegate authority, not just work, and delegate fully. Delegating a task, and not the authority that goes with it, can be demoralising for the subordinate, especially tasks that require creativity, insight or commitment. Therefore, the delegator should delegate fully yet remain accountable.

It may be tempting to make promises of something in exchange for the task but the delegator should think carefully before making such an offer; subordinates have control of their own levels of passion and commitment. The delegator needs to acknowledge that subordinates might agree to accept what is delegated, but unless they are truly committed, delegation can create trouble.

There are risks in all work situations, which means that emergencies are inevitable. It is important to create reserves to manage emergencies through delegation.

What is very important is to keep the lines of communication open; there must be agreement to communicate timeously any change in the risk profile of the delegated task; this agreement applies to both the delegator and the subordinates. Both the subordinates and the delegator should be able to identify signs of trouble.

Ineffective delegation can lead to poor patient care and an increase in the incidence of omissions. As the leader of a nursing team, the professional nurse is accountable for the consequences of such missed care, particularly where there is a threat to patient safety.

## 14.5 Principles of delegation

The principles which govern delegation in the healthcare context can be broadly described as profession-based, organisation-related or task-based.

### 14.5.1 Profession-based principles of delegation

These principles are:

- The nursing profession determines the scope of nursing practice.

- The nursing profession defines and supervises the education, training and use of delegated roles involved in providing direct patient care.

- The professional nurse takes responsibility and accountability for the provision of nursing practice.

- The professional nurse directs nursing care and determines the appropriate utilisation of subordinates involved in providing direct patient care.

- The professional nurse accepts assistance from subordinates in providing nursing care for the patient.

### 14.5.2 Organisation-related principles of delegation

These principles are:

- The organisation is responsible and accountable for delegation through the allocation of both human and material resources to ensure that the professional nurse can delegate appropriately.

- The organisation is accountable for documenting competencies for all staff through organisational policies and procedures that assist in providing direct patient care. The organisation must also ensure that the professional nurse has access to competency information for subordinates to whom patient care is delegated.

- Organisational policies on delegation are developed with the active participation of all employees, including healthcare professionals, managers and administrators.

- The organisation ensures that the educational needs of healthcare personnel are met through the implementation of a system that allows for nurse input eg nursing in-service education.

- Organisations have policies in place that allow input from nurses indicating that delegation is a professional right and responsibility.

### 14.5.3 Task-based principles of delegation

Task-based principles of delegation refer to:

- The professional nurse may delegate elements of patient care, but does not delegate the nursing process itself.

- The professional nurse has the duty to answer for the subordinate's personal actions relating to the task that was delegated.

- The professional nurse takes into account the knowledge and skills of any individual to whom she or he may delegate the duties related to patient care.

- The decision of whether or not to delegate is based upon the professional nurse's judgement. Aspects that are considered are the condition of the patient, the competence of all members of the nursing team, and the degree of supervision that will be required if a task is delegated.

- The professional nurse delegates only those tasks for which she or he believes the other subordinate has the knowledge and skill to perform, taking into consideration training, competence, experience and organisational policies and procedures.

## 14.6 Considerations guiding nurses to delegate

The following assist the delegator when delegating tasks in the healthcare context:

- the scope of practice
- the subordinate's job description
- patient needs
- subordinates' competencies
- policies and procedures of the healthcare institution
- the clinical situation
- professional standards for nursing practice.

### 14.6.1 The scope of practice

- Assists in providing guidance in terms of the legal implications related to delegation.

- Tasks are not spelt out, but the scope of practice serves as a guide to understand the required competencies of a delegated person.

- The professional nurse needs to understand the legal scope of practice of the delegated person.

### 14.6.2 The subordinate's job description

- A job description aligns the healthcare professional's tasks, duties and responsibilities and is required as a condition of employment.

- It should comply with regulations and organisational standards of care in order to provide the proper legal framework within which the subordinate works.

- The professional nurse should be aware of training needs and competencies as spelt out in the job description.

- It should be noted that legal requirements and legislative specifications supersede organisational standards and the job description.

### 14.6.3 Patient needs

- The delegator must have assessed the patient and must have a clear knowledge and understanding of the condition of a patient before delegating the patient's care to subordinates.

- The delegator should be able to identify potential for change in the patient's condition as a result of the delegated task.

- The delegator must be certain that the patient's safety will always be maintained in the hands of the subordinate.

### 14.6.4 Subordinates' competencies

- Subordinates must have the necessary skills and knowledge required to perform the delegated task.

- Regulatory requirements sometime require written proof of staff competencies.

- The professional nurse should be aware of the subordinates' competencies.

### 14.6.5 Policies and procedures of the healthcare institution

- Other specific skills and supervisory requirements for tasks are contained in written policies and procedures.

- The professional nurse must ensure that the subordinates are trained in and understand the organisation's standards of care.

### 14.6.6 Clinical situation

- The professional nurse must ensure that the subordinate is familiar with the type of ward and the patients being cared for.

- The subordinate must also understand the complexity of the task delegated.

- The resources need to be available for the subordinate to be able to perform the tasks as required.

- Adequate level of supervision must be provided so as to put the subordinate at ease.

### 14.6.7 Professional standards for nursing practice

The professional standards should be related to the scope of practice as prescribed by the South African Nursing Council.

## 14.7 Responsibilities and roles

To maintain a high standard of care when delegating activities, the professional nurses' responsibilities include:

- Teaching, for example, on-spot teaching, which includes coaching while some tasks are being performed.

- Competence assessment to ensure that the person delegated to perform a task is able to carry it out to the required expectations.

- Providing guidance, assistance, support and clinically focused supervision.

- Ensuring that the person to whom the task is being delegated understands their accountability and is willing to accept the delegation.

- Evaluation of outcomes.

- Reflection on practice.

A key aspect of delegation is the readiness of the recipient of the delegation to accept the delegation. The recipient has the responsibility to:

- Negotiate, in good faith, the teaching, competence assessment and level of clinically-focused supervision needed.

- Notify the supervisor timeously if unable to perform the activity for an ethical or other reason.

- Be aware of the extent of the delegation and the associated monitoring and reporting requirements.

- Seek support and direct clinically focused supervision until confident of own ability to perform the activity.

- Perform the activity safely.

- Participate in evaluation of the delegation.

- Take authority of the delegated task to ensure that the task is accomplished to its finality.

- Accept the delegated tasks within her or his scope of practice, education and training.

- Perform and accomplish the delegated task.

- Communicate effectively with the delegator while performing and on completion of the delegated task.

The role of a delegator is to:

- delegate a task to the subordinate

- have time and willingness to assist and train in order to accomplish the delegated task

- supervise to ensure the delegated task is performed to the required standard

- assess and follow-up with the aim of evaluating

- ensure safe and effective delegation by intervening and administering corrective action if necessary.

Interpersonal skills are key to successful delegation, namely:

- sensitivity to the capabilities of the team members
- ability to communicate clearly and directly
- knowledge of the stages involved in effective delegation
- a vision of how delegation can benefit the patients, the delegator and the organisation.

## 14.8 The five 'rights' of delegation

Unit managers should pay attention to the five 'rights' of delegation.

### 14.8.1 Delegate the right task

Along with knowing how to delegate work, unit managers need to know what type of work can be delegated. When deciding whether or not to delegate a task consider the following:

- Can a person considered for delegation do it better than a delegator? If so. delegate. If not, one can still consider delegating, but only with an aim of using it as a good opportunity to start building independence.

- Can the person delegated do the task instead of the delegator? If so, delegate. As a supervisor, one usually has a full plate all the time. Delegate when you can.

- If your subordinate can do the task more competently and efficiently than you, delegate.

- Lastly, delegate when you see a chance for your subordinates to grow.

Choices should be made as to priority of tasks to delegate:

- *Routine tasks*: These may be tasks that need to be done on a regular basis either daily, once a week, once a month, or once every time a project is completed. Before delegating these tasks, make sure that they are necessary. Unnecessary tasks should be eliminated as they are time wasters.

- *Interesting tasks*: Do not keep all of the enjoyable tasks for yourself. This will upset your subordinates and make them resist the boring tasks that you give them.

- *Some tasks others could do better*: Use your subordinates' skills and abilities. Give them the tasks that they could do better, so that you can devote your time to other things. Do not compete against your subordinates. If they can do a task better, let them do it.

- *Tasks others might enjoy*: If you have completed a certain task repeatedly, you may have become bored with it. Delegate this task to a subordinate if you think they would enjoy it and encourage your subordinates to volunteer.

- *Tasks good for development*: Delegate tasks to subordinates who would benefit from the additional skills development. If you are already good at implementation and completion of a certain task, let someone else have a chance to try it.

- *Whole tasks*: Try to pass on whole tasks instead of dividing them into pieces. In this way, your subordinates will see the development and outcome of the task and enjoy it more. This will also prevent you from having to worry about keeping the pieces together.

- *Time-consuming tasks*: If you need to spend more time preparing, planning and strategising, delegate your most prolonged tasks. This will free-up the time you need to do your job.

- *Tasks for which you are not responsible*: People like hoarding and keep tasks that they enjoy most for themselves even if the task is not their responsibility. These tasks are not the best way on which to spend your time and energy.

## 14.8.2 Delegate under the right circumstances

A manager or a supervisor should not show partiality or favouritism to anyone, as this will demoralise the other employees, whose negative attitudes and low morale will affect the whole team. For effective delegation to take place, the supervisor should provide subordinates with the proper coaching and training to execute the delegated job effectively, especially when the task is complicated and requires technical expertise. Subordinates should be given sufficient time for preparation and gradually be given more responsibilities that they can handle at a comfortable pace.

## 14.8.3 Delegate to the right person

Tasks should be delegated to people with the experience, knowledge and skills to carry out the delegated task. The individual's preferred work style in terms of independence should be taken into consideration. Consider the current workload of this person including whether the person has enough time to cover all the tasks delegated.

## 14.8.4 Give the right information and directions

The supervisor should communicate information related to the task, including time frames and expectations regarding the outcomes.

## 14.8.5 Give the right amount of supervision

The supervisor should be transparent about the supervisory and/or evaluation methods and times.

## 14.9 Eight barriers to delegation

Factors which negatively affect effective delegation include the following:

- *Lack of clinical leadership experience*: To delegate effectively, the professional nurse must possess some traits and characteristics of a leader.

- *Poorly developed partnerships between the professional nurse and the subordinates*: When the relationship is poor, subordinates can resist delegation or, the manager may have to do the job herself or himself to avoid eliciting front-line staff resentment. Issues of poor partnerships can sometimes be resolved with leadership skills.

- *Attitude*: Sometimes negative attitudes are caused by conflicts related to age, work ethic, role misunderstanding, behaviour and disagreements. Even incompatible attitudes among team members can create bitterness within the nursing care team and obstruct delegation. Different attitudes may also arise from different values of such as generational, cultural, social, religious, political, and other factors.

- *Lack of trust among professionals*: The professional nurses should not delegate care to a subordinate unless they feel able to trust the subordinate; therefore the professional nurse has the duty to determine the individual's competency in a particular situation prior to delegation. Likewise, the subordinate has a duty to demonstrate their abilities to earn the trust of the professional nurse.

- *Absence of a clear chain of command*: This is mostly experienced during the following of scope of practice and what arises from the reality of the situation in the practice area and the corporate policies and procedures. There can be a difference between how facilities are actually organised, structured or staffed and what professional nursing organisations require.

- *Collective bargaining is sometimes a barrier to delegation*: Some professional nurses have expressed that subordinates' use collective bargaining discourages them from delegating to these subordinates.

- *Failure to communicate*: A lack of effective communication may result in unsatisfactory performance and unnecessary errors and even harming the patient.

- *Failure to demonstrate*: This includes failure to require return demonstration from the subordinates.

## 14.10 What is supervision?

Supervision is the process of directing, guiding and influencing someone to carry out a task. It is usually done by a senior staff member over a junior staff member and is done for the purposes of enhancing the junior's professional functioning and monitoring the quality of the professional services offered to the patients.

Supervision should be a democratic process during which subordinates are given help and encouragement by the ward sister or supervisor (Jooste in Booyens, 2006:286). The supervisor should recognise the value of each member of the team and acknowledge that each one has a vital role to play in achieving quality patient care and in creating a high level of motivation among the nurses.

Supervision is aimed at ensuring that work is done well, and at directing the activities of those engaged in nursing practice towards safe, efficient and compassionate care. Supervision occurs at many levels in the nursing hierarchy. It starts at the top of the hierarchy of any healthcare institution, but has a more direct and personalised aspect in the unit as this is where the patient receives care.

For supervision to be effective, the supervisor should also display some form of respect towards the subordinates and should not judge them and should relate to them with 'unconditional positive regard' (Consedine, 2004). Good supervision is positive, respectful and non-judgemental and produces positive outcomes for both the patient and the nurse. Supervision provides insight which leads to reduced anxiety and enhances surety to the subordinate about the way forward.

Supervision aims to promote high clinical standards and develop professional expertise by supporting staff, thereby helping to prevent problems in busy, stressful practice settings (McSherry, 2002:30).

## 14.10.1 Relationships in supervision

The process of supervision occurs within the rapport which is established between the supervisor and the subordinate, which is characterised by an ongoing relationship that allows growth and development. This therefore means that both the supervisor and subordinate have a duty to contribute to the relationship and have responsibilities within the process.

Proper relations between the professional nurse and the subordinates during supervision are based on the following principles:

- improved knowledge about each other's competence and continued growth in competence
- increased commitment to each other and ability to deal with more complex situations
- increased efficiency in getting the work done through natural synergy with potential to maximise delegation.

## 14.10.2 The principles of supervision

Supervision is a role that is played by managers, starting from senior managers to lower-level managers of various units within the healthcare institution. An organisational chart should therefore be available to determine that clear lines of communication and authority are understood by all in the institution.

The key principles of effective supervision include:

- Supervision supports practice, enabling nurses to maintain and promote standards of care.

- Supervision is a practice-focused professional relationship involving a subordinate reflecting on nursing practice, guided by a skilled professional nurse.

- Supervision allows the development of nurse practitioners and managers according to local circumstances.

- Ground rules should be agreed so that healthcare practitioners and supervisors approach supervision openly, confidently and are aware of what is involved.

- Every professional nurse should have access to supervision.

- Each supervisor should supervise a realistic number of subordinates.

- Supervisors should be trained through 'in house' training or external education programmes.

- A decision should be made whether or not evaluation of supervision is needed to assess how it influences patient care, nursing practice standards and organisational policies and procedures.

The supervisor could use Table 14.1, which shows the management functions in a unit, to plan certain aspects of supervision and to focus on important and specific aspects in the unit or clinic. Table 14.1 could also be used as a guide to develop unit managers' supervisory skills and competencies. The 'aspect' column could be changed according to the needs of, and the context in which, supervision must be managed. These should be seen as guidelines to help improve supervisory functions.

**Table 14.1**: Management functions

| No. | Aspects | Action to be taken | Time frame | Unit manager | Supervisor |
|---|---|---|---|---|---|
| **1** | **Staffing** | | | | |
| 1.1 | Vacant posts | | | | |
| 1.2 | Disciplinary action | | | | |
| 1.3 | Staff establishment up to date | | | | |
| 1.4 | Staff development programme in place | | | | |
| 1.5 | Staff meetings done and minutes available | | | | |
| **2** | **Communication logistics** | | | | |
| 2.1 | Telephone working | | | | |
| 2.2 | Electronic services | | | | |
| 2.3 | Radio working | | | | |
| **3** | **Supervision** | | | | |
| 3.1 | Monthly visits planned and diarised | | | | |
| 3.2 | Visits are on schedule | | | | |
| 3.3 | Written reports up to date | | | | |
| 3.4 | Schedule for staff development in place | | | | |
| **4** | **Information** | | | | |
| 4.1 | Registers used properly | | | | |
| 4.2 | Statistics done properly | | | | |
| 4.3 | Information up to date | | | | |
| **5** | **Equipment** | | | | |
| 5.1 | Maintenance | | | | |
| 5.2 | Requisition for repairs | | | | |
| 5.3 | Suppliers | | | | |
| 5.4 | Report system for shortages | | | | |
| 5.5 | Recording of problems | | | | |
| **6** | **Drugs/suppliers** | | | | |
| 6.1 | Monthly review | | | | |
| 6.2 | Stock control | | | | |
| 6.3 | Storage conditions | | | | |

Date: ........................................................................

Source: Adapted from DoH (2003). *Clinic Supervisor's Manual.* Section 3

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### 14.10.3 Components of supervision

Supervision consists of two major parts:

- *Initial direction*: The instructions provided when the task is first delegated.

- *Periodic inspection*: The frequency of monitoring how the delegated task is performed.

### 14.10.4 Critical roles of a supervisor

In order to enhance the professional functioning of the subordinate and assure quality of care, the supervisor has critical roles to play.

- Supervisors have an ethical and legal responsibility to monitor the quality of care that is being delivered to the subordinate's patients.

- The supervisor constantly monitors and provides feedback regarding the subordinate's performance.

- The supervisor serves as a gatekeeper for those who want to enter the profession.

- The supervisor formally evaluates the subordinate after there has been enough supervision to expect a certain degree of competence.

## 14.11 Supervision and the team

Healthcare teams have the potential to increase productivity and morale or destroy it. It is important, therefore, to look at teams and team effectiveness in healthcare and the role that the supervisor plays in team effectiveness.

It is a journey with predictable progression for a group of individuals to build a high-performing team. Three keys to effective team supervision and leadership are: diagnosis, development, and matching leadership behaviour to the team's development. Teams go through various developmental stages. Understanding the stages and the characteristics and needs of a team is essential for the supervisor to be able to lead the team in the right direction. See Figure 14.1, which illustrates a team's developmental stages – orientation, dissatisfaction, integration and production – and the four situational leadership styles of the supervisor, namely directing, coaching, supporting and delegation.
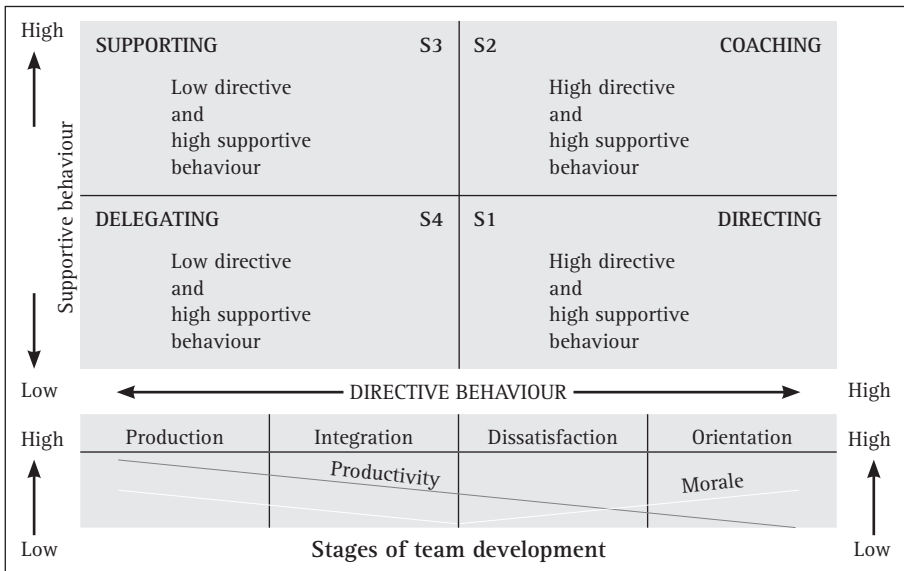
**Figure 14.1**: Team development stages

Orientation is the first stage, where the team is dependent on the leader for purpose and direction. Expectations are accompanied by anxiety about how they will fit in and whether they can trust each other (see Figure 14.1, S1). Many aspects, such as norms, roles, goals and time frames are not clear and the ground rules need revision from time to time to ensure that team members understand their functions and roles in the team. The supervisor needs to focus on directing, strong leadership and visibility to enable the team to start functioning.

Secondly, there is the stage of dissatisfaction and dipping morale as the team members experience a discrepancy between their initial expectations and reality (see Figure 14.1, S2). The difficulty of working together leads to confusion, frustration and dissatisfaction. The supervisor needs to pay special attention to team cohesiveness during this stage and coach the team on how to function in the team in order to work towards productivity and goal attainment. The supervisor should focus on directing and supporting the team's efforts. Motivation is very important during the second stage, as team members get dissatisfied easily. The supervisor must keep the team focused on the vision and goals of the organisation. It is possible for the team to get stuck at the dissatisfaction stage and continue to be both demoralised and relatively unproductive.

Thirdly, the integration stage follows. Productivity increases and team members work together more easily. Moderate to high productivity and improving morale characterise a team at this stage of integration. The supervisor needs to support the team and the directive functions could be scaled down during this stage (see Figure 14.1, S3). The team reaches a point of clear goals and there is an increased commitment to its members' purpose, values, norms and roles. Trust

and cohesion grow as communication becomes more open and task-orientated. The team shares the leadership and the supervisor needs to support their efforts.

Lastly, the production and termination stages follow, during which the team's functions reach closure and productivity and morale increase as the end of the experience draws closer (see Figure 14.1, S4). In health services, part of the team terminates as people move on to get experience in another unit or speciality of healthcare. Productivity and morale are high within the team and the supervisor only delegates at this stage, as the team focuses on performance (Blanchard, 2007:177–187).

## 14.12 Summary

Mastering effective delegation can increase productivity and help to develop the skills of the subordinates that unit managers lead. A professional nurse should always evaluate delegated tasks by reassessing the patient or any situation that was part of delegation. This is to evaluate the subordinate's performance and to offer support and further interventions where required. Appropriate supervision provides assurance to the patients that a nursing practice is safe as the senior person is around to make sure that tasks are done correctly.

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# 15

# Disaster Preparedness

VJ Werely

## Chapter Outcomes

After studying this chapter, you should be able to:

- describe the basic principles of disaster preparedness in a healthcare service;
- discuss factors that may influence the effective management of health services during a disaster;
- describe the preparation of an emergency preparedness, response and recovery plan.

## 15.1 Introduction

Events of disastrous proportions have occurred over the years, such as the Laingsburg (South Africa) floods in 1981; the terrorist attacks in New York on 11 September, 2001; Hurricane Katrina that caused devastation in Louisiana, USA, in 2005; and the Ebola outbreak that killed thousands in West Africa between 2013 and 2015. These events were characterised by death, injury and the crippling of communities on a large scale. Authorities and healthcare organisations had to be responsive and able to act timeously. In order to respond quickly, there had to be intense collaboration and co-operation between the many role players.

To strengthen the provision of care and prevent an increase in morbidity (disease) and mortality (death) during mass events, each level of service (ie national, provincial, regional and district level) has to be aware of their responsibility and deliverables. Therefore, the establishment of standards of care to deliver service consistently and without interruption is fundamental to efficient service delivery.

Nurses play a pivotal role in disaster management and often unintentionally work outside of their scope of practice. Of necessity, a nurse may have to take on additional functions, such as making clinical decisions akin to a medical doctor. Characteristics and qualities of leadership, clinical efficiencies and competence are needed to make decisions at this most critical time, in order to preserve the life of the patient.

## 15.2 Strategic preparation

A disaster has the potential to cause unprecedented and radical change in the socio-economic and healthcare environments of a community; it is therefore vital to be prepared for such an event. The main aspects that should be considered when an organisation prepares for disaster management are:

- an understanding of the terms and concepts associated with emergency preparedness and disaster management
- legal and accountability frameworks

- types of disasters, including historic incidents
- effective emergency response planning
- understanding the roles of the functionary teams
- the emergency action, response and recovery plan, and processes or procedures
- ethics and legality relevant to pre- and post-action
- managerial responsibility and governance processes.

## 15.3 Defining terms and concepts

It is important to distinguish between the following concepts:

- *Disaster management*: The discipline of dealing with and avoiding both natural and manmade disasters. It involves preparedness, response and recovery in order to lessen the impact of disasters.

- *Emergency management*: Refers to the ongoing process to prevent, mitigate, prepare for, respond to, and recover from an incident that threatens life, property, operations or the environment.

Key activities and factors which must be included in an emergency preparedness programme are:

- *Prevention*: Activities undertaken in advance to prevent a potential disaster.

- *Multiple casualties*: The number and severity of injuries do not exceed the ability of the facility to treat the injured. The patients with life-threatening injuries are treated first.

- *Mass casualties*: The number and severity of injuries exceeds the ability of the facility to treat the injured. Patients with the greatest chance of survival with the least expenditure of personnel, equipment and time, are treated first.

- *Mitigation*: The activities which an organisation embarks on in advance to lessen the severity and impact of a potential emergency or disaster.

- *Preparedness*: Activities to build capacity and identify resources that may be used should an emergency or disaster occur.

- *Response*: The activities immediately before, during and after an emergency or disaster occurs.

- *Recovery*: Activities undertaken after an emergency or disaster occurs, to restore services and move towards long-term restoration.

- *All hazards preparedness*: This term came into use post-Hurricane Katrina (AWHONN, 2012). It refers to a process whereby a deliberate thoughtful plan is formulated for responding to a variety of emergencies and disasters, be they natural, accidental, or deliberate. The plan must include the management of entities such as state, local, regional and district government, healthcare facilities, as well as the business sector (Wallis & Smith, 2011).

- *Triage*: The process of prioritising patients for treatment and evacuation (Smith, 2010). Triaging can happen at different levels and is underpinned by the goal of providing care to the right patient, at the right time, in the right place.

## 15.4 Legal framework

The International Council of Nursing (ICN) stipulates the importance of the inclusion of disaster preparedness, risk management and interprofessional and/or multidisciplinary strategies at all levels and phases of disaster management. This is to ensure an effective and efficient response to short-, medium- and long-term healthcare needs of the disaster-afflicted population (ICN, 2006).

As enshrined in the Constitution of South Africa, services must be equitable, accessible and available to all citizens. The South African government promulgated the National Disaster Act 57 of 2002. This Act requires the provision of the following:

- an integrated and co-ordinated disaster management policy to prevent and/or reduce the risk of disasters, mitigate the severity of disasters, maintain emergency preparedness, and provide a rapid and effective response to disasters and post-disaster recovery
- the establishment of national, provincial and municipal disaster-management centres
- the establishment and management of volunteers to respond to disasters.

The South African Nursing Council (SANC) maintains that nurses will serve their patients with care and dignity and cause no harm. Nongovernmental organisations (NGOs) often play a pivotal role in times of disaster. These organisations and associations, such as Red Cross, Gift of the Givers and others, provide humanitarian assistance during and after a disaster. NGOs fill unique and beneficial roles:

- They provide additional specialised skills, knowledge and capacity.
- They assist and support with effective and efficiency advocacy, mobilisation, lobbying and communication between structures.
- These organisations can serve as the link between the disaster-management team and the affected community (Wallis & Smith, 2011).

### 15.4.1 Ethical framework

The preservation of human life and the prevention of human violation should be the primary concern during and after disasters. The promotion of social support, justice and equitable access to the required resources is important. Furthermore, all parties must adhere to credible and accountable practices, in preventing the abuse of human and financial resources (ICN, 2006).

The ICN Code of Ethics (ICN, 2012) mandates respect for human rights, sensitivity to values and customs, dignity, fairness and justice. Although nurses are required to work within their scope of practice, during disasters they need to adjust their practice to serve the needs of the disaster-stricken environment (Deeny, Davies, Gillespie & Spencer, 2007). Cognisance should be taken of the values which underpin customs, culture and individual dignity; confidentiality may, however, be reduced in the act of the greater need of assistance.

According to Wallis and Smith (2011), ethics refers to standards of conduct, or moral judgement, or a system of codes of morals – the conceptual understanding of right and wrong. The following principles govern ethics:

- *Beneficence*: Doing the best for the patient in order to promote the most advantageous outcome, that is, achieve the greatest amount of good.

- *Nonmaleficence*: Doing no harm; provide helpful treatment rather than inflict harm.

- *Autonomy*: Respect for the individual patient's informed choice as it pertains to their own medical care.

- *Justice*: Equitable distribution of resources among all patients; recommend actions that are fair to those involved.

## 15.4.2 Ethical and legal questions

There are innumerable ethical and legal demands that may arise during natural disasters, quarantine and/or public health emergencies, and due consideration should be given during the phases of disaster and emergencies (Delooz, 2011). Aspects are:

- the disaster preparedness and education process
- illness prevention, which includes quarantine
- diagnosis and treatment of epidemic disease
- disaster response
- state policies for public health emergencies
- research and ethics
- media presence during natural and man-made disasters.

The responsibilities and accountabilities of healthcare practitioners during disasters and emergencies should encompass the principles of beneficence and nonmaleficence. Healthcare practitioners often encounter an ethical dilemma during emergencies in that, while in doing what is necessary and reasonable to prevent illness and save lives, they may have to work outside their scope of practice as defined by the regulatory body.

Healthcare practitioners should understand the obligatory guidelines that must be executed in emergencies or to manage disasters, for example when quarantine is a state requirement to prevent or limit the spread of disease.

Proper triaging of patients is very important and the correct processes should be followed to prevent further fatalities.

## 15.5 Types of disasters

Wallis and Smith (2011:ix) classify disasters as either natural or man made. Natural disasters include such things as earthquakes, tsunamis, volcanoes, floods, avalanches, thunderstorms and lightning strikes. Wallis and Smith include pandemics in this category. Man-made disasters include wars, terrorist activities, travel and transportation accidents, explosions and bombs. Epidemics are placed in this category. Examples include:

- fires, which can be internal or external in nature, and include bush fires, electrical, oil or gas
- floods, chemical spills, power failures, engineering or structural instabilities, gas leaks, which can all be either internal or external
- rain storms, tsunamis, floods, avalanches, thunderstorms and volcanoes are all external in nature
- bomb and substance threats
- chemical, biological or radiation exposure
- acts of terrorism
- disasters caused by strike action
- medical emergencies such as food poisoning can be either internal or external
- internal medical emergencies such as hospital-acquired infections
- earthquakes.

### 15.5.1 Disasters in the past

Disasters are not a new phenomenon and records exist of disasters that occurred centuries ago; examples include the Great Plague in London during 1666, which reportedly killed almost 100 000 people, and the 1918 influenza pandemic which spread throughout the world and killed between 3% and 5% of the world's population. Today, with modern communication systems, we soon hear of disasters in other parts of the world, such as the following:

- In January 1981, a devastating flood engulfed Laingsburg, South Africa, which is classified as one of the worst natural disasters in South Africa. Many people lost their lives.
- On 11 September 2001, a co-ordinated terrorist attack against the United States of America toppled the twin towers of the World Trade Centre in New York, killing thousands of people.
- On 26 December 2003 in Bam, Iran, an earthquake of magnitude 6.6 (on the Richter scale) killed more than 30 000 people, injured more than 10 000 and left many people homeless.

- In December 2004, a tsunami in the Indian Ocean killed approximately 400 000 people between Indonesia and Madagascar.

- The outbreak of the Ebola virus in West Africa, which began in 2014, has claimed many thousands of lives.

## 15.6 The phases of a disaster

The phases of a disaster are stated in the National Disaster Management Act 57 of 2002 and described in Table 15.1 and Figure 15.1 below.

**Table 15.1**: The phases of a disaster

| Pre-disaster reduction | Post-disaster recovery |
|---|---|
| Prevention | Response |
| Mitigation | Recovery |
| Preparedness | Rehabilitation |
| Early warning | Reconstruction |
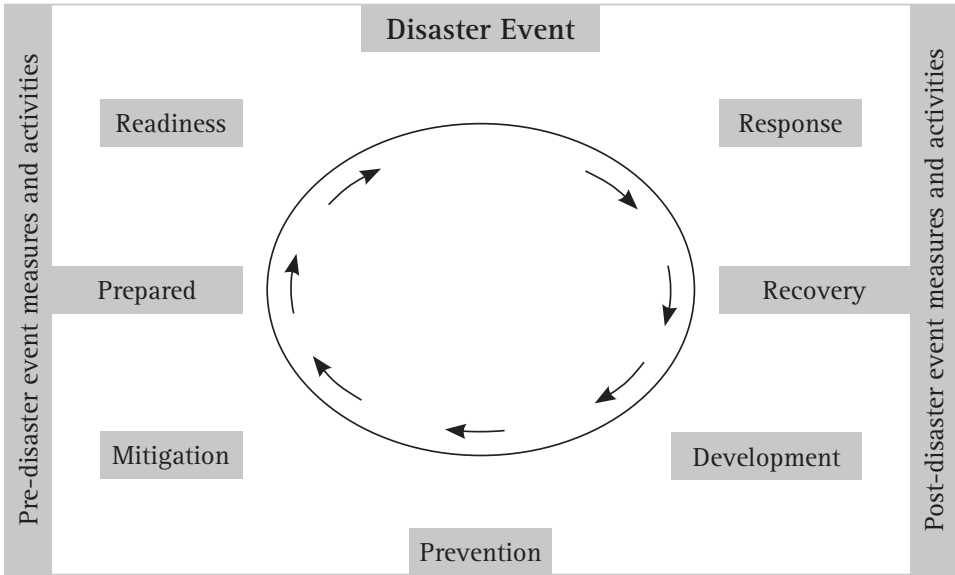


**Figure 15.1**: Phases of a disaster during pre- and post-disasters and activities
Source: Wallis & Smith (2011)

### 15.6.1 Pre-disaster phase

The pre-disaster phase consists of activities aimed at prevention, mitigation and preparedness, and the focus is on the quick response plan (Wallis & Smith, 2011).

In the pre-disaster phase, the emphasis is to ensure that the necessary resources are available to respond to the emergency, the people who must respond are aware of how to use the resources, and the location of needed resources is known. Activities include the developing and planning processes to guarantee readiness, for example hospital disaster plans, regular multidisciplinary exercises, and management of stocks needed for effective response. It also includes the development of staff knowledge, skills and competences in order to ensure effective management and performance of these disaster-focused functions.

Emphasis is progressively placed on recovery preparedness, which is planning not only to respond effectively during and immediately after disasters, but also in order to successfully navigate challenges associated with short- and long-term recovery (Sutton & Tierny, 2006). In the mitigation phase the organisation must develop and implement mitigation strategies to limit or control the consequences, extent, or severity of an incident that cannot be reasonably prevented.

## 15.6.2 Disaster occurrence

This is the phase where all measures must be activated to ensure the preservation of life of the injured, protect assets such as buildings and housing, and safeguard the well-being of the affected community. The disaster phase can vary in onset; it can be slow but very intense eg infectious diseases, or it can be fast and destructive eg an air disaster or tsunami.

The mitigation strategies must be based on the results of the hazard identification, risk assessment and the business impact analysis. Mitigation strategies will also depend on programme constraints, operational experience and cost-benefit analysis. The mitigation plan must include interim, medium- and long-term actions to reduce the impact of risks that cannot be eliminated.

## 15.6.3 Post–disaster phase

The response phase consists of relief and rescue activities (Wallis & Smith, 2011). During this phase, survivors are searched for in order to provide emergency treatment and transport the injured to the healthcare facilities. The main objective of this phase is to restore the situation or community to its former conditions, that is, to attempt to restore normality. The recovery and rehabilitation phases happen simultaneously; recovery refers to restoring processes and infrastructure, while rehabilitation focuses on the human element, with specific emphasis on emotional, mental and physical health (Wallis & Smith, 2011).

## 15.7 Triage

According to Smith (2010), much attention and evidence-based research was considered when relating these efficacies into the preparation for major events. These major incidents often result in mass casualties. The National Department of Health adopted the Major Incident Medical Management Support System (MIMSS) in 2010, as part of the preparations for the soccer FIFA World Cup (Smith, 2010). The South African Triage Score (SATS) is currently in use in the

South African healthcare service, whereby patients are prioritised by a suitably qualified healthcare practitioner. At most healthcare facilities, the nursing staff fulfil this function (Wallis & Smith, 2011).

The triage system is based on sift-and-sort measures, which identify the physiological parameters and the priority for treatment. The following triage coding was identified and prioritised according to the patient's condition is prioritised, ranging from minor to life-threatening to death.

## 15.7.1 Triage priorities according to coding

According to Wallis and Smith (2011), there are two treatment systems in use, either the priority (P) or treatment (T) system, depending in which country the service is being rendered. Both of these systems are used in conjunction with colour coding.

- *Red (T1 or P1)*: These are the seriously affected or ill patients whose physiological situation is life-threatening and in danger.

- *Yellow (T2 or P2)*: The patient's life is not in immediate danger; however, surgical or medical intervention is required within 2–4 hours.

- *Green (T3 or P3)*: The patient has minor injuries which will eventually require treatment.

- *Blue (T4 or no priority)*: The patient is either dead or has extensive injuries and cannot be saved with the limited resources available.

## 15.7.2 Performing the triage function

Two types of triage can be done in a disaster situation, namely the primary or secondary triage. The area or place where the triaging takes place can vary from situation to situation.

### Primary triage

In any major incident, primary triage is critical and should be immediate and accurate to decrease morbidity and mortality. It should be:
- fast
- reliable
- reproducible
- easy to use
- easy to teach.

### Secondary triage

Secondary triage takes place when the patients are evacuated to the casualty clearing station or when they arrive at the healthcare facility.

## 15.8 Emergency management and business continuity

Developing and managing an emergency preparedness, response and recovery plan (EPRRP) involves planning, organising, equipping, training, exercising, evaluating, monitoring and making amendments as required.

### 15.8.1 The governance process

To ensure that all role-players are aware of their responsibilities, a detailed EPRRP must be available that includes the following components:

- an approved policy for the establishment, which includes a vision, mission statement, roles and responsibilities, and enabling authority
- clear goals and objectives which are clearly indicated in the programme plans and procedures
- clear roles and responsibilities for each role player and their functions
- a budget which indicates all the stages and contingencies
- an established and effective records-management system which clearly states the maintenance of logs, records of activities and all decisions taken related to the programme
- a programme review to check the processes for validation, evaluation, change management and continued improvement of the programme and plan.

### 15.8.2 Legal and legislative compliance

The EPRRP should comply with all the applicable national legislation, policies, guidelines, regulatory requirements and directives. It is important to consistently adhere to and maintain the codes of practice.

### 15.8.3 Financial management

The establishment and projections of proper financial procedures and controls to support the programme during and after the emergency should be available. The financial procedures should include:

- establishment and definition of responsibilities for the programme finance authority, including its reporting relationships to the programme co-ordinator
- programme procurement procedures
- salaries for personnel involved with the programme
- proper and accurate accounting systems to track and document costs
- proper, effective and efficient management of funding from external sources.

### 15.8.4 Risk management and quality improvement

The importance of risk management is to ensure the protection of the institution's assets, control of any liabilities and injuries to the patients, as well as ensuring that the institution is functioning within effective and economical boundaries (Booyens, 2007:583). Therefore, a risk assessment must be done to eliminate

negative consequences. The risk identification and assessment have to include evaluating the likelihood of a risk or combination of risks occurring, taking into account factors such as threat analysis, frequency, history, trends and probability (Booyens, 2007:585). The risk assessment must consist of data on the impact of the risk event on the institution, on people, property and the environment.

### 15.8.5 Business impact analysis (BIA)

A business impact analysis (BIA) is the responsibility of the management of the healthcare institution and must include the entire institution's critical business functions, associated resource requirements and interdependencies. It is imperative that it is established on the findings from the risk assessment and thus considers possible events and how they could affect the institution over time.

### 15.8.6 Planning

The healthcare institution should follow a planning process to develop and maintain its emergency management and business continuity programme, including key stakeholders in the planning process where applicable. Planning requirements depend on the programme's objectives and the results of the risk identification, risk assessment and business impact analysis.

### 15.8.7 Management and leadership

Emergency management requires leadership and management approaches which extend beyond the usual business processes. A new leadership approach is needed to address the challenges of the unpredictability, with emphasis on emergency and disaster management situations. A leader is needed who is able to find the most suitable approach and be creative, when they examine and evaluate their healthcare environment, and make the adjustments with ease and calmness (Jooste, 2007). Jooste (2007:10) further suggests that traditional management skills such as planning, organising, directing and controlling have become outdated and ineffective in the contemporary ever-changing climate.

In emergency situations, senior managers are expected to provide leadership and assume overall responsibility, accountability and authority for the formulation, co-ordination and implementation of the emergency response programme. An interactive and integrative team approach is needed; it is the leader's responsibility to create and unify teams with commitment and dedication to ensure success.

## 15.9 The institution's EPRRP

It is expected that all hospitals or healthcare facilities must have an updated emergency preparedness, response and recovery plan (EPRRP). The plan should have clear goals and objectives which are simple, specific, relevant, realistic and achievable (DoH, 2014). The EPRRP should include the following:

- The plan must be approved and endorsed by the Chief Executive Officer of the healthcare facility.

- All functionaries must be clearly defined and stipulated, per area and responsibility.

- An organogram must show the hierarchical positions and actions of all the key strategic people who have responsibilities assigned to them.

- There must be an operational plan available and contingency plans which are in the care of all responsible functionaries.

- There must be a clear crisis management strategy on how to ensure efficient support services such as human resources, food, cleaning, porter, administrative support (clerical staff) and security services. The strategy must also ensure adequate supplies of goods, technology and equipment.

- The human resource management plan must include the full organisational staff establishment structure of the Institutional Disaster Committees and Emergency Operations or Command Centre. The Emergency Respond Squad which consists of the Chief of Emergency Operations, Emergency Co-ordinator, Medical staff, Nursing staff (Head of Nursing and the Chief Specialist Nurse in Trauma and Emergency services), and other key emergency management team members.

- Details must be given of how to deal with the vulnerable victims eg children, persons with disabilty, mentally challenged patients.

- There must be a contingency plan on medication management, especially during disasters such as floods, fire, earthquakes, biochemical, emerging and re-emerging infections or diseases, radio-nuclear terrorism, chemical, as well as infections acquired while institutionalised eg nosocomial infections.

- The training and education of staff is very important because a well-developed, informed and equipped team will have good outcomes. Therefore, staff should be trained in basic life support and cardiopulmonary resuscitation; all staff should be competent in first aid; trauma specialist nurses and medical doctors must receive advanced life support training. It is important that the hospital management cadre are kept informed and knowledgeable to ensure they are competent in institutional disaster management of mass casualty management.

- Quality improvement must include the proper patient management procedures; keeping statistics of incidents; monitoring and reporting of adverse incidents; ensuring the accurate documentation of the management of the patient, and maintaining patient confidentiality and privacy at all times.

The EPRRP should include procedures and protocols which need to be followed. The following are of critical importance:
- guidelines on the prevention and control of infections
- decontamination procedures and guidelines
- the proper referral system to manage the flow of patients
- management and treatment of patients at the appropriate levels

- the procedure for resource mobilisation, advocacy and communication
- policy on the management of the flow of communication from the key emergency planners
- human resource policies including the allocation, distribution, shifts and remuneration of staff
- policies relating to the admission, transfer and discharge of patients, the expanding of services and opening of beds
- a protocol should be available for proper laboratory service management eg taking of blood, timeous receiving of results, epidemiological surveillance
- policy for the temporary storing of the deceased patients
- a proper food management policy for the adequate receipt and provision of food
- user manuals on the operation of medical equipment.

## 15.9.1 Nurses in the emergency response team

An integrated and collaborative multidisciplinary team is needed to successfully deal with a mass casualty event or major incident. The success of the response will depend on the co-operation of the nursing team. Nursing services that are rendered on a 24-hour basis and are always available, play a significant role.

The team should consist of medical, nursing and paramedical staff, such as:
- a medical team ranging from specialist to junior doctors
- a social worker and a psychologist
- a representative from a religious group
- a pharmacist
- a haematologist
- a biochemist
- the blood transfusion services and virologist.

The responsibilities and functions of nurses are vast and much needed. The nurses fulfil essential roles, such as:

- *Head of Nursing*: Responsible for all nursing matters and is the strategic member of the institutional emergency co-ordination team.

- *Assistant Manager Nursing and/or Operational Manager Nursing*: Responsible for the management and co-ordination of the trauma and emergency services. This person also collaborates closely with the Trauma Medical Specialist.

- *The Operational Manager Nursing of the intensive care units (ICUs)*: Ensures that the ICUs are available, prepared and stocked with adequate equipment. This incumbent collaborates closely with the Head of Clinical Service ICUs.

- *The Senior Nurses in the wards*: Prepare the wards for the influx of patients. The wards must be stocked with the required equipment to provide an uninterrupted service.

- *The Emergency Co-ordinator (EC) and the Senior Nurse from Trauma and Emergency Service*: Working closely, they ensure that staff allocation is done optimally and efficiently to ensure that all critical areas are covered.

- *Assistant Manager Nursing and/or Operational Manager Nursing from the theatre*: Ensure that the theatres are prepared, with all technology and equipment available during the critical time.

- *Experienced Registered Professional Nurse*: Manages the triage area.

- *Additional Nursing Staff*: Required to ensure all nursing service areas are covered.

- *Central Sterilisation Service Department (CSSD)*: Must be optimally staffed to ensure that clinical service operations are effectively supplied with the necessary sterilised equipment.

## 15.9.2 Responsibility for administration of the programme

To ensure the continual and effective co-ordination process, it is imperative that a programme co-ordinator is appointed by the institution. Management must provide the authorisation to administer the programme and ensure that the programme is upheld and sustained. A clearly documented programme must be available, which includes all the components required for an efficient disaster management process. The programme should be revised on a regular basis and be kept up to date with current trends and technology.

## 15.9.3 Advisory committee

An advisory committee must be established as required by the institution's policy. The advisory committee provides input and assistance in co-ordinating the preparation, implementation, evaluation, maintenance and revision of the programme. The advisory committee should include the programme co-ordinator, nursing manager and relevant role players who have the appropriate expertise, knowledge of the institution, and the capability to identify resources from all key functional areas within the institution. Relevant external representation must also be included, such as the fire department, municipality, law enforcement and civic organisations. The Safety Committee plays a pivotal role because it must promote safety and identify potential risks at the healthcare facility.

## 15.9.4 The emergency co–ordinator (EC)

The EC, when becoming aware of an emergency (or simulating the activation of a training exercise), must:

- Ascertain the nature of the emergency and determine the appropriate action.

- Ensure emergency officials, such as fire services, have been notified of the emergency, usually via the institution's telephonic or emergency alarm system.

- Co-ordinate evacuation and control entry to the affected areas.

- Ensure that the progress of the evacuation and any action taken is recorded in an incident logbook or register.

- Brief the emergency services personnel upon arrival on the nature, type, extent and locality of the emergency and the status of the evacuation and, thereafter, act on the incident controller's instructions.

- Complete a detailed evacuation report, for the purpose of identifying and correcting any deficiencies in the implementation of procedures.

- Ensure that a well-designed fire plan is available at strategic places and visible to all. A fire safety programme must stipulate the fire drills, evacuation details, and techniques to prevent, mitigate and respond to fires.

- Conduct a review after each emergency evacuation or exercise to identify improvements to evacuation procedures.

### 15.9.5 Resource management

The organisation must establish resource management procedures to ensure that adequate human, physical, information and financial resources are provided. An assessment must be conducted to identify the resource capability shortfalls and the steps necessary to address them. The organisation or institution shall determine if donations will be forthcoming and, if required, establish objectives and procedures to manage donations of solicited and unsolicited goods, services, personnel, facilities and money.

The functionaries and responsibilities comprise of:
- the hospital management co-ordination team
- the clinical team
- the nursing team
- the clinical support staff
- the support service staff.

## 15.10 Incident management

Plans should identify the functional roles and responsibilities of internal and external agencies, organisations, departments and positions. The organisation must establish an incident management system to direct, control and co-ordinate operations during and after an emergency. The incident management system must assign specific organisational roles, titles and responsibilities for each incident management function.

The organisation must establish procedures for co-ordinating response, continuity and recovery activities. The communication needed to support the programme must be determined. The institution must co-ordinate communication activities with key stakeholders in accordance with the incident management requirements. Telecommunications and other communication and warning systems must be established and regularly tested.

Emergency communication and warning procedures to advise the public of threats to people, property and the environment, either directly or through authorised agencies, should be developed and exercised. Communication procedures must include protective action guidelines for emergencies, which advise potentially impacted populations to shelter-in-place, evacuate or take any other action as directed.

## 15.11 Summary

Emergency preparedness and management of disasters should be key performance areas for the unit manager. Capacity-building sessions should be regularly conducted for all nursing staff, to ensure that they are prepared to deal with an emergency or disaster event. The main objective of emergency preparedness is to ensure that all aspects have been addressed and that staff are prepared and able to respond quickly.

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# Quality Improvement in Health Services

A Minnaar

## Chapter Outcomes

After studying this chapter, you should be able to:

- understand the philosophy and principles of quality management and customer relations management;
- implement strategies for the delivery of improved quality of service;
- apply problem analysis tools, like fishbone analysis, to separate the root causes from the symptoms;
- link the application of the principles of Batho Pele with the organisational elements (systems, structure, strategy, policy and culture);
- understand quality management systems and models, such as ISO 9000 and Deming's principles of quality management;
- assist in monitoring the quality of service in healthcare organisations;
- understand and take part in infection control aspects in the unit.

## 16.1 Introduction

Leaders envision high-quality care and encourage their followers to be involved in quality improvement. Leaders do this by encouraging healthcare workers to maintain high standards, be proactive and build a culture of quality management in the healthcare organisation. In management literature, the term quality management reflects an organisation's concern to be able to offer services and products that are better than the average, to perform to the expected level and still be affordable.

This chapter looks at the philosophy and principles of quality management and customer relations management by explaining Deming's 14 points, Juran's quality trilogy and Grosby's quality conformance to requirements. Thereafter, an explanation is provided on the use and implementation of quality management tools and processes. The application of problem analysis tools, for example, fishbone analysis to separate the root causes from the symptoms will assist the reader with problem solving in health services. Furthermore, a systematic process on how to plan a project to improve the health service is provided. The South African White Paper on Transformation of Public Services is used to guide the practice of every healthcare professional and thus guide quality improvement processes in health services and is explained in terms of the creation of quality care for all patients. Each professional needs to understand and take part in infection control aspects in the unit to ensure quality care to the patient and to safeguard the patient against nosocomial infections. A practical guide for healthcare professionals regarding infection control is provided and focuses on the main sources of nosocomial infections. Lastly, a description is

provided on how to implement the best available research evidence in health services.

## 16.2 Definitions and history of quality improvement

There are various definitions of quality improvement and quality management. Quality assurance refers to the formal, systematic exercise of problem identification, designing activities to overcome the problems, taking follow-up steps to eliminate new problems and the implementation of corrective steps. Conversely, Total Quality Management (TQM) means that the organisation's culture is defined by and supports the constant attainment of customer satisfaction through an integrated system of tools, techniques and training.

Quality management originated in the manufacturing environment and has subsequently been extended to every other part of the economy. The early roots of quality management can be found in the production of military goods for the Second World War. Statistical tools were used to predict where there was the greatest possibility that defective goods would be produced. This then allowed for preventive action and forward planning.

In the 1950s, planning, organising and evaluating healthcare services became a public concern. In 1952, the Joint Commission on Accreditation of Hospitals, now the Joint Commission on Accreditation of Healthcare Organisations (JCAHO), was established. In the 1960s, the American Nurses Association (ANA) started a division of healthcare that was tasked with the development of standards for healthcare practice. These standards became the basis for quality assurance programmes in healthcare. Instruments for evaluating healthcare were developed during the 1970s, but limited data was generated or published in quality assurance studies. During the 1980s, costing became a major issue in healthcare. The diagnosis-related groups' (DRGs) payment systems and other similar systems that applied diagnostic-related hospital reimbursement systems from medical aid providers were the main issues in healthcare pertaining to standards and quality.

The emphasis on the management of quality in the early days was on measurement and corrective action. The term often used in those days was quality assurance. As time passed, it became increasingly clear that achieving quality really entailed establishing change in every aspect of an organisation. In essence, it is a process of improvements. Reflecting on this shift of emphasis, the term TQM came to be used increasingly or interchangeably and has been called Continuous Quality Improvement (CQI). For the purpose of this chapter, no distinction is made between these three concepts because they are not contradictory and have all evolved over time in the same direction. The expression quality management is used as an overarching term that includes elements of all these streams of thinking.

Five main ideas underpin quality management. The first is the idea of the systems approach, in which all parts of the organisation must work together optimally to achieve organisational excellence.

The second is the idea of problem solving. Among the most famous sayings of Deming is his statement that 85 per cent of problems come from the systems and only 15 per cent from the workers. Through a systematic approach to measuring current performance and identifying those areas that need to be targeted for improvement, ideas are generated to identify the best solution to the problem.

Third is the focus that is placed on the customer. Early attempts at improving quality got lost in problem solving to an extent that the needs of the customer were not recognised. Achieving quality demands a deep understanding of customers in order to meet their needs.

The fourth idea is the role of management in quality management. According to this theory, it is assumed that all quality problems begin in the boardroom and offices of senior management.

The fifth idea is about employee participation, where empowerment means letting employees make decisions at all levels of an organisation without asking for approval from managers. The people who actually do the jobs are in the best position to learn how to do them best. When there is an opportunity to make changes, people doing the job should make the improvements without asking for permission.

Although quality management was born in the US, it flourished in post-war Japan. Edward Deming, an American, was invited to help the Japanese improve the quality of their production. The Deming chain reaction is as follows: firstly, improve quality; secondly, reduce costs by making fewer mistakes, do less rework, establish fewer delays and make better use of time and materials; thirdly, improve productivity; fourthly, capture the market with better quality at lower prices and, lastly, stay in business and keep on providing jobs (Marriner-Tomey, 2004:436–437).

In the words of Jay Kate (1992 in Kelly-Heidenthal, 2003:376), 'If you always do what you've always done you will always get what you've always gotten'.

## 16.2.1 Deming's 14 points

These five main themes are reflected in Deming's famous 14 points for managing quality, which can also be applied to the healthcare environment. They are:

1.  *Create consistency of purpose for improvement of products and services.* The purpose is to stay in business and provide jobs through maintenance, research, innovation and constant improvement.

2.  *Adopt the new philosophy of quality improvement.* Embrace the quality management philosophy. Management must awaken to the challenge; managers must learn their responsibilities and lead the organisation to quality healthcare for all. There must be a commitment to improve quality that runs throughout the organisation. Mistakes and negativism should be seen as unacceptable.

3.  *Cease dependence on inspection.* Focus on preventing mistakes, rather than correcting them. Move away from a psychology of inspection towards

a culture in which quality is part of every aspect of organisational life. It should form part of the way products and services are designed.

4. *End the practice of awarding business on the basis of the price tag*. Move towards a single supplier for any one item on a long-term relationship of loyalty and trust. Minimise your costs as your relationship with your suppliers shows you how to make improvements.

5. *Improve constantly*. The root causes of most problems are faulty processes. Keep on redesigning the way you work. Strive to raise your standards.

6. *Institute training on the job*. Health service managers should look for ways to reduce waste and improve quality continuously.

7. *Institute leadership*. The traditional top-down style of supervision is inadequate. The manager should be a coach and not a boss. Deming believes that people who do not do well are just misplaced in the organisation and the leader must identify workers who need individual attention and help them to do a better job.

8. *Drive out fear so that everyone may work effectively in the organisation*. Let there be a culture of openness. Break down barriers between organisational units and create interdisciplinary teams. Competition should be against external organisations and not within the healthcare organisation itself. Many workers are afraid to ask questions or point out problems for fear of being blamed for the problem.

9. *Break down barriers between staff areas*. Conflict between departments is harmful to the growth and improvement of health services.

10. *Eliminate slogans, exhortations and targets*. You only frustrate workers by asking them to do things that the existing systems prevent them from doing. Instead, provide staff with the tools and methods necessary to render quality care.

11. *Eliminate production targets, for example numerical quotas, because they deal with numbers and not quality*. Eliminate management by objective, numerical goals. Substitute them with effective leadership and supervision.

12. *Remove barriers to proud workmanship*. People are eager to do a good job. Barriers such as faulty equipment, defective materials and misguided supervision should be removed from the workplace.

13. *Institute a vigorous programme of education and self-improvement*. Managers and staff alike need to be educated about new methods in supervision and teamwork.

14. *Transformation is everyone's job*. A critical mass of people must understand these 14 points of quality improvement for quality of services to improve in healthcare organisations (Marriner-Tomey, 2004:438).

Deming introduced the plan-do-check-act cycle (PDCA). FOCUS-PDCA is an acronym for quality improvement and monitoring of actions. The PDCA-cycle methods include the following:

- Planning, which includes planning the change, identifying opportunities, development of a vision, data collecting and using CQI tools to organise the data and decide on improvement initiatives.

- Doing includes implementing the planned change and initiatives, testing with a trial run, identifying costs, people and materials and, lastly, educating staff and management regarding the change processes.

- Checking involves observing the effect of change, monitoring progress, meeting staff to discuss changes, delegating monitoring activities to staff, comparing new data with original data using the CQI tools and monitoring results.

- Acting is making necessary adjustments, incorporating changes in policies, informing all staff of the changes and retraining them where needed, distributing new policies and policy changes and looking for new opportunities (Marriner-Tomey, 2004:440).

FOCUS-PDCA involves the following stages:

- Find a process to improve: look for problems; study complaints in the system.

- Organise a team that knows the process: train and identify experts in the field of quality improvement.

- Clarify current knowledge of the process by consulting, asking and verifying practices in the healthcare environment.

- Understand causes of process variation: clarify variation and do problem analysis to ensure that improvement action is targeted at the most important aspects in the organisation.

- Select the process to be used to bring about the improvement by brainstorming techniques.

- Plan the improvement and continue data collection on all aspects of concern.

- Do the improvements and continue data collection and analysis.

- Check the results and identify lessons learned from the team effort.

- Act in a way that you are sure to retain the benefits of the exercise in order to continue to improve the process in healthcare services.

Juran and Crosby were also strong exponents of managing for quality. Juran in Marriner-Tomey (2004) identified a quality trilogy advocating total quality management. This is composed of three activities, namely, quality planning, control and improvement.

Quality planning includes determining who the customers are and their needs. Furthermore, product features that respond to the customers' requirements need

to be developed. Thereafter, processes that produce the desirable product features are developed and, lastly, the resulting plans are transferred to the operations stage.

Secondly, quality control includes the evaluation of quality performance, comparing actual performance with quality goals and then acting on the differences.

Thirdly, quality improvement includes establishing the infrastructure needed to secure annual quality improvement. Thereafter, the specific needs for improvement, which become the improvement projects, should be established. This step should be followed by the establishment of the project team, which takes responsibility for bringing the project to a successful closure.

Lastly, the resources and training needed by teams to diagnose the problems are provided, remedies developed, evaluation established and control measures instituted (Marriner-Tomey, 2004:439).

Crosby defines quality as conformance to requirements. He believes that the system for creating quality is the prevention of errors, instead of an appraisal of the output. Crosby identifies 14 steps to quality improvement (Marriner-Tomey, 2004:439).

1. There must be a commitment from management towards quality improvement.

2. Quality improvement teams composed of people with knowledge of the process and commitment to actions should be established.

3. The focus should be on quality measurements that identify areas for improvement and change.

4. Measuring the costs of quality in relation to the cost of 'non-quality' needs to be done.

5. To achieve mainstream quality awareness among all personnel these activities need to be discussed continually at meetings and in memos so that everyone is on the same page.

6. Corrective actions through improvement strategies need to be instituted on a continuous basis to improve quality.

7. Quality improvement efforts must focus on planning for zero defects. This means doing it right the first time.

8. Efforts need to be made to develop and empower all employees regarding quality improvement.

9. Implement a zero defect day in the healthcare organisation as a method of demonstrating commitment to quality.

10. Goal setting must be towards zero defects.

11. The factors that cause errors to occur must be removed by removing the barriers. It is not good practice to allow errors.

12. Management must give recognition to staff for meeting the goals.

13. Quality councils or committees in the health services must be set up to assist staff with quality improvement.

14. Repeat the above: a 'do it all over again' philosophy must apply.

Generally, the process of quality improvement includes the following aspects, according to Juran in Marriner-Tomey (2004:438):

1. Identify the customers, their expectations and the outputs using strategies such as brainstorming, focus groups and individual interviews.

2. Describe the current processes using flow charts and focus groups.

3. Measure the reality and analyse discrepancies using tools such as checklists, check sheets and surveys.

4. Focus on an important opportunity using decision-making tools, Pareto charts (bar diagrams to present findings) and allow for voting on important aspects.

5. Identify the root causes of problems by using fishbone analysis, tree diagrams or focus groups.

6. Generate and select solutions through brainstorming and other strategies, such as decision matrices and diagrams.

7. Map out a trial run through brainstorming, diagrams and flow charting.

8. Implement the trial run using check sheets, logs and histograms.

9. Evaluate the results using check sheets, logs, surveys and trend charts.

10. Draw conclusions using Pareto diagrams or other applicable tools.

11. Standardise the change using force field analysis, brainstorming, action planning and Gantt charts.

12. Monitor the process by using Gantt charts and action planning tools.

## 16.3 Tools and processes for continuous quality improvement

Bar diagrams represent changes in the value of a variable or different data sets. A bar diagram can represent a set of data that does not need to be subcategorised, as shown in Figure 16.1. The cluster bar diagram can divide simple bar diagrams into subtotals. A Histogram is a type of bar diagram, as shown in Figure 16.2.

Brainstorming is a process of creating a free flow of ideas without fear of criticism and thereafter thinking about the good in the unfettered range of ideas generated (Marriner-Tomey, 2004:441). A cause and effect, or fishbone, analysis is used to identify the root causes of a problem or outcome. It is done as follows: identify a problem, then use brainstorming to identify the root causes. Start with the outcome and then identify causal categories, such as facilities or equipment, materials or supplies, methods and people and items within those categories that cause the problem. Ask why at least three times to identify the root causes.

Identify first-, second- and third-level causes until the causes become narrow enough to address. This can be represented as a fishbone diagram, as show in Figure 16.3.
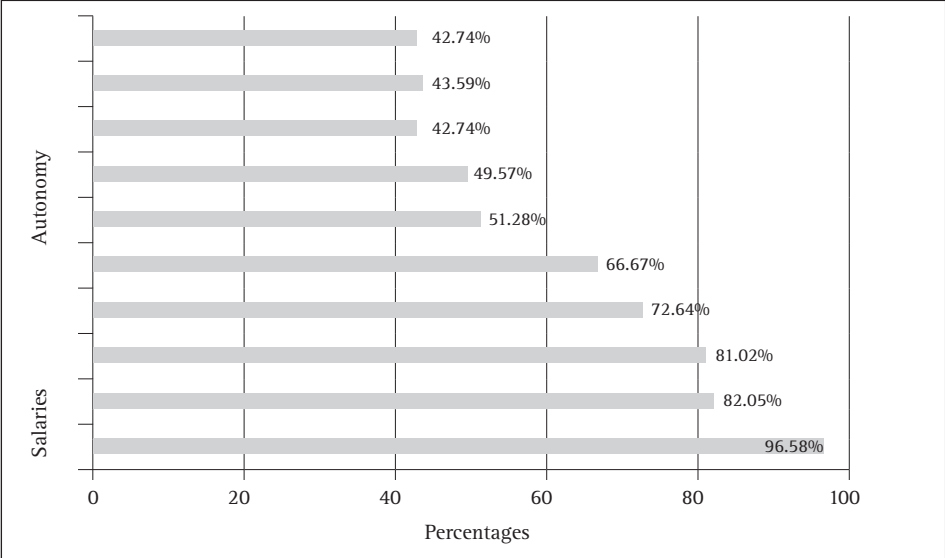


**Figure 16.1:** Simple bar diagram illustrating issues that dissatisfied healthcare professionals in a public hospital

Source: Selebi and Minnaar (2007)
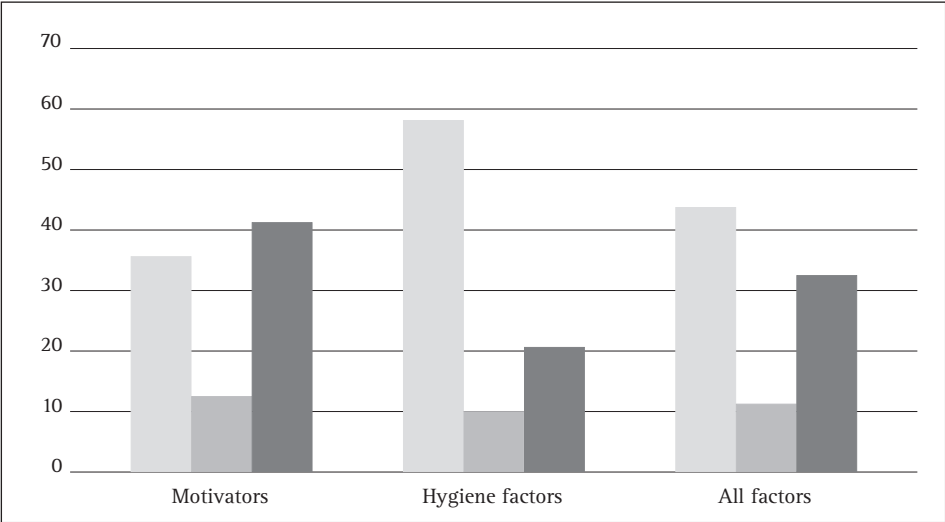


**Figure 16.2:** Clustered bar diagram on job satisfaction of all nurses on the Minnesota job satisfaction questionnaire in percentages (n = 117)

Source: Selebi and Minnaar (2007)
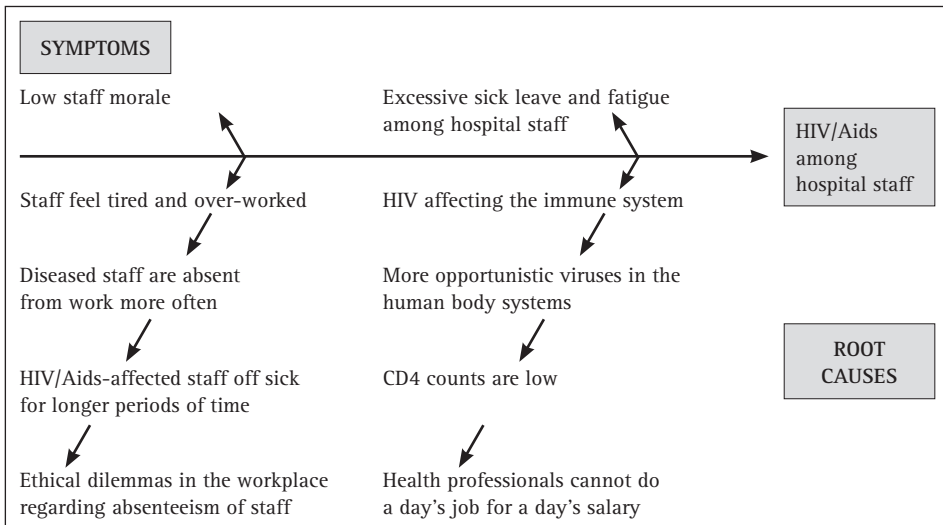
**Figure 16.3:** Fishbone analysis for HIV/AIDs among health professionals in a hospital

Source: Selebi and Minnaar (2007)

Check sheets – as displayed in Table 16.1 – are grids that can be used to collect and classify raw data. Check sheets are good tools for monitoring key performance indicators and can be used to count events or issues, such as infections, diseases or care to patients.

**Table 16.1:** Check sheet for patient diseases

| Disease | Counts |
|---|---|
| Pneumonia | ///// ///// ///// ///// |
| Stroke | // |

A decision matrix is a grid that helps prioritise options (see Table 16.2). One starts with a brainstorming session to identify options and then the options are evaluated. Viable alternatives are listed down the left side of the grid. Criteria for evaluating each viable option are identified and indicated at the top of the grid and options are rated, for example, 1 = poor, 2 = adequate, 3 = good. Viable alternatives are also ranked, such as 1 = unimportant, 2 = important and 3 = very important, depending on the option. Costs could be added to identify the least costly viable alternative.

For example, if you look at the awareness programme in the decision-making matrix, 3 was allocated (ie very important) and the ease of implementation was rated as 2 (ie adequate). You multiply 3 x 2 and it gives you 6.

**Table 16.2:** Decision-making matrix

| Viable alternatives | Ease of implementation 2 | Cost 3 | Timeliness 2 | Value added 3 | Quality impact 3 | Weighted score | Rank |
|---|---|---|---|---|---|---|---|
| Awareness programme | 3/**6** (3 x 2) | 3/**9** (3 x 3) | 3/**6** (3 x 2) | 2/**6** (2 x 3) | 3/**9** (3 x 3) | 36 (6+9+6+6+9=36) | 1 |
| Workshop training | 1/**2** (1 x 2) | 1/**3** (1 x 3) | 1/**2** (1 x 2) | 3/**9** (3 x 3) | 2/**6** (2 x 3) | 22 (2+3+2+9+6=22) | 2 |
| Buying books | 1/**2** (1 x 2) | 1/**3** (1 x 3) | 1/**2** (1 x 2) | 2/**6** (2 x 3) | 2/**6** (2 x 3) | 19 (2+3+2+6+6=19) | 3 |

Managers are increasingly searching for new and easier techniques to control and manage project complexities, information and time deadlines. In the last few decades, scheduling techniques have continuously improved. We have seen, for instance, the emergence of bar charts, milestone charts, network diagrams, such as PERT (Program Evaluation and Review Technique) and CPM (Critical Path Method).

Bar charts are the most common way of presenting project information. They are simple to understand and easy to modify. The most widely used bar chart in project management is the Gantt chart. A simple version of the Gantt chart lists the project activities against time. The more complex versions of Gantt charts may include further project elements/activities, such as responsibilities, events, milestones, projected versus completed activities, critical path analysis and parallel activities (see Table 16.4 and Figure 16.4 as examples).

Scheduling includes the following steps: activity listing, resource allocation, sequencing and taking corrective action. The questions to be asked in scheduling are as follows:

- *Activity listing*: What specific activities must be carried out or which things must be done and how must they be carried out to achieve the project objectives? (See Table 16.3.)

- *Resource allocation*: Who will carry out each activity listed and what other resources will they need (eg money, equipment and advice)?

- *Sequencing*: How long should each activity take? What other activities must be completed before this activity takes place? When should this activity start and by when must it be completed? What is the best sequence for activities to take place?

- *Taking corrective action*: Which activities have been completed and which activities have not that should have been? Why have they not been completed and what needs to be done to get them back on schedule? What resources have been used? Has too much of any resource been used (eg money)? Why has too much been used and what must be done to get planned resource utilisation back on track?

Table 16.3: Activity listing for training session

| Activity | Person responsible | Resources required | Deadline date |
|---|---|---|---|
| Invite all the participants | Jabu | List and contact details of all participants | March 15 2008 |
| Book the venue | Pete | List of venues | April 1 2008 |
| Book the facilitator | Pete | List of facilitators | April 15 2008 |
| Develop the programme for the workshop | Busi | Consultation with the facilitator | April 30 2008 |
| Secure the budget for the workshop | Busi | Budget line items | May 1 2008 |

The work breakdown structure (WBS) is one of the most common project planning tools used to divide and structure a project into smaller, detailed elements, which are specific and manageable. A WBS enables a project manager to see the total project as a sum of the smaller units, design various schedules, establish responsibilities and accountabilities, develop costs and budgets and monitor finances, resources, time, quality, risk, performance and the overall implementation of a project.

A WBS may be used to plan and present information graphically and includes elements such as goals, objectives, activities, indicators of success, project structure (authorities, accountabilities and responsibilities), budget structure (cost centres, suppliers), project time and the decision-making process, as depicted in Table 16. 4.

Table 16.4: Work breakdown structure for planning a building project

| Activity | Responsibility | Time frame | Resource required | Budget | Indicator of success | Assumption |
|---|---|---|---|---|---|---|
| Building a structure | Peter | July 10 – July 20 | List of approved vendors | R12 000 | Walls are built | Bricks available at the right prices |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

Flow processes help to analyse how a task is being performed. A flow process chart makes us of symbols, such as **O** = operation, → = transportation, ❏ = inspection, **D** = delay and ▲ = storage.

A Gantt chart is a grid with time frames across the top that could be in minutes, hours, days , weeks or months (see Figure 16.4).

| Task or activity | Responsibility | Week 1 | Week 2 | Week 3 | Week 4 | Week 5 |
|---|---|---|---|---|---|---|
| Lay foundation | Davy | | | | | |
| _ _ _ | | | | | | |
| Build walls | Samuel | | | | | |
| _ _ _ | | | | | | |
| Pitch roof | Peter | | | | | |
| _ _ _ | | | | | | |

Key:

⟵————————⟶ Planned beginning and end of activity

_ _ _ _ Critical path
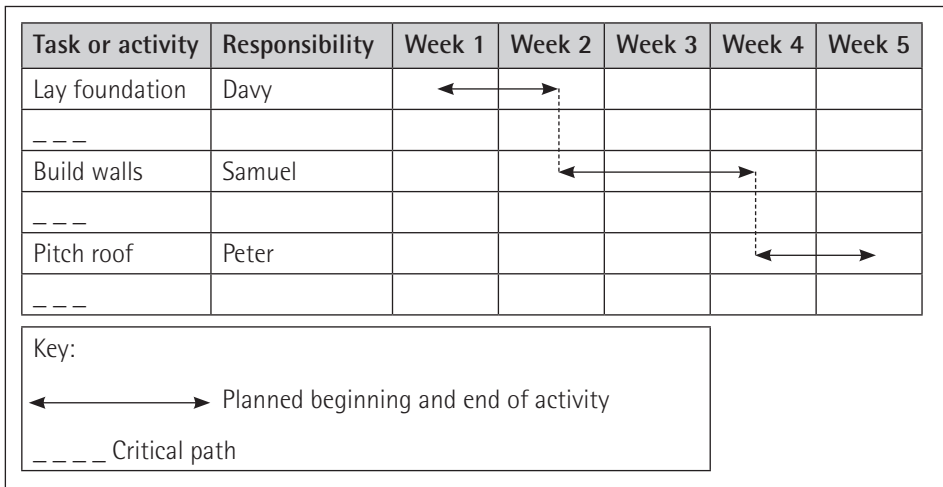
**Figure 16.4:** Gantt chart for a building project at a clinic

Nominal group technique is a process for the development of team goals and priorities. Individuals list in writing ideas or issues during a silent generation of ideas. Each participant gives one idea at a time during a round robin session. The ideas are written onto a board or flip chart. Ideas are expressed around the circle until they have all been given. Then there is a discussion session on clarification before voting. Ideas or issues are then weighted.

There are various other tools available for tracking activities and decision making that are not described here, such as Pareto charts, pie diagrams, PERT evaluation techniques, radar charts, run charts, scatter diagrams and others.

## 16.4 Conducting a quality audit: ISO 9001: 2000

When an organisation decides to embark on a quality improvement journey, it must start out by conducting a quality audit. This is rather like looking into the mirror and asking what is happening or not happening in the organisation. According to ISO 9001: 2000, quality means giving complete satisfaction to the customer through the utilisation of standards that are accepted by both supplier and the customer. Quality also involves complying with an agreed standard at an accepted specification and at an acceptable cost. ISO 9001: 2000 is not about only complying with a specification, because the specification could be wrong. It is not about being the best and only producing a product that is fit for the purpose, because that purpose may be completely different to the customer's actual needs (Tricker & Sherring-Lucas, 2005:1). The product must be fit for the purpose and in totality must bear the ability to satisfy a given need.

A quality audit is conducted in four phases:

*Phase 1*: Plan the audit (form a team, define objectives and scope, identify sources of information).

*Phase 2*: Execute the audit (gather information and record non-conformities).

*Phase 3*: Report on the audit (present findings and make recommendations).

*Phase 4*: Correct any problems (set timetable, implement recommendations, inspect and certify).

Different tools for conducting such an audit exist. Probably the most famous one is ISO 9000. (ISO is an acronym for International Organization for Standardization). The ISO 9000 family of standards represents an international consensus on good management practices with the aim of ensuring that the organisation can time and time again deliver the products or services that meet the quality requirements of the client. These good practices have been distilled into a set of standardised requirements for a quality management system, regardless of what the organisation does, its size, or whether it is in the private or public sector.

The requirements for a quality system have been standardised – but most of us like to think our organisation is unique. So how does ISO 9000 allow for the diversity of a small enterprise, a multinational manufacturing company with service components, a public utility, or a government administration?

The answer is that ISO 9000 lays down *what* requirements your quality system must meet, but does not dictate *how* they should be met in your organisation. This leaves great scope and flexibility for implementation in different business sectors and business cultures, as well as in different national cultures.

So, the ISO 9000 family includes standards that give organisations guidance and requirements on what constitutes an effective quality management system. The family also includes models against which this system can be audited to give the organisation and its clients assurance that the system is operating effectively. Lastly, the family includes a standard on terminology as well as other items, which can be described as supporting tools that give guidance on specific aspects, such as auditing quality systems.

What does an organisation need to do to implement ISO 9000? It should audit its ISO 9000-based quality system itself to verify that it is managing its processes effectively, or, to put it another way, check that it is fully in control of its activities.

The ISO 9001: 2000 standards focus mainly on the following principles:

*Principle 1*: Customer focus, where organisations rely on customers and, therefore, focus on customer needs and requirements.

*Principle 2*: Leadership in organisations, where leaders create purpose towards the vision and mission of the organisation.

*Principle 3*: Involvement of people in all decisions to the benefit of the organisation.

*Principle 4*: Process approach towards more efficiency of the organisation.

*Principle 5*: Systems approach, where the degree of synergy and alignment between the organisation, team and individuals' goals and objectives determines

the success or failure of an organisation. It is, therefore, imperative that each organisation ensures that the team and individuals' goals and objectives are aligned with the organisation's strategies (vision, mission, goals and objectives); structure (organogram, decision-making structure); systems (human resources, finance, communication, administration, information) and culture (values, level of openness, democracy, caring). Hence, an effective work environment should be characterised by the organisational systems, strategies, structures and culture being aligned with people who operate synergistically.

*Principle 6*: Continual improvement of all aspects in the organisation and performances.

*Principle 7*: Factual approach to decision making grounded in analysis of data and information.

*Principle 8*: Mutually beneficial supplier relationships to enhance the ability for both to create value.

In addition, the organisation may invite its clients to audit the quality system in order to give them confidence that it is capable of delivering products or services that will meet their requirements.

The South African White Paper on Transformation of the Public Services is concentrating on quality improvement in the public sector organisations. Batho Pele – which means 'people first' – is a guideline for quality improvement in South Africa.

## 16.5 Quality service to the people: Batho Pele

The White Paper on the Transformation of the Public Services (WPTPS) (RSA, 1997) provides a policy framework and a practical implementation strategy for the transformation of public service delivery to improve efficiency and effectiveness. The WPTPS requires national and provincial departments to identify the following issues to promote improvements in the quantity and quality of all public services, in particular the health services:

- mission statement for service delivery
- services to be provided to which groups and at what service charges
- service standards, defined outputs and targets and performance indicators benchmarked against comparable international standards
- plans for staffing, human resource development and organisational capacity building tailored to service delivery needs
- financial plans that link budgets to service needs and personnel plans to potential partnerships with the private sector or non-government organisations
- the development of a culture of customer care
- the development of approaches to service delivery that are sensitive to issues of race, gender and disability.

Putting the principles of Batho Pele into practice in healthcare services involves eight steps, which need to be implemented on a continuous basis.

*Step 1: Consulting users of services*

Clients and patients should be consulted about the level and quality of the services they receive and, wherever possible, be given a choice about the services that are offered. Consultation processes should be undertaken sensitively, comprehensively and with an emphasis on representativeness.

*Step 2: Service standards*

Clients and patients should be told what level of quality they will receive so that they are aware of what to expect.

*Step 3: Increasing access*

All clients and patients should have equal access to the services to which they are entitled. One of the aims of Batho Pele is to provide a framework for making decisions about delivering public services to many South Africans who were (and still are) denied access to them within the parameters of the government's GEAR strategy (RSA, 1997:18).

*Step 4: Ensuring courtesy*

Citizens should be treated with courtesy and consideration. Courtesy goes much further than a smile and saying please and thank you. The Code of Conduct for Public Servants, issued by the Public Services Commission, makes it clear that courtesy and regard for the public is one of the fundamental duties and customers or clients are entitled to receive the highest standards of service. It covers, among others, the following (RSA, 1997:19):

• greeting and addressing customers

• identification of staff by name when dealing with patients

• the style and tone of written communication

• simplification and customer friendliness

• the maximum length of time within which responses must be made to enquiries and how complaints should be dealt with

• the conduct of interviews

• dealing with people with special needs, such as the elderly, in a caring manner

• sensitivity towards gender and language issues.

*Step 5: Providing better information*

Clients and patients should be given full, accurate information about the public services that they are entitled to receive. Implementing Batho Pele will require

a complete transformation of communication with the public and patients. Information must be provided in a variety of media and languages to meet the differing needs of patients and the public.

*Step 6: Increasing openness and transparency*

Clients and patients should be told how national and provincial departments are run, how much they cost and who is in charge. Open days may be utilised to increase the transparency of public services.

*Step 7: Remedying mistakes and failures (redress)*

If the promised standard of service is not delivered, clients and patients should be offered an apology, a full explanation and a speedy and effective remedy. When complaints are made, citizens should receive a sympathetic, positive response. The Batho Pele principle of redress requires a completely new approach to handling complaints. The first step is to acknowledge that all dissatisfaction, expressed in writing or verbally, is an indication that the citizen does not consider that the promised standard of services is being delivered and then to establish ways of measuring all expressions of dissatisfaction.

The principles are outlined below.

1.  Accessibility for complaints should be provided.

2.  Speedy actions – the longer it takes to respond to a complaint, the more dissatisfied customers will become.

3.  Fairness ensures that complaints are fully and impartially investigated.

4.  Complainants' confidentiality should be protected so that they are not deterred from making complaints by feeling that they will be treated less sympathetically in future.

5.  Responsiveness to a complaint and where a mistake has been made, or service has fallen below the promised standard, should be immediate, starting with an apology, a full explanation and assurance that it will not happen again.

6.  A review system for complaints and feedback must be in place, suggesting changes for providing a service so that mistakes and failures do not recur.

7.  Training should be implemented throughout the organisation to prevent failure and improve services.

*Step 8: Getting the best value for money*

Public services should be provided in an economical and efficient way in order to give clients and patients the best possible value for money. Simplify procedures and eliminate waste and inefficiency in health services. Patients also have a right to quality health services that are safe and without risks (RSA, 1997:1–23).

## 16.6 Standards and criteria in healthcare

The terms standards and criteria are often used interchangeably when quality improvement issues are discussed. Although closely related, they are not synonymous. Standards are statements of what good healthcare should be. In other words, a healthcare standard is a description of the desired level of performance for judging the quality of healthcare.

Criteria, as defined by Sale (1990:11 in Booyens & Minnaar, 1996), are 'descriptive statements of performance, behaviour, circumstances or clinical status that represent a satisfactory, positive or excellent state of affairs'. Criteria are related to the standard in the sense that they serve as detailed indicators of the standard and thus make the standard work. Criteria serve as a practical measuring scale to assess the quality of care. They can, therefore, be seen as 'mini-standards'.

## 16.6.1 Prerequisites of criteria

Criteria must be achievable, specific, concise, understandable and clinically sound.

1.  Achievability of criteria means that they must involve achievable and reasonable actions. It might be desirable or ideal for a nurse to take the vital signs of a patient every five to ten minutes for 24 hours. It is, however, unrealistic, unachievable and unreasonable to expect vital signs to be monitored so frequently in an ordinary nursing unit, unless the patient is attached to the necessary mechanical monitors.

2.  Specificity means that the criteria will describe the specific action or specific result in clear language, for example: 'observe and document the level of consciousness for painful stimuli every four hours'.

3.  Conciseness means that the criteria specifications should convey clearly the desired actions in as few words as possible.

4.  Comprehensibility implies that each criterion should spell out only one main idea. Clear, simple, unambiguous wording must be used. Two or more individuals should be able to interpret the statement in the same way.

5.  Clinical soundness signifies that the criteria must measure those features of the healthcare that are relevant to the disease(s) the patient is suffering from. It is necessary to validate clinical soundness by using clinical experts and current texts.

## 16.6.2 Rules for the formulation of clinical criteria

1.  Commence with a verb that describes the desired behaviour or clinical status, for example, 'assess, teach, demonstrate, observe, refer, monitor and verbalise'.

2.  Follow the verb with the activity involved, for example, *assess* the character, depth and rate of respiration; *observe* dressing for evidence of bright-red bleeding; *monitor* the number of millilitres of urinary output per hour.

When formulating healthcare process criteria for the auditing of healthcare records, the verb is usually left out, for example:

- Documentation of site, size and type of laceration
- Status of skin condition.

### 16.6.3 Types of criteria

There are three types of criteria: structure, process and outcome.

### *Structure criteria*

These relate to the items of service that are in the system and necessary for accomplishing the task described. In other words, they refer to the expected performance of the organisation. Included as structure criteria are (Sale, 1990:11 in Booyens & Minnaar, 1996):

- physical layout
- mission of the organisation
- staff members' skill mix, training and expertise
- information, policies, procedures, rules and regulations and
- organisational system.

### *Process criteria*

These relate to the action(s) that need to be taken by staff in order to achieve the standard. In other words, they refer to what the nurse will do to achieve certain results. This also includes invisible actions, such as decision making. Process criteria are:

- assessment techniques
- interpretation of signs, symptoms and appropriate intervention
- informing and educating patients
- documentation of care and
- utilisation of resources.

### *Outcome criteria*

These refer to the expected performances of patients or the results expected after good healthcare has been rendered. Outcome criteria are:

- patient behaviours and responses
- level of knowledge
- health status (Sale, 1990:12 in Booyens & Minnaar, 1996).

### 16.6.4 Examples of general healthcare criteria

1. The patient's vital signs should be recorded within 12 hours of admission.

2. The patient's physical and emotional condition should be assessed on admission.

The process of formulating standards will vary according to the basic underlying orientation towards standard setting – that is, whether generic, specific, or problem-orientated standards are to be set.

### 16.6.5 Setting specific disease–related criteria

The conceptualisation and formulation of criteria is a demanding mental exercise. It is, however, easier to do when the following steps are followed:

*Step 1*: Select a specific disease for which criteria will be formulated, for example, tuberculosis.

Define the admission phase. To measure the entire continuum of care, criteria should be developed to reflect the desired processes or outcomes at various points along the health/illness spectrum. Usually, there is an *admission phase*, an *interim phase* and a *discharge phase.* Other terms may also be used to indicate the phases of care, for example, for a patient undergoing surgery, the following phases might be used: admission phase, immediate pre-operative phase, operative phase, post-operative phase, convalescent phase and discharge phase. The different phases must be stipulated clearly, for example, interim phase = third post-operative day until first day prior to discharge; discharge phase = first day prior to discharge until discharge.

*Step 2*: Consider what a nurse should do during the admission phase for a patient with the selected disease.

*Step 3*: Write down the required healthcare actions for the admission phase, for example, documentation of the speed of respiration; documentation of the rhythm of respiration.

*Step 4*: Explain what the patient should do or what his or her clinical status would be during the admission phase.

*Step 5*: Write down the anticipated patient's actions or the expected clinical status in the form of criteria, for example, the patient's coughing pattern; the patient's smoking habits; the kind of sputum coughed up.

*Step 6*: Follow the same steps for the interim and discharge phases.

Examples of specific healthcare criteria for a patient with chronic obstructive airways disease are as follows:

- the respiration rate and depth should be recorded on admission
- during the patient's physical assessment on admission, the presence or absence of pitting edema should be noted.

## 16.7 Standard healthcare plans

Standard healthcare plans play a significant role in the process of quality improvement because the expected standards have already been formulated and many of the criteria have been identified.

### 16.7.1 Patient/client satisfaction

Patient satisfaction with healthcare is an important quality and outcome indicator. Satisfaction may be seen as the crux for survival and gaining a competitive edge in healthcare. Jennings, Heiner, Loan, Hemman and Swanson (2005:173–80) researched patient satisfaction and developed care features from the data analysis. The features offer lessons for all healthcare leaders to use when making improvements in healthcare delivery systems. These improvements are more focused on patient-centred care to boost patient satisfaction. Satisfaction is in the eye of the beholder; consequently, attention in healthcare should be given to aspects such as patients' needs, values and preferences. Jennings et al (2005:173) explain that if healthcare organisations are serious about improving patient satisfaction and quality then they need to explore what they might do to delight their patients, what they must do to avoid disappointing their patients and what they should do to meet their basic expectations consistently, efficiently and compassionately.

### 16.7.2 Features of patient satisfaction

Patients want to be treated in a way that makes them feel they matter as individuals: they want to be treated in a caring way, with compassion, attentively, courteously, respectfully and gently. Healthcare professionals with a bad attitude do not belong in health services, according to patients. Patients count on healthcare professionals, so competence and accuracy are important qualities in healthcare professionals when dealing with patients. The patient must be the priority for each healthcare worker: patients expect healthcare professionals to listen, pay attention to the whole picture and communicate with them. Healthcare professionals should always be sure to note what the patient really wishes to know, such as test results, answering their questions and concerns or their desire for other providers to be involved in their care and informed.

Patients do not want to be seen by new healthcare workers all the time; they want continuity and they want to know their health professionals. Patients want their care to be well co-ordinated and appointments to be handled efficiently. They also want healthcare professionals to respect their time: when healthcare provision takes too long it has an impact on the patient's work. Patients want

the phone system to be much more user-friendly and efficient. They want to be able to choose their healthcare provider and paperwork to be simpler. Healthcare professionals need to keep their promises about protecting the health of patients (Jennings et al, 2005:175).

In South Africa, we have the Batho Pele principles (see section 16.5). Serving the needs of people and their community is the very *raison d'être* of government. But what are the needs of the people and what can be deemed to be quality service? Generally speaking, the emphasis of health providers is on providing clinically competent services; users, on the other hand, stress the experience of being cared for. These different expectations often result in tension between health personnel and patients. Ultimately, it is the patient and the community at large who are the real judges of what constitutes good, high-quality care. Research identifies the following areas that are important to the patients in public health organisations (see Table 16.5).

**Table 16.5:** Improving quality of services

| Aspect | Percentages (%) |
|---|---|
| Better service | 37 |
| Get the staff to treat patients better | 26 |
| Increased availability of drugs/medicine | 24 |
| Improve staff skills | 13 |
| Nothing | 11 |
| Make it affordable | 10 |
| More convenient hours of opening | 9 |
| Wider range of services | 8 |
| Make it easier to get to | 6 |
| Don't know | 9 |
| Other | 13 |

Source: Health Systems Trust (1999)

One of the critical issues in the successful implementation of community projects is the consultation process, or the involvement of key policy stakeholders. If the stakeholders are not involved from the beginning of a project, they may sabotage the implementation of the project or they may not support it. However, too much stakeholder participation may also become frustrating, time wasting and destructive. It is important, therefore, to identify the key stakeholders and plan how to manage them successfully. See Table 16.6 for an example of a stakeholder analysis.

**Table 16.6:** Stakeholder analysis template

| | | Needs/interests of stakeholders | | Participation tactic |
|---|---|---|---|---|
| List of all stakeholders | Stakeholders prioritised | Positive | Negative | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Problems regarding patient satisfaction and organisational problems that cause patient dissatisfaction can be analysed by using various tools, as examined in section 16.3. One of them is the fishbone diagram. Nosocomial infections pose a threat to all patients in healthcare organisations; healthcare management, therefore, needs to pay special attention to infection control and infection risks.

# 16.8 Infection control in healthcare services

Infection control in health services comprises a set of principles and guidelines to improve quality of care to patients. Infection control is part of risk management in any health service. In the general population, infection control concerns itself with food and water supplies and effective waste disposal, which all contribute to an increased life expectancy for community members. In healthcare facilities these basic concerns also apply. In addition to general infection controls that apply to the community at large, health and food legislation and various control mechanisms further impose obligations on hospitals and healthcare services to ensure a safe environment for patients and staff.

Nosocomial infections (hospital-acquired infections) remain a serious problem in hospitals and, to make matters worse, it is difficult to measure the cost. Healthcare services must learn to see infection rates as a quality indicator for accreditation of the hospital. However, a robust surveillance system and infection control programmes must be in place in all circumstances. A surveillance system for healthcare services must, firstly, include structures for infection control and adequate resources, including staff. Secondly, health services need policies and standards for the effective control of infections. Thirdly, healthcare institutions need a surveillance system with written programmes, effective measures for data collection, a report system for infection rates and training programmes for all categories of staff on infection control (Weaving & Cooper, 2006:18).

## 16.8.1 Factors contributing to the emergence of infectious diseases

The following is a list of contributing factors to infection. Hospital staff need to consider these in order to be successful in their infection control measures:

- microbial adaptation and change, for example, strains that become more virulent
- human susceptibility to infections
- climate and weather: heavy rains, for example, may provide breeding sites for mosquitoes and may cause malaria in subtropical areas
- changing ecosystems: dam building, for example, may cause vector ecology changes
- human demographics and behaviour, for example, body piercing and potential hepatitis C infection
- economic development and land use: clearing of forests, for example, could increase mouse populations and outbreaks of diseases
- international travel and commerce, for example, the import of meat products and Creutzfeldt-Jacob and other diseases
- technology and industry: the treatment of infected chickens, for example, with fluoroquinolones and human resistance to other organisms
- breakdown of public health measures, for example, breakdown in vector control and the consequent outbreak of diseases
- poverty and social inequality: eating animals, for example, that have died from disease, causing anthrax in humans
- war, civil unrest and overcrowding could lead to disruption of public services and control measures, resulting in an outbreak of infectious diseases
- lack of political will, such as in the case of SARS (severe acute respiratory infection)
- intent to harm in biological warfare, for example the spread of *bacillus anthraces.*

## 16.8.2 Quality control standards for infection control

Infection control is everyone's business, not the job of a few specialists. Infection control must be mandated at the highest level of management in the hospital. It must be the responsibility of the hospital board, with clear lines of accountability to hospital board level. The hospital should have an infection control committee with an infection control team. This team should have an annual programme with clear objectives and priorities for the surveillance and monitoring of infections. The infection control policy must reflect current guidelines on infection control and legislative issues and include annual audits of these infection control policies. A specialist microbiologist must support the infection control team. Annual and monthly reports must be presented by the infection control team. All healthcare staff, including support staff, need to have training in infection control (Weaving & Cooper, 2006:18–19).

### 16.8.3 Action areas for infection control, according to the UK Department of Health

The following actions could assist health services to control infections better in hospitals by implementing a seven-point plan. The seven areas are outlined below (Weaving & Cooper, 2006:20).

## Area 1: Active surveillance and investigation

• Conduct mandatory surveillance of MRSA (methicillin-resistant *staph. aureus* infection) and *C. difficile* (*clostridium difficile* infection); investigate surgical site infections, serious infection-related incidents and infections after hospital discharge.

• Conduct root cause analysis of the food processing system.

• Provide information to clinical teams.

• Report serious outbreaks.

## Area 2: Reduce the infection risks from medical devices

• Implement the best practice guidelines for use of urinary tract catheters, intravenous cannulae and other devices and the decontamination of reuseable devices.

## Area 3: Reduce reservoirs of infection

• Unit managers must work with infection control officers regarding adequate isolation facilities and procedures.

• High standard of cleaning of equipment and the environment should be in place.

• Infection control teams must be involved in the planning of hospitals and healthcare facilities.

• Proper waste control and pest control systems must be in place.

## Area 4: High standards of hygiene in clinical practice

• Clinical teams must demonstrate high levels of compliance with hand washing and other standard infection control precautions.

• Induction programmes on infection control practices must be carried out for all staff, including agency and locums.

• Infection control should be considered part of staff development.

• All staff members must be up to date with their immunisations.

## Area 5: Prudent use of antibiotics

## *Area 6: Management and organisation*

- Heads of clinical units must ensure that infection control forms a core part of clinical governance and patient safety. They should promote low levels of infections.

- The organisation will designate a director for infection control.

- Accreditation teams will give high priority to the assessment of performance regarding the reduction of infections.

## *Area 7: Research and development*

- A national research strategy is formulated that focuses on infection control.

- A rapid review process for the assessment of new products is in place.

### 16.8.4 The major infection control problems in health services

The four major infection control problems in healthcare services, which are addressed in this section, are as follows:

- urinary tract infections – the most frequent (35 per cent of nosocomial infections (catheter-associated));

- surgical site infections – the second most frequent (20 per cent of nosocomial infections);

- bloodstream infections – less common (15 per cent), but associated with a high mortality rate and costs (usually associated with the use of an intravascular device);

- pneumonia – 15 per cent infection rate and also associated with a high mortality rate (usually ventilator-associated).

A quarter of nosocomial infections involve patients in intensive care units and nearly 70 per cent are due to micro-organisms resistant to one or more antibiotics (Burke, 2007: 651–6).

## *Urinary tract infection (catheter-associated)*

Urinary tract infections are the most common infection acquired in the health service. The normal bladder has a number of defences against infection. Micro-organisms have difficulty passing along the urethra, the epithelial cell lining of the bladder is resistant to bacterial adherence and the process of urination ensures that bacteria do not manage to gain access to the bladder, as they are normally diluted by fresh urine and removed by the next urination. The presence of a urethral catheter, however, interferes with these defence mechanisms. The urethral catheter is a major predisposing factor in urinary tract infections in health services (Wilson & Jenner, 2006:215).

A thorough understanding of how biofilm forms on the surfaces of in-dwelling catheters is central to understanding the pathogenesis of urinary tract

infection. A biofilm is not a static, filmy slime layer, but a living organism composed of multiple species of bacteria and their secreted polysaccharide matrix and components deposited from bodily fluids. The urinary catheter becomes encrusted with proteins, electrolytes and other organic molecules from the host's urine. Once a catheter has acquired a conditioning film, the features of the underlying catheter surface may be partially or completely obscured. The bare catheter surface is inhospitable to colonisation, but the conditioning film may encourage microbial attachment (Trautner & Darouiche, 2004:842–50).

## Guidelines for insertion of urinary tract catheters

Guidelines for the insertion of urinary catheters indicate that it should always be done with the minimum of infection risk. It is safer, therefore, to insert the catheter in the operating theatre. As it is impossible to remove the perineal flora completely before catheterisation, the area should be cleaned with soap and water or saline and an antiseptic solution applied regularly to contribute to a reduction in urinary tract infections. The healthcare worker performing the procedure should be properly trained and competent. The catheter must be secured on the patient's leg to prevent movement in the urethra, so reducing discomfort for the patient. A controlled trial by Burke (1988), as described in Wilson and Jenner (2006:222), showed that catheterised patients who received no meatal cleansing had the lowest infection rate. Routine bathing or showering is all that is needed.

## Prevention of urinary tract infection

The most frequent causative agents of nosocomial urinary tract infections are from the patients' colonic flora or from the hands of healthcare personnel; they include *E. coli, enterococci*, *pseudomonas*, *klebsiella*, *enterobacter* or *candida* (Trautner & Darouiche, 2004:847). The difficulty of preventing urinary tract infections is compounded by catheter location, duration of the catheter in situ and the numbers and types of organisms. The best ways of prevention for patients with urinary catheters are probably a closed drainage system and intermittent catheterisation.

Dependent drainage and catheter removal when no longer needed should be the norm, or indeed, catheterisation should be avoided. For long-term catheterisation, clean, non-sterile, intermittent catheterisation leads to low rates of colonisation, namely, 20 per cent to 40 per cent. Urinary tract infections are lower with suprapubic catheters, condom catheters and clean, non-sterile, intermittent catheterisation.

Lastly, nurses must ensure dependent drainage at all times, because a drainage tube below the level of the collection bag is associated with an increased risk of urinary tract infections. The need for the urinary tract catheter should often be reviewed to ensure the catheter is removed as soon as possible. If healthcare workers comply with the following nine-point plan and the guidelines for maintenance of the drainage system it could positively impact on the incidence of urinary tract infections in a hospital or healthcare service.

The nine point plan for practice for urinary tract infection and catheterisation is as follows:

1.  Wash hands and use sterile gloves.

2.  Prepare the patient and position the patient in a comfortable way.

3.  Clean perineum and external meatus with saline, water and soap or antiseptic agent as per policy.

4.  Instil anaesthetic lubrication gel into the urethra.

5.  Use sterile equipment.

6.  Select the appropriate catheter.

7.  Insert catheter directly into urethra.

8.  Inflate balloon with correct amount of sterile water.

9.  Remove the catheter as soon as possible.

Guidelines for maintenance of the drainage system:

1.  Use a bag with an integral measuring chamber for patients on urine output monitoring.

2.  Do not change the urine bag routinely.

3.  Do not disconnect the catheter from the drainage bag unless absolutely necessary.

4.  Empty the bag as infrequently as possible.

5.  Wash hands before and after handling the drainage system.

6.  Use clean gloves to handle the drainage system.

7.  Empty urine into a clean container and disinfect afterwards.

8.  Take urine specimens from the sample port, not the drainage bag.

9.  Ensure the urine always flows downwards.

10. Avoid kinks in tubing.

11. Hang bag evenly on stand.

12. Do not change leg bag at night, but connect it to an overnight drainage bag.

13. Avoid use of bladder installations.

## Surgical site infections

It must be recognised that two-thirds of surgical site infections are superficial and stem from bacterial inoculation during surgery and that interventions to decrease them after surgery have little impact. There is a relationship between the timing of antimicrobial administration and the effectiveness of antibiotics prophylaxis. If antibiotics are administered intra-operationally and in a high dose, the patient

has the best chance of not becoming infected. The longer the period before the administration of antibiotics, the greater the chance of a surgical wound infection. It is evident that administering antibiotics four hours after the operation is too late to prevent the infection of a wound.

Hospital-acquired infections, or nosocomialinfections, in the surgical patient are a huge problem in hospitals. Of all surgical patients, 42 per cent acquire urinary tract infections, 40 per cent acquire surgical site infections. Figure 16.5 indicates the genesis of surgical site infections in a hospital or healthcare service. Surgical site infections may occur within the surgical site at any depth, starting from the skin itself and extending through the subcutaneous tissue, deep soft tissue (facia and muscle) into the deepest cavity of an organ.

There are certain risk factors in surgical site infections that need to be mentioned here. Procedures involving sterile tissues, for example, orthopaedic surgery, are likely to encounter less colonisation of bacteria and fewer wound infections. Some parts of the body, for example, the intestines, are colonised by large numbers of bacteria that could enter the wound site when surgery is performed. For instance, in colon surgery, various methods are used to reduce the number of bacteria in the bowel. Surgery that involves a pre-existing infection or necrotic tissue is significantly more likely to result in surgical site infection. The infection risk is the highest for limb amputation, second highest for small bowel surgery, third for large bowel surgery, fourth for vascular surgery, then for coronary bypass graft, open reduction of long bone fractures, hip prosthesis, abdominal hysterectomy, while least affected by infections is knee prosthesis.
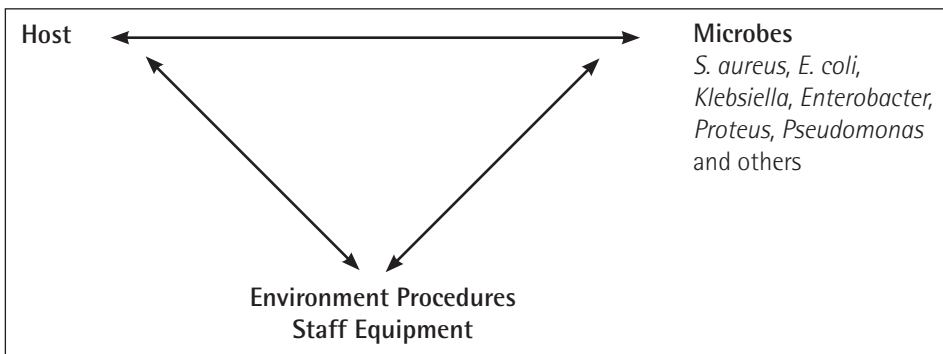


Figure 16.5: Genesis of surgical site infections

Most surgical site infections are caused by gram-positive *cocci*, which include *Staphylococcus aureus*, *Etaphylococcus epidermidis* and the *enterococcus* species. There are certain measures to minimise the risk of surgical infections, according to Cruse and Foord (1980, in Wilson & Jenner, 2006:182). These measures are:

- A short, pre-operative hospital stay to prevent hospital organisms colonising on the patient's skin.

- A disinfectant shower before operation reduces the bacterial colonisation of the skin before the incision and minimises the risk of infection. Alcohol solutions of iodine or chlorexidine should be used to cleanse around the operation site.

- Avoiding shaving the skin.

- Avoiding contamination of the wound.

- Punctilious surgical technique.

- Short operation time.

- Scrupulous operation care for elderly, obese, malnourished and diabetic patients.

- No drains brought out through the operation wound.

- Meticulous coagulation technique.

- Information to each surgeon on his/her wound infection rate compared to peers.

**Table 16.7:** Classification of wound contamination

| Category of wounds | Type of system or conditions involved | Type of surgery | Surgical wound infection percentage |
|---|---|---|---|
| *Clean wounds* | Gastrointestinal, genitourinary or respiratory tract not entered, no evidence of inflammation or infection, no break in technique | Orthopaedic, neurosurgical, cardiac surgery | 2–5% |
| *Clean contaminated wounds* | Gastrointestinal, genitourinary or respiratory tract entered but no spillage of contents | Abdominal hysterectomy, resection of prostate | 4–8% |
| *Contaminated wounds* | Open traumatic wounds, major break in surgical technique, spillage from gastrointestinal tract, inflamed tissue encountered | Reduction of open fracture, some large bowel surgery | 15% |
| *Dirty wounds* | Delayed treatment of traumatic wounds, pre-existing clinical infection, perforated viscera at site of operation | Drainage of abscess | 40% |

Source: Wilson and Jenner (2006:182)

Numerous factors determine whether the patient will develop a surgical site infection. The National Nosocomial Infections Surveillance System lists the factors outlined below as the key elements in the development of surgical wound infections. Patients should be assessed for factors that can be corrected

in the pre-operative period before elective surgery. Open skin lesions should be allowed to heal and patients should be free from bacterial infections. The patient should stop smoking if possible, preferably one month before the surgery and the nutritional status of the patient should get attention (obese patients should lose weight). See Table 16.7 for the categories and patient conditions involved in surgical site infections.

## Risk factors for the development of surgical site infections

### 1.  Patient factors

The following host-derived factors are present in patients at the time of the surgery and may contribute to surgical site infection.

Ascites present in the patient prior to the operation could cause infection of the wound. Ascites is caused by transudation of fluid from the liver surface because of portal and lymphatic hypertension and increased membrane permeability, which leads to increased hydrostatic pressure and decreased oncotic pressure in the portal venous system, which is in itself an infection risk.

Chronic inflammation poses a risk to surgical wounds in the sense that the inflamed tissue could be a source of infection in itself. Corticosteroid therapy is controversial in its ability to cause surgical site infection, as it depresses the immune response and enables bacteria to multiply more easily in the wound.

Obesity poses a relative risk for surgical site infections, as deep layers of adipose tissue can increase the complexity of the procedure and reduce the blood flow to the wound during healing.

Diabetes mellitus poses a relative risk for the development of surgical site infections among diabetic patients. Extremes of age pose a risk to patients because of the immune response and other underlying diseases.

Hypocholesterolaemia, hypoxaemia and peripheral vascular disease, with impairment of tissue oxygenation, such as may occur with vascular insufficiency or diabetes, will delay healing and increase the risk of infection.

Other independent factors could also contribute to surgical site infections, such as prior site irradiation, recent previous operation, remote infection sites in the patient, skin carriage of staphylococci, skin disease (psoriasis) in the area of infection (which could be a site for bacteria to colonise), under-nutrition, which causes delayed wound healing and tobacco use, which could prevent sufficient oxygenation of the tissue.

### 2.  Environmental factors

Environmental factors can be present during and after the surgical procedure. The anaesthetic area must be controlled and checked for unacceptable equipment and personal belongings, which are not allowed in the operating theatre. In addition, contaminated or expired medication must be checked and cleanliness must prevail. Inadequate skin preparation before the operation: the patient should be assessed for factors that can be corrected in the pre-operative time before elective surgery. The patient should shower with an antibacterial soap the night before and should not be shaved, as the risk of infection is increased

by bacteria that colonise the inevitable small cuts and abrasions on the skin. The skin of the operation area must be cleaned with alcohol and needs to be completely dry before the incision is made. Special attention should be paid to the belly button regarding cleaning and disinfection as it could harbour bacteria, such as the *staphylococcus* species. Peri-and intra-operative measures to prevent surgical site infections must be adhered to in hospitals.

The preparation of the surgical team is important regarding total coverage of beards and the handling of masks. The surgical team should focus on their hand-washing procedures and prevent team members from operating with jewellery on their hands and arms. Movement in the theatre must be restricted and behaviour during the operation is crucial in preventing surgical site infections. There should be no nailbrushes at the hand basins: scrubbing nails, hands and arms opens up the scales of the skin and exposes skin bacteria on the hands and arms of the operation team, contributing to surgical site infections. Brushes in a tray of antiseptic agent (eg Savlon) could act as a biofilm and provide a breeding place for bacteria.

### 3. Treatment factors

Treatment factors received by patients before, during and after surgery play a role in wound sepsis. Wound drains provide a route through which bacteria can enter the wound. However, a drain can facilitate wound healing by preventing the formation of haematomas. A closed drainage system must be used when a drain needs to be inserted during the operation. Another factor is making a separate incision for the drain so that the main incision is not affected by the drain. Drains should not be left in place for too long, as they may enable bacteria to colonise the site.

Emergency procedures, hypothermia, inadequate antibiotic treatment, prophylaxis and prolonged pre-operative hospitalisation are factors in surgical wound infections. Prolonged operative time causes a greater chance for bacteria to settle onto the tissue or be carried from the hands or instruments to the wound. Although the infection of a wound usually presents itself four to ten days after an operation, most of these infections were introduced during surgery. As soon as the wound has been sutured, a loose mesh of fibrine is formed and is gradually infiltrated by fibroblasts and collagen. This structure becomes impervious to the entry of bacteria within a few hours and, with the theatre dressing in place undisturbed for 48 hours, pathogens are unlikely to gain access to the wound (Wilson & Jenner, 2006:182).

### 4. The post-operative period

Blood transfusion and post-operative anaemia treated with a blood transfusion are common and may be a life-saving act, but blood transfusions have been associated with increased rates of nosocomial infections following the penetration of the abdomen with related factors, such as shock or acute blood loss. According to Barie and Eachempati (2005:11, 15–35), a recent meta-analysis estimated that transfusion of any volume of red blood cell concentrates more than triples the risk of nosocomial infections compared to cases where no transfusion take place. Furthermore, observational studies have suggested that transfusion of critically ill patients may worsen organ dysfunction and increase mortality rates. An

expanding body of evidence suggests that blood transfusions should be avoided as far as possible. Hyperglycaemia, nutrition and blood sugar control have several effects on the host's immune function. Hyperglycaemia may also be a marker of the catabolism and insulin resistance associated with surgical stress response. Poor control of blood glucose during surgery and in the peri-operative period increases the risk of infection and thus worsens the outcome from sepsis. Ileus is common in surgical critically ill patients and parenteral nutrition is frequently used for feeding despite the lack of efficacy and possible complications. Every effort should be made to provide enteral feeding as it reduces the risk of nosocomial infections by more than half among critically ill patients (Barie & Eachempati, 2005:1128–1129). Oxygenation and the administration of oxygen during the post-operative period should promote wound healing and prevent infection of the wound. There are conflicting results, however, regarding the use of oxygen post-operatively and more clinical trials need to be carried out regarding this subject (Barie & Eachempati, 2005:1129–1130).

## Bloodstream infections (usually associated with the use of an intravascular device)

Intravascular catheters, now an indispensable part of medical care, are used to administer fluids, blood and nutritional support and for haemodynamic monitoring of patients. The most serious infections associated with intravenous therapy are bloodstream infections and these contribute considerably to mortality among critically ill patients. The management of the intravenous catheter has an important effect on the incidence of infections.

Guidelines for the insertion of an intravenous catheter are as follows:

1. Wash hands before insertion.
2. Use chlorexidine to clean the skin and allow to dry before insertion.
3. Avoid shaving the skin.
4. Secure catheter, but do not cover the insertion site with non-sterile tape.

Guidelines for the insertion of a central vascular catheter are:

1. Use a single lumen catheter if possible.
2. If the catheter is needed for a period of 30 days or longer, use a tunnelled or implantable device.
3. Consider an antimicrobial-impregnated device.
4. Use optimal aseptic technique for insertion, with hand decontamination, sterile gloves, gowns and a large sterile drape.

Guidelines for care of the insertion site are:

1. Wash hands before contact with insertion site.
2. Use sterile gauze or transparent film to cover the site.

3. Change dressing only when it is no longer intact or when moisture collects at the site.

4. Replace dressing at least every seven days.

5. Clean site with aqueous chlorexidine each time the dressing is changed.

6. Inspect the site every two to three days for signs of infections (Wilson & Jenner, 2006:199–210).

Sepsis is infection in the bloodstream, usually by bacteria, which enter the bloodstream after intravenous (IV) fluids or a blood transfusion are administered. There are always bacteria on the skin and on the surfaces of most objects. This is why healthcare providers clean the skin to kill bacteria before they give an injection or insert an intravenous needle/cannula. They also use gloves and sterilised instruments and equipment to prevent the spread of bacteria and viruses. A blood infection may occur when the IV line is given through an infected area of skin or when there is a clot in the vein so that the blood does not flow well. It may also occur when an infection from one part of the body is spread to the injection site; when contamination of the catheter hub occurs as a result of the patient's endogenous skin flora or exogenous flora carried on healthcare workers' hands and, lastly, through contamination of intravenous fluid (Trautner & Darouiche, 2004: 842).

Sepsis is more common in people whose immune systems are not functioning well as a result of cancer treatment (radiation or chemotherapy), immune-suppressing drugs (for transplants or autoimmune diseases), chronic disease or immune-suppressing infections (such as HIV).

Symptoms of sepsis usually include signs such as fever, chills, body aches, nausea or vomiting, a rapid heart rate, dizziness when you stand up and confusion. The diagnosis of sepsis is made after a careful history is taken and a physical examination made. Sepsis is usually confirmed by blood tests to check the complete blood count and to culture blood for bacteria. Sepsis is treated with intravenous antibiotics; the patient may also need oxygen or intravenous fluids. The symptoms usually last about two to five days after the start of treatment. Even when the symptoms are gone, it is important to finish the full antibiotic treatment to make sure all bacteria have been killed.

The cornerstone for prevention of intravascular catheter-associated infections is infection control. Good hand hygiene, the use of maximal sterile barriers for catheter insertion and the deployment of specialised intravenous teams for catheter insertion and maintenance have all shown benefits.

## Pneumonia (usually ventilator-associated)

Infections of the upper respiratory tract are usually minor, mostly caused by viruses and commonly acquired in the community, such as influenza. Occasionally, upper respiratory tract infections may progress to more serious infections of the lower respiratory tract. Infections of the lower respiratory tract, such as pneumonia, are more serious and can be life-threatening. Infection

control and education remain the cornerstones in preventing nosocomial infections. A nasogastric tube is associated with an increased risk of pneumonia. The nasogastric tube may favour reflux of the gastric contents and enable micro-organisms to migrate along the tube to the upper airway. Enteral feeding may increase microbial colonisation of the stomach by raising the pH of the stomach, thereby providing a conducive environment for the growth of micro-organisms.

The major risk factor for healthcare-associated pneumonia is mechanically assisted ventilation, together with the underlying disease. Intubated patients are more likely to acquire pneumonia than those who are not. Irritation and injury of the mucosa contributes to pneumonia, because of the fact that micro-organisms colonise the irritated areas. The nose filter is also bypassed and intubation allows respiratory secretions to pool in the trachea above the cuff. These heavily contaminated secretions may leak around the cuff, particularly when it is deflated or during suctioning procedures. Like all invasive tubing, endotracheal tubes are suspected of encouraging the formation of biofilms, which further add to the infection risk of intubated patients. Orotracheal intubation is associated with a lower risk for ventilator-associated pneumonia. There are certain risk factors for post-operative pneumonia, which include the following:

- type of surgery (abdominal aortic aneurysm repair, thoracic surgery, upper abdominal surgery)
- emergency surgery
- general anaesthetics
- transfusion of blood (more than four units)
- critically ill patients
- age greater than 60 years
- impaired sensors
- chronic obstructive airway disease
- cerebrovascular accident
- history of alcohol abuse
- smoking
- weight loss
- steroid usage
- low or high blood urea/nitrogen.

**Table 16.8:** Strategies for the prevention of ventilator–associated pneumonia (VAP)

| No. | Strategy | Efficancy |
|---|---|---|
| 1 | Use of protective gowns and gloves | Proven |
| 2 | Provision of adequate nutrition support | Proven |
| 3 | Dedicated use of disposable suction catheters | unProven |
| 4 | Adequate hand washing between patient contact | Proven |
| 5 | Maintenance of adequate pressure in endotracheal tube cuff | Proven |
| 6 | Chest physiotherapy | unProven |
| 7 | Avoidance of gastric over-distention | Proven |
| 8 | Removal of nasogastric tube as soon as clinically feasible | Proven |
| 9 | Humification with heat and moisture exchanges | Proven |
| 10 | Routine changes of ventilator circuit | unProven |
| 11 | Postural changes | Proven |
| 12 | Humification with heat and moisture exchanges with bacterial filter | unProven |
| 13 | Semi-recumbent positioning of patient | Proven |
| 14 | Daily changes of heat and moisture exchanges | unProven |
| 15 | Chlorhexidine oral rinse | Proven |
| 16 | Use of a formal infection control programme | Proven |
| 17 | Routine changes of in-line catheter | unProven |
| 18 | Scheduled drainage of condensate from ventilator circuits | Proven |
| 19 | Scheduled subglottic suctioning | Proven |

Sources: Cocanour et al (2006:122–128); Ricart et al (2003:2695)

Contaminated respiratory equipment has frequently been incriminated in outbreaks because it could act as a reservoir and vehicle for the transmission of pathogens. Most of this equipment is in direct contact with the patient's mucous membranes. Therefore, it requires thorough cleaning and a high level of disinfection. Nebulisers and humidifiers should be decontaminated every 48 hours and always be filled with sterile water. Nebulisers and humidifiers should always be used for one patient only, should be cleaned between patients and stored clean and dry.

Several strategies are available for the prevention of ventilator-associated pneumonia (VAP).

Non-pharmacological strategies have been evaluated for the prevention of VAP based on identified risk factors. The role of healthcare workers is essential in many of these strategies. Ricart, Lorente, Diaz, Lollef and Rello (2003:2693) identify strategies for the prevention of VAP: see Table 16.8.

## 16.9 Infection control precautions for healthcare staff

The risk of HIV transmission to healthcare workers is low if the following standard precautions and transmission-based precautions are followed.

### 16.9.1 Standard precautions in ICU

- Wash hands after touching blood, body fluids, secretions, excretions and contaminated items, regardless of whether gloves are worn. Wash hands immediately after gloves are removed, between patient contacts and whenever indicated to prevent transfer of micro-organisms to other patients. Use plain soap for routine hand washing and an antimicrobial agent for specific circumstances.

- Wear clean, non-sterile gloves when touching blood, body fluids, excretions or secretions, contaminated items, mucous membranes and non-intact skin. Change gloves between patients and tasks.

- Wear mask, eye protection or face shield during procedures and care activities that are likely to generate splashes or sprays of blood or body fluids. Use a gown to protect skin and prevent soiling of clothes.

- Ensure that patient care equipment that is soiled with blood or body fluids, secretions and excretions is handled carefully to prevent transfer of micro-organisms. Clean appropriately.

- Use adequate environmental controls to ensure that routine care, cleaning and disinfection procedures are followed.

- Handle the transportation and processing of linen soiled with blood and body fluids, excretions and secretions in a manner that prevents exposures and contamination of clothing and transfer of organisms.

- Use preventative measures when using sharps and place them in appropriate containers.

### 16.9.2 Transmission–based precautions

Precautions for airborne infections are as follows:

- Place the patient in a private room with negative air pressure.

- Use respiratory protection when entering the room of a patient with known suspected tuberculosis.

- Transport the patient out of the room only when necessary and place a surgical mask on the patient if possible.

- Consult infection control for preventative strategies.

Precautions for droplet infections are as follows:

- Use a private room, if available. Wear a mask when working within a metre of the patient.

- Transport the patient out of the room only when necessary and place a surgical mask on the patient if possible.

Precautions for contact infections are as follows:

- Use a private room, if available. Wear a mask when working within a metre of the patient.
- Transport the patient out of the room only when necessary and place a surgical mask on the patient if possible.
- Wear a gown if contact with an infectious agent is likely or the patient has diarrhoea, an ileostomy, colostomy or wound drainage not contained by a dressing (Morton, Fontaine, Hudak & Gallo, 2005:1140).

## 16.10 Summary

The quality improvement movement process has evolved over time: the views of the main proponents of this movement, Juran and Deming, have been outlined. Standards and criteria, integral components of a quality improvement programme, were also examined. As the prevention of nosocomial infections in hospitals is such an important aspect of a quality improvement programme, special emphasis was placed on the variety of measures that have to be taken into account in any hospital's infection control programme. The role of research regarding evidence-based practice has also been analysed.

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# 17

# Unit Records, Reports and Statistics in Health Services

BL Dolamo

## Chapter Outcomes

After studying this chapter, you should be able to:
- describe the purpose of keeping records and statistics in a health services unit;
- indicate the requirements for compiling a report and keeping statistics;
- utilise critical thinking to assess information;
- identify the importance of electronic nursing documentation;
- describe the ethical and legal aspects of an informed consent;
- discuss the reasons for writing incident reports and the essential points to consider when writing these reports;
- illustrate the use of and ways of portraying statistics kept in a unit.

## 17.1 Introduction

Quality healthcare depends on the accurate and chronological recording of the care provided. There is a universal dislike of paperwork among healthcare professionals in general and nurses in particular. A sizeable number of the South African Nursing Council's disciplinary measures result from inaccurate record keeping (Ngidlana, 2006:47).

Although managers and most practising healthcare professionals realise the importance of accurate and timely documentation, they also see it as an activity that removes them from the patient's bedside and increases their overall workload. Medico-legal risks resulting from omitting or duplicating medication or treatment can be costly to both the patient and the service. The diligent recording of the patient's condition, diagnostic and therapeutic interventions and all observations done during all the stages of a patient's illness is a function the nurse cannot delegate to a unit clerk (Booyens, 2008:132). Unfortunately, accurate record keeping is often neglected and the reason usually cited for this is that there is a shortage of nursing staff.

## 17.2 The importance of record keeping

According to the South African Nursing Council (SANC), standards for nursing practice (hence quality nursing practice) are based on, among others, 'timeous, accurate and complete/comprehensive recording, document information in a manner meaningful for improving quality care' (SANC, 2004:42). The purpose of timely and accurate record keeping, as stated by the Nursing and Midwifery Council (2008), is as follows:

- to provide current, comprehensive and concise information on the condition and care of the patient in an accurate manner
- to record and report on problems experienced in providing the care and the actions taken to solve them
- to note the factors that have an effect on the patient's physical, psychological and social well-being
- to inform staff of treatment required, the rendering of care by all staff concerned with provision of care, and the response of the patient to treatment
- to keep a chronological record of all the events concerning patient care, from admission to discharge
- to improve auditing of care rendered and to provide information on where improvement is necessary
- to measure compliance with standards
- to report on incidents and the steps taken to prevent them from recurring
- to protect staff from legal action taken against them
- to use as a teaching tool for staff in the unit
- to plan for the future, using the statistics available
- to determine the cost of patient care – records can be viewed by the accounting department to determine the costs incurred in caring for a patient.

As can be seen from this list, record keeping is important to ensure effective communication between everyone involved in the delivery of healthcare. Health records provide evidence about the care and treatment patients receive. The nurse's role is central. The responses of the patient to interaction, and observations made during the time he/she receives treatment are recorded chronologically. Reporting on incidents provides protection to staff and gives information on possible risks in the service. The statistics that can be derived from patients' records are essential for future healthcare planning. When a nurse does not keep proper records, the chain of communication and continuity of care are jeopardised, as it is not possible to rely on the memories of all those involved in caring for the patient (Booyens, 2008:133).

## 17.3 Principles of record keeping, statistics and reports

The following requirements apply to all healthcare professionals involved in patient care:

- All recording should be done as soon as possible after the event to which it relates. According to Roussel (2013:572), the medical records generally serve as a means of determining whether a deviation existed in the standard of care.
- The ethical practice should be honoured and, at the same time, factors that could jeopardise the safety and standard of care should be taken into account.
- Patient records are owned by the healthcare facility and access is granted to the patient (under The National Patients' Rights Charter 1999), to healthcare

professionals involved in patient care, professionals doing research, those compiling statistics and the next of kin or legal guardian.

- Confidentiality refers to respecting privileged information and means that the necessary steps are taken to ensure this. Confidential information should only be revealed with the permission of the patient and health services authority.

- The person who does the recording must ensure that all the information is accurate and that it will help the patient to make informed decisions.

- Patient data management systems (computer records) have resulted in more accurate, accessible and available patient records. These systems not only monitor the patient's condition, but also store the information and can be displayed at the patient's bedside. This practice allows access to certain kinds of data from terminals at specific locations. Technical, legal and ethical questions need to be raised regarding the confidentiality of such accessible records. However, the advantages of a computerised patient record system outweigh the disadvantages. Personnel can be assured of accurate, legible and accessible information on patients, which can be used for a number of purposes. Patients' progress can be monitored accurately; information is more accessible for case histories and quick to retrieve for reviewing purposes. These records can also be used for quality control (Booyens, 2008:134).

Geyer (2005:83) gives the following golden rules for recording health information. Records must be:

- factual and objective
- honest and truthful
- specific and accurate
- appropriate and complete
- accessible but remain confidential
- made only on completion of tasks
- compliant with format and legislative requirements.

## 17.3.1 Basic rules for all written communication

The main reason for keeping records, statistics and reports is essentially the provision of safe, high quality care to the patient. To ensure this, all recording should aim at providing a chronological report on events related to patient care. The following basic rules for all written communication apply to records, statistics and reports:

- Legible and indelible writing will ensure that everyone who makes use of the records will be able to read them and that the erasure of entries will be prevented. The use of correction fluid is not permitted. A single line can be drawn through what is written when something needs to be changed and this must be signed.

- If any additions or corrections are made to existing entries, they should be individually dated and signed.

- Clear, unambiguous recording, which includes not using meaningless phrases (for example 'slept well'), or abbreviations that are not internationally accepted, will ensure that the staff who have to interpret records will understand exactly what should be done. The central problem should be identified and recorded. Short and simple sentences improve interpretation. Duplication should be avoided.

- Entries regarding treatment and observations should be made only after their completion, but these entries must be made promptly. If an entry is made late, this must be recorded and no attempt should be made to alter the records.

- Each entry should be accurately dated, timed and signed and if it is necessary to continue on another page, the date and time should be reflected at the beginning of each new page. The use of initials is not advised: the nurse making an entry should use her or his full signature and this should be legible.

- The name and registration number of the patient should appear on all documentation related to patient care. All particulars required by the document should be filled in.

- Scientific and correct terminology should be used.

## 17.4 Legal status of records

The professional, ethical and legal framework within which nurses function requires that they adhere to a set standard of nursing care. If the nurse is held accountable for her/his acts and omissions, all documentation that relates to patient care may be required as evidence before a court of law or during a preliminary hearing of the SANC. The documentation can prove or disprove negligence on the part of healthcare professionals and should, therefore, be accurate and up to date. It is also important that records are kept safely (for a period of five years in level one record keeping, and then moved to another level of record keeping and destroyed after fifteen years) because litigation may arise a long time after the incident in question. These records can also be used to prove that the nurse did not exceed his/her scope of practice.

Staff should be aware that all documents could be used for accident or personal claims as they indicate the patient's condition before admission, during the stay in the unit, and the treatment that was received. The sequence of events that lead to the claim should be obvious when scrutinising the records. It is, therefore, absolutely essential that all documentation should be meticulously maintained to protect the patient, nurse and institution.

## 17.5 Unit records, reports and statistics

The healthcare professionals in the unit are responsible for keeping records, writing reports, compiling patients' clinical records, staff performance and

attendance records, and keeping required statistics. The most important elements are discussed in the following sections and examples given of the different types of records, reports and statistics.

## 17.5.1 Patient clinical records

These include, among others, the admission record and nursing assessment form, clinical record while the patient is in the unit, consent record, medicine prescription and administering chart, record of patients receiving blood, and discharge record.

### Admission record and nursing assessment form

This record should have complete information relating to the patient's details, including full name, country of residence, identity number, residential address, age, next of kin, religious denomination and telephone number(s). Although this information is usually obtained by the admission clerk, the nurse receiving the patient should carefully check it and confirm the particulars with the patient or patient's relatives.

When a patient is received in the unit, an accurate description of the patient's condition must be systematically recorded. Assessment is the first step in the nursing process. It involves obtaining information from the patient or relatives; observation of the patient's physical and emotional state; sifting the information and identifying the needs and problems requiring attention (Booyens, 2008:136).

Gathering information should be done in an orderly manner, then sorted and organised so that documentation of the information can take place in an orderly format. The process of assessment begins with admission of the patient and ends with his or her discharge. Where a computerised information system is in use, all information from the admission office will be available in the unit where the patient is admitted.

On receiving the patient in the unit, an accurate description of the patient's condition and complaints should be entered into the record. Matters such as bruises, injuries, injection marks, rashes and mental state must be carefully recorded. This is important should the patient claim damages for problems incurred while in the unit. The manner in which the patient was brought into the unit should also be recorded: did the patient walk into the unit, or was he or she brought by ambulance, wheelchair, stretcher and who accompanied him or her? The patient should be wearing an identification band or should be immediately supplied with one when received in the unit. The mental state of the patient on admission should be noted and recorded, for example, whether the patient is conscious, comatose, depressed or disorientated. Any prosthetic aids should be noted down (Booyens, 2008:136). The patient's medical history, allergies and medications should be recorded. Also note information given to the patient on food or drink intake, smoking, bathroom facilities, and any other relevant information.

The date and time the doctor was notified of the patient's admission to the unit and whether the doctor was personally notified or a message was left, should

be recorded. Also mention the name of the person who notified the doctor. All observations, for example, temperature, pulse and respiration rate and treatment given on admission, should be accurately recorded.

The level of information required depends on the length of the patient's stay in the hospital, the reason for hospitalisation and the patient's degree of dependence. In other words, the level of information will differ. The case of a self-sufficient patient admitted for a series of examinations differs from the case of an elderly patient with a communication problem who is admitted after a cerebral incident. For the former, it is not as important to note likes and dislikes in relation to food or mobility, for example, as in the case of the aged patient. The aged person is dependent on the nurse to meet his or her needs and the information, therefore, assists in maintaining quality care (Booyens, 2008:137).

The information obtained is divided into subjective and objective data. Subjective data is obtained during the interview with the patient and includes the views, feelings, ideas and expectations of the patient, which cannot be observed directly. This information is used to assess the needs of the patient and can only be obtained if the nurse asks the necessary questions. It comes directly from the patient and it is essential. Objective data is obtained through observation and comprises physical observation, observation of the patient's behaviour and information obtained from other sources, including family or friends. When writing the report, the nurse should ensure that the needs and/or problems identified are clearly described. Clear nursing prescriptions must be given, medical prescriptions referred to and mention made of prescriptions being carried out.

## Clinical records while the patient is in the unit

The clinical records kept while the patient is in the unit entail documentation during the period after admission up to discharge, transfer or death. All healthcare professionals should be made aware of the importance of these records. Record keeping provides:

- a basis for planning both medical and nursing care
- a basis for reviewing, studying and evaluating the diagnostic measures, treatment and care of a special condition
- guidelines on daily management of the patient and his/her problems
- information needed for research
- communication between various members of the health team
- continuity of care, evidence of improvement or deterioration of the patient's condition
- an assessment of the quality of care rendered
- proof of care given and the response of the patient
- evidence of complications occurring
- the patient's level of communication and dependence on staff and family
- evidence of visits from other healthcare personnel and orders given (Unisa, 2009:111).

## Key expressions when compiling patients' clinical records

There are a number of ways of recording information in a healthcare institution. In some institutions, there is a prescribed format that should be followed. Ehnfors, Thorell-Ekstrand & Ehrenberg (1991:15) developed the following list of key words with explanations for use when writing clinical records. These are listed below.

| | |
|---|---|
| **Admission**: | Patient's description and reason for admission |
| **State of health**: | Health problems, retardation, can the patient manage, health management, selfcare |
| **Hypersensitivity**: | Any sensitivity to medication; allergies and related medication |
| **Previous health record**: | Previous contact with hospital or other health services, reference number |
| **Social background**: | Social network and ethnic background, recent critical life events, contact numbers |
| **Lifestyle**: | Values, culture, religion, outlook on life, interests, exercise, feeding habits (eg vegetarian, alcohol, tobacco, remedies used) |
| **Breathing and circulation**: | Any respiratory problems, body temperature (eg dyspnea, cough, risk of aspiration) |
| **Elimination**: | Elimination patterns, urine, faeces, sweat, incontinence |
| **Skin**: | Skin/mucous membrane, hair, nails, colour, hygiene, lacerations, dryness, rash, bed position |
| **Activity**: | Functional levels of selfcare in relation to nutrition, continence, mobility (eg walking ring or wheelchair), steps, use of toilet, personal hygiene, cooking and housekeeping, shopping, intellectual activities, reading, aids, drugs and support |
| **Sleep**: | Sleep and rest, chronic fatigue, factors inhibiting sleep |
| **Pain**: | Acute or chronic pain, location pattern, intensity assessment in accordance with scale and patient's complaints |
| **Sexuality**: | Sexual relations, inhibitions, values, productive phase, contraception |
| **Psychosocial**: | Mood, behaviour and reactions (eg happiness, social and emotional confidence and safety, anxiety and depression, reaction to a crisis); role relations, causes of stress, social network, social |

|                  | adaptation, involvement, isolation, dependence and responsibility, cognitive skills or limitations, memory, strength and endurance |
|---|---|
| **Spirituality**: | Beliefs and religious practices of importance to the patient and family; significance and purpose of suffering, life and death; sources of faith and hope; spiritual pain or despair. feelings of guilt, punishment and shame; requests for certain rituals or symbols (eg prayer, the Bible) |
| **Objectives**: | Objectives and result criteria in measurable terms; expectations and priorities agreed on with patient and family; long-term and short-term objectives, prevention and safety |
| **Participation**: | Promote participation and communication, conditions necessary for planning and care |
| **Information**: | Verbal and written, of patient and others; factual and sensory information prior to examination and treatment; effect of treatment, diagnosis and results |
| **Education**: | Education of the patient or family in regard to nutrition, exercise, prevention of illness, stoma treatment |
| **Support**: | Emotional support, communication and listening, prevention, treatment, diagnosis, prognosis, family situation |
| **Environment**: | Adjustment to the environment physically, psychologically and socially; promotion of safety, comfort and integrity of bedridden patients by way of bedside pillows, positioning |
| **General**: | Selfcare and the need for help in relation to eating, hygiene, continence, bandages, mobility, hearing aids and special diets |
| **Training**: | Physical, psychological, social mobility; toilet, memory training, devices or aids |
| **Observation**: | Monitoring of vital signs (eg respiration, circulation and consciousness); emotional state, intake and excretion |
| **Special care**: | Special nursing care (eg in relation to tests or examinations, treatment, medication, infusions, drainage tubes) |
| **Continuity**: | Promote continuity (eg selfcare, patient's wishes in regard to care, habits and contact with family) |

| | |
|---|---|
| **Co-ordination**: | Promote co-ordination (eg time planning, distribution of examinations and treatments to ensure adequate rest) |
| **Nursing discharge notes**: | Summary of the patient's progress and nursing care during the episode of care; present nursing status, including communication problems and potential future needs for nursing care |
| **Progress notes**: | Updating to status, interventions and effects related to certain events; notes of unit rounds |

## Informed consent

According to Roussel (2006:375), informed consent does not involve just signing a consent form. This procedure relates to the patient's understanding of the procedure to be performed. Informed consent is the provision of sufficient information by the professional to a patient – or to his or her guardian – in order that the patient or guardian understands what will be done to enable him or her to make a rational decision. Informed consent may be sought for the diagnosis, nature and purpose of proposed treatment, the risks and consequences of the proposed treatment and feasible treatment alternatives. Responsibility for making sure that the person or parents of a child have all the information needed for them to give informed written consent rests with the healthcare practitioner who is undertaking the procedure or operation (usually a doctor or nurse).

## Medicine prescription and administering chart

Only medical practitioners may prescribe for the patient. The prescription, dosage, date, time and doctor's signature should be clearly written. The nurse should ensure that all the information is filled in properly. No transcribing should be done by the nurse. This means that the nurse is not to rewrite the prescription as previously written by the medical practitioner. If medication is to be given for longer than seven days, then the medical practitioner must represcribe (issue a new prescription).

Should a patient receive blood, a special form from the blood bank is completed and kept in the patient's documents; an entry into a book provided for this purpose should be made. The essential information needed is the date, name of the patient, registration number, doctor, batch number, blood unit number, blood group, rhesus (RH) factor, time put up, nurse's name and witness, time absorbed/taken down, condition of the patient and signature of the nurse.

## Other documents in the patient's file

Various other records and documents may be compiled, depending on the requirements of the institution and the patient's condition. These include:

• In private institutions, a record is kept of all unit stock used by the patient, for the purposes of charging to his or her account.

- Laboratory and other reports related to patient care, including X-rays and other diagnostic tests should be attached to the patient's records. It is the responsibility of the nurse to inform the medical practitioner when reports are received.

- Records should also be kept of all special tests or treatment, for example, physiotherapy treatment sessions and their dates and times.

Other healthcare personnel involved in the patient's care should have access to the records at all times and should know where the records are kept. The nurse in charge of the unit should, however, monitor the movement of the records from the unit at all times. It is important to remember that it is not the format of the forms used in recording that determines the standard of record keeping, but the contents of the records.

## *Discharge records*

The patient should be prepared for discharge from the day he or she is admitted to the unit. This preparation must include giving health education, which should then also be recorded on the patient's file. Some institutions have a duplicate of the discharge record which can be given to the patient. Information on this record includes health education, medication, exercise, relatives informed, transport arranged and escort to transport, follow-up appointment(s) and the patient's and nurse's signatures. Important information that should appear in all discharged patients' records includes:

- the condition and health status of the patient on the day of discharge
- the vital signs and all observations made before discharge
- the date and time of discharge from the unit
- the name of the medical practitioner who signed for the discharge of the patient
- the name of the nurse who discharged the patient
- how the patient was sent home (family, ambulance, wheelchair, stretcher or walking)
- where the patient went (another institution, an outpatient clinic or home)
- the instructions given to the patient and/or family regarding continuation of treatment at home
- the possible effects of medication that need to be explained to the patient and/or family
- the arrangements made for attending ongoing treatment, for example, the local clinic, outpatients department or physiotherapy
- if medication to be taken home was prescribed, whether the patient received it before going home or received a prescription to take to his/her pharmacist.

## 17.5.2 General unit reports

These include the following:

- Report handover: It is essential to have both a report handover when shifts change and a briefing after doctor's rounds to ensure continuity of care. It is important that time is set aside on a regular basis so that the nurses are given an opportunity to communicate with each other.

- Verbal reporting to the medical practitioner during unit rounds and when doing rounds with a supervisor.

- The report of midnight data sent to the administrative offices to assist managers in planning the service and keep them informed of the number of patients in the institution and the number of intakes, transfers and discharges. This assists the administrative staff to determine the daily bed occupancy of the different units.

- The diet list sent daily to the dietary department with the names of patients on special diets and types of diet prescribed or patients' preferences where applicable.

- Written patient reports on important aspects of patient care for the use of all healthcare professionals during day and night duty (use of nursing care plans).

- A separate written report submitted to the health services manager in the morning and evening before the handover report. This report is intended to inform the manager about very ill patients, staff members admitted, patients going for surgery or special diagnostic procedures, admissions, discharges, deaths and transfers that occurred in the unit during the previous 12 hours.

- The theatre list sent by theatre staff to the unit concerned, informing them of the time patients will have to go to theatre the following day. Other departments, like radiology and physiotherapy, could also inform unit staff in a similar way when patients have to go for treatment or tests.

- Project reports, annual report, and other reports that may be required after attending a conference or on coming back after attending a specific course.

## 17.5.3 Forms used at clinics, outpatient and casualty departments

It is essential to record the numbers of patients who visit the clinics, outpatient and casualty departments. These records are then turned into statistics to assist with the planning of finances, staffing, supplies and equipment (Unisa, 2009:120). In Figure 17.1, a sample template is given of a form that could be used in a clinic, outpatient or casualty department for this purpose.

The most important information to record is the category and gender of the patient, plus the type of procedure performed. If the institution caters for both private and public patients, this should also be indicated. At the end of the month, a summary of these statistics is sent to management by the unit manager.

**UNIVERSAL HOSPITAL**

MONTH:.............................................................................. CLINIC:...............................................................

Daily record of number and type of treatment and examinations at clinic, outpatient and casualty.

1 = examination, 2 = injection, 3 = medication, 4 = surgical procedure, 5 = dressing, 6 = referred to X-ray.

M = male, F = female, C = Child.

| Date | M | F | C | Total | 1 | 2 | 3 | 4 | 5 | 6 | Total | Sign |
|------|---|---|---|-------|---|---|---|---|---|---|-------|------|
|  |  |  |  |  |  |  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |  |  |  |  |  |  |

**Figure 17.1**: Daily record for statistical purposes of examinations and treatments given at health clinics

## 17.5.4 Incident reports

An incident is any happening that is not consistent with the routine operation of the health service or routine care of a particular patient, relative, visitor or member of the staff. It may be an accident or a situation that could have serious implications for the patient or staff member.

Roussel (2013:574) states that incident reporting is an effective tool used to identify potential losses, opportunities, or potential claims. This report should be compiled as soon as possible after any unusual occurrence or near miss involving people or property, whether or not injury or damage occurred. The person who compiles it, however, should be sufficiently calm to think rationally and record precisely what happened. An incident report is important, as investigations usually occur sometime after the incident. A report written soon after the incident will assist the nurse and authorities to remember exactly what took place. A form for incident reporting should be designed to collect complete and accurate information, including the name, address, age and condition of the individual involved; the precise location, time and date of the incident; a description of the occurrence in the sequence it happened; the physician's examination data; the reasons for hospitalisation and the names of witnesses.

## *Reasons for writing incident reports*

The reasons for writing an incident report are:
- to inform the authorities so that they can handle any complaints or queries that may result from it
- to give legal protection to the staff

- to prove the integrity of staff
- to serve as a control measure
- for use in research and training purposes
- risk management programmes can be based on the information obtained from the analysis of these reports.

### *Points to remember when writing an incident report*

All points mentioned above regarding writing reports also apply here, but in addition:

- All incident reports should be written in triplicate.

- Be wary of using uncomplimentary adjectives and use correct technical terms.

- It is advisable not to put the report in the patient's file, as this could cause problems if unsuspecting people have access to the file.

- The policy of the institution should be followed regarding the number of copies to be kept, but the nurse should keep a copy of the report and one should be kept by the unit manager in charge.

### *Essentials of an incident report*

The key points that will guide the nurse in compiling this report are as follows:

- A factual and objective summary of the incident must be given.

- Specific, relevant details of the incident, the sequence in which events occurred and, if necessary, the medical follow up should be included.

The following incidents could require the compilation of an incident report:
- errors in medication
- omission of treatment
- accidents that happened to patients, hospital staff or visitors
- complaints by patients
- problems or incidents concerning patients
- problems relating to staff
- problems relating to equipment or supplies.

## 17.5.5 Statistics

Statistics are numerical facts or data collected and classified for providing the information needed to make informed decisions. Statistics are an essential part of record keeping, as they serve to plan for the future. Computerised information systems have improved the ability to retain statistics. A whole gamut of statistical information is kept in a health service, including the rates of attendance at clinics, bed occupancy, morbidity, epidemiology, most prevalent diseases, as well as statistics on staff availability, attendance and training, to mention but a

few examples. The basic reasons for and principles involved in keeping statistics are highlighted in the following sections.

## Reasons for keeping statistics

Statistics are kept for future reference and cross-reference purposes. When information is needed on the attendance of in-service education programmes in order to plan for the future, reference can be made to statistics regarding rates of attendance, the topics presented and areas or topics that still need attention. Statistics are also kept for the purposes of comparison, for example, to compare the number of sepsis cases occurring in a unit after certain preventive measures have been taken with the number of cases recorded the previous month. Future planning can be done taking the statistics into consideration, for example, additions to existing services can be planned based on information from statistics kept over a period of time, showing the increase in attendance rates. Statistics can provide a visual presentation of data collected in the form of graphs to indicate, for example, the growth of children.

## Methods of presenting statistics

Once data has been analysed, it can be presented visually in the form of histograms, bar graphs, line graphs, pie charts and tables. This section includes various examples of the presentation of statistics.

Figure 17.2 is a histogram indicating babies' birth weights. From this histogram, it is obvious that the weight that occurs most frequently is 3.4kg, as no fewer than 24 baby boys born during the past eight months were this heavy.

This weight (3.4 kg) is known as the median, or the arithmetic mean, as can be calculated from the table of weights that served as the basis for this histogram. To calculate the arithmetic mean:

1. Compile a table from raw data showing the number of babies with a particular weight (see Table 17.1).

2. Add all the weights in kilograms and divide the total by the total number of baby boys (344 kg ÷ 100 = 3.44 kg, rounded off to 3.4 kg).

Figure 17.2 ⮕

Table 17.1 ⮕
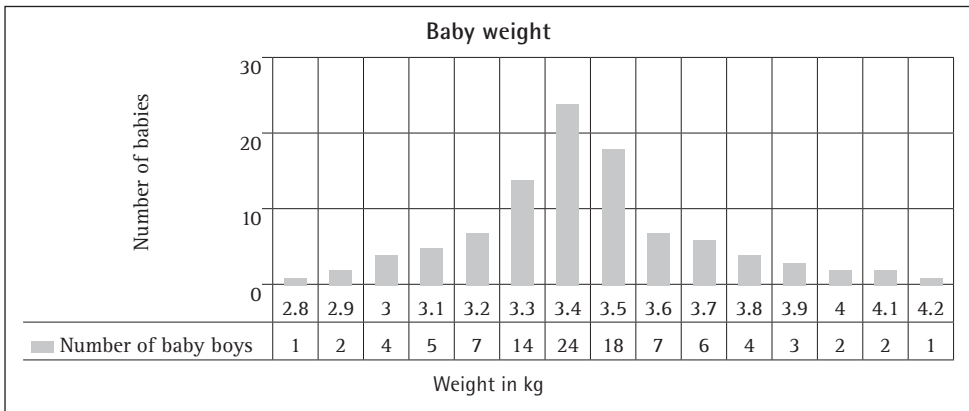
**Figure 17.2**: Histogram of babies' birth weights

**Table 17.1**: Babies' birth weights

| Weight in kilograms | | Number of baby boys | | kilograms |
|---|---|---|---|---|
| 2.8 | x | 1 | = | 2.8 |
| 2.9 | x | 2 | = | 5.8 |
| 3.0 | x | 4 | = | 12.0 |
| 3.1 | x | 5 | = | 15.5 |
| 3.2 | x | 7 | = | 22.4 |
| 3.3 | x | 14 | = | 46.2 |
| 3.4 | x | 24 | = | 81.6 |
| 3.5 | x | 18 | = | 63.0 |
| 3.6 | x | 7 | = | 25.2 |
| 3.7 | x | 6 | = | 22.2 |
| 3.8 | x | 4 | = | 15.2 |
| 3.9 | x | 3 | = | 11.7 |
| 4.0 | x | 2 | = | 8.0 |
| 4.1 | x | 2 | = | 8.2 |
| 4.2 | x | 1 | = | 4.2 |
| | | **100** | | **344.0** |

Figure 17.3 overleaf is a bar graph representing the percentage attendance of 18 new staff members at orientation sessions. The bar graph shows a most unsatisfactory picture: there were only three sessions with satisfactory attendance percentages, namely, the sessions on the scope of practice, nursing documentation and blood transfusions. The attendance figures for the other five topics or sessions were dismal. From this graph, it can be deduced that the health services manager will have to take some steps to rectify matters. She or

he should firstly identify the reasons for the low attendance by consulting the 18 staff members themselves, then make sure that all the newcomers attend a second session on each of the topics.
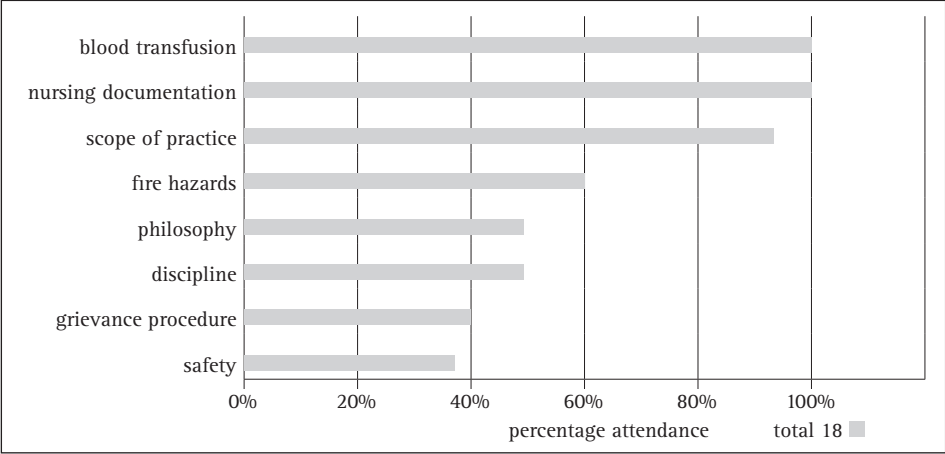


**Figure 17.3**: Bar graph showing attendance levels at orientation sessions

It can be noted from Figure 17.4 that cigarette consumption is the lowest among the age group 60+ years and the highest among 25–34 year-olds. It is also interesting to note that the consumption is high among the group of 50–59 year-olds. It seems that the 15–19 year-olds' smoking habit is quite severe at first, but far from the level of the 25–34 age group. Could one deduce that the stresses of life are to blame for the consumption pattern in each age group?
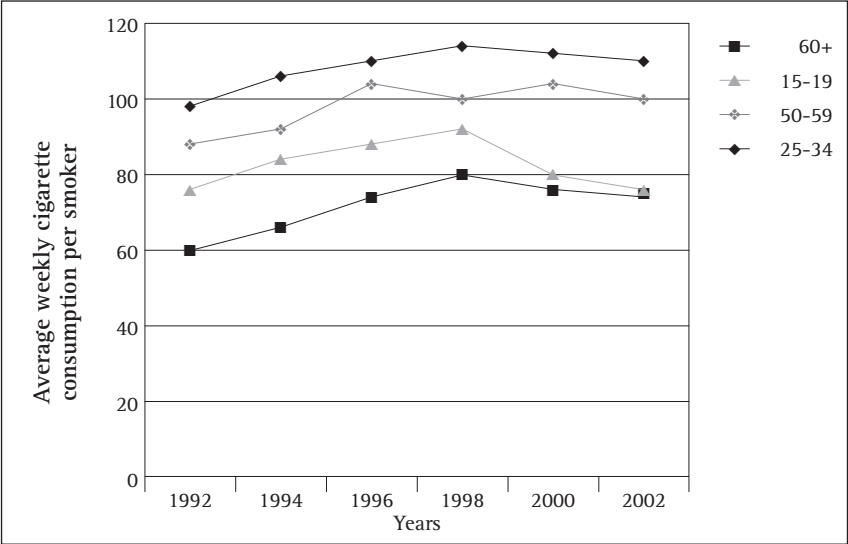


**Figure 17.4**: Line graph showing cigarette smoking among different age groups

If the graph continued for four more years it could perhaps be that what appears now to be a small to gradual decline in consumption in the 15–19 age group, from relatively high figures in the years between 1994 and 1998 to those in 2002, could follow the same pattern. Could it be that the recent emphasis in health education on the dangers of smoking shows an effect here?

In the pie charts (Figure 17.5), the number of deaths as well as the percentage from the total of all deaths under a specific age group are shown. If one looks closely at the different shadings and the key for these shadings, it is also possible to calculate the number of deaths from a specific disease in a specific age group.



Under 1 year
(14 600 deaths)
2.2% of all
deaths

15–44 years
(24 000 deaths)
3.6% of all
deaths

1–14 years
(5 600 deaths)
0.8% of all
deaths

45–64 years
(141 700 deaths)
21% of all
deaths

Perinatal causes
Congenital abnormalities
Respiratory diseases
Accidents
Cancer
Heart disease
Stroke
Other

65 years plus
(487 800 deaths)
72.4% of all
deaths

**Deaths in age groups indicating the main causes**

Figure 17.5: Pie charts indicating the main causes of death in a country

## *Statistics that must be kept*

Examples of the forms used to keep statistics in the unit are explained in this section. In a clinic, records are kept of the number of patients attending the different types of clinics. The same is done in the outpatient and casualty departments. Statistics are also kept in the operating theatre on the number of operations performed in a 24-hour period, as well as the type of operation. In the maternity unit, statistics on deliveries are kept. Data collected here will display the number of live births, still births, multiple pregnancies, as well as whether normal delivery, forceps delivery or Caesarian sections were involved. On discharge of the baby, it should also be indicated whether the child received immunisations, for example, against polio or tuberculosis.

With the implementation of free services for pregnant mothers and children under the age of six, statistics must also be kept wherever patients receive treatment. Figure 17.6 overleaf indicates the number of inpatients, outpatients (normal and after hours), casualty (normal and after hours), as well as the classification according to income. When a pregnant woman attends the clinic or hospital, it is indicated whether her condition is related to her pregnancy or not.

Statistics are also kept on nosocomial infections and any other incidents occurring in the unit. This provides information to improve risk management. In the operating theatre, information on the length of time of operations is kept, as well as on the type of operations. In each specialised unit, a number of forms must be completed to enable the effective planning of the service and to protect the staff.

The real value of statistics hinges on what is done with the data gathered. Only when actions are taken as a result of the information gathered through statistics, does keeping statistics serve its purpose.

## 17.6 Staff records and reports

To enable the unit manager to utilise her or his staff effectively, a variety of records and reports related to the staff should be kept. The records include items such as personal information, training and performance. Reports should be written on the progress made by staff in the unit, as well as on how they have adapted to the environment. Reports on incidents involving staff, such as injuries sustained on duty and critical incident reports used to evaluate staff performance, should be kept to ensure that the correct procedures are being followed.

**FREE HOSPITAL TREATMENT OF CHILDREN UNDER THE AGE OF SIX YEARS AND PREGNANT WOMEN**

HOSPITAL: _____     RACE: _____     MONTH: _____

| | | Previous Classification | | | | | Previous Classification | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | H1 | H2 | H3 | HG | Total Hospital Free | Private without medical aid | Private Hospital without medical aid | Total Private Free | Medical Aid Patients |
| **IN-PATIENT ACTIVITIES** | | | | | | | | | | |
| **IN-PATIENT DAYS:** | | | | | | | | | | |
| Pregnant Women | Related to pregnancy | | | | | | | | | |
| | Not related to pregnancy | | | | | | | | | |
| Childbirth | Mothers | | | | | | | | | |
| | Babies | | | | | | | | | |
| Children under the age of six years | | | | | | | | | | |
| **OUT-PATIENT ACTIVITIES** | | | | | | | | | | |
| **OUT-PATIENT COUNT:** **NORMAL HOURS** | | | | | | | | | | |
| Antinatal Examinations | | | | | | | | | | |
| Postnatal Examinations | | | | | | | | | | |
| Pregnant Women | Related to pregnancy | | | | | | | | | |
| | Not related to pregnancy | | | | | | | | | |
| Children under the age of six years | | | | | | | | | | |
| **OUT-PATIENT COUNT:** **AFTER HOURS** | | | | | | | | | | |
| Pregnant Women | Related to pregnancy | | | | | | | | | |
| | Not related to pregnancy | | | | | | | | | |
| Children under the age of six years | | | | | | | | | | |
| **CASUALTY ACTIVITIES** | | | | | | | | | | |
| **CASUALTY COUNT:** **NORMAL HOURS** | | | | | | | | | | |
| Pregnant Women | Related to pregnancy | | | | | | | | | |
| | Not related to pregnancy | | | | | | | | | |
| Children under the age of six years | | | | | | | | | | |
| **CASUALTY COUNT:** **AFTER HOURS** | | | | | | | | | | |
| Pregnant Women | Related to pregnancy | | | | | | | | | |
| | Not related to pregnancy | | | | | | | | | |
| Children under the age of six years | | | | | | | | | | |

*Note although medical aid patients do not receive free treatment, the statistics are still required.*

**Figure 17.6**: Example of the form used for reporting the numbers of children under the age of six years and pregnant women treated

## 17.6.1 Duty rosters

Duty rosters are discussed in detail in chapter 8. They are mentioned here briefly because they provide an important record of staff attendance and experience. Duty rosters are kept for a period of at least three years, as they can serve as evidence in a court of law should there be a problem regarding patient care.

Duty rosters are also kept in the health service manager's office to inform her or him of the coverage of units for a period of time – usually one week. These rosters indicate the number and categories of staff and the names of staff on duty. Should a member of staff be absent from duty, the health services manager should be informed as soon as possible so that assistance can be organised if possible and if the need arises. An indication of the absence should be made on the current duty roster.

## 17.6.2 Assessing nursing records and reports

The following checklist can be used to review recording done in the unit. The guidelines given by Morrison (1993) in Booyens (2008:154) serve as a quick, accurate way to review all recordings in a nursing unit.

- Only authorised personnel have access to the records, as they contain confidential information and can be used in a court of law.

- All data are accurate and objective (data must be facts and not opinions). Information gathered using the five senses, namely seeing, hearing, feeling, smelling and tasting can be regarded as objective. Accurate data can give legal protection.

- Data recorded is appropriate and relates directly to the patient's health problem. Unless the data relates directly to the patient's health problem it is personal and the patient's privacy can be invaded.

- Ensure that there are no blank spaces. If a certain column or space is not applicable, draw a line through or write 'not applicable'.

- All statements should be to the point, using as few words as possible. Patients' names or reference to the patient are not needed, as all information on the chart relates to the specific patient.

- A complete description of all events, observations, treatment and procedures is given. These include visits by the healthcare team; changes in the patient's physical, mental and psychological condition; signs and symptoms; all nursing interventions and orders from other healthcare professionals.

- Make sure all dates and times are noted.

- Are there any erasures? If mistakes were made, how were they corrected?

- All entries should be in ink.

- Only standardised abbreviations should be used.

## 17.6.3 Critical thinking involved in assessing information

Because of the volume of information that lands on the average unit manager's desk each day in the form of emails, advertisements, duty rosters, reports, circulars on policies and procedures, it is necessary for the unit manager to be able to look critically at what is useful and necessary for the functioning of the unit, and be able to discard that which is not useful. To do this, critical-thinking skills are necessary.

Nordquist (2003) defines critical thinking as the process of independently analysing, synthesising and evaluating information as a guide to behaviour and beliefs. Critical thinking skills include the ability to interpret, verify, and reason, all of which involve applying the principle of logic.

Healthcare professionals should be able to independently collect, analyse, synthesise and evaluate information in order to compile statistics, which must be recorded in such a way that they are useful to the end user. The end user must be able to interpret and verify the information, or it will be useless.

# 17.7 Electronic health records

An electronic health record (EHR) is a digital version of a patient's paper chart, which can be updated each time the patient visits the clinic or hospital. The primary purpose of an EHR is to support efficient, high quality integrated healthcare, independent of the time and place of care delivery (Häyrinen, Saranto and Nykänen, 2008:291–304).

In many parts of the world, especially Europe and North America, such records have been in use for a number of years. Though still in its infancy in South Africa, it is envisaged that EHRs will be an important part of the National Health Insurance scheme currently being rolled out (Weeks, 2013). A move to electronic records will not be without difficulties however, one of which is access to a regular and reliable broadband service.

As mentioned earlier in this chapter, healthcare professionals generally do not enjoy record keeping and there may be resistance to changing from an existing method to a new and 'untested' method. De Veer and Francke (2010:846–854) undertook a study to assess attitudes towards the usefulness and acceptance of EHRs in Dutch hospitals. The results of this study found that nurses feel the use of EHR improved patient care generally, especially qualitatively better care and safer care. However, attitudes to the use of EHRs were not positive across all categories of nurses; acceptance appeared to be linked to the perceived usefulness of the EHR.

Häyrinen et al (2008) carried out a systematic review to establish the reliability of information within the EHR. This review concluded that information within the EHR is considered to be more complete and accurate than the traditional method of information gathering.

It is likely that EHRs will become part of the future of healthcare in South Africa. However, with a move to this new technology, certain new ethical questions will have to be answered, for instance controlling access to information and maintaining confidentiality.

Jooste (2009) suggests the following with regard to the use of EHRs:

- Every person (user) who is authorised to add or update an EHR is issued with a unique and confidential access code, which serves the purpose of identifying the user, and maintains confidentiality.

- There is no longer the need for each entry to be signed because the computer identification serves the same purpose as a signature.

- The user remains accountable for what is entered into the EHR.

- The use of the unique code records the time and date of entry which, should the need arise, further confirms the identity of the user.

- The EHR system does not allow an entry to be deleted, although there must be provision to be able to mark an entry as 'incorrect' or 'no longer valid'. The system would be able to identify the user who makes such an entry.

## 17.8 Summary

Accurate reporting and diligent recording should be the aim of all nursing staff. These records are needed for many purposes, such as gathering statistics, as a history of patient care and for use in legal proceedings should it ever be necessary to authenticate nursing care given. Records and reports are not only essential in the evaluation of the quality of the nursing care, but are also channels of communication. It has also been explained why keeping statistics is necessary and how raw data can be displayed in histograms, pie charts, or graphs in a user-friendly manner.

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