THE ROLE OF A QUALITY ASSURANCE PROGRAMME IN PROMOTING PATIENT SATISFACTION AND SAFETY IN COMMUNITY HEALTH CENTRES OF EMFULENI LOCAL MUNICIPALITY

NTHABELENG MALISE

23236094

Mini-dissertation submitted in partial fulfilment of the requirements for the degree *Master of Arts in Development and Management* at the Vaal Triangle Campus of the North-West University

Supervisor: Dr L.B. MZINI

November 2013

DECLARATION

I DECLARE THAT THE MINI-DISSERTATION TITLED "**THE ROLE OF A QUALITY ASSURANCE PROGRAMME IN PROMOTING PATIENT SATISFACTION AND SAFETY IN COMMUNITY HEALTH CENTRES OF EMFULENI LOCAL MUNICIPALITY"** IS MY OWN WORK AND THAT ALL THE SOURCES THAT I HAVE QUOTED HAVE BEEN INDICATED AND ACKNOWLEDGED BY MEANS OF COMPLETE REFERENCE.

ACKNOWLEDGEMENTS

I would like to thank and acknowledge the contribution of each of the following persons in the completion of this study:

- First and foremost my Creator, who fearfully and wonderfully crafted my being with compassion and who knows my thoughts even ahead of me. Thank You for revealing Jeremiah 29:11 to me over and over again.
- Dr L.B. Mzini, for playing a role even bigger than that of a Supervisor. I thank you for the support, guidance, input, motivation and constant reassurance of reaching the summit. And yes, we did it! Thank you for believing in me even beyond this scope. My deepest gratitude.
- My wonderful earthly parents; where would I be without you? Thank you for bringing me on earth and for teaching me the values of humankind. You are my biggest role-models and pillars of strength. Mama, thank you for your constant support, motivation. Your 3am prayers inspired my soul. I also enjoyed your accompany for my scheduled interviews at the CHCs which kept me motivated. Words alone are not enough to express my gratitude, Ke a leboha batswadi baka!
- To the rest of my very supportive family and friends. If I had to name you all, this page would be fully packed. I thank you all, for always being there when I needed you. I also appreciate your willingness and time that you offered to me when I asked for help. You are living legends indeed!
- The financial support which I received was helpful and it enabled me to complete this study.
- The approval and consent from the Sedibeng District Health Services (Quality Assurance managers of the CHCs and the patient-community) complemented my goals to complete this study.
- This was a chapter of my life that really challenged me, but at the same time, built me up as an individual. Here's to the next chapter.

ABSTRACT

This study concentrates on the strategic framework of quality assurance in the South African health sector. The study focused the Community Health Centres (CHCs) situated in the Emfuleni Local Municipality (ELM). The study aimed to analyse the administrative issues of a quality assurance programme for promoting patient satisfaction and safety in the CHCs of the ELM. The position of patients in the health services emanates from the provision made by the Constitution of the Republic of South Africa Act of 1996 (hereafter 'the Constitution'). Two of the objectives of the Constitution are to "provide services that are sustainable" and to "promote a safe and healthy environment". In addition the health care sector in South Africa also places patients at the forefront. The Constitution also makes provision whereby municipalities are required to encourage the involvement of communities in the affairs of the local government. Patient satisfaction represents intense interest in giving voice to the patients in the developed world, whereas patients in the developing countries have very little voice.

Quality assurance is defined as a process which ensures that any product or service meets a required standard which has been set. Quality assurance as a process can be compared to the framework of a house and the foundation is always linked to customer needs. Quality Assurance as a tool strives to establish and maintain quality improvement activities which are integral and sustainable part in any organization.

The main objective of this study was to evaluate main models, approaches and indicators used to implement a quality assurance programme within the CHC's. The study also provides recommendations of how quality could be improved, based on the perception of the service users. For this study, a qualitative technique was used for data collection. A qualitative method was also used to report statistical data provided in Chapter 4. The objectives were realised by means of literature reviews, interviews and field work.

The study found that a quality assurance programme is meaningful and has reached the needs of the patients. Access to the CHCs was impressive as the services offered were generally of good quality. However, the participants still does not understand the role of the CHCs. The CHCs was established to offer services which are closer to the people as compared to public hospitals. The hospitals provide chronic patient treatment with

specialised resources (staff and equipment) whereas the CHCs offer acute treatment. The staff complement was assuring whereby there is a medical doctor allocated to each facility. Many community members still need to be educated about the services offered in the CHCs. Such awareness would empower the health service users about the benefits of the CHCs and to retain public trust for improved health service delivery.

TABLE OF CONTENTS **Page**

DECLARATION	ii
ACKNOWLEDGEMENTS	iii
ABSTRACT	iv
CHAPTER 1 INTRODUCTION: ORIENTATION AND BACKGROUND	
1.1 INTRODUCTION	1
1.2 ORIENTATION AND BACKGROUND	1
1.3 PROBLEM STATEMENT	5
1.3.1 Health professionals	5
1.3.2 Information systems	6
1.3.3 The health service delivery system	6
1.3.4 Patients and the community	7
1.4 RESEARCH QUESTIONS	8
1.5 AIMS AND OBJECTIVES	8
1.6 HYPOTHESIS	10
1.7 RESEARCH METHODS	10
1.7.1 Literature review	10
1.7.2 Empirical research and design	11
1.7.2.1 Sampling	11
1.7.2.2 Clinical participants and Non-clinical participants	12
1.7.3 Research ethics	12
1.8 PRELIMINARY CHAPTERS	13
CHAPTER 2 THEORETICAL EXPOSITION OF CONCEPT QUALITY OF ASSURANCE, PATIENT SATISFACTION AND SAFETY	
2.1 INTRODUCTION	14
2.2 ORGANIZATIONAL LEVELS OF THE HEALTH SECTOR	14
2.2.1 Primary health care	16
2.2.2 Tertiary health care	16
2.2.3 Home and community care	16
2.3 DEFINITION OF CONECPTS	17
2.3.1 Quality	17
2.3.2 Quality assurance in the health care context	18
2.3.3 Quality health care and patient satisfaction	19

2.3.4 Patient safety 20
2.4 LINK BETWEEN QUALITY ASSURANCE AND HEALTH SECTOR REFORM 22
2.5 LEGISLATIVE FRAMEWORK FOR THE HEALTH SECTOR 23
2.5.1 White Paper on the Transformation of the Public Service (1995) 24
2.5.2 The White Paper for the Transformation of the Health System in South Africa (1997) 25
2.6 PILLARS OF QUALITY ASSURANCE 25
2.7 DIMENSIONS OF QUALITY OF CARE 26
2.8 BENEFITS OF QUALITY ASSURANCE 27
2.9 CONCLUSION 28

CHAPTER 3 OVERVIEW OF QUALITY ASSURANCE PROGRAMMES IN THE COMMUNITY HEALTH CENTRES

3.1 INTRODUCTION 29
3.2 HEALTH SECTOR IN THE EMFULENI LOCAL MUNICIPALITY 29
3.2.1 Synopsis of the health centres 29
.2.1.1 Quality assurance functionaries 31
3.3 THE PROBLEMS WITH HEALTH CARE SERVICES 34
3.4 INTERVENTIONS FOR TARGETING QUALITY ASSURANCE 35
3.4.1 Health professionals 35
3.4.2 Interventions aimed at patients 36
3.4.3 Interventions aimed at the community 36
3.4.4 Interventions aimed at systems 37
3.5 HEALTH STANDARDS AND CLINICAL GOVERNANCE CRITERIA 38
3.6 QUALITY ASSURANCE PROGRAMME 41
3.6.1 Rationale for a quality assurance programme 41
3.7 QUALITY ASSURANCE MAINTENANCE TOOLS 44
3.8 METHODS FOR MONITORING QUALITY OF CARE 44
3.8.1 Programme evaluation 45
3.8.2 Performance improvement plan 47
3.8.2.1 Monitoring standards 47
3.8.2.2 Supervisory visits 48
3.9 IMPROVE PATIENT SATISFACTIO AND PATIENT SAFETY 49

3.10 DETERMINANTS OF QUALITY CARE 49
3.11 CONCLUSION 50

CHAPTER 4 RESEACH METHODOLOGY AND RESULTS
4.1 INTRODUCTION TO QUALITY 52
4.2 RESEARCH METHODOLOGY 52
4.3 LITERATURE REVIEW 52
4.4 STUDY AREA AND SAMPLING 53
4.5 QUESTIONNAIRE 54
4.6 INTERVIEWS 54
4.6.1 Face to face interviews 54
4.7 PARTICIPANT OBSERVATION 57
4.8 ETHICS IN RESEARCH 57
4.9 RESEARCH RESULTS 58
4.9.1 Distributions of questionnaires 58
4.10 COMMUNITY QUESTIONNAIRE 59
4.10.1 Demographic information 59
4.10.2 Access to health facilities 60
4.10.3 Patient health professional relations 63
4.10.4 Patient perceptions 65
4.11 INSTITUTIONAL QUESTIONNAIRE 65
4.11.1 Stakeholder involvement 65
4.11.2 Situational analysis 66
4.11.3 Confirmation of health goals 67
4.11.4 DEVELOPMENT OF QUALITY GOALS 68
4.11.5 CHOOSING INTERVENTIONS FOR QUALITY 69
4.11.6 IMPLEMENTION PROCESS 74
4.11.7 MONITORING PROCESS 75
4.11.8 The researcher’s view inside the CHC’s 76
4.12 CONCLUSION 76

CHAPTER 5 SUMMARY, CONCLUSION AND RECOMMENDATIONS
5.1 INTRODUCTION 77
5.2 SUMMARY 77
5.2.1 The overall aim of the study 77

5.2.2 Summary of chapters 78
5.3 RESEARCH FINDINGS 79
5.4 TESTING THE HYPOTHESIS 81
5.5 RECOMMENDATIONS 82
5.6 CONCLUSION 83

BIBLIOGRAPHY 84

APPENDICES

APPENDIX 1: APPROVAL LETTER FOR CONDUCTING RESEARCH 91
APPENDIX 2: EDITING CERTIFICATE LETTER 92
APPENDIX 3: CLINICS OF THE SEDIBENG DISTRICT MUNICIPALITY 93
APPENDIX 4: HEALTH SECTOR REFORM FRAMEWORK 96
APPENDIX 5: QUALITY ASSURANCE MAINTENANCE PROGRAMME 98
APPENDIX 6: PATIENT QUESTIONNAIRE 99
APPENDIX 7: INSTITUTIONAL QUESTIONNAIRE CHC 104

FIGURES

FIGURE 2.1 Stakeholder in the health sector 15
FIGURE 2.2 Link between quality assurance and health sector reform 23

TABLES

Table 2.1 Typology of mobile patients 20
Table 2.2 Action areas of WHO global world alliance for patient safety (2004) 22
Table 2.3 Pillars of quality 26
Table 2.4 Dimensions of quality of care 27
Table 3.1 The national quality assurance team and the quality assurance team 32
Table 3.2 The health facilities of the Gauteng province 33
Table 3.3 The facilities of the Sedibeng District Municipality 33
Table 3.4 Clinical governance criteria 39
Table 3.5 The 10-point plan and issues addressed in developing the policy 43
Table 3.6 Monitoring Standards 48
Table 4.1 Community questionnaire and institutional questionnaire 59

Table 4.2	Characteristics of respondents (N=50)	59
Table 4.2	Characteristics of respondents (N=50) (continued)	60
Table 4.3	Distance travelled to the health facility	60
Table 4.4	Frequency of visits	61
Table 4.5	Waiting period at health facilities	62
Table 4.6	Reasons for visiting the CHC	62
Table 4.7	Staff attitude	63
Table 4.8	The use of language when being serviced	63
Table 4.9	Level of cleanliness	64
Table 4.10	Dispensing medication	64
Table 4.11	Stakeholder involvement	66
Table 4.12	Situational analysis	67
Table 4.13	Current performance of the health system	67
Table 4.14	Confirmation of health goals	68
Table 4.15	Development of quality goals	68
Table 4.16	Leadership and patient and population engagement	70
Table 4.17	Information	71
Table 4.18	Regulation and standards	72
Table 4.19	Organisational capacity	73
Table 4.20	Models of care	74

PICTURES

Picture 4.1	Interviews at the Sharpeville CHC	55
Picture 4.1	Interviews at the Boipatong CHC	56
Picture 4.3	Interviews at the Levai Mbatha CHC	56
Picture 5.1	Community health centre service provision	80
Picture 5.2	The Sharpeville CHC	80

CHAPTER 1
INTRODUCTION: ORIENTATION AND PROBLEM STATEMENT

1.1 INTRODUCTION

This study concentrates on the framework of quality assurance (QA) in the South African health sector, and it analysed the community health centres (CHCs) of the Emfuleni Local Municipality (ELM). The researcher chose the ELM because it is where she resides and as such has a genuine interest in how this study affects the area. This chapter presents the background as well as the problem statement of the study. The chapter provides research questions, objectives and a hypothesis. The chapter also describes the research methodology which is used to realize the objectives of the study. This chapter concludes by giving a chapter outline of the study.

1.2 ORIENTATION AND BACKGROUND

This study focuses only on administrative issues aimed at evaluating the Quality Assurance programmes as a tool for promoting patient satisfaction and safety in the CHCs of the ELM. The position of patients in the health services emanates from the provision made by the Constitution of the Republic of South Africa, Act 108 of 1996 (hereafter ‘the Constitution’). Chapter 7, Section 152 of the Constitution provides two objectives that relate to the health services. The first is to “provide services that are sustainable”. The second objective seeks to “promote a safe and healthy environment”. In addition the health care sector in South Africa also places patients at the forefront. Chapter 7, Section 152 of the Constitution also makes provision whereby municipalities such as the ELM should “encourage the involvement of communities in the affairs of the local government”. Patient satisfaction represents intense interest in giving voice to the patients (Andaleeb, *et al.*, 2007:265). The interest for conducting this research arises from the health care system reforms in South Africa.

Evidence for a transformed health sector is demonstrated by the development of impressive legal and policy frameworks. The researcher of this study believes that both legal and policy framework serve as a guarantee for the right to access health care to all persons in South Africa. The Health Ministry launched the National Patient's Rights Charter in November 1999 (Pillay and Asia, 1999:20). The Health Department’s Quality Assurance Directorate developed a list of “core norms” and standards (Cullinan, 2006:6). The core norms and standards improve the quality of care in the clinics

(Cullinan, 2006:6). The National Policy on Quality in Health Care and the Batho Pele (*People First*) (Gildenhuys, 2000:20), principles guides the health care sector. The principles helps the health facilities to continuously improve the care that is being provided to the community (South Africa: National Department of Health [SA: NDoH], 2007:2). The execution of the health public policy relies on resources and instruments to achieve the set goals. The health care system in the Gauteng province comprises of public health facilities such as hospitals (*n*=33) and clinics (*n*=747) (Gauteng Department of Health and Social Development [GDHSD], 2011:20) to implement the abovementioned programmes.

The health facilities in Gauteng comprises of three regions for providing health care in the province. These regions include - Region A: the City of Johannesburg-West Rand Municipality; Region B: Ekhurhuleni Metro and Sedibeng District; and the Region C: the City of Tshwane and Metsweding District. National aims for improvement looks at addressing access to health care; ensuring the appropriate use of health care services; and reducing health care errors (adverse events) (SA: NDoH, 2007:2). The policy further aims to encourage the people of the province to take greater ownership of their own health status (Gauteng Department of Health, 2007: 5). To realise the goals of the reformed health sector, different programmes are established to provide the respective services whereby the Gauteng province comprises of eleven programmes to deliver the health services. The health system in Gauteng province includes programmes such as the Central Hospital Services, Provincial Hospital Services and District Health Services and Quality Assurance (GDHSD, 2011:17).

As indicated above, the Gauteng province consists of three regions that are created to render health services to the respective communities. This study concentrates only on Region B that carries out the health services to the community of the Sedibeng District Municipality (SDM). The SDM is made up of three municipalities, namely: "Emfuleni Local Municipality (ELM), Lesedi Local Municipality (LLM) and Midvaal Local Municipality (MLM)" (Sedibeng District Municipality, 2011). The SDM comprises of three public hospitals (two district: Kopanong and Heidelberg Hospital; and one provincial: Sebokeng Hospital). There are also 42 public clinics (29 clinics; 5 CHCs; 6 mobile; 2 satellite clinics) and the private health facilities (GDHSD, 2011:20). Since this study is a mini-dissertation the researcher focuses only on the four CHCs which are around the ELM. The ELM is a Category B municipality. Section 157 of the Constitution defines a

Category B municipality as a municipality that share municipal executive and legislative authority in their area with Category C municipality which is the SDM (Sedibeng District Municipality, 2011). The four CHCs in the ELM are the Johan Haynes CHC; Levai Mbatha CHC; Sharpeville CHC; and Boipatong CHC (GDHSD, 2011:29).

Cullinan (2006:5) defines a CHC as a facility that provides Primary Health Care (PHC) services at grass root level. The PHC services cover a comprehensive range of preventative, promotional, curative and rehabilitation services (Phaswana-Mafuya, *et al.*, 2008:611). The CHCs provides services beyond the scope of other PHC clinics. The CHCs normally provides a 24 hour maternity service (Cullinan, 2006:5). Emergency services are also offered. These facilities have close to 30 beds where patients can be observed for a maximum of 48 hours (Cullinan, 2006:5). The Levai Mbatha CHC, provide services to the surrounding community of Evaton, Evaton North and West, Palm Springs, Lakeside and Beverly Hills. The Sharpeville CHC provides services to the community of Sharpeville (Rooi Steen; Tshepiso ext 1, 2, 3, 4; Putswa Steen; and Phelindaba). The Bophelong CHC renders its services to the community of Bophelong (all extentions, e.g.1-17). Johan Heynes CHC used to be a district hospital (before health facilities restructuring) and it serves the community of Vanderbijlpark (all sections, e.g. CW-I, Bedworthpark). Addresses and contact details of the clinics within the Sedibeng District Municipality are provided in Appendix 2. These CHCs are complemented by the services offered in the three hospitals which serve as tertiary health services with the other clinics. The residents of Vereeniging as well as the surrounding areas access the specialised health services from the Kopanong Hospital, however there are also clinics in the jurisdiction of the ELM (Participant observation).

The abovementioned health reform initiatives represent an important effort to make patient safety a priority and sets goals to reduce medical harm (GDHSD, 2011). The quality assurance programme monitors the quality of patient care in the health facilities (GDHSD, 2011). Quality Assurance (QA) is defined as a process that ensures that any product or service meets a required standard (Koller, 2006:592). Bossert (1999:1) views QA as a process which provides structure to any development cycle or stage, and such structure can be compared “to the framework of a house and the foundation is always likened to customer requirements”. The QA as a tool strives is to establish and maintain quality improvement activities which are integral and sustainable part in any organizations (Uganda Ministry of Health, 2011:1; Danida, 2004:20). QA in the health

sector is sustained by four main targets of intervention. These interventions include the health professionals; patients; the community; and the health service delivery system (RSA: NDoH, 2007: 6). These main targets contribute to the design, assessment, monitoring of standards towards improving quality of service delivery and client satisfaction.

Improvements to health care quality depend on sufficient financial, structural and personnel resources (GDHSD, 2011). As a desired outcome there are no absolute guarantees that the product will match the desired standards especially where there are reported irregularities in the sector (Crosby, 2000:6-7). However, strong management and support staff will be essential to meet the milestones of the reform. To reach these milestones the creative ways such as contracting non-profit organisations (NPOs) are being explored by the South African government to reach all those who need PHC services (Phaswana-Mafuya *et al.*, 2007:611). For example, the capacitation of the service health service is evident in the surrounding areas of the ELM. The researcher of this study is aware of the services that are rendered in the hospice centres (Sebokeng in Golden Highway and HoneyBee Hospice in Vanderbijlpark) and home-based facilities whereby the community health workers also assist in health care provision (Participant Observation).

Koller (2006) points out that the QA in the health sector intends to "maintain performance and to ensure that the facility operates as mandated by the health system". The health facilities recognise the importance of delivering patient satisfaction (Andaleeb, *et al.*, 2007:264). Patient satisfaction is seen as a strategic variable and a crucial determinant of long-term viability and success (Andaleeb, *et al.*, 2007:264). The health sector's approach to patient satisfaction and safety is largely influenced by the eight (8) principles of "Batho Pele" developed in 2007 for improving service delivery in the health fraternity (SA: NDoH, 2008). Patient satisfaction is recognized as a strategic variable and a crucial determinant of long-term viability and success in the health sector (Davies and Ware 1988: 20). The World Health Organisation (WHO, 2004:4) regards safety as a fundamental principle of patient care and critical component of quality management. As a principle, patient safety relates to the QA's four main targets of intervention for improving the health service delivery system mentioned above (SA: NDoH, 2007:6). The promotion of patient safety demands the health facilities to apply a broad range of actions to improve performance

and (WHO, 2004:4). Furthermore; the health facilities are expected to reduce the possibility of adverse events resulting from exposure to the health-care system across a range of diseases and procedures (SA: NDoH, 2008).

The four main targets of intervention for QA depend on the integrated workforce to enhance leadership, entrepreneurial and administrative skills which will assist. The aforementioned skills complement the socio-political, economic and technological standards for sustainable growth (Omachonu and Ross, 2004:56). Despite the health care system reforms in a global environment, the health care context operates in a highly complex environment, whereby care is delivered in a pressurised and fast-moving environment (WHO, 2004:1). Such complexities result into lack of service delivery and unmet patient expectations.

1.3 PROBLEM STATEMENT

The South African health system reform has come a long way since 1994. The aim was to redress the imbalances of the Apartheid regime (prior 1994). Its building blocks are in place to provide a comprehensive health system that is underpinned by quality, a skilled workforce and appropriate infrastructure. However, some difficulties lie in its implementation. A fair amount of attention has been paid to the establishment of the District Health Services, the building and upgrading of clinics and the strengthening of management at certain hospitals. However, not much attention has been paid to strengthening the management of clinics and CHCs in the past years (Pillay and Asia, 1999:30). As stated above the QA in the health sector concentrates on the four main targets for improving service delivery in the health facilities. The following subsections describe the challenges encountered by the health sector and these are categorised according to the four main targets of the QA. These are discussed in detail below.

1.3.1 Health professionals

Many quality problems in health care have been identified, in both the public and the private sectors. One of the greatest challenges facing health professionals is the rate of change and technical innovation in the health sector (SA: NDoH, 2007:6). The sector introduced new health technologies. Innovations are recommended, but if its management is lacking, it will lead to redundancy and ineffectiveness in the sector. Lack of quality assurance at CHC's occurs frequently. Mwongera (2008:20) indicates that these unfortunate incidents such as long-waiting periods and loss of life occurring in the

CHCs results from staff shortage, lack of motivation and also lack of efficient training and skills. The workload has increased due to demands on health services (Andaleeb *et al.,* 2007:263). The challenges faced by the health professionals are disturbing (Andaleeb *et al.*, 2007:263). Andaleeb *et al.,* (2007:263) also points that the health professionals developed a lack of empathy and aggressive pursuit of monetary gains. For example, public health professionals leave their jobs to join the private sector or become employed in foreign countries such as Europe or are employed in other sectors. This is often because foreign countries offer better working conditions and better salaries and benefits (participant observation). In the ELM, community members are dissatisfied about the perceptions of the health workers. Issues such as the lack of respect and timely service delivery are issues that require urgent attention in the ELM.

1.3.2 Information systems

The public sector often encountered problems in the area of technological advancements. In 2008, the Gauteng province launched the Health Information System (HIS) to improve data management on patient profile (Gauteng Provincial Government, 2008). The HIS is aimed at improving the data management and record systems as well as to help deal with the referral system (SA: NDoH, 2007:3). Some of the responsibilities of health professionals include performing critical teaching and research functions, which seems impossible when accurate information is lacking. Technological advancement is also another key requirement in this area.

1.3.3 The health service delivery system

The QA aims to maintain resources in a standardised form (Koller *et al.*, 2006:595) and the CHCs are required to provide the necessary health care to the community. However, in ELM the CHCs are confronted by "uneven community demands and perceptions of poor quality" (Andaleeb *et al.*, 2007:264). These cannot be expressed enough given the increased complexity within the health care system (Pillay, 2008:31). Pillay (2008:31) revealed that the health sector in South Africa is often unable to significantly improve the health and wellbeing of the large population it is expected to serve. In terms of the health service delivery system, the sector encountered the following challenges: poor delivery systems; under-use and overuse of services; variation in services; lack of resources and drug shortages; and inefficient use of resources (SA: NDoH, 2007:3).

WHO (2004:4) indicates that there is a problem of wide-spread lack of awareness of the problem of adverse events and still in 2011 such problems are being encountered by the health facilities as specified by Parker (2012). A study conducted by Quigley (2011:12) further indicates that health facilities still lack to initiate steps to identify and eliminate medical errors in health care. Parker (2012) also points out that the media reports in Gauteng province over the past years have highlighted medicine stock-outs, equipment failures, staff shortages and financial mismanagement in many provincial hospitals.

The researcher hereof believes that the workplace should be attractive in such a way that staff can be hired and retained and that they should also have the appropriate skills to execute the work. The health sector also needs to be managed in an efficient and effective manner and has to comply with government as well as community concerns. The complexity and demand of illnesses treated in public hospitals have increased over the years (Participant Observation).

1.3.4 Patients and the community

Patient safety has become a national priority (Quigley, 2011:11). Poor people rely on public services to provide them with the skills and healthcare service. Such skills help to support the livelihood needed to fulfil basic human rights and to succeed in the labour market (Unsworth, 2010:36). A large proportion of the population does not have medical assistance/ funds and as such cannot afford the fees and services of private hospitals for health purposes. There is however inadequate diagnosis and treatment as well as a disregard for human dignity (SA: NDoH, 2007:3).

While visiting the CHCs, the researcher observed that patients from different backgrounds find themselves in critical conditions sleeping for hours in the waiting rooms and in corridors as they wait to be attended to by nurses and doctors. These shortcomings endanger the health and lives of all patients, add costs to the health care system, and reduce productivity. The unmet health perceptions by the community have led to public protests over service delivery.

Concerns over the quality of health care services have led to loss of faith in the public health care sector (Andaleeb *et al.*, 2007:263). In the ELM there were service delivery protests, where community members complained about the lack of medication;

unavailability of doctors in the clinics and the distance travelled to the clinics. Concerns pertaining to shortage of CHCs in the informal settlements such as Boiketlong and Sonderwater were also raised as lack of democratic rights among the residents of the ELM (Andaleeb *et al.,* 2007:263).

Based on the above-mentioned problems, this study reviews the CHCs on how they can improve patient satisfaction and safety in order to instil trust and high utilization of the CHCs in the ELM. To address the intentions of this study, the questions listed below are designed as a focal point for the research to be undertaken in the ELM. Since the CHCs provide comprehensive health care services in a unique manner, this study aims to analyse the capability of the CHCs in the ELM in improving patient satisfaction and safety. The study also observes whether the CHCs in the ELM do adhere to the mandate and commitment of patient satisfaction and safety as stipulated by the health care system.

1.4 RESEARCH QUESTIONS

This research responds to the following questions:

- What does the concepts quality assurance programmes, patient satisfaction and patient safety for implementing sustainable PHC services within South African health services mean?
- What are the key models, approaches and indicators used to implement an effective quality assurance programme in the South African CHCs particularly in the ELM?
- What is the impact a of quality assurance programme in the CHCs of the ELM?
- What recommendations can be offered towards an effective implementation of QA programme in improving patient satisfaction and safety in the CHCs of ELM?

1.5 AIMS AND OBJECTIVES

From the questions raised above the following aims apply:

- To give a theoretical explanation of the concepts quality assurance, patient satisfaction and patient safety for implementing sustainable PHC services within the South African CHCs.

- To evaluate the main models, approaches and indicators used to implement quality assurance programme in the CHCs particularly in the ELM.
- To analyse the impacts of quality assurance programme in the CHCs of the ELM.
- To provide recommendations on implementing QA programme for improving patient satisfaction and safety in the CHCs of ELM.

Institutions rely on research to determine their institutional achievements. Controlled research settings are seen as important to evaluate the effectiveness of solutions in real-life settings in terms of their impact, acceptability and affordability (World Health Organization, 2011). A performance review framework was applied to evaluate the implementation of the QA programme in the ELM health services. The overall objective of this research was to assess whether QA programmes in these CHCs have been successful in achieving their objectives.

The health system reform mandates are still in their infant stages and QA programmes have shown to work in some institutions. Achieving the goal of a quality health care system is crucial. It requires a national commitment to measure, improve and maintain high-quality health care for all its citizens (SA: NDoH, 2007:2). In this regard the study reviewed whether there is capacity building within the CHCs of the Sedibeng Districts Health services in sustaining QA initiatives. Since QA serves to monitor the success of health activities, the researcher had to assess the credibility of the monitoring indicators for Quality of Care in the respective facilities.

The context of QA in the health sector is not yet known by most stakeholders and need to be disseminated at all levels, hence with this research project the researcher aimed to increase the awareness of QA among the communities using CHCs. This study attempts to identify the determinants and impact of QA programme on patient satisfaction and safety in the CHC's the ELM. By this the study also aimed to find ways which could help improve the management of clients in the CHCs around the ELM for reaching the desired levels of quality. Existing strategies aimed at strengthening community participation and to mobilise communities to participate in QA in the CHCs were also evaluated.

The abovementioned actions are complemented by a set of recommendations which will contribute to the sector regarding the implementation of QA programmes, safety of

patients as well as client satisfaction. Furthermore the researcher believes that this study will help raise awareness of the situation surrounding the CHC's and how quality assurance can benefit the health services and citizens as a whole.

1.6 HYPOTHESIS

According to Blessing and Chakrabarti (2009:92) the term hypothesis is a "proposed explanation for a phenomenon". For this particular study, the hypothesis is formulated under the following statement:

"A well-defined quality assurance programme can serve as a tool for continuous monitoring, measuring and improving quality of health services in the ELM".

1.7 RESEARCH METHODS

A researcher may use one or more techniques to collect data. For this study, qualitative and quantitative techniques were used. The qualitative technique guided the researcher to conduct field research, to analyse research by means of historical-comparative analyses when the aspects of social life for the health sectors were examined (Neuman, 1991:33). A Quantitative approach is also considered, since the study prefers the use of surveys, content analysis and existing statistics of previously collected information (Neuman, 1991:33). The two approaches are complemented by the use of literature review and empirical research to collect data.

1.7.1 Literature review

A literature review that was consulted in this study was aimed to "review older and current research" (Maree & Van der Westhuizen, 2009:8). A literature review is defined as "a body of text that aims to review the critical points of current knowledge" (Hart, 2001). Such reviews include the application of substantive findings as well as theoretical and methodological contributions to a particular topic Literature reviews are secondary sources, and as such, do not report any new or original experimental work" (Hart, 2001).

The literature study on QA and patient satisfaction-safety was obtained from the secondary sources. The secondary sources consisted of books, journals, articles, internet, legislative frameworks, medical reports, newspaper articles and previous database of thesis and dissertation of tertiary institutions. Journals such as the International Journal of Health Care Quality Assurance, Health Care Information

Management Journal were also consulted since they public research on QA issues. The Journal of Public Administration were consulted to access data on public policy issues, service delivery and performance improvement and management. The information was accessed through public sector reports available in the public sector libraries and from the health sector.

The study also accessed policies such as the Quality-Health Care policy for South Africa (April 2007); White Paper on the Transformation of Public Service of 1995;the annual reports of the Department of Health (in the three spheres of government) as well as related websites.

1.7.2 Empirical research and design

The researcher conducted surveys by means of structured and semi-structured, face-to-face interviews and questionnaires. For this study, surveys assisted the researcher to examine the data comprehensively; to inspect carefully and to scrutinize the QA programme. According to Brandford (1994:969) surveys assist researchers in determining the boundaries for the research environment. The study utilized interviews and questionnaires for accessing data. Interviews involve a dialogue between the researcher and the participants. The questions designed for this research were aimed at obtaining information from participants (Soanes & Hawker, 2006:532). The interviews lasted for ten minutes per patient and other community members.

Another method that was utilized in the conducting of this research was the use of questionnaires that comprised of open-ended questions and Likert scaling. A questionnaire is "a form containing a set of questions, submitted to people to gain statistical information". Branford (1994:785). The researcher distributed the questionnaires to respective participants.

1.7.2.1 Sampling

Sampling in research enables a researcher to measure variables on the smaller set of cases and to generalise results accurately to all cases (Neuman, 1991:202). The researcher made use of non-probability and snowball sampling in order not to limit the research (Neuman, 1991:202). In terms of the sample selected the researcher approached the respondents individually. The sampling method enabled the researcher to select and interview the respondents without bias since any person can be approach

for the interviews. The respondents were chosen from the community of Emfuleni Local Municipality (ELM). Because this is a mini-dissertation, a sample population of 50 people was drawn from the four selected CHCs in ELM, which include: Johan Haynes Clinic; Levi Mbatha; Sharpeville CHC; and Boipatong CHC.

Interviews held with the respondents were conducted in order to determine what motivates managers and providers of health services to work effectively and to promote QA. Therefore the sample comprised clinical and non-clinical participants. These are explained below.

1.7.2.2 Clinical participants and non-clinical participants

The clinical participants included the three (3) Quality Assurance Managers who manages the Quality Assurance Unit in the three CHCs. The Quality Assurance Managers are also responsible to monitor the process of quality improvement processes in the respective health facilities.

The non-clinical participants encompassed the patients who visited the clinic at the time of the interview. In this case fifty (50) community members were interviewed in the ELM. To improve quality, the community must be involved in defining and participating in QA. This category included patients selected in the CHCs and community members who had services at the respective health facilities.

1.7.3 Research ethics

This study is based in the field of the Social Sciences. The setting of this study is based on the health sector framework and limits its scope on administrative functions (and not the clinical issues) of the CHCs in terms of the evaluation of the quality assurance programme. The health sector operates on confidentiality clause-policy and continuously engages with vulnerable communities. Research activities rely on adhering to ethical principles, whereby a community member may decide to participate voluntarily in the study. In cases where a community member decides to be excluded in the study, such an individual was not forced to participate. Adherence to ethical norms enables researchers to be aware of the general agreements between the/a researcher and the gatekeeper(s) about what is proper and improper in the conduct of scientific enquiry (Babbie, 2011:477). Ethical norms guided the researcher throughout this project to

avoid errors and to ensure that voluntary participation was maintained at all times. As a result all participants who took part in this study did on their own free will.

This research deals mainly with the administrative processes of quality assurance in the respective CHCs. The researcher intends not to harm the images of the institutions and the participants who took part in the study. In order to sustain the relationship with the intended participants, the researcher submitted a letter to request permission from the Gauteng Department of Health; particularly the regional office thereof (Sedibeng District Health Services) to gain access for the observations and for generating data. In this case a letter of permission was submitted and the approval obtained served as an accountability mechanism during the study. Data gathered was stored with the name of the participant. For reporting purposes, the names of the participants (clinical and non-clinical respondents) were not reported in this mini-dissertation, however the researcher used the coding system.

The responses were reported in a collective form, whereby the words like the “participants” or “respondents” were used to report the results of the interviews. In some cases the participants used the interviews as a platform for reporting their dissatisfaction about particular services rendered to them. In cases were such cases were reported to the researcher, the participants were advised to consult the office of the Ward Committee or the Ward Councillor in their area. The Ward Committee or the Ward Councillor is responsible for advocating community interest and assist in solving the problems that exist in the clinic or to a particular area.

1.8 PRELIMINARY CHAPTERS

The study has the following chapter outline for reviewing the role of the QA programme in promoting patient satisfaction and safety in the CHCs of ELM:

Chapter 1: Introduction: Orientation and Problem Statement
Chapter 2: Theoretical exposition of concept of quality assurance, patient satisfaction and safety
Chapter 3: Overview of quality assurance programmes in the CHCs
Chapter 4: Research methodology and research results
Chapter 5: Findings, conclusion and recommendations

CHAPTER 2
THEORETICAL EXPOSITION OF THE CONCEPT OF QUALITY ASSURANCE, PATIENT SATISFACTION AND SAFETY

2.1 INTRODUCTION

This chapter describes the concept of quality assurance as it pertains to the health sector. The concepts of quality and quality assurance in the context of health services are also defined. This chapter also provides the background of quality care and health reform. The three levels of health care system are also explained in this chapter. Furthermore, the action areas of the WHO's "Global World Alliance for Patient Safety" are presented in the sections below.

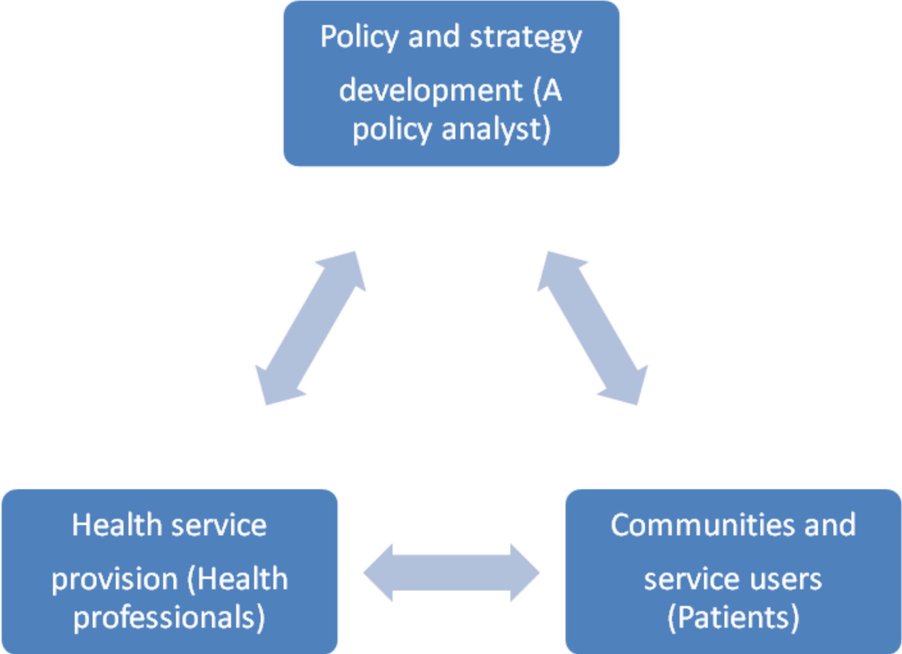
Execution of the health sector activities is regulated by various guidelines for ensuring compliance and efficiency within the system. In this chapter, two legislative frameworks are discussed, namely: the White Paper on the Transformation of the Public Service (Batho Pele) (1995); and the White Paper for the Transformation of the Health System in South Africa (1997). The sections below illustrate the seven pillars and the six dimensions of quality assurance. Institutions strive to achieve and maintain the set goals by the international bodies on health service delivery. Such interventions are sometimes difficult to maintain and this chapter gives a picture of the benefits associated with the implementation of a quality assurance programme.

2.2 ORGANIZATIONAL LEVELS OF THE HEALTH CARE SECTOR

Access to health care differs across countries. The concept *health care* refers to the execution of the health policy for providing primary care, secondary care and tertiary care, as well as in public health. The health care services are offered in the public and private sector. Quality assurance strategies normally fall under the three core activities, namely: "defining quality, measuring quality, and improving quality" (Mantilla, *et al.*, 1998:7). Measuring quality and improving quality is discussed in Chapter 3.

The health care sector is usually represented by three groups of stakeholders as presented in Figure 1 below.

Figure 2.1: Groups of stakeholders in the health sector



Source: Bengoa, *et al.*, 2006:11

Figure 1 above identifies the three stakeholders in the health care services. The policy and strategy development may include the policy analyst, policy makers as well as the legislative authority and the political authority. The ministry of health also forms part of the policy and strategy development. The health sector regulations and policies are passed by the policy and strategy development. The Health Service Provision forms part of the operational level for implementing public policies. This consists of the provincial government departments and the local government/ municipality (Bengoa *et al.*, 2006:11).

The health services provided by the provincial government departments and municipalities are unique, whereby the two spheres of government have discretionary mechanisms for implementing the national health policy. The provincial government departments and the local government are accountable to the Ministry of Health. The government sector also account to the community who are the service users. The community consists of civic organisations, ordinary citizens and the patients who receive medical treatment throughout (Bengoa *et al.*, 2006:11).

Patients are required to participate in the health decision process in order to ensure that the health facilities they use do meet their needs. Patient involvement relies on “access

to information and other tools" which will help patients to understand the process (Legido-Quigley, *et al*., 2008:20). Patients involvement allows them to be entirely satisfied, as this is a major requirement to ensure that clinics are serving the people accordingly (Carruthers, 1999:10). The three stakeholders are represented in the following three levels of the health care.

2.2.1 Primary health care

Primary Health Care (PHC) is viewed as a "holistic approach" which provides elementary health services to local communities (Macagba, 2001:30). The PHCs includes CHCs, local government clinics, mobile and satellite centers. The CHCs plays a pivotal role in "the provision of ambulatory primary health services" (Wilson, 2009:10). They provide ways to improve the overall health status in communities. The delivery system uses the latest technology for realising the goals of the health sector. The PHCs includes CHCs, local government clinics, mobile and satellite centres. In South Africa, the first CHC was established in 1940's by the Union Health Department. By then the CHC was called Pholela Community Health Centre (Department of Health, 2001:20).

2.2.2 Tertiary health care

Tertiary care refers to the health services provided in a hospital. A hospital play an imperative goal in "promoting and providing PHC" (Macagba, 2001:30). The hospitals provide specialised health services, and treat extreme cases such as heart transplants, amputation and chronic illness management. Hospitals serve as a referral from the PHC.

2.2.3 Home and community care

Hospitals on their own, cannot carry all the responsibilities, and can only contribute to the health needs of society. Macagba (2001:31-32) indicates that some of the developing countries are unable to provide health care services to its population. The health sector works with different stakeholders to provide a variety of services. The NGOs are used to manage the treatment for substance abuse.

The home and community care centres has created opportunities for the less fortunate people through public participation. Wilson (2009:10) indicates that a lot of jobs have been created and training programmes were incorporated to capacitate the beneficiaries (Wilson 2009:10).

2.3 DEFINITION OF CONCEPTS

The concept of quality is multidimensional. This section discusses the concept of quality in relation to the health sector. The sections below define the concepts: quality; quality assurance; quality health care assurance; patient satisfaction and patient safety.

2.3.1 Quality

Quality cannot be taken lightly when placing it in the healthcare arena. Quality could be described in a number of different ways. Quality can be viewed as a “technical aspect” which focuses on “the timely delivery of efficient and safe care” (Brenzel, 2001: 45). It plays a central role for guiding and regulating the implementation of policies. Quality in the health sector is linked to a product or a service. Today’s world operates in competitive and technological environment whereby most managers pursue quality merely to “satisfy customer needs and meet customer expectations” (Evans, 2008:3). Meeting customer’s needs is a challenge to a lot of institutions since managers are required to continually develop strategies that will improve the service provided to their respective customers (Evans, 2008:3)

Cullen & Hollingum (1987:21) further describe quality as a “system”. Simply put, quality should be the centre and main focus of how an organization is managed in the day to day running of a business. A system is used for integrating quality improvement efforts in an organisation. A system is used to provide goods and services to the customer. Effective systems allow customers a platform to enjoy the service rendered to them in a responsive and satisfactory manner. If good management practices are designed, and well implemented in the organization, then good results should naturally follow. The system includes the management practices and the investments made by an institution to realise the goals of their customer care. The study conducted by Evans (2008:3) in the United States further describes quality as it aims for:

- Perfection;
- Consistency;
- Eliminating waste;
- Speed of delivery;
- Compliance with policies and procedures;
- Providing a good, usable product;
- Doing it right the first time;
- Delighting or pleasing customers; and

- Total customer service and satisfaction.

Quality in the health care industry is achieved when services are “accessible, provided in an efficient manner and are cost-effective” (Sheahan, 2012:12). Cullen and Hollingum (1987:19) concur with the above description. However the author indicates that some of the above descriptions are difficult to attain. The goals do not succeed simply because the customers expect too much from the institutions.

2.3.2 Quality assurance in the health care context

The previous section indicated that the concept of quality aimed to satisfy the patient’s needs (Lindsey & Petrick, 1998:53-54). The significance of a quality assurance extends “beyond achieving an acceptable quality of the administered health care” (SRCC Quality assurance, 2012). Quality assurance in the health sector is based on three elements, namely: Structure, Process and Result (Mantilla *et al.*, 1998:4). In this regard quality assurance can be viewed as a “process that ensures that any product or service meets a required standard” (Koller *et al.*, 2006:592). A process comprises a set of actions that may be taken to improve healthcare at the service delivery entry point and across the continuum of care (Mantilla *et al.*, 1998:1). Crosby (1989:32-33) presents the quality assurance measurement categories for managing patient satisfaction and patient safety as follows:

- Management understanding & attitude;
- Quality organization status;
- Problem handling;
- Cost of quality;
- Quality improvement actions; and
- Summation of company quality posture.

The health sector uses such actions to monitor the quality of patient care. The actions for carrying out quality assurance are dependent on issues such as sufficient financial, structural and personnel resources. Quality assurance forms part of service delivery. Coetzee (2006:20) defines service delivery as “a service which is provided to a customer”. For example, in terms of the health sector the services are rendered to the patients who serve as beneficiaries for the allocation of resources. The following are complementing elements that used for determining quality assurance in the provision of services in any institution:

- “Time;
- Timeliness;
- Completeness;
- Courtesy;
- Consistency;
- Accessibility and convenience;
- Accuracy; and
- Responsiveness” (Lindsey & Petrick 1998:55).

The above-mentioned elements are also used as guiding principles for service provision in the public sector. The Batho Pele principles are used to attain quality in the Public Service. A further discussion on quality assurance will be discussed in Chapter 3.

2.3.3 Quality health care and patient satisfaction

Quality health care is a multi-dimensional and multi-faceted concept. Quality of health care focuses on issues of “patient’s welfare” (Legido-Quigley *et al.*, 2008:3). Quality health care depends on the three elements, namely: the structure, process and results. The structure is defined as “concrete and quantifiable inputs used in buildings, equipment, medications, medical supplies, vehicles, personnel, money and organizational systems” (Mantilla *et al.*, 1998:4). The process refers to “everything that is actually done to provide adequate services to the patient” (Mantilla *et al.*, 1998:4).

The process addresses issues of quality from a health systems perspective (Bengoa, *et al.*, 2006:3). The result is defined as an” adequate culmination of the patient care process, using the required time and inputs” (Mantilla *et al.,* 1998:4). Table 2.1 presents the typology of mobile patients.

With this, the institutions aim to measure the manner in which services are provided. The realisation of patient’s welfare is characterised by various factors since managers tries to incorporate all strategies to realise the organisational goals

Table 2.1: Typology of mobile patients

Patients who are abroad when in need of health care	Patients who go abroad for the purpose of obtaining health care
Temporary visitors abroad	People living in border regions
Long-term residents abroad	People sent abroad by their home systems
	People who go abroad on their own initiative to seek treatment

Source: Legido-Quigley *et al.*, 2008:44

Mantilla *et al.*, (1998:3) presents some of the characteristics pertaining to the quality health care as it:

- include a measure of scale;
- encompasses a wide range of elements of care with reference to health services;
- identifies both individuals and populations as targets for quality assurance efforts;
- is goal oriented;
- recognizes the importance of outcomes;
- highlights the importance of individual patients' and society's; and
- underlines the constraints placed on professional performance.

The abovementioned characteristics point toward the importance of a patient who is the end user of the services provided by the state. It also implies how the patients have been taken into account in health care decision- and policy-making. Patient satisfaction relies on the inputs made available in the health sector for meeting the clients expectation. Legido-Quigley *et al.*, (2008:3) further state that the above can only be attained if the state of technical, medical and scientific resources are present in the health sector.

2.3.4 Patient safety

Roben (2003:20) that the state of patient safety has become a national priority whereby health professionals have begun to "make some efforts to find solutions for safer care within the health sector". In the nineteenth century, Florence Nightingale launched a process of reforms aimed at improving the quality of health care at the hospital level.

The respective measures included: “cleaning, basic sanitation, improving the quality of the food as well as the appropriate handling thereof, and the establishment of strict disciplinary regulations and the organization of hospital routine” (Mantilla *et al.*, 1998:4). Florence Nightingale’s approach constituted a true revolution at the time which led to a drastic drop in the mortality rate in different hospitals.

Patient safety emanates from the extent of the adverse events occurring in the health sector. Patient safety emphasises on the “reporting, analysis and the prevention of medical error that often leads to adverse healthcare events (World Health Organisation (WHO), 2004)”. Patient safety relies on interdependence between the health professionals in order to avoid system failure as well as communication breakdown.

There are strategies that are being developed to create a safe care environment for the patient. Patient safety is managed through by means of: “identifying and reducing medical errors; traditional reporting practice; and measuring on the intensity of the impact (Quigley, 2003:40). The abovementioned strategies are supported by proactive planning and inclusive decision making. During 2005–2006 the WHO’s proposed the “*Global Patient Safety Challenge” which focused* on the challenge of health care-related infection. Table 2.2 presents the action areas initiated by the WHO.

The framework presented in Table 2.2 was initiated by the WHO in 2000 with the aim to create an assessment grid to help rank the participating countries on a set indicator (Clark *et al.*, 2001:20). The above action areas are global perspectives. However the implementation is sometimes delayed. Legido-Quigley *et al.*, (2008:25) indicates that in 2005 only “Denmark, Germany, Spain, the Netherlands and the United States were the only country who established specific institutional structures to ensure patient safety (Legido-Quigley *et al.,* 2008:25)”.

The author assumes that the delays could be caused by budget constraints and technological advancements. Furthermore the author of this study indicates that the barriers could be caused by natural illnesses such as malaria, chronic diseases, lifestyle behaviour and opportunistic diseases. Public participation is also seen as a barrier, because the patients do not report their illnesses and such factors make the system ineffective.

Table 2.2: Action areas of WHO Global World Alliance for Patient Safety (2004)

ACTION AREAS	DESCRIPTION
Global Patient Safety Challenge:	Focusing throughout 2005–2006 on the challenge of health care-related infection.
Patients for Patient Safety:	Involving patient organizations and individuals in the work of the Alliance.
Taxonomy for Patient Safety:	Ensuring consistency in the concepts, principles, norms and terminology used in patient safety work.
Research for Patient Safety:	Developing a rapid assessment tool for use in developing countries and undertaking global prevalence studies on adverse effects.
Solutions for Patient Safety:	Promoting existing interventions and coordinating activity internationally to ensure new solutions are delivered.
Reporting and Learning	Generating best practice guidelines for existing and new reporting systems, and facilitating early learning from the information available.

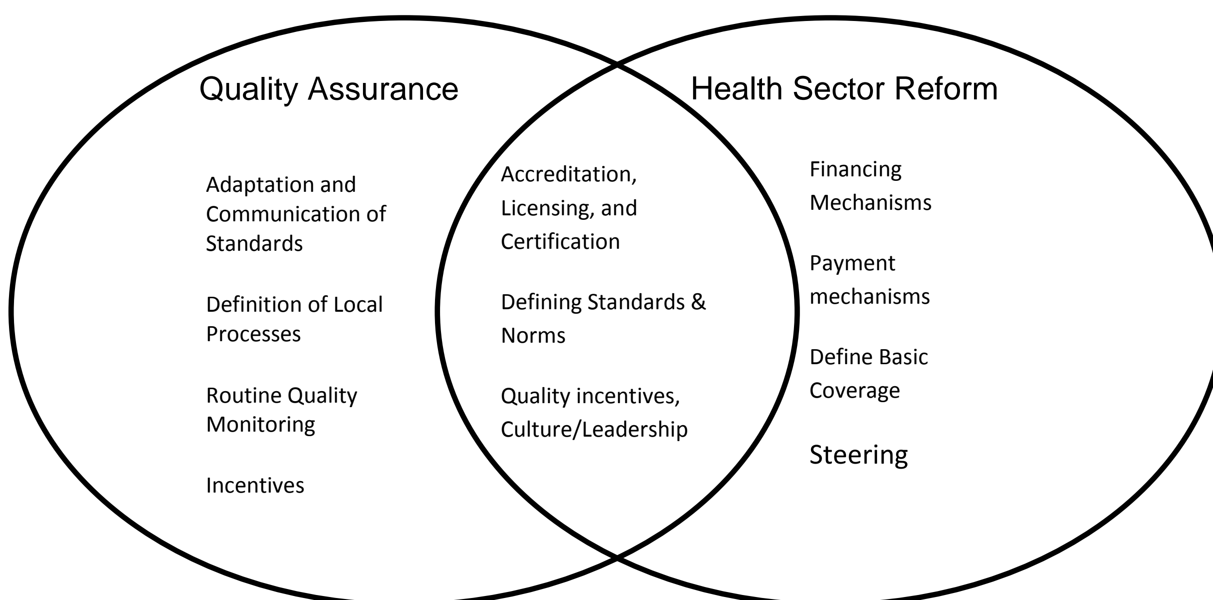
Source: Legido-Quigley *et al.*, 2008:25

2.4 THE LINK BETWEEN QUALITY ASSURANCE AND HEALTH SECTOR REFORMS

The sections above provided a brief description of the concept quality assurance within the health sector. The discussion above demonstrated a strong link between quality assurance and health sector. Quality of care strives to "increase the likelihood of desired health outcomes" (Kirkpatrick, 2002:20). Brenzel (2002:19) presents the link between quality assurance and health sector reform.

Quality assurance and health sector reform have their own unique attributes. The two also have common ground as they interrelate with each other. Quality assurance and health sector reform define the relevant standards and norms for the health sector. It also gives incentives for culture as well as good leadership. It is for this reason that one cannot mention one without mentioning the other, as they are both very important within the health sector. In Figure 2.1, the researcher presents the linkage between quality assurance and the health sector reform. .

Figure 2.2: Link between quality assurance and health sector reform



Source: Brenzel, 2002:19

Quality assurance is goal oriented as it strives to get the work done. Health sector reform can be defined as efforts or activities which seek to "improve health sector performance (Mantilla *et al*., 1998:1). Performance is geared for "making fundamental changes in the way healthcare is organized financed and the way legal mechanisms regulate care" (Mantilla *et al*.,, 1998:1). The health sector reform framework focuses on four components of the healthcare system: stewardship and steering, financing mechanisms, healthcare guarantees, and delivery (Clark *et al*., 2001:23).

2.5 LEGISLATIVE FRAMEWORK FOR THE HEALTH SECTOR

Legislative can be described as a type of representative deliberative assembly which authorizes the power to create and change laws (Branford 1994). Quality has also become the "business strategy" which has taken over the health sector environment (Carey & Lloyd, 1995:2). The health sector is guided by a framework, guidelines and principles, which includes the following:

- South African Constitution of 1996;
- Health Professions Act of 1974;
- The Millennium Development Goals of South Africa;
- National Health Act No 61 of 2003;
- Kwa-Zulu Natal Provincial Health Act 2009; and

- Nursing Act of 2005.

The following are the two main legislative frameworks for implementing public policy processes: namely:

- White Paper on the Transformation of the Public Service (Batho Pele) (1995); and
- The White Paper for the Transformation of the Health System in South Africa (1997)

2.5.1 White Paper on the Transformation of the Public Service (Batho Pele) of 1995

This White Paper on the Transformation of the Public Service (1995) comprises eight Batho Pele principles, and it was published on 24 November 1995. This legislation does not specifically apply to the health sector, but rather serves as a guideline to all the public sectors. The eight principles of Batho Pele include the following:

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

Consultation allows citizens the opportunity to influence decisions on public services by providing objective evidence which will help determine service delivery priorities (Gildenhuys & Knipe, 2000:131). Access to the health sector focuses on the inclusion of all groups for accessing the health benefits. Access also focuses on the right attitude and customer's etiquette to address the customers in the language that they understand. Many of institutions are guided by their different codes of conduct that compels them to treat the customers with courtesy. Courtesy is described as a platform of politeness, friendliness and treating people with respect. The best value for money concentrates on giving the customers the best services possible by using all the

resources. It focuses on eliminating waste, fraud, corruption and also finding new ways of improving services at little or no cost (Ostrom & Bish, 1999:253).

All these principles are important and they all interrelate and it is important for every public institution to execute them in a meaningful manner.

2.5.2 The White Paper for the Transformation of the Health System in South Africa (1997)

The main goal of the White Paper is to provide the manner upon which the unified National Health System of South Africa is based. The mission statement for the White Paper is to "promote leadership and to provide caring and effective services through a primary health care approach". The White Paper also gives different strategies designed to meet the basic health needs of fellow citizens by making efficient and effective use of available resources. The White Paper for the Transformation of the Health System in South Africa, (1997) outlines the aims of the restructuring of the South African health sector. The restructuring aimed to:

- to unify fragmented health services at all levels into a comprehensive and integrated National Health System;
- to promote equity, accessibility and utilisation of health services;
- to extend the availability and ensure the appropriateness of health services:
- to develop health promotion activities;
- to develop the human resources available to the health sector;
- to foster community participation across the health sector;
- to improve health sector planning and the monitoring of health status; and services.

2.6 PILLARS OF QUALITY ASSURANCE

Quality assurance is important as it aims to provide stability in the health sector. Realisation of such goals relies on the health professional attitudes for linking reaching the desired goals. Teamwork is crucial. Renshaw and Gould (2012:20) indicate that the health sector is sometimes experiencing challenges for achieving quality assurance in health care. The following are typical problems encountered by the health sector:

- Lack of a strategic plan for change;
- Lack of customer focus;

- Poor inter-organizational communication;
- Lack of employee empowerment;
- View of quality as a quick fix;
- Emphasis on short-term financial results;
- Lack of strong motivation;
- Lack of time devoted to quality initiatives; and
- Lack of leadership vision (Boloko, 2009:33-34).

The identified problems are not a threat to the institution, since institutions continuously develop strategies for improving the health sector. Table 2.3 presents the description which enables the institutions to execute the policy meaningfully.

TABLE 2.3: Pillars of quality

PILLARS OF QUALITY	DESCRIPTION
Quality Improvement.	It applies strategic change model.
Process Improvement.	Includes process mapping.
Quality Assurance.	Monitoring of adherence to standards.
Risk Management.	Adverse event management.
Care Management.	Concurrent monitoring of quality indicators.
Utilization Management.	Monitoring resource utilization.
Safety & Regulatory.	Patient safety officer positioned "regularized."

Source: Kirkpatrick, 2002: 25

2.7 DIMENSIONS OF QUALITY OF CARE

Quality improvement includes making a change for the best, which will enhance achievement, as well as reliability (Kirkpatrick, 2002:23). There are several dimensions in quality healthcare. Table 2.4 presents the six dimensions of quality assurance.

The six dimensions expects the health care to be "*effective*, *efficient*, *patient-centred*, *equitable and portray patient safety*" (Legido-Quigley *et al.*, 2008:5). Effectiveness emphasises on early detection as well as prevention (Kirkpatrick, 2002:25). Early detection helps to save money and to avoid waste, since medical resources are scarce. Patient satisfaction is also influenced by accessible delivery of services.

TABLE 2.4: DIMENSIONS OF QUALITY OF CARE

DIMENSION	DEFINITION
Technical performance.	Compliance with technical standards.
Access to services.	Removal of geographic, economic, social, organizational or linguistic.
Effectiveness of care.	Degree to which desired health results are achieved.
Efficiency of care.	Extent to which minimal resources are used to achieve desired results.
Interpersonal relations.	Effective listening and communication, establishment of trust, respect, responsiveness, and confidentiality.
Continuity of services.	Consistency of provider where feasible and appropriate, as well as timely.
Safety.	Degree to which risk of injury, infection, or side effects is minimized.
Physical infrastructure/ comfort.	Amenities of care such as physical appearance, cleanliness, comfort and privacy.
Choice.	Choice of provider, treatment, or insurance plan, as appropriate and feasible. Access to information that allows client to exercise autonomy.

Source: Mantilla *et al.,* 1998:4

Equity implies considerations of fairness (Legido-Quigley *et al.*, 2008:6). Patient-centred approach is realised by means of “establishing the levels care (Kirkpatrick, 2002:25)”. Patient safety has traditionally been considered as one among many dimensions of quality of care, but it is increasingly being seen as absolutely key to quality overall (Legido-Quigley *et al.*, 2008:5). Safety refers to the reduction of risk and forms an important component of several definitions (Bengoa *et al.*, 2006:9).

2.8 THE BENEFITS OF QUALITY ASSURANCE

Renshaw & Gould (2012) provides the following eight benefits for having a quality assurance programme in the workplace. The eight benefits aims to:

- eliminate and avoid dysfunctional situations, such as loss of life and negative attitudes among the patient’s and the health professionals;
- Reduce in loss of time due to re-work or ineffective or inefficient practices.”

- develop a better communication structure;
- train the staff to perform their roles;
- enhance employee morale by having an effective, well-run practice;
- increase confidence that controls are in place and the risk error is reduced;
- enhance reputation in the business and social community attributed to members of a professional body that prescribes; and
- demonstrate and enforces high standards of quality control (Renshaw & Gould, 2012).

From the above, it is very evident that quality produces great rewards. When a system has been put in place, but does not function the way it is supposed to, errors and inefficiency begin to surface. In the health sector, these errors should be avoided at all costs, because the lives of people are at stack. The benefits of quality assurance are experienced both by the staff as well as the patients. This is because if everything is running smoothly on the side of the CHC's, patients benefit by receiving higher quality service, as well as increased reliability by the staff. The importance of improved quality service, and reliability cannot be expressed enough.

2.9 CONCLUSION

The above sections presented the literature review of quality assurance within the health care sector. The discussions focused on the terminology used for quality health care in order to orientate the reader about the quality assurance. It then went on to discuss exactly what quality assurance is and also the role it plays in the sector. The chapter also discussed the levels of the health care system. One cannot compromise on quality and the improvement of it thereof. From this chapter it can be concluded that quality assurance is a very important component in the CHCs. This is mainly because the majority of South Africans depend on these CHCs for their health needs since they cannot afford private care services. The next chapter will present the overview of the quality assurance programme and its framework in the health sector.

CHAPTER 3
OVERVIEW OF QUALITY ASSURANCE PROGRAMMES AT COMMUNITY HEALTH CENTRES

3.1 INTRODUCTION

This chapter begins by describing the health services of the ELM and the existing problems in the health sector before the implementation of the quality assurance programme. A synopsis of the health centres is outlined. Furthermore, this chapter presents discussions about the interventions initiated for improving health care in the country. The health sector reform framework as well as the outline of the quality assurance programme is also discussed. The framework of the quality assurance programme is explained with reference to its establishment and maintenance programme. The process, methods, monitoring standards and mechanisms for ensuring quality of care is also described in this chapter.

3.2 HEALTH SERVICES IN THE EMFULENI LOCAL MUNICIPAPLITY

The ELM is one of the three local municipalities in the Sedibeng District Municipality. The other two municipalities in the Sedibeng District Municipality are Midvaal and Lesedi Local Municipalities. The ELM comprises of public and private health sectors. Health services in the ELM are provided to the six large peri-urban townships and ten suburban small settlements. The six large peri-urban townships include areas such as: Evaton, Sebokeng, Sharpeville, Boipatong, Bophelong and Tshepiso (Sedibeng District Municipality, 2011). The ten suburban small settlements include: Bonanne, Steel Park, Duncanville, Unitas Park, Arcon Park, Sonlandpark, Waldrift, Rust-ter-vaal, Roshnee and Debonairpark (Sedibeng District Municipality, 2011).

3.2.1 SYNOPSIS OF THE HEALTH CENTRES

In many countries, the health system is decentralized whereby services are rendered “on districts or equivalent administrative structures” (World Health Organisation, 2008:3). Globally, the health sector service delivery comprises of two sectors, namely: the public sector and the private sector. Both the public and the private sectors are regulated by a single health policy which is formulated by the national government. Public health facilities and private health facilities have a close relationship. The private health practitioner depends on the public health facility for rendering services, for example, in instances wherein a patient is due for major treatments, which include

aseptic operating theatre suites with anaesthetic machines, intensive care units and radiological services (SA: DOH, 2007:18).

National level

The Department of Health is responsible for planning, developing and promoting clinical governance standards and safety and quality strategies across the Western Australia health system (Government of Western Australia: Department of Health, 2005:5). The role of national level is to give direction and support to regions in the implementation of quality assurance.

Provincial level

Provincial health departments control the implementation of the quality health services and facilities in their respective provinces (SA: NDoH, 2007:19).

Regional level

The regions have an important role to play in supporting the districts through facilitations, coaching, monitoring and supervision (Offei *et al.*, 2004:17). The Gauteng province consists of three regional level offices, namely:

- Region A: Johannesburg region;
- Region B: Tshwane-Metsweding region; and
- Region C: Ekurhuleni-Sedibeng Region (SA: DOH, 2007:22)

District level

The district level refers to the health administrative structures (World Health Organisation, 2008:3). The district level consists of a health management team responsible for planning and coordinating the district health activities. In the Gauteng province there are three district offices (WHO, 2008:3).

Facility level

Facility Based Quality Teams (Service Improvement Teams) monitor the quality of the services they provide through analysing the core data they collect on, for example (SA: NDoH, 2007:22).

3.2.1.1 Quality assurance functionaries

The international organisations like WHO stresses the importance of establishing a health care quality assurance programme. Establishing a viable quality assurance programme in the health sector has been one of the objectives unsuccessfully targeted by many health ministries. A Quality Assurance Team consists of the Quality Assurance Manager and relevant Sub District Managers, Area Managers, and the Administration Manager (City of Cape Town, 2012).

The following are the functionaries of managing quality health programmes:

- Facility Based Quality Teams;
- Hospital Boards and Clinic Committees;
- Clinical audit;
- The Quality Assurance Team;
- The QA Coordinator;
- The QA manager; and
- The QA Staff.

Table 3.1 below presents the functions of the national Quality Assurance Team and the regional quality assurance team.

The quality assurance team is made up of different categories of health workers. The unit is responsible for co-ordinating the implementation of quality assurance. The Quality Assurance Team visit facilities on an annual basis and do a mock external survey of certain criteria as predetermined by the team (City of Cape Town, 2012). The clinical governance forms part of the essential services and it is the largest service sector. The provision of the public health sector is inclusive and consists of multi-sectoral facilities to benefit the service users.

The provision of the public health services is implemented through the following structures:

- sub-centres;
- primary health centres (PHC);
- community health centres (CHC);

- district hospitals;
- mobile health centres; and
- satellite clinics (Subhasis and Amitava, 2007:465).

Table 3.1: The national QA team and the Quality Assurance Team

The national Quality Assurance **team**	**The Quality Assurance Team**
Developing policies and strategies	Co-ordinate and provide guidance and information to heads of department and facility management teams
Co-ordinating countrywide quality assurance program	Promoting QA awareness;
Developing clinical guidelines and protocols	Conducting patient satisfaction surveys;
Setting national standards	Using facility data to improve quality of care;
Monitoring quality of care	Identifying quality problems and drawing up action plans;
Comparing and ranking performance of facilities	Monitoring the implementation of quality activities;
Providing technical support to regional QA teams	Producing/adapting/updating relevant local standards, guidelines and protocols; and
Mobilizing resources for quality assurance	Disseminating information on quality assurance to staff (Offei, Bannerman & Kyeremeh, 2004:19).

Source: Offei *et al.*, 2004:17-19

The health facilities provide health services to various locations. The number of facilities identified in this chapter signifies the access given to the community in this regard. It also shows the values of redress and compassion as espoused by the health sector. Health services are basic requirements for meaningful livelihood approach. The opportunities given to the community are acknowledged in this study. Table 3.2 below presents a breakdown of the health facilities in the Gauteng province. Furthermore, in Appendix 2, the researcher also listed the names of the clinics situated in Region B for the Sedibeng District Municipality.

Table 3.2: The Health facilities of the Gauteng province

District Name	Clinics	Fixed	Satellite	CHC	MOU
City of Johannesburg	136	106	12	10	9
City of Tshwane	67	51	3	7	5
Ekurhuleni Metro	90	71	6	7	7
Metsweding	18	10	3	1	1
Sedibeng	45	31	2	4	4
West Rand	36	27	6	2	2
Total:	**392**	**296**	**32**	**31**	**28**

Source: Gauteng Department of Health and Social Development, 2011

Table 3.3 below presents the breakdown of the health facilities in the Sedibeng District Municipality.

Table 3.3: The Health facilities of the Sedibeng District Municipality

TYPE OF HEALTH FACILITIES	**NUMBER OF FACILITIES**
Primary health centres (PHC)	29
Community health centres (CHC)	5
District hospitals	3
Sub-centres: Mobile health centres	6
Sub-centres: Satellite clinics	2

Source: Subhasis and Amitava, 2007:465; Gauteng Department of Health and Social Development, 2011)

There are a total of 29 Primary Health Centres and 5 CHCs operating in the Sedibeng District Municipality, and these are managed by both the local government and the provincial government. The sub-centres are managed by a multipurpose health worker and an auxiliary nurse midwife (ANM) (Subhasis & Amitava, 2007:465). The PHC is managed by a medical officer, 14 staff and 4-6 patient beds (Subhasis & Amitava, 2007:465). The CHCs are furnished with medical specialists, staff and have at least 20 beds for overnight services. The CHCs also provide basic surgical and lab facilities for emergency services and maternal services. There are district hospitals which serve as a

referral unit for all health facilities. Health services are also provided in the private sector. The infrastructure for the private health sector is classified as follows:

- private dispensaries;
- private hospitals;
- charity hospitals, including medical centres managed by NGOs; and
- corporate hospitals (Krishnamurthi in Subhasis & Amitava, 2007:465):

CHCs also provide basic surgical and lab facilities for emergency services as well as maternal services beds (Subhasis & Amitava, 2007:465). CHCs serve as a referral system for the patients coming from the PHCs, Satellite clinics and Mobile health centres. The ELM comprises of four CHCs, namely: Boipatong CHC; Johan Heynes CHC; Levai Mbatha CHC and Sharpeville CHC (Gauteng Department of Health and Social Development, 2011). Levai Mbatha CHC serves community members who reside in Evaton, Evaton North; Evaton West (Known as Hlala-kwa bafileyo/Hlalas or Mkhelele); Beverly Hills; Palm Springs. Boipatong CHC offer services to the community of Boipatong (Known as Tshirella). The Sharpeville CHC delivers health care services to the community of Sharpeville. The area of Sharpeville consists of the following sections, namely: Rooi Steen, Putswa Steen, Vuka, and Tshepiso sections The Johan Heynes CHC makes its services available to the residents of Vanderbijlpark, Bonnane and Bedworthpark (Participant Observation).

3.3 THE PROBLEMS OF HEALTH CARE SERVICES

The implementation of health services is sometimes hindered by multi-factorial issues which interrupt the health service delivery. The South African National Department of Health (2007:3) identified the problems that relates to the health sector in both the public and the private sectors. The identified problems are presented below:

- Under-use and overuse of services;
- Avoidable errors;
- Variation in services;
- Lack of resources;
- Inadequate diagnosis and treatment;
- Inefficient use of resources;
- Poor information;
- An inadequate referral system;

- Disregard for human dignity;
- Drug shortages;
- Records not well kept; and
- Poor delivery systems (SA: NDoH, 2007:3).

The above-mentioned problems are associated with the reasons for the transformation of the health services.

3.4 INTERVENTIONS FOR TARGETING QUALITY ASSURANCE

The changing business environment demands policy makers and public officials to develop effective measures that will align national policies with institutional objectives. The health sector comprises of a diverse community with unlimited needs. The South African government approved the Quality in Health Care policy for South Africa which was developed in 2007. The abovementioned policy was established to concentrate on the following four interventions to target quality assurance:

- Interventions aimed at health professionals;
- Interventions aimed at patients;
- Interventions aimed at the community; and
- Interventions aimed at systems.

3.4.1 Health professionals

According to Oracle Corporation (2008:3) public institutions execute their policies in a progressive-thinking manner as they thrive to link their organisational goals with the current staff complement. The Quality in Health Care policy for South Africa came at the right time whereby administrative and technological reforms have been implemented to improve service delivery in the public sector. The provision of the Quality in Health Care policy for South Africa can be associated with the role of human resources management, which aims to ensure that the workplace is capacitated with skilled and productive employees. Organizations often “miss a decided competitive advantage when it comes to areas such as user adoption, the optimal use of technology and employee development, which is so critical in the talent shortage” (Oracle Corporation, 2008:3).

The health professional interventions aimed to develop the expertise of the health professionals in order to keep them abreast with technological instruments. Furthermore, the health professional intervention focuses on training the health officials.

Training is important for improved efficiency within the health sector. Training also assists to keep the health professionals up-to-date with the changing environment. Yunus (2012:3) indicates that training is beneficial as it is used to change the "mind-set and attitude" of the health professionals. Training is beneficial as it allows institutions to achieve the following, among others:

- excellence;
- ethics and morality;
- experiences and skill in human capital development;
- excellent work culture; and
- leadership quality (Yunus, 2012:3).

The health sector also hosts the "continuing medical education (CME) conference" for improving capacity within the sector. These conferences serve as a platform for the health professionals to discuss and develop strategies for dealing with the patients (Yunus, 2012:3).

3.4.2 Interventions aimed at patients

Improvements to quality are dependent on issues such as sufficient financial, structural and personnel resources (Lindsey & Petrick 1998:53-54). QA extends beyond achieving an acceptable quality of the administered health care (SRCC Quality assurance, 2012). All these factors are aimed at benefitting the patient who is the service user of the health sector. Institutions develop strategies to manage the relationship between the service provider and the service users (patients). Such strategies consist of communication channels which aim to interact and share information pertaining to the respective health facility. The health sector has developed multiple approaches for interaction with the service users.

3.4.3 Interventions aimed at the community

The Quality in Health Care policy for South Africa is acknowledged for the role it plays as it recognises the diverse community in the health sector. The policy points out the importance of partnership between the health sector and the community structures established to represent the needs of the community (Quigley 2003:40). The policy talks about the partnerships with community structures such as NGOs and community-based organisations (CBOs). NGOs and CBOs also play a vital role in the delivery of services like home-based care and community health workers. The policy also cites the

establishment of partnership with structures like clinic committees and hospital boards which help to "facilitate community participation in local decision-making on health issues of concern to the local community" (Quigley, 2003:40).

3.4.4 Interventions aimed at systems

Quigley (2003:40) indicates that the health sector lacked the ability to integrate the technology and to apply appropriate decisive support. Lack of integration always delays the implementation of health programmes. The Quality in Health Care policy for South Africa also focused on modernising the delivery of the health care systems. Execution of health services operates in an environment which relies on "knowledge, technology and information" (Yunus, 2012:3). As the health sector operates in a changing environment, a lot of problems could be encountered since the sector applies the old infrastructure to deliver services.

The systems intervention specifically looks at the impeding factors that may delay the transformation process for improving quality health care. The health systems aim to:

- Set strategic direction;
- Ensure organisational capacity;
- Implement quality staffing;
- Build workforce competency;
- Manage performance, recognition and reward; and
- Shape high performance work culture and environment conducive to workforce excellence (Yunus, 2012:3).

The realisation of the health quality programmes may somehow be complex and unmanageable. The health system interventions are aimed at monitoring and evaluating the quality processes for improved programme outcomes. The section below describes the health sector reform framework. The WHO has identified the four elements of a health sector framework as being the following: "stewardship and steering, financing mechanisms, healthcare guarantees and delivery (World Health Organisation, 2008:2)". The health sector framework is presented in Appendix 3 and a brief explanation is outlined below.

Stewardship and steering

The outcomes of a health care system are realised by means of “regulatory framework” to channel clinical governance. The regulations define the leadership roles and the roles and responsibilities of the health professionals (World Health Organization, 2008:2).

Financing mechanisms

Financing mechanisms refer to income generating mechanisms that aim to provide resources for healthcare, preventive services, early detection, and health promotion (World Health Organisation, 2008:2).

Health care guarantees

Health care guarantees refer to the manner in which a department wishes to provide the services. The aim of public health care services is to benefit all recipients. The Department of Health initiated criteria for its service packages and pledged to address the reduction of disease burden, efficiency in resource allocation and equitable access to all (World Health Organisation, 2008:2).

Delivery

The delivery of the health services is based on four pillars, namely: “consumer value, clinical performance and evaluation, clinical risk and professional development and management” (Government of Western Australia: Department of Health, 2005:1). The service d*elivery* framework defines how the services will be delivered. Health service delivery is undertaken on a sector-wide basis, whereby there is a partnership between the public sector; private sector and the NGOs. Some of the service users reside in remote areas; hence the framework was developed to decide about the service provision to the respective areas (Government of Western Australia: Department of Health, 2005:1).

3.5 HEALTH STANDARDS AND CLINICAL GOVERNANCE CRITERIA

This section describes the standard used for implementing the health care policy. Patient satisfaction and safety seems to be the cornerstone of the health sector reforms. Realisation of patient satisfaction and safety is guided by a set of health standards designed to “develop and implement clinical governance processes and systems” within their Health Services (Government of Western Australia: Department of Health, 2005:1). The standards seek to:

- increase organisational awareness of clinical governance;

- assist clinicians and health service management to embed clinical governance within their organisational culture; and
- assist Health Services to demonstrate improved accountability for the delivery of safe, high quality health care services (Government of Western Australia: Department of Health, 2005:1).

The health standards support the execution of the national health policy. Table 3.4 below presents the criteria for clinical governance.

Table 3.4: Clinical governance criteria

HEALTH STANDARDS		EXAMPLE
Standard 1	Accountability	-Top-down & bottom-up approach.
Standard 2	Policy and strategy	-The Constitution of the RSA, 1996 -The policy on quality in health care for South Africa, 2007. -Health care plans. -Quality assurance programme.
Standard 3	Organisational structure	-Regions. -District health services. -Primary health care.
Standard 4	Appropriate resource allocation	-Physical resources. -Human capital. -Financial resources.
Standard 5	Communication	-Health education, -pamphlets. -Notice board.
Standard 6	Professional development and training	-Adequate information. -Resources, training and -Professional Development.
Standard 7	Measuring effectiveness	-Indicators.
Standard 8	External review	-Accreditation. -Facility visit and inspection. –Quality assurance unit.

Source: Government of Western Australia: Department of Health, 2005:7

Government departments have a responsibility to the community members for the efficient delivery of services. Accountability is a bottom-up approach, whereby delegated officials report to senior authority. The health sector is led by the Ministry of Health managed by the Minister who reports to the Parliament. All health sector services are executed and guided by a set of legislative framework approved at the legislative level. South Africa comprises of nine provinces which comprises of nine provincial health departments responsible for implementing health services.

The respective provincial health departments are allowed to develop their own policies that are in line with the facility principles. In 1997, the Department of Health introduced the White Paper for the Transformation of the Health System in South Africa (1997). The White Paper presents a set of policy objectives and principles for the unified National Health System of South Africa.

In addition, the White Paper describes the design of the implementation strategies and the allocation of resources for realising the basic needs of the service users. In 2007 the South African government also introduced the Policy on Quality in Health Care for South Africa (2007) which serves as a guiding policy framework for improving health care services. The health plan and a quality assurance programme are also to form part of the strategic framework for service delivery in the health sector. Public policies are implemented for a period of five year. The health sector strategic plan reflects the strategic intentions of the health sector for the specified period.

The provision of health services is realised through resource allocations. Resource allocations forms part of the inputs provided for health service provision (World Health Organisation, 2008:2). Resource allocation in the health sector consists of the physical infrastructure and human resources (Subhasis & Amitava, 2007:465). The main resource is the financial resources which makes it possible for executing services.

The health sector applies verbal and non-verbal communication for interacting with the service users. Billboards, charts, health talks-shows are used as communication strategies for interacting with the service users. The health sector developed indicators to measure efficiency of the services rendered. Standards have also been designed to complement other organisational safety and quality policies and standards.

3.6 QUALITY ASSURANCE PROGRAMME

The health sector provides different services to a diverse community. Various programmes were developed to accommodate all service users, whereby the extent of quality assurance is also crucial for realising the developmental goals of the health sector. The Ministry of Health in South Africa (The Department of Health and Social Development, 2011) developed some goals to find ways for improving the quality of patient care. A 10-Point NDoH Plan was developed for implementation during the period of 2009-2014. A quality health care programme is a multi-dimensional and multi-faceted plans aimed to improve healthcare service delivery (Mantilla *et al.*, 1998:1). A quality assurance programme is seen as a critical component of a modern health care system (SRCC Quality assurance, 2012).

Quality assurance programmes are undertaken for valid reasons. Its main objective is to improve the health care centres all across the nation. A quality assurance programme is executed through various processes and projects (Coetzee, 2006:20). A Quality assurance programme is designed to objectively and systematically monitor the quality and appropriateness of medical or clinical care (Sheahan, 2012:30). Such processes and projects are monitored on monthly basis. Stravropolou and Stroubouki (2009:255) indicate that the realisation of quality assurance programmes is be determined by a set of “coordinated activities” and “flexible systems”. A Quality assurance programme is a decentralised activity (Department of Health and Social Development, 2011).

3.6.1 The Rationale for a quality assurance programme

The National Policy on Quality in Health Care (SA: NDoH, 2007:2) provides a mechanism for improving the quality of care in both the public and private sectors. The policy sets out the main objectives of government to assure quality in health care and to continuously improve the care that is being provided. To realise the objectives of the National Policy on Quality in Health Care, the 10-Point plan and the six issues aimed for the development of the policy of quality in health care for South Africa were formulated.

The establishment of the CHCs serve as a service link between hospitals and the community. The hospitals and the CHCs operate for twenty-four hours (24hrs) throughout the seven days of the week. Prior to the establishment of the CHCs, access to hospitals was a challenge to communities who required services after hours (especially at night). The clinics operated for five days (Monday-Friday) and for only

eight hours (7am to 4pm). Communities in low-income locations such as Evaton, Sebokeng, Bophelong and Sharpeville, were required to use paid road transport to access the respective hospitals especially during off-peak hours. In some cases communities were required to hire a private vehicle to access the health facility after-hours. It was indicated that the hired vehicles was costly for transportation to and from the hospital (Participant Observation).

The participants interviewed indicated that they had to pay an amount of R500 for transportation to get to the nearest health care centre after-hours. The amount paid for such transport is called "special price", since the means of transport is during night-time, whereby the owner of such vehicle could be asleep at night. However, the night-time residential transportation is still used for ferrying sick people to the health facility at night due to shortage of ambulance services. Some communities continue to use such transport for their daytime transport requirements (Participant Observation).

In some cases, some families lose their next of kin due to delayed transport since they are supposed to knock at each household which had a vehicle seeking for help. The high rate of mortality that was indicated by the participants were caused by lack of knowledge for first-aid and for resuscitation by community members (Participant Observation)

The health sector also aims to enhance patients' participation. Patients' participation includes empowering communities to know the basics of health care in the absence of health workers. In some cases a child consumed paraffin or an adult overdosed with tablets for some reasons (suicide) during the day, such child would have complications at night. Cases such as dizziness, nausea, unconsciousness, and stomach-ache are the most threatening moments to some families. In such cases lack of knowledge among family members and the communities resulted to mortality rates either at home or upon arrival at the health centre (Participant Observation).

The CHCs are aimed at delivering health care services to the previously under-served populations. Access to knowledgeable and experienced health professionals is essential to improve access to quality health care (SA: DoH, 2007:3). Table 3.5 below outlines the establishment of a quality assurance programme.

TABLE 3.5: The 10-Point plan and issues addressed in developing the policy

The 10-Point plan	Issues addressed in developing the policy
Reorganization of support services.	Improve access to quality health care.
Legislative reform.	Increase patients' participation and the dignity afforded to them.
Improving quality of care.	Reduce underlying causes of illness, injury, and disability.
Revitalization of hospital services.	Expand research on treatments specific to South African needs and on evidence of effectiveness.
Speeding up delivery of an essential package of services through the district health system.	Ensure appropriate use of services.
Decreasing morbidity and mortality rates through strategic interventions.	Reduce errors in health care (SA: NDoH, 2007:3-6).
Improving the resources mobilization and the management of resources without neglecting the attainment of equity in resource allocation.	
Improving health human resource development and management.	
Improving communication and consultation within the health system and between the health systems and communities we serve.	
Strengthening co-operation with our partners internationally (GDSH).	

Source: SA: NDoH, 2007:3-6

3.7 QUALITY ASSURANCE MAINTENANCE TOOLS

The management tools discussed below are all essential for maintaining a quality assurance programme in the health sector. Each management tool is used differently as required for a particular part of the project and how each is used.

- Health and safety;
- Infection control;
- Housekeeping;
- Resuscitation; and
- Non-compliant areas
- Questionnaire (City of Cape Town, 2012).

A Quality Assurance Maintenance Programme is used for maintaining the health standards for the all facilities that have been accredited. Re-accreditation happens within 2/3 years. Appendix 3 presents the Health sector reform framework.

3.8 METHODS FOR MONITORING QUALITY OF CARE

In achieving the goal of a quality health care system, requires a national commitment to measure, improve and maintain high-quality health care for all its citizens. In the health care sector, quality assurance programmes are typically overseen by the specific facility manager. The facility manager is responsible to "manage, monitor and evaluate" the quality assurance programme (Sheahan, 2012:22). Monitoring within the quality health care aimed to assess the state of the implemented health standards, protocols or guidelines. Offei *et al.*, (2004:29) further describe the importance for monitoring quality of care as follows:

- Monitoring helps us to identify gaps in quality of our health care delivery;
- It provides lessons to learn from as we progress with our implementation; and
- It tells a story about the progress of improving quality of care (Offei *et al.*, 2004:29).

Programme monitoring is applied to:

- determine why a specific program is put in place;
- identify if there are any problems experienced;
- determine some kind of solutions to the problems; and

- recommend solutions for improving service provision in the health sector (Theodoulou & Kofinis, 2004:193-194).

Sheahan (2012:30) indicates that the evaluation methods are designed to capture specific data for evaluating the public health delivery. Evaluation methods usually involve the tools which are used to document hard data and statistics. The health care sector uses a checklist to audit and analyse the performance standards (Sheahan, 2012:32). The health sector uses the following methods for monitoring quality of care, namely:

- Review of routine health information.
- Client satisfaction surveys.
- Patient's complaints system.
- Critical incidents - Adverse events.
- Mystery clients and
- Supervision (Offei *et al.*, 2004:31).

Strengthening health service delivery is a key strategy to achieve the Millennium Development Goals (World Health Organisation, 2008:2). Institutions make use of different methods to monitor quality in the health sector. The following sections discuss the programme evaluation and performance improvement plan as part of monitoring quality in the health sector.

3.8.1 Programme evaluation

Programme evaluation forms part of the "management sciences" which aim to "provide a heuristic method for identification of preferable policy alternatives (Holden & Zimmerman, 2009:92). Programme evaluation allows all stakeholders in the public arena to measure the level to which a particular programme is established. Programme evaluation concentrates on the application of reason, evidence, and a value added framework to public decisions. Programme evaluation allows the health professionals to analyse the policy objectives and outcomes.

Theodoulou & Kofins (2004:192) outline that programme evaluation focuses on how an institution can "judge quality; goal attainment, program effectiveness, impact and costs can be determined". Policy evaluation is a prerequisite or an imperative requirement

(Rossi *et al*, 1999) and it cannot be overlooked or underrated as it gives a clear guidance for the future of a policy. A number of appropriate alternatives need to be made available. Another role of policy evaluation is making it possible to improve the quality of choice from among the given alternatives. The evaluation needs to be focused to assess the issues of greatest importance to stakeholders. The available sources need to be utilized (Holden & Zimmerman, 2009:25).

The evaluator must have short and long term goals in mind when conducting the evaluation. The purpose of policy evaluation is to determine whether the implemented program achieved its purpose. Institutions also take advantage of performance improvement plan for advancing the mission statement of the policy. Programme evaluation for quality assurance focuses on process evaluation; outcome evaluation; impact evaluation; and cost benefit analysis. These tools are discussed below.

Process evaluation

Process evaluation refers to the actual rendering of health care services (City of Cape Town, 2012). This type of evaluation is often employed by managers or policy implementer in order to determine what still needs to be done to improve the policy in terms of service delivery.

Outcome evaluation

This type of policy evaluation is mainly concerned about the results of the programme. The CHCs were established to address the inconveniences caused when patients consulted the hospitals which were far-off from their residential areas. Community members would use multiple modes of transport to reach the respective hospitals. Furthermore the CHCs were developed to be the intermediary between the PHCs and the tertiary hospitals (Participation observation). Therefore, the outcome evaluation will assess the patient’s perceptions of the initiatives implemented (City of Cape Town, 2012).

Impact evaluation

Impact evaluation aims to determine whether the implemented policy is actually achieving its intended goals as set out in the policy. Impact evaluation concentrates on the following areas:

- Theoretical objectives of the policy;

- The actual goals;
- Policy objectives; and
- Policy results and whether they are negative or positive.

Cost benefit analysis

Cost benefit analysis compares the costs of a policy or programme to the benefits generated by the policy. It can however be seen as one of the methods used to determine the efficiency of government action. Public service delivery is executed by means of available resources. Most of the resources needed are scarce. As a result, the policy implementers are required to use the available resources in a meaningful way. Cost benefit analysis enables the institution to use the resources in a meaningful and sustainable manner. Reduction of resources may be used for purchasing a mobile or satellite office, instead of allowing the health officials to travel (by car) on a daily basis.

3.8.2 Performance improvement plan

A performance improvement plan focuses on structural standards that pertain to the "physical and organizational structures within which the care is rendered" (City of Cape Town, 2012:1). Such evaluation concentrates on the resources allocated for implementing the programme, whereby the health policy, staff, buildings and equipment will be assessed for advancing the programme objectives.

Evaluation helps to determine if a policy is still in line with the goals which were set out at the beginning of the programme. Programme evaluation can help to assess the effects of the programme and also to identify any needed changes to a policy. A performance improvement project is used for enhancing a quality assurance programme, especially where there is "low scores" of patient satisfaction (Sheahan, 2012:13). Various factors may get in the way when implementing the programmes. Therefore it is important for the programme managers to develop a performance improvement plan in order to deal with the impeding factors in the implementation process.

3.8.2.1 Monitoring standards

Performance improvement is an on-going process for managing quality assurance initiatives. The health sector has adopted the following monitoring standards as presented in Table 3.6 below to manage the improvement of the programme

performance, which is working effectively within the current health system (SA: DoH, 2007: 19-22).

Table 3.6: MONITORING STANDARDS

Quality monitoring by the user of services	**Quality monitoring through structures of governance**	**Quality monitoring by the provider of services**	**Quality monitoring by professional bodies**
A national complaints procedure.	The office of standards compliance.	A staff satisfaction survey.	Accreditation board
A patient satisfaction survey.	The provincial inspectorate for health establishments.	Clinical audit.	
	Hospital boards and clinic committees.		

Source: SA: NDoH, 2007: 19-22

3.8.2.2 Supervisory visits

Health services are led by managers who are responsible for ensuring that the health programmes are implemented meaningfully. The management enter into an agreement with their immediate employees to find quantifiable mechanisms for the achievement of the institutional goals. Supervisory visits are undertaken within a specified (frequency) period. Supervisory visits are performed on a continuous basis. The supervision involves the following functions:

- providing support in solving problems;
- training to help improve performance;
- reviewing individual performance;
- monitoring clinic services; and
- Inspecting mandatory or statutory functions (SA: NDoH, 2007:22).

The supervisory visits mentioned above are also conducted by the professional bodies within the health sector. The role of the professional bodies is to monitor standards of professional conduct in accordance with relevant legislation.

3.9 IMPROVEMENT OF PATIENT SATISFACTION AND PATIENT SAFETY

Health facilities continue to develop measures for improving patient satisfaction and patient safety. The following are identified as the mechanism for improving patient satisfaction and patient safety:

- Establishing a multidisciplinary control committee;
- Identifying appropriate resources for a programme to monitor infections and apply the most appropriate methods for preventing infection;
- Ensuring education and training of all staff through support of programmes on the prevention; and
- Delegating technical aspects of hospital hygiene to appropriate staff, this should include nursing; housekeeping; maintenance; clinical laboratory (Evans, 2008:20).

The health sector particularly in the CHC uses technology and waiting times as indicator levels to improve patient satisfaction. The public service uses technology for improving the level of satisfaction of their clients. The technology is used to admit the patients, for filing purposes and for reporting. The electronic filing enables the health professional to find ways to carefully examine the causes and find new ways to streamline the quality health assurance process. The health sector utilise a patient flow analysis to improve waiting times in the Emergency Department (Curtis, 2001:45).

3.10 DETERMINANTS OF QUALITY CARE

The improvement of quality health care focuses on the relationship between the following determinants:

- Staff motivation;
- Staff competence;
- Adequate resources;
- Appropriate content and process of care defined; and
- Good flow and organization of services along a continuum of care.

- Active participation in defining and receiving care by client/community (Mantilla, *et al.*, 1998:4).

Quality may also be determined by job satisfaction. Chinamele (2010:25) outlines the five factors which contribute towards job satisfaction for employees. The respective factors are presented as follows:

- Achievement;
- Recognition;
- The work itself;
- Responsibility; and
- Advancement.

Redman (2003:47) states that the abovementioned determinants and factors focus on "motivating" staff. The factors of responsibility are seen as having a long lasting effect on staff and this is followed by work and advancement. The achievement and recognition factors are seen as short-term rewards. From a motivational point of view it is important to provide the employees with a responsibility to perform their own work. When employees feel that a certain level of trust is given to them, they develop a different personality and desire to be more efficient. A responsible official allows the development of positive attitudes towards the service user needs. Instilling responsibility among employees is beneficial for "producing work conformance and job satisfaction" (Roben, 2004:48). The advancement of the employee skills contribute to organizational performance and it is aimed to develop competency and professionalism in the health sector (Evans, 2008:389). It is apparent that when the employees are happy and content, the patients benefit as the service rendered by staff is more friendly and efficient.

3.11 CONCLUSION

The discussions above demonstrate government's accountability towards the service users. According to the abovementioned facts, it can be concluded that quality is imperative in the health environment. Achieving the goal of a quality health care system requires a national commitment to measure, improve and maintain high-quality health care for all its users. The successful implementation of a quality assurance programmes relies on a well-defined structure at all levels. A health care policy is implemented by both the provincial and the local spheres of government.

Peoples' lives are dependent on the level of quality experienced at the hands of the staff at the CHCs. When patients arrive at the clinics, care needs to be taken to ensure that their primary needs are met both efficiently and effectively. There is a strong link between patient safety and patient satisfaction. The linkage is realised by means of clarified roles, responsibilities and linkages of the structures within the health sector. This chapter also discussed policy evaluation as a form of quality monitoring system. Every policy and programme undergoes a process before it can be established. It is therefore imperative to know the different types of policy evaluation and how each one is relevant. The next chapter discusses the research methodology and also present the results of the empirical survey which was conducted at the CHCs operating within the ELM.

CHAPTER 4
RESEARCH METHODOLOGY AND RESULTS

4.1 INTRODUCTION

This chapter describes the research methods used for obtaining data for this study. Researchers use a variety of research methods to find solutions for a study conducted. This section provides a brief discussion of the application of the literature review, questionnaire and interviews as employed in this study. The results of the interviews conducted are also presented in this chapter. Four CHC's were referred to in Chapter 1, but the interviews were conducted in the three CHC facilities that are situated in the three townships of the ELM. The three CHCs that were consulted are: Levai Mbatha CHC, the Sharpeville CHC and the Boipatong CHC of the ELM. The research sample is also described in the sections below.

4.2 RESEARCH METHODOLOGY

The research methodology for this research project is discussed in the sections below. The main emphasis was placed on details of quality assurance initiatives, and how each initiative contributes towards organizational effectiveness. The following methods were utilised in the conducting of this study:

- Literature review - an overview of the relevant academic literature on Quality Assurance initiatives, patient safety and patient satisfaction; and
- Empirical research in the form of primary data collection by means of questionnaires completed by the quality assurance unit and the patients.

The next section describes the manner in which the literature review, questionnaires and interviews were used for this study.

4.3 LITERATURE REVIEW

The literature reviewed for this research project is reflected in Chapters 1, 2 and 3. A literature review is a very important part of a study as it affords a researcher an opportunity to analyse the existing data on the same topic he or she is conducting research on. It enables the researcher to review the documented data and to compare it with the facts emerging from his or her current study. The literature review conducted in this research project enabled the researcher to understand the framework of quality assurance. The literature review also analysed the principles patient satisfaction and

safety. The literature reviewed also assisted the researcher in comprehending the context of implementing a quality assurance programme (Maree & Van der Westhuizen, 2009:8).

4.4 STUDY AREA AND SAMPLING

The three CHCs under investigation are the Levai Mbatha CHC; Sharpeville CHC and Boipatong CHC. These three CHCs were mainly chosen because of their different sizes and their ability to accommodate patients from different backgrounds who seek minor clinical assistance. There are also different racial disparities who attend these centres.

Sampling

Wales (2009:20) defines sampling as a “practice” whereby the researcher “selects the subset of individuals within a population being studied”. Normally, researchers do not involve the whole community for undertaking their studies. Some part of the community is selected in order to draw the conclusions about the topic under review. The sampling technique is not biased as it involves a limited part of the population.

For this particular study, a random sampling method was used to identify the non-clinical participants of the study. Random sampling enabled the researcher to have a choice of selecting the participants. Random sampling is inexpensive and it is flexible. It allows the researcher to conduct the interviews at any given time. The advantage of the random sampling is that it did not require the researcher to schedule appointments with the patient community. The sample of the population was among the three CHC’s established in the ELM. The following two groups were the participants who were given questionnaires and, they include:

- Patients who are the service users of the CHCs among the chosen three CHC’s; and
- Quality assurance managers who deal directly with the quality matters of the CHC’s.

Sampling size

Participants from the three CHCs of the ELM were interviewed. Fifty (50) questionnaires were distributed to the patients who were visiting the CHCs during the interviews. Three (3) CHC facilities were also given the questionnaires with the aim of collecting essential data for purposes of this study.

4.5 QUESTIONNAIRE

This research deals specifically with the implementation of a quality assurance programme. Two sets of questionnaires were developed, namely, an institutional questionnaire and a patient community questionnaire. An institutional questionnaire was developed to probe the quality assurance unit of the three CHCs identified. The institutional questionnaire aimed to obtain feedback on how a quality assurance programme is implemented, monitored and evaluated. The quality managers were consulted to respond to the questions asked as they form a linkage between the patient and the staff members. A patient community questionnaire was also developed to solicit data from the patients who consulted the specified health facilities during the interview schedule.

The questionnaires that were issued consisted of open ended as well as closed questions. The patient questionnaires were given to a diverse range of people based on their ethnicity; age and experience. Questionnaires were given to patients who freely volunteered to participate. The selection was therefore random. The patient questionnaires were anonymously distributed for measuring the patient opinions on their satisfaction against the service delivered by the respective CHCs. The two sets of questionnaires are written in English. In terms of the patient community questionnaire, the researcher interpreted the questions in Sesotho and IsiZulu in order to help the participants who did not understand the questions as some of them were not fluent in English writing and reading.

4.6 INTERVIEWS

The respondents of the study were interviewed though a self-administered questionnaires by the researcher of this study. Telephone interviews were only used for scheduling interview appointments with the facility managers of the selected three CHCs. Face-to-face interviews were preferred for this study and this is described in the following section.

4.6.1 Face-to-face interviews

The face-to-face interviews were used to interact with research participants (patient community and the CHC facility managers). The questions were pre-set and were administered by the researcher. The face-to-face interviews with the patients were done within a period of five weeks. The researcher aimed to discover a perspective on the

operation of the CHCs. The face-to-face interviews were effective as it allowed the researcher to be flexible in her endeavour to probe the questions. They also allowed the researcher to make follow-up interviews and to ask more questions.

The face-to-face interviews also allowed the patients to be confident in expressing their opinions. A neutral researcher makes them feel comfortable since their identities will remain anonymous. The pictures below were captured during the interviews in the respective CHCs. These pictures showcase that the researcher really undertook the interviews in the selected CHCs. The pictures also shares the moments that the researcher experienced when she interacted with the participants.

Picture 4.1 Interviews at the Sharpeville CHC

The pictures illustrate the moment when the researcher was busy conducting face-to-face interviews with the patients at the Sharpeville CHC and Boipatong CHC.

Picture 4.2 Interviews at the Boipatong CHC

The picture illustrates the signage board for the Levai Mbatha CHC.

Picture 4.3 Interviews at the Levai Mbatha CHC

The group interviews preceded the interviews. The group interviews enabled the researcher to acquire knowledge about the patient consultations. Informal group interviews were also conducted with the patient community in the three CHCs. Such individuals were asked to give an overview of how they felt about the established CHCs and how they benefit from the established facilities. These interviews were informal and the respondents did not want their names to be used. The discussions of the group interviews were informal and are not recorded in this research.

4.7 PARTICIPANT OBSERVATION AT THE CHC's

This method of research is a very discreet way of actually gathering information without interviewing anyone specific. The Family Health International (FHI, 2010:14), described participant observation as a "qualitative method with roots in customary ethnographic research". Participant observation enabled the researcher to learn the behaviour and the viewpoints held by the selected participants. The researcher became part of the research process since she is also a recipient of the health services provided to the community of Three Rivers, Vereeniging.

The researcher observed the patient community through group interviews. As stated earlier, these interviews preceded the face-to-face interviews conducted for purposes of this study. The group interviews enabled the researcher to acquire knowledge about the patient consultations. Informal group interviews were also conducted with the patient community in the three CHCs. Such individuals were asked to give an overview of how they felt about the established CHCs and how they benefit from the established facilities. These interviews were informal and the respondents did not want their names to be used. The discussions of the group interviews were informal and are not recorded in this research.

4.8 ETHICS IN RESEARCH

People often think of ethics as some kind of rules for distinguishing between right and wrong. Ethical norms are universal as it stipulates the manner in which the research should be undertaken. This study formed part of the social sciences. It was important for the researcher to adhere to the principles of the research ethics. The names of the participants are not mentioned in this study.

Research ethics are broadly illustrated with the following descriptions:

- Honesty;
- Objectivity;
- Integrity;
- Openness;
- Carefulness;
- Respect for Intellectual Property;
- Confidentiality;
- Social responsibility; and
- Legality (Resnik, 2011:34).

The participants volunteered to participate in this study. Sensitive information is not recorded in this study as the study only dealt with the administrative functions for implementing a quality assurance programme in the respective CHCs.

4.9 RESEARCH RESULTS

This is the stage of reporting the research results and brings conclusions which may assist the future implementation of the quality assurance programme. The researcher believes that these results can be used to help bridge the gap of service delivery grievances between the patient and the health practitioner (nurse/doctor).

4.9.1 Distributions of questionnaires

Table 4.1 below illustrates the distribution of the questionnaires administered by the researcher of this study. A total of 60 questionnaires were distributed to the patient community visiting the selected CHCs and only 50 of them were fully completed, whilst the other ten were returned incomplete.

All the respondents were given the same questionnaire to complete and different gender, age groups and race variables were taken into account in this regard. All the questionnaires were handled with utmost confidentiality and privacy. All the three facilities completed the questionnaires that were self-administered by the researcher of this study.

Table 4.1: Community questionnaire and institutional questionnaire

Community Health Centres	Distributed	Received	Missing
Patients interviewed during the interview schedule in the CHCs			
Levai Mbatha CHC	20	14	1
Sharpeville CHC	20	15	5
Boipatong CHC	20	11	4
TOTAL	**60**	**50**	**10**
Institutional Questionnaire (Quality Assurance Managers)			
Levai Mbatha CHC	1	1	0
Sharpeville CHC	1	1	0
Boipatong CHC	1	1	0
TOTAL	**3**	**3**	**0**

4.10 COMMUNITY QUESTIONNAIRE

4.10.1 Demographic information

The results of the interviews conducted are presented in the sections below.

Table 4.2: Characteristics of respondents (N=50)

VALUE LABLE	Number of participants	Percentage %
Gender		
Male	23	46%
Female	27	54%
Race		
Black	48	96%
White	0	0%
Indian	0	0%
Coloured	2	4%
AGE GROUP		
<21	7	14%
21-25	12	24%
26-35	8	16%
35-55	9	18%
60+	14	28%

Table 4.2: Characteristics of respondents (N=50) (continued)

MARITAL STATUS		
Single	28	56%
Married	9	18%
Divorced	3	6%
Widow	5	10%
Never Married	5	10%

Table 4.2 above illustrates the demographic information of the participants interviewed.

4.10.2 Access to health facilities

Participation of community members in terms of gender, age groups and race, differ from one CHC to another. The opinion of the community as well differs in relation to their age groups. Participants were asked to indicate whether they had a health insurance. Eighty-percent (80%) of the respondents were mainly the youth and they indicated that they did not have any kind of health insurance, reason being, they have never thought that they needed it. Few patients who are between the ages of 21-25 said that they still depend on their parents' care; therefore they do not have their own insurance. The respondents who were above 50 years do not have health insurance because they simply cannot afford it. They depend on the CHCs because they do not have money to go to private doctors or the pharmacy (chemist) to get medication.

Distance travelled

The participants were asked to indicate the distance travelled to the health facility that is closest to their homes as listed in Table 4.3 below.

Table 4.3: Distance travelled to the health facility

VALUE LABLE	Number of participants	Percentage (%)
<5km	21	42%
<10km	22	44%
<20km	7	14%
TOTAL	**50**	**Average distance: 10km**

As shown in Table 4.3 above, forty-two (42%) of the residents said they travel less than 5km to reach the closest CHC. The participants have access to the PHC facilities (local clinics); however they consult the CHCs for the services that are not offered by their respective clinics. They also have the option of consulting private doctors although it is very expensive. The participants who travelled 20km to the CHCs indicated that they cannot afford to consult a private doctor because of the expensive consultation fees, which also requires a person to purchase medication.

The participants complained about the referral letters which deprive them of opportunities to consult secondary and tertiary (specialised hospitals) health facilities. The complaint in this regard was around the delays in accessing such letters from the health practitioners. The respondents felt that the delay (routine process for referral letters) was unacceptable; however this was an advantage to chronic patients.

Frequency of visits

The participants were asked about the frequency of their visits to the CHCs.

Table 4.4: Frequency of visits

VALUE LABLE	Number of participants	Percentage (%)
Monthly	28	56%
Bi-monthly	12	24%
Weekly	10	20%
TOTAL	**50**	**100%**

48% of participants indicated that they visit the CHCs on a monthly basis. Such visits are undertaken on a monthly basis or every fort-night for collecting medication especially for chronic ailments. All the patients indicated that they arrive before midday at the clinics on every occasion.

Waiting period

This section aimed to find out about the waiting period experienced by the participants before they could be attended to. Most participants indicated that they do not like to wait for long periods because they become hungry and often do not have money to buy food.

Table 4.5: Waiting period at health facilities

VALUE LABLE	Number of participants	Percentage (%)
<20 minutes	3	6%
An hour	4	8%
Over an hour	43	86%
TOTAL	**50**	**100%**

The participants indicated that they do not travel long distance, but their concern was that they often spend up to three hours in the CHC before seeing a doctor or nurse.

Reasons for visiting the CHC

The researcher wanted to find the reasons for the patients to consult the CHCs. The participants indicated that they consult the CHCs for their routine monthly check-up (medical examination). The patients visit the health facilities on a monthly basis for their treatment. Only few patients go for a random visit. The patients indicated that they preferred to go to the health facility before midday (12pm) because they are afraid of being sent back home. When they are sent back home they are required to report back to the facility the following day. They believe that it will be a waste of time to be sent back whereby they could have done their household chores.

It was indicated that if the patients are sent back, they make it a point that they arrive early the following day, around 7 o'clock so that they could finish early and be relieved.

Table 4.6: Reasons for visiting the CHC

VALUE LABLE	Number of participants	Percentage (%)
Monthly check-up	24	48%
Medication Refill	10	20%
Random Visit	16	32%
TOTAL	**50**	**100%**

One resident suggested that the health facility must provide food parcels for them because they leave their houses without having breakfast in the morning. The suggestion made for the provision of food parcels will be difficult for the health professionals since they work on constrained budgets.

4.10.3 Patient-health professional relations

The researcher aimed to ascertain the relationship between the health professionals and the patients. The questions wanted to take notice of the views of the patients interviewed about the attitudes of the health professionals.

Table 4.7: Staff attitude

VALUE LABLE	Number of participants	Percentage (%)
Unfriendly (irritated)d	22	44%
Professional	25	50%
Eager to help	3	6%
TOTAL	**50**	**100%**

The results above indicate that the patients were not happy about their interaction with the health professionals as they were not always friendly towards them. One patient was quoted as saying "*ba tlisa mathata a bona mosebetsing, of which hae fair for rona*". This means that the "staff brings their problems to work, of which it is not fair to the patients". 50% of the patients reported that the personnel were professional towards them. It was comforting to observe that only 6% of the respondents were happy about the staff attitude, as they were eager to help them during their consultations in the respective CHCs.

The use of language when being serviced

The participants were asked if they understood the language spoken by the health personnel.

Table 4.8: The use of language when being serviced

VALUE LABLE	Number of participants	Percentage (%)
Understandable	48	96%
Not understandable	0	0%
Sometimes, understandable	2	4%
TOTAL	**50**	**100%**

Almost all the patients were satisfied with the language used to engage or communicate with them. In some CHCs the doctors are either English or Afrikaans proficient and such

doctors were able to communicate well with the patients. Most of the respondents are familiar with the language spoken by such personnel.

Image of the facility

Participants were asked to rate the facilities in terms of cleanliness.

Table 4.9: Level of cleanliness

VALUE LABLE	Number of participants	Percentage (%)
Dirty	16	32%
Very Dirty	1	2%
Clean	33	66%
TOTAL	**50**	**100%**

Majority of the patients were in agreement that the health care centres are clean. According to the respondents, it is only seldom that you find papers and other things on the floor. Some of the respondents mentioned that the restrooms are always dirty and often do not even function properly.

Dispensing medication

The researcher asked the participants how the health professionals dispense the medication due to them.

Table 4.10: Dispensing medication

VALUE LABLE	Number of participants	Percentage (%)
At the CHC	50	100%
Prescription referred by the health professionals	0	0%
TOTAL	**50**	**100%**

It was a relief to observe that the patients obtained their medication at the CHCs. Access to medication allows the service users to depend on the health system. This system of dispensing medication at the health facility (CHC) seems to be a good practice because people sometimes misuse the medication or consume wrong medication. Some people rely on chronic medication; therefore the issuing of medication in the respective facilities allows the health professionals to monitor the

usage of medication issued. The facilities also use the medication system to analyse their effects, since it is dispensed by the health facilities.

4.10.4 Patient perceptions

The health sector provides its services to a diverse community. Such recipients have different challenges that they face when contacting these facilities. A lot can be said about the dilemmas experienced in the respective facilities. However when a patient is asked about their encounters, the response will be the long waiting period. The researcher wanted to obtain the inputs from the service users in the CHCs under review for this study. The participants (patients) suggested the following points:

- The need to increase capacity and having more nurses and staff. This was specifically mentioned for overcrowded seasons such as the immunisation of the children and for ante-natal clinics;
- Continuous training. They saw a need for continuous training especially when the personnel became unfriendly towards them. It is indicated that the training will also impact on their emotional being and to feel more relaxed if they default or use wrong medication.
- One patient suggested a course of how to take care of the patients who are the customers in the health sector.
- Another patient suggested that the support staff should be increased to manage the queue system. Some facilities do not have dedicated personnel to manage the system.

4.11 INSTITUTIONAL QUESTIONNAIRE

The institutional questionnaires were given to the Quality Assurance department/unit, of the three selected CHCs. The respective units were very co-operative in answering the questions posed to them. Below is an analysis of their responses. The researcher decided to use tables for documenting data that was obtained from the CHCs.

4.11.1 Stakeholder involvement

The following questions were posed to the three CHCs regarding stakeholder involvement in promoting quality health care.

Table 4.11: Stakeholder involvement

Stakeholder Involvement	Levai Mbatha CHC	Sharpeville CHC	Boipatong CHC
Is there a clear process for involving stakeholders?	Yes	No	No
Is there a list of all key stakeholders?	Yes	No	No
Are there clear terms of reference for all interested parties?	Yes	No	No

The quality assurance managers believe that there is a clear process for involving stakeholders. The stakeholders may consist of the communities who want to participate in the decision making of the health care services. The manager mentioned that the stakeholders in the health sector consist of the public and private sector, NGOs, churches, traditional leaders and local business owners.

4.11.2 Situational analysis

The three CHCs each have a dedicated unit which deals with quality assurance, and ensuring that all the policies are in place. Those respective units are guided by policies which enable the facility to streamline the programme for effective implementation. According the quality assurance managers, the QA policies are in line with the provincial as well as national health policies. The quality managers emphasised their main goal of addressing patient satisfaction and safety in all they programmes.

Current performance of the health system

A quality assurance manager in one of the three CHCs strongly believed that they have achieved the mandate prescribed by the health policy and their performance is effective. She gave a very positive response to most of her responses. The manager at Sharpeville believes that action needs to be taken in order to improve the services they offer.

Table 4.12: Situational analysis

Situational analysis	Levai Mbatha CHC	Sharpeville CHC	Boipatong CHC
Does the CHC have a Quality Assurance unit/department?	Yes	Yes	Yes
Does the quality assurance unit/department have a structural composition?	Yes	Yes	Yes
Does the CHC have quality assurance policies to guide the implementation of the programme?	Yes	Yes	Yes
Are the quality assurance policies linked to the provincial and national health?	Yes	Yes	Yes
Are there programme priorities for addressing patient satisfaction and safety?	Yes	Yes	Yes

Table 4.13: Current performance of the health system

Current performance of the health system	Levai Mbatha CHC	Sharpeville CHC	Boipatong CHC
Effective	Yes	Yes	Yes
Efficient	Action required	Yes	Action required
Accessible	Yes	Yes	Yes
Acceptable	Yes	Yes	Yes
Equitable	Yes	No	Action required
Safe	Yes	Yes	Yes

4.11.3 Confirmation of health goals

The strategies that are in place to improve patient satisfaction and safety include the application of a Quality Assurance Programme. The CHCs monitor client satisfaction by means of client satisfaction surveys; suggestion boxes and after-service evaluation.

Table 4.14: Confirmation of health goals

Confirmation of health goals	Levai Mbatha CHC	Sharpeville CHC	Boipatong CHC
Are there strategies in place to improve patient satisfaction and safety	Yes (monitoring of client satisfaction)	Yes	Yes
Are there systems used to enhance the improvement of patient satisfaction and safety in the CHC?	Yes	Yes	Yes
Are there any new interventions to realise the quality assurance goals?	Yes	Yes	Yes

4.11.4 Development of quality goals

Below is the development of quality goals, the quality managers were asked if there are any deficiencies in the running of the CHCs

Table 4.15: Development of quality goals

Development of quality goals	Levai Mbatha CHC	Sharpeville CHC	Boipatong CHC
Are there deficiencies in effectiveness?	Yes	Yes	Yes
Are there deficiencies in efficiency?	Yes	Yes	Yes
Are there deficiencies in accessibility?	Yes	Yes	Yes
Are there deficiencies in acceptability?	Yes	Yes	Yes
Are there deficiencies in equity?	Yes	Yes	Yes
Are there deficiencies in safety?	Yes	Yes	Yes

According to the quality managers it is confirmed that there are some deficiencies in terms of effectiveness and efficiency. The managers of facilities believed that more could be done to improve the level of quality within their centres for improving the system. They believe that good staff moral will help in ensuring that the patients' needs are met and hence improve satisfaction and safety. All the managers of the CHC's agree that the centres are accessible (easy to reach), acceptable and have a strong level of equity as well as safety.

4.11.5 Choosing interventions for quality

The quality managers confirmed that there are strategies developed for improving patient satisfaction. The respective strategies include community outreach programmes as well as community participation drives. All these help the facility managers to have an idea of what the community expects in order to increase satisfaction. Through these outreach strategies, new interventions are developed. The quality managers are aware that the health care centres plays an imperative role in the community, as the health of the community rests on their shoulders.

Leadership

With regards to leadership, the quality managers stated that development programmes are provided throughout the health system. The programmes are used to strengthen each individual's strong points and to enhance the overall leadership capacity.

The three managers all agreed that the health system allows access for the community to participate. It was said that the interaction between the health sector and the community is crucial for decision making and sustainable health service delivery process.

Information

Information is always available at all the CHCs which allow quality and performance to be monitored on a continuous basis across the health centres. The information of the health sector is transparent and accessible to all citizens.

Table 4.16: Leadership and patient and population engagement

Leadership and patient and population engagement	**Levai Mbatha CHC**	**Sharpeville CHC**	**Boipatong CHC**
Leadership			
Are leadership development programmes provided throughout the health system to strengthen individual leadership skills and to enhance overall leadership capacity	Yes	Yes	Yes
Are leaders in quality supported by an appropriate infrastructure and resources to facilitate their leadership activities?	Yes	No	Action required
Are leaders throughout the health system interacting with communities, service users, and those who choose not to use services, in order to understand their needs and preferences?	Yes	Action required	Action required
Do leaders throughout the health system ensure that information about the quality of service provision and about quality outcomes is widely shared with stakeholders?	Yes	Yes	Yes

Table 4.17: Information

Information	Levai Mbatha CHC	Sharpeville CHC	Boipatong CHC
Does existing information system allow quality and performance to be monitored on a continuing basis across the health system?	Action required	Yes	Action required
Do existing information systems have the capacity to respond to future demands in quality improvements?	Yes	Yes	Yes
Do the users of health services have sufficient information to enable them to make informed choices about how they use these services?	Yes	No	Yes
Are patient and population satisfaction surveys used across the health system to assess community and user perceptions of the quality of services being provided?	Yes	Yes	Yes
Does the national policy agenda on quality relate to marginalized groups of the poor?	Yes	Yes	Yes
Patient and population engagement			
Are service users and communities properly involved in the governance of all parts of the health system	Action required	No	Yes

Access to information enables the service user to be familiar with the programmes of the health institution and to know the channels of communication and where to access the respective services. Information is transmitted through 24 hour telephone lines. There are pamphlets which inform the public about the health issues, and are obtainable from the information helpdesk which is at the reception of all three CHCs. Patients are free to take the pamphlets they want. Pamphlets are issued across the health facilities and they provide important information such as the contacts, pilot

programmes that informs about the new projects programmes. Suggestion boxes are also available in all the health centres and there is a person who is responsible to do follow-ups and to provide feedback. Committees and sub-committees have been established to assist the service users. The established committees are involved in the governance of all the different parts of the health system. Regulations are kept underway and this is done through the means of workshops scheduled. These regulations are always reviewed for improving quality of the health system.

Regulation and standards and Organisational capacity

The health system provides a level of leadership and accountability for quality outcomes.

Table 4.18: Regulation and standards

Regulation and standards	Levai Mbatha CHC	Sharpeville CHC	Boipatong CHC
Are existing systems of regulation and standard setting kept under review, and is their impact on quality outcomes assessed?	Yes	Yes	Yes
When new standards and regulations are developed and introduced, do they reflect the goals and priorities of the health system	Yes	Yes	Action required

The three CHCs developed a capacity development for the relevant staff to analyse quality data, identify the problems which are likely to delay the process. These interventions are developed to promote the organisational culture and improve the health system.

Table 4.19: Organisational capacity

Organisational capacity	Levai Mbatha CHC	Sharpeville CHC	Boipatong CHC
Within health-service-provider organisations, is local leadership and accountability for quality outcomes always clear?	Action required	No	No
Do health-service-provider organisations systematically promote a culture within which quality improvement is central to the purposes of the organization	Yes	Yes	Yes
Do health service provider organisations regularly review those key systems which contribute to quality goals, including systems for managing risk and safety, systems for obtaining user views, and systems for training and education?	Action required	Yes	Yes
Do health service provider organisations systematically develop the capacity of their staff to analyse quality data, identify problems and manage change?	Action required	Yes	Yes
Do communities have the capacity and resources to identify and articulate their health needs and preferences?	Yes	No	Yes

Models of care

According to the quality assurance managers, there are mechanisms in place which allow new models of care to be developed with the full involvement of health-service providers, service users and communities.

TABLE 4.20: Models of care

Models of care	Levai Mbatha CHC	Sharpeville CHC	Boipatong CHC
Is the reorganisation of the delivery of health care perceived as a tool for quality improvement?	No	No	Action required
Are there mechanisms in place which allow new models of care to be developed with the full involvement of health	Action required	Yes	Yes
Is the implementation of new models of care always appropriately provided with resources?	Yes	No	No

New models of care are always provided with resources when the need arises.

4.11.6 Implementation process

Quality assurance initiatives can be well implemented, because health centres have separate units which specifically work with quality assurance. One of the quality assurance managers in the selected CHCs indicated that they have efficient support structure in place to achieve such purposes. The use of technology in delivering health services through internet enabled the health sector to reach a large number of people. But this bears in mind that fact that not all people have access to the web, therefore. The marshals are hired to distribute pamphlets door to door in order to introduce new quality initiatives and to get the community involved in giving suggestions.

The decision-makers in the health sector draw up a plan of quality initiatives and before implementation they distribute their ideas to the relevant stakeholders (community members, NGOs and ward committee members) through a form which is called the quality initiative plan strategies. Before they can be implemented, the relevant stakeholders, e.g., NGOs, churches and community patients need to sign a pledge of acceptance, so the initiatives can be implemented. The implementation process for the health sector is sometimes flexible, whereas in some cases the process tends to be rigid. The rigidness of the implementation process may result from the dysfunctional

situations such as the acute sicknesses such as the outbreak of flu and cold, meningitis, diarrhoea and high mortality rates.

4.11.7 Monitoring process

Different strategies are being developed on a regular basis. The free mobile testing for HIV/Aids, TB and other diseases raises awareness. A good working environment is also developed to increase staff morale. Everyone is encouraged to act professionally. This is instilled within the ranks of the security guards at the gate, to the reception lady, the nurses or doctors and even the pharmacist. All these people are seen as contributors for improving quality services. There are rehabilitation centres. These programmes are well appreciated by the community as a motivation and support mechanism given to them.

The framework for institutionalizing quality assurance at the three CHCs is done through the main steps which include defining, measuring as well as improving quality. A very crucial step to the framework is pre-awareness, which the quality managers play a big role. The quality managers ensure that the guiding policies are well placed. The quality managers are closely monitoring the process from its beginning to the end and responsive mechanisms are made whenever challenges arise.

As in any other programme, challenges arise and there are factors which hinder the effective implementation of a quality assurance programme. These according to the quality managers, include:

- staff shortages or inadequate supervision;
- Existing structures for community participation is currently weak;
- Lack of moral from staff;
- System failure; and
- lack of compliance with specified guidelines or clinical practices.

The quality managers always ensure that the computers are in a good working condition in order to overcome the technological challenge. Training courses are always available in order for the staff to be empowered with new knowledge, whether it is new medication or new equipment which they need to be aware of. New Quality strategies are also being developed which integrates the patient as well as the staff.

4.11.8 The researcher’s remarks about the CHCs observed

When you arrive at these clinics, you are greeted with many charts on quality, patient safety as well as the Gauteng Health Department guidelines, which show a pledge of service laid on the hearts of the staff, for the patients. These charts grabbed the attention of the researcher. This gave hope in the fact that the patients are well regarded. There are steps which can be taken should a patient not be completely satisfied with the service received at any given time. There was one particular chart had a toll-free number which could be used by patients for lodging complaints and complements. On the walls you also find other charts which pledge commitment to the patients. Looking at these charts somehow gave hope to the fact that the staff members aspired to put the needs of the patients first and foremost.

4.11.9 CONCLUSION

Patient safety and patient satisfaction were seen as two different or distinct domains, which were believed to have separate entities as well as different people to be laid accountable for. But over the years it has been proven that they are inter-twined since one needs the other to gain success. Teamwork plays a significant role in the two developments. Patients are the biggest stakeholders in healthcare, and it is clear that patient satisfaction and patient safety are paramount for success.

Combined teamwork as well as patient engagement addresses issues such as satisfaction through tools which mainly focus on staff-patient communications which provide some kind of linkage. When the communication between the patient and staff improves, satisfaction and safety also increases. Other benefits of clear communication include reduced rates of readmission; medical errors; and hospital acquired infection as well as in patient mortality.

CHAPTER FIVE
SUMMARY, FINDINGS, RECOMMENDATIONS AND CONCLUSIONS

5.1 INTRODUCTION

This study assessed the implementation of a quality assurance programme in the CHCs, as a tool for promoting patient satisfaction and safety. There are many challenges in development of such initiatives. This section presents a summary of this research project by outlining the realisation of the study objectives. The researcher also describes the findings and the recommendations of this study. An overall conclusion of the study is also presented in this chapter.

5.2 SUMMARY

A summary of the previous chapters is discussed in the following section.

5.2.1 The overall aim of the study

The aim of this study was to analyse the implementation of a quality assurance programme in the health sector and focused at the health services offered in the ELM. It is apparent that the absence of an effective quality assurance programme can have a negative impact on patient attitude towards service delivery. The study consisted of four objectives which are briefly outlined below.

The first objective of the study aimed to provide a theoretical exposition of the concept of quality assurance, patient satisfaction and patient safety. The concepts were defined and explained in chapters one, two, and three.

The second objective intended to provide an analysis of the impact of a quality assurance programme, as well as evaluating the main models, approaches and indicators used in implementing an effective QA programme. This was particularly addressed in chapter three.

The third objective aimed to analyse the implementation of a quality assurance programme and how it is received by the patients who utilise a particular CHC. Information was accumulated by means of an empirical survey through the use of questionnaires distributed both to the community as well as the quality assurance managers. The analysis of responses was done and reported in chapter four.

The fourth objective of this study anticipated to provide a set of recommendations which will assist the health sector to improve the quality of health services in order to provide patient safety and satisfaction in the CHCs operating in the Emfuleni Local Municipality. This shall therefore be done in this chapter.

5.2.2 Summary of chapters

The following provides a summary for the preceding chapters

Chapter one

Chapter one presented an outline of the health sector and provided a brief overview of a quality assurance programme for improving patient satisfaction and safety. This chapter also described the problem statement as it relates to the health sector and its quality assurance programme. The research questions, objectives, hypothesis, research methods and chapter formations were also described.

Chapter two

The second chapter addressed the theoretical explorations of the concepts of quality assurance and the health care services. The legislative framework and the components of a quality assurance in the health sector were discussed.

Chapter three

Chapter three provided an overview of quality assurance programmes. It is imperative that quality is constantly improved on different levels. Patients need to be involved in order to benefit from the improvement and this can be achieved by constantly addressing their needs. Chapter three described the implementation process of a quality assurance programme. The mechanism for measuring the impact of a programme was also discussed.

Chapter four

This chapter addressed the research methods which were used to obtain data for this study. Questionnaires were utilised to collect data. The results were also presented. The questionnaires were completed by members of the community who used any of the three CHCs researched. The results of the interviews conducted with quality assurance managers were also presented in chapter four.

Chapter five

This chapter focuses on the summary, findings, recommendations and conclusions on the preceding chapters. The chapter provides the recommendations on the possibilities of improving a quality assurance programme for patient safety and satisfaction.

5.3 RESEARCH FINDINGS

The study showed that a QA programme can serve as a tool for continuous monitoring, measuring and improving quality of health services in the ELM. Three CHCs were visited by the researcher namely; Levai Mbatha CHC; Sharpeville CHC as well as Boipatong CHC. The only difference between the three clinics is their locality. The author discovered that most of the activities of the CHCs are similar. The findings are discussed below.

Another concern raised by patients during the conducting of this study was that they wanted insisted on being anonymous as they were afraid that they would not get professional service should they mention their frustrations. The researcher of this study assured them that their names would not be disclosed.

Services provided

The CHCs provide acute services as compared to hospitals which provide chronic health services. The CHCs have limited beds because the patients are not required to stay for long periods. In actual fact they are not allowed to stay more than 48 hours.

Access

- The CHCs are open 24 hours per day and accommodate most of the residents residing in the ELM (Sebokeng, Evaton, Sharpeville, Boipatong, Bophelong, Palm Springs). *The Sharpeville CHC* caters for the residents of Rooi-steen, Tshepiso ext 1, 2, 3, 4; Putswa Steen as well as Phelindaba.
- The sizes of the CHCs vary according to the population size of each township. The Levai Mbatha CHC is the second biggest CHC around Emfuleni. The Boipatong CHC is the smallest since the Boipatong location does not have a large population as compared to Evaton, Sebokeng and Sharpville.

Picture 5.1 below briefly outlines the services provided in the CHCs.

Picture 5.1 Community health centre service provision

Picture 5.1 indicates all the departments or units which are available within the CHC's.

Picture 5.2 The Sharpeville CHC

Health System

The CHCs operates in a systematic manner in controlling their management. All patients need to first go to the CHCs, even in cases of emergency. They cannot consult the provincial Hospital (Sebokeng Hospital), without a referral letter from the respective *CHCs.* The health sector has a dedicated team to manage the implementation of a quality assurance programme.

Service efficiency

- All the patients interviewed during the research claimed that they rely on the clinic because they cannot afford a private doctor.
- The participants seemed to be happy with the services they received at the CHCs. Some have gone to an extent of indicating that the services offered in the respective CHCs were reliable. These sentiments were captured in expressions such as "*it is number one"*.
- When asked to rate the service, the participants gave a rating of a bold 8/10.
- However there are cases whereby the participants indicated their dissatisfaction on the services provided in the CHCs. It was indicated that the average service received was efficient. When asked to rate the service, the participants gave a rating of a bold 8/10.

Waiting period

The waiting period seemed to be the problem to most participants. The patients wished that the services given by the staff would be faster. However it was found that limited employees are employed to control the waiting period, this has brought positive changes to the clinic, in the last two years. Prompt health services are good, however, it was found that there are a few delays in the systems which are often caused by the health procedures that are used to diagnose and obtain accurate data from the patients. In terms of the waiting period it seemed that the patients did not consider such procedures.

5.4 TESTING THE HYPOTHESIS

The hypothesis for this study stated that a well-defined quality assurance programme can serve as a tool for continuous monitoring, measuring and improving of quality health services in the Emfuleni Local Municipality. Findings gathered from both the literature review and empirical research support the preliminary statement. It is thus concluded

that indeed a well-defined Quality Assurance programme proves to play a significant role in improving patient safety and satisfaction.

5.5 RECOMMENDATIONS

This section presents the recommendations based on the findings of this study, the challenges which were identified through the interviews as well as the observations undertaken at the three CHCs. The following recommendations are tabled by the author for improving patient satisfaction and safety:

- According to census South Africa, the ELM has a population of about 1.2 million residents. This is the largest population in the whole Sedibeng District Municipality; therefore it would be more beneficial for more CHCs to be built around Emfuleni.
- To ensure that patients get quality service, each CHC needs to employ more staff and even have staff on standby in case of emergency.
- Staff requires continuous training on customer care particular in the case of patient care.
- The patients suggested that they be given food parcels at the clinics as they often wait for many hours before being attended to because they need to take their medication while they wait for their turn. The researcher of this study feels that the recommendation made by the participants would be difficult especially when the sector operates on a limited budget and scarce resources.
- Management should invest in team-building projects as these could help with staff morale.
- Encouragement of commitment among staff members is crucial especially in getting them to take an extra-mile in their duties.
- The respondents indicated that their inputs and grievances are not fully considered. It was indicated that the voices of the patients need to be taken seriously. In this regard the researcher recommends the appointment of an official who could manage the "suggestion box" and the complaint system. Such an appointment would enable the health sector to respond to the patient complaint promptly.
- The respondents felt that quality may be improved if the CHCs could improve their communication channels. Staff members need to respect each other as well as respect the patients they serve. They need to serve their patients with professionalism and eagerness.

5.6 CONCLUSION

Quality is a crucial part of the health care system; it therefore cannot be compromised in any way. When an individual goes to a clinic it is because he or she seeks immediate medical attention, therefore quality service needs to be given at any given day at such places. The lives of the people who visit the CHCs depend on the nurses and doctors who work there. When a QA programme is in place and regularly monitored and evaluated, patients will become satisfied with the services and a sense of safety will be felt by the health consumers. Public participation in ensuring patient safety and satisfaction is thus imperative. The study provided the importance of such a programme being well in place at all these CHCs reviewed.

BIBLIOGRAPHY

Andaleeb, S.S., Siddiqui, N. and Khandakar, S. 2007. Patient satisfaction with health services in Bangalesh. *Health Policy and Planning.* 2(1): 263-273.

Babbie, E. 2011. Introduction to social research. 5th edition. Wadsworth: Cencage Learning.

Bengoa, R., Kawar, R., Key, P., Leatherman, S., Massoud, R. and Saturno, P. 2006. Quality of Care: A process for making strategic choices in health systems. Geneva: World Health Organization: WHO Press.

Boloko, T.M. 2009. An evaluation of total quality management in the chemical industry. Thesis (M.B.A.). Vanderbijlpark: North-West University, Vaal Triangle Campus.

Bossert, J.L, 1999. Quality function deployment: A Practitioners approach. Winsconsin: ASQC Quality Press.

Branford, W. 1994. The South African Pocket Oxford Dictionary of current English. 8th ed. Cape Town: University Press.

Blessing, L.T.M. and Chakrabarti, A. 2009. DRM, a Design Research Methodology. London: Springer.

Brenzel, L. 2002. LACHSR initiative. *In* Mantilla, F.L., Renteria, V.M.C., Anavi, J.E.R. 1998. Quality surveillance manual: Manual and instructions for quality accreditation and surveillance at the policlinics of Caja Nacional de Salud in La Paz, Bolivia. Bolivia: Management Sciences for Health (MSH).

Carey, R.G and Lloyd, R.C. 2008. Measuring quality improvement in healthcare: A guide to statistical process control and applications. New York: Oxford Press.

Carruthers, M. 1999. Principles of management for quality projects. London: International Thomson Business Press.

Chinamale, H.M. 2010. An investigation into the status of quality assurance and quality control measures in diagnostic X-r. Raton City: CRC Press.

City of Cape Town. 2012. Quality Assurance. www.capetown.gov.za. Date of access: 19 Mar. 2013.

Clark, P., Clark D, Day, D and Shea, D. 2001. Healthcare reform & the workplace experience of nurses: Implications for patient care & union organizing. *Industrial Labour Relations Review*, 55(1): 133-148.

Coetzee, C.J.H. 2006. Barriers to change in a governmental service delivery type organization. Pretoria: University of Johannesburg Press.

Crosby, P.B. 2000. Quality without tears: The art of hassle-free management. New York: McGraw-Hill.

Cullen, J. and Hollingum, J. 1987. Implementing Total Quality. New York: IFS Publications.

Cullinan, K. 2006. Health services in South Africa: A basic introduction. Health-e News Services. www.health-e.org.za Date of access: 27-07-2012.

Curtis, D.S. 2001. Current issues in nursing. St. Louis: Mosby Press.

Danida, J. 2004. Healthcare Quality Assurance Manual. London: Wiley & Sons.

Davies, A.R and Ware, J.E. 1998. Involving consumers in quality of care assessment. *Health Affairs*. (7):33-48. London: Macmillan Press.

Department of Health. 2001. History of Pholela CHC. http://www.historyofpholela/org.htm Date of access: 26 Jul. 2012.

Evans, J. 2013. Quality and Performance Excellence: Management, Organization, and Strategy. 5th Edition. United Kingdom: Cencage Learning.

Family Health International. 2010. Qualitative Research Methods: A Data Collector's Field Guide. http://www.fhi.org/org/nr/rdonlyres" Date of access: 01 May 2013.

Gauteng Department of Health. 2007. Gauteng Department of Health Annual Report 2006/07. Marshalltown: Gauteng Department of Health.

Gauteng Department of Health and Social Development. 2011. Programmes. www.gdhsd.gov.za Date of access: 21 Aug. 2011.

Gauteng Provincial Government, 2008. SA: Hlongwa: Quarterly media briefing by the MEC for Health in Gauteng, Brian Hlongwa (12/11/2008). http://m.polity.org.za/article/sa-hlongwa-quarterly-media-briefing-by-the-mec-for-health-in-gauteng-brian-hlongwa-12112008-2008-11-12 Date of access: 27 Jul. 2012.

Gildenhuys, J.S.H. and Knipe, A. 2000. The organisation of government. Pretoria: Van Schaik Publishers.

Government of Western Australia: Department of Health. 2005. Clinical governance standards for Western Australian Health Services. *Information Series*. 1(4):10-35.

Hart, C. 2001. Doing a Literature search. A comprehensive guide for the Social Sciences. London: Sage.

Holden, D.J., and Zimmerman, M.A. 2009. A Practical Guide to Program Evaluation Planning: Theory and Case Examples. United States of America: Sage Publications, Inc.

Kirkpatrick, C. 2002. Dimensions of quality in healthcare. Washington: Tacoma Press.

Koller, C.J., Eatough, J.P., Mountford, P.J., and Frain, G. 2006. A survey of MRI quality assurance programmes. *The British Journal of Radiology*. 79(943): 592-596.

Krishnamurthi, G. 2004. "Some issues of governance in rural health sector. *In* Subhasis, R. and Amitava, M. 2007. Development of a framework towards successful implementation of e-governance initiatives in health sector in India. *International Journal of Health Care Quality Assurance*. 20(6): 464-483.

Legido-Quigley, H., McKee, M., Nolte, E., and Glinos, I.A. 2008. Assuring the quality of health care in the European Union. A case for action. Denmark: World Health Organization.

Lindsay, W.M. and Petrick, J.A. 1998. Total Quality and Organization Development. New Delphi: St. Lucie Press.

Macagba, R.L. 2001. An International Study from the International Hospital Federation. London: Wiley & Sons.

Mantilla, F.L., Renteria, V.M.C., and Anavi, J.E.R. 1998. Quality Surveillance Manual: Manual and instructions for quality accreditation and surveillance at the policlinics of Caja Nacional de Salud in La Paz, Bolivia. Bolivia: Management Sciences for Health (MSH). London: Oxford University Press

Maree, K. and Van der Westhuizen, C. 2009. Head start in designing research proposals in the social sciences. Cape Town: Juta.

Mwongera. V. 2008. Shortage of staff, poor service delivery of public hospitals. : www.africasciencenews.org Date of access: 30 Apr. 2011.

Neuman, W.L. 1991. Social research methods: Qualitative and quantitative Approaches. *3rd edition*. Boston: Allyn & Bacon.

Offei, A.K., Bannerman, C., and Kyeremeh, K. 2004. Healthcare quality assurance manual. For Sub-Districts July 2004 with support from Danida. Accra: Ghana Health Service.

Omachonu. V.K. and Ross, J.E. 2004. Principles of Total Quality. *3rd Edition*. London: CRC Press.

Oracle Corporation. 2008. Integrated Talent Management: Extending the Value of a Strategic Framework. *An Oracle White Paper.* Redwood Shores: Oracle Corporation. www.oracle.com Date of access: 12 Oct. 2012

Parker, F. 2012. Gauteng health promised “major shake-up”. www.mg.co.za Date of access: 27 Aug. 2012.

Phaswana-Mafuya, N., Petros,G., Peltzer, K., Ramlagan, S., Nkomo, N., Mohala, G., Mbelle, M. and Seager, J. 2008. Primary health care service delivery in South Africa. *International Journal of Health Care Quality Assurance*. 21(6):611-624.

Pillay, Y. and Asia, B. 1999. Handbook for Clinic/CHC Managers. www.doh.gov.za Date of access: 01 Oct. 2009.

Pillay, R. 2008. Health Services: Management Services. Volume 23: No. 1. 30-36. New York: Quality Press.

Quigley, E. 2003. Contributions of the Professional, public, and private sectors in promoting patient safety. *Online Journal of Issues in Nursing*. 8(3):105-120.

Redman, C. 2003. Measurement tools in patient education. New York: Springer Publications.

Renshaw. A. and Gould. E.W. 2012. Quality Assurance measures for critical diagnosis in anatomic pathology. *American Journal of Clinical pathology*. 3(4):10-12.

Resnik, D.B. 2011. National Institute of Environmental Health Sciences: What is ethics in research & Why is it important? www.niehs.nih.gov/research/resources. Date of access: 01 May 2013.

Roben, J. 2004. Evidence based practice manual: Research and outcome measures in health and human sciences. New York: Oxford University Press.

Rossi, P., Freeman, H. and Lipsey, M. 1999. Evaluation: A systematic approach. New Orleans: Platinum Press.

Sedibeng District Municipality. 2011. Flagship projects. Vanderbijlpark: Sedibeng District Municipality.

Sheahan, K. 2012. Quality assurance programs in Medical Clinics. www.ehow.com Date of access: 13 Apr. 2012.

Soanes¸ C. and Hawker, S. 2006. Compact Oxford English Dictionary for University and College Students. Cape Town: Oxford University Press.

South Africa. 1995. White Paper on the Transformation of the Public Service (WPTPS). Government Gazette No. 16838. Pretoria: Government Printers.

South Africa. 1996. Constitution of the Republic of South Africa Act 108 of 1996. Pretoria: Government Printers.

South Africa: National Department of Health. 1997. White Paper for the Transformation of the Health System in South Africa. Pretoria: Government Printers.

South Africa: National Department of Health (NDoH). 2007. A Policy on Quality in Health Care for South Africa: Abbreviated version. Pretoria: Government Printers.

South Africa: National Department of Health (NDoH). 2008. Patient safety in African health services: Issues and solutions- speaking notes for the Minister of Health Republic of South Africa. Pretoria: Government Printers.

SRCC Quality assurance. 2012. Quality assurance challenge in health care reform in future Syria. http://www.strescom.org Date of access: 20 Oct. 2013.

Subhasis, R., Amitava, T. and Mukherjee L. 2007. Development of a framework towards successful implementation of e-governance initiatives in the health sector in India, *International Journal of Health Care Quality Assurance*. 20(6): 464-483.

Theodoulou, S.Z. and Kofinis, C. 2004. The Art of the Game: Understanding American Public Policy Making. Belmont, CA: Wadsworth

Stevenson, R., Wallace. K. and Wallace, G. 1998. The Quality roadmap: How to get your company on the Quality Track-and keep it there. New York: Amacom.

Uganda Ministry of Health. Strategic framework for quality assurance component. www.health.go.ug Date of access: 21 Jul. 2011.

Unsworth, S. 2010. 'Mobilising for better public services', in an Upside-down view of governance. Brighton: Institute of Development Studies.

Wales, J. 2009. Sampling (statistics). www.wikepedia.org Date of access: 20 Aug. 2013.

Wilson, R. 2009. Community health centres - Optometric care within the public health community. Cadyville: Old Post Publishing.

Wolosin, R.J. 2008. Safety and Satisfaction: Where are the connections? Patient Safety & Quality Healthcare online. www.psgh.com/enews Date of access: 11 Jul. 2011.

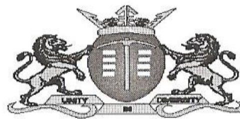
World Health Organisation (WHO). 2004. World alliance for patient safety. World Health Organisation. www.who.int/patientsafety Date of access: 27 Aug. 2012.

World Health Organisation (WHO). 2008. Service delivery. Toolkit on monitoring health systems strengthening. www.who.org Date of access: 21Jul. 2011.

World Health Organisation (WHO). 2011. The research cycle: evaluating impact. www.who.org Date of access: 21 Aug. 2011.

Yunus, A.J.M. (2012). Performance management and service delivery at local governance: Malaysia’s frontline experiences. Malaysia: National Institute of Public Administration.www.unpan1.un.org Date of access: 20 Oct. 2012.

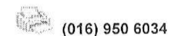
APPENDIX 1: APPROVAL LETTER FOR CONDUCTING RESEARCH



GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

En: Dr. Victor Figueroa

(016) 950 6116

 (016) 950 6034

To: Sedibeng District Management
PHC services

From: Dr. Victor Figueroa

Sedibeng District Research Co-ordinator

Re: Consent to conducting research to Ms. Nthabeleng Malise, North West University

This is to certify that Ms. Nthabeleng Malise, currently conducting research on her Masters Degree has successfully obtain ethical clearance received by North-West University, Vaal Campus on 4 April 2013

The Title of the study is: **The role of quality assurance programme in promoting patient satisfaction and safety in community health centres of Emfuleni Local Municipality**

Ms. Malise is requesting permission to utilize Community Health Centres in Emfuleni sub-district as research domain.

I, Dr. Victor Figueroa in my capacity as Sedibeng District Research Co-ordinator recommend and support for permission to be granted to the above researcher.

Regards,

Dr. Victor Figueroa

2013/05/20

1

APPENDIX 2: EDITING CERTIFICATE LETTER

LM Language Solutions (Pty) Ltd

(Best Language Services Ever!)

TO WHOM IT MAY CONCERN

EDITING CERTIFICATE LETTER

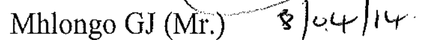
This serves to confirm that the academic work in a form of a mini dissertation belonging to:

Ms. N Malise

titled

THE ROLE OF QUALITY ASSURANCE PROGRAMME IN PROMOTING PATIENT SATISFACTION AND SAFETY IN COMMUNITY HEALTH CENTRES OF EMFULENI LOCAL MUNICIPALITY

was proofread and grammatically edited by the undersigned during the period March 16-24,2014.



Mhlongo GJ (Mr.) 8/04/14

Lecturer and Language Practitioner

Tel : 016 910 3430

Cell : 076 161 3118

Reg No: 2012/206688/07

P.O. Box 3656, Vanderbijlpark, 1911

Mobile 083 952 8492, Fax 086 507 5936, e-mail lebomath@yahoo.com

APPENDIX 3: CLINICS OF THE SEDIBENG DISTRICT MUNICIPALITY

name	Type of facility		address	location
Bophelong (Region B) Clinic	Clinic	Local Go v	632 Matthews Street	Bophelong
Evaton Main Clinic	Clinic	Local Gov	1459 Adams Road	Evaton
Osizweni Clinic	Clinic	Local Gov	320 West Road	Evaton
Thlokomelong Clinic	Clinic	Local Gov	43 - 6 Thandi Modise Str	Evaton
Mpumelelo (Evaton North) Clinic	Clinic	Local Gov	1836 Rabotapi Rd	Evaton North
Beverly Hills Clinic	Clinic	Local Gov	1971 Hollywood Str	Evaton West
Rus ter vaal Clinic	Clinic	Local Gov	1 Kiepersol Street	Rus-Ter-Vaal
Albertina Sisulu Clinic	Clinic	Local Gov	Stand 14863	Sebokeng Zone 11
Zone 13 Clinic	Clinic	Local Gov	76 Kananelo Str	Sebokeng Zone 13
Zone 14 Clinic	Clinic	Local Gov	Stand 65	Sebokeng Zone 14
Zone 17 Clinic	Clinic	Local Gov	Stand 62064	Sebokeng Zone 17
Zone 3 Clinic	Clinic	Local Gov	Stand 570014	Sebokeng Zone 3
Retswelapele Clinic	Clinic	Local Gov	8884 Mareka Street	Sharpeville
Driehoek Clinic	Clinic	Local Gov	Stuttaford Str	Vdbijlpark
Tshepiso Clinic	Clinic	Local Gov	1986 Tshepiso Township	Vdbijlpark

Market Ave Clinic	Clinic	Local Gov	22 Market Ave	Vereeniging
Ratanda Clinic	Clinic	Local Gov	2844 Boschoek St	Ratanda
Ratanda Ext 7 Clinic	Clinic	Local Gov	Nelson Mandela Drive	Ratanda
Rensburg Clinic	Clinic	Local Gov	C/O Roets And Cilliers	Rensburg
Kookrus Clinic	Clinic	Local Gov	C/O Verwoerd Ave And M Oosthuizen Str	Meyerton
Randvaal Clinic	Clinic	Local Gov	84 Rooibok St	Randvaal
Boitumelo Clinic	Clinic	Provincial	2001 Nelson Mandela Drive	Boitumelo
Johan Deo Clinic	Clinic	Provincial	1098 Johan Deo	Johan Deo
Empilisweni Clinic	Clinic	Provincial	C/O Johanna Vd Merwe And Ezenidimevi	Sebokeng Unit 7
Sepei Motsoeneng	Clinic	Provincial	Stand 5964	Sebokeng Zone 12
Dr Helga Kuhn Clinic	Clinic	Provincial	2063 Chestnut Street	Vereeniging
Usizolwethu Clinic	Clinic	Provincial	Lillian St	Devon
Heidelberg Clinic	Clinic	Provincial	C/O Uckerman And Strydom St	Heidelberg
Pontshong (Walkerville) Clinic	Clinic	Provincial	60 Balmoral Estates	Walkerville
Boipatong CHC	CHC	Local Gov	1990 Lekoa Street	Boipatong
Sharpeville CHC	CHC	Local Gov	9173 Zwane St	Sharpeville

Midvaal CHC	CHC	Local Gov	C/O Boet Kruger And Junius Sts	Meyerton
Levai Mbatha CHC	CHC	Provincial	814 Hamilton Road	Evaton
Johan Heyns CHC	CHC	Provincial	C/O Frikkie Meyer And Pasteur	Vdbijlpark
Emfuleni East LA Mobile	Mobile Service	Local Gov	22 Market Ave	Vereeniging
Midvaal Provincial Mobile	Mobile Service	Local Gov	C/O Boet Kruger And Junius Sts	Meyerton
Emfuleni South Provincial Mobile	Mobile Service	Provincial	C/O Frikkie Meyer And Pasteur	Vdbijlpark
Lesedi East Provincial Mobile	Mobile Service	Provincial	Lillian St	Devon
Lesedi West Provincial Mobile	Mobile Service	Provincial	C/O Roets And Cilliers St	Rensburg
Groendenne Mobile	Mobile Service	Provincial	Plot 58	Vereeniging
Jameson Park Satellite Clinic	Satellite Clinic	Local Gov	Dorbie Avenue	Jameson Park
Vischuil Satellite Clinic	Satellite Clinic	Local Gov	116 Melman Street	Viskuil

APPENDIX 4: HEALTH SECTOR REFORM FRAMEWORK

STEWARDSHIP AND STEERING	STRATEGIES:
Definition: **Regulatory actions** (Rules, laws and decrees provided by an authority to standardize, change or channel provider behaviour, and to protect patients rights), **Stewardship** efforts that define the roles of actors within the system, and **Leadership efforts** that shape the culture of the healthcare system itself.	-Licensing -Certification and Accreditation -Develop national norms and practice standards -Legislation re: patients' rights -Regulate insurance companies -Separation/ redefinition of functions (insuring, financing, providing) -Define coordination, cooperation and healthy competition among actors in tri-dimensional system -Centralization/ decentralization initiatives -Develop stewardship/steering capacity -Foster essential public health functions -Promote awareness about citizen's rights and responsibilities in healthcare -Promote awareness about provider rights and responsibilities
FINANCING MECHANISMS	**STRATEGIES**
Definition: **Income generating mechanisms** that provide resources for healthcare, preventive services, early detection, and health promotion. **Payment mechanisms** that provide funds to individual and institutional providers of healthcare, preventive services, and health promotion.	-Fee structure for social and private insurance schemes -User fees -Community financing -Financial allocation formulas for services to populations and/or communities -Individual provider payment (capitation, fee-for-service, fixed salary, etc.) -Payment to provider organizations (per day, per diagnosis, per admission, cost reimbursement, global budget) -Financial incentives based on performance -Financial and allocation mechanisms for decentralization

HEALTHCARE GUARANTEES	STRATEGIES:
Definition: Specification of a **package of health benefits** to be provided to **all citizens** or specified **subpopulations**. Criteria may include reduction of disease burden, efficiency in resource allocation, equitable access, and others.	-Defining what services will be covered for the overall populations -Defining service packages for subpopulations such as pregnant women, mothers and infants, and the elderly -Rationing care for individuals -Coverage requirements for insurance policies
DELIVERY	**STRATEGIES:**
Definition: Determination of **how** services are to be provided and **by whom**, both sector-wide and **within specific service delivery settings**.	-Definition of service delivery model(s): scope and continuum of care -Human resource interventions -Innovations in information systems -Regionalization strategies -Allocation of more resources to primary care and less to secondary care

Source: Mantilla, Renteria and Anavi, 1998:2).

APPENDIX 5: QUALITY ASSURANCE MAINTENANCE PROGRAM

QA MAINTENANCE PROGRAM	DESCRIPTION
Health and Safety	-Ensure that Health and Safety programme is implemented and attended to. -Monitor Health and Safety representative inspections/audits and that corrective action is taken.
Infection Control	-Ensure that Infection Control Policy is correctly implemented. -Ensure that facility Infection Control committee meets and that problems are identified and correctly addressed. -Infection Control Training needs of all staff must be identified and addressed. -Infection Control Audit must be done monthly by the Facility Manager or delegated staff member in charge of Infection Control. -Feedback re: audit must be given to all staff, followed by corrective action, training and evaluation. Use feedback checklist and keep records.
Housekeeping	-Ensure that policies relevant to housekeeping are adhered to e.g. Infection Control Policy and Health and Safety Policy. -Complete checklist on a monthly basis, discuss problems, implement corrective action and document.
Resuscitation	-Resuscitation equipment must be checked daily by the Clinic Manager or delegated person and record kept. -Ensure training of all staff and 2 yearly updates in CPR as required.
Non-Compliant Areas	-Non-compliant areas identified must be corrected and documentation kept of correction action.
Questionnaire	-Facility Managers to be completed on a monthly basis and discussed with immediate line manager.

Source: City of Cape Town. 2012

APPENDIX 6: PATIENT QUESTIONNAIRE

Good day

My name is **Ms Nthabeleng Malise,** and I am a student (Master Degree in Development and Management) at the North-West University (Vaal Triangle Campus). The survey looks at "***The role of quality assurance programme in promoting patient satisfaction and safety in community health centres of Emfuleni Local Municipality*".**

This research aims to understand the level of quality assurance in CHC's and how it affects patient satisfaction as well as patient safety. It attempts to investigate how patients generally view the services they receive when attending these CHC's. The findings will be used for the improvement of the health care quality services for the Department of Health and citizens as well, for future administration. The findings of this survey will be used for academic purpose only. All information will be treated as STRICTLY CONFIDENTIAL and will only be used for academic purposes.

GENERAL INSTRUCTIONS

1. The randomly selected patients who have attended any of the four selected CHC's must complete this questionnaire.
2. Please answer the questions as objectively and honestly as possible.
3. Please answer all the questions, as this will provide sufficient information to the researcher so that an accurate analysis and interpretation of data can be made.

All the questions may be answered by making a cross (with a pen) in the relevant block.

SECTION A: DEMOGRAPHIC INFORMATION

Location: ____

A1.	Gender	Male	Female

A2.	Age group	≤21	21-25	26-35	35-39	60+

A3.	Do you have an Identity Document?	Yes	No

A4.	What is your race?	African	White	Asian	Coloured	Other

EDUCATION BACKGROUND

A5. What is the highest level of education you have completed?

Less than high school	High school	Diploma	Junior Degree	Other

A6. What is your current marital status?

Single	Married	Divorced	Widow	Never Married

RESIDENTIAL DATA

A7. Indicate the type of your residence.

House	Flat	Hostel	Low Cost Housing (RDP)	Informal Resident/ Shack
1	2	3	4	5

A8. How many people, including yourself, are there in your household?

1		2-3		4-5		6-7		8+	

A.9 How long did you live in your current home?

1-4		5-10		11-20		21-35		35 and more	

SECTION B: ACCESS TO HEALTH FACILITIES

B1. Is there a health facility in your area? Yes/ No

B2. Do you have health insurance? Yes/ No

B3. What type of health insurance coverage do you carry?

Indigent	Self-purchased	State provided	Private provided	Other
1	2	3	4	5

B4. Do the following facilities exist in your municipality?	Yes	No	Never used
Private Doctor			
Health centre/clinic			
Public Hospital			
Private Hospital			
Pharmacy (chemist)			

B5. Do you and your household members use the following Health facilities on a regular basis?	**Yes**	**No**	**If not, why is this so?** ***(1-Cost of service, 2-too far from home, 3-high cost of transport, 4-poor quality of service*** ***5- wait is too long, 6-Does not need, 7-Other)***
Private Doctor			
Health centre/clinic			
Public Hospital			
Private Hospital			
Pharmacy (chemist)			

B6	**Is the facility within your area of jurisdiction?**	**Yes**	**No**

B7	**How far do you travel to the facility?**	**<5km**	**<10km**	**<20km**

B8	**How often do you visit the clinic?**	**Very often**	**Sometimes**	**Seldom**

B9	**What times do you usually visit the clinic?**	**Before 12**	**After 12**	**Late afternoon**

B10	**How long do you normally wait in queue before being attended?**	**≤ 20 minutes**	**An hour**	**≥ an hour**

B11	What is the main reason you visit the centre?	Monthly check-up	Medication refill	Random visit

SECTION C: PATIENT-HEALTH PROFESSIONAL RELATIONS

C1.	How does the staff sound when they speak to you?	Irritated	Professional	Eager to help

C2.	Do the nurses/doctors speak a language you understand?	Yes	No	Sometimes

C3.	In terms of hygiene, how does the health care centres look?	Dirty	Very dirty	Clean

C4.	Do you receive medication at the centre or a written prescription?	Yes	No	Sometimes

SECTION D: COMMUNITY/PATIENT PERCEPTIONS

D1. Please tell us the biggest obstacle you face for access to health care.

____

D2. Are there any suggestions you have for improving the quality of health care services?
If yes, please briefly state below your suggestions on improvement of the CHC.

____

Thank you for the time you took to answer this questionnaire.

APPENDIX 7: INSTITUTIONAL QUESTIONNAIRE: CHC

QUESTIONNAIRE NR …………………INTERVIEW DATE………………………

STUDENT NAME: Ms. Nthabeleng Malise, North West University (Vaal Triangle Campus)

Please tick (x) your answer(s) below.

Question 1: STAKEHOLDER INVOLVEMENT

	Description	**Yes**	**No**	**Action Required**
1.1	Is there a clear process for involving Stakeholders?			
1.2	Is there a list of all key stakeholders?			
1.3	Are there clear terms of reference for all interested parties?			

Question 2: SITUATIONAL ANALYSIS

	Description	**Yes**	**No**	**Action Required**
Current structures and systems within the ministry of health relating to quality improvement				
2.1	Does the CHC have a quality assurance Section/ unit/ department/directorate?			
2.2	What is the composition of the quality assurance unit/department?			
Current policies in health and across sectors				
2.3	Does the CHC have quality assurance policies to guide the implementation of the programme?			
2.4	Are the quality assurance policies linked to the provincial and national health policies?			

Current health goals and priorities				
2.5	*Are there programme priorities for addressing patient satisfaction and safety?*			

Current performance of the health system

2.6 Is the health care in your CHC effective, efficient, accessible, acceptable, equitable, and safe? Use the following table to respond the abovementioned question:

	Description	**Yes**	**No**	**Action Required**
2.6.1	Effective			
2.6.2	Efficient			
2.6.3	Accessible			
2.6.4	Acceptable			
2.6.5	Equitable			
2.6.6	Safe			

Question 3: CONFIRMATION OF HEALTH GOALS

	Description	**Yes**	**No**	**Action Required**
3.1	Are there strategies are in place to improve patient satisfaction and safety?			
3.2	Do systems that are used to enhance the improvement of patient satisfaction and safety in the CHC exist?			
3.3	Are there any new interventions to realise the quality assurance goals?			

Question 4: DEVELOPMENT OF QUALITY GOALS

The choice of quality goals is driven by the agreed health goals, and relates to the different dimensions of quality. Based on the health goal what are the deficiencies in effectiveness, efficiency, accessibility, acceptability, equity, safety? Use the following table to respond the abovementioned question:

	Description	**Yes**	**No**	**Action Required**
4.6.1	Are there deficiencies in effectiveness?			
4.6.2	Are there deficiencies in efficiency?			
4.6.3	Are there deficiencies in accessibility?			
4.6.4	Are there deficiencies in acceptability?			
4.6.5	Are there deficiencies in equity?			
4.6.6	Are there deficiencies in safety?			

Question 5: CHOOSING INTERVENTIONS FOR QUALITY

	Description	**Yes**	**No**	**Action Required**
5.1 Leadership				
5.1.1	Are leadership development programmes provided throughout the health system to strengthen individual leadership skills and to enhance overall leadership capacity?			
5.1.2	Are leaders in quality supported by an appropriate infrastructure and resources to facilitate their leadership activities?			
5.1.3	Do leaders throughout the health system ensure that information about the quality of service provision and about quality outcomes is widely shared with stakeholders?			
5.2 *Information*				
5.2.1	Do existing information systems allow			

	quality and performance to be monitored on a continuing basis across the health system?			
5.2.2	Do existing information systems have the capacity to respond to future demands in quality improvement?			
5.2.3	Do the users of health services have sufficient information to enable them to make informed choices about how they use these services?			
5.2.4	Are patient and population satisfaction surveys used across the health system to assess community and user perceptions of the quality of services being provided?			
5.2.5	Does the national policy agenda on quality relate to marginalized groups and the poor?			
5.3 Patient and population engagement				
5.3.1	Are service users and communities properly involved in the governance of all parts of the health system?			
5.4 Regulation and standards				
5.4.1	Are existing systems of regulation and standard setting kept under review, and is their impact on quality outcomes assessed?			
5.4.2	When new standards and regulations are developed and introduced, do they reflect the goals and priorities of the health system?			
5.5 Organizational capacity				
5.5.1	Within health-service-provider organizations, is local leadership and			

	accountability for quality outcomes always clear?			
5.5.2	Do health-service-provider organizations systematically promote a culture within which quality improvement is central to the purposes of the organization?			
5.5.3	Do health-service-provider organizations regularly review those key systems which contribute to quality goals, including systems for managing risk and safety, systems for obtaining user views, and systems for training and education?			
5.5.4	Do health-service-provider organizations systematically develop the capacity of their staff to analyze quality data, identify problems and manage change?			
5.5.5	Do communities have the capacity and resources to identify and articulate their health needs and preferences?			
5.6 Models of care				
5.6.1	Is the reorganization of the delivery of health care perceived as a tool for quality improvement?			
5.6.2	Are there mechanisms in place which allow new models of care to be developed with the full involvement of health-service providers, service users and communities?			
5.6.3	Is the implementation of new models of care always appropriately provided with resources?			

Question 6: IMPLEMENTATION PROCESS

6.1 What resources are available to support implementation?

…………………………………………………………………………………………………..

6.2 What technical expertise will be available to support implementation?

………………………………………………………………………………………………….

6.3 Does the CHC have the accountability framework for implementing a quality assurance programmes?

……………………………………………………………………………………………………

6.4 What is the timetable for implementing a quality assurance programme?

……………………………………………………………………………………………………

6.5 How does the decision-makers communicate with stakeholders?

…………………………………………………………………………………………………..

Question 7: MONITORING PROGRESS

7.1 What strategies are in place to monitor the quality assurance programme?

…………………………………………………………………………………………………….

7.2 What is the framework for quality assurance programme?

……………………………………………………………………………………………………..

Question 8

8.1 Which factors hinder the **implementation of** quality assurance programmes?

....

8.2 How did the CHC overcome such factors which hinder the implementation of assurance programmes?

....

Thank you for your cooperation