DEVELOPMENT OF A TRAINING PROGRAM TO FACILITATE THE IMPLEMENTATION OF THE SIX MINISTERIAL PRIORITIES BY PROFESSIONAL NURSES IN LIMPOPO PROVINCE HEALTH CARE FACILITIES, SOUTH AFRICA

by

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THESIS

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DECLARATION

I declare that **Development of a Training Program to Facilitate the Implementation of the Six Ministerial Priorities by Professional Nurses in Limpopo Province Health Care Facilities, South Africa** hereby submitted to the University of Limpopo, for the degree of Doctor of Philosophy in Nursing Science has not previously been submitted by me for a degree at this or any other university; that it is my work in design and in execution, and that all material contained herein has been duly acknowledged.

Legodi E.M. (Mrs) **26 April 2022**

DEDICATION

The thesis is dedicated to the memory of my late Mother, Augoster Maledile Marokane, who raised me to be the person I am today. I will always be indebted to her leadership and guidance. It is also dedicated to my beloved family, my husband Charles for being a pillar of support throughout this journey, my lovely daughter, Lerato, for the administrative support during my studies and always being available to help, my grandchildren, Ntebogeng and Lesedi, for assisting with IT, drawing of graphs and tables.

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ABSTRACT

The purpose of this study was to develop a training programme to facilitate the implementation of the 6 Ministerial Priorities by Professional Nurses in the Health Care facilities in Limpopo Province. The purpose of the training programme was to capacitate the Professional Nurses to enable them to facilitate the implementation of the 6 Ministerial Priorities in the Health Care facilities of Limpopo to improve the provision of quality service.

The study was conducted in three phases, namely, qualitative, quantitative and development of a training programme. Phenomenological semi-structured one-to-one interviews were conducted to explore the perceptions of Professional Nurses on the implementation of the 6 Ministerial Priorities in the public hospitals in Limpopo Province. Interviews were conducted until saturation was reached. Themes and sub-themes were coded manually.

The results of the qualitative phase were used to develop a questionnaire for the quantitative phase. Self-administered quantitative questionnaires were given to Professional Nurses to describe their experiences, knowledge and perceptions on the implementation of the 6 Ministerial Priorities in the Health Care facilities of Limpopo.

The results that emerged from the integration of qualitative and quantitative results revealed that 6 Ministerial Priorities were not implemented effectively in the Health Care facilities due to challenges such as shortage of Professional Nurses and cleaners, shortage of cleaning material, linen and patients clothing. Shortage of medication, lack of in-service training on the 6 Ministerial Priorities and lack of orientation programme for the newly appointed Professional Nurses. These challenges affected the implementation of 6 Ministerial Priorities negatively thus compromising the provision of quality patient care. The training programme was developed for Professional Nurses to capacitate them on the facilitation of the implementation of the 6 Ministerial Priorities to improve quality care.

Keywords: Develop, Training Programme. Facilitate, Implementation, Professional Nurses, 6 Ministerial Priorities

ABBREVIATIONS/ACRONYMS

BRICS	Brazil, Russia, India and China
CEO	Chief Executive Officer
EDL	Essential Drug List
ICN	International Council of Nurses
LDoH	Limpopo Department of Health
NDoH	National Department of Health
NSDA	Negotiated Service Delivery Agreement
OHSC	Office of the Health Standard Compliance
RSA	Republic of South Africa
SAHRC	South African Human Rights Commission
SANC	South African Nursing Council
SAQA	South African Qualification Authority
SDGs	Sustainable Development Goals
UNDP	United Nations Development Programme
WHO	World Health Organization

DEFINITION OF CONCEPTS

Development

Development is a process in which someone or something grows or changes and becomes more advanced. Synonyms are, namely: evolving, matured, expand, enlarge, spread, progress, thrive, flourish, blossom (*Oxford South African Dictionary* 2010). In the context of this research, the development refers to the development of a training programme for Professional Nurses to enable them to facilitate the implementation of the 6 Ministerial Priorities.

Facilitation

Facilitation is an action or process of making something possible/easy/easier. Synonyms of making easy/easier are ease, making possible, to make smooth/ smoother, smooth the path of, clear the way for and open the door for (*Oxford South African Dictionary* 2010). In the context of this research, 'facilitation' refers to the process of capacitating equipping Professional Nurses with skills and resources to enable them to facilitate the implementation of the 6 Ministerial Priorities

Ministerial Priorities

'Ministerial Priorities' are six critical priorities identified by the Minister of Health based on patients' complaints, feedback and surveys, which reflect the acceptability of the care provided at the delivery level.

National Core Standards

'National Core Standards' are standards that are structured into seven crosscutting domains. The first three are directly involved with the core business of the health system of delivering quality Health Care to users or patients (NDoH 2011).

Negotiated Service Delivery agreement.

A charter that reflects the commitment of key sectoral and inter-sectoral partners linked to the delivery of identified outputs as they relate to a particular sector of government (*The South African Health Reform* 2009-2014).

Nosocomial Infections

A ‘nosocomial infection’ is an infection that originated and contracted in a hospital (*Oxford South African Dictionary* 2010).

Nursing

Nursing Act 33 of 2005 (South African Nursing Council) defines ‘nursing’ as a caring profession practised by a person registered under Section 31, which supports, cares for and treats a Health Care user to achieve or maintain health and where this is not possible, cares for a Health Care user so that he or she lives in comfort and with dignity. In the context of this research study, ‘nursing’ refers to the provision of quality care in terms of implementation of the 6 Ministerial Priorities by Professional Nurses who are registered with the South African Nursing Council under Section 31 of the act.

Patient

According to the *Cambridge English Dictionary*, a ‘patient’ is a Person receiving medical care or who is cared for by a particular doctor (*Cambridge English Dictionary* 2018). In the context of this study, patients will refer to all patients admitted at the selected public hospitals in Limpopo Province.

Professional Nurse

The South African Nursing Council (Nursing Act 33 of 2005) defines a ‘nurse’ as a person registered in a category under section 31(1) to practise nursing or Midwifery. In the context of this study, a ‘nurse’ refers to Professional Nurses in the selected facilities who are Implementing 6 Ministerial Priorities.

Programme

A programme is a planned series of events or a set of related measures or activities with a long term aim (*Oxford South African Dictionary* 2010). In the context of this study, a programme is a set of related planned activities to achieve a particular set goal.

Quality

'Quality' refers to the characteristics or features associated with excellence, and these characteristics form the criteria for evaluating the quality of a specific service (Booyens, 2010). In the context of this study, 'quality' Health Care refers to the implementation of the 6 Ministerial Priorities.

Sustainable Development Goals

'Sustainable Development Goals' (SDGs) are officially known as 'transforming our world': the 2030 agenda for Sustainable Development is a set of 17 'Global Goals' with 169 targets between them. They are goals aimed at providing quality life and promoting the life expectancy of the people of the world. SDGs preceded the Millennium Development Goals (UNDP 2017). In the context of this study, Sustainable Development Goals are goals aimed at providing quality of life and promoting the life expectancy of the people of Limpopo.

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CHAPTER 1
OVERVIEW OF THE STUDY

1.1 Introduction and Background

Quality improvement is a core component of a national health systems framework in countries like Ireland, with emphasis on the development of support structures and leadership at multiple levels (Health Services Executive, Ireland 2016). In New Zealand, the health systems framework aims to improve quality, health equality and best practices to obtain the greatest value from public health resource utilization. Gray and Vawda (2017) reported that the emphasis is placed on improving Health Care quality through a commitment to ongoing learning, leadership, informed practice and clearly defined responsibilities for all role players.

In Brazil, Health Care organizations utilize quality certification through a process of accreditation. In Russia, the federal and regional laws have support the transformation of the healthcare system and the government is committed to developing policies that emphasize greater primary care (Health Systems Trust 2015). However, in China, government investment supported the expansion of health infrastructure and promotion of equal health access, as well as universal health coverage. Furthermore, the Indian National Quality Assurance Framework was established to improve quality standards for District Hospitals and Community Health Centres (Health Systems Trust 2015). Countries such as Ghana, Ethiopia, Mexico, Scotland and Nigeria developed National Quality Strategies in 2010 and highlighted key lessons learned (Health Systems Trust 2017).

South Africa as well has taken giant strides in reforming its health system. In 1997, the White Paper on the transformation of the Health System in South Africa set the foundation for the development of a unified health system aimed at delivering quality Health Care for all citizens, using a primary Health Care approach (NDoH 2017). In 2001, the first Policy on Quality in Health Care was published and revised in 2007. This policy proposed the development of quality assurance, including effective interventions and monitoring strategies across the public and private sectors, towards the national aim of quality improvement (NDoH 2017).

Access to Health Care services is a constitutional right of all citizens in South Africa. *The Constitution of the Republic of South Africa Act* 108 of 1996 enshrines the right to quality Health Care and provides the basis for numerous policies and legislation aimed at improving access, eliminating inequalities and increasing health system safety (South Africa 1996).

In 2010, the South African National Department of Health re-emphasized its commitment to prioritizing health systems quality through the 10-Points Plan for improvement of the Health Sector (NDoH 2010) and the Negotiated Service Delivery Agreements (NDoH 2010) which sought to implement key quality assurance activities towards improvement of patient care and satisfaction, as well as the advancement of health facility accreditation. South Africa joined Brazil, Russia, India and China (BRICS) in 2010 in an association of five emerging national economies. Insights gathered from the development and implementation of national strategies and frameworks for health system quality improvement in these developing nations may ultimately inform similar procedures in South Africa.

In 2012, the National Department of Health again published the quality improvement Guide defining quality and how it should be tested, implemented and sustained. In 2013, the Office of the Health Standards Compliance (OHSC) was established, the objects of which are to protect and promote the health and safety of users of health services by monitoring and enforcing compliance with national quality standards across the public and private sector (NDoH 2013).

South Africa faces an enormous challenge in transforming its Health Care delivery system, not only to meet citizens' expectations of good quality care but also to improve critical Health Care outcomes linked to the Sustainable Development Goals (NDoH 2012). Better quality of care is fundamental in improving South Africa's current poor health outcomes and in restoring patients' and staff confidence in the public and private Health Care system (NDoH 2012).

National Department of Health also developed National Core Standards for Health Establishments in South Africa against which service delivery by health establishments can be assessed by the Office of the Standard Compliance and

Accreditation body. The purpose of the National Core Standards was to develop a common definition of quality care which should be found in all health establishments in South Africa (SA) as a guide to the public, managers and staff at all levels, establish a benchmark against which health establishments can be assessed, gaps identified and strengths appraised and provide the national certification of compliance of the health establishment with mandatory standards (NDoH 2012).

National Core Standards have been established to address issues of quality in Health Care establishments. They form a basis of a process that will appraise the performance of health facilities against a uniform set of expectations for what constitutes excellence (NDoH 2012). Six Ministerial Priorities were extracted from the National Core Standards to fast track improvement of service delivery in the Health Care system. The 6 Ministerial Priorities were launched in all Health Care facilities by the National Department of Health (NDoH 2012), namely, values and attitude of staff, cleanliness, waiting time, patient safety and security, infection prevention and control and availability of basic medications and supplies.

- **Values and attitude of Staff**

Staff attitude is fundamentally important in delivering acceptable and quality care. The values and attitude of staff ensure that patients are treated respectfully. Health Workers were often rude and uncaring to patients (NDoH 2012).

- **Cleanliness**

Cleanliness of health includes buildings, grounds, amenities and equipment to prevent nosocomial infections. People visiting a hospital for treatment are already vulnerable to the spread of infections. The cleanliness of hospitals is key in curbing the spread of infections. A clean environment is also important for the speedy recovery of patients therefore health facilities should be kept clean at all times (NDoH 2012).

- **Waiting Time**

Waiting time is an important indicator in the assessment of Health Care quality and patients' satisfaction. Patients often wait for a long time in Health Care facilities for treatment. Patients' waiting time need to be monitored and managed (NDoH 2012).

- **Patients Safety and Security**

Many patients suffer injury or death every year because of unsafe medical practices and care. Patients are mostly harmed due to preventable causes that they receive during Health Care in hospitals. Health establishments should ensure that patients, staff and property are protected from safety and security risks (NDoH 2012).

- **Infection Prevention and control**

Hospital-acquired infections are a major cause of morbidity and mortality in Health Care facilities. All health establishments are expected to reduce the risk of Health Care-associated infections through ongoing monitoring and management. Policies and protocols for the prevention and management of infections should be available and be implemented (NDoH 2012).

- **Availability of basic medications and supplies**

Health establishments should ensure that medicines as per the relevant Essential Drug List (EDL) are available all the time. Appropriate medicines should be available as prescribed. Patients should be able to obtain their medications from pharmacies or providers within an acceptable period (Zaracostas, 2010).

Despite the introduction of the 6 Ministerial Priorities in the healthcare facilities, complaints about the quality of care provided in Health Care facilities continued to be raised. The researcher believed that the 6 Ministerial Priorities addressed the vital elements in the Health Care system which if properly addressed would eradicate the complaints raised by patients and the clients. Six Ministerial Priorities were compiled based on the complaints mostly raised by patients and clients in the Health Care facilities.

The researcher also believed that if 6 Ministerial Priorities were implemented correctly there would be a huge reduction in complaints raised, as well as an improvement in the provision of quality Health Care. The researcher also believed that nurses formed a large number of healthcare professionals in the healthcare system and spend much more time with patients than any other healthcare professional. Therefore, if Professional Nurses were trained in the implementation of the 6 Ministerial Priorities,

a huge impact would be made in the improvement of the provision of quality care. Professional Nurses would be able to transfer the knowledge and skills to other Health Care professionals.

Health Care facilities in South Africa were inundated with numerous litigation cases regarding the poor Health Care services provided to patients. The Life Esidimeni saga in which One hundred and forty-three (143) patients died in Gauteng Province due to poor Health Care services was one of the many examples of poor quality service (*News 24*, 2018; and & *Daily Dispatch* 2017).

The Limpopo Department of Health as well was inundated with cases of litigations due to poor quality of care provided in its Health Care facilities. To date, the Limpopo Department of Health has spent 23 billion Rands on cases of litigation. This money was supposed to be directed at important resources to facilitate and improve the provision of Health Care services. This left the department with a huge budgetary gap that affected the health system in terms of recruiting adequate skilled staff; procurement of equipment and other related resources; and maintenance of facilities as well as servicing of the existing equipment. The question the researcher asked was whether the 6 Ministerial Priorities were being implemented correctly in the Limpopo Health Care facilities.

Behind this background, the study sought to develop a training program for nurses to improve the implementation of the 6 Ministerial Priorities. The program would also identify Professional Nurses' strengths and limitations in the knowledge of the implementation of the 6 Ministerial Priorities to improve the implementation thereof. It was the researcher's view that if the 6 Ministerial Priorities were implemented correctly by all Health Care facilities there would not be so many complaints as well as increased cases of litigations.

1.2. Research Problem

Despite a clear agenda for quality Health Care and significant annual expenditure, health system shortcomings continued to endanger the health and lives of South African citizens, resulting in a loss of confidence among users (Honda, Ryan, Van Niekerk & McIntyre, 2015). Discontent with service quality escalated medico legal

claims, thus burdening both health services and Health Care professionals (NDoH 2017). Poor quality was associated with patient safety hazards, duplication of efforts, variable standards of care, unsafe work areas and labour grievances (NDoH 2017). Promoting healthcare quality improves health service access and health outcomes, and increases life expectancy. The right to quality Health Care is enshrined in the South African Constitution, which provides the basis for multiple policies and legislation promoting sustained quality improvement (South Africa 1996).

Despite the quality improvement strategies, that the government employed there was continuous decline in the provision of quality service delivery. The implementation of National Core Standards in Health Care facilities proved to be a nightmare hence the extraction of the 6 Ministerial Priorities. The 6 Ministerial Priorities were introduced to fast track the improvement of service delivery, but this seemed to be bearing no fruits as complaints about the quality of care continued to increase and that was also evident in the number of litigation cases in the Department of Health.

It was the researcher's view that Professional Nurses in Health Care system formed the biggest number of the Health Care human resources, and they spent more time with patients than all other healthcare professionals. Therefore, their knowledge and effective implementation of the 6 Ministerial Priorities would go a long way in improving the quality care provided to patients, restoring dignity and confidence of the consumers of health and reducing cases of litigation. Therefore, the study was aimed at developing a training program for Professional Nurses to facilitate the improvement of the implementation of the 6 Ministerial Priorities to improve quality care.

1.3. Theoretical Framework

Dickoff, James and Wiedenbach's (1968) Practice-Orientated Theory and Knowles' Adult Education Theory was used as a theoretical framework to develop a training program for nurses to improve the implementation of the 6 Ministerial Priorities in the Health Care facilities. The knowledge and practice of Professional Nurses, which was elicited during this study, was used to develop a training programme. The theoretical framework is the structure that puts together or gives support to the theory of a research study. It gives the introduction and description of the theory that explains why the research problem understudy exists. Dickoff, James and Wiedenbach (1968)

further state that nursing theory; nursing practice and nursing research are interrelated and interdependent. Nursing theory emanates from nursing practice and the generated theory in nursing should be applied and have the ability to be articulated with nursing practice and contributes meaningfully to improved nursing practice. The researcher, therefore, intertwined the Practice Orientated Theory by Dickoff, James and Wiedenbach (1968) with Malcolm Knowles' principles of adult learning in the development of the training programme.

The diagram below depicts a visual theoretical framework of the training program for nurses to implement the 6 Ministerial Priorities in the hospital.

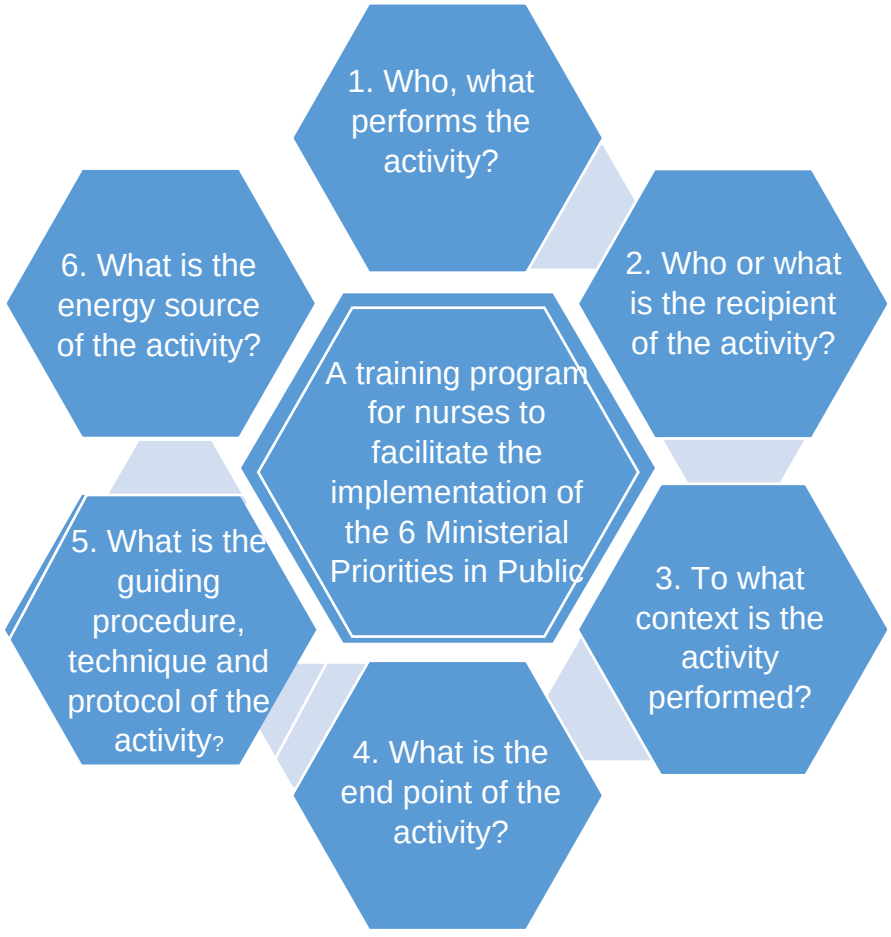

Figure 1.1: Dickoff, James and Wiedenbach's Practice Orientated Theory (1968), *adapted*

The following concepts of Dickoff et al., (1968) were utilized in this study to describe the conceptual framework for the development of a training program for nurses for the facilitation of the implementation of the 6 Ministerial Priorities.

1.3.1. Who, Performs the Activity?

The researcher developed a training program for Professional Nurses to enable them to facilitate and implement the 6 Ministerial Priorities.

1.3.2. Who or What is the Recipient of the Activity?

Professional Nurses received training guidelines on how to facilitate and implement the 6 Ministerial Priorities in the selected Health Care facilities of Limpopo Province.

1.3.3. In What Context is the Activity Performed?

The training took place at the selected Health Care facilities of Limpopo Province.

1.3.4. What is the End of the Activity?

The end of the activity was skilled and knowledgeable Professional Nurses who would be able to facilitate and implement the 6 Ministerial Priorities.

1.3.5. What is the Guiding Procedure, Technique or Protocol of the Activity?

The guiding procedure was the training programme.

1.3.6. What is the Energy Source for the Activity?

The energy source was the challenges the Professional Nurses experienced during the implementation of the 6 Ministerial Priorities.

Knowles' Theory of Adult Education

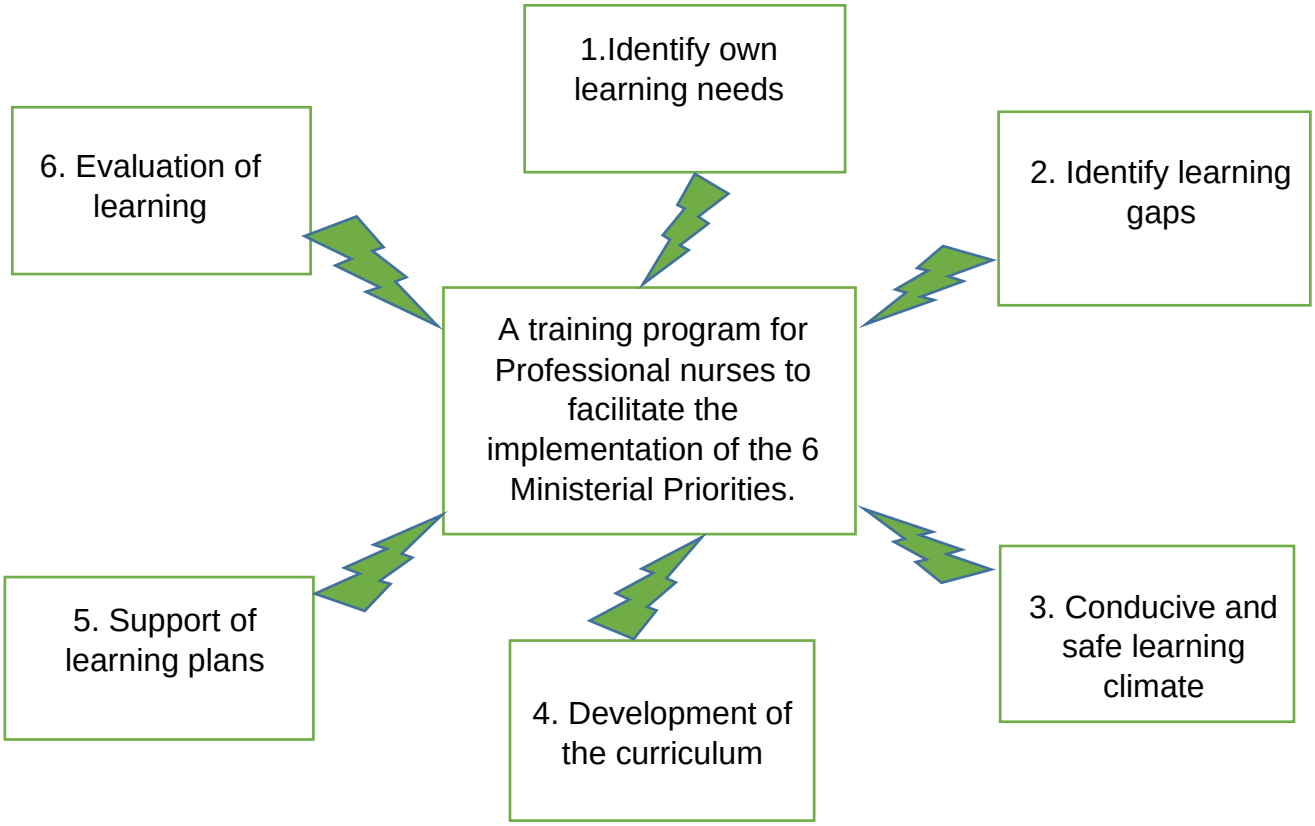

Figure 1.2: Knowles' Theory of Adult Education *(Adapted from Kaufmann, 2003)*

The Malcolm Knowles' Adult Education principles indicated the following related to the facilitation of training for adult learners:

- Adult Education Facilitators should Ensure that Learners are Allowed to Identify Their Own Learning Needs
  - The facilitator ensured that Professional Nurses were allowed to identify their own learning needs.

- Adult Learners were Encouraged and Allowed to Identify Their Learning Objectives Based on Their Learning Gaps to Provide Learners with an Opportunity to have Control over Their Learning.
  - The Professional Nurses were encouraged and allowed to identify their learning objectives based on their learning gaps and that allowed them to have control over their learning.

- Facilitators for Adult Education must Ensure that the Learning Climate for Learning is Safe and Conducive for Adult Learners to Express Themselves
    - The training was conducted in a boardroom that was comfortable and free from distractions;
    - The lighting was adequate;
    - The seats were comfortable; and
    - The Professional Nurses were allowed to freely express themselves.

- Adult Learners should be Allowed to Participate in the Development of Their Curriculum, and Determination of the Relevant Method to be Used in Their Teaching that will Enhance Learning for Adult Learners
    - Professional Nurses were allowed to participate in the development of their plan for their training and will determine the relevant method used for their training that will enhance their learning.

- Adult Learners should be Supported in Carrying Out Their Learning Plans
    - The Professional Nurses were supported by the facilitator in carrying out their learning plans.

- Adult Learners should be Involved in the Evaluation of Their Learning to Ensure that They Develop Critical Reflection Skills
    - The Professional Nurses were involved in the evaluation of their learning to ensure that they develop critical reflection skills.

1.4 Development of a Training Program

Phase 1 and Phase 2 of this study assisted the researcher in identifying skills and practice gaps of Professional Nurses that hampered their ability to adequately implement the 6 Ministerial Priorities in hospitals. The knowledge and practice gaps identified were used to develop the training program for Professional Nurses to implement the 6 Ministerial Priorities. Furthermore, the guidelines to implement the Training Programme were formulated to enhance the implementation of 6 Ministerial Priorities.

1.5 Aim of the Study

The purpose of the study was to develop a training program for Professional Nurses to enable them to facilitate the implementation of the 6 Ministerial Priorities in the Health Care facilities of Limpopo Province, South Africa to improve the provision of quality patient care.

1.6 Research Questions

- What are Professional Nurses' experiences in the implementation of the 6 Ministerial Priorities in the Health Care facilities in Limpopo Province?
- What are the Professional Nurses' knowledge and practices in the implementation of the 6 Ministerial Priorities in the Health Care facilities in Limpopo Province?
- What support do Professional Nurses require for the effective implementation of the 6 Ministerial Priorities in the Health Care facilities in Limpopo Province?
- How can a training program for Professional Nurses to implement the Six Ministerial Principles in the Health Care facilities of Limpopo Province be developed?
- What are guidelines that enhance the implementation of the training program of the 6 Ministerial Priorities in the health facilities of Limpopo Province?

1.7 Objectives of the Study

The objectives of the study were to:

- Explore and describe the experiences of Professional Nurses on the implementation of the 6 Ministerial Priorities in the selected Health Care facilities in Limpopo Province.
- Describe the Professional Nurses' knowledge and practices in the implementation of the 6 Ministerial Priorities in the selected Health Care facilities in Limpopo Province;
- Identify the support and resources required by Professional Nurses for the effective implementation of the 6 Ministerial Priorities in the selected Health Care facilities in Limpopo Province;

- Develop a training program for Professional Nurses on the implementation of the 6 Ministerial Priorities in the selected Health Care facilities in Limpopo Province; and
- Formulate guidelines that enhance the training program on the implementation of the 6 Ministerial Priorities in Health Care facilities in Limpopo Province.

1.8 Researcher's Assumptions

The assumption was that effective implementation of the 6 Ministerial Priorities by nurses improves the provision of quality care thus reducing health risks and improving patient outcomes. The assumptions of this study include the meta-theoretical, ontological and epistemological that are described as follows;

1.8.1 Meta-Theoretical Assumptions

Meta-theory refers to broad perspectives, which make claims regarding the nature of reality and, as such, a meta-theory addresses the fundamental beliefs about the world that guide an individual's actions and can be termed to be a paradigm or worldview. Accordingly, meta-theories philosophically underpin research, practice and substantive theory in any field of study (Lor, 2011). Meta-theoretical assumptions were based on the researcher's view of the world and society. The researcher believed that Professional Nurses were capable of implementing 6 Ministerial Priorities effectively to improve quality care and patient outcomes because of the knowledge and skills they acquired during their training and their experience.

The researcher believed that effective implementation of the 6 Ministerial Priorities would yield patients positive outcomes thus reducing unnecessary patient health risks and cases of litigation. The researcher was influenced by the positivist (quantitative) paradigm and constructive (qualitative) tradition in which self-alignment was done. In the positivist paradigm, therefore, the nurses create their realities by attaching meaning to different situations that are expressed through words and the meaning of words forms the basis of actions and interactions of respondents and participants.

1.8.2 Ontological Assumptions

All research participants have knowledge of the existence of the 6 Ministerial Priorities and that Ministerial Priorities should and or were implemented in Public Health Care facilities in Limpopo Province.

1.8.3 Epistemological Assumptions

The epistemological assumption in the qualitative study means that the researcher tried to get as close as possible to the participants being studied. Therefore, subjective evidence is assembled based on individual views. During the Sequential Mixed Method research, at the epistemological assumption, which reflected the relationship of the researcher to that researched, the level concerning what knowledge entails, it was assumed that:

- In terms of the positivist paradigm (quantitative phase) the researcher was independent and objective using larger samples from Professional Nurses who have been researched; and
- In the constructivism (qualitative phase), the researcher interacted and sought to examine the context of human experience as multiple realities and different interpretations that might result from any research endeavour (Doyle, Brady & Byrne, 2009).

1.8.4 Methodological Assumptions

Development of a training program to facilitate the implementation of the 6 Ministerial Priorities by Professional Nurses in the Public Health Care facilities was developed based on the findings derived from the sequential mixed-method approach. The researcher developed the theoretical framework and gaps were identified based on the data. The theoretical framework developed by the researcher was used as a guide to the Professional Nurses to facilitate and implement the Ministerial Priorities to improve quality care.

During Phases 1 and 2 of the study, at the methodological level. At the level of operationalizing and implementing the study, it was assumed that:

- Face-to-face, individual semi-structured interviews with the aid of an interview guide yielded data that sought to answer the research questions

and objectives. Narrated data from Professional Nurses were accurate and reliable through verification of member checks;

- The quantitative methodological assumption, as a deductive process, yielded the accurate reliable numeric data that sought to answer the research questions and objectives; and
- The self–developed questionnaires through reliability and validity also yielded the data sought to answer the research questions and objectives. Generalization leading to prediction, explanation and understanding was done in this study.

The knowledge that was gained from this study was used to develop the training program for Professional Nurses to facilitate the implementation of the 6 Ministerial Priorities in the Public Health Care facilities of the Limpopo Department of Health.

1.9 Overview of Research Method and Design

The mixed method of sequential explanatory qualitative and quantitative research was used to provide answers to the research questions and research problem. The study aimed to develop a training program for Professional Nurses to facilitate the implementation of the 6 Ministerial Priorities. The use of the mixed method enabled the researcher to confirm and corroborate the findings of the study (Babbie, 2013).

A mixed-method, an exploratory sequential research design was used in this study to achieve the study purpose (Creswell, 2014). The methodology comprised both collecting and analysing qualitative and quantitative data respectively. This research method assisted the researcher to form a complete picture of problems or challenges experienced by Professional Nurses during the implementation of the 6 Ministerial Priorities and a training program was developed and validated (Creswell, 2014). This method assisted the researcher to explore the phenomenon by identifying qualitative themes, and the information guided the subsequent quantitative examination of the initial qualitative results such as developing a measurement instrument of the initial qualitative.

The first stage entailed the collection and analysis of qualitative data. Based on the qualitative results, the researcher was engaged in a second stage, the quantitative

phase, to test and make the general view of the initial findings. The researcher then interpreted the results (Creswell, 2013; and de Vos, Strydom, Fouche & Delport, 2011).

The study had four (4) phases, namely: Phase 1 was qualitative, Phase 2 was quantitative, Phase 3 was the development of a training programme and Phase 4 was the formulation of guidelines for the implementation of a training program for 6 Ministerial Priorities.

The study was conducted in five (5) selected Public Health Facilities of Limpopo Province. The target population was Professional Nurses working in the selected public hospital of Limpopo Province. Non–Probability Purposive Sampling was used to select the participants. Semi-structured face-to-face interviews were used to collect qualitative data, while self-developed questionnaires were used to collect quantitative data from the Professional Nurses in the selected hospitals. Narrative data collected were analysed qualitatively through Tesch's approach (Polit & Beck, 2012). A detailed discussion of the research methodology and design followed in Chapter 3 of this thesis.

1.10 Significance of the Study

- **Nursing Practice**

The findings may provide an opportunity for Professional Nurses and other Health Workers to identify their knowledge and skills in the implementation of the 6 Ministerial Priorities, and use the plan to close the gap thus improving service delivery. Furthermore, it will improve the service delivery, quality and improving patient outcomes by implementing the 6 Ministerial Priorities effectively.

- **Research**

The findings may be useful in formulating a basis for further research to either confirm or refute the findings of this study. The findings may also prompt other researchers to explore more on the development of a training program for nurses to facilitate the implementation of the 6 Ministerial Priorities.

- **Nursing Education**

The findings of this study may also serve to improve the body of knowledge in nursing education on how to improve the provision of quality care by effective implementation of the 6 Ministerial Priorities. The training programme will benefit the newly qualified Professional Nurses in acquiring skills and knowledge in implementing the 6 Ministerial Priorities.

- **Nursing administration and Policy**

The findings of this study may be of great benefit to the management of Health Care in facilitating a training program for nurses to provide quality care to patients. The study will also benefit the health planners and decision-makers by mobilizing the resources required for the improvement of quality service.

1.11 Delineation of the Subsequent Chapters

Chapter 1: Overview of the Study
Chapter 2: Literature Review
Chapter 3: Research Methodology
Chapter 4: Discussion of Qualitative and Quantitative Results
Chapter 5: Integration of Qualitative and Quantitative Results
Chapter 6: Development of Theoretical Framework
Chapter 7: Development of a Training Program
Chapter 8: Summary, Conclusions, Limitations and Recommendations.

1.12 Conclusion

Chapter 1 provided an overview of the study, including an introduction and background as well as the research problem. The theoretical framework and the aim of the study, research question, objectives and the overview of the research method and design were also outlined. The significance of the study and the delineation of the subsequent chapters were highlighted.

The next chapter discusses the literature review.

CHAPTER 2
LITERATURE REVIEW

2.1 Introduction

This chapter discussed the health system in South Africa looking at the progress made in improving the health status of the people of South Africa, as well as the impact of the implementation of 6 Ministerial Priorities in an endeavour to improve quality service delivery. The literature review will also look into the development of a training programme for health professionals to improve skills and competencies for the improvement of quality service delivery. The purpose of the literature review was to provide an appraisal of current research that related to the study, discussed and provided a supportive theoretical framework. The researcher conducted an electronic search in the following databases: Science Direct, SABINET and PubMed.

These databases provided access to abstracts and full-text articles related to the research topic. Published scholarly articles related to the research topic, books chapters and computer-accessed materials were also reviewed. Google Scholar was also used which provided a broad search for literature across many disciplines and sources such as theses, books, abstracts and articles from academic publishers. The information obtained from the literature search was used to control and support the observed results, as well as to contribute to the writing of this thesis.

2.2. An Overview of the Literature Review

2.2.1. Purpose of Literature Review

There are several reasons why researchers conduct literature reviews, namely, the primary studies that researchers conduct and publish; the reviews of those studies that summarise and offer new perceptions, conclusions, opinions and interpretations that are shared informally in the field (Fink, 2014). The researcher aligned with the latter as was related to the topic under study. Authors classify literature reviews into argumentative review; integrative review; historical review, methodological review, systematic review and theoretical review (Fink, 2014). For this research, a systematic literature review was used.

2.3. Quality in the Health Care System in South Africa

Delivery of quality Health Care is a constitutional obligation in South Africa (Stuckler, Basu & McKee, 2011). The government has therefore introduced numerous developments and programmes to improve Health Care, efficiency, safety and provision of quality services and access for all users (Mogashoa & Pelser, 2014). There have been major changes in health policy and legislation to ensure compliance in delivering quality care (Moyakhe, 2014), including the 6 Ministerial Priorities.

Despite several commendable goals having been set by the government for improved quality of service delivery in healthcare settings, reports by media and communities revealed that services in public health institutions were failing to meet basic standards of care and patient expectations (National Department of Health 2012), hence the public lost trust in the Health Care system (Zubane, 2011). Koelble and Siddle (2014) describe the healthcare system in South Africa as ruined and in serious need of repair.

Many of the problems in the South African healthcare system could be traced back to the apartheid period (1948–1993) in which the healthcare system was highly fragmented, with discriminatory effects, between four different racial groups, namely, black, mixed-race, Indian and whites (Baker, 2010). To worsen the situation, the apartheid government developed Bantustans also called ethnic homelands into which Africans were unwillingly segregated, and each of which had their Departments of Health with their professional bodies (Baker, 2010). This led to deterioration in health system delivery because of lack of resources, and poor communities were especially affected (Chassin & Loeb, 2013).

South Africa has made great strides since the end of apartheid in 1994 in improving the overall population health and well-being, reflected in increased life expectancy and reduction in mortality rate (Lancet Commission 2017). Despite the improvements made as indicated by the commission there were findings as well made by the same commission, which had a negative impact on health, namely; gaps in leadership, management and governance contributed to poor quality care, poor quality of care costs lives. Malpractice cases and medical litigation are threats to the realisation of the right to Health Care in South Africa.

The implementation of 6 Ministerial Priorities was and still is about improving the provision of quality care in the Health Care system. *The Constitution of the Republic of South Africa* (Act 108 of 1996) enshrines the right to quality Health Care and provides the basis for numerous policies and legislation aimed at improving access, eliminating inequalities, and increasing health system safety (South Africa 1996).

Access to quality Health Care services is a constitutional right of all citizens in South Africa (WHO 2018). Perceptions of quality vary according to the needs of different stakeholders. Health Care providers, for example, tend to emphasise the 'technical quality' of care, such as adherence to treatment protocols, infection prevention and the desired outcomes related to successful treatment; reduction in morbidity, mortality and disability (WHO 2018). Patients or community members are more concerned with their experience in the facility such as cleanliness, amenities, waiting time, and/or the behaviour of staff. Policymakers and Health Care managers focus on the health systems performance, value for money and population-level outcomes (WHO 2018).

A policy on quality in Health Care for South Africa (NDoH 2008) has reiterated quality challenges in Health Care, both in the public and the private sectors. These problems included under-use and overuse of services; avoidable errors; variation in services; lack of resources; inadequate diagnosis and treatment; inefficient use of resources; poor information; inadequate referral system; disregard for human dignity; drug shortages; records not well kept; and poor delivery systems (NDoH 2008).

Significant levels of error occur with Health Care, which often results in injury to patients. Health Care and health status can be improved by way of improving patient safety and reducing the level of error in Health Care delivery (NDoH 2017). Systems can be designed and health professionals trained in methods to improve patient safety by reducing hazards in Health Care, and making the consequences of errors less serious when they do occur (NDoH 2017).

Providing quality care to patients requires training skilled Health Workers and establishing a culture that values lifelong learning and recognizes its important role in improving quality. Continuous Quality Improvement (CQI) skills and techniques need to become an integral part of the management training of Health Workers. A

learning framework for quality assurance should be developed and used to establish expertise at each level of care. Every training programme should provide a strategy for ongoing support and mentorship (NDoH 2008).

A report by the South African Human Rights Commission (SAHRC) into access to Health Care services has depicted that access to health services, especially for the poor, is still severely constrained by expensive, inadequate or non-existent transport, a serious shortage of medicines, emergency transport and long waiting times at clinics and other Health Care facilities (SAHR 2009).

National Core Standards for the Health Establishments were developed in South Africa by the National Department of Health to set standards for quality service through a detailed definition of what is expected. Achieving compliance with the standards would assist Health Care facilities in putting systems in place to avoid risks to poor quality care (NDoH 2016). The purpose of the National Core Standards was to develop a common definition of quality of care, which should be found in all healthcare establishments in South Africa. This was to be used as a guide to the public and to managers and staff at all levels as a benchmark against which health establishments can be assessed, identify gaps, appraise strengths, as well as provide a national framework for certification of health establishments as compliant with standards (NDoH 2016).

The democratic government has made huge efforts to improve the quality of healthcare delivery in South Africa since the 1994 elections, but the public regarding public institutions has raised several issues. Issues raised include among others prolonged waiting time because of shortage of human resources, adverse events, poor hygiene and poor infection control measures, increased litigation because of avoidable errors, shortage of resources in medicine and equipment and poor record-keeping. In addressing the above issues, the Minister of Health introduced the 6 Ministerial Priorities, which were derived from the National Core Standards to fast tract improvement of service delivery (NDoH 2016).

2.4. Six Ministerial Priorities

Six Ministerial Priorities were derived from the National Core Standards. The process of improving quality through the application of the National Core Standards was viewed as being long, while there were critical areas that needed to be addressed speedily. Hence the extraction of the 6 Ministerial Priorities from the National Core Standards. This was done to fast track the improvement of quality service. These 6 Ministerial Priorities were also based on the challenges commonly raised by patients (NDoH 2011).

Six Ministerial Priorities were identified to fast track quality improvements to meet patients' immediate expectations. Despite the efforts made by the Minister of Health to improve the provision of quality Health Care in health facilities the researcher noted the complaints raised by patients regarding negative attitudes they received from Health Care Workers, increasing cases of medical negligence from newspapers and radios. The researcher believed that if 6 Ministerial Priorities were implemented effectively, the quality of care provided to patients in the Health Care facilities would be better than where it was, and cases of litigation against the department would not be where they were.

The World Health Organization (WHO) defines "quality" as the level of attainment of health systems' intrinsic goals for health improvement and responsiveness to legitimate expectations of the population (World Health Organization). Quality has six dimensions according to WHO. Accordingly, quality should be effective, efficient, accessible, acceptable, patient-centred, equitable and safe (WHO 2016).

To be compliant with standards, managers and staff were expected to be conversant with the standards, as well as their current situation that is how far their performance was from meeting the standard (NDoH 2016). It was expected of all health establishments to ensure that they are compliant with the National Core Standards, however improving quality is a process and not an event, hence six critical areas were identified to fast track improvements to meet patients' immediate expectations.

These six critical areas are called the 6 Ministerial Priorities, namely:

2.4.1. Values and Attitudes of Staff

A qualitative study conducted in Western Lithuania in three multidisciplinary hospitals in 2014 on Health Care Professionals' attitudes regarding patient safety indicated generally positive attitudes toward patient safety. Sivero, Eriksson and Raharjo (2014) conducted a study that attempted to examine the attitudes toward quality improvement among Health Care professionals. The findings of the study revealed that the construct of attitudes was significantly associated with the change in behaviour toward quality improvement in the targeted hospitals.

Staff attitudes have been and continue to be, fundamentally important in delivering acceptable quality care. The attitude of staff reflects the culture and context of the situation within which they work. There is no quick fix for engendering positive and caring attitudes. An organization has to engender a positive attitude to staff by paying attention to training and continuous monitoring. Change of attitude in an organization is the responsibility of both management and staff. Focus on caring for the carers is fundamental in helping staff to empower themselves, reminding them of who they are and what their values are, and increasing their sense of agency, their creativity, and ultimately their job satisfaction. This will enable Health Workers to treat their patients with compassion and care (South African Health Reform 2009-2014).

Values and attitudes ensure that patients are treated respectfully by staff with due respect for patients' privacy and choice. Health Providers are expected to be courteous to patients at all times. Courtesy incorporates basic social values, such as being friendly, polite and helpful, and treating patients with dignity and respect, no matter who they are (NDoH 2014). Health Care Workers are too often rude and uncaring to their patients. Patients' complaints and Patient Satisfaction surveys both highlight this problem. Patients feel that they are not being treated well. Health Workers tell patients about their feeling of demotivation and a lack of recognition for their effort (NDoH 2011).

2.4.2. Cleanliness of Health Care Facilities

Controlling the spread of infections is vitally important in many different locations and settings such as schools, leisure centres and workplaces but it is even more crucial for healthcare providers. People visiting or receiving treatment in these environments

are already vulnerable to the spread of infections, so making sure that effective cleaning regimes are in place for waiting rooms, corridors, reception areas and wards is key (NDoH 2011). A clean and welcoming environment is also important from an aesthetic point of view, engendering feelings of well-being and trust in people who may be anxious or unwell. A survey conducted by Kurt (2016) showed that patients' perception of a hospital's cleanliness can have a major impact on their overall care and hospital experience.

NDoH (2011) indicated that most health facilities in South Africa are found to be dirty, untidy and unhygienic, showing that the staff do not care or respect their patients or their colleagues. Shortage of resources such as cleaning material, equipment and maintenance reinforces the poor condition of health facilities and contributes to nosocomial infections. According to NDoH (2011), cleanliness should include cleanliness of hospitals, and clinics, including buildings, grounds, amenities, equipment and staff. All health establishments should ensure that cleaning service is effectively managed to ensure a clean and safe environment for patients. A suitably experienced person must manage cleaning services in health establishments. Standard Operating Procedures/Protocols for cleaning should be in place and be implemented. There should be ongoing in-house training for cleaning staff. Cleaning equipment and materials should be available at all times (NDoH 2011).

2.4.3. Waiting Time

Patient waiting time is considered a crucial parameter in the assessment of healthcare quality and Patient Satisfaction with healthcare services. Patients waiting time is defined as the time patients have to wait before meeting clinical staff or using the health service needed (NDoH 2017). Patient waiting times are considered an important indicator in the assessment of healthcare quality and Patient Satisfaction with healthcare services (NDoH 2017). Lengthy outpatient waiting time has posed a great challenge to maximising healthcare quality.

Waiting times in health establishments should be locally determined and managed. A maximum waiting time should be reflected in each health establishment so that patients should be aware of how long they will wait before being attended to. There

should be fast lane queues. Very sick patients, children and older persons. Screening should be initiated at the point of patient entry into the hospital.

Waiting times in key areas should be monitored and measures taken by management to address the causes of blockages (NDoH 2011). The NDoH (2011) stated that patients often wait for a long time in Health Care facilities before they are attended to. Patients also wait for hours to get their files, to see a nurse or doctor, and to get their medication. In some instances, patients have to come back the next day to be seen by the doctor.

2.4.4. Patient Safety and Security

WHO stated that millions of patients worldwide suffer injury or death every year because of unsafe medical practices and care, and patients are mostly harmed due to preventable causes that they receive during Health Care in hospital settings. However, Health Care professionals may know that their role is important in the delivery of safe care and that they should have positive safety attitudes (WHO 2012). WHO describes patients' safety as a Health Care discipline that emerged with the evolving complexity in the healthcare system and the resulting rise of patients harm in healthcare facilities. It further states that patients' safety is fundamental to delivering quality essential health services (WHO 2019).

According to the NDoH (2017), all health establishments should ensure that people and property are actively protected from safety and security risks. There should be a security system that safeguards the building, patients, visitors and staff. There should be adequate lighting inside and outside to protect patients, visitors and staff. All security incidences should be reported and addressed. Safety and security awareness should be promoted among staff members. Security guards should be designated for specific areas.

2.4.5. Infection Prevention and Control

Controlling the spread of disease and minimizing the number of healthcare-associated infections are primary concerns of any healthcare facility. There are elements in the environment of a healthcare facility that could facilitate the development and spread of infectious diseases. NDoH (2017) indicated that

everything from the air in the building to the people who work there can be potential carriers of contamination. Hospital-acquired infections are a major cause of mortality and morbidity and provide a challenge to clinicians.

Infection control is a series of steps that healthcare facilities and hospitals take to prevent the spread of infectious diseases. It is estimated that approximately 1.7 million preventable illnesses are spread each year. To prevent the further spreading of disease, steps that many facilities take include; hand hygiene compliance, tracking staff contacts with assets and patients and ensuring appropriate environmental conditions for medication, vaccines, and biological material (NDoH 2011).

According to NDoH (2011), all health establishments are expected to reduce the risk of Health Care-associated infections through ongoing monitoring and management. Policies and protocols for the prevention and management of infections should be available and implemented. There should be officers who are appropriately trained to monitor infections in the health establishments. Protective clothing for staff and patients should be made available, infection surveillance data should be routinely collected, analysed and used. Furthermore, NDoH (2011) stated that Nosocomial infections outbreaks should be investigated and reported. Ongoing hand hygiene improvement interventions should be in place. Proper Waste Management at all times and ensure that waste is protected from theft, vandalism and scavenging.

2.4.6. Availability of Basic Medications and Supplies

The World Health Organization (WHO) defines essential medicines as a medicine that satisfies the needs of the majority of the population and therefore should be available at all times, in adequate amounts, inappropriate dosage forms and at a price the individual and community can afford (WHO 2013). Health Care consumers see availability of medicines as the most important element of quality. The provision of affordable, high quality and appropriate essential medicines is a vital component of a well-functioning health system, however, providing universal access to essential medicines is a major challenge in low and middle-income countries (WHO 2014).

An article published by Shankar Prinja, Pankaj, Bahuguna and Rajesh Kumar on the availability of medicines in Public Sector health facilities of North Indian States carried

out in 80 Public Health Facilities across 12 districts in Haryana and Punjab indicates the overall availability of medicines at 45% and 51.1% in Punjab and Haryana respectively, which is well below the WHO standards of 80% (WHO 2014). Access to free of cost essential medicines was a critical component of universal health coverage in India. It was considered a key intervention in the Government of India's proposed National Health Assurance Mission (NHAM) (2014). Ensuring the availability of free essential medicines in India significantly reduced the burden on private expenditure. World Health Organization has indicated that India had limited or no access to essential medicines. Studies show that almost 68% of the people in India have limited or no access to essential medicines (WHO 2014).

Poor availability of medicines in India has affected many households and pushed them out of pocket with expenditure. Unavailability of medicines in India was also found to be the major reason for dissatisfaction among patients, lack of supplies affected negatively upon the staff morale through community pressures (WHO 2014).

A study conducted in Kenya also shows the unavailability of certain essential medicines in Public Health Care facilities. The study found out that majority of the essential medicines were out of stock for a month. Inadequate funding was found to be the major causal factor (WHO 2016). Studies also show that the availability of essential medicines in Malawi is generally higher in the private for-profit and non-profit sectors than in the Public Sector. This goes hand in hand with studies in a range of other developing countries where the availability of medicines in the Private sector was usually the highest (Ewen, Zweekhost, Regeer & Laing, 2017).

The National Department of Health in South Africa has highlighted the fact that the Health Care landscape in South Africa has changed since the establishment of the country's new democratic government in 1994 and the subsequent adoption of the National Drug Policy (NDP) for SA, published in 1996 (NDoH 2012). However, a study conducted in South Africa in four provinces on the availability of essential medicines for South Africa – an analysis of in-depth interviews with national essential medicines has shown that the availability of medicine is still a challenge. The provinces included Gauteng, Kwa Zulu- Natal, Eastern Cape and Western Cape. These are the provinces that are considered to be densely populated and are still

experiencing shortages of medicines (Rampamba, Meyer, Helberg & Godman, 2017).

A study conducted in India by Zarocostas (2017) highlighted that improving the availability and accessibility of medicines indicated challenges concerning availability of medicines in India. Public health infrastructures were experiencing a gross shortage of medicinal supplies in India even though India's pharmaceutical sector was the third-largest producer in the world in terms of volume and 14th in terms of value (Zarocostas, 2017).

An inspection conducted by Public Service Commission in South Africa to three provinces, namely, Free State, North West and Western Cape showed a shortage of medicines as one of the challenges identified (NDoH 2011). Health establishments should ensure that medicines as per the relevant Essential Pain Killer List (EDL) are available 90% of the time. Appropriate medicines are available as prescribed. There should be a locally- determined maximum waiting time for acute and chronic patients. Patients should be able to obtain their medicines from a pharmacy or provider within an acceptable period (NDoH 2011).

Furthermore, Zarocostas (2017) indicated that Public health infrastructures were experiencing a gross shortage of medicinal supplies in India even though India's pharmaceutical sector was the third-largest producer in the world in terms of volume and 14th in terms of value. An inspection conducted by Public Service Commission in South Africa to three provinces, namely, Free State, North West and Western Cape showed a shortage of medicines as one of the challenges identified (NDoH 2011). Health establishments should ensure that medicines as per the relevant Essential Drug List (EDL) are available 90% of the time. Appropriate medicines are available as prescribed. There should be a locally-determined maximum waiting time for acute and chronic patients. Patients should be able to obtain their medicines from a pharmacy or provider within an acceptable period (NDoH 2011).

Shortage of essential medicines is a daily occurrence in many of South African's Public Health Facilities. While the National Department of Health is committed to improving access to medicines, the procurement and distribution of medical supplies

remain inadequate in many health districts. A national Audit published by Health Systems Trust (HST) of healthcare facilities' compliance with key priorities included a measure on the availability of medicines and supplies.

The Eastern Cape Province's compliance score for this was 54% in 2012. The audit also found an extremely high failure percentage (77%) in clinics for the measure "Tracer medicines as per applicable EDL or formulary available in the pharmacy (Visser et al., 2012). The findings were that stock-outs arise from the inability to manage medical supplies, report shortages, and act swiftly and effectively to prevent their occurrence. Stock-outs were intertwined with other challenges in the health sector such as shortages of Healthcare Workers, inadequate training, weak oversight and management and inadequate monitoring and evaluation of clinic data (Visser et al., 2012).

2.5. A Training Programme

Booyens (2010) states that employees of a Health Care institution are the most valuable asset, and the quality of patient care rendered by the staff can be directly related to their knowledge and skills. The organization that invests in the continuous development of staff is rewarded with better patients' outcomes and better-motivated staff who will perform to the best of their ability. Training is done to develop personnel, their knowledge, skills and attitudes and their personal growth and fulfilment (Booyens, 2010).

The development of the training programme will be based on the theory of Dickoff et al., (1968) Practice-Orientated Theory, which consists of related activities that will be adopted in developing the conceptual framework. Knowles' Adult Education Theory will be used as a theoretical framework to develop a training programme for Professional Nurses. The Practice-Orientated Theory of Dickoff et al., (1968) consists of components that apply to the development of the training programme for Health Care facilities. The theory of Dickoff et al., (1968) Practice-Orientated Theory is discussed in detail in Chapter 4 of this study.

2.5.1. Programme Development Process

The process of developing the training programme was based on the theories of Dickoff et al., (1968) and Malcolm Knowles.

2.5.2. The Importance of Training

Rodriquez and Walters (2019 state that employee performance affect the bottom line forces of an organization therefore it is imperative that managers recognize the importance of training and development in an organization. They further reiterated that training and development affect the performance and evaluation of employees and assist the organization and employees in attaining diverse goals, such as improving morale, sense of security, employee engagement, and overall competencies necessary to perform a particular job. Mwena and Gachunga (2014) added by saying employees are the backbone of the organization and issues experienced by the organization are contingent on the performance of its employees. The authors further stressed that the enhanced capabilities, knowledge, and skills of the employees are the foundation for the organization's competitive advantage in today's global market.

Every organization aspire to be successful by meeting its goals. This can be achieved by investing in employees' performance. Jehanzeb and Bashir (2013) added by saying that employees can positively influence organizational outcomes if they are trained. Training is an organized activity aimed at imparting information and or instructions to improve the recipient's performance or help to attain a required level of knowledge or skills. It is also described as planned and systematic activity, which are focused on enhancing the level of skills, knowledge, and competency (Nassazi, 2013). It is a process of conveying essential skills and programme behaviour, which makes the individuals, become aware of rules and procedures to guide their behaviour to accomplish their job effectively.

2.5.3. Approaches to Training and Development.

Nassazi (2013) identifies three different levels for identifying training needs in an organization, namely, a strategic level, the tactical level, and an operational level. Senior leaders based on organizational goals, mission and strategy identify training needs that occur at the strategic level. Middle management is also responsible for

identifying the training needs at the tactical level with the cooperation of other Line Managers, while at the operational level leaders at lower levels identify the training needs. Leaders are also responsible for selecting the best methods, approaches, strategies, programs, implementation, and assessment venues to achieve expected individual performance and organizational results (Nassazi, 2013).

Nassazi (2013) identified three categories of identifying employee training and development needs:

- Resolving problems that are focused on individual performance.
- Continuous improvement of working practices regardless of individual performance issues.
- Renewing the organization through innovation and strategic changes.

2.5.4. Benefits of Training and Development

Employees' Benefits

- Increases employee morale, confidence and motivation.
- It lowers production costs because individuals can reduce waste.
- It promotes a sense of security, which, in turn, reduces turnover and absenteeism.
- It increases employees' involvement in the change process by providing the competencies necessary to adjust to new and challenging situations.
- It opens doors for recognition, higher pay and promotion.
- It helps the organization in improving the availability and quality of its staff. (Nassazi, 2013).

Organizational Benefits

- Training and development programs assist organizations in staying competitive in the marketplace.
- Training and development help organizations in retaining their talents differentiate themselves against other organizations, improve their appearance as the best employer in the job market, and increase the overall organizational effectiveness (Nassazi, 2013).

2.5.5. Approaches Used in the Employee Training and Development Arena

- Problem-centred, which is focusing on analysing and resolving performance, issues due to insufficient skills;
- Profile comparison is used to match the competencies with the new or existing job filled;
- Formal training and development programmes which is a pre-planned approach, which includes performance evaluations and learning solutions that may be completed during work or off work for a specific duration of time;
- On-the-job training is provided to individuals while performing their work in the same working venues such as job rotations, job transfers, coaching and mentoring;
- Off-the-job training involves taking individuals away from their workplace so they can concentrate on training;
- Coaching and mentoring are focused on developing particular skills for the task and performance expectations in the workplace;
- Job rotation and transfers are focused on moving individuals from one responsibility to another one to acquire knowledge about diverse operations;
- Orientation is focused on getting new employees familiarized and trained on the new roles, responsibilities, systems, technology, workplace layout, culture, benefits, working conditions, processes, and procedures;
- Conferences include presentations on the same or diverse topics at hand.
- Role-playing is where individuals are provided with minimal, stress-free work scenarios, roles, responsibilities, issues, objectives, emotions and other information to enhance their decision-making skills; and
    - Career planning and goal setting being used to assist individuals in managing the diverse stages of their professional lives by classifying work, priorities, and skills necessary for promotion or particular goals. (Jehanzeb & Bashir, 2013)

Training and development is a vital tools used to maximize the performance of employees and help them in becoming more efficient, productive, satisfied, motivated and innovative in the workplace (Elnaga & Imran, 2013). Employees are the most

valuable asset of the organization. Without proper training and development opportunities, they will not be able to accomplish their task at their full potential.

2.6. Conclusion

This chapter provided the literature review on the provision of quality health service in South Africa and other countries and the miles' stones achieved in the stride to provide quality service, including various commissions conducted to monitor quality health services, Ministerial Priorities and guidelines on the development of a training programme. There seemed to be a knowledge gap regarding progress made in the implementation of the Ministerial Priorities.

CHAPTER 3
RESEARCH METHODOLOGY

3.1 Introduction

This chapter discussed the research methodology, the mixed methods research and the rationale for the selection of the mixed-method approach.

3.2. Mixed Method Research

The term mixed method "refers to an emergent methodology of research that advances the systematic integration, or "mixing" of quantitative and qualitative data within a single investigation or sustained program of inquiry. The basic premise of this methodology was that such an integration permits a more complete and synergistic utilization of data than separate quantitative and qualitative data collection and analysis (Creswell, Plano & Clark, 2011).

3.2.1. Characteristics of a Mixed Method

- Collecting data and analysing both quantitative (close-ended) and qualitative (open-ended) data.
- Using rigorous procedures in collecting and analysing data appropriate to each method's tradition, such as ensuring the appropriate sample size for quantitative and qualitative analysis.
- Integrating the data during data collection, analysis and discussion.
- Using procedures that implement qualitative and quantitative components concurrently or sequentially, either with the same sample or with different samples.
- Framing the procedures within philosophical/theoretical models of research, such as within a Social Constructionist Model that seeks to understand multiple perspectives on a single issue.

(Creswell et al., 2011)

3.2.2 The Rationale for Conducting a Mixed Methods Research

This design allowed the researcher to qualitatively analyse the data and also obtained statistical and quantitate results, taking advantage of the strength of each and enabling confirmation, corroboration and cross-validation of the findings of the study.

Plano-Clark et al., (2010) and Creswell (2009) affirmed that the rationale for conducting the Sequential Mixed Methods research was to complement, converge or triangulate broad numeric trends from quantitative research and the specific details from qualitative research.

3.3 Adopted Mixed Methods Research

The researcher adopted a mixed methods research in a single study because the researcher opted to develop proficiency and competency in both qualitative and quantitative methods.

Sequential Exploratory Mixed Method Design

The study was conducted in two phases, depicted as follows:

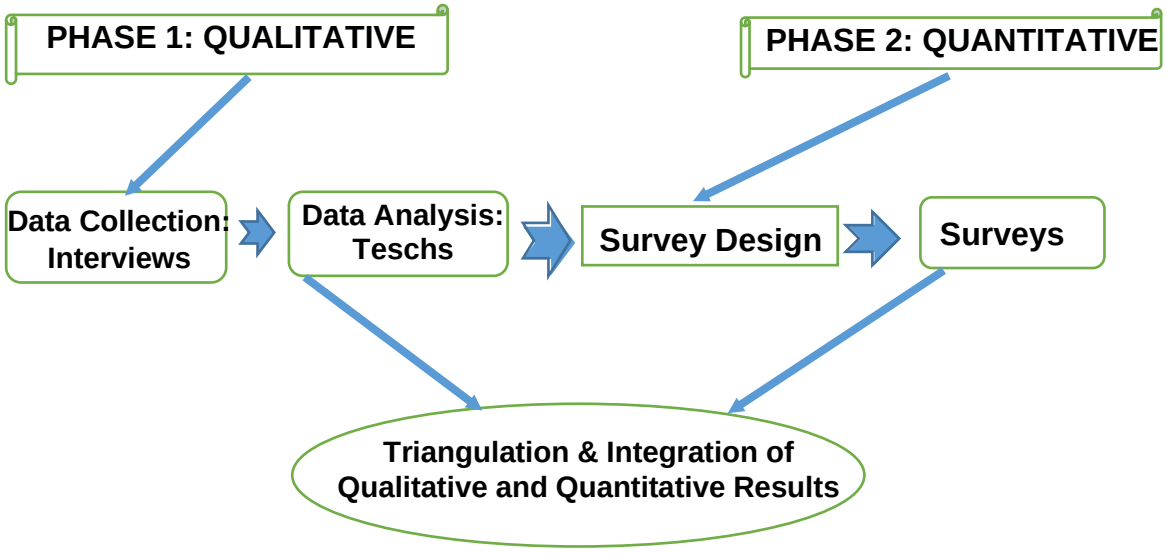

Figure 3.1: Exploratory Sequential Mixed Method Approach

Figure 3.1 depicts the schematic representation of the exploratory sequential research mixed method that the researcher adopted for this research study. A Sequential Exploratory Mixed-Method Design was chosen for this research study. The Sequential Exploratory Mixed Method design is characterised by the collection and analysis of qualitative data in the first phase followed by a collection of quantitative data in the second phase. The two phases were given equal priority and more time involved in data collection with the two separate phases (Teddlie &

Tashakkori, 2010). The chosen design was believed to be capable of providing answers to the research question.

3.4.1. Purpose of Sequential Exploratory Design

The purpose of choosing this sequential exploratory mixed method design was to develop a training program for Professional Nurses to enable them to facilitate the implementation of the Ministerial Priorities.

- Collection and analysis of qualitative data from Professional Nurses followed by the development of quantitative data collection questionnaire, collection and analysis of data.

3.4.2. Rationale for Conducting Sequential Exploratory Mixed Methods Research

The researcher's rationale for conducting Sequential Mixed Method research was to complement each other and to increase its objectivity. It also made it possible for the researcher to confirm, cross-validate and corroborate the qualitative and quantitative findings of the study. The researcher gained a comprehensive, in-depth understanding of the phenomenon of the facilitation and implementation of the Ministerial Priorities. Firstly, the qualitative analysis of narratives of Professional Nurses followed by a quantitative analysis of numeric data was done.

3.5 Research Setting

Limpopo Province is located in the northern part of the Republic of South Africa and shares borders with three neighbouring countries: Botswana, Zimbabwe and Mozambique. South Africa is known as the gateway to other African countries. The province consists of five districts, namely, Capricorn, Sekhukhune, Waterberg, Mopani and Vhembe Districts. Five Health Care facilities were selected from Limpopo to participate in the study.

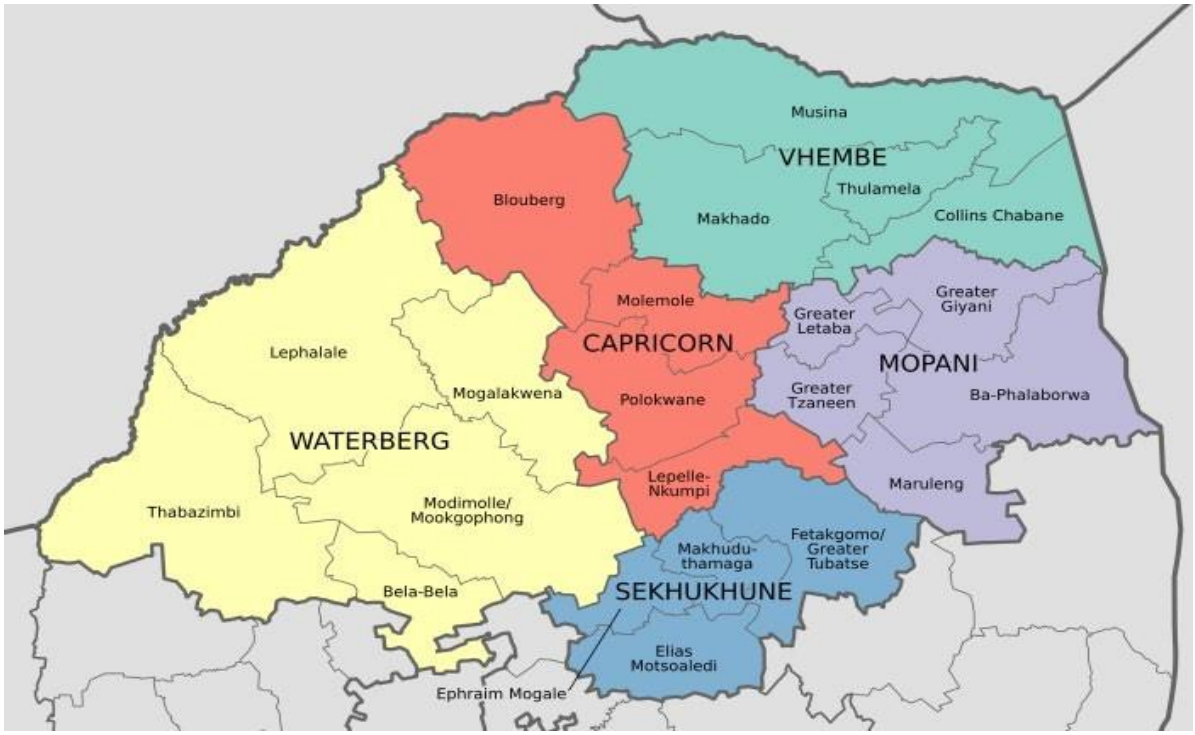

Figure 3.2. Map of Five Districts of Limpopo Province
(Source: https:// municipalities.co.za/provinces/view/5/Limpopo)

Figure 3.2 shows the map of five districts of Limpopo Province in which the participating hospitals are located.

3.6 Research Design

LoBiondo-Wood and Haber (2014) define research design as a blueprint for conducting. The blueprints guided the planning and implementation of a study in such a manner that the intended goal can be achieved (Burns & Grove, 2009).

3.6.1. Phase 1: Qualitative Phase

A qualitative phenomenological explorative contextual research design was used to explore and describe the knowledge and practices of the Professional Nurses in the facilitation of the implementation of the 6 Ministerial Priorities in the selected hospitals of the Limpopo Province. The phenomenological research assisted the researcher to describe the lived experiences of the phenomenon from the point of view of the research Professional Nurses (Streubert & Carpenter, 2011).

A qualitative design was the first phase of the research. The researcher chose to start with qualitative design. This was done to acquire a better understanding of Professional Nurses' lifestyle behaviour, lived experiences, knowledge, feelings, attitudes, opinions and values regarding the implementation of the 6 Ministerial Priorities through explorations, in-depth and first-hand experience, truthful reporting and quotations of actual conversations in a natural setting.

Babbie and Mouton (2009) define the qualitative research method as "in-depth contextual research aimed at gaining insight into the world and lived experiences of a small sample of people. Qualitative research seeks to answer questions that stress how social experience is created. Qualitative research is used when little used when little is known about the phenomenon, and it is an approach in which procedures are not strictly formalized, where the scope is more likely to be undefined. Creswell (2009) further stated that qualitative research aims to acquire a better understanding through first-hand experience, truthful reporting and quotations of actual conversations and understand how participants derive meaning from their surroundings and how their meaning influences that behaviour.

In the context of this research, qualitative design enabled the researcher to describe events as accurately as possible as they occurred in the participant's concrete natural context. Furthermore, it helped the researcher to gain a deep understanding and generate data about human groups in social settings and the meaning that emerged from the participants. The researcher listened to Professional Nurses in their working environment allowing them to share their experiences and perceptions, knowledge and practices regarding the implementation of the 6 Ministerial Priorities. Each design was discussed in the following paragraphs, namely, descriptive, explorative, phenomenological and contextual designs.

3.6.1.1. Purpose of the Qualitative Phase

The purpose of using a qualitative phase was to provide insights into people's lifestyle behaviour, lived experiences, knowledge, feelings, attitudes, opinions and values, through explorations, in-depth and in smaller groups of participants in a natural setting.

3.6.1.2. Objectives of the Qualitative Phase

The objectives of the qualitative phase were to:

- Explore and describe the experiences of the Professional Nurses on the implementation of the 6 Ministerial Priorities in the selected Health Care facilities in Limpopo; and
- Describe the knowledge and practices of Professional Nurses on the implementation of the 6 Ministerial Priorities in the selected hospitals of Limpopo Province.

Research Design

An exploratory sequential design was used in this study. This research design had three stages. The first stage entailed the collection and analysis of qualitative data. Based on the qualitative results, the researcher engaged in a second stage, the quantitative phase, to test and make the general view of the initial findings. The researcher then interpreted the results (Creswell, 2013).

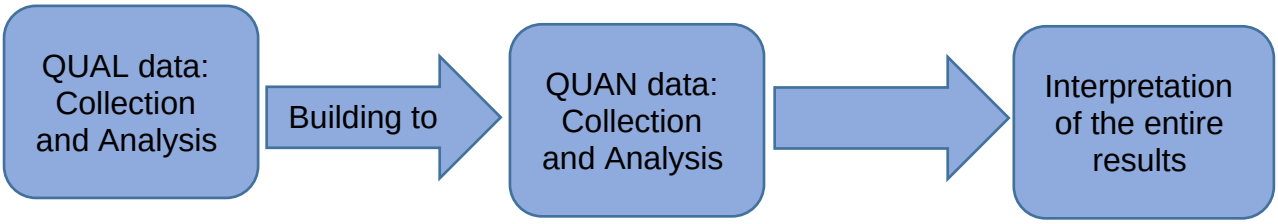

Figure 3.3: Schematic Representation of Exploratory Sequential Design (Exploratory Mixed Methods design)
(Source: Adapted from Creswell & Plano Clark, 2007)

3.6.1.3. Descriptive Design

A descriptive design is a method that yields findings based on conversations and observations (Creswell, 2015). The purpose of which was to provide a picture of a situation as it naturally happened, to determine what others in similar situations are doing (Burns & Grove, 2009). The important element of descriptive studies is the researcher's goal of describing what, existed as accurately as possible. Descriptive design allowed the researcher to describe the lived experiences of Professional Nurses concerning the implementation of the Ministerial Priorities in the selected public hospitals as they narrated.

3.6.1.4. Exploratory Design

The exploratory design was used in this study to gain insight into and an understanding of the facilitation and implementation of the 6 Ministerial Priorities by Professional Nurses in the selected Health Care facilities of Limpopo Province. Exploratory research aimed to establish the facts, gather new data, determine whether there were new patterns in the data and gain new insights about the phenomenon under study (Babbie & Mouton, 2009)

3.6.1.5. Phenomenological Design

A phenomenology is an approach to qualitative research that focuses on the commonality of a lived experience within a particular group. The fundamental goal of the approach is to arrive at a description of the nature of a particular phenomenon (Creswell, 2013). The phenomenological design is an inductive, descriptive and interpretative approach that is appropriately used when the purpose is to understand and describe the subjective perspective of an individual's experience and behaviour (LoBiondo-Wood & Haber, 2010).

The purpose of phenomenology is to develop an understanding of phenomena or events through human experience. Thus the lived experiences of Professional Nurses in the Health Care facilities regarding the facilitation and implementation of the 6 Ministerial Priorities were explored, described and studied in-depth. The Professional Nurses narrated their experiences regarding the implementation of the 6 Ministerial Priorities. The researcher used bracketing and intuition. Bracketing occurred when the researcher suspended what was known about the implementation of the 6 Ministerial Priorities by excluding preconceived ideas.

The researcher identified what was expected to be discovered and deliberately bracketed out any preconceived ideas and considered every available perspective (Hammock, 2009). Maxwell (2013) argues that bracketing is used by the researcher to document personal experiences with the subject to help remove him or herself from the process.

3.6.1.6. Contextual Design

Qualitative research is contextual due to the unique defined context of the real event. Contextual research is used when exploring the context of the usage of a product or service or cultural context. It is applied when the user's tasks are involving other people or processes, which need to be observed to fully understand the user's needs and goals (Hotzblatt et al., 2017). This means that the research is valid within a certain time, space and value context. The implications of in contextualising engender a style of research in which the meanings that participants ascribed to their own and other's behaviour, have to be set in a context of values, practices and underlying structures of the appropriate entity, as well as multiple perceptions that pervade that entity (Ross, 2012).

In this study, a training programme was developed for Professional Nurses to facilitate the implementation of the 6 Ministerial Priorities effectively. The training programme was founded on the experiences and perceptions that were explored and described by Professional Nurses in the selected Health Care facilities of Limpopo Province. The study was conducted within the context of Limpopo in South African Health Care facilities with Professional Nurses whose profession is founded and guided by the ethical and legal framework governing the practice.

3.6.1.7. Population

The population for this study was Professional Nurses working in the selected Health Care facilities of the Limpopo and are implementing the 6 Ministerial Priorities.

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3.6.1.8. Sampling

Sampling means the process of selecting a portion or subset of the designated population to represent the entire population so that inferences about the population can be made (Polit & Beck, 2012). The sampling strategy that was used in this study was Purposive Sampling. A sample comprises elements or subset of a population for actual inclusion in the study (de Vos et al., 2011). Twenty Professional Nurses were selected from each hospital. Purposive Sampling was used to select the participants who were included in the study. The researcher requested Professional Nurses who were facilitating the implementation of the 6 Ministerial Priorities to participate in the study.

3.6.1.9. Data Collection

The data collection process involves the gathering of the information required to address the research problem (Polit & Beck, 2012). The data collection method employed in this study was semi-structured one-to-one in-depth interviews. A tape recorder was used and field notes were taken. Professional Nurses who were working in the selected Health Care facilities and willing to participate in the study were interviewed. The central question for the study during the interview was: Please tell me your perception and your knowledge of the implementation of the 6 Ministerial Priorities in your health facility. Prior to conducting the semi-structured interviews, the researcher explained the purpose of the interview to the Professional Nurses. Informed consent was obtained from each participant. Interviews were conducted from June to July 2021. The interview sessions lasted between 30 to 45 minutes and were conducted until data were saturated.

3.6.1.10. Semi-Structured One-to-One Interviews

A semi-structured one-to-one interview is referred to as an in-depth interview of the participant by the researcher. It allowed the researcher and participants to explore the topic under discussion. It was also used to determine individual Professional Nurses' opinions, facts, forecast, and reactions to initial findings and potential solutions.

The researcher used semi-structured one-to-one interviews to elicit information to achieve an understanding of the Professional Nurses' point of view or situation (de Vos et al., 2012). The sitting arrangement allowed for two-way communication. The private rooms were utilized for interviews. The central question was asked to the Professional Nurses, followed by probing questions that encouraged Professional Nurses to elaborate more and clarify their experiences about their experiences, perceptions and their knowledge of the implementation of the 6 Ministerial Priorities. The English language was used during the interviews with all Professional Nurses.

3.6.1.11. Interview Guide

The researcher prepared an Interview guide, which contained the central question and probing questions (see Appendix F) to guide the conversation. When responses lacked sufficient detail, depth, or clarity, the interviewer puts out a probe to complete

or clarify the answer or request further examples and evidence. Follow-up questions were pursued and follow up made to the implications of answers to the main questions.

3.6.1.12. Piloting

A Pilot study is the first step of the entire research protocol and is often a smaller sized study assisting in the planning and modification of the main study (Arnold et al., 2009; and Thabane et al., 2010). A pilot study is performed reflecting all the procedures of the main study and validates the feasibility of the study by assessing the inclusion and exclusion criteria of the participants and testing the instruments used for measurement in the study (Benger et al., 2016). The researcher used a small number of Professional Nurses who possessed homogenous characteristics to the research population to test the questionnaire before being used in the main study. The interview guide was piloted at one of the Health Care facilities with 10 Professional Nurses. This allowed the researcher to come to grips with some practical aspects of establishing access, making contact and conducting the semi-structured interviews, as well as becoming alert to their level of interviewing skills.

3.6.1.13. Number of Participants

The number of participants was not determined before the interviews. Data were collected until saturation was reached, that is until when no new information was no longer collected**.**

3.6.1.14. Conducting the Interview

The researcher introduced herself to guide active participants through the open terrain of their experience. The researcher confirmed once again the general purpose of the research and the role that the interview plays in the research. The participants were informed about the time required for the interview. The Professional Nurses were assured that their information would be treated confidentially.

The researcher explained how the responses would be recorded and obtained permission for tape recording. The signing of the voluntary Consent Forms was finalized. Professional Nurses were informed that if they wished to withdraw at any time, they were free to do so. A referral system was available should the interview

cause any discomfort. Rapport was established by attentive listening and showing interest.

The researcher showed respect for what the Professional Nurses said. The Professional Nurses were allowed to finish what they were saying and were allowed to proceed at their own pace and rate of thinking and speaking. The researcher was neither objective nor detached but engaged. A balance between flexibility and consistency was maintained. Flexibility for discovery and eliciting the participants' stories. Consistency was applied in the type of questions asked. The tape recorder was used to capture the interviews. The central question asked was *"Please tell me about your experiences with the implementation of the 6 Ministerial Priorities in your facility"*. This was followed by a probing question to tell more about her experiences. The interviews were conducted in a private room to prevent any distractions and disturbances.

The duration of the interview was ranging between 30 minutes to 45 minutes for each Professional Nurse. The interview was not ended abruptly rather it was allowed to wind down. The researcher summarized the major points and asked the participants if they had any questions. The Professional Nurses were given contact details of the researcher should they want to contact the researcher. Professional Nurses were interviewed until data was saturated. The researcher thanked the Professional Nurses for their availability and participation.

3.7. Data Analysis

The transformation and Data Analysis of raw data and the phenomenon under study was carried out using Tesch's eight steps of a systemic process of analysing verbatim data, to assist the researcher in shaping and reducing data collected by the researcher as cited in Creswell (2009); and Polit and Beck (2008). The Data Analysis method used involved the following steps:

Tesch's Eight Steps of Data Analysis:

- Data were prepared;
- The unit of analysis was defined;
- Categories and a coding Scheme were developed;

- The coding scheme on the sample was tested;
- All the text was coded;
- Coding consistency was assessed;
- Conclusions were drawn from the coded data; and
- Methods and findings were reported.

3.8. Measures to Ensure Trustworthiness

Trustworthiness refers to the ability of the researcher to convince themselves, the participant and the reader that the findings of the enquiry are trustworthy as outlined (Polit & Hungler, 2008). Qualitative research is trustworthy when it accurately represents the experiences of the studied participants and not the researchers' bias. This was achieved by adhering to the following criteria: credibility, dependability, confirmability and transferability (Polit & Beck, 2008).

3.8.1. Credibility

Credibility refers to the confidence in the truth of the data and interpretation of them (Polit & Hungler, 2008). Thomas and Magilvy (2011) refer to credibility as an element of a study that allows others to recognize the experiences contained within the study within the study through the interpretation of participants' experiences. Credibility was ensured by doing the following:

- Prolonged engagement between the investigator and the participants for both to gain adequate understanding and establish a relationship of trust between the parties;
- Purposive Sampling of individuals to serve as informants;
- Triangulation, which involved the use of different methods, especially observation, and individual interviews, maintenance of field notes, which formed the major data collection strategies for qualitative research;
- Participants were encouraged to be frank from the outset of each session;
- Peer scrutiny of the research project by consultation with the supervisor;
- An independent Coder was consulted and the transcripts, themes and subthemes were submitted for coding; and

- Background, qualification and experience of the investigator are important in qualitative research as the major instrument of data collection and analysis

3.8.2 Dependability

Dependability in research is determined by the extent to which the study is consistent in its enquiry process that includes the techniques used in data collection, findings of the study, interpretations and recommendations of the study (Polit & Beck, 2012). Dependability also seeks evidence that indicates the research process used, and whether it could be replicated with the same subjects in a similar context; its findings would be similar to the research study undertaken (Babbie & Mouton, 2009). In this study, dependability was ensured as follows:

- Through the extensive description of the research methodology and the use of an independent Coder and recognized experienced qualitative researcher who independently coded a set of data and came together to reach a consensus on the emerging codes and categories;
- An independent Coder was used to verify the data. Interview notes, field notes and audio recordings will be used and kept safely for audit trail to determine acceptability and attest the study findings, interpretation and support recommendations that emanate from the study; and
- On an ongoing basis, the supervisor provided guidance and feedback on the study processes.

3.8.3. Transferability

Transferability is the criteria against which applicability is measured in a qualitative study. It is the ability to transfer findings to another similar situation (Babbie & Mouton, 2009). In this research, transferability was ensured by doing the following:

- Through a collection of detailed information, dense description of data and Purposive Sampling;
- Convenience Sampling for the selection of Health Care facilities was used as the selected hospitals already are implementing the 6 Ministerial Priorities; and
- Purposive Sampling was used to select study participants based on the judgment of the researcher.

3.8.4. Confirmability

According to Babbie and Mouton (2009), confirmability refers to the degree to which the findings are the product of the inquiry and not the biases of the researcher. The objectivity of data included an agreement between two or more people about the relevance or meaning of data.

- The research study was supervised by two supervisors and an external examiner was appointed by the University to externally assess the research report during the completion of the report (Polit & Beck, 2012);
- The research report was compiled and the research results communicated to the Department of Health and professional peers in the form of presentation of papers at a conference and the Peer-Reviewed journals;
- Voice recordings and field notes will ensure that the researcher carried out the data collection;
- The proposal, research results and the project report was presented to peers and the research committee for critiquing (Babbie & Mouton, 2009);
- The researcher maintained neutrality during the research process and the description of the research findings (Babbie & Mouton, 2009);
- The independent Coder audited trials to ensure that conclusions, interpretations and recommendations can be traced to their source, which is what the participants have said; and
- Triangulation reduced the effect of investigator bias, recognition of shortcomings in the study's methods and the potential effects, in-depth methodological description to allow the integrity of research results to be scrutinized and the use of diagrams to demonstrate the "audit trail."

3.9. Phase 2: Quantitative Strand

3.9.1 Overview of Quantitative Research Method

The quantitative design was the second part of the study. The researcher started with a qualitative study to explore the phenomenon using qualitative data before attempting to measure or test it quantitatively. The results of the first phase (qualitative) helped the researcher to develop or informed the second phase (quantitative data) (de Vos et al., 2012).

The quantitative epistemological view is that the researcher remained objective when collecting numerical data using self-developed questionnaires for Professional Nurses facilitating and implementing the 6 Ministerial Priorities. In this study, quantitative research design was used to identify and describe factors that influenced the existing implementation of the Ministerial Priorities and established relations among those factors to determine the nature of the training program developed for Professional Nurses in the Limpopo Department of Health.

3.9.2 Purpose of the Quantitative Research Method

The purpose of the quantitative phase was to identify the variables of the study and to specify how variables would be measured, related and described.

3.9.3 The Objectives of the Quantitative Research Method

- Describe the Professional Nurses' knowledge and practices in the implementation of the 6 Ministerial Priorities in the selected Health Care facilities in Limpopo Province.
- Identify the support and resources required by Professional Nurses for the effective implementation of the 6 Ministerial Priorities in the selected Health Care facilities in Limpopo Province.

3.9.4 Descriptive Research Design

A descriptive design was used to describe the identified factors that influenced the implementation of the 6 Ministerial Priorities and the relations among them. Furthermore, the design described the implementation of the 6 Ministerial Priorities in the health facilities in Limpopo. These factors were pertinent in the development of the training programme to improve the facilitation and implementation of the 6 Ministerial Priorities.

3.9.5 Population and Sampling

The term population refers to the total of all subjects that conform to a set of specifications (Polit & Beck, 2012). The population comprised 295 Professional Nurses of the five districts, namely, Capricorn, Mopani, Sekhukhune, Waterberg and Vhembe of Limpopo Province. The study population is Professional Nurses facilitating and implementing the 6 Ministerial Priorities in the selected hospitals in Limpopo Province**.**

• **Sampling**

Sampling means the process of selecting a portion or subset of the designated population to represent the entire population so that inferences about the population can be made (Polit & Beck, 2012). Simple Random Sampling was used to select participants. Simple Random Sampling ensures that everyone in the population has an equal chance of being selected in the sample (Babbie, 2013).

The sample size in all the selected hospitals was calculated using the Taro Yamane formula outlined by the Department of Sociology and Criminal Justice (2017) and was as follows:

n= *N* /1+ *N* (e)2, The *N* = Population size, n=sample size and e=error margin of 5%.

Therefore, the sample size was as follows:

Table 3:1 Sampling

No	Name of District	Name of Hospital	Number of Professional Nurses	Sample size
1.	Capricorn	Hospital 1	314	82
2.	Mopani	Hospital 2	213	56
3.	Sekhukhune	Hospital 3	154	40
4.	Waterberg	Hospital 4	137	36
5.	Vhembe	Hospital 5	308	81
	TOTAL		1126	295

Table 3.1 shows how a sample was selected indicating hospitals and the number of Professional Nurses sampled in each hospital.

3.9.5.1. The Inclusion Criteria

The study included all Professional Nurses who were working in the selected Health Care facilities and facilitating the implementation of the 6 Ministerial Priorities and were willing to participate in the study.

3.9.5.2. The Exclusion Criteria

This study excluded Professional Nurses who were working at the selected hospitals facilitating and implementing the Ministerial Priorities and were not willing to participate in the study, as well as Professional Nurses who were not working in the selected facilities as well as all other categories of nurses who are not registered as Professional Nurses.

3.9.6. Development of a Questionnaire

The questionnaire was developed based on the results of the qualitative study and was given to the statistician for verification. The questionnaire consisted of four sections, namely, Sections A, B, C and D:

Section A: Demographic Profile with eleven (11) item questions, which included age, gender and qualification.

Section B:

Consisted of questions that assessed Professional Nurses' experience regarding the 6 Ministerial Priorities, with forty-five (45) item questions.

Section C:

Consisted of questions that assessed Professional Nurses' knowledge regarding the 6 Ministerial Priorities, with fifteen (15) item questions.

Section D:

Consisted of questions that assessed nurses' perception of the importance of the implementation of the 6 Ministerial Priorities, with six (6) item questions.

The total item questions were seventy-seven (77).

3.9.7. Pilot Study

A pilot study is the first step of the entire research study in a small-sized study assisting in planning and modification of the main study. The pilot was performed reflecting all the procedures of the main study and validated the feasibility of the study by assessing the inclusion and exclusion criteria of the participants and testing the instrument used in the measurements in the study (Thabane et al., 2010).

The pilot study was carried out with a small population that possessed homogenous characteristics to the research population to test the questionnaire before being used in the main study. The pilot was conducted with a convenience sample of ten (10) Professional Nurses. Internal validity was tested by asking the Professional to give feedback on the readability and the time it took them to complete the questionnaire. The study was conducted on the 10% of the total respondents for the quantitative part of the study to pre-test the questionnaire at the selected hospitals in Limpopo Province.

Professional Nurses who participated in the pilot study were not included in the main study. Piloting of the questionnaire ensured that ambiguous questions were rectified before the main study data collection sessions started. The appropriateness of the language used was clarified. The Professional Nurses involved in the pilot study were not included in the main study.

3.9.8. Purpose of the Pilot Study

The multipronged purpose of the Pilot Study was to:

- Assess the feasibility of the main study;
- Establish the effectiveness of the recruitment of the respondents;
- Obtain information to assess and test the validity and reliability of the main study;
- Ensure clarity and operational appropriateness of questions;
- Assess if respondents understood the questions and were able to respond to all questions;
- Assess if the questions were worthy of informing the study;
- Ensure that the questions answer the aim and objectives of the study;
- Enable the researcher to refine the questionnaires should that be necessary prior to embarking on the actual data collection process; and
- Ensure that ambiguity of questions and vague questions could be rectified before the main study.

3.9.10. Results of the Pilot Study

The results of the Pilot Study Post analysis were the following:

- The questionnaires were readable;

- Time taken to complete the questionnaire was 30- 45 minutes and the time was not adjusted; and
- There were no typing errors.

3.9.11. Data Collection

Data were collected using a structured questionnaire based on the results of the qualitative study. A structured questionnaire is a document containing questions designed to solicit information appropriate for analysis, which was used to develop a training program for the Professional Nurses to facilitate the implementation of the 6 Ministerial Priorities in the Health Care facilities (Babbie, 2013).

3.9.11.1. Preparation for Data Collection

The researcher wrote a letter to the CEO of all the selected Health Care facilities to request permission to conduct the study in the facility, the approval granted by the head of the department, as well as the research proposal was attached. The letter was followed up by a telephone. A date was granted telephonically.

3.9.11.2. Procedure for Data Collection

The researcher went to the selected Health Care facilities and met with the nurse manager who released all Professional Nurses who were willing to participate in the study. The researcher presented the approval granted by the Department of Health to the Professional Nurses and introduced the study, aims and objectives to the Professional Nurses. The Professional Nurses were also informed about the benefits of participating in the study, confidentiality was assured and voluntary participation. The questionnaires were distributed to the Professional Nurses for completion. After completion of the questionnaires, they were given to the researcher. The questionnaires took about 20 to 30 minutes to be completed. A total of 295 questionnaires were completed by Professional Nurses at different facilities and returned to the researcher.

3.9.11.3. Description of the Questionnaires

Appendix B: Consisted of Sections A, B, C and D.

Section A

Section A was for the demographic profile of Professional Nurses, which included the following:

A 1: Age

The ages ranged from 22-35, 36-45, 46-55 and 55-65 years.

A2: Sex:

Female or Male

A3: The highest level of qualification

Highest qualification included the following:

- Diploma in General Nursing and Midwifery;
- Diploma in general Nursing, Midwifery, Community and Psychiatric nursing;
- BA Cure;
- Masters in Nursing Science; and
- Doctor of Nursing Science.

Section B

Section B consists of questions assessing Professional Nurses' experience regarding the 6 Ministerial Priorities in the selected hospitals. The questions were closed-ended. They were 45 in number. There were questions on all Ministerial Priorities. The response expected was "Yes", "No" and "Partial". The Professional Nurses were requested to indicate if they were agreeing with the statements indicated.

Section C

Section C assessed the Professional Nurses' knowledge regarding the 6 Ministerial Priorities in the selected hospitals. The questions were closed-ended. The section consisted of 5 points Likert scale of 15 close-ended questions. The Professional Nurses were requested to indicate the extent to which they agreed with each statement.

Section D

Section D assessed Professional Nurses' perception of the importance of the implementation of the 6 Ministerial Priorities in the selected hospital of Limpopo Province Department of Health. The questions were 6 in number on a 4-point Likert scale. The Professional Nurses were expected to indicate if the implementation of the Ministerial Priorities was very important, important, partially important and not important.

3.9.12. Data Analysis

The quantitative data were analysed using *Statistical Package for the Social Sciences* (SPSS) Version 25. The statistical procedure enabled the researcher to organize, evaluate, interpret, summarize and communicate numeric information. Data Analysis was done using descriptive and inferential statistical procedures to facilitate impartial interpretation of the findings (Tashakkori & Newman, 2010). Descriptive statistics included frequency distributions which was presented as tables, graphs, bar charts and histograms, range, variance, means and standard deviation as measures of variability was performed to describe how widespread values were in a distribution, and Chi-Square and cross-tabulation table as measures of relationship was done to determine the nature and extent of the relationship between variables.

3.9.12.1. Validity

Validity is defined by Babbie (2013) as a quality measurement method that suggests that the same data would have been collected each time in repeated observations of the same phenomenon. Furthermore, Leedy (2010) explains the validity of a measurement instrument as the extent to which the instrument measures what it is intended to measure. Validity takes different forms, each of which is important in different situations, namely:

- **Face Validity**

Face Validity is the quality of an indicator that makes it easy to measure a variable (Babbie, 2013). It is an extent to which, on the surface, an instrument looks like it is measuring a particular characteristic. Face validity is often useful for ensuring the cooperation of people who are participating in a research study (Leedy, 2010). The researcher ensured validity by getting some of the colleagues in the research and the

supervisor to test-run the instrument to see if the questions appear to be relevant, clear and unambiguous.

- **Content Validity**

According to Leedy et al. (2010), content validity is the extent to which a measurement instrument is a representative sample of the content area (domain) being measured. He further asserts that content validity is often a consideration when a researcher wants to assess people's achievements in some area. Content validity looks at whether the instrument adequately covers all the content that it should concerning the variables. In other words, does the instrument cover the entire domain related to the variables or construct it was designed to measure? (Polit & Beck, 2010) Content validity was ensured through the literature review and by giving the questionnaire to the supervisor and biostatistician to check if the instrument covered all aspects under study.

- **Construct validity**

Construct validity is defined as the degree to which the instrument measures a characteristic that cannot be directly observed but is assumed to exist based on patterns in people's behaviour, such a characteristic is a construct (Leedy & Ormrod, 2010). Construct validity was ensured by making sure that different kinds of meanings are relevant to the participants in their natural environment and by grounding the measures in a wide literature search that outlines the meanings of the construct and its elements.

- **Criterion-related validity**

Criterion validity is the extent to which the results of an assessment instrument correlate with another, presumably related measure (Leedy et al., 2010). Criterion-related validity is sometimes referred to as predictive validity and is grounded on some external criterion (Babbie, 2013). Criterion-related validity was ensured by adhering to the inclusion criteria.

3.9.12.2. Reliability

Reliability of a measurement instrument is the extent to which the instrument yields consistent results when the characteristics being measured have not changed. Like validity, reliability also takes different forms in different situations (Leedy et al., 2010). In this study, reliability was ensured by conducting a pilot study to pre-test the questionnaires so that vague questions and statements could be attended to.

According to Leedy et al. (2010), the following are several forms of reliability that are frequently of interest in research studies, namely:

- **Interrater reliability**

Interrater reliability is the extent to which two or more individuals evaluating the same product or performance give identical judgement.

- **Internal consistency reliability**

Internal consistency reliability is the extent to which all the items within a single instrument yield similar results

- **Equivalent forms reliability**

Equivalent forms reliability is the extent to which two different versions of the same instrument (e.g., “form A and Form B” of a scholastic aptitude test) yield similar results.

- **Test-retest reliability**

Test-retest reliability is the extent to which a single instrument yields the same results for the same people on two different occasions.

3.9.12.3. Data Interpretative Integration

Findings of qualitative analysis were used to develop the questionnaires for the quantitative phase of the study. Qualitative data were collected through semi structured individual interviews of 20 Professional Nurses from the selected hospitals. Data were captured employing audiotapes and field notes. This enabled the researcher to examine the data. The data provided a complete picture of the world of the Professional Nurses who were facilitating and implementing 6 Ministerial Priorities. The Phenomenological Approach was used for the qualitative section. The

goal of qualitative was to describe the world as experienced by Professional Nurses and to interpret and understand rather than to observe and explain. Two hundred and Ninety-five (295) Professional Nurses from the selected Health Care facilities of Limpopo Province completed quantitative questionnaires. The response rate was 100%, which was viewed as very good. Quantitative Data Analysis was done using Statistical Package for Social Sciences (SPSS) version 25.

The results from both qualitative and quantitative research were summarised and interpreted (Creswell, 2011). Based on the results the training programme was developed.

3.9.12.4. Data Analysis

All quantitative data were analysed using SPSS descriptive statistics to identify the percentages of respondents who agreed or disagreed with statements that were given.

3.10. Phase 3: Development of the Training Program

During this phase, the training program was developed using Dickoff, James and Wiedenbach (1968) framework for the facilitation of the implementation of the Six Ministerial Priorities for hospitals in Limpopo Province. The program was based on the data collected and analysed. The aim was to improve the knowledge and skills of Professional Nurses in the facilitation of the implementation of the 6 Ministerial Priorities in selected Health Care facilities in Limpopo Province. The development of a training program is described fully in Chapter 7.

PHASE 4: Formulation of guidelines of the training program for the implementation of 6 Ministerial Priorities are also discussed in Chapter 7.

3.11 Ethical Considerations

Ethical principles safeguard participant's rights and safety. The following ethical principles were adhered to:

3.11.1. Ethical Clearance and Permission to Conduct the Study

The researcher obtained the approval from the Turfloop Research and Ethics Committee (TREC) of the University of Limpopo (Annexure A) and permission to

conduct research was obtained from the Head of Department of Limpopo Department of Health (Annexure B), as well as the permissions from the Chief Executive Officers of the selected hospitals (Annexure C).

The research process ensured that the following important ethical principles were adhered to, to meet the research ethics requirements.

3.11.2. Informed Consent and Voluntary Participation

Participation in the research study was voluntary. The participants were sensitively treated by respecting their beliefs, habits, culture and lifestyle. Information about the importance, purpose and objectives of the study was explained to the participants in the language they understand. An opportunity was provided for each participant to ask questions and express their feelings. A written Consent Form was given to the participants to sign as a way of proving their agreement to participate voluntarily in the study (Annexure D).

3.11.3. Privacy, Anonymity and Confidentiality

Privacy of the participants was maintained throughout the study by not interviewing them in public. Participants were interviewed in private separate rooms of the hospital. Names of the participants were not used anywhere in the study. Participants were allocated a code. Information obtained from participants was treated as confidential and voice recorder files were allocated codes that are known only to the researcher. The voice recorder and the field notes are kept in a safe for a minimum of 5 years.

3.11.4. Protection from Harm

The participants were requested to fill in the Consent Form to participate in the study. Any participant who is not well and not comfortable with participating in the research study were excused. Participants who became emotionally affected during the research study were referred to a psychologist. The researcher worked on maximizing the possible benefits while decreasing possible harm.

3.11.5. Principle of Non-Maleficence

The principle of non-maleficence was ensured by considering that no practice opposes the welfare of any research participants intentionally, through lack of knowledge or negligence. The participants were attended to in a way that avoided any possible harm physically and emotionally. This ensured consistently using process consent questions such as: *"I am going to ask a sensitive question; can I continue?"*

3.12. Bias

Bias is any influence and or distortion in the results of the study that strongly favours the outcome of a particular finding of a research study (Brink, van der Walt & van Ransburg, 2010). In minimizing bias, the researcher adhered to the prepared methodology for the research study. A prepared interview guide was used to enter into conversation with each study participant and the same question was asked each study participant. The researchers included unfavourable results that occurred during and at the point of the research study, methodology steps (Pannucci & Wilkins, 2010). The use of audiotape and field notes minimized bias.

3.13. Conclusion

The chapter discussed research methodology, ethical consideration and the next chapter discusses the qualitative results and the development of themes and subthemes.

CHAPTER 4
PRESENTATION AND DISCUSSION OF QUALITATIVE AND QUANTITATIVE RESULTS

4.1 Introduction

This chapter focused on the analysis and discussion of the qualitative and quantitative data of the study. The findings were based on the narratives from the semi-structured individual interviews of Professional Nurses, as well as quantitative results based on descriptive and inferential statistics. The services of the independent Coder were sought (see Appendix E). The audiotapes and the transcripts were submitted for verification purposes and the formulation of themes and sub-themes. The researcher and the independent Coder agreed on the themes and subthemes.

4.1.1. Presentation and Discussion of Qualitative Findings

Table 4.1: Themes and Sub-Themes

Themes	Sub-themes
1. Experiences of Professional Nurses in the implementation of the Ministerial Priorities	1.1 Positive attitudes towards the implementation of the Ministerial Priorities 1.2 Negative attitudes towards the implementation of the Ministerial Priorities. 1.3 Poor monitoring of the implementation of Ministerial Priorities
2. Knowledge of staff of the Ministerial Priorities	2.1. Poor knowledge of the staff of the ministerial Priorities
3. Availability of resources	3.1 Shortage of human resources. 3.2 Shortage of material resources. 3.3 Shortage of medicines at the pharmacy 3.4 Poor servicing of equipment
4. Staff training programs on the Ministerial Priorities	4.1 Inadequate orientation programs 4.2 Lack of in-service training programs
5. Psycho-social support system	5.1 Poor staff support from management on the Ministerial Priorities 5.2 Poor feedback from management on the Ministerial Priorities

4.1.1.1 Theme 1: Experiences of Professional Nurses in the implementation of the Ministerial Priorities

Professional Nurses experienced both positive and negative attitudes toward the implementation of Ministerial Priorities which affected the implementation of Ministerial Priorities. Attitudes of staff have been and continue to be fundamentally important in delivering acceptable and quality care. The attitude of staff reflects the culture and context of the situation within which they work (South African Health Reform, 2017). Bergman and Klefjo (2010) state that service quality is a reflection of the attitudes of employees or customers in a service encounter. They further argue that long-term success in quality improvement requires changes in attitude as well as behaviour.

Kendra (2021) states that in psychology, an attitude refers to a set of emotions, beliefs, and behaviours towards a particular object, person, thing or event. He further indicated that attitudes are often the results of experience or upbringing, and they can have a powerful influence over behaviour. He, however, indicated that even though attitudes are enduring, they can also change. Kendra (2021) further explained that attitudes components include cognitive, which are thoughts and beliefs about the subject; effect, which is how the object, person, issue, or event makes one feel; and behavioural components, which are how attitudes influence behaviour.

Attitudes can also be explicit and implicit. Explicit attitudes are those that we are consciously aware of and that influence our behaviours and belief. Attitudes are formed by experience, social factors, learning, conditioning and observation. Chaiklin (2013) states that, while attitudes can have a powerful effect on behaviour, they are not set in stone, the same influences that lead to attitude formation can also create attitude change.

4.1.1.1.1. Sub-theme 1: Positive attitudes towards implementation of 6 Ministerial Priorities

Rudolfson and Berggren (2012) state that nurses should display attributes of respect, compassion, wisdom, sensitivity and care. Nursing activities include protection, promotion, improvement of health and abilities, prevention of illness/injury, alleviation of suffering, diagnosis, treatment, and advocacy for the care of individual, families

and communities, therefore their attitudes will enable them to achieve the purpose of their profession.

The results of this study indicated that the majority of the participants exhibited positive attitudes towards implementation of the 6 Ministerial Priorities. This was shown by improved patient care, reduced complaints by patients as well as cases of litigation. These positive attitudes are shown in the excerpts below: Dias et al. (2012) state that Health Care Workers' attitudes affect behaviour, quality of care and health outcomes.

> *"Six Ministerial Priorities are implemented well in the hospital" "The attitude of staff towards implementation has improved. There is a good impact. We have fewer complaints and more compliments.''*
>
> (Participant 3 from Hospital B)

> *"Nurses show commitment towards implementing Ministerial Priorities."*
>
> (Participant 7 from Hospital C)

> ***"**Nurses are eager to know more on how to implement Ministerial Priorities. Attitude is very important in the healthcare field. As a nurse, patients are affected by everything you do. This includes attitudes and demeanour. A positive attitude can increase the consistency of high performance and guarantee patients' satisfaction."*
>
> (Participant 3 from Hospital E)

Dias et al., (2012) stated Health Workers' attitude affect behaviour, quality of care and health outcomes. They emphasize that nurses need to have a positive attitude towards patients and patient care. Frazer et al., (2010) add that negative attitude affects the care of vulnerable patients, while Gray (2008) postulates that caring is important in nursing.

4.1.1.1.2 Sub-theme 2**:** Negative attitude towards the implementation of 6 Ministerial Priorities

Nurses work at the front of most healthcare systems, and their contributions are recognized as essential in delivering effective patient care (Buchanan & Aiken, 2008). Providing quality nursing care is, therefore, an important consideration when discussing patient care standards. Nurses who are satisfied with their work and with the conditions under which care is provided are more likely to provide quality care that satisfies the patient. Literature has shown that job dissatisfaction

leads nurses to have negative attitudes towards their work, which negatively affects the quality of care they provide (De Melo et al., 2011). The attitude that a nurse holds towards patients and their state of ill health strongly determines the quality and extent of the emotional, physical, and psychological help that patients receive from that nurse (Rana et al., 2008).

The study found that some participants indicated that the 6 Ministerial Priorities were not a management priority and as such not adequate resources were provided for patient care resulting in nursing staff becoming overworked and burnt out. Nursing personnel that had resigned, retired or died were not replaced and this caused a severe shortage of staff. This, in turn, led to long patient waiting times.

These sentiments are expressed in the following quotations:

> ***"****Six Ministerial Priority is not a management priority. The staff is overworked. There is poor placement of staff. Patients wait a long time for services."*
>
> (Participant 3 from Hospital B)

> ***"****Top management is not supporting the implementation of 6 Ministerial Priorities. Six Ministerial Priorities does not form part of the agenda of top management."*
>
> (Participant 1 from Hospital C)

> *"Lack of resources negatively impact on the implementation of 6 Ministerial Priorities. There is only one cleaner per unit which affects cleanliness. Staff is not being replaced."*
>
> (Participant 4 from Hospital C)

> ***"****There is no feedback on the implementation of 6 Ministerial Priorities and is not put on the agenda in management meetings. No feedback is given concerning progress on the implementation of 6 Ministerial Priorities. We are not receiving support from top management. Waiting time is prolonged due to shortage of personnel."*
>
> (Participant 7 from Hospital E)

A study conducted on exploring nurses' attitudes toward providing care to patients in one rural hospital in KwaZulu-Natal from the perspective of nurses and patients revealed that the poor attitude of nurses results in poor patient care and could severely undermine the ability of the health system to provide quality care and improve outcomes for patients (Haskin et al., 2014)

4.1.1.1.3. Sub-theme 3. Poor monitoring of the implementation of Ministerial Priorities Monitoring is a systematic and continuous collection and analysis of data about the progress of a project or program over time. It involves a continuous process of data gathering and analysis that allows adjustments to be made to the objectives. On the other hand, evaluation is a systematic periodic collection and analysis of data about the progress of a project or program. An evaluation provides credible and useful information enabling the incorporation of lessons learned into the decision-making process of both recipients and financiers (donors) (Lwanga, 2015). Monitoring and Evaluation poised to continue playing a prominent role in monitoring performance, accountability, and most importantly understanding and tracking deliverables in the health sector through answering what, when, how and who questions (Lwanga, 2015).

The majority of the participants indicated that the lack of feedback regarding the implementation of Ministerial Priorities made it difficult for nurses to measure performance. These excerpts express these sentiments:

> "*The tool for monitoring 6 Ministerial Priorities is still been developed."*
> (Participant 3 from Hospital B)

> *"There are no tools to measure implementation."*
> (Participant 1 from Hospital D)

> *"There are no monitoring tools to monitor implementation. We only receive feedback from the quality manager on certain aspects."*
> (Participant 9 from Hospital D)

> *"No meetings were held therefore there is no platform for discussion and feedback."*
> (Participant 8 from Hospital E)

> *"There are no monitoring tools to monitor compliance to 6 Ministerial Priorities, therefore we do not know if we are complying or not. Feedback on the implementation of SMP is not done hence we do not know how we are doing. Implementation of SMP is not taken seriously. There is a need for constant monitoring."*
> (Participant 10 from Hospital E)

According to Uganda in Figures 2013, a publication by the Uganda Bureau of Statistics, the Infant Mortality Rate (2010/11) was 54 and is expected to reduce to 31 by 2015 in a bid to reduce child mortality. The Maternal Mortality Ratio (per 100,000

live births) (2010/11) was 438 and is expected to reduce to 131 by 2015 to achieve the millennium goal of improving maternal health. To achieve these targets, a strong, effective and efficient Monitoring and Evaluation system needed to be in place so that the deliverables can be tracked against the set targets, which are in line with the objectives to be attained (Lwanga, 2015).

4.1.1.2. Theme 2: Knowledge of Staff of the Ministerial Priorities

Knowledge of staff regarding Ministerial Priorities was very crucial in the implementation of the Ministerial Priorities. Nursing practice is team-based, and therefore nursing students and staff nurses are to be equipped with knowledge for proper understanding of the care of their clients. This knowledge is supposed to be applied in caregiving by the nurse through a proper understanding of rational care and prompt nursing interventions. The clinical environment of the client may change and the nurse will not be required to insist on routine nursing care but may have to apply critical thinking to devise another intervention method based on another theory. Therefore, education in theory application is advocated based on knowledge (Ihekwaba, 2009). A nurse in the clinical setting must be intelligent and be able to make quick decisions based on findings. These decisions are often life-saving (Brunner & Siddhartha, 2008).

Nurses in the clinical setting were expected to have in-depth knowledge and experience of the Ministerial Priorities to be able to implement them. The findings of the study as presented by a study on Knowledge Practice and Outcome of Quality Nursing Care among nurses at the University of Calabar Teaching Hospital (UCTH) revealed that there is a significant influence of knowledge on the practice of quality nursing care among nurses at the University of Calabar Teaching Hospital. The result was supported by Brunner and Suddart (2008) who reported that a nurse in the clinical setting must be intelligent and be able to make quick decisions based on findings.

Theme 2 has one sub-theme that is as follows:

4.1.1.2.1. Sub-theme 1: Poor knowledge of the Staff of the Ministerial Priorities

This study found that the majority of the participants had poor knowledge the 6 Ministerial Priorities. Some of the participants indicated that they have heard about the Ministerial Priorities but had not implemented them because they were not trained to do so. They also indicated that Ministerial Priorities were not given a priority which is the reason they were not implemented. Participants expressed that they did not have sufficient knowledge and skills which will enable them to implement 6 Ministerial Priorities. Some of the participants recalled few, while others were reminded about them.

A research study conducted at the University of Calabar on knowledge practice and outcome of quality nursing care among nurses indicated that nurses at Calabar University had knowledge associated with the quality of nursing care rendered to patients at the hospital. Nurses' practised quality nursing care, and rendered nursing care that was reflected in the positive responses by patients in the hospital. The research results showed that there was a significant influence of knowledge on the practice of quality nursing care among nurses at the University of Calabar Teaching Hospital (Akpabio, 2008).

Ihekwaba (2009) argue that nursing practice is team-based, and therefore, nursing students and staff are to be equipped with knowledge for proper understanding of the care of their clients. This knowledge is supposed to be applied in caregiving by the nurses through proper understanding of rational care and prompt nursing interventions. Ihekwaba (2009) further emphasized that education is advocated in nursing. Nursing as a profession is vested with the knowledge and responsibility of providing holistic and quality care at every level of service delivery.

The results of the study were in line with Sherwood et al., (2012) that nursing actions are intended to produce beneficial effects concerning identified responses. Poor knowledge of the staff of the Ministerial Priorities will affect the provision of quality patient care negatively. These sentiments are expressed as follows:

"I cannot remember all of them".

(Participant 2 from Hospital A)

"Unlike Batho Pele Principles there are no posters for 6 Ministerial Priorities in the wards. No one is talking about them."

(Participant 4 from Hospital A)

"They are not included in our monthly and quarterly reports."

(Participant 1 from Hospital C)

"Nurses lack adequate knowledge on the effective implementation because there are no training conducted."

(Participant 7 from Hospital B)

"Nurses require special knowledge and skills to be able to implement 6 Ministerial Priorities."

(Participant 6 from Hospital D)

"Nurses require special knowledge and skills to be able to implement 6 Ministerial Priorities."

(Participant 1 from Hospital E)

Waters and Easton (2008) state that nurses' skills and knowledge level are positively related to their ability to provide quality care and Patient Satisfaction. Provision of patient care should be done by competent health professionals who have up-to-date knowledge.

4.1.1.3. Theme 3: Availability of Resources

In this study, the majority of participants indicated that the lack of resources was one of the key aspects that affected the implementation of 6 Ministerial Priorities negatively. These are further explained in the following sub-themes.

4.1.1.3.1. Sub-theme 1: Shortage of human resources

The majority of the participant indicated that there was a severe shortage of Professional Nurses and cleaners which affected the implementation of the 6 Ministerial Priorities negatively. Participants indicated that the shortage of Professional Nurses resulted in staff being overworked and leading to staff burn-out. Participants also highlighted that the shortage of cleaners affected the cleanliness of the hospitals. In some instances, nurses had to clean wards thus, compromising nursing care.

Nurses mopped the floors and washed the dishes. Participants also stated that Professional Nurses and cleaners who have retired, passed on or resigned were not replaced. Participants also indicated that some of the staff members perform duties that are beyond the scope of practice. These sentiments were expressed as follows:

> *"The Lack of resources impacts negatively on the implementation of 6 Ministerial Priorities. There is a shortage of staff. Nurses are overworked and exhausted."*
>
> (Participant 3 from Hospital A)

> *"Nurses are burned out and this affects their attitudes towards patients."*
>
> (Participant 6 from Hospital B)

> *"Lack of resources such as shortage of staff affect the implementation of 6 Ministerial Priorities. There is only one cleaner per unit which affects cleanliness. Coverage of shifts is done by using overtime."*
>
> (Participant 4 from Hospital D)

> *"There is a shortage of nurses. Nurses get agitated due to overwork and lack of support from management."*
>
> (Participant 8 from Hospital D)

> *"Nurses sometimes perform beyond their scope of practice when implementing Ministerial Priorities, especially lower categories, e.g., perform procedures which they do not have knowledge of and put patients into danger* [Application of Plaster of Paris]. *Some the Professional Nurses do not have midwifery but they perform Termination of Pregnancy which exposes patients to danger''.*
>
> (Participant 7 from Hospital E)

World Health Organization (2017) report indicates that South Africa has a shortage of over 30 000 nurses, forcing some hospitals to operate at a ratio of one nurse for every 18 patients, while the accepted norm in general wards is 1:4. The same World Health Organization report notes that the Chris Hani Baragwanath Hospital in Soweto, the biggest and one of the busiest hospitals in the country, has 238 nursing vacancies, while KwaZulu-Natal's Addington Hospital has 151 unfilled nursing posts.

The major brunt of the nursing shortage is borne by the Public Sector (Horwitz & Pundit, 2008), which employs 58,9% of the country's nurses but is unable to compete with the improved salaries and working conditions offered by the private sector (Horwitz & Pundit, 2008). Irrespective of the sector, however, there is general agreement that South Africa does not have the nursing personnel to adequately service its growing population (Daviaud & Chopra, 2008).

Christmas (2007) suggests that nursing staff shortages often lead to increased workplace tension, which has the potential to erupt into workplace abuse, contributing to an exodus of nurses from the profession, such factors also contribute to nurses seeking alternative employment outside the formal nursing profession in occupations such as sales and marketing for pharmaceutical manufacturers, and reception and administration functions in medical practices. Gostin (2008) reports that the cost of nursing shortages includes high rates of patient injury, disease, cross-infection, premature mortality and increased maternal, infant and child mortality rates.

4.1.1.3.2. Sub-theme 2: Shortage of material resources

Participants cited a shortage of material resources such as linen, blankets, patients' gowns, syringes and vaccines, and cleaning material as factors, which impacted negatively the implementation of the 6 Ministerial Priorities. The participants indicated that, at times, patients had to come back the following day for medication. Babies were discharged without being vaccinated. Hospitals were borrowing each other medication and other consumables. Participants cited incidences where, at times, nurses had to buy some of the items such as cleaning material with their money.

> *"Lack of resources impact implementation negatively. There is no linen for patients. Patients put on their clothes."*
>
> (Participant 2 from Hospital B)

> *"There are no pillows, patients sleep without pillows."*
>
> (Participant 4 from Hospital B)

> *"Nurses become frustrated due to lack of resources. Resources are insufficient which affect the safety of patients. There are no adequate resources to enable nurses to implement Ministerial Priorities. There is a shortage of cleaning material and handwashing materials."*
>
> (Participant 7 from Hospital A)

Nurses require tools of the trade to enable them to perform their professional duties. Shortage of material resources harms quality service delivery and poses a danger to patients and clients. A study conducted by Mokoena (2017) revealed the lack of material resources, equipment and supplies (e.g., glucometers for monitoring blood glucose and needles for lumbar puncture in investigating or diagnosing meningitis), resulting in prolonged patient stay in the hospital.

Participants also mentioned that the scan machine was not in proper condition and that patients were therefore referred to other hospitals for investigations or they had to wait until the machine was fixed, resulting in delayed diagnosis and treatment (Mokoena, 2017). Manyisa and Van Aswegen (2017) supported the sentiments that the lack of administrative equipment and skilled professionals adversely affects the quality of care offered in health institutions.

4.1.1.3.3. Sub-theme 3: Shortage of medicines at the pharmacy

The continuous and adequate supply of medicines is a key element in managing diseases especially chronic diseases (Greene, 2010), with the availability of essential medicines dependent on efficient supply chain systems among other factors (Meyer et al., 2018). Shortage of medicines has been a challenge to the effective delivery of quality healthcare services worldwide, including in South Africa (Gray & Manasse, 2012) with shortages of even essential medicines becoming a global problem irrespective of the economic status of countries (WHO 2018). More than half of the world's population does not have access to essential services (Yadav, 2014) exacerbated by medicine shortages.

The origins of medicine shortages are complicated. Some of the contributing factors to the shortage of medicines include manufacturing and quality problems, production delays, lack of manufacturing capacity, shortage of raw materials, political instability, and profitability issues (Acosta et al., 2019). Other factors include long lead times, delays in awarding tenders, absence of national contracts on the regional code lists of medicines, the failure of suppliers to meet demand, and the failure to pay suppliers (Collins, 2013).

In the United States (US), shortages exceeded 450 in 2012 (WHO 2016). In Europe, a recent survey among hospital pharmacists showed there had been a significant increase in medicine shortages across Europe with 91.8% of hospital pharmacists in 2018 experiencing shortages compared to 86.2% in 2014**,** with 35% experiencing them daily and 38% every week **(**EAHP's 2018), which is a concern**.**

Shortage of medicines was expressed as a daily occurrence in hospitals which affected the provision of patient care. Participants indicated that they were many medicines

items that were out of stock and it took time before being available. Hospitals are borrowing medication from each other. Patients have to come back the following day to get their medication. Shortage of medication affected the provision of patient care negatively. These excerpts express these sentiments:

> *"Nurses sometimes buy medication for patients out of their pocket."*
> (Participant 6 from Hospital A)

> *"Availability of drugs is a challenge There is a communication problem with Depo concerning medication which are out of stock."*
> (Participant 1 from Hospital C)

> *"Medications often out of stock. Availability of medication is always a problem."*
> (Participant 2 from Hospital B)

> *"Medications are always not available at Pharmacy. When patients come to collect medication they are given few which are less than 30 days. Lack of vaccines for newborn babies. Many are discharged without being vaccinated. Medication is never enough which affects SMP."*
> (Participant 7 from Hospital E)

> *"Medication is requested from other institutions".*
> (Participant 10 from Hospital E)

The medicine value chain plays a critical role in the overall performance of any health system. Consequently, there is a need to ensure patients have a dependable supply of the right medicines, available at the right time, in the right quantity, and at the right place (NDoH, 2017). Ensuring adequate supplies of medicines, at affordable prices, has been a key element of managing diseases, including Non-Communicable Diseases (NCDs), effectively in South Africa (NDoH, 2016). To ensure this, comprehensive procurement systems and robust Supply Chain Management systems are key to managing those medicines deemed essential. Functioning logistic networks will improve access to medicines, and innovative programmes to assess medication usage will lead to a better understanding of how rationally medication is being used in a country, as well as ensuring sustainability (NDoH, 2012 & 2015).

South Africa is continually developing and evaluating programmes to monitor the care of patients and to assess the use of medicines in the country, from improving antimicrobial use (Messina et al., 2015, 2017; and Brink et al., 2016), to improve the

functionality of Pharmaceutical and Therapeutics Committees (PTCs) at all healthcare levels (Matlala et al., 2017a), and ongoing pharmacovigilance programmes (Suleman, 2010; Mehta et al., 2014; MCC, 2016; and Gauteng, 2017).

There are several innovations that have already been implemented in South Africa in recent years to improve medicine availability and access. A National Surveillance Centre and innovative early warning system have now been established in South Africa, with dashboards showing medicine stock levels at PHC facilities, hospitals and suppliers throughout the country. This system uses mobile applications, or electronic systems, to gather information and generate warnings where shortages are likely to occur (NDoH 2017). The NDoH (2017) in South Africa has also been piloting and implementing several health system strengthening reforms, aimed at improving medicine availability and use in recent years that centre on five core medicine value chain functions.

4.1.1.3.4. Sub-theme 4: Poor servicing of equipment

Medical equipment is an essential health intervention tool used by nurses for the prevention, diagnosis and treatment of disease and rehabilitation of patients. However, access to functioning medical equipment is a challenge in low- and middle-income countries. The World Health Organization estimated that 50 to 80 percent of medical equipment in developing countries is not working, creating a barrier to the ability of the health system to deliver health services to patients (WHO 2011). Hospital medical equipment is defined by the National Health Surveillance Agency as medical care equipment, which is directly or indirectly used for diagnosis, therapy and monitoring in the Health Care of patients in Intensive Care Units, Emergency Department and Surgical centres. These devices have great relevance in care procedures, high cost, diversity of models, great sensitivity in the handling and operation, being among the equipment with high potential to cause harm to patients (WHO 2011). Well maintained, properly functioning medical equipment is vital for the health and wellbeing of hospital patients, clinic patients, people benefiting from assisted living, and in-home medical patients.

Participants in this study indicated the frustrations they encountered regarding the functionality of equipment which affected the readings of vital signs. They indicated

that equipment is not serviced regularly and those which are serviced are poorly done because they are not being serviced by the manufacturers. The poor servicing of equipment posed a danger to patients as it gave incorrect readings.

> *"There is no servicing of equipment at the right time and they end up breaking.''*
>
> (Participant 2 from Hospital 5)

> *"Equipment takes a long time to be serviced. No one checks the functionality of equipment in the wards. There are no replacements of equipment when they are taken for servicing. Equipment breaks easily".*
>
> (Participant 5 form Hospital 6)

> *"Medical equipment do not last due to poor servicing plan."*
>
> (Participant 5 from Hospital 5)

> *"The service plan is not available."*
>
> (Participant 1 from Hospital 5)

Public hospitals in South Africa experience varying shortages of medical equipment and in general, the country scored below 50% in a national Health Care facilities baseline audit conducted in 2012 (Health Systems Trust 2012; and McQuoid-Mason 2016). The shortage is higher in rural hospitals than in urban hospitals like in other countries (American Hospital Association 2011; and Eygelaar et al., 2012).

Poor maintenance and repair, as well as limited financial resources, are responsible for the shortages. Medical equipment maintenance refers to regular servicing and prompt repair of broken equipment to keep it in the best possible working condition (WHO, 2012). A Maintenance Plan requires sufficient planning, management and implementation, which are controlled by the financial, physical and human resources available in a country (WHO, 2012).

Availability of sufficient and well-functioning medical equipment is therefore a challenge to low- and middle-income countries with limited resources (Penfold et al., 2013). A Maintenance Plan prolongs the life of medical equipment and minimises the cost associated with buying new equipment. Medical equipment defects and failures are very common in hospitals where there are poor Maintenance Plans and can lead to injury or death (Penfold et al., 2013)

Hospitals have a responsibility to regularly maintain medical equipment in use to avoid equipment malfunctioning or failure. Medical equipment is an essential health intervention tool used by nurses for the prevention, diagnosis and treatment of disease and rehabilitation of patients. However, access to functioning medical equipment is a challenge in low- and middle-income countries.

The World Health Organization estimated that 50 to 80 percent of medical equipment in developing countries is not working, creating a barrier to the ability of the health system to deliver health services to patients. The results of a study conducted at a rural hospital on the experiences of nurses on the critical shortage of medical equipment explored and described the lived experiences of nurses. The experience revealed a critical shortage of medical equipment at the hospital in the form of unavailability of equipment, low quality and poor maintenance of the few that were available (WHO, 2012). Shortage affected negatively nursing care, the nursing profession and the hospital.

Health Care workers should be provided with functional medical equipment to provide quality nursing care. Management, leadership and governance structures should be strengthened to ensure that procurement and Maintenance Plans for medical equipment are developed and implemented (WHO, 2012).

4.1.1.4. Theme 4: Available Training Program of the Ministerial Priorities

Nurses' skills and knowledge level are positively related to their ability to provide quality care to patients and improve Patient Satisfaction. Further emphasized that nurses need skills to act as educators, advocates, promoters, safeguards and supporters for different patients at different times.

The increased level of Professional Nurses' knowledge, skills and experience will improve quality service delivery. Ministerial Priorities should be implemented by people who have been trained and are knowledgeable. Participants expressed that they did not have sufficient knowledge and skills which will enable them to implement 6 Ministerial Priorities.

Theme 4 has two sub-themes, namely, inadequate orientation programs, lack of in-service training programs.

4.1.1.4.1. Sub-theme 1: Inadequate orientation programs

Participants indicated that there was an inadequate orientation program in the facility. The orientation program for newly employed staff and was not conducted consistently and did not include Ministerial Priorities.

> "*Orientation program should include Six Ministerial Priorities."*
>
> (Participant 1 from Hospital 3)

> *"Orientation program is not consistent."*
>
> (Participant 7 from Hospital 3)

> *"Orientation program is very important and it is not conducted consistently. Some are oriented on appointment some are not, I was personally not orientated."*
>
> (Participant 3 from Hospital 5)

An orientation process is an introduction of new employees to new technologies, procedures, and policies at the workplace, and it should be considered at all levels of an organization (Kiel, 2012). Research conducted to evaluate a nursing orientation program in a multicultural acute Health Care setting revealed that the overall competence of the newly employed nurses was high and there was an overall gain in the competence score among nurses (Lalithabai, 2021). The objective of the research was competence motivates newly employed nurses to provide high-quality care, which leads to appropriate patient care and satisfaction. The research study concluded by indicating that new nurses were found to be competent and the orientation program had a significant impact on the competence of the nurses (Lalithabai, 2021). Therefore, orientation for newly employed staff has a positive impact on the competency of newly employed nurses.

4.1.1.4.2. Sub-theme 2: Lack of in-service training programs

Participants expressed a lack of in-service and continuous professional development as a cause for non-implementation of Ministerial Priorities in certain Health Care facilities. They further indicated that in hospitals where in-service training is conducted, not all nurses can attend due to a shortage of staff because patients cannot be left alone.

"Nurses require continuous Professional Development; Nurses require special skills to implement Ministerial Priorities. It should be part of the orientation program."

(Participant 6 in Hospital A)

"Training is very important for nurses to be able to implement 6 Ministerial Priorities properly."

(Participant 9 in Hospital D)

A study conducted on the training of Health Care Workers on immunization data management in low and middle-income countries regarding data handling and the importance of data use for improving service delivery showed that training interventions are fundamental in skill acquisition. The results of the study showed that 83% of district staff who participated in the in-service training demonstrated improved knowledge and were fully prepared to conduct activities (Nicol et al., 2019). Furthermore, Nicol et al., (2019) elaborated that Health Care providers are the drivers of health interventions, yet, some lack the necessary training and skills to adequately perform the tasks of responding to the health needs and expectations of the population.

The researcher concluded by defining competency as a combination of knowledge, skills and abilities needed to perform a specific task in a given context which can be gained through experience or training. The author further stated that training for Health Care professionals is geared toward building professional competencies through pre or in-service training (Nicol et al., 2019).

4.1.1.5. Theme 5: Psycho-Social Support System

Participants expressed that there was a lack of psycho-social support from the management to enable them to implement the 6 Ministerial Priorities. Psychosocial support refers to the actions that address both the psychological and social needs of individuals, families and communities. Psycho-social support involves a range of care and support interventions. It includes care and support offered by caregivers, family members, friends, neighbours, teachers, Health Workers and community members daily (https:// papyrus-project.org).

Empirical research showed that psychological risk factors such as social isolation, depression and anxiety increase the risk of incident of coronary heart disease and also contribute to poorer health-related quality of life. Therefore, the researcher concludes that motivation and staff support is exceptionally crucial in influencing the quality of Health Care Worker outcomes. Given the mounting challenges and stressful work environment faced by nurses during the implementation of the Ministerial Priorities psycho-social support system has been identified as an essential resource that helps promote their work motivation.

Bailey et al., (2015); and Bergh et al., (2018) state that psycho-social risks and work-related stress are among the most challenging issues in occupational safety and health, impacting significantly on the health of individuals, organizations, and national economies. They further reiterated that the psychosocial risks and work-related stress arise from inadequate work design, management, organization, and poor social context of work, resulting in adverse physical, psychological, and social outcomes such as depression or burnout.

The European Agency of Health and Safety (2020) supported by indicating that psychosocial risks are related to low job satisfaction, and work accidents, while Fornell et al., (2018) added by saying work-related stress and burnout are closely related to work stress. Work stress is also associated with a reduction in social interaction and the ability to concentrate at work, increased physiological pain and cardiovascular problems, and a higher incidence of mental illness such as depression and anxiety.

Guadix et al., (2015) state that proper management of psycho-social risk helps to prevent accidents and absenteeism, increase productivity and promote well-being in the workplace. Antwi et al., (2018) have added that nurses' contribution to global health is undisputed, and investing in improving their quality of life benefits society (Buchanan et al., 2008). Improved working conditions and professional development affects not only the well-being or quality of life of nurses but also their performance and the functioning of the entire Health Care system (Everhart et al., 2013).

Theme 5 had 2 sub-themes, namely:

4.1.1.5.1. Sub-theme 1: Poor staff support from management on the implementation of the Ministerial Priorities

The participant indicated that management did not support the implementation of 6 Ministerial Priorities, hence they did not provide resources to enable staff to implement 6 Ministerial Priorities. The majority of Professional Nurses indicated that they were not receiving support from top management. They further indicated that there was no dedicated person to monitor the implementation of the 6 Ministerial Priorities and that they were not discussed in strategic meetings. These ideas are expressed in the following excerpts:

> "*No support from management. Ministerial Priorities are not a priority to top management."*
>
> (Participants 7 and 12 from Hospital A)

> *"We are not receiving support from top management."*
>
> (Participant 3 from Hospital B)

> *"Top management is not providing support regarding effective implementation of Ministerial Priorities."*
>
> (Participant 1 from Hospital C)

> *"Management also does not discuss with us."*
>
> (Participant 13 from Hospital D)

> *"Top management is not taking the implementation of 6 Ministerial Priorities seriously."*
>
> (Participant 9 from Hospital E)

A study conducted on the support for human resources development on perceived organizational support and its effect on employee job satisfaction has revealed that employees who perceived that the management is not supporting the human resource development activities within the organization and not receiving coaching from the supervisor become more dissatisfied. Employees in the organizations who are competent, face some issues regarding management support and coaching behaviour, leading to a decrease employees perceived organizational support and job satisfaction. Noone (2008) indicated that these issues are harmful to organizations because employees feel dissatisfaction which leads to turnover intentions, sick leaves, and low quality of performance associated with services etc.

The conclusion was that managerial support for HRD is important for the job satisfaction of the employees and the managerial coaching behaviour of the manager makes the relationship between support for HRD and perceived organizational support stronger as compared to the employees who are not supported by the management for HRD activities and managerial coaching behaviour exercised by the manager or supervisor (Eisenberger et al., 2014).

4.1.1.5.2. Sub-theme 2: Poor feedback from management on the ministerial priorities

Constructive feedback in the workplace is extremely important. Workplaces need effective communication to succeed and thrive. As well as increasing staff morale, feedback helps us learn more about ourselves, our strengths and weaknesses, our behaviours, and how our actions affect others. It also increases our self-awareness and encourages personal development. Inadequate, untimely and unconstructive non–critical feedback is a problem (Engebretson, Smith & Seibold, 2008) and poor feedback leads to negative supervisory experience (Cekiso, Tshotsho, Masha & Saziwa, 2019). Positive feedback strategies include regular meetings, a balance between written and verbal, and synchronous and asynchronous feedback (Ezebilo, 2012). Lindsay (2015) further reiterated that feedback enhances the learning process, it is important at every education level. Timely, supportive and high-quality feedback is critical for facilitating and supporting learning

Participants in this study indicated that management did not discuss the Ministerial Priorities in their meetings as it was not a priority hence there was no feedback. Ministerial Priorities were not monitored as there was no specific person delegated to monitor them. Delivering feedback is an essential aspect of any supervisor's job. Whether you give employees positive feedback or negative feedback, you help them recognize areas where they can improve to achieve professional growth.

These sentiments were expressed in the following excerpts:

> *"Top management is not supporting the implementation of Ministerial Priorities hence there is poor feedback on their implementation."*
>
> (Participant 3 from Hospital 3)

"Implementation of the Ministerial Priorities is not monitored."
(Participant 1 from the Hospital)

"*No one is delegated to monitor implementation of Ministerial Priorities. Ministerial Priorities are not part of the agenda in management meetings.*"
(Participant 6 from Hospital 1)

4.1.2. Presentation and Discussion of Quantitative Results

The research design was explanatory Sequential Mixed Methods. The results are presented in a consistent flow of the design. The discussion of quantitative results is based on descriptive and inferential statistics to allow for proper summarization, organization, evaluation, analysis, interpretation and communication of numeric information. Descriptive statistics helped in making sense of a large volume of data whereas inferential statistics helped in making inferences about a subset of the population from the study. The results were presented in tables, bar graphs and pie graphs.

4.1.2.1. Respondents' Response Rate

Two hundred and ninety-five (295) questionnaires have ministered to Professional Nurses and all (i.e., 100%) were completed and returned.

4.1.2.1.1. Section A: Demographic Data

Demographic data of respondents were, namely, age, qualifications and gender. The respondents who participated in the study were 295. The respondents were from five hospitals in the Limpopo Department of Health. The purpose of using the demographic information was to depict an accurate picture of the group of respondents who participated in the study.

4.1.2.1.1.1. Age and Gender

Figure 4.1: Age of Respondents

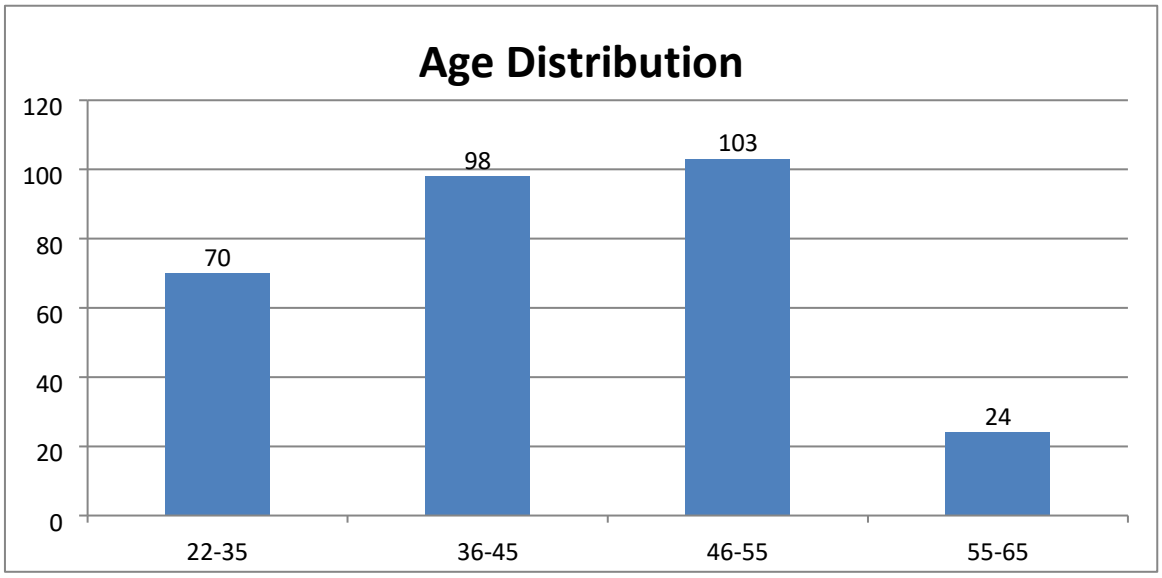

Figure 4.1 indicates the ages of Professional Nurses who participated in the study. The majority of the Professional Nurses was between the ages of 46-55 years (at 35%) followed by ages between 36-45 years (at 33%), 22-35 years (at 24%) and the lowest number aged 55-65 years (at 8%).

4.1.2.1.1.1.1. Gender of Respondents

Figure 4.2. Gender of Respondents

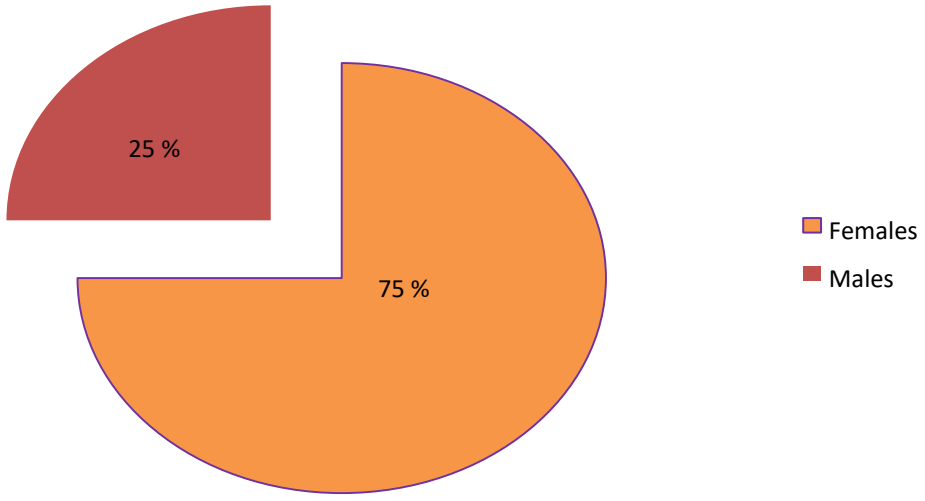

Figure 4.2 indicates the gender distribution of respondents, which indicates that 75% was females and 25% was males. This is an indication that the nursing profession are predominantly females.

4.1.2.1.1.1.2. Respondents' Highest level of Education

Figure 4.3. Respondents' Highest level of Education

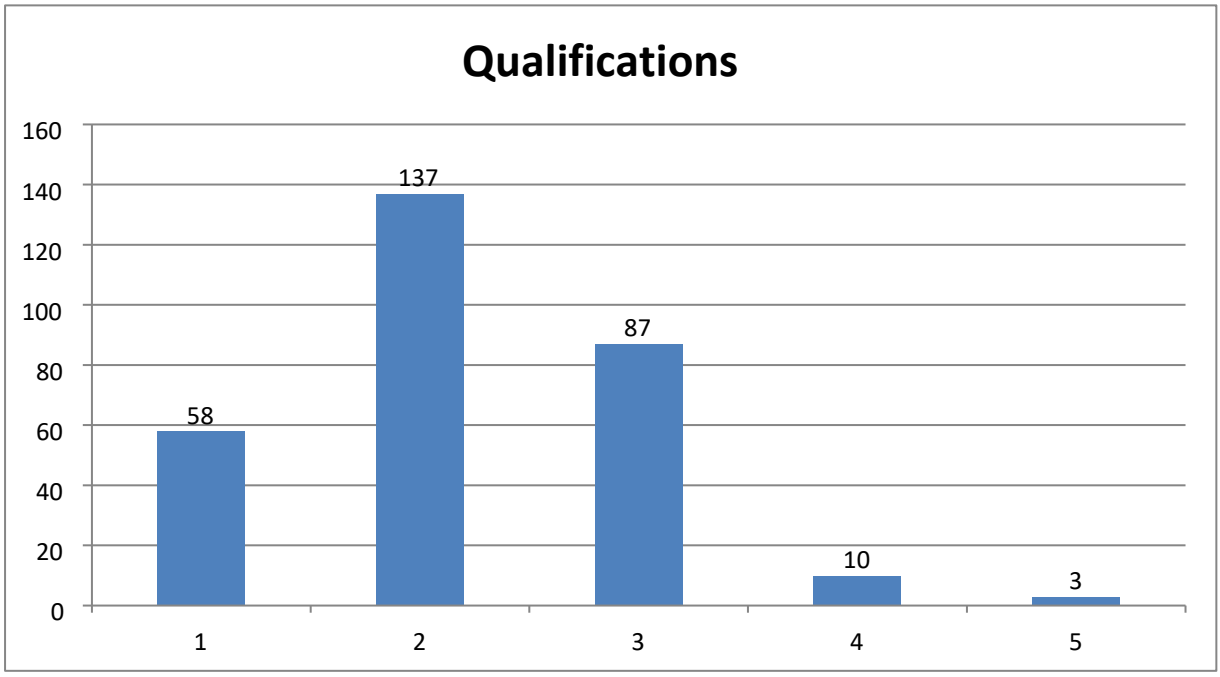

Figure 4.3 represents the highest level of education of the respondents. According to the findings, the respondents' highest qualifications were as follows; Diploma in General Nursing, Midwifery, Community and Psychiatric Nursing was 137 (i.e., 46.4%), followed by BA Cur that were 87 (i.e., 29.5%), then Diploma in General Nursing and Midwifery were 58 (i.e., 19.7%), Master's in Nursing Science were 10 (i.e., 3.4%) and Doctoral in Nursing Science were 3 (i.e., 1%).

4.1.2.1.2. Section B

This section assessed Professional Nurses' experience regarding the implementation of the 6 Ministerial Priorities with 45 questions from B1-B45.

Table 4.2. Assessment of Professional Nurses' Experience Regarding Values and Attitude of the Staff of Implementation of 6 Ministerial Priorities

	N	Yes	No	Partial
B1: Patients are treated with compassion and caring	295	23(7.8%)	13(4.4)	259(87,8)
B2: Patients are treated courteously at all time	295	0(0%)	184(62.4%)	111(37.6%)
B3: Patients are treated with dignity and respect all the time	295	17(5.8%)	78(26.4%)	200(67.8%)
B4: Health Workers are too often rude and uncaring to their patients.	295	0(0%)	198(67.1%)	97(32.9%)
B5: Patient Satisfaction surveys highlight patients' complaints	295	202(68.5%)	3(1%)	90(30.5%)
B6: Patients feel that they are not treated well.	295	86(29.2%)	100(33.8%)	109(36.9%)
B7: Health Care Workers tell patients about their feeling of motivation and lack of recognition for their efforts.	295	0(0%)	289(97.9%)	6(2%)
B8: Patients' questions about their health problems are always addressed	295	8(2.7%)	10(3.4%)	277(93.8%)

Table 4.2 shows the responses of Professional Nurses in terms of values and attitudes of nurses toward the implementation of 6 Ministerial Priorities and the responses are indicated below:

B1: The patient treated with compassion and caring

Twenty-three (23) (i.e., 97.8%) respondents indicated that patients were treated with compassion and caring, while 13 (i.e., 4.4%) said that patients were not treated with compassion and caring and 259 (i.e., 87.8%) indicated that patients were partially treated with compassion and caring.

B2: Patients treated courteously at all times

None of the respondents indicated that patients are treated courteously at all times 184 (i.e., 62.4%) indicated patients are not treated courteously at the time and 111 (i.e., 37.6%) stated that patients are partially treated courteously at all times. Therefore, the conclusion was that patients were partially treated with dignity and respect.

B3: Patients are treated with dignity and respect all the time

Seventeen (17) (i.e., 5.8%) indicated that patients are treated with dignity and respect all the time, and 78 (i.e., 26.4%) indicated that patients are not treated with dignity and respect all the time, while 200 (i.e., 67.8%) indicated that patients are partially treated with dignity and respect.

B4: Health Workers are too often rude and uncaring to their patients

None (i.e., 0%) of the respondents has agreed that Health Workers are often rude and uncaring to patients, while 198 (i.e., 67.1%) agreed that Health Workers are often rude and uncaring to their patients and 97 (i.e., 32.9%) indicated that Health Workers are partially often rude and uncaring to their patients.

B5: Patient Satisfaction surveys highlights patients' complaints 202 (i.e., 68.5%) respondents agreed that Patient Satisfaction surveys highlight patients' complaints, while only 3 (i.e., 1%) said no and 90 (i.e., 30.5%) said partially.

B6: Patients feel that they are not treated well.

Eighty-six (86) (i.e., 29.2%) respondents agreed that they were not treated well, 100 (i.e., 33.8%) indicated that they were not treated well, while 109 (i.e., 36.9%) indicated that they were partially not treated well.

B7: Health Care Workers tell patients about their feeling of motivation and lack of recognition for their efforts, none (i.e., 0%)of the respondents agreed that Health Workers tell patients about their feeling of motivation and lack of recognition for their efforts, and 289 (i.e., 97.9%) did not agree that Health Care Workers tell patients about their feeling of motivation and lack of recognition for their efforts, while only 6 (i.e., 2%) indicated that it is partially done.

B8: Patients' questions about their health problems are always addressed

Eight (8) (i.e., 2.7%) of respondents indicated that patients' questions about their health problems are always addressed, while 10 (i.e., 3.4%) indicated that patients' questions about their health problems are always not addressed and 277 (i.e., 93.8%) indicated that patients' questions about their health are partially addressed.

Table 4.3. Assessment of Professional Nurses' Experience Regarding the Implementation of the Ministerial Priorities in Terms of Cleanliness of the Hospitals

Cleanliness	N	Yes	No	Partial
B9: Cleaning equipment and material is available at all times		0(0%)	293(99.3%)	2(0.7%)
B10: There is a shortage of cleaning materials and equipment	295	200(67.8%)	0(0%)	95(32.2%)
B11: Poorly maintained environment contributed to nosocomial infections	295	70(23.7%)	27(9.2%)	198(67%)
B12: Cleaning services are effectively managed	295	0(0%)	195(66%)	100(33.8%)
B13: A suitably experienced person manages cleaning services	295	30(10%)	86(29%)	179(60.6%)
B14: There is ongoing in-house training for cleaning staff	295	5(1.6%)	90(30.5%)	200(67.8%)
B15: Standard Operating procedure/ Protocol for cleaning is in place and implemented.	295	0(0%0	211(71.5%)	84(28.5%)

Table 4.3 indicates the assessment of Professional Nurses' experience regarding the implementation of the 6 Ministerial Priorities in terms of cleanliness

B9: Cleaning equipment and material is available at all times

None (0%) of the Professional Nurses has indicated that cleaning equipment and materials were available at all times, and 293(99.3) indicated that the cleaning equipment and materials were not available at all times, while 2 (i.e., 0.7%**)** indicated that cleaning equipment and materials were partially available at all times.

B10: There is a shortage of cleaning materials and equipment

Two hundred (200) (i.e., 67.8%) of Professional Nurses indicated that there was a shortage of cleaning materials and equipment and 95 (i.e., 32.2%) indicated that there was a partial shortage of the cleaning material and equipment.

B11: Poorly-maintained environment contributed to nosocomial infections

Seventy (70) (i.e., 23.7%) of Professional Nurses agreed that a poorly maintained environment contributed to nosocomial infections, 27 (i.e., 9.2%) Professional Nurses' response was "no", while 198 (i.e., 67%) Professional Nurses indicated that it was partial.

B12 Cleaning services are effectively managed

None (i.e., 0%) of the Professional Nurses agreed that the cleaning services were effectively managed while 95 (i.e., 66%) Professional Nurses indicated that cleaning services were not managed effectively and 100 (i.e., 33.8%) Professional Nurses indicated that the cleaning services were partially managed effectively.

B13: A suitably experienced person manages cleaning services

Thirty (i.e., 10%) of Professional Nurses indicated that a suitably experienced person was managing cleaning services, while 86 (i.e., 29%)Professional Nurses indicated that there was no suitable person who was managing cleaning services and 179 (i.e., 60.6%) of Professional Nurses indicated that a suitably experienced person was partially managing cleaning services.

B14: There is ongoing in-house training for cleaning staff

Five (i.e., 1.6%) Professional Nurses indicated that there was an ongoing in-house training for cleaning staff, 90 (i.e., 30.5%) Professional Nurses indicated that there was no ongoing in-house training for cleaning staff and 200 (i.e., 67.8%) indicated that there was partial ongoing in-house training for cleaning staff.

B: 15 Standard Operating Procedure/ Protocol for cleaning is in place and implemented.

None (i.e., 0%) of the Professional Nurses 'response was 'yes', while 211 (i.e., 71.5%) Professional Nurses 'response was no and 84 (i.e., 28.5%) Professional Nurses' response was partial.

Table 4.4 Assessment of Professional Nurses' Experience Regarding the Implementation of the Ministerial Priorities in Terms of Waiting Time in the Hospitals

	Waiting Time	n	Yes	No	Partial
B16	Patient's maximum waiting time is displayed in each service area	295	198 (67.1%)	97 (32.9%)	0 (0%)
B17	Patients are aware of the maximum time to wait before being attended to	295	126 (42.7%)	121 (41%)	48 (16.3%)
B18	There are fast lane queues for very sick patients, children and older persons	295	174(60%)	88 (29.8%)	33 (11.2%)
B19	Screening is done at the point of patients entry into the hospital	295	290(98.3%)	0 (0%)	5 (1.6%)
B20	Waiting time in key areas are monitored and measures taken by management to address causes of blockages	295	27(9.2%)	73(24.7%)	195 (66.1%)
B21	Waiting time is locally determined	295	295(100%)	0(00%)	0 (0%)
B22	Patients wait a long time to open a file	295	26(8.8%)	66(23.4%)	200 (67.8%)
B23	Patients wait a long time to see a nurse	295	90(30.5%)	100 (33.89%)	105 (35.6%)
B24	Patients wait a long time to see a doctor	295	199(67.5%)	6 (2%)	90 (30.5%)
B25	Patients wait a long time to get medication at Pharmacy	295	51(17.3%)	202(68.5%)	42 (14.2%)
B26	Patients have to come back the following day to be seen by a doctor	295	96(32.5%)	100(33.9%)	99 (33.6%)

Table 4.4 indicates the assessment of Professional Nurses' experience regarding the implementation of the 6 Ministerial Priorities in terms of waiting time

B16: Patients' maximum waiting time is displayed in each service area

One hundred and ninety-eight (198) (i.e., 67.1%) responses of respondents indicated that maximum waiting time was displayed in each

service area, while 97 (i.e., 32.9%) responses indicated that maximum waiting time was not displayed in each service area.

B17: One hundred and twenty-six (126) (i.e., 42.7%) indicated that patients were aware of the maximum time to wait before being attended to, while 121 (41%) indicated that patients were not aware and 48 (16.3%) said patients were partially aware of the maximum time to wait before being attended to.

B18: One hundred and seventy-four (174) (i.e., 60%) of the respondents indicated that there were fast lanes queues for very sick patients, children and older persons, while 88 (i.e., 29.8%) respondents said no and 33 (i.e., 11.2%) respondents' response was partial.

B19: Two hundred and ninety (290) (i.e., 98.3%) respondents indicated that screening was done at the point of patient's entry into the hospital, while 5 (i.e., 1.6%) respondents were partial.

B20: Twenty-seven (27) (i.e., 9.2%) respondents indicated that waiting time in key areas was monitored and measures taken by management to address causes of blockages, while 73 (24.7%) said no and 195(66.1%) said it was partial.

B21: Two hundred and ninety-nine (295) (i.e., 100%) respondents indicated that waiting time is locally determined

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B22: Twenty-six (26) (i.e., 8.8%) respondents indicated that patients waited a long time to open a file, while 66 (23.4%) respondents indicated that patients did not wait a long time to open a file and 200 (i.e., 67.8%) indicated that patients partially waited a long time to open a file.

B23: Ninety (90) (i.e., 30.5%) respondents indicated that patients waited a long time to see a nurse while 100 (i.e., 33.89%) respondents said patients did not wait a long time to open a file and 105 (i.e., 35.6%) respondents indicated that patients partially waited a long time to open a file.

B24: One hundred and ninety-nine (199) (i.e., 67.5%) respondents said patients waited a long time to see a doctor, while 6 (i.e., 2%) said patients did not wait a long time to see a doctor and 90 (i.e., 30.5%) said patients waited partially to see a doctor.

B25: Fifty-one (51) (i.e., 17.3%) respondents indicated that patients waited a long time to get medication at Pharmacy, while 202 (68.5%) respondents indicated that did not wait a long time at Pharmacy and 42 (i.e., 14.2%) indicated that patients partially waited a long time at the pharmacy.

B26: Ninety-six (i.e., 32.5%) respondents indicated that Patients have to come back the following day to be seen by a doctor and 100 (i.e., 33.9%) respondents indicated that patients did not come the following day to be seen by a doctor, while 99 (i.e., 33.6%) indicated that patients partially had to come the following day to be seen by the doctor.

Table 4.5. Assessment of Professional Nurses' Experience Regarding the Implementation of the Ministerial Priorities in Terms of Safety and Security in the Hospitals

B27	There is a security system that safeguards the building, patients, visitors and staff,	295	259(87.8%)	0(0%)	36(12.2%)
B28	There is adequate lighting inside and outside to protect patients, visitors and staff.	295	100(33.9%)	81(27.5%)	114(38.6%)
B29	All security incidences/ breaches are reported	295	245(83%)	7(2.4%)	43(14.6%)
B30	All security incidences/ breaches are addressed	295	88(29.8%)	100(33.9%)	107(36.3%)
B31	Safety and security awareness are promoted among staff members	295	9(3%)	98(33.2%)	188(63.7%)
B32	Security guards are designated for specific areas	295	235(79.7%)	5(1.7%)	55((18.6%)

Table 4.5 indicates the responses of Professional Nurses on their experience regarding the implementation of the 6 Ministerial Priorities in terms of the safety and security of patients in hospitals.

B27: Two hundred and fifty-nine **(**259) (i.e., 87.8%) respondents indicated that there was a security system that safeguards the building, patients, visitors

and staff, while 36 (i.e., 12.2%) indicated that there was a partial security system that safeguards the building, patients, visitors and staff.

B28: Hundred (100) (i.e., 33.9%)respondents indicated that there was adequate lighting inside and outside to protect patients, visitors and staff and 81 (i.e., 27.5%) indicated that there was no adequate lighting inside and outside buildings to protect patients, visitors and staff, while 114 (i.e., 38.6%) indicated that there was partial lighting inside and outside buildings to protect patients, visitors and staff.

B:29 Two hundred and forty-five (245) (i.e., 83%) of respondents indicated that all security incidences/breaches were reported while 7 (i.e., 2.4%) indicated that they were not reported and 43 (14.6%) were partially reported.

B30: Eighty-eight (88) (i.e., 29.8%) indicated that all security incidences/ breaches are addressed, while 100 (i.e., 33.9%) indicated that they are not addressed and 107 (i.e., 36.3%) indicated that they were partially addressed'

B31: Nine (9) (i.e., 3%) indicated that safety and security awareness was promoted among staff members while 698 (i.e., 33.2%) indicated that they were not promoted and 188(63.7%) indicated that they were partially promoted.

B32: Two hundred and thirty-five (235) (i.e., 79.7%) respondents indicated that security guards were designated for specific areas, while 5 (i.e., 1.7%) indicated that they were not designated for specific areas and 5 (i.e., 18.6%) indicated that they were partially designated to specific areas.

Table 4.6. Assessment of Professional Nurses' Experience Regarding the Implementation of the Ministerial Priorities in Terms of Infection Prevention and Control in the Hospitals

B33: There is hand hygiene compliance	295	90(30.5%)	3(1%)	202(68.5%)
B34: There is ongoing monitoring and management of infection prevention and control practices	295	271(91.9%)	0(0%)	24(8.1%)
B35: Policies and Protocols for the prevention and management of infections are available and implemented	295	85(28.8%)	0(0%)	210(71.2%)
B36: There are officers who are appropriately trained to monitor infections	295	195(66%)	23(7.8%)	77(26.1%)
B37: Protective clothing for staff and patients are available and used properly	295	40(13.6%)	52(17.6%)	203(68.8%)
B38: Nosocomial infections outbreaks are investigated and reported	295	278(94.2%)	0(0%)	17(5.8%)
B39: Waste is managed appropriately	295	280(95%)	5(1.7%)	10(3.4%)
B40: Waste is protected from theft, vandalism and scavenging	295	266(90%)	8(3%)	20(7%)

Table 4.6 indicates the responses of Professional Nurses' experience regarding the implementation of the Ministerial Priorities in terms of infection prevention and control in the hospitals

B33: Ninety (90) (i.e., 30.5%) respondents indicated that there was hand hygiene compliance while 3 (i.e., 1%) indicated that there was no hand hygiene compliance and 202 (i.e., 68.5%) indicated that there was partial hand hygiene compliance. The conclusion was that there was partial hand hygiene compliance

B34: Two hundred and seventy-one (271) (i.e., 91.9%) respondents indicated that there was ongoing monitoring and management of infection prevention and control practices while 24 (i.e., 8.1%) indicated that it was partial.

B35: Eighty-five (85) (i.e., 28.8%) respondents indicated that policies and protocols for the prevention and management of infections are available and implemented, while 210 (i.e., 71.2%) indicated that policies and protocols for the prevention and management of infections are partially available and implemented.

B36: One hundred and ninety-five (195) (i.e., 66%) the respondents indicated that there were officers who were appropriately trained to monitor infections, while 23 (i.e., 7.8%) indicated that there were no officers who were appropriately trained to monitor infections and 77 (i.e., 26.1%) indicated that they were partially trained to monitor infections.

B37: Forty (40) (i.e., 13.6%) indicated that protective clothing for staff and patients were available and were used properly, while 52 (i.e., 17.6%) they were not available and those which were there were not used properly and 203 (i.e., 68.8%) indicated that they were partially available and partially used properly**.**

B38: Two hundred and seventy-eight (278) (i.e., 94.2%) respondents indicated that nosocomial infections outbreaks are investigated and reported, while 17 (i.e., 5.8%) indicated that they were partially investigated and reported.

B: 39 Two hundred and sixty-six (266) (i.e., 90.2%) indicated that waste was managed appropriately, while 9 (i.e., 3%) said it was not managed properly and 20 (6.8%) indicated that it was partially managed.

B: 40 Two hundred and sixty-six (266) (i.e., 90%) respondents indicated that waste was protected from theft, vandalism and scavenging, while 8 (i.e., 3%) indicated that it was not protected and 20 (i.e., 7%) said it was partially protected.

Table 4.7 Assessment of Professional Nurses' Experience Regarding the Implementation of the Ministerial Priorities in Terms Availability of Medication in the Hospitals

Basic medications are available at all times, in:

B41: Adequate amounts, inappropriate dosage forms	295	2(0.7%)	233(79%)	60(20.3%)
B42: There is sometimes a shortage of medications	295	10(3.4%)	200(67.8%)	85(28.8%)
B43: Essential Drug List (EDL) is available 90% of the time	295	90(30.5%)	4(1.4%)	201(68.1%)
B44: Appropriate medications are prescribed and administered for patients	295	109(36.9%)	86(29.1%)	100(33.9%)
B45: Shortage of medicines is a daily occurrence in the facility	295	209(70.8%)	6(2%)	80(27%)

Table 4.7 indicates responses of Professional Nurses' experience on the implementation of the Ministerial Priorities in terms of availability of medication in the hospitals.

B41: Two (2) (i.e., 0.7%) respondents indicated that basic medications were available at all times, in adequate amounts, inappropriate dosage forms, while 233 (i.e.,79%) indicated that basic medication was not available at all times, in adequate amounts and appropriate dosage forms and 60 (i.e., 20.3%) said it was partially available

B42: Ten (10) (i.e., 3.4%) respondents indicated that there was sometimes a shortage of medications while 200 (i.e., 67.8%) others indicated that there was a shortage of medication most of the time 85 (i.e., 28.8%) said that medication was partially available.

B43: Ninety (90) (i.e., 30.5%) respondents indicated that the Essential Drug List (EDL) is available 90% of the time, while 4 (i.e., 1.4%) said no and 201 (68.1%) said the Essential Drug List (EDL) was partially available 90% of the time.

B44: One Hundred and Nine (109) (i.e., 36.9%) respondents indicated that appropriate medications were prescribed and administered to patients, while 86 (i.e., 29.1%) said no appropriate medications were prescribed and

administered to patients and 100 (i.e., 33.9%) said appropriate medications were partially prescribed and administered to patients.

B45: Two Hundred and Nine (209) (i.e., 70.8%) respondents indicated that a shortage of medicines is a daily occurrence in the facility, while 6 (i.e., 2%) indicated that it was not a daily occurrence and 80 (i.e., 27%) said it was a partial occurrence.

Table 4.8. Assessment of Professional Nurses' Knowledge Regarding the Six Ministerial Priorities

		N	Strongly agree	agree	neutral	disagree	Strongly disagree
C1	Values and attitude of staff ensures that patients are treated in a respectful manner by staff	295	200 (67.8%)	95 (32.2%)	0	0	0
C2	Courtesy incorporates basic social values such as being friendly, polite, helpful, and treating patients with dignity and respect.	295	192 (65%)	103 (34.9%)	00		0
C3	Cleanliness of a hospital plays a large role in patient's perception of the health care setting	295	211 (71.5%)	84 (28.5%)	0	0	0
C4	There is a correlation between patient's perception of hospital cleanliness and risk of acquired infection	295	203 (47.3%)	92 (31.2%)	0	0	0
C5	A clean and welcoming environment is important from aesthetic point of view, engender feelings of wellbeing and trust in people who may be anxious or unwell.	295	198 (67.1%)	97 (32.9%)	0	0	0
C6	Waiting time is a parameter for assessment of patients satisfaction	295	207 (70.2%)	88 (29.8%)	0	0	0
C7	Patients perceive long waiting time as barriers to obtaining services.	295	94 (31.9%)	201 (68.1%)	0	0	0
C8	Waiting time is a determinant for patient satisfaction towards health care services	295	237 (80.3%)	58 (19.7%)	0	0	0
C9	Availability of medicines is seen as the most important element of quality by health care consumers	295	287 (97.2%)	8 (2.7%)	0	0	0
C10	Provision of universal access to essential medication is a major challenge in health care services	295	97 (32.9%)	190 (64.4%)	8 (2.7%)	0	0

C11	Unavailability of medicines is a major reason for dissatisfaction among patients	295	200 (67.8%)	76 (25.8%)	19 (6.4%)	0	0
C12	Lack of supplies impact negatively upon the staff morale through community pressures	295	198 (67.1%)	97 (32.9%)	0	0	0
C13	Patients suffer injury or death every year as a result of unsafe medical practices and care	295	0	100 (33.9%)	195 (66%)	0	0
C14	Patients are mostly harmed due to preventable causes	295	200 (67.79%)	58 (19.7%)	37 (12.5)	0	0
C15	Patients safety is seen as the most important aspect in the health care system	295	94 (31.8%)	201 (68.1%)	0%	0%	0%

Table 4.8 indicates the responses of Professional Nurses' knowledge regarding the 6 Ministerial Priorities.

C1: Two hundred (200) (i.e., 67.8%) respondents strongly agreed that values and attitude of staff ensured that patients were treated respectfully by staff, while 95 (i.e., 32.2%) agreed that values and attitude of staff ensured that patients were treated respectfully by staff.

C2: One hundred and ninety-two (192) (i.e., 65%) respondents strongly agreed that courtesy incorporates basic social values such as being friendly, polite and helpful and treating patients with dignity and respect, while 103 (i.e.,34.9%) agreed.

C3: Two hundred and eleven (211) (i.e.,71.5%) strongly agreed that cleanliness of a hospital plays a large role in patients' perception of the Health Care setting, while 84 (i.e., 28.5%) respondents agreed that cleanliness of a hospital plays a large role in patient's perception of the Health Care setting.

C4: Two hundred and three (203) (i.e., 68.81%) strongly agreed that there is a correlation between patient's perception of hospital cleanliness and risk of acquired infection, while 92 (i.e., 31.2%) agreed that there is a correlation between patient's perception of the hospital.

C5: One hundred and ninety-eight (198) (67.1%) strongly agreed that a clean and welcoming environment is important from an aesthetic point of view, engenders feelings of well-being and trust in people who may be anxious

or unwell, while 97 (i.e., 32.9%) agreed that a clean and welcoming environment is important from an aesthetic point of view, engender feelings of wellbeing and trust in people who may be anxious or unwell.

C6: Two hundred and seven (207) (i.e., 70.2%) respondents strongly agreed that waiting time is a parameter for assessment of Patient Satisfaction, while 88 (i.e., 29.8%) agreed that waiting time is a parameter for assessment of Patient Satisfaction.

C7: Ninety-four (94) (i.e., 31.9%) strongly agreed that patients perceived long waiting times as barriers to obtaining services, while 201 (i.e., 68.1%) agreed that patients perceived long waiting times as barrier to obtaining services.

C8: Two hundred and thirty-seven (237) (i.e., 80.3%) respondents strongly agreed that waiting time is a determinant for Patient Satisfaction towards healthcare services, while 58 (i.e., 19.7%) agreed that waiting time is a determinant for Patient Satisfaction towards Health Care services.

C9: Two hundred and eighty-seven (287) (i.e., 97.2% respondents strongly agreed that availability of medicines is seen as the most important element of quality by Health Care consumers, while 8 (i.e., 2.7%) agreed that availability of medicines is seen as the most important element of quality by Health Care consumers**.**

C10: Ninety-seven (97) (i.e., 32.9%) respondents strongly agreed that the provision of universal access to essential medicines is a major challenge in Health Care services, while 190 (i.e., 64.4%) agreed that provision of universal access to essential medication is a major challenge in healthcare services and 8 (i.e., 2.7%) were neutral.

C11: Two hundred (200) (i.e., 67.8%) respondents strongly agreed that the unavailability of medicines is a major reason for dissatisfaction among patients, while 76 (i.e., 25.8%) respondents agreed and 19 (i.e., 6.4%) were neutral.

C12: One hundred and ninety-eight (198) (i.e., 67.1%) Professional Nurses strongly agreed that lack of supplies impacted negatively upon the staff morale through community pressures, while 97 (i.e., 32.9%) agreed that lack of supplies impacted negatively upon the staff morale through community pressures.

C13: One hundred (100) (i.e., 33.9%) Professional Nurses strongly agreed that patients suffered injury or death every year as a result of unsafe medical practices and care, while 195 (i.e.,66.1%) agreed that patients suffered injury or death every year as a result of unsafe medical practices and care.

C14: Two hundred (200) (i.e., 67.79%) Professional Nurses strongly agreed that patients were mostly harmed due to preventable causes, while 58 (i.e., 19.7%) agreed that patients were mostly harmed due to preventable causes and 37 (i.e., 12.5%) were neutral.

C15: Ninety-four (94) (i.e., 31.8%) Professional Nurses strongly agreed that patient safety was seen as the most important aspect of the healthcare system, while 201 (i.e., 68.1%) agreed that patient safety was seen as the most important aspect of the Health Care system.

Table 4:9 Assessment of Professional Nurses' Perception of the Importance of the Implementation of the 6 Ministerial Priorities

	N	Very important	Important	Partially important	Not important
D1: Values and attitudes of staff	295	295(100%)	0	0	0
D2: Cleanliness	295	295(100%0	0	0	0
D3: Waiting Time	295	115(40%)	180(61%)	0	0
D4: Patients safety and Security.	295	176(59.7%)	119(40.3%)	0	0
D5: Infection prevention and Control.	295	293 (99.3%)	2 (0.67%)	0	0
D6: Availability of basic Medication and supplies	295	209(70.8%)	86(29%)	0%	0%

Table 4.9 indicates the responses of the participants on their perception of the importance of the implementation of the 6 Ministerial Priorities. Two hundred and ninety-five (295) (i.e., 100%) of the participants indicated that the implementation of the Ministerial Priorities was very important, namely, values and attitude of staff, cleanliness of the environment, waiting time of patients, patient safety and security, infection prevention and control and availability of basic medication and supplies. Respondents viewed the implementation of all 6 Ministerial Priorities as very important. Two hundred and ninety-five (295) (i.e., 100%) of the participants indicated that values and attitudes in the implementation of the 6 Ministerial Priorities are very important in the improvement of quality service.

D1: Values and attitude.

Two hundred and ninety-five (295) (i.e., 100%) respondents perceived the values attitudes of staff to be very important in the provision of quality care.

D2: Cleanliness of the environment.

Two hundred and ninety-five (295) (i.e., 100%) respondents perceived the cleanliness of the healthcare facilities to be very important in the provision of quality and safe healthcare services.

D3: Patients waiting Time

One hundred and fifteen (115) (i.e., 40%) of respondents perceived patients waiting time to be very important, while 180 (i.e., 61%) perceived patients waiting time to be important in the improvement of service delivery.

D4: Patients safety and security

One hundred and seventy-six (176) (i.e., 59.7%) respondents' perception of patient safety and security to be very important, while 119 (i.e., 40.3%) perceived patient safety and security to be important.

D5: Infection Prevention and control

Two hundred and ninety-three (293) (i.e., 99.3%) of the respondents perceived infection prevention and control to be very important, while 2 (i.e., 0.67%) perceived infection prevention and control to be important in the provision of quality care.

D6: Availability of basic medication and supplies

Two hundred and nine (209) (i.e., 70.8%) perceived the availability of basic medication and supplies to be very important, while 86 (i.e., 29%) perceived the availability of basic medication and supplies to be important.

4.2. Summary of Quantitative Results

4.2.1 Age

According to this study, the majority of the Professional Nurses were between the ages of 46-and 55 years followed by ages between 36-45 years, 22-35 years and, lastly, 56-to 65 years. The South African Nursing Council registration of Professional Nurses by provinces as of 31 December 2016 reflected a total number of Professional Nurses on the register as 154023. The age group as reflected as follows; ages of 35-39 years were 11.63% (at 17914), 40-44 years were12% (at 18474), 45-49 years were 13.75% (at 21180), 50-54 years were 13.42% (20680), 55-59 years were 13.76% (at 21195), 60-64 years were 11.7% (at 17956), 65-69 years were 5.3% (at

8186) and above 69 years were 3.02% (at 4654). SANC register reflects that the age between 5-59 years (13.76%) was in the majority, followed by ages between 45-49 years (13.75%). There are similarities between the ages of Professional Nurses depicted in this study with that of the SANC register of 2016 (SANC 2016).

4.2.2 Gender

The findings of this study show that 73(i.e., 24.75%) were males and 222 (i.e., 75.25%) were females. There was a huge gap between male and female Professional Nurses. This is an indication that nursing is still to a larger extent a female-dominated profession. Through the efforts of Florence Nightingale in the mid-nineteenth century, nursing was established as a women's profession. Nightingale's image of the nurse as subordinate, nurturing, domestic, humble and self-sacrificing, as well as not too educated, became prevalent in society. The American Nursing Association ostracized men from nursing until 1930 when, as a "result of a bylaw amendment, provision was made for male nurses to become members of the American Nurses Association" (In Review - American Nurses' Association 2018). Looking back in nursing history, Florence Nightingale and the American Nursing Association ostracized men from the nursing profession.

Health Care is considered a “naturally female” activity; thus, it is to be expected that, as a result, women should staff a caring profession. In such a profession, men are an “anomaly” because they have chosen a lower status, female-based profession. Battice (2010) states that Care, which is the essence of the nursing profession, comes in two forms, basically: physical care (hygiene and mobilization) and emotional care (support and nearness). The traditional role division may lead us to conclude that male nurses work particularly in physical, pragmatic or “instrumentalist” care in higher posts, whereas women are leaders in emotional or “expressive” care, even though, in fact, they both perform daily, in an increasingly instrumental environment.

4.2.3 Qualifications

According to the results of this study, the respondents’ highest qualifications were Diploma in General Nursing, Midwifery, Community and Psychiatric Nursing which were 137 (i.e., 46.4%), followed by BA Cure which was 87 (i.e., 29.5%), Diploma in

General Nursing and Midwifery were 58 (i.e., 19.7%), Masters in Nursing Science were 10 (i.e., 3.4%) and Doctoral in Nursing Science were 3 (i.e., 1%).

A study conducted on the extent of knowledge on falls by staff nurses in Baguio-Benguet healthcare settings assessed the relationship between nurses' education and experience and the quality of care provided indicated that there is a relationship between the education of nurses and the medication errors. There were lower medication errors and lower patient falls among nurses who upgraded their education (https://pubmed.ncbi.nlm.nih.gov)

Blegen et al., (2013) argued that more educated and experienced nurses made fewer medication errors as compared their counterparts. More advanced training for nurses has often been presented as a way to improve patient care (Blegen et al., 2013). The CNL White Paper articulated the need for an education and career pathway to keep experienced, expert nurses at the bedside to improve care quality and safety. Professional Nurses' experience regarding values and attitude of staff revealed that patients were partially treated with compassion, caring, dignity and respect. Health Workers were sometimes rude and uncaring to patients and patients' questions about their health were partially addressed.

4.2.4 Values and Attitude

All of the 295 (i.e., 100%) respondents perceived values and attitudes of staff to be very important in the provision of quality care. Siverbo, Eriksson and Raharjo (2014) conducted a study that attempted to examine the attitudes toward quality improvement among Health Care professionals. The findings of the study revealed that the construct of attitudes is significantly associated with the change in the behaviour toward quality improvement in the targeted hospitals.

The findings of the narrative from the qualitative study show that Professional Nurses also indicated both negative and positive attitudes of nurses in Sub-themes 1 and 2 of Theme 1. This is an indication of the correlation between the qualitative and quantitative results. Values and attitudes are significantly associated with behaviour as stated by Siverbo, Erickson and Raharjo (2014). Narratives also indicated that

nurses became frustrated due to a lack of resources, which might have contributed to the attitude of the nurse

The results of the study revealed that cleaning services were not effectively managed; cleaning equipment and materials were not available at all times; shortages were experienced from time to time; and the environment was poorly maintained, which contributed to nosocomial infections. There was no suitable person to manage cleaning services. There was no ongoing in–house training for cleaning staff. Standard Operating Procedures and or cleaning protocols were not in place for cleaning. In the narratives, Professional Nurses indicated that there was a shortage of equipment and material resources, which have an impact on cleanliness. It was also indicated that equipment were not serviced regularly. Theme 3 indicated the availability of resources, which stated in Sub-themes 1 and 2 that there was a shortage of human resources, as well as a shortage of material resources, which supported the poor cleanliness in hospitals. Cleanliness of hospitals played a large role in patients' perception of the Health Care setting and there was a correlation between patients' perceptions of hospital cleanliness and the risk of acquired infections. Professional Nurses strongly agreed that a clean and welcoming environment was important from an aesthetic point of view, engendered feelings of well-being and trust in people who might be anxious or unwell.

Professional Nurses' experience regarding waiting time revealed that maximum waiting time was displayed in each service area. Some of the patients were aware of the maximum waiting time, while others were not aware. There were fast lanes queues for sick patients, children and older persons. Screening of patients was done at the point of patient entry into the hospital. Waiting time was locally determined, however, patients waited for a long time. Some of the patients waited for a long time to open a file and or see a doctor. Some of the patients had to come back the following day to be seen by the doctor however, patients did not wait a long time to get medication at a pharmacy. Waiting time in key areas was not monitored and measures were not taken by management to address the causes of blockages.

The narratives from Professional Nurses indicated that there was a shortage of human resources, which had a direct bearing on the long waiting time of patients in

the hospital. The other factor was a shortage of material resources and shortage of medical equipment, which were exacerbated by poor servicing of medical equipment, which means that patients had to wait to be attended to due to limited medical equipment. Professional Nurses strongly agreed that waiting time was a parameter for the assessment of Patient Satisfaction. Patients perceived long waiting time as a barrier to obtaining services and it was a determinant for Patient Satisfaction with Health Care services

Professional Nurses' experience regarding patient safety and security revealed that a security system was in place to safeguard buildings, patients, visitors and staff. There was adequate lighting in some of the health facilities, while in others the lighting was not adequate. Security breaches were reported, however, they were partially addressed. Safety and security awareness was partially promoted among staff members. Security guards were designated for specific areas. The narratives from the findings of the qualitative results showed that there was a shortage of resources in terms of human resources and material resources however in terms of patients' safety and security hospitals seemed to have adequate security systems even though it was indicated that security breaches were reported but not attended to. This is supported by the narrative from the results of the qualitative results that top management did not support the implementation of the 6 Ministerial Priorities, as well as give feedback to employees. Professional Nurses strongly agreed that waiting time was a parameter for the assessment of Patient Satisfaction. Patients perceived long waiting time as a barrier to obtaining services and it was a determinant for Patient Satisfaction with Health Care services

Professional Nurses' experience regarding infection prevention and control revealed that Health Care facilities were partially compliant with hand hygiene. There was ongoing monitoring and management of infection prevention and control practices. Policies and protocols for the prevention and management of infections were partially available and partially implemented. Some officers were appropriately trained to monitor infections however; infection prevention and protective clothing for staff and patients were partially available and were partially used properly. Nosocomial infections outbreaks were investigated and reported. Waste was managed appropriately and protected from theft, vandalism and scavenging. The narrative

from Professional Nurses indicated that there was a shortage of material resources and human resources, which supported by the fact that hospitals were partially compliant with hand hygiene, protective clothing was partially available and policies and protocols were partially implemented.

Professional Nurses' experience regarding the availability of medications and supplies revealed that basic medication was not available at all times, in adequate amounts and appropriate dosage forms: it was a daily occurrence. The Essential Drug List (EDL) was partially available 90% of the time. However, appropriate medications were prescribed by the doctors and administered to patients. The narratives from Professional Nurses, which indicated that shortage of medicines affected the quality of care, supported the quantitative results. Professional Nurses indicated that patients had to come back the following day to receive medications and, at times, nurses had to buy medication for patients from their pockets. Health Care consumers saw availability of medicines as the most element of quality. Provision of universal access to essential medication was a major challenge in Health Care services and the unavailability of medicines was a major reason for dissatisfaction. Lack of supplies affected negatively upon the staff morale through community pressures.

The research also revealed inadequate resources for the effective implementation of the priorities such as medication, protective clothing, cleaning equipment and materials. There was the failure to identify and deal with blockages, which prolonged waiting time. The environment was poorly managed and Standard Operating Procedures and protocols were not available to guide cleaning services. In-house training for cleaning was not conducted. Patients were partially treated with dignity and respect. Patients' questions about their Health Care were partially addressed. Patients were harmed due to preventable causes. Protective clothing for staff and patients was not utilized appropriately. Based on the gaps identified, a training program will be necessary for Professional Nurses to capacitate them on the proper implementation of the Ministerial Priorities to provide quality care.

National Department of Health (NDoH 2017) stated that the medicine value chain plays a critical role in the overall performance of any health system. Consequently,

there is a need to ensure patients have a dependable supply of the right medicines, available at the right time, in the right quantity and at the right place (NDoH 2017). Department of Health emphasized that health establishments should ensure that medicines are available 90% of the time as per the relevant Essential Drug List (EDL). Appropriate medicines should be available as prescribed, and patients should be able to obtain their medicines from a pharmacy or provider within an acceptable period (NDoH 2011).

Ensuring adequate supplies of medicines, at affordable prices, is a key element of managing diseases, including non-communicable diseases, effectively. To ensure this, comprehensive procurement systems and robust Supply Chain Management systems are key to managing those medicines deemed essential. Functioning logistic networks will improve access to medicines, and innovative programs to assess medication usage will lead to a better understanding of how rationally medication is being used in a country, as well as ensuring sustainability (NDoH 2015).

Sivero, Eriksson and Raharjo (2014) conducted a study that attempted to examine the attitudes toward quality improvement among Health Care professionals. The findings of the study revealed that the construct of attitudes is significantly associated with the change in the behaviour toward quality improvement in the targeted hospitals A survey conducted by Bobby Kutter (2016) showed that patients' perception of hospitals' cleanliness could have a major impact on the overall care and hospital experience.

All health establishments should reduce the risk of Health Care-associated infections through ongoing monitoring and management. Policies and protocols should be available and implemented. Officers should be appropriately trained to monitor infections in health establishments. Protective clothing for staff should be available. Nosocomial infections outbreaks should be investigated and reported. Waste must be properly managed and waste was protected from theft, vandalism and scavenging (NDoH 2011).

4.3. Conclusion

The research revealed challenges experienced by Professional Nurses in the implementation of 6 Ministerial Priorities in hospitals in Limpopo such as lack of resources; lack of knowledge; lack of medication and other material resources; and lack of support from management. The results also show that the implementation of the 6 Ministerial Priorities was not constantly monitored and Professional Nurses did not have adequate knowledge and skills to implement Ministerial Priorities effectively. These challenges compromised the provision of quality care resulting in increased cases of litigation. The result also revealed a need for training of Professional Nurses to capacitate them on the implementation of the Ministerial Priorities. Professional Nurses could not win the battle of improving service delivery alone but the involvement of a multidisciplinary team with the support of the top management.

CHAPTER 5
INTEGRATION OF QUALITATIVE AND QUANTITATIVE RESULTS

5.1. Introduction

Chapter 4 discussed the presentation and discussion of the qualitative and quantitative results of the study. This chapter discusses the integration of qualitative and quantitative results.

5.2. Purpose of Integration of Results

The purpose of the integration of results was to align the results of both studies, which were used in the development of the study, and improves the credibility of the results.

The qualitative objective was, namely, to:

- Explore and describe the experiences of Professional Nurses on the implementation of the 6 Ministerial Priorities in the selected Health Care facilities in Limpopo Province.

The quantitative objectives were, namely, to:

- Describe the knowledge and practices of Professional Nurses on the implementation of the 6 Ministerial Priorities in the selected hospitals of Limpopo Province; and
- Identify the support required by Professional Nurses to enable them to facilitate and implement 6 Ministerial Priorities

5.3 Presentation of Integration of Qualitative and Quantitative Results

Table 5.1 Integration of Qualitative and Quantitative Results

QUALITATIVE RESULTS	QUANTITATIVE RESULTS
Identified Themes Theme 1. Experiences of Professional Nurses on the implementation of the Six Ministerial Priorities	**Findings** • Waiting time was displayed at all service areas and patients were aware
Sub-theme 1.1 • Positive attitude towards the implementation of the 6 Ministerial Priorities	• There were fast lane queues for very sick patients, children and older persons. • Screening of patients was done at the point of entry into the hospital.
Sub-theme 1.2. • Negative attitudes towards implementation of ministerial Priorities	• Patients were partially treated with compassion and caring • Patients were not treated courteously at all times • Patients' questions about their health questions were always partially addressed. • Patients felt that they were not treated well.
Sub-theme 1.3 • Poor monitoring of the implementation of 6 Ministerial Priorities.	• Policies and protocols for prevention and management of infection were partially implemented.
Theme 2. Knowledge of staff of the Ministerial Priorities **Sub-theme 2.1** • Poor knowledge of the staff of the 6 Ministerial Priorities	• Policies and protocols for prevention and management of infections were partially implemented • The environment was poorly managed

Theme 3 **Availability of resources** **Sub-theme 3.1** • Shortage of human resources	• Patients waited a long time to open a file The patient waited a long time to see a nurse. • Patients waited a long time to see a doctor. • There was no suitably experienced person to manage cleaning services.
Sub-theme 3.2 • Shortage of material resources	• Cleaning material and equipment are not available all the time. • Shortage of protective clothing.
Sub-theme 3.3 • Shortage of medicines at the pharmacy	• Shortage of medicines was a daily occurrence. • Basic Medication was not available in adequate amounts all the time
	• The Essential Drug List was partially available 90% of the time.
Sub-theme 3.4 • Poor servicing of equipment	• Shortage of cleaning equipment

Theme 4 • The staff Training program of the 6 Ministerial Priorities **Sub-theme 4.1.** • Inadequate orientation programme	• Non-compliance with hand hygiene • Policies and protocols for prevention and management of • infections were partially implemented.
Sub-theme 4.2. • Lack of in-service training programme	• Cleaning services were partially managed • Ongoing in-house training for staff was conducted partially. • Safety and security awareness was partially promoted to staff.
Theme 5 Psycho-social support **Sub-theme 5.1.** • Poor staff support from management on the implementation of the Six Ministerial Priorities	Policies and protocols for prevention • and management of infections were • partially available • Shortage of staff • Shortage of equipment • Shortage of material resources Shortage of cleaning material • Shortage of protective clothing • Waiting time in key areas was monitored and measures were partially taken by management to address the causes of blockage.
Sub-theme 5.2 • Poor feedback from management on implementation of the Six Ministerial Priorities	Waiting time in key areas was • monitored and measures were partially taken by management to address the causes of blockage.

Table 5.1 depicts the integration of the findings of the qualitative and quantitative phases of the study.

5.4 Discussion of Integrated Results

The narrative and numeric results of Professional Nurses are in Table 5.1.

The qualitative results emerged from the semi-structured one-on-one interviews and the quantitative results emerged from the questionnaires used. These two (2) methods complemented each other based on the findings since more information and support for findings emerged. Qualitative results revealed five themes and twelve sub-themes were developed from the narratives of the Professional Nurses during the qualitative Data Analysis. The quantitative questionnaire was developed based on the findings of the qualitative study. There is corroborative evidence from both findings that there were gaps in the implementation of the 6 Ministerial Priorities. The two sets of findings support each other.

Under the themes, there were two sub-themes that identified the attitude of staff regarding the implementation of the Ministerial Priorities. A positive attitude from the qualitative phase was supported by the findings from quantitative results regarding waiting time, in that:

- Waiting time was displayed in all service areas and patients were aware of the time that they were expected to wait before being attended to;
- Patients were screened at the point of entry into the hospital; and
- There were fast lanes for very sick patients, children and older persons.

Negative attitudes identified from the qualitative phase were supported by the findings of the quantitative in that:

- Patients' were partially treated with compassion and caring;
- Patients' were not treated courteously at all times;
- Patients' questions about their health questions were always partially addressed; and
- Patients' felt that they were not treated well.

Poor monitoring of the implementation of the 6 Ministerial Priorities from the qualitative finding was supported by the following quantitative results, namely:

- Policies and protocols for the prevention and management of infections and control practices were partially available;
- Partial implementation of policies and protocols;
- There was poor hand hygiene compliance; and
- Waiting time in key areas was monitored, however, measures were partially taken by management to address the causes of blockages.

Poor knowledge of the staff of the Ministerial Priorities was supported by the following quantitative results':

- Security incidences and breaches were reported but they were partially addressed;
- Poor hand hygiene; and
- The lack of Policies and protocols is an indication that the staff did not know.

The shortage of Human resources identified from the results of qualitative corroborate with the results from quantitative as follows:

- Cleaning services were not effectively managed;
- Patients waited a long time to open a file, to see a nurse and a doctor; and
- There was no suitably experienced person to manage cleaning services.

The shortage of material resources was supported by the following the quantitative results:

- Equipment was not available all the time;
- There was a shortage of cleaning material; and
- There was a shortage of protective clothing for patients and staff.

The shortage of Medicines was supported by the following results from quantitative results:

- Basic medication was not available at all times;
- Shortage of medication was a daily occurrence in many health facilities; and
- The essential drugs list was partially available 90% of the time.

Poor servicing of equipment was supported by a shortage of cleaning equipment as well as a poorly maintained environment.

The following supported an inadequate orientation programme;

- Noncompliance with hand hygiene; and
- Policies and protocols were partially implemented.

The lack of an in-service training programme was supported by the following findings from quantitative results:

- There was partial ongoing in-house training for cleaning staff;
- Cleaning services were not effectively managed;
- Safety and security awareness was partially promoted among staff;
- There was partial compliance with hand hygiene; and
- Waiting time in key areas was monitored, however, measures were not taken to address the causes of blockages.

Poor Staff support from management on the implementation of the 6 Ministerial Priorities was supported by the following findings from a quantitative study:

- Shortage of human resources;
- Shortage of equipment;
- Partial availability of policies and protocols;
- Security incidences and breaches were reported but not addressed by management;
- Policies and protocols were partially available and partially implemented; and
- Policies and protocols for cleaning services were not available.

Poor feedback from management on the implementation of 6 Ministerial Priorities was supported by the fact that:

- Security breaches and incidences were reported and they were partially attended to by management who did not inform staff of the reasons why they were not fully addressed;

- Shortage of resources was experienced but the staff was not given reasons why resources were not adequate for the provision of quality care; and
- Policies and protocols were not available but information on the reasons for the shortage was not discussed with staff.

5.5. Summary

The corroboration of the qualitative and quantitative results confirms challenges concerning the implementation of 6 Ministerial Priorities in the Health Care facilities. A need for a training programme for Professional Nurses was supported by the findings. However, management has a responsibility to ensure that resources are available to enable the nurses and other Health Care Workers to implement the 6 Ministerial Priorities in the selected hospitals of Limpopo in South Africa of 6 Ministerial Priorities.

CHAPTER 6
CONCEPTUAL FRAMEWORK OF TRAINING PROGRAMME

6.1 Introduction

Chapter 5 described the integration of results of the experiences, knowledge and perceptions of the Professional Nurses on the facilitation of the implementation of the 6 Ministerial Priorities. This chapter captures Phase 3 of the research and described the conceptual framework, which guided the training program.

The objective of this phase were;

- Describe the conceptual framework of the training programme. The discussion in this chapter was based on the results of the collected data represented in Section B

6.2. Conceptual Framework

The conceptual framework of this study was based on the Practice-Orientated Theory of Dickoff et al., (1968) as well as Malcolm Knowles' Theory of Andragogy. The theory of Dickoff et al., (1968) explained concepts and analysed the prescribed activities that were aimed at realizing the training programme goals, while Malcolm Knowles guided the process of the development of the training programme.

6.2.1. Practice Orientated Theory

- Who or what performs activities (agent)?
- Who or what is the recipient of the activity?
- In what context is the activity performed?
- What is the guiding procedure technique of protocol of the activity?
- What are energy sources for the activity?
- What is the product of the activity?

(Dickoff, James & Wiedenbach, 1968)

The hierarchical representation of the reasoning map consisted of the following components: Agent (viz., Operational Manager), recipients (viz., Professional Nurses), context (viz., Health Care facilities), dynamics (viz., Challenges hampering the successful implementation of the 6 Ministerial Priorities), procedures (viz.,

Training programme for Professional Nurses) and terminus (viz., knowledge, skills, abilities acquired during the training programme).

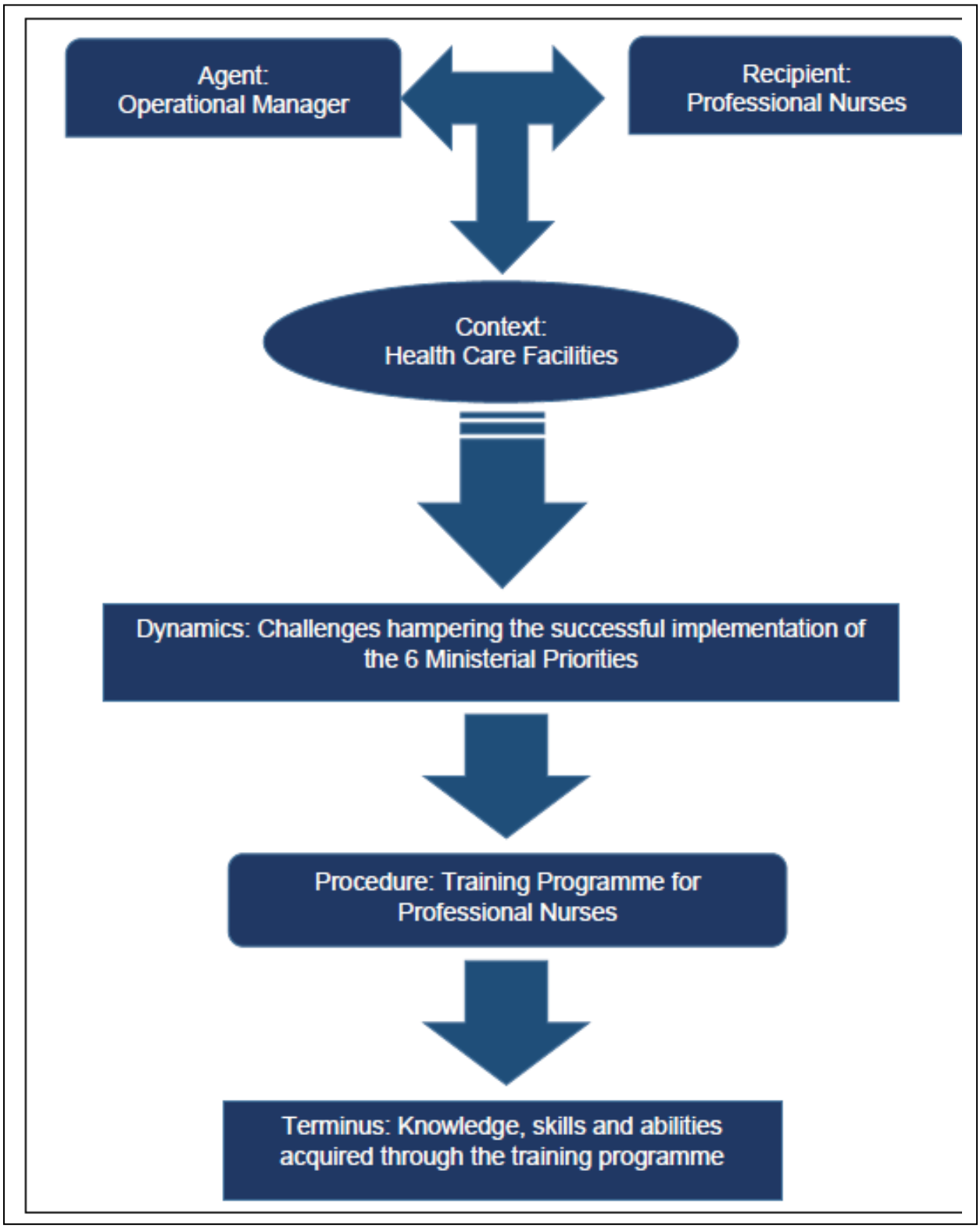

Figure 6.1. The Reasoning Map *(Source: as adapted from Dickoff et al., 1968)*

Figure 6.1 presents the elements or activities adapted from Dickhoff et al.'s Practice-Orientated Theory (1968) to describe the conceptual framework and the process of developing a training programme for Professional Nurses.

6.2.1.1. Agent

The agent in this study was the Operational Manager who conducted the training which was developed by the researcher to capacitate the Professional Nurses to facilitate the implementation of the 6 Ministerial Priorities (Dickoff et al., 1968)

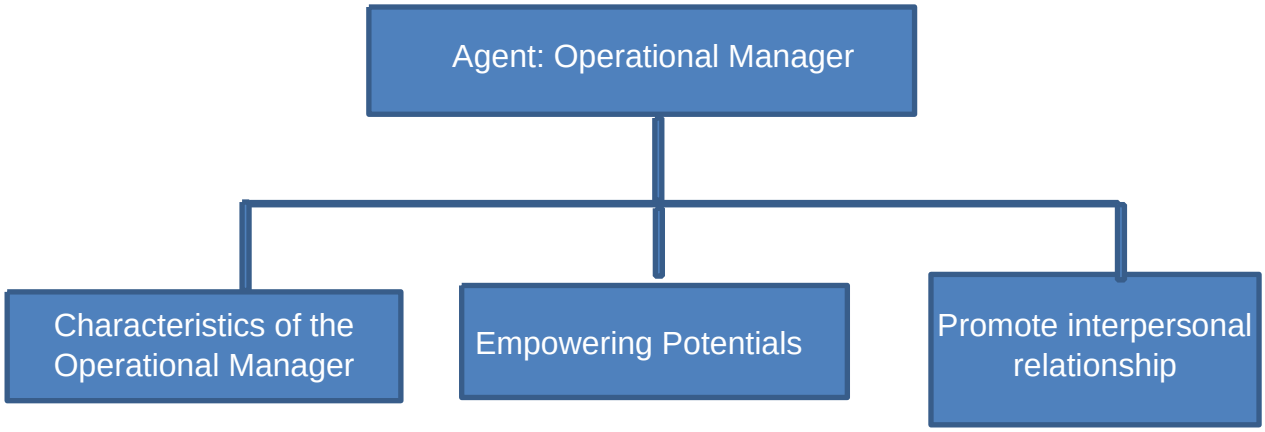

Figure 6.2. Characteristics of Agent

6.2.1.1.1. Characteristics and roles of the Operational Manager (Agent)

The agent was the Operational Manager who is a Professional Nurse with midwifery and in possession of a post-graduate qualification in nursing Education and Health Service management. The Operational Manager had an extensive experience in health service management and was in-charge of a unit (ward). The Operational Manager implemented the training programme developed by the researcher.

The Operational Manager had qualities of both a leader and a teacher. She/ he was able to guide, support, direct and encourage the Professional Nurses who will be the recipient of the training. The Operational Manager was also committed and able to teach and organize, self-motivated and energetic. She had good communication and listening skills (Nongame & Hans Justus, 2016).

Qualities of a leader will include planning, implementing, monitoring and evaluating a training programme. The Operational Manager will be hard working, committed and passionate about quality improvement, assertive, inventive, approachable, honest, trustworthy, self-motivated, energetic, attentive, knowledgeable and proficient to handle the situations concerning quality in Health Care. The agent has to be a good mediator and mentor (Nongame & Hans Justus, 2016).

6.2.1.1.2. Empowering potential

The agent, who is the Operational Manager, will be able to empower the Professional Nurses (recipients) by encouraging them to give input during the need analysis of the training programme. The Operational Manager (agent) will encourage the Professional Nurses (Recipients). The recipients will be encouraged by the Operational Manager (Agent) to contribute meaningfully, give inputs during the training, and share the experiences they have gained during the implementation of the Ministerial Priorities**.**

6.2.1.1.3 Promotion of interpersonal relationships

The agent who is the Operational Manager should be able to promote interpersonal relationships during the implementation of the training programme to improve communication among the recipients and other Health Professionals. The agent should be able to accept the contributions made by recipients.

6.2.1.2. The Recipient

Who or What is the Recipient of the activity

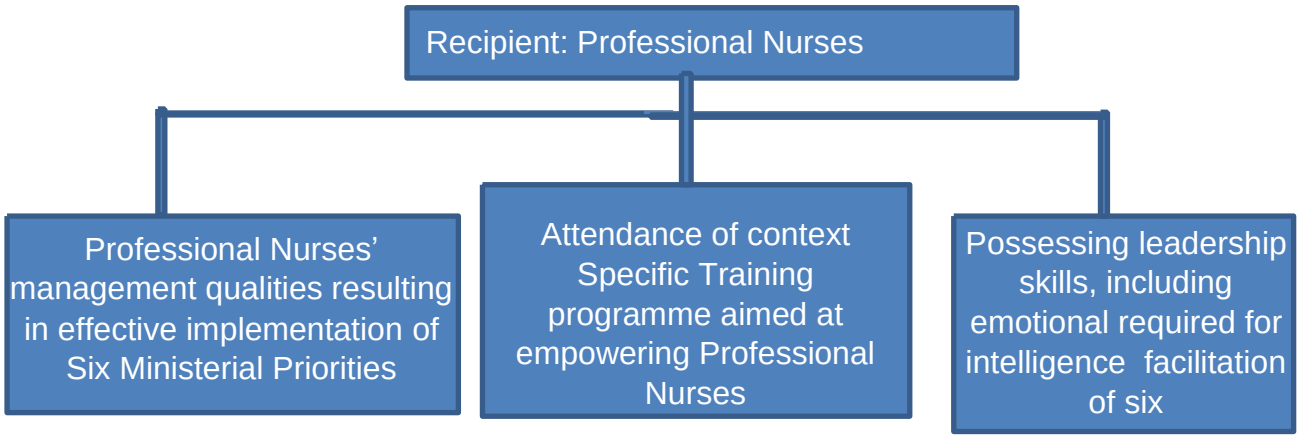

Figure 6.3. The Recipient *(Source: Dickoff, James & Wiedenbach, 1968)*

Figure 6.3 shows how Dickoff, James and Wiedenbach (1968) describe the recipient as the person(s) receiving the activity. The recipient of the training will be all Professional Nurses in the Health Care facilities in Limpopo Department.

6.2.1.2.1 Characteristics of a Recipient

The recipient was a qualified Professional Nurse who was implementing 6 Ministerial Priorities in the Public Health Care facilities in Limpopo Department of Health. According to Dickoff et al. (1968), the recipient was expected to possess certain qualities to benefit from the training programme such as teamwork, good interpersonal relationships, communication, listening skills and be responsible so that he or she could be able to share the knowledge and skills with other health professionals.

The recipient was equipped with relevant knowledge, skills, abilities and attitudes to manage 6 Ministerial Priorities effectively. Managerial competencies were acquired through the training programme, which was designed to empower Professional Nurses to enable them to facilitate the implementation of the 6 Ministerial Priorities by the health professionals in the health facilities. Attending the training programme would empower recipients to change attitudes towards patient safety, create a favourable environment and promote a positive culture that focused on change management. The training programme was informed by the outcome of the interviews of the Professional Nurses during the study, as well as their experiences in the implementation of the 6 Ministerial Priorities.

The training was expected to improve the skills and knowledge of the providers of patient care. It is also expected to promote ownership, effective interpersonal relationships and motivational strategies to improve the facilitation of implementation of 6 Ministerial Priorities to improve quality care in the Health Care system. Attending the training programme would enhance knowledge, skills and abilities to enable the recipients to implement 6 Ministerial Priorities. The Professional Nurses had a heightened capacity to adapt and innovate. Health professionals' motivation was increased. Company productivity was also improved. Job satisfaction and morale of the health professionals was increased. Better employee retention and reduction in

employee turnover. There were gains in risk management and an enhanced company reputation and employee recruitment.

The Operational Manager was expected to influence and motivate Professional Nurses to accept change and develop mechanisms to facilitate the implementation of the 6 Ministerial Priorities. Operational Managers were expected to provide coaching and mentorship tutorials to Professional Nurses to encourage them to participate actively in the training programme. The top management were expected to possess relevant leadership qualities to manage quality improvement programmes at the Health Care facilities. Leadership qualities such as good communication and a leader with the vision for the future, shows empathy to employees. Such ones who hold themselves accountable and show gratitude to employees (Ryba, 2020). Competence, ability to inspire confidence, provision of support and promotion of teamwork were required for the development of a training programme.

6.2.1.3. Context

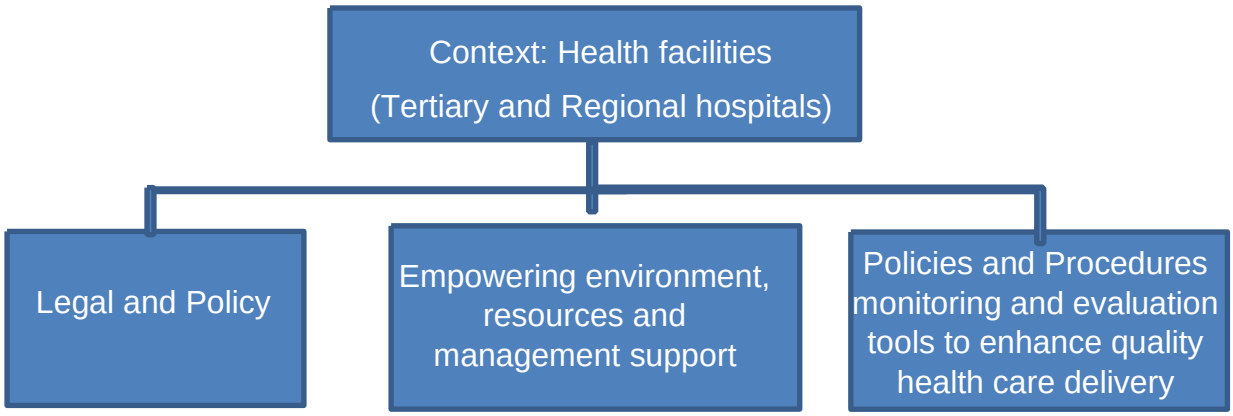

Figure: 6.4. Context

Figure 6.4 describes the third aspect of the Practice-Orientated Theory described by Dickoff et al., (1968). In this study, the context was the healthcare facilities that were providing healthcare services to patients and clients. The specific context of this programme was the Health Care facilities of the Limpopo Department of Health. The context consisted of the legal framework, empowering environment, resources and

management support. Policies, procedures, monitoring and evaluation tools to enhance quality Health Care delivery.

6.2.1.3.1 Legal Framework and Policies

Different statutes regulate the Health Care system in South Africa, namely:

- *The Constitution of the Republic of South Africa Act* of 1996, Section 27, enshrines the rights to health of all citizens of South Africa. Lack of access to Health Care services violates the rights of citizens;

  The National Health Act 61 of 2003, provides a framework for a structured uniform health system within the Republic of South Africa, taking into account the obligations imposed by the constitution and other laws on the national, provincial, and local governments concerning health services, regulates the provision of Health Care in South Africa;
- Nursing Act 33 of 2005 regulate the nursing profession and provide for matter connected to the profession;
- Labour Relations act 66 of 1995 gives effect to the public international law obligation of the Republic relating to labour relations. Nursing Act prescribes the scope of practice of nurses and how they should conduct themselves; and
- Public Finance Management Act No 1 of 1999 regulates financial management in the national government, to ensure that all revenue, expenditure, assets and liabilities of the government are managed efficiently and effectively.

In empowering health professionals, it is crucial to understand the policies that shape the day-to-day activities in the Health Care system. The link between the legal frameworks, as well as the health context policies and procedures, needs to be established with the view of supporting health professionals to improve quality Health Care delivery.

In Limpopo, the Health Care facilities consist of Tertiary services hospitals, Regional Hospitals also referred to as Provincial Hospitals, Specialized Hospitals, District Hospitals, Health Care Centres and Primary Health Care services. Health Care facilities provide care and services at different levels as prescribed by the National Health Act with different inputs and resources at their disposal.

6.2.1.3.2 Empowering environment with resources and management support

Kutney-lee, Germack, Hatfield, Kelly, Maguire, Dierkes, Gidice and Aiken (2016) state that an environment that empowers and motivates nurses is necessary to rejuvenate and sustain the nursing workforce. They further alluded that organizations should be creative in meeting the needs of nurses, while providing the best and safest care to patients.

Health professionals are executing their roles and responsibility in the health context, which is a Health Care facility. The environment should enable Professional Nurses to executive their roles by providing tools of the trade, as well as support from the leadership of those facilities. Policies and procedures should also be available to guide the daily activities and operations in the health environment. It is crucial to understand the policies that shape the day-to-day activities in Health Care facilities. Health Care facilities face different challenges that affect service delivery negatively such as a shortage of human and material resources, shortage of medication and poor support from top management.

Effective management of resources is one of the important elements to enhance quality Health Care delivery since no Health Care facility would function effectively without adequate resources; such as human, material and financial resources to procure medical equipment and capacitate employees. Empowering an environment with resources and management support will improve service delivery and motivate Professional Nurses to execute their duties effectively

Senge (2013) states that an empowering environment can be related to a “learning organisation” that supports the development of capacity and strengthens the confidence to take initiative in quality improvement Health Care delivery activities.

> Learning organizations are organizations where people continually expand their capacity to create the results they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free, and where people are continually learning to see the whole together.
>
> (Senge, 2013)

The management should provide an empowering environment by sharing the vision of the organization with the Professional Nurses, provide ways to contribute to the

vision; respect employees, their opinions, and their inputs; communicate well and more often with them; rewards efforts and success; and use failures and mistakes as learning opportunities.

6.2.1.3.3 Policies and Procedures, monitoring and evaluation tools to enhance quality Health Care delivery

Training of Professional Nurses took place in the Health Care facilities, which were established under certain regulations, acts and policies, which govern all the operations and activities taking place within them. Therefore, when the training programme is developed it took into consideration the aim of the existence of the organization and ensured that the goals were achieved. Every activity within the health system was guided by certain procedures, which were followed at all times to ensure the safety of the recipient of care and maintained quality at all times. The policies also outlined the roles and responsibilities of all the participants within the health system, as well as the requirements for the employment of all role players.

6.2.1.4. The Dynamics

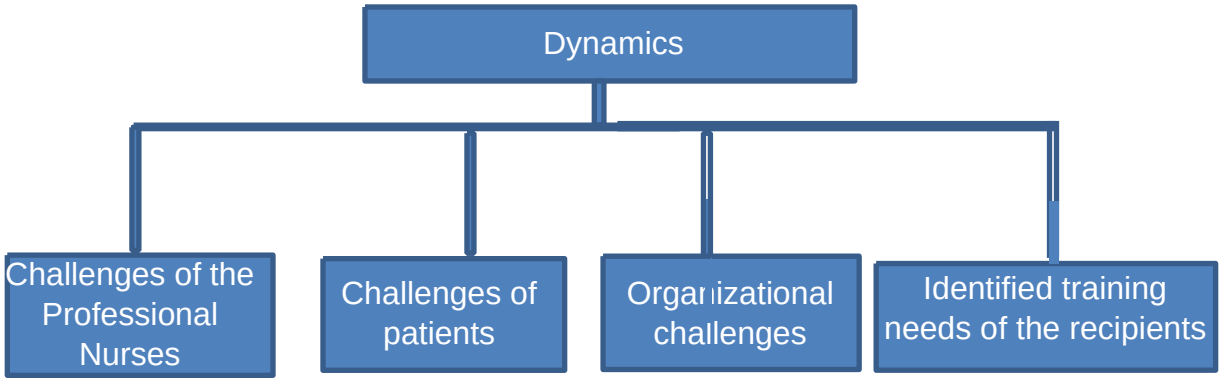

Figure 6.5: The Dynamics

Figure 6.5 shows the dynamics of this study for the successful implementation of the programme (Dickoff, James & Wiedenbach, 1968).

6.2.1.4.1. Dynamics for successful implementation of the training programme

Dynamics refers to the energy source of the activities, which reside inside the individual or the internal motivating factor for the successful implementation of the

programme (Dickoff, James & Wiedenback, 1968). The dynamics in this study consisted of the challenges experienced by the Professional Nurses during the implementation of the 6 Ministerial Priorities and the training needs. The recipients identified the challenges during data collection. The dynamics were divided into challenges experienced by the recipient, challenges related to patients, challenges related to the organization, and the identified training needs of the recipient.

6.2.1.4.2. Challenges experienced by Professional Nurses

Challenges experienced by Professional Nurses included poor knowledge of the implementation of the Ministerial Priorities. The findings in this research revealed that training was not given regarding the implementation of the Ministerial Priorities, as well as lack of orientation programme for newly employed staff; poor support and lack of feedback from management; poor monitoring of the implementation of Ministerial Priorities; shortage of human resources; and poor service of equipment.

Training of Professional Nurses in the implementation of 6 Ministerial Priorities was to equip them with the necessary skills and knowledge to be able to implement the 6 Ministerial Priorities effectively. Orientation of newly employed Professional Nurses was to ensure that they become acquainted with the environment and acquire knowledge of procedures and processes in the organization. Monitoring the implementation of 6 Ministerial Priorities will enable the manager to assess if they are implemented effectively.

6.2.1.4.3. Organizational challenges experienced by Professional Nurses

Organizational challenges during the implementation of the Ministerial Priorities included lack of cleaning material, lack of protective clothing and lack of orientation programme for newly employed staff. Lack of medicines and other supplies. Lack of policies and Standard Operating Procedures to guide the actions of the nurses.

The negative attitude of nurses towards patients

Cleaning material is very important in maintaining a clean environment, as well as preventing the spread of infection. Protective clothing protects the staff and patients from acquiring infection. Newly appointed staff needed to be orientated to the environment to ensure that the employee is acquainted with the environment. This

would minimize errors and improve efficiency and effectiveness. Availability of medication was essential, as patients could not be treated without medication

6.2.1.4.4. Challenges experienced by patients as viewed by Professional Nurses

Challenges experienced by patients as viewed by nurses included negative attitudes towards patients by some of the nurses. Lack of protective clothing. Patients' questions about their health problems were not satisfactorily answered. Patients waited for a long time to open their files at the hospital, as well as see a doctor. Some of the patients had to come back the following day to see a doctor. Medication was not always available for the patient.

6.2.1.5. Procedure

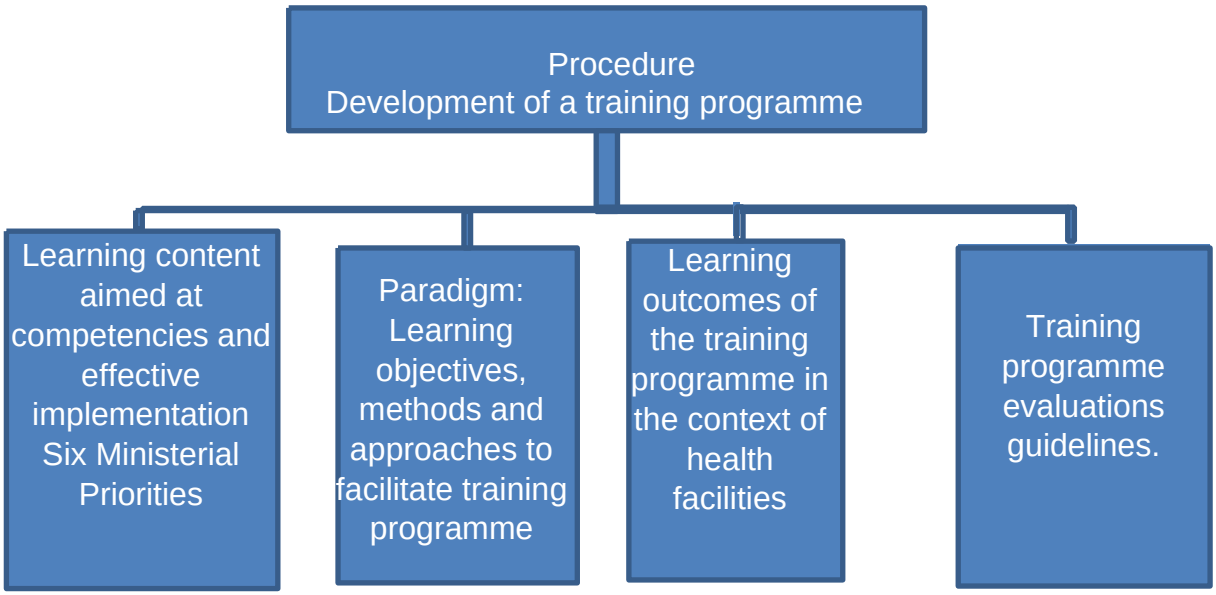

Figure 6.6 Procedure (Training Programme).

Figure 6.6 depicts the Procedure for the development of the Training Programme.

Procedure

The procedure is referred to by Dickoff, James and Wiedenbach (1968) as the guiding principle, which includes the process in the development of the training programme. The training programme will include the following:

- The learning content was aimed at improving competencies for the effective implementation of the Ministerial Priorities. The identified gaps,

knowledge, and skills of Professional Nurses in the facilitation and implementation of the 6 Ministerial Priorities informed the learning content;

- Learning objectives, methods and approaches to facilitate training programme. The learning objectives, methods and approaches to facilitate the training programme were based on the gaps identified; and
- Learning outcomes in the context of health facilities. Learning outcomes were competent Professional Nurses who acquired knowledge and skills to be able to facilitate and implement 6 Ministerial Priorities.

- **Training programme evaluations guidelines**

The procedure followed was guided by the needs assessment, which guided the procedure for the development of the training programme for the facilitation of the Ministerial Priorities. Training strategies included the active participation of the recipients, Case Studies, group discussion and role-playing. The topics, which were included in the training programme, covered the 6 Ministerial Priorities and all aspects of the themes and sub-themes which were uncovered during the narratives such as poor support from management, shortage of resources and lack of feedback from management.

6.2.1.6. Terminus

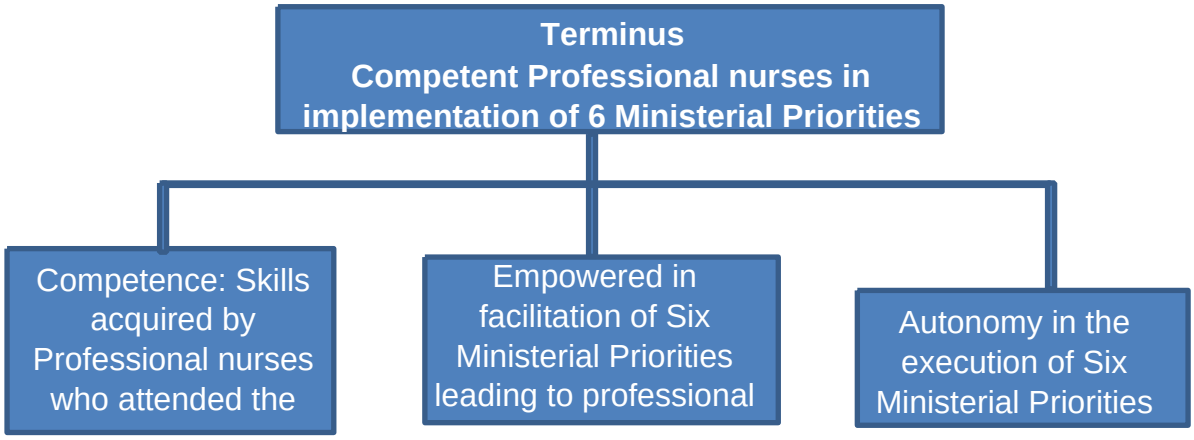

Figure 6.7 The Terminus (The Endpoint of the Training Programme) (Competent Health Professionals)

Terminus

Terminus refers to the endpoint of the training programme, which completed the activities in the cycle of developing the conceptual framework of the training programme, as described by Dickoff et al.'s (1968) Practice Orientated Theory. The terminus is the point where the agent evaluates whether the goals were achieved and all the training needs of the recipient were covered in the programme. The terminus includes whether all the problems-based activities dealt with in the training programme met the needs of the recipients and were relevant to the context of the study. Whether the knowledge was improved to enable the recipient to execute the task at hand, namely, that of implementing the 6 Ministerial Priorities. Whether the recipients were self-sufficient to respond to the needs of patients.

Aspects of terminus included the following:

- **Competence**

Competence refers to skills acquired during the training. At the end of the training, Professional Nurses are expected to acquire the skills and competence necessary to enable them to facilitate and implement the 6 Ministerial Priorities. Skills acquired by Professional Nurses.

- **Empowerment in the facilitation of the 6 Ministerial Priorities leads to professional and personal growth**

Professional Nurses would be empowered in the effective facilitation and implementation of the 6 Ministerial Priorities. This will improve the provision of quality care, which is the aim of the study.

- **Autonomy in the execution of 6 Ministerial Priorities**

Professional Nurses who were empowered and skilled would be able to function with autonomy in the facilitation and implementation of the 6 Ministerial Priorities.

Upon completion of the training programme, the Professional Nurses would have acquired knowledge and skills to be able to facilitate and implement the 6 Ministerial Priorities. Competence would be seen in the skills acquired by those Professional Nurses who attended the training. The Professional Nurses would also become

autonomous and confident when facilitating the implementation of 6 Ministerial Priorities.

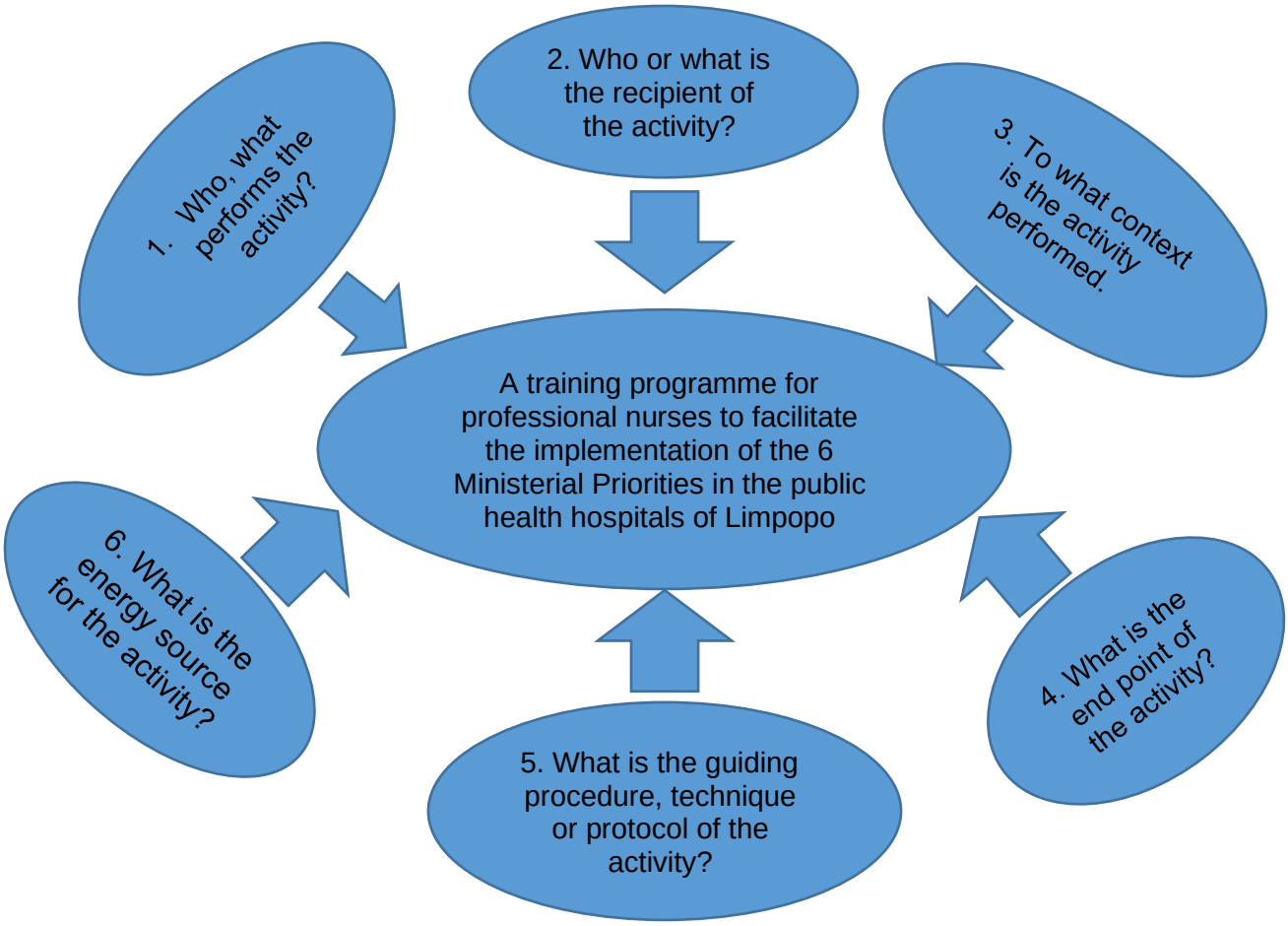

Figure 6.8. Conceptual Framework of Dickoff et al., (1968) for the Development of the Training Programme for Professional Nurses

6.2.2. Theoretical Framework for the Development of the Training Programme of Malcolm Knowles

Andragogy (Adult) Malcolm Knowles' theory was used to guide the process of the development of a training programme for Professional Nurses because they are adult learners. Knowles' Theory of Andragogy is an attempt to develop a theory specifically for adult learning. Knowles emphasizes that adults are self-directed and expect to take responsibility for decisions (Knowles, 1984).

Malcolm further stated that adult learning needs to focus more on the process and less on the content being taught. The author indicated that strategies such as Case Studies, role-playing, simulations and self-evaluations are most useful and instructors

should adopt the role of facilitator or resource rather than lecture or grader (Knowles, 1984).

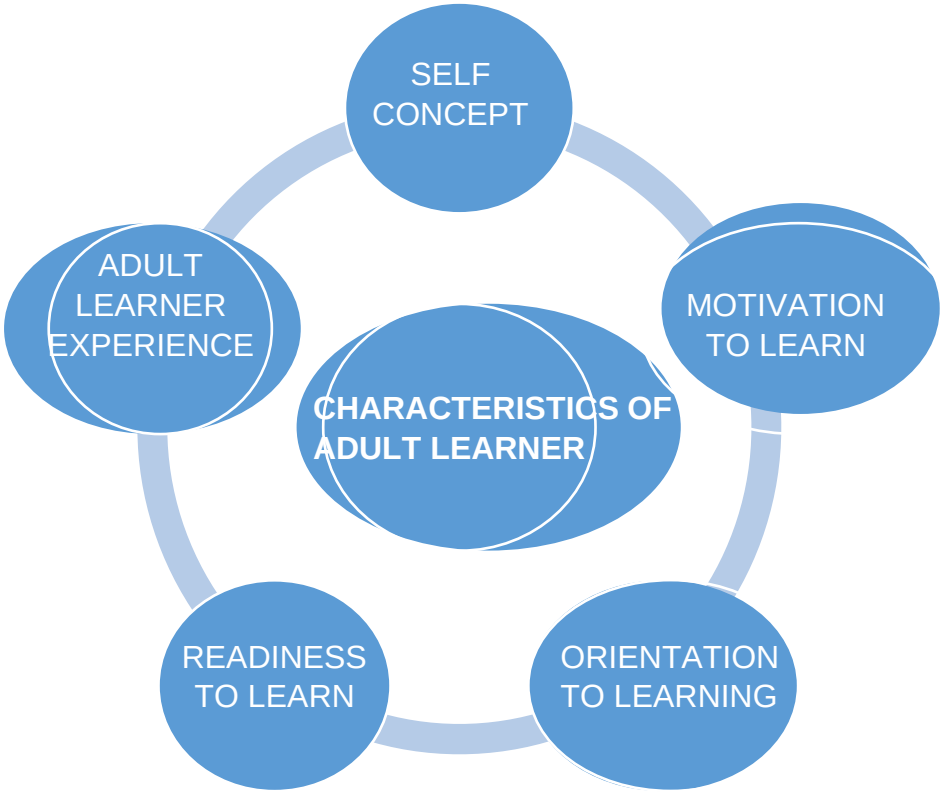

Figure 6.9. Knowles' Assumptions of Adult Learning

- **Self-Concept**

Adults often have a psychological need for self-direction. They want to be treated as capable of self-direction, with time to work on their own or collaboratively. In the context of this study, the Professional Nurses who were recipients were allowed to direct their learning and be treated as capable adults who accept responsibility for their learning.

- **Adult Learner Experience**

Professional Nurses have accumulated a wealth of experience during their training and their interaction with patients and clients, therefore the purpose of learning was established before engaging in the process. Their readiness to learn was strongly impacted by the relevance of the task to their lives and work. They would be expected to engage in real-world problem solving; seek solutions in education to bridge the gap

to where they want to be. Adults have competing interests; establishing the importance of a given study makes it more valuable and meaningful.

- **Readiness to learn**

Professional Nurses' experiences formed the foundation of their learning and were part of their continual growth. These experiences were tapped into for the benefit of all learners. They will come to learning with expectations about the process and established patterns of learning. As a person matures, his/her readiness to learn becomes orientated increasingly to the developmental tasks of his/her social roles.

- **Orientation to learning**

Adults are performance-centred and want to immediately apply new knowledge. Adults may be sceptical about new learning and want to test ideas before accepting them. They often have specific outcomes in mind and may disengage in learning if it does not move towards those outcomes.

- **Motivation to Learning**

Adults work best when they are involved in setting relevant and achievable goals. The path to those goals should be related to and applicable to their learning. Intrinsic motivation is strongest when the task is timely and appropriate. As a person matures, the motivation to learn is internal (Knowles, 1984).

- **Desired Outcomes of adult Learning**

Knowles recognizes that critical skills and abilities were ultimately formed in various educational settings, which, in turn, allowed everyone to get along. Adult learners are also called 'citizen-rulers' are necessary for a democracy.

Knowles Seven Desired Outcomes

- *Self-knowledge*

Knowing their "needs, motivations, interest, capacities, and goals" allows adults to better understand themselves, which leads to personal growth, self-knowledge and self-respect.

- *Global citizenship*

Ideally, adults should learn to differentiate between people and ideas and learn to respect others, while allowing for mutual disagreement. Ultimately, the goal is to promote acceptance, show empathy and help others in need.

- *Positive attitude*

Being open and accepting of changes develops resilience in adults, which allows them to see each moment as a learning opportunity.

- *Seeking truth*

Often people react to the outcome, symptoms, or a situation, mature adults seek to understand the root of the behaviour and, therefore, find a solution that addresses the cause of the behaviour.

- *Personality*

Everyone has strengths and weaknesses, and adults should capitalize on their strength by learning skills that support their role. Education can offer many avenues that support each individual to their fullest potential in society.

- *Essential Values.*

Adults should not only respect the common values of the society in which they live but understand that they are binding. Shared ideas and traditions are a key component of “the heritage of knowledge” and are collectively valued by each community.

- *Social order.*

Not only is it important to understand the rules and values of the society in which we live, but adults must also contribute as productive citizens. Demonstrating intelligence and being able to mobilize social change show that you are an effective contributor to society.

Key Factors in a Successful Adult Learning Programme

- A safe environment that supports individual needs, while honouring the uniqueness of each person. This means that every skill level is respected and the educator acknowledges the life achievements of each individual;

- An environment that promotes creativity and experimentation, while encouraging intellectual freedom;
- An environment in which each adult is honoured, appreciated and respected as an intelligent being. Educators listen to each student as they would their peers, which shows appreciation for their life experiences and allows mutual learning to happen;
- An environment that promotes self-directed learning, as outlined above. Educators to co-create lessons with their students based on each individual's needs to help them reach their full potential for success in their field;
- An environment that challenges adults at their intellectual ability level. Finding the optimum pace at which each individual learns is crucial to success in the classroom. If they find it too easy, they will be bored, but if they find it too hard, they will give up;
- An environment that promotes active participation in learning; and
- An environment that implements feedback from students. Educators who take the time to listen to feedback from their students and implement the changes create a classroom in which students are willing to learn.

6.3. Conclusion

The conceptual framework based on the six factors of the Practice-Orientated Theory by Dickoff et al., (1968), as well as Andragogy (Adult), Malcolm Knowles' theory, were used to develop the training programme for Professional Nurses in the Health Care facilities in Limpopo. The six factors of the Practice-Orientated Theory by Dickoff et al., (1968) discussed the roles of the agent, recipients, context, procedure, dynamics and terminus, which were adapted to suit the Health Care facilities context in the Limpopo Department of Health. Malcolm Knowles' five assumptions of adult learning described the process to be followed when developing a training programme. These factors were aligned with the goals and objectives of the training programme.

CHAPTER 7
DEVELOPMENT OF A TRAINING PROGRAMME

7.1 Introduction

Chapter 6 presented Practice-Orientated Theory of Dickoff et al., (1968) as well as Andragogy (Adult) of Malcolm Knowles, which supported the development of a training program. This chapter outlines the development of a training programme for the Professional Nurses to facilitate the implementation of the 6 Ministerial Priorities to improve service delivery. The theories of Dickoff et al., (1968) and Malcolm Knowles were used to inform the development of the training programme for Professional Nurses.

The training programme was based on the results of qualitative and quantitative results. The findings of the research indicated the following challenges: poor attitude of staff towards the implementation of Ministerial Priorities; poor monitoring of the implementation of Ministerial Priorities; poor knowledge of the staff of the Ministerial Priorities; shortage of human resources, material resources and medicines; poor staff support from management; and poor feedback from management.

• Objective 4

Objective 4 of the study was to develop a training programme for Professional Nurses to enable them to facilitate and implement the 6 Ministerial Priorities in the Health Care facilities in Limpopo**.**

7.2. Overview of the Training Programme

Employees are a significant and most important component of an organization's assets. Caring for them entails caring for the organization as a whole, therefore any organization that invests its time and money in its employees, education, training and development will succeed in achieving its business goals and advance further. For this study, training was provided to empower Professional Nurses with skills and knowledge to enable them to facilitate and implement the 6 Ministerial Priorities.

7.2.1. Definition of a Training Programme

Peretomode and Peretomode (2011) refer to training as a systematic setup whereby employees are instructed and taught matters of technical knowledge related to the job.

7.2.2. Objectives

The objective of a training programme is to enhance employees' skills, behaviour and expertise in the implementation of 6 Ministerial Priorities. It also helps in updating employee's skills and knowledge to increase their productivity in the organization (Peretomode & Peretomode, 2011).

7.2.3. Purpose

It focuses on teaching employees how to use particular machines or how to perform a particular task. They further explained training as a planned organizational effort or activities concerned with helping an employee acquire specific and immediate useable skills, knowledge, concepts, attitudes and behaviour to enable him or her to perform more efficiently and effectively on the job (Peretomode & Peretomode, 2011). The purpose of training is an overall improvement of the required skills and personality of the employee to improve productivity or outcomes in an organization. In the context of this research study, the purpose of the training is to improve the facilitation of the implementation of the 6 Ministerial Priorities by Professional Nurses to improve the provision of quality care. Provision of quality service and patient outcomes.

7.2.4. The Importance of Training Program

Training is very important in all spheres of life as life is not static but ever changing. Training equips the employees to be able to carry out the mandates of the organization. Training and development are also used to fulfil the gaps between current and expected performance. Training is focused on improving the skills necessary for accomplishing organizational goals. Training and development are required when a company revises its objectives and goal to adjust to the changing conditions (Elnaga & Imran, 2013). The introduction of 6 Ministerial Priorities required all health professionals to be trained and capacitated on the implementation of the 6 Ministerial Priorities to attain the intended goal. The orientation programme was supposed to include 6 Ministerial Priorities. There are many complaints of poor

service delivery in the health facilities; training will set new benchmarks against which the health professional will set their performance. Training develops employees' new skills and tests new methods of enhancing organizational productivity. It is used for succession planning as it helps in the improvement of skills. It also develops team spirit and teach employees to perform the job properly without any risks (Elnaga & Imran, 2013).

7.2.6. Benefits of Training

Benefits to the Staff

- Investing in staff training and development boost work satisfaction and increases employee morale, confidence and motivation.

Employee turnover is reduced.

Benefits to the Customer

- The programme will improve customer care by reducing adverse events and improving clinical outcomes; and
- Improve customer satisfaction.

Benefits to the (Organization) Department of Health

- The programme will improve service delivery, reduce cases of litigation, reduce patient complaints and improve utilization of the health facility;
- Improves process efficiency, resulting in financial benefits;
- Aids in the adoption of new technology;
- Increases strategy and innovation; and
- Increases performance.

(Nassazi, 2013)

7.2.7 Background of the Training Programme in the Context of this Study

The researcher noted that the Limpopo Department of Health was inundated with cases of litigations due to poor quality of care provided in its Health Care facilities and millions of Rands were spent paying for the lawsuits. In 2013, Limpopo Department of Health spent 23 billion Rands for payment of lawsuits, the money that was supposed to be used for service delivery. The researcher also believed that if 6

Ministerial Priorities were implemented correctly there would be an improvement in the provision of quality Health Care by a reduction in reported cases of adverse events, as well as a reduction in complaints raised by patients. The 6 Ministerial Priorities were introduced by the then Minister of Health Dr Aron Motswaledi to fast track the improvement of quality service delivery. The 6 Ministerial Priorities were extracted from South African National Core Standards and were based on the complaints mostly raised by patients and Health Care systems users. The researcher also believes that nurses form a large number of healthcare professionals in the healthcare system and spend much more time with patients than any other healthcare professional. Therefore, if Professional Nurses were properly trained in the implementation of the 6 Ministerial Priorities, there would be a huge impact.

The outcome of the analysis of collected data from both qualitative and quantitative studies confirmed gaps in the implementation of the Ministerial Priorities caused by challenges related to the following:

- Knowledge of Ministerial Priorities;
- Negative attitudes of staff;
- Shortage of human resources;
- Shortage of cleaning equipment;
- Poor servicing of equipment;
- Shortage of medicines;
- Long waiting times of patients;
- Lack of in-service training of staff;
- Lack of orientation of newly appointed staff;
- Poorly maintained hospital environment;
- Lack of SOPs and protocols for cleaning;
- Nosocomial infections were due to poorly maintained hospital environments;
- Failure of nurses to address questions raised by patients;
- Poor monitoring of the implementation of Ministerial Priorities;
- Poor support from management;
- Lack of feedback from management on the performance of the hospital regarding Ministerial Priorities; and
- Shortage of medication.

The results confirmed the assumption of the researcher that Ministerial Priorities were not implemented effectively and supported the development of the training programme for Professional Nurses. The majority of challenges identified point to the effectiveness of the management, as the provision of equipment and human resources is the competency of top management.

7.3. The Process of the Development of a Training Programme for Professional Nurses According to the Theories of Dickoff et al., (1968) and Malcolm Knowles

Steps in the process of the development of the training programme for Professional Nurses. The steps of the development of training programme according to Dickoff et al., (1968) was used applying Malcolm Knowles' Theory of Andragogy because the Professional Nurses are adults.

1. Agent

The agent was the Operational Manager who possessed the qualities of a leader. The Operational Manager executed the training of the Professional Nurses to capacitate them to be able to facilitate the implementation of the 6 Ministerial Priorities. The Operational Manager promoted interpersonal relationships among the Professional Nurse to promote active participation

2. Recipient

The recipients the Professional Nurses who received training to capacitate them to be able to facilitate the implementation of the 6 Ministerial Priorities. The Professional Nurses possessed management qualities that enabled them to facilitate the effective implementation of the 6 Ministerial Priorities

3. Context

The training programme was conducted in the selected Health Care facilities in Limpopo. The management of health facilities was based on the legal aspects, as well as policies, procedures and guidelines. During the training of the Professional Nurses, all legal and facilitation of implementation of the 6 Ministerial Priorities all policies and guidelines would be applied

4. The Dynamics

The findings of the study revealed challenges experienced by the facilities regarding the facilitation of the implementation of the 6 Ministerial Priorities. These challenges were used as a guideline for the content of the training programme, which needed to be addressed during the training. The purpose of the training was to capacitate the professional.

The challenges were discussed in Chapter 6 and were used as identified training needs.

5. Procedure

The training programme included the following: learning objectives, learning outcomes, as well as evaluation guidelines.

6. Terminus

The programme was aimed at producing competent Professional Nurses in the facilitation of the implementation of the 6 Ministerial Priorities. Professional Nurses would be empowered to function with autonomy and be able to lead and guide other young newly qualified Professional Nurses and other categories of a nurse.

7.4 Content of the Training Programme

The training programme consists of the following components, namely; Purpose Statement, Outcomes, Objectives, Prerequisite, Learning Approaches. Learning Environment, Activities and Assessment Methods.

Table 7.1. Content of the Training Programme

No	Heading	Content of Training Programme
7.1.	Purpose/ Aim of the training programme	The purpose of this training programme was to empower Professional Nurses with the knowledge and skills to be able to facilitate and implement 6 Ministerial Priorities effectively t
7.2.	Programme objectives	• Empower Professional Nurses to improve their values and attitudes towards • Implementation of the Six Ministerial Priorities • Improve the knowledge of Professional Nurses on the implementation of the Six Ministerial Priorities. • Improve the monitoring and evaluation of Ministerial Priorities l

7.3	**Benefits of the programme**	• **Benefits to the participant(recipient)** • **The benefit to Customer/ Society** • **Benefits to the Department of Health** • **The benefit to the body of knowledge**
7.4.	**Programme structure/ design**	• **Name of the programme** • **Unit standard** • **Outcome standard** • **Duration of training** • **Completion of successful training**
7.5.	Programme process (Facilitation process)	**Educational Approached** Knowles theory of adult learning **Programme components/ Content** Session 1: Ministerial Priorities Session 2: Challenges affecting implementation of the Ministerial Priorities Session **3:** Monitoring and evaluation of Ministerial **Facilitation technique/ Teaching and learning method** □ Lecture □ Group Discussion □ Role Play □ Case Studies □ Simulations Evaluation/ Assessment Techniques • Ongoing evaluation based on specific outcomes

7.6.	**Implementation process**	**Introductory Phase** • **Introduction and welcoming remarks** • **Synopsis of the workshop** • **Discussion of purpose and objectives of the workshop** • **Setting up workshop ground rules.** **Working Phase** • **Discuss the background for the introduction of 6 Ministerial Priorities, Challenges faced by Professional Nurses, legislative framework, Resources required for the implementation of the S** **Ministerial Priorities** • **Guidelines for implementation** • **Guidelines for facilitation** • **Monitoring and evaluation of the implementation of the Six Ministerial Priorities.**
7.7.	**Evaluation of programme**	**Termination Phase** • **Evaluation and feedback on the training outcome** • **Closing of the workshop**

Process of the evaluation of the programme

- **Evaluation techniques**

Process evaluation

- **Outcome evaluation**

- **Feedback process**

7.5. Process of Implementation of Training Programme

7.5. 1. Steps in the Implementation Process of a Training Programme

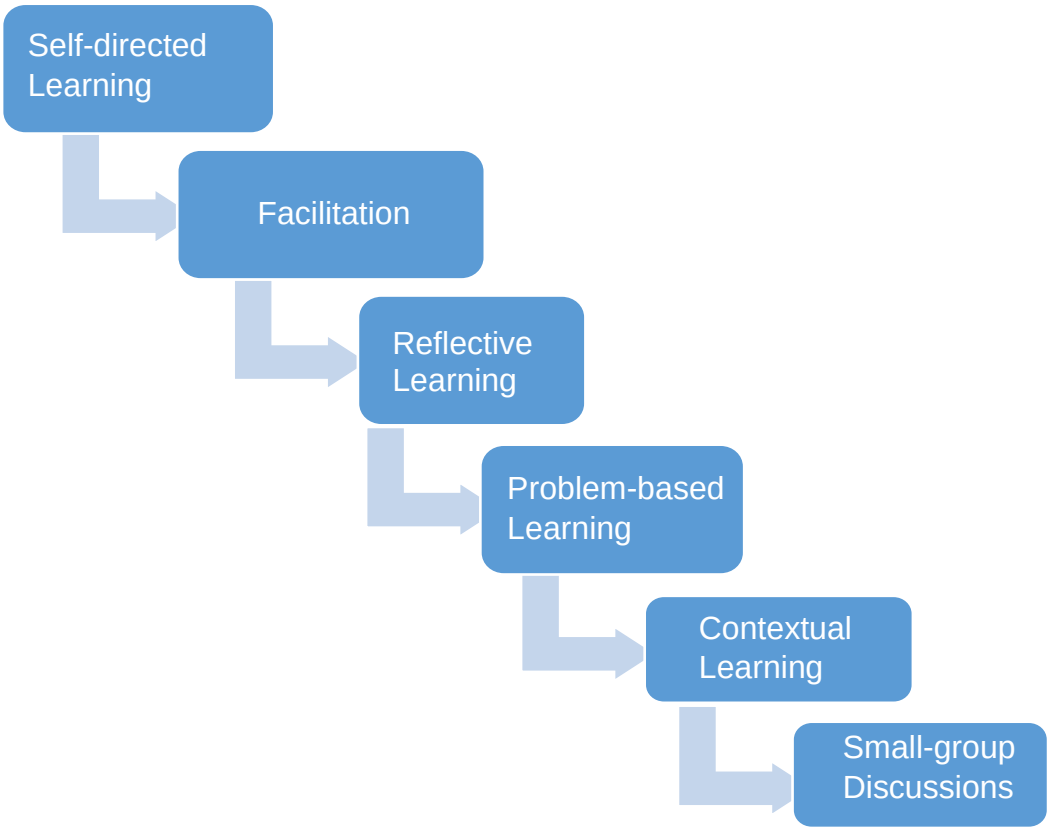

Figure 7.1. Six Steps of the Implementation of the Training Program

The six steps in the implementation of the training programme are described below.

7.5.1.1. Self-Directed Learning

Self–directed learning is an effective approach used for adult learners because they are responsible for their learning. Adult learners have the desire for directing their learning therefore the Professional Nurses were encouraged to take full responsibility for their learning, determine their learning requirements and goals, and select resources to achieve the learning objectives. They were allowed to choose the preferred learning strategies to be used.

7.5.1.2. Facilitation

Facilitation is the act of engaging participants in creating, discovering and applying learning insights. The agent who is the Operational Manager in the context of this training programme facilitated the training by providing guidance and support and encouraged the recipient who was the Professional Nurse to ask questions and participates in discussions. The Professional Nurses were encouraged and guided to work together more efficiently by creating synergy and generating new ideas.

7.5.1.3. Reflective Teaching

Reflective learning is a form of learning in which learners reflect upon their learning experiences, also called experiential learning (Patrick, 2011). Reflective learning is an important tool in practice-based professional learning settings where people learn from their own professional experiences, rather than formal learning or knowledge transfer. It may be the most important source of personal professional development and improvement. It is also an important way of bringing theory and practice together (Paterson et al., 2013). During this phase, the Professional Nurses were able to recapture their experiences, think about them, mull them over and evaluate them. They stepped back from their actions to permit critical reflection. The Professional Nurses (recipient) already had experience of what is happening concerning the implementation of the Ministerial Priorities in their Health Care facilities therefore they utilized the experience to develop new goals.

7.5.1.4. Problem–Based Learning Approach

Problem-Based Learning (PBL) is a teaching method in which complex real-world problems are used as a vehicle to promote the learning of concepts and principles as opposed to the direct presentation of facts and concepts. Problem Based Learning can promote the development of critical thinking skills (Akhdinirwanto, Agustini & Jasminka, 2020). The problems identified during the data collection were used by Professional Nurses for problem solving. The problems identified were used to motivate the Professional Nurses to sought out a deeper understanding of concepts, make reasoned decisions and defend them (Akhdinirwanto, Agustini & Jasminka, 2020).

7.5.1.5. Contextual Learning

Contextual learning is a method of instruction that enables students to apply new knowledge and skills to real-life situations (Suryawati & Osman, 2017). The Professional Nurses were encouraged to apply the Ministerial Priorities in the context of their working environment.

7.5.1.6. Small Group Activities

This teaching strategy gets students to work together in a group. This strategy will encourage the group to learn from each other

7.6. Training Schedule

Name of the programme:

- In-service Training on Ministerial Priorities.

SESSION 1

Objectives were as follows;

- The recipient should be able to describe the background of the Ministerial Priorities; and
- The recipient should be able to describe each ministerial priority

Table 7.2 Session 1: In-service Training schedule

Time	Topic	Presenter
09h00-09h05	Welcoming remarks	Manager Nursing Service
09h05- 09h10	Introductions	All participants
09h10- 09h20	Learners expectation of the programme	All participants
09h20- 09h45	Background information on the 6 Ministerial Priorities	Facilitator (Operational Manager)
09h45-10h00	Questions and answers	All participants
10h00-10h15	Tea Break	All
10h15- 10h45	6 Ministerial Priorities	Facilitator
10h45-13h00	Break into groups to discuss Ministerial Priorities (3 group of 5 each)	All participants
13h00- 14h00	Lunch Break	All

14h00- 15h40	Report back from group Discussion Group 1: 15 min Group 2: 15 min Group 3: 15 min	All participants
15h40	Summary of Day I and closure	Facilitator

Table 7.2. Indicates the In-Service Training schedule for the Professional Nurses for Day 1. The schedule included the objectives, time of the programme and the presenter.

Day 2: Session 2

Objectives were that, the recipient should be able to;

- Describe the legislative framework of the 6 Ministerial Priorities; and
- Identify resources required for the implementation of the 6 Ministerial Priorities.

Table 7.3. Session 2: In-Service Training Schedule

Time	Topic	Presenter
09h00-09h05	Welcoming remarks	Facilitator
09h05- 09h10	Revision of the work covered the previous day	Facilitator
09h10- 11h00	Legislative Framework for supporting 6 Ministerial Priorities	All participants
11h00- 12h00	Legislative Framework supporting 6 Ministerial Priorities	Facilitator (Operational Manager)
09h45-10h00	Questions and answers	All participants
10h00-10h15	Tea Break	All
10h15- 10h45	Role play	Facilitator
10h45-13h00	Discussion of the role play	All participants
13h00- 14h00	Lunch Break	All
14h00- 15h40	Resources required for the implementation of the Ministerial Priorities	All participants
15h40	Summary of Day 2 and closure	Facilitator

Day 3

- Objectives were as follows:

The recipient should be able to conduct monitoring and evaluation of the 6 Ministerial Priorities

Table 7.4. Session: 3 In-service Training Schedule

Time	Topic	Presenter
09h00-09h05	Welcoming remarks	Facilitator
09h05- 0920	Revision of the work covered in Session 2	Facilitator
09h20- 10h00	Monitoring and evaluation of the 6 Ministerial Priorities	Facilitator
10h00-10h15	Tea Break	All
10h15- 11h00	Monitoring and evaluation of the 6 Ministerial Priorities	Facilitator
11h00-13h00	Break into groups	Participants
13h00-14h00	Lunch	All
14h00- 15h00	Report back by learners	Facilitator
15h00-15h30	Questions and Answers	Participants
15h30- 16h00	Assessment of learners	All
16h00-16h15	Evaluation of the facilitation of the training programme by learners	Participants
16hh15-16h30	Closure	Facilitator

7.7. Guidelines for the Implementation of the Training Programme

7.7.1 Goals

The goal was to equip Professional Nurses to be able to facilitate and implement the Six Ministerial Priorities to improve the provision of quality.

7.7.2 Outcome

To improve the facilitation and implementation of the Ministerial Priorities to improve the provision of quality.

7.7.3 Education and Training

The agent (Operational Manager) should be able to describe the Ministerial Priorities, challenges regarding the implementation of 6 Ministerial Priorities, and the resources required for the effective implementation of the Ministerial Priorities.

7.7.4 Guidelines for Implementation of the Training Programme

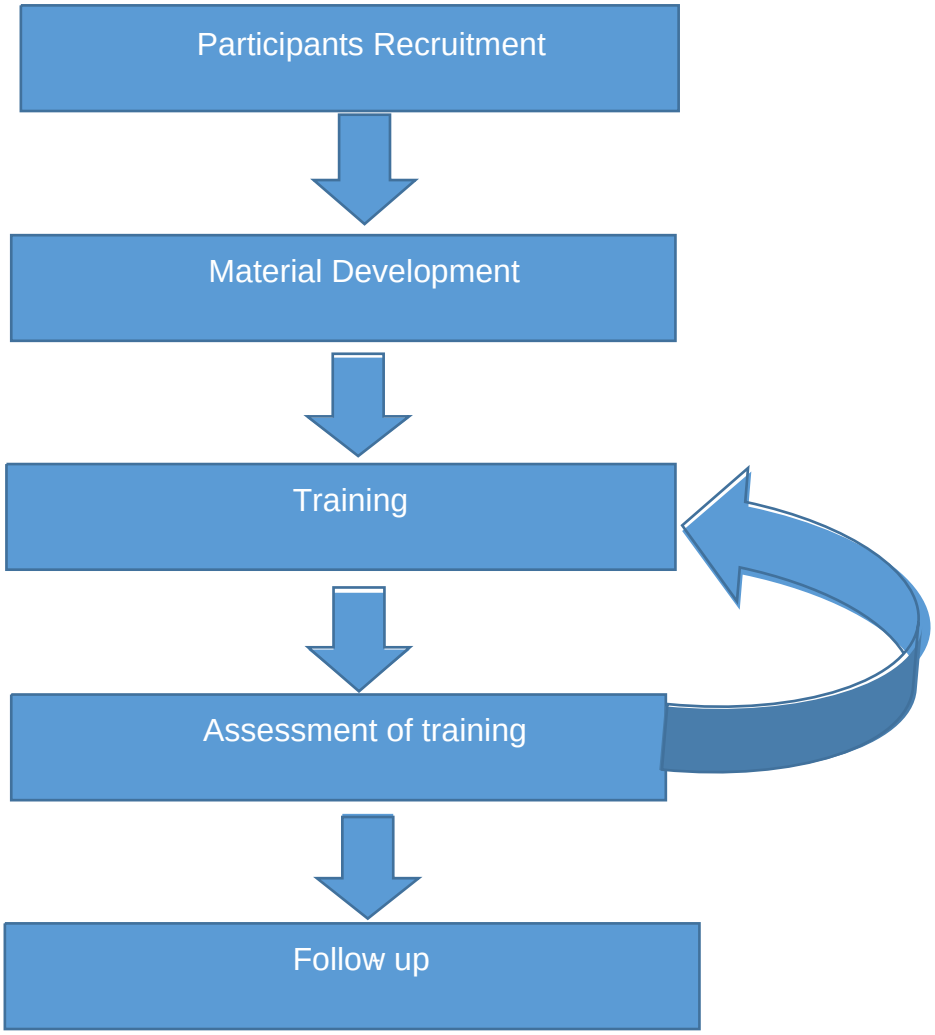

Figure 7.2 Guidelines for Implementation of the Training Programme

7.7.4.1. The Agent (Operational Manager) Should Do the Following:

- Arrange a planning meeting with the Nursing Service Manager to discuss the need for training;
- Recruitment of participants;
- Share the date of the programme and the target audience;

- Call a meeting of all the recipients, discuss the plan with them and share the program;
- Arrange all the training material and the venue, which is conducive for training**;**
- Conduct the training; and
- Evaluate the effectiveness of the training.

7.7.4.2. The Recipient. (Professional Nurse) should Do the Following:

- Agree to attend the training programme;
- Accept the responsibility for completing the training;
- Be ready to participate in all learning activities;
- Achieve the learning outcomes; and
- Attend all classes/ sessions and submit assignments.

7.7.4.3. Evaluation Tool

- The evaluation tool should be completed by all the recipients of the programme (Professional Nurses); and
- Feedback should be given to all recipients who participated in the training to motivate them.

7.8. Conclusion

Chapter 7 discussed the development of the training programme for Professional Nurses to equip them with knowledge and skills in the facilitation and implementation of the 6 Ministerial Priorities. Dickoff et al., (1968) and Malcolm Knowles' theories were used for development of a training programme. Guidelines for the implementation of the training programme were developed to empower the agent to be able to conduct the training.

CHAPTER 8
SUMMARY, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

8.1 Introduction

This chapter focused on the summary of the study conducted, conclusions drawn from the study, limitations of the study identified and recommendations. The recommendations were formulated based on the findings of the study concerning the provision of quality service through the effective utilization of the 6 Ministerial Priorities. The study aimed to develop a training programme for the Professional Nurses to enable them to facilitate and implement the 6 Ministerial Priorities effectively to improve the provision of quality care.

8.2 Summary

The researcher adopted the Sequential Mixed Method research design, which allowed one strand (qualitative) to occur before and inform the second strand (quantitative). In such well-conceived sequential designs, the analysis and the interpretations in one phase informed the collection and analysis in the second phase. The goal of this design was to converge on the truth about a phenomenon by allowing the limitation of one approach to be offset by the strength of the other.

The purpose was to develop a training programme for Professional Nurses to facilitate the implementation of the 6 Ministerial Priorities in the health facilities of Limpopo Province. In this study, the researcher utilized Purposive Sampling in both sampling approaches, starting with one-to-one interviews in qualitative design followed by the distribution of questionnaires in quantitative design. The results of the qualitative design informed the development of the quantitative questionnaire tool. Different participants used qualitative and quantitative sessions of data collection.

8.3. The Purpose of the Study

The purpose of the study was to develop a training program for Professional Nurses to enable them to facilitate the implementation of the 6 Ministerial Priorities in the Health Care facilities in Limpopo Province, South Africa to improve the provision of quality patient care.

8.4 Phase 1: Qualitative

The objective of the qualitative Phase 1 was as follows.

- Explore and describe the experiences of Professional Nurses on the implementation of the 6 Ministerial Priorities in the selected Health Care facilities in Limpopo Province.

The study results from semi-structured one-on-one interviews with Professional Nurses indicated that Professional Nurses displayed both positive and negative attitudes toward patients. The experiences of Professional Nurses in the implementation of the 6 Ministerial Priorities were both positive and negative. Professional Nurses work at the front of most healthcare systems and their contributions are recognized as essential in delivering effective patient care.

The study also indicated that there was poor monitoring of the implementation of Ministerial Priorities. This is supported by the poor quality service provided in the Public Health Care facilities evidenced by the increasing number of adverse events. The majority of the participant indicated that there was a severe shortage of Professional Nurses and cleaners, which affected the implementation of the 6 Ministerial Priorities negatively. Participants indicated that the shortage of Professional Nurses resulted in staff being overworked and leading to staff burnout. The shortage of Professional Nurses is a problem within the South African health system contributing to poor patient care, poor staff morale and poor staff retention. Participants cited a shortage of material resources such as linen, blankets, patients' gowns, syringes and vaccines, and cleaning material as factors that influenced negatively on the implementation of the 6 Ministerial Priorities. The participants indicated that, at times, patients had to come back the following day for medication. Babies were discharged without being vaccinated. Hospitals were borrowing each other medication and other consumables. Participants cited incidences where, at times, nurses had to buy some of the items such as cleaning material with their money.

Shortage of medicines has been a challenge to the effective delivery of quality healthcare services worldwide, including in South Africa with shortages of even essential medicines becoming a global problem irrespective of the economic status

of countries. Shortage of medicines was expressed as a daily occurrence in hospitals, which affected the provision of patient care. Participants indicated that they were many medicine items that were out of stock and it took time before being available. Hospitals are borrowing medication from each other. Patients have to come back the following day to get their medication. Shortage of medication affected the provision of patient care negatively**.**

Hospital medical equipment is defined by the National Health Surveillance Agency as medical care equipment, which is directly or indirectly used for diagnosis, therapy and monitoring in the Health Care of patients in Intensive Care Units. These devices have great relevance in care procedures, high cost, diversity of models, great sensitivity in the handling and operation, being among the equipment with high potential to cause harm to patients.

8.5 Phase 2: Quantitative

The objective of the quantitative phase was to:

- Describe the Professional Nurses' knowledge and practices in the implementation of the 6 Ministerial Priorities in the selected Health Care facilities in Limpopo Province; and
- Identify the support and resources required by Professional Nurses for the effective implementation of the 6 Ministerial Priorities in the selected Health Care facilities in Limpopo Province.

The second phase was quantitative through which: the knowledge and practices of Professional Nurses have described; and the identification of support and resources required for effective implementation of 6 Ministerial Priorities. Data were collected through the distribution of questionnaires for respondents to complete. These respondents were Professional Nurses. Findings from quantitative numeric data revealed challenges that needed to be addressed by developing a training programme for Professional Nurses to facilitate and implement Six Ministerial Priorities.

This study also found that the majority of the participants had poor knowledge of the 6 Ministerial Priorities. Some of the participants indicated that they have heard about the Ministerial Priorities but had not implemented them because they were not trained to do so. These participants also indicated that Ministerial Priorities were not given a priority and thus were not implemented. Participants expressed that they did not have sufficient knowledge and skills to enable them to implement 6 Ministerial Priorities.

The results of the study revealed that there was an inadequate orientation program in the Health Care facilities. The orientation program for newly employed staff was not conducted consistently and did not include Ministerial Priorities. This was supported by the demotivation of staff leading to a negative attitude toward patients. An orientation process is an introduction of new employees to new technologies, procedures and policies at the workplace, and it should be considered at all levels of an organization (Kiel, 2012). Therefore, orientation for newly employed staff has a positive impact on the competency of newly employed nurses.

The research results revealed that there was a lack of in-service and continuous professional development. This was found to be the cause for poor implementation of Ministerial Priorities in certain Health Care facilities. It was revealed that in hospitals where in-service training was conducted, not all nurses were able to attend due to a shortage of staff because patients could not be left alone.

The research results revealed that there was a lack of psychosocial support from the management to enable Professional Nurses to implement the 6 Ministerial Priorities. This was supported by the findings that equipment was poorly serviced; there was a lack of material resources and human resources. The supply of resources is the competency of the management. Non-supply of resources made it difficult for nurses to implement the Ministerial Priorities. Because of the mounting challenges and stressful work environment faced by Professional Nurses, social support has been identified as an essential resource that helps promote their work motivation.

The results of the study revealed that management did not support the implementation of 6 Ministerial Priorities in that they failed to provide resources to enable staff to implement 6 Ministerial Priorities. Participants indicated that they were not receiving

support from top management and that there was no dedicated person to monitor the implementation of the 6 Ministerial Priorities.

Constructive feedback in the workplace is extremely important. Workplaces need effective communication to succeed and thrive, as well as to increase staff morale. Feedback helps workers learn more about themselves, their strengths and weaknesses; behaviours; and how actions affect others. It also increases self-awareness and encourages personal development.

8.6 Phase 3: Development of a Training Program

The objective of Phase 3 was, namely, to:

- Develop a training program for Professional Nurses on the implementation of the 6 Ministerial Priorities in the selected Health Care facilities in Limpopo Province.

The development of a training programme was based on the findings of qualitative and quantitative phases. The narrated and numeric data were analysed qualitatively and quantitatively, respectively. The evidence described the scenario regarding the provision of quality service in terms of 6 Ministerial Priorities that needed to be addressed. The gap was identified and the ideal situation was formulated to develop a training programme

The findings of this study also revealed that the training programme was not conducted as expected. Participants expressed that they did not have sufficient knowledge and skills to implement 6 Ministerial Priorities. The increased level of Professional Nurses' knowledge, skills and experience will improve quality service delivery.

Ministerial Priorities should be implemented by people who have been trained and are knowledgeable.

8.7 Phase 4: Formulate Guidelines

The objective of Phase 4 was to:

- Formulate guidelines that enhance the training program on the implementation of the 6 Ministerial Priorities in Health Care facilities in Limpopo Province.

The guidelines were formulated based on the findings of the study. The guidelines included all 6 Ministerial Priorities and how to implement and monitor them.

8.8 Limitations

A limitation of this study was that the research excluded Private Health Care facilities.

8.9 Recommendations

Nursing Practice

- Nurses treat patients with compassion, caring, dignity and respect;
- Nurses to address patients' questions about their healthfully at all times and where they do not have answers they should consult or refer to doctors;
- Nurses to improve their attitude towards patients;
- Suggestion boxes to be provided and be implemented constantly to check the views of the patients;
- Training to be given to all cleaners on cleaning, use of chemicals, prevention and control of infections, and the use of protective clothing;
- Hand hygiene should be reinforced and monitored;
- Implementation of the 6 Ministerial Priorities to be part of an orientation programme to capacitate newly employed nurses;
- Six Ministerial Priorities should be part of in-house ongoing training in all facilities to capacitate Health Care Workers;
- Implementation of 6 Ministerial Priorities should be monitored;
- Champions should be identified and be capacitated to facilitate the implementation of the 6 Ministerial Priorities;
- Waiting time should be displayed for all patients to see how long they are expected to wait;
- Fast lanes for very sick patients, the elderly and babies should be established and be implemented;
- There should be ongoing training for cleaning staff;
- Waiting time should be monitored regularly and blockages are addressed; and

- Adverse events should be monitored, reported and remedied.

Nursing Education

- Six Ministerial Priorities to be part of the training of the students; and
- Further study is to be conducted to explore the role of the Chief Executive Officer in the implementation of the 6 Ministerial Priorities.

Nursing Administration

- Top management to provide psychosocial support to Healthcare Workers and healthcare professionals;
- Top management to improve the supply of resources for the provision of quality care such as human and material resources;
- Top management to improve the servicing of equipment to enable Health Workers to provide safe and quality care to patients;
- Top management to give feedback to workers on the implementation of 6 Ministerial Priorities;
- The cleanliness of the facility should be improved;
- A well-trained, experienced person to be in charge of cleaning services in the hospital;
- Provision of protective clothing for patients and staff to be improved;
- Policies and Standard Operating Procedures for infection and prevention should be developed and implemented fully;
- A dedicated person should be allocated to monitor cleaning services;
- The availability of medication should be improved and monitored;
- Reported security incidences and breaches should be addressed; and
- Adverse events to be recorded and reported and remedial measures should be taken to minimise them.

8.9. Conclusion

This chapter concludes the research. The qualitative and quantitative research objectives have been achieved in that a training programme has been developed for Professional Nurses to facilitate and implement the 6 Ministerial Priorities to improve the provision of quality care in Limpopo health care facilities.

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APPENDIXES
Appendix A: Turfloop Ethics Clearance Certificate

University of Limpopo
Department of Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 3935, Fax: (015) 268 2306, Email: anastasia.ngobe@ul.ac.za

TURFLOOP RESEARCH ETHICS COMMITTEE

ETHICS CLEARANCE CERTIFICATE

MEETING: 05 November 2019

PROJECT NUMBER: TREC/520/2019: PG

PROJECT:

Title: Development of A Training Program to Facilitate the Implementation of the Six Ministerial Priorities by Professional Nurses in Limpopo Province Health Care Facilities, South Africa

Researcher: EM Legodi
Supervisor: Prof MK Thopola
Co-Supervisor/s: Prof TM Mothiba
School: Health Care Sciences
Degree: PhD in Nursing

PROF P MASOKO
CHAIRPERSON: TURFLOOP RESEARCH ETHICS COMMITTEE

The Turfloop Research Ethics Committee (TREC) is registered with the National Health Research Ethics Council, Registration Number: **REC-0310111-031**

Note:

i) **This Ethics Clearance Certificate will be valid for one (1) year, as from the abovementioned date. Application for annual renewal (or annual review) need to be received by TREC one month before lapse of this period.**

ii) **Should any departure be contemplated from the research procedure as approved, the researcher(s) must re-submit the protocol to the committee, together with the Application for Amendment form.**

iii) **PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES.**

Finding solutions for Africa

Appendix B: Department of Health Approval Letter

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquires : Mrs Motemele
Tel : 015-2936206
Email : naledzani.ramalivhana@dhsd.limpopo.gov.za

Elizabeth Mmalehu Legodi
18 College Street
Polokwane, 0699

PERMISSION TO CONDUCT RESEARCH IN DEPARTMENTAL FACILITIES

Your Study Topic as indicated below;

DEVELOPMENT OF A TRAINING PROGRAM TO FACILITATE THE IMPLEMENTATION OF THE SIX MINISTERIAL PRIORITIES BY PROFESSIONAL NURSES IN LIMPOPO PROVINCE HEALTH CARE FACILITIES, SOUTH AFRICA.

1. Permission to conduct research study as per your research proposal is hereby Granted.
2. Kindly note the following:
    a. **Present this letter of permission to the institution supervisor/s a week before the study is conducted.**
    b. In the course of your study, there should be no action that disrupts the routine services, or incur any cost on the Department.
    c. After completion of study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
    d. The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
    e. The approval is only valid for a 1-year period.
    f. If the proposal has been amended, a new approval should be sought from the Department of Health
    g. Kindly note that, the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated.

Head of Department
Dr Mhlongo TF

Date 15/7/2020

Appendix C: Hospitals' Permission Letter

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA
DEPARTMENT OF HEALTH

NURSING SERVICES

Enquiries : Ms. Manaka J.M

Contact Number: 015 483 4174

Email address : Raisibe.Nyatlo@dhsd.limpopo.gov.za

Date : 16th July 2020

Attention: Ms. Legodi E.M
8 Tambotie Street
FLORA PARK
0699

RE: PERMISSION TO COLLECT DATA FOR A RESEARCH STUDY: YOURSELF

GREETINGS

The above matter bears reference:

1. The office of the Hospital Nursing Management and CEO has acknowledged your request to collect data for a research study titled: **Development of a training program to facilitate the implementation of the six ministerial priorities by the professional nurses.**
2. We therefore grant you the permission.

Yours in service delivery.

Ms. Magagane S.L
Chief Executive Officer

DEPARTMENT OF HEALTH
MOKOPANE HOSPITAL
CEO'S OFFICE
16 JUL 2020
PRIVATE BAG X1602
MOKOPANE, 0600
LIMPOPO PROVINCE

Date

Restricted

LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH
MANKWENG HOSPITAL

Ref: S5/3/1/2
Enq: Modula MC
Ext: 1017/1282
Email: motlatso.modula@dhsd.limpopo.gov.za

To Legodi EM
Email: Elizabeth.legodi@dhsd.limpopo.gpv.za
076 191 4032

REQUEST FOR PERMISSION TO CONDUCT RESEARCH AT MANKWENG HOSPITAL: DEVELOPMENT OF A TRAINING PROGRAMME TO FACILITATE THE IMPLEMENTATION OF THE SIX MINISTERIAL PRIORITIES BY PROFESSIONAL NURSES IN LIMPOPO PROVINCE HEALTH CARE FACILITIES, SOUTH AFRICA.

1. The above matter has reference.
2. This is to confirm that the CEO has granted permission to conduct research on "the **development of a training programme to facilitate the implementation of the six ministerial priorities by professional nurses in Limpopo Province health care facilities, South Africa".**
3. The permission to conduct the research will be for a period of 1 year as stipulated on the approval letter from the Provincial Head Office.
4. Attached please find her application letter, and approval from Provincial Office.

Yours in service delivery

Acting Director: Corporate Services
Mr. Mohatli NT

20200720.
Date

Appendix D: Consent Form

UNIVERSITY OF LIMPOPO (Turfloop Campus) ENGLISH CONSENT FORM

Statement concerning participation in a Research Project*

Name of Project/Study: Development of a training programme to facilitate the implementation of the 6 Ministerial Priorities by Professional Nurses in hospitals in Limpopo, South Africa

I have read the information and heard the aims and objectives of the proposed study and was provided with the opportunity to ask questions and given adequate time to rethink the issue. The aim and objectives of the study are sufficiently clear to me. I have not been pressurized to participate in any way.

I know that sound recordings will be taken of me. I am aware that this material may be used in scientific publications which will be electronically available throughout the world. I consent to this provided that my name and hospital number are not revealed.

I understand that participation in this Study/Project is completely voluntary and that I may withdraw from it at any time and without supplying reasons.

I know that this Study/Project has been approved by the University of Limpopo Research Ethics Committee (TREC). I am fully aware that the results of this Study/ Project* will be used for scientific purposes and may be published. I agree to this, provided my privacy is guaranteed.

I hereby give consent to participate in this Study/Project.

....
Name of Respondent Signature of Respondent

....
Place. Date. Witness

Statement by the Researcher

I provided verbal and/or written* information regarding this Study/Project*
I agree to answer any future questions concerning the Study/Project* as best as I am able. I will adhere to the approved protocol.

....
Name of Researcher Signature Date Place

Appendix E: Independent Coder's Repo

QUALITATIVE DATA ANALYSIS

DOCTOR OF PHILOSOPHY

IN NURSING SCIENCE

LEGODI ELIZABETH MMALEHU

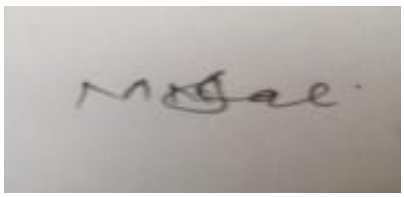
THIS IS TO CERTIFY THAT

Professor Martha Nozizwe Jali has co-coded 25 semi-structured in-depth interviews of Professional Nurses from five selected regional hospitals, in Limpopo Province.

For the study:

Development of a Training Program to Facilitate the Implementation of the 6 Ministerial Priorities by Professional Nurses in Limpopo Province Health Care Facilities, South Africa

I declare that the candidate and I have reached a consensus on the major themes reflected by the data during a consensus discussion. I further declare that data saturation was reached as evidenced by repeating themes.



Appendix F: Interview Guide: Semi-Structured One-To-One Interviews for Professional Nurses

- Welcoming the participant.
- Introduction of the researcher
- Explain the objectives and purpose of the research to the participant.
- Explain the process of informed consent.
- Explain how the interview will be conducted
- Explain how the findings of the research will be utilized.

CENTRAL RESEARCH QUESTION

Please tell me about your perceptions/experiences of the implementation of the 6 Ministerial Priorities in your facility.

PROBING RESEARCH QUESTIONS

- How effective are 6 Ministerial Priorities implemented in your hospital?
- Was any training provided for the implementation of the 6 Ministerial Priorities?
- Which knowledge is skills are required for the implementation of the 6 Ministerial Priorities?
- What are the challenges you are experiencing regarding the implementation of the 6 Ministerial Priorities?

Appendix G: Transcript

SEMI-STRUCTURED ONE-TO-ONE INTERVIEWS FOR PROFESSIONAL NURSES

- Participants were welcomed.
- The researcher introduced herself
- The researcher explained the objectives and purpose of the research to the participant.
- The process of informed consent was explained.
- The researcher also explained how the interview would be conducted.
- The researcher explained how the findings of the research would be utilized.

CENTRAL RESEARCH QUESTION

Please tell me about your perceptions/ experiences of the implementation of the 6 Ministerial Priorities in your facility.

PROBING RESEARCH QUESTIONS.

- How effective are 6 Ministerial Priorities implemented in your hospital?
- Was any training provided for the implementation of the 6 Ministerial Priorities?
- Which knowledge is skills are required for the implementation of the 6 Ministerial Priorities?
- What are the challenges you are experiencing regarding the implementation of the 6 Ministerial Priorities?
- Is the implementation of the 6 Ministerial Priorities on the agenda of the hospital management?

Interviewer: *Please tell me about your perceptions/experiences of the implementation of the 6 Ministerial Priorities in your facility*

Interviewee: *Six Ministerial Priorities are implemented in the hospital, but they are not implemented effectively.*

Interviewer: *What do you mean when you say they are not implemented effectively.*

Interviewee: *Yes, they are not implemented effectively because of a shortage of resources such as a shortage of nurses and cleaners. There are no porters in this hospital and nurses have to carry on with pottering of patients. There are no cleaners in most of the wards, especially during the night.*

Interviewer: *Where did the staff go? Have they resigned to go and work in other places?*

Interviewee: *No, most of the staff have retired and were not replaced, some have passed on also they were not replaced.*

Interviewer: *What is the reason for not replacing them?*

Interviewee: *Management says there is no money to replace them.*

Interviewer: *What happened to the money?*

Interviewee: *I do not know.*

Interviewer: *How severe is the shortage?*

Interviewee: *We are doing overtime to cover all the shifts. Many nurses get exhausted and are not able to come to work and the shortage in the*

wards becomes severe. We have only one cleaner in our ward. When this cleaner is off nurses take over the work of a cleaner.

Interviewer: *Is money for procurement of equipment and other services available?*

Interviewee: *Eish! We are struggling. There is a shortage of equipment, cleaning material, linen for patients and even protective clothing and medication. We rely on requesting medication from other hospitals via pharmacy. Equipment breaks easily because they are of poor quality and are poorly serviced and not regularly.*

Interviewer: *How do all these issues affect the implementation of the 6 Ministerial Priorities?*

Interviewee: *Implementation of 6 Ministerial Priorities is affected by lack of resources. We are not able to provide quality patient care which is expected due to the high ratio of nurse to patient. Position changing are not done as expected because of a shortage of staff. Wards are dirty because there is a shortage of cleaners and cleaning material.*

Interviewer: *Is management aware of these challenges and what is it that is being done.*

Interviewee: *Management is aware but I do not know what they are doing about it.*

Interviewer: *Are all these challenges discussed in your meetings and that of management?*

Interviewee: *These challenges are discussed in our meetings but I do not know if they are elevated to management. I have never seen any manager coming to monitor the implementation of the Ministerial Priorities and we have not received any report talking about how we are doing. The only time when we see management is when there is a complaint from a patient or a client to be answered. That is the only time we see them coming to get the story.*

Interviewer: *Is there anyone who is monitoring the implementation of 6 Ministerial Priorities?*

Interviewee: *No one is monitoring the implementation of the Ministerial Priorities.*

Interviewer: *Is training provided to staff to be up-to-date with the implementation of the Ministerial Priorities?*

Interviewee: *Eish! Training is not conducted because of shortage. It is a long I heard about training taking place for staff. Let me say no, training is no longer provided. Orientation of newly employed staff is also no longer conducted. I do not know the reasons why. Maybe HRD can know better because it is their competence.*

Interviewer: *How does lack of training affect the implementation of the 6 Ministerial Priorities.*

Interviewee: *There is generally poor knowledge and implementation of the Ministerial Priorities, not only by nurses but all Health Care Workers. It is very important to conduct training to improve knowledge on the implementation of 6 Ministerial Priorities. This should also be part of the orientation programme for the newly employed staff.*

Interviewer: *How is the safety and security of patients and personnel?*

Interviewee: *There are security officers who are deployed to identified areas.*

Interviewer: *Having alluded to all these challenges, how do they affect nurses' attitudes.*

Interviewee: *Many nurses display a negative attitude towards their work and patients due to overwork and shortage of tools of the trade. They are*

demotivated and this affects how they interact with patients, however other nurses show dedication to their work and still treat patients with courtesy and with respect despite all that is experienced.

Interviewer: *What is the impact of a lack of resources on the implementation of 6 Ministerial Priorities?*

Interviewee: *Patients wait for a long time for services, to open a file, to see a nurse, sometimes patients come back the following day to be seen by the doctor. We have a poorly maintained environment due to the lack of a person who is adequately trained to manage cleaning services and this exposes patients to nosocomial infections. There is also a lack of protective clothing which exposes both patients and staff to infections.*

Interviewer: *Do you think it is important to implement the 6 Ministerial Priorities*

Interviewee: *Yes. It is very important to implement the 6 Ministerial Priorities. If they were implemented properly quality of service delivery will improve and the safety of patients will be guaranteed. Management should also provide us with resources to enable us to implement 6 Ministerial Priorities.*

Interviewer: *Do you think management supports the implementation of the Ministerial Priorities?*

Interviewee: *There is a lack of support from top management.*

Interviewer: *Why do you say there is a lack of support from management?*

Interviewee: *Because there are no resources to enable us to execute our duties and I have never heard management talking about Ministerial Priorities. There is no one in the hospital monitoring its implementation.*

Appendix H: Questionnaire

SECTION A
Demographic data of the Professional Nurse
Tick in the appropriate column

A1: AGE (Years)

22-35	
36-45	
46-55	
56-65	

A2: GENDER

Female	
Male	

A3: HIGHEST LEVEL OF QUALIFICATION

Diploma in General Nursing and Midwifery	
Diploma in General Nursing, Midwifery, community and Psychiatric nursing	
BA Cure	
Masters in Nursing Science	
Doctor of Nursing Science	

SECTION B
Assessment of Professional Nurses' experience regarding the implementation of the 6 Ministerial Priorities.

INSTRUCTION: Please choose the appropriate response to each statement and mark with an [x]

VALUES AND ATTITUDE OF STAFF				
		Yes	No	Partial
B1	Patients are treated with compassion and caring			
B2	Patients are treated courteously at all times.			
B3	Patients are treated with dignity and respect all the time			
B4	Health Workers are too often rude and uncaring to their patients.			
B5	Patient Satisfaction surveys highlight patients' complaints			
B6	Patients feel that they are not treated well.			
B7	Health Care Workers tell patients about their feeling of motivation and lack of recognition for their efforts.			
B8	Patients' questions about their health problems are always addressed			
CLEANLINESS				
B9	Cleaning equipment and material is available at all times			
B10	There is a shortage of cleaning materials and equipment			
B11	A poorly maintained environment contributed to nosocomial infections			
B12	Cleaning services are effectively managed			
B13	A suitably experienced person manages cleaning services			
B14	There is ongoing in-house training for cleaning staff			
B15	Standard Operating procedure/ Protocol for cleaning is in place and implemented.			
WAITING TIME				
B16	Patients' maximum waiting time is displayed in each service area			
B17	Patients are aware of the maximum time to wait before being attended to			
B18	There are fast lane queues for very sick patients, children and older persons			
B19	Screening is done at the point of patients entry into the hospital			
B20	Waiting time in key areas are monitored and measures are taken by management to address causes of blockages			

B21	Waiting time is locally determined			
B22	Patients wait a long time to open a file			
B23	Patients wait a long time to see a nurse			
B24	Patients wait a long time to see a doctor			
B25	Patients wait a long time to get medication at Pharmacy			
B26	Patients have to come back the following day to be seen by a doctor			
PATIENTS' SAFETY AND SECURITY				
B27	There is a security system that safeguards the building, patients, visitors and staff,			
B28	There is adequate lighting inside and outside to protect patients, visitors and staff.			
B29	All security incidences/ breaches are reported			
B30	All security incidences/ breaches are addressed			
B31	Safety and security awareness is promoted among staff members			
B32	Security guards are designated for specific areas			
INFECTION PREVENTION AND CONTROL				
B33	There is hand hygiene compliance			
B34	There is ongoing monitoring and management of infection prevention and control practices			
B35	Policies and Protocols for the prevention and management of infections are available and implemented			
B36	Some officers are appropriately trained to monitor infections			
B37	Protective clothing for staff and patients are available and used properly			
B38	Nosocomial infections outbreaks are investigated and reported			
B39	Waste is managed appropriately			
B40	Waste is protected from theft, vandalism and scavenging			
AVAILABILITY OF BASIC MEDICATIONS AND SUPPLIES				
B41	Basic medications are available at all times, in adequate amounts, inappropriate dosage forms			
B42	There is sometimes a shortage of medications			
B43	Essential Drug Lists (EDL) are available 90% of the time			
B44	Appropriate medications are prescribed and administered for patients			
B45	Shortage of medicines is a daily occurrence in the facility			

B41	Basic medications are available at all times, in adequate amounts, inappropriate dosage forms			

C: ASSESSMENT OF PROFESSIONAL NURSES' KNOWLEDGE REGARDING THE 6 MINISTERIAL PRIORITIES

INSTRUCTION: Please choose the appropriate response to each statement and mark with an [x] [only 1 answer]

		Strongly agree	agree	neutral	disagree	Strongly disagree
C1	Values and attitude of staff ensure that patients are treated respectfully by staff					
C2	Courtesy incorporates basic social values such as being friendly, polite and helpful and treating patients with dignity and respect.					
C3	The cleanliness of a hospital plays a large role in patients' perception of the Health Care setting					
C4	There is a correlation between patient's perception of hospital cleanliness and the risk of acquired infection					
C5	A clean and welcoming environment is important from an aesthetic point of view and engenders feelings of well-being and trust in people who may be anxious or unwell.					
C6	Waiting time is a parameter for the assessment of Patient Satisfaction					
C7	Patients perceive long waiting times as barriers to obtaining services.					
C8	Waiting time is a determinant of Patient Satisfaction with Health Care services					
C9	Availability of medicines is seen as the most important element of quality by Health Care consumers					
C10	Provision of universal access to essential medication is a major challenge in Health Care services					
C11	Unavailability of medicines is a major reason for dissatisfaction among patients					
C12	Lack of supplies impacts negatively upon the staff morale through community pressures					
C13	Patients suffer injury or death every year as a result of unsafe medical practices and care					

C14	Patients are mostly harmed due to preventable causes					
C15	Patients safety is seen as the most important aspect of the Health Care system					

D: ASSESSMENT OF PROFESSIONAL NURSES' PERCEPTION OF THE IMPORTANCE OF THE IMPLEMENTATION OF THE 6 MINISTERIAL PRIORITIES

QUESTION: How important is the implementation of the f 6 Ministerial Priorities?

INSTRUCTION: Tick in the appropriate column by marking a [x]

		Very important	Important	Partially important	Not important
D1	Values and attitude of staff				
D2	Cleanliness				
D3	Waiting Time				
D4	Patients' safety and security				
D5	Infection prevention and control				
D6	Availability of basic medication and supplies				

Appendix I: Statistician Letter

University of Limpopo
Research Administration and Development
Private Bag X1106, Sovenga, 0727, South Africa
Tel: (015) 268 3982, Fax: (015) 268 2306, Email: peter.mphekgwana@ul.ac.za

To: To whom it may concern

From: Mr MP Mphekgwana
Biostatistician
Date: 04 October 2021

Letter of Confirmation

Dear Sir/Madam

I hereby confirm that I have read the protocol of Elizabeth Mmalehu Legodi (201834589) titled "*Development of a Training Program to Facilitate The Implementation of the Six Ministerial Priorities by Professional Nurses in Limpopo Province Health Care Facilities, South Africa*".

Hope you find everything in order.

Kind Regards,

Mphekgwana MP

Mr Peter Mphekgwana, University Biostatistician

Appendix J: Confirmation by Language Editor

Fax: 0152682868
Tel. 0152862684
Cell: 0822198060
Rammalaj@ul.ac.za

Dr J R Rammala
440B Mankweng
Box 4019
Sovenga
0727

2 November 2021

EDITORIAL CERTIFICATE

Author: **ELIZABETH MMALEHU LEGODI**

DOCUMENT TITLE: **DEVELOPMENT OF A TRAINING PROGRAMME TO FACILITATE THE IMPLEMENTATION OF THE 6 MINISTERIAL PRIORITIES BY PROFESSIONAL NURSES IN LIMPOPO PROVINCE HEALTH CARE FACILITIES, SOUTH AFRICA**

This document certifies that the above Thesis was edited by Dr JR Rammala (PhD, Linguistics). The document was edited and proofread for proper English language, grammar, punctuation, spelling and overall style. The editor endeavoured to ensure that the author's intended meaning was not altered during the review. Track changes have been used in editing to allow the client to view the changes suggested.

Kind regards

Dr J R Rammala