EXPERIENCES OF NURSES REGARDING THE IMPLEMENTATION OF AN IDEAL CLINIC PROJECT IN ETHEKWINI DISTRICT, KWAZULU-NATAL

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Declaration

This is to certify that the work is entirely my own and not of any other person, unless explicitly acknowledged (including citation of published and unpublished sources). The work has not previously been submitted in any form to the Durban University of Technology or to any other institution for assessment or for any other purpose.

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Approved for final submission

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Abstract

Introduction and background: The key outcome of the vision of the government of South Africa is the attainment of a long and healthy life for all of its citizens. In view of this, the government of South Africa has embarked on a phased implementation of the National Health Insurance (NHI) scheme in order to achieve universal health coverage so that there is access to appropriate, affordable efficient quality health care services for all.

The South African National Department of Health introduced the ideal clinic realisation and maintenance programme in response to the current shortages of primary health care (PHC) services and to lay a strong foundation for the implementation of NHI. The programme includes an algorithmic approach to change all the PHC clinics to adhere to the NHI standards. An ideal clinic is defined as a clinic with good infrastructure, adequate staff, adequate medicine and supplies, good administrative processes, and sufficient adequate bulk supplies. Nevertheless, reports indicated that the target of achieving the 50% mark in selected vital areas such as staffing, resource allocation and utilisation, by 2019, has not been achieved.

Aim and objectives of the study: The aim of the study was to explore and describe the experiences of nurses regarding the implementation of an ideal clinic project in eThekwini district, KwaZulu-Natal. The objectives of the study were to: explore and describe the experiences of nurses regarding the implementation of an ideal clinic project; determine the perception of nurses regarding the implementation of an ideal clinic project, describe the support, if any, received by the nurses during the implementation of the ideal clinic project; determine the challenges if any experienced by nurses during the implementation of an ideal clinic, and to determine the strategies that can be instituted to facilitate successful implementation of an ideal clinic project.

Method: A qualitative research design which using an explorative and descriptive approaches was employed with Donabedian's structure, process and outcome model used as a theoretical framework to guide the study. Data were collected

through one-on-one semi-structured interviews with the nurses who were involved in the implementation of ideal clinic projects in the 18 PHC clinics under Prince Mshiyeni Memorial Hospital between the 16th September 2020 and the 26th October 2020.

Findings: The six major themes that emerged from the interviews included structural limitations, processes involved in the running of the clinic, support offered to the PHC clinics, communications and staff involvements, staff training and administration of an ideal clinic project all of which interfered with successful implementation of this project.

Conclusion: The findings of the study confirmed that the nurses who are the drivers of this ideal clinic project have many negative experiences and perceptions which make it difficult to fulfil the ideal clinic project standards. It was evident from the study that there was little support offered to them when it came to ideal clinic implementation. However, the study also revealed that there are a number of actions that could be instituted in order to bring the ideal clinic status to fruition such as improvement of infrastructure, training of staff and addition of more staff and instituting staff involvement in the ideal clinic project as a whole.

Recommendations: Recommendations are made in relation to policy formulation and implementation, service delivery, nursing education and research. The recommendations made from this study were based on the strategies that can be instituted to improve the ideal clinic implementation. The recommendations were made with special reference to the employment of more trained staff, improvement of infrastructure of the facilities, staff involvement in the implementation of any programmes and adequate support of staff members regarding the implementation of the ideal clinic project.

Dedication

I dedicate this dissertation to my late parents Angel and Fikile Zulu, and to my three sisters Zamakhosi Agnes Mthembu, Mhlopekazi Zulu and Thiza Zulu – they are all my pillar of strength.

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Glossary of Terms

- A **clinic** (or outpatient clinic or ambulatory care clinic) is a healthcare facility that is primarily focused on the care of outpatients. Clinics can be privately operated or publicly managed and funded (Tsasis et al. 2013).

- A m**obile clinic** is a customised vehicle that travels to the heart of the community, both urban and rural and provide prevention and healthcare where people work and live (Hill et al. 2014: 261).

- A **Professional nurse** is a person who is qualified and competent to independently practice comprehensive nursing in the manner and to the level prescribed and who is capable of assuming responsibility and accountability for such practice (South Africa, Department of Health *2004*).

- An **'ideal clinic'** is a clinic with good infrastructure, adequate staff, adequate medicine and supplies, good administrative processes and adequate bulk supplies that use applicable policies, protocols, guidelines as well as partner and stakeholder support, to ensure the provision of quality health services to the community (South Africa, DoH 2016 a: 19).

- A **fixed clinic** is a clinic that is designated to operate in the same spot over a long period of time (Segen's Medical Dictionary 2012).

- A **satellite clinic** is afacility owned by a hospital but operated at a distant site (Miller-Keane Encyclopedia 2003).

- A **health post** is an integrated approach that provides health services including basic health care and preventive medication through primary health posts in remote rural areas (Yang 1985).

- **Primary Health Care** is a whole of society approach to health and wellbeing centred on the needs and preferences of individuals, families and communities. Its addresses the determinants of health and focuses on the

comprehensive and interrelated aspects of physical, mental and social health and wellbeing (World Health Organisation 2019).

- A **primary health care clinic** is a clinic that is accessible as a first level health service included as part of the package of basic essential health services (South Africa, DoH n.d.).

- The **National Health Insurance (NHI)** system is a health financing system that is designed to pool funds to provide access to quality affordable personal health services for all South Africans based on their health needs, irrespective of their socio-economic status (South Africa, DoH 2020).

- **Gatekeeper permission** refers to access into an institution/organisation. This access can either be physical or informational. All institutions/organisations have the right to be aware of and be given the right to grant or decline permission to a researcher to conduct research in their domains (UKZN 2014).

List of Acronyms

Acronym	Full term
APC	Adult Primary health Care
CINALH	Cumulative Index to Nursing and Allied Health Literature
CPG	Clinical Practice Guidelines
CHW	Community Health Worker
DoH	Department of Health
DUT	Durban University of Technology
EN	Enrolled Nurse
ENA	Enrolled Nursing Assistance
HIV	Human Immunodeficiency Syndrome
ICP	Ideal Clinic Project
ICRM	Ideal Clinic Realisation and Maintenance
ICSM	Integrated Clinical Services Management
IREC	Institutional Research Ethics Committee
KZN	KwaZulu-Natal
MTSF	Medium Term Strategic Framework
NGO	Non-Government Organisation
NHI	National Health Insurance
OHSC	Office of Health Standard Compliance
OM	Operational Manager
PC 101	Primary Care 101
PHC	Primary Health Care
PN	Professional Nurse
SAGE	South African Guidelines Excellence
SANC	South African Nursing Council
TB	Tuberculosis
USA	United States of America
WHO	World Health Organization

Chapter Outline

Chapter no	Title	Contents
Chapter 1	Overview of the study	Introduction and background, purpose and objectives, problem statement and significance of the study
Chapter 2	Literature review	The views, assumptions and investigations made by various authors and researchers on chronic illness and post-basic learning
Chapter 3	Research methodology	Describes and justifies the research design, method the theoretical framework and its application to the study used for this study
Chapter 4	Presentation of the findings	The findings of the study are presented, highlighting the themes and subthemes that emerged from the interviews
Chapter 5	Discussion of the results	Presents the discussion of the study findings. The literature used in the previous chapters, and new relevant literature, are integrated to contextualise the meaning of the themes and subthemes
Chapter 6	Summary of findings, conclusions, limitations and recommendations of the study	Discusses the summary of findings, conclusions, limitations and recommendations of this study

CHAPTER 1: OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND BACKGROUND

The key outcome of the vision of the South African government is the attainment of the long and healthy life for all its citizens (South Africa, Department of Health [DoH] 2014: 11]). In view of this, the government of South Africa has embarked on a phased implementation of National Health Insurance (NHI) in order to achieve universal health coverage so as to provide access to appropriate, affordable efficient quality health services for all (South Africa, DoH 2014: 10). Hunter et al. (2017: 111) are of the view that the Ideal Clinic Realisation and Maintenance (ICRM) programme was formed in response to the current shortages of primary health care (PHC) services and to lay a strong foundation for the implementation of NHI.

The 'ideal clinic project' (ICP) is an initiative that was established in July 2013 as a way of systematically improving and correcting shortages in the PHC facilities in the public sector (South Africa, DoH 2016b: 10). An ideal clinic is defined as a clinic with good infrastructure, adequate staff, adequate medicine and supplies, good administrative processes, and sufficient adequate bulk supplies (South Africa, DoH 2014: 19). The South African DoH (2014: 19) emphasises that an ideal clinic uses applicable clinical policies, protocols and guidelines, and it harnesses partner and stake holder support and also collaborates with other government departments, the private sector and non-government organisations to address the social determinants of health. The South African DoH (2016b: 10) states that the Integrated Clinical Services Management (ICSM) model is a key within the ideal clinic. The ICSM model is a health system strengthening model which builds on the strengths of the HIV programme to deliver integrated care to patients with chronic and/or acute disease or who come for preventive services, by taking a patient-centric view that encompasses the value of continuum of care and support (South Africa, DoH 2016b: 10).

The ICP was developed to address gaps in primary health care clinics and establish an algorithmic approach to change all the PHC facilities to adhere to the NHI standards

(South Africa, DoH 2016b: 19). Operation Phakisa was launched in 2014 to develop a plan to hasten the scale-up of the ideal clinic movement across South Africa. Operation Phakisa proposed that the package of a service should transform to ensure a comprehensive set of services which should be guided by the principle of dealing with the whole life cycle from pregnancy to death (South Africa, DoH 2016b: 10).

In order to achieve the status of an ideal clinic a number of components and sub-components need to be adhered to; ICSM aims to achieve compliance with Domain 2 of the national core standards which is patient safety, clinical governance and clinical care (South Africa, DoH 2016b: 10).

The South African DoH (2014: 21) proposes the following components and subcomponents for an ideal clinic:

- *Administration,* which deals with legible signage and notices, proper staff dress code and identity, client service organisation and lastly management of client records.
- *ICSM,* which focuses on clinical service provision, management of client appointments, coordination of PHC services, clinical guidelines and protocols, infection prevention and control, clinic waiting times and patient experience of care.
- *Medicines, supplies and laboratory services,* which focuses on the availability of medicines and supplies and management of laboratory services.
- *Human Resources for health,* which deals with staff allocation and use, professional standards and availability of medical, mental health and allied health practitioners.
- *Support services,* which involves finance, hygiene and cleanliness, security and disaster preparedness.
- *Infrastructure,* which focuses on physical space and routine maintenance, essential equipment and furniture and bulk supplies.
- *Communications*, which entails of internal communication and community engagement.

- *District systems support,* which deal with physical space and routine maintenance, planned and emergency patient transport and referral system and
- *Implementing partners and stakeholders,* which deal with multi-sectoral collaboration.

1.2 RESEARCH PROBLEM

The ICP initiative was established as a way of improving the status of PHC clinics, quality of services and staff establishment in PHC clinics (South Africa, DoH 2016b: 10). This initiative was first introduced in 2013, thus it is close to ten years since the initiative was first introduced. The South African target was to achieve the 50% of clinics mark in selected vital areas such as staffing, resource allocation and utilisation, to name a few, by 2019. According to Hunter et al. (2017: 116) only 24% (121 out of 600) of PHC clinics in South Africa have been declared as ideal clinics, with a number of PHC clinics still scoring low on these vital areas by 2017. Furthermore, many patients continue to bypass the PHC clinics to attend hospitals for their initial contact visits due to overcrowded PHC clinics, long waiting times, lack of sufficient medication, inadequately trained personnel, bad staff attitudes and poorly structured and inaccessible PHC clinics (South Africa, DoH 2014: 19). This results in waste of time and resources because of hospitals needing to attend to less ill patients who might have been seen and treated at local clinics instead of dedicating hospitals to patients who need them the most. These findings are evidence that there are some problems in the implementation and the maintenance of the ICP in eThekwini district, KwaZulu-Natal (KZN). Therefore, there is a case for critical examining the experiences of nurses in the implementation of the ICP in eThekwini district, KZN.

1.3 RESEARCH QUESTION

The study aimed to answer one research question which was: What are the experiences of nurses in the implementation of the ICP in eThekwini district, KwaZulu-Natal?

1.4 RESEARCH AIM

The aim of the study was to explore and describe the experiences of nurses regarding the implementation of an ICP.

1.5 RESEARCH OBJECTIVES

The objectives of the study were to:

- Explore and describe the experiences of nurses regarding the implementation of an ideal clinic project.
- Determine the perception of nurses regarding the implementation of an ideal clinic project.
- Describe the support if any, received by the nurses during the implementation of the ideal clinic project.
- Determine the challenges, if any, experienced by nurses during the implementation of an ideal clinic.
- Determine the strategies that can be instituted to facilitate successful implementation of an ideal clinic project.

1.6 SIGNIFICANCE OR RATIONALE FOR THE STUDY

The researcher hoped to identify through this study, the successes made, challenges experienced, and the factors that influenced implementation of the ICP. These findings can be useful in policy formulation and/or amendments and could play a pivotal role in the creation of new protocols aimed at improving quality of health care.

Furthermore, the findings from this study are available to assist the clinics that are struggling in the implementation of this project by highlighting the successes of the ICP of some of the clinics and to give the less successful clinics the answers to their shortfalls. The findings of this study may also facilitate and sustain the implementation of the ICP in clinics thus improving the quality of health care in the country. The findings of this study have a potential benefit both to the health care personnel in the

clinics by facilitating improvement of the working environment, and the community by improving the quality of health care services.

1.7 CHAPTER SUMMARY

Chapter 1 presented the background and orientation regarding the ICP. The problem statement, significance, aims and objectives of the study were presented with the aim of highlighting the need for the current study. The next chapter focuses on a literature review.

CHAPTER 2: LITERATURE REVIEW

2.1 INTRODUCTION

Chapter 2 lays out the present literature from a global, national and South African context regarding health care service delivery with a particular focus on strategies to improve quality of care.

2.2 STRATEGIES USED TO SEARCH LITERATURE

The strategies used to gather relevant literature started with establishing and maintaining a good working relationship with the Durban University's post-graduation librarian, who was of great help in showing the researcher ways of gathering literature. The different search engines that were used in gathering data included EbscoHost, Google Scholar, Summon, Durban University of Technology (DUT) Open Scholar, CINALH and Google Chrome. The search terms used included health care delivery, quality health care, ideal clinic, clinical practice and clinical outcomes.

2.3 GLOBAL STRATEGIES TO IMPROVE CLINICAL PRACTICE AND OUTCOMES

The term 'ideal clinic' is not universal but is used in a South African context. However, several strategies are adopted globally to improve clinical practice and outcomes, which are similar to what an ICP is intended for in South Africa. Hurh, Ko and Lee (2017: 826) stated that all around the world the health care systems share common goals for improving clinical care outcomes, reduction in costs and expanding access to care in a patient-centred manner. However, there are challenges in this which are ever increasing costs, and wide variations in patients' clinical outcomes. According to Benny (2015: 123), there is a big paradigm shift in global health care systems as they transit for "health carer provider-centric" to "patient-centric" and from a fractured to an integrated health care system. Benny (2015: 123) describes a "patient-centric approach" as a care approach where a patient is motivated, informed and involved in

his/her healthcare and actively participates in choosing from services offered and interventions available. He further describes the “provider-centric” approach as being a situation in which the patient is a passive consumer/consumer of interventions offered to him or her. In the past, health care providers have been rewarded in terms of the volume of services they have provided rather than the value of those services provided, this being the main reason for the skyrocketing of health care expenditure (Hurh, Ko and Lee 2017: 826). There is growing evidence that health is a result of social, political and economic environments (Bhatia and Rifkin 2013: 459). The conceptual framework of Thomas Kuhn traces the emergence of PHC as a new paradigm based on social determinants to address poor health among populations (Bhatia and Rikin 2013: 459).

Harfield et al. (2018) found in their study that populations of indigenous origins have poorer health outcomes compared to their non-indigenous counterparts. Indigenous PHC services evolution arose from the indigenous people often being excluded from mainstream health care services (Harfield et al. 2018: 1). The success of indigenous PHC services is that there are comprehensive programmes that incorporate treatment and management, prevention and health promotion, as well as addressing the social determinants of health (Harfield et al. 2018: 1).

Thomson, Rivas and Giovannoni (2015: 1) stated that there has been a drive to improve patient experience through service redesign and good information provision. The authors further explained that active engagement by front line staff is necessary to improve the quality of interaction between staff and patients. Baum et al. (2017: 1) explained that since the WHO Alma-Ata Declaration there has been an ongoing debate about whether to adopt a comprehensive or selective PHC approach. The differences between comprehensive and selective PHC is that comprehensive PHC uses multidisciplinary health services and emphasises disease prevention and health promotion. A selective PHC approach, on the other hand, marginalises preventive actions and emphasises responses to specific diseases (Baum et al. 2017). This is the approach that was used as a temporary measure in developing countries which could not afford a comprehensive approach. With the comprehensive PHC approach being more widely used, community health centres came into play. The characteristics of

community health centres are multidisciplinary health teamwork, a social understanding of health, community participation in management, advocacy for policy changes to address the social determinant of health at higher government levels, and rehabilitation, treatment, prevention and promotion services (Baum et al. 2017: 2). These centres, however, have faced opposition from mainstream medicine and have struggled to maintain their comprehensiveness.

In 1978 the WHO had a vision that PHC would be comprehensive, which would benefit the low-income nations, help democratic participation in health, and improve the social and environmental context that creates disease and risk of disease (Baum et al. 2017: 1). In high-income countries such as the USA, Australia and Canada, there are community health centres that serve as examples of comprehensive PHC approach (Baum et al. 2017: 2). Mosquera et al. (2013: 1) stated that initially in the Columbian health care service, there was high segmentation, which was causing problems. Subsequently by the year 2004, a PHC strategy through home health programmes was implemented by the Bogota District Government which then gave birth to transformation of health care delivery network of the first level public health care facilities (Mosquera et al. 2013: 1).

Pina et al. (2015: 670) stated that in the USA there needs to be a standardised method to describe measure, compare and evaluate the delivery of system changes. The Institute of Medicine ranks the comparative effectiveness of delivery of care as a top priority: however, there is no standard way to describe the care delivery unity or systems that encompasses their breadth, ranging from independent individual provider units to large health care systems (Pina et al. 2015: 670). A novel set of routines and ways of working that are directed at improving health outcomes, administrative effectiveness, cost effectiveness and users' experience define the very essence of innovation in service delivery (Shahid et al. 2018: 2). Transformations in health care are aimed at improving quality and efficiency by empowering and supporting the primary care sector to better link with the rest of the health care system all across Europe, North America, Australia and New Zealand (Nicholson, Jackson and Marley 2013: 1). Moreover, the integration of care between sectors and continuity of chronic care for facility and families in close proximity to where they live and work

is beneficial to the community (Nicholson, Jackson and Marley 2013: 1). The integration of care that improves patient care delivery and experience through improved coordination between primary and secondary care has shown change in the United Kingdom (Nicholson, Jackson and Marley 2013: 1). In Australia the National health and Hospitals reform commission report has recommended significant governance transformation as a crucial element to increase the efficiency of health care delivery (Nicholson, Jackson and Marley 2013: 1).

Smith et al. (20176: 3) are of the view that many government health policies are attributed to organisational characteristics that facilitate or hinder implementation including the priorities which are held essential by leadership. However, the power behind the facilitation of changes, culture or values or climate also play a role in the success of failure of implementation (Smith et al. 2017: 3). Organisational culture has been linked to different organisational practices affecting work processes in various ways including provider effectiveness, patient care quality and improved patient health (Smith et al. 2017: 3). Programme implementation, employee creativity and effective management of preventive care of chronic conditions in health care settings have been linked to organisational innovation (Smith et al. 2017: 3). A lot of contemporary health and social care delivery models have incorporated the concept of integration, a transformational strategy that is a means of improving efficiency, quality of care and patient experience (Tsasis et al. 2013: 10). With all this in mind, care is aimed at ceasing fragmentation and allow care to be patient-centred by bringing together multiple professionals, services and organisation (Tsasis et al. 2013: 10). Since the development of integrated care is multifaceted in nature, the learning process for those involved needs knowledge to be able to diffuse across professional and organisational boundaries through interaction and dialogue. However, many integration efforts usually focus on the redesign of organisational structures and process, not on health and social care integration (Tsasis et al. 2013: 10). In complex systems not everything that takes place will occur in the way it was designed, and therefor emphasis must be put on the cultivation of the capacity to learn rather than the capacity to predict the culture.

2.4 AFRICAN STRATEGIES TO IMPROVE CLINICAL PRACTICE AND OUTCOMES IN AFRICAN COUNTRIES

Willcox et al. (2015: 1) confirm that in South Africa, there is a dire shortage of health care personnel as measured by there being only 2.28 health workers per 1000 population as explained by the WHO. Willcox et al. (2015: 2) also highlight the fact that child and maternal mortality can be reduced effectively by primary health care. In 2006 57 countries met the WHO definition of 80% deliveries with skilled attendants, 36 of which were in sub-Saharan African countries and the statistics pertains to all the health care system not only primary health care.

Yakob and Ncama (2017: 2) reported that health care in Ethiopia is such that clients' satisfaction with the health services is a function of the health system, and is achieved by rendering quality care and service provision. In an environment where resources are constrained, where a lot of people are deprived of access to private health care, the need to use clients' perceptions to identify system weakness is essential (Yakob and Ncama 2017: 2). The interaction between the clients and service care providers, which relates to client satisfaction, needs to be explored to understand their role in provision of care. Health care service provision involves many interlinked processes, ensuring people's wellbeing, protecting them from the very high costs of illness, and providing them with care (Yakob and Ncama 2017: 2). The environment in which all these take place affects clients' perceptions as well as influences the people's centredness of health care service provision (Yakob and Ncama 2017: 2).

Awoonor-Williams and Appiah-Denkira (2017: 90) stated that in the last century there were huge improvements in the knowledge of prevention and management of the many conditions that cause suffering and mortality all over the world. Efforts to perpetuate the strengths of primary health care in low and middle-income countries has contributed to the reduction of deaths caused by infectious diseases such as HIV, malaria and TB and causes of maternal and child deaths (Awoonor-Williams and Appiah-Denkira 2017: 91). A strong primary care delivery system, which serves as an effective and efficient implementation of intervention, is required (Awoor-Williams and Appiah-Dentira 2017: 91). Rwanda has made the integration of disease-specific

services into primary care settings as a strategy to harness specific gains for more generalised improvement in health care delivery. With all this having been achieved, little attention has been paid directly to strengthen primary health care delivery service for adults and adolescents.

Malawi is a low-income sub-Saharan African country with a population of approximately 15 million people with the majority (80%) the people living in the rural areas and depending on rain fed agriculture for their livelihood. Many low-income countries such as Malawi have taken the initiative on health care systems transformation with the objective of achieving universal health coverage (Abiiro, Mbera and De Allegri 2014: 1). There are three main dimensions of universal health coverage in this approach: population coverage, financial protection and access to services, which are interlinked and interdependent (Abiiro, Mbera and De Allegri 2014: 1). Universal coverage includes a number of sub-dimensions which are: availability of health care services, availability of personnel and facilities, health services accessibility with regard to user friendly location, and transportation convenience (Abiiro, Mbera and De Allegri 2014: 1).

The links between primary care and broader issues of social protection such as sanitation, nutrition and food security are often overlooked (Vasa et al. 2013: 2). The decades since the Alma-Ata Declaration have seen dramatic shifts in the priorities, political law, and funding of global health. However, there have been only limited successes including improvement in child survival and immunisation coverage (Vasa et al. 2013: 2). In sub-Saharan Africa, the health-related Millennium Development Goals remain out of reach for many countries in the developing world. Although primary health care as a whole has been advanced, Alma-Ata did not have a clear implementation plan and failed to bring about agreement on how it would be implemented; instead it focused on primary health care as a high concept encompassing inter-sectoral approaches with a distinct community and socio-political approaches (Vasa et al. 2013: 2).

Sherr et al. (2013: 2) describe Mozambique as a high disease burdened country despite the formal health service being provided through the National Health Service.

There has been an increase in health sector investment and policies in line with the improvement of public sector health networks, which have prioritised maternal, and child health indicators (Sherr et al. 2013: 1). The government of Mozambique has sought to decentralise the management of public sector resources to district level, including in the health sector, with the aim of bringing decision-making and resources closer to the beneficiaries (Sherr et al. 2013: 1).

Awoonor-Williams et al. (2016: 2) report that some countries, including Ghana, have taken initiatives to implement the national health insurance reforms as one of the strategies towards achieving universal coverage. Were et al. (2017: 1) state that in Kenya and other developing countries health insurance is gaining attention and is striving to achieve coverage. This approach seeks to address the limited access to health care to critical health services for specific populations including pregnant women and children. However, there has been limited evaluation of the impact of health insurance on maternal health (Were et al. 2017: 1). In Nigeria, a National Health Insurance scheme was passed into law in 1999 (Mohammed et al. 2013). The National Health Insurance scheme's aim is to provide health insurance which enables its insured users and their dependents to receive good quality health care. The National Health Insurance scheme has been divided into four programmes including: formal sector, informal sector, vulnerable sector and other (international health insurance, retirees, and the unemployed) (Mohammed et al. 2013). The National Health Insurance scheme is intended to provide financial protection, improved health care delivery and utilisation of equitable and affordable health service (Mohammed et al. 2013). In Ghana there is evidence that women who are enrolled in the National Health Insurance scheme are more likely to attend antenatal services than those who are not, despite their socio-economic or democratic factors (Dickson, Darteh and Kumi-Kyereme 2017: 2).

2.5 SOUTH AFRICAN STRATEGIES TO IMPROVE CLINICAL PRACTICE AND OUTCOMES

The DoH (2015a: 7) highlighted that the ICRM is built on a number of transformations that have been established to strengthen PHC since 1994. When the new constitution

of South Africa was adopted in the year 1996, every South African was guaranteed access to health care (South Africa, DoH 2015a: 7). In 2004, a new National Health Act took effect to provide a structured uniform health system. In 2011, the concept of National Health Insurance was established; this was done with the aim of achieving universal health coverage for all South Africans (South Africa, DoH 2015a: 7). The Office of Health Standard Compliance (OHSC) was established in 2014 as a statutory body to standardise compliance and was given the task of monitoring compliance with the norms and standards of health care delivery (South Africa, DoH 2015a: 7). There are 3507 PHC facilities across the country offering free PHC services to 54 million people. It has been identified that increasing numbers of South Africans are using the clinics: PHC visits increased from 67 million to 128 million in 2013 (South Africa, DoH 2015a: 9). The achievement of PHC in South Africa over the last 29 years includes improved immunisation coverage to almost 100%, and anti-retroviral (ARVs) support for more than 2.8 million patients (South Africa, DoH 2015a: 10). In the midst of all these visible achievements, PHC in South Africa has some challenges, which could hinder the essential role it plays in the country (South Africa, DoH 2015a: 10). The ICRM initiative hopes to transform PHC in line with broader national priorities as laid out in Chapter 10 of the national development plan 2030. The ICRM initiative aspires to ensure that each of the 3507 PHC facilities displays the elements of an ‘ideal clinic’ (South Africa, DoH 2015a: 10).

Kredo et al. (2017) stated that South African government developed the ICP and initiated it in 2013 in order to systematically consider and ensure adequate infrastructure, human resources, good governance and equipment for primary health care. The ICP is governed by clinical policies and protocols and aims to involve stakeholders across government departments, private sector and non-government organisations (NGOs) to address health issues (Kredo et al. 2017). In South Africa, there are currently no clinical practice guidelines (CPG) to provide guidance on standard approaches. In order to address this problem, the South African Guidelines Excellence (SAGE) project was established as a multi-partner research initiative to contribute to the understanding of standards of natural clinical practice guidelines (Kredo et al. 2017).

Egbujie et al. (2018: 311) stated that long waiting times are a huge contribution to the dissatisfaction of patients who attend health care facilities and this issue is a challenge for health care providers. Clinic visits are long in most public health care facilities across South Africa, sometimes leading to patients missing their scheduled appointment times and jumping around from clinic to clinic all in search of a clinic with shorter waiting times (Egbujie et al. 2018: 311). South Africa had a plan of revitalising the primary health care system by introducing the primary health care outreach team due to take effect in the year 2020 (Schneider et al. 2014: 311). The Community Health Workers (CHWs) are the drivers of the outreach team forming links between the community and the health care facilities, and further supported by professional nurses (Schneider et al. 2014: 2). These CHWs. with financial support from the government and NGO(s), have a strong focus on preventing TB/HIV, maternal-child health and chronic non-communicable diseases (Schneider et al. 2014: 2)

Fairall, Mohamed and Bateman (2017: 279) stated that there has been an adoption of Adult Primary Health Care (APC) by the National Department of Health to be used in PHC facilities in South Africa, which constitutes one of the aspects of an ideal clinic. APC is the new name that has been developed by the Knowledge Translation Unit at the University of Cape Town Lung Institute from the previously known name of Primary Care 101 (PC 101), following a decade of formative research (Fairall, Mohamed and Bateman 2017: 279). APC has been developed to be a set of comprehensive clinical management guidelines and training approaches for clinicians in South Africa (especially nurses), providing easy algorithmic and integrated management of multiple conditions (Fairall, Mohamed and Bateman 2017: 279). A great advantage regarding the implementation of APC is that it uses the already available staff and staff trainers and simply involves standardisation of clinical management and healthcare worker training. Furthermore, APC is designed around the needs of nurses and their scope of practice and is also compliant with all policies and official guidelines (Fairall, Mohamed and Bateman 2017: 279).

Naidoo (2012: 149) stated that after the 1994 democratic elections the process of creating a single, non-discriminatory health care system was hindered by the development of a two-tiered health care system, which is the public and a private

sector. The author further explained that the public sector serves 16% and 84% of the public sector most of which is the poor black population. The NHI policy states that the two-tiered streams system is unsuitable and very expensive; this is further compounded by the shortage of human resources especially the public sector (Naidoo 2012: 149). South Africa's under performance is attributed to poor quality of care and missed opportunities at health care facility levels as contributing factors. The NHI is regarded as a tool for transition towards high quality for all (Naidoo 2012: 149). The NHI has been developed to ensure that everyone has access to appropriate, efficient and quality health services (Naidoo 2012: 149). The WHO has described NHI as a form of universal coverage which has been globally accepted as a model of delivery of health care services to the population (Robinson 2015: 531).The South African DoH describes the NHI as a health financing system that is designed to pool funds to provide access to quality, affordable personal health services for all South Africans based on their health needs, irrespective of their socioeconomic status and is intended to ensure that the use of health services does not result in financial hardships for individuals and their families (South Africa DoH 2020). Studies conducted in South Africa among general practitioners have found a mixed response in terms of supporting the NHI implementation as some support it due to personal benefits and others do not support it as they view it as being detrimental. A study conducted in at Johannesburg metropolitan district D2 among PHC nurses found that nurses were optimistic and positive about NHI coming into effect (Matsi 2015: 12).

2.6 CHAPTER SUMMARY

Chapter 2 presented the literature review. International and local perspectives regarding strategies to improve clinical practice were explored including successes and challenges experienced in such ventures. The researcher compared and contrasted South African perspectives with international and national perspectives which afforded the researcher a better understanding of this phenomenon including the implementation of the ICP as a strategy to improve quality of care. The next chapter will present the research design and methods that were employed to conduct the study.

CHAPTER 3: RESEARCH METHODOLOGY

3.1 INTRODUCTION

Chapter 3 describes the research method and design used in the study to explore the experiences of nurses regarding the implementation of the ICP in the eThekwini district in KZN. The chapter focuses on the research design, setting, study population, sampling process, data collection, data analysis, ethical considerations and the theoretical framework used to guide the study.

3.2 RESEARCH DESIGN

An exploratory descriptive qualitative design was employed. A research design is the overall plan for addressing a research question, including specifications for enhancing the study's integrity (Polit and Beck 2017: 99).

In the current study the qualitative design assisted the researcher to explore the experiences of nurses regarding the implementation of the ICP in eThekwini district in KZN. The researcher chose to use qualitative methodology based on the description by Hancock, Ockleford and Windridge (2007) that the aim of qualitative studies is to assist understanding of social concepts and exploration of matters for example views, perceptions, opinions, attitudes and experiences.

Given that the ICP is a fairly new project, limited studies have been conducted on this subject regarding the experiences of nurses. Therefore, it was fitting to use an exploratory design. According to Polit and Beck (2017), explorative study designs involve the identification of key issues and variables of a phenomenon.

A descriptive design may be used to identify problems with current practice, justify current practice, make judgements or determine what others are doing (Grove, Burns and Gray 2013: 215). Sandelowski (2000) further clarifies that descriptive design is the description of the experiences or events, and states that researchers use the

descriptive approach to investigate the “who, what and where” of events or experiences and how these aspects are related to the research topic. In the current study, the researcher provides descriptive information regarding the experiences of nurses regarding the implementation of the ICP. The description includes the experiences, perceptions and challenges faced by nurses, support given to nurses, and strategies which nurses can use to influence the successful implementation of an ideal clinic.

3.3 THEORETICAL FRAMEWORK GUIDING THE STUDY

A theoretical framework is a frame of reference that is a basis for observations, definitions of concepts, research designs, interpretations and generalisations (LoBiondo-Wood and Haber 2014: 141). A framework is the overall underpinning of the study. The Donabedian model was used to guide this study.

The Donabedian model is a conceptual model that provides a framework for examining health services and evaluating quality of health care (McDonald et al. 2007). Avedis Donabedian, a physician and a health care services researcher at the University of Michigan, developed the original model in 1966. The model describes the information about the quality of care in three categories: “structure”, “process” and “outcomes” (Donabedian 2003).

Structure

Structure includes all the factors that affect the context in which care is delivered. This includes the physical facility, equipment, and human resources, as well as organisational characteristics such as staff training and payment methods. All these factors control how providers and patients in a healthcare system act and are measures of quality of care within a facility or system (Donabedian 2003).

Process

Processes commonly include diagnosis, treatment, preventive care, and patient education but may be expanded to include actions taken by the families of the patient. Processes may also be technical processes and interpersonal processes which is how care is delivered and which care is delivered respectively. According to Donobedian, the measurement of process is nearly equivalent to the measurement of quality care (Donabedian 2003).

Outcome

Outcome contains all the effects of healthcare on patients or populations, including changes to health status, behaviour, or knowledge as well as patient satisfaction and health-related quality of life. Outcomes are usually seen as the most important indicators of quality because improving patient health status is the primary goal of healthcare. The Donabedian model was developed to assess quality of care in clinical practice (Donabedian 2003).

3.3.1 How the model was used to guide the study

The national DoH proposed a number of components and sub-components that need to be fulfilled in order to achieve an 'ideal clinic' status which includes structures and processes in the clinics which are intended for specific outcomes which is quality of health care services (South Africa, DoH 2016b: 10). In this study the researcher focused on the experiences of nurses related to the structure which included the factors that affected the context in which the nurses were required to implement the ICP, and various technical and interpersonal processes undertaken during this process. All this informed the quality of care provided to patients as the intended outcome of the ICP. Through this exploration, the researcher was able to gain a deeper understanding of the perception of nurses regarding the implementation of an ICP, the support received and the challenges they faced during the implementation of this project. This led to determination of the strategies that can be instituted to facilitate successful implementation of an ICP, a number of which are presented as

recommendations arising from the current study. The model also guided presentation and interpretation of findings, structuring the recommendations from the study in a manner that can facilitate implementation thereof.

3.4 RESEARCH PARADIGM

A paradigm is a world view, a way of looking at natural phenomena, that encompasses a set of philosophical assumptions and that guides one's approach to inquiry (Polit and Beck 2017: 13-15). The naturalist paradigm, sometimes referred to as constructivist paradigm, is mostly allied to qualitative research and assumes that reality is not a fixed entity but rather a construction of the individual participating in the research, and that many constructions are possible. The researcher's position was aligned with this paradigm, believing that the reality regarding implementation of an ICP can be constructed through the information provided by nurses who are involved with this implementation. The researcher embraced this paradigm based on three philosophical assumptions, namely, ontology, epistemology and methodology (Creswell 2014: 19-22 and Botma et al. 2010: 14).

Ontology is characterised by previous exposure of nurses which is meant to have prepared them for assuming this new role of implementing an ICP. The researcher believe that the experiences of the nurses have a strong influence on the implementation of an ICP. Thus, the researcher intended to explore their experiences. Notwithstanding the challenges that influence implementation of this project an analysis and description of which also forms part of the study.

The *epistemological premise* in the current study was that both the nurse managers and the other categories of nurses were the best sources of knowledge and information about the phenomenon.

The *methodological premise* was that the nature of reality is inherently meaningful and that the participants had the ability to provide details regarding their own experiences in this regard and that the study method and processes adopted were ideal (Creswell 2014: 24-25).

3.5 STUDY SETTING

The study was conducted in the PHC clinics under Prince Mshiyeni Memorial Hospital (PMMH) in the eThekwini Health district in KZN. The South African DoH describes the eThekwini Health District as a Metropolitan Health District made up of 103 wards which are urban, rural and peri-rural. It forms one of the 11 districts in KZN province. Its boundaries are uMkomaas in the south, Tongaat in the north and Cator Ridge in the west. The eThekwini Health district is divided into 3 sub-districts namely the south, west and north. The eThekwini Health district is about 2,297 km2 in size and has a population of 3.44 million according to the South African census that was last done in 2011 and 3,090,126 of the population that resides in this district are Zulu people (South Africa DoH 2015b: 8).

PMMH is one of 18 government owned hospitals in eThekwini district. The hospital was officially opened on 20 March 1987. It is a 1,200 bedded facility that serves the surrounding area, up to and including part of the Eastern Cape. It is a designated level 2 Specialist Hospital in the Durban Functional Region, with most of its Clinical Specialist sections functioning in conjunction with the Medical School of the University of Natal. The actual population it serves is difficult to estimate because of the ever-mushrooming informal settlements, but statistics estimate the population to be approximately 2 million. The hospital has 1,200 beds and attends to an average of 1,500 patients per day in the outpatient clinics. Much emphasis is being put on primary health care which is being rendered by the satellite clinics. PMMH's vision is to provide optimal health care to all patients in the catchment area; this is supported by the hospital mission and core values. The hospital offers health services to the community at regional and district levels.

PMMH has 18 PHC clinics attached to it which are referred to as satellite or feeder clinics. These are the clinics that are located in eThekwini district and whose operation is controlled by PMMH. For the purpose of this study all the PHC clinics will be referred to as satellite clinics. All the satellite clinics are involved in the implementation of the ICP and from time to time, usually at six months interval, they are assessed for compliance to the specification of the project regarding the progress and sustainability

of the ideal clinic programme. This process is referred to as 'Ideal Clinic Realisation and Maintenance' (ICRM). The ICRM is one of the PHC re-engineering interventions. The concept makes provision for continuous and robust quality improvement principles aligned with the National Core Standards. This is one of the Presidential priorities that provides a systematic quality improvement approach to fast-track improvements on efficiencies and quality at PHC clinics. There are health posts and mobile clinics attached to the PMMH as well, but the focus of this study was the 18 fixed PHC clinics.

3.6 STUDY POPULATION

According to Grove, Burns and Gray (2013: 44), population is all the elements (individuals, objects, or substances) that meet a certain criterion for inclusion in a given universe. The intended target population of this study was all the nurses who were working in the PMMH satellite PHC clinics. All categories of nurses, namely, operational managers (OMs), professional nurses (PNs), enrolled nurses (ENs), and enrolled nursing assistants (ENAs), were included.

The staff establishment in the PHC clinics differed according to the size and services offered in each PHC clinic. The number of staff for each category also differed from clinic to clinic according to the size of the PHC clinic, catchment population and the package of health care services provided. However, all clinics had one operational manager. The estimated population for nurses in the 18 PHC clinics at the time of the study was 377 nurses.

3.7 SAMPLE AND SAMPLING TECHNIQUE

Sampling is the process of selecting cases to represent an entire population, to permit inferences about the population (Polit and Beck 2017: 250). The aim was to include all the PHC clinics, referred to as census sampling (De Vos et al. 2005: 2017). Sampling for nurses was purposive in that only nurses who met the inclusion criteria were included. Polit and Beck (2017: 739) describe purposive sampling as a non-probability sampling method in which the researcher selects participants based on individual judgement. Although data saturation was monitored concurrently for all

nurses irrespective of categories, sampling ensures that different categories of nurses were represented in the sample (OM, PN, EN and ENA). This ensured that in-depth and wide range of information was gathered as different categories have varying scope of practice and therefore would have experience the implementation differently.

Inclusion criteria

- All fixed PHC clinics under PMMH.
- Nurses who have been working in the clinic for three months or more.

Exclusion criteria

- Mobile clinics and health posts
- Non-nursing employees working in the selected fixed PHC clinics.
- All nurses who have been working in the selected fixed PHC clinics for less than three months.

3.7.1 Sample size

Sampling in a qualitative study is flexible and continues until no new themes emerge from the data collection process, a process referred to as data saturation (Maree 2012: 79). All 18 fixed PHC clinics were included in line with the census sampling approach.

Sampling in a qualitative study is flexible and continues until no new themes emerge from the data collection process, a process referred to as data saturation (Maree 2012: 79). The total number of nurses included was guided by data saturation. Data saturation for nurses was monitored together for all categories of nurses and was confirmed when no new information was evident from the interviews. Six additional nurses were interviewed to confirm data saturation. The researcher ensured that he moved from one fixed PHC clinic to the next sampling one nurse at a time till all 18 fixed PHC clinics had been covered and continued rotating to all fixed PHC clinics in this fashion till data saturation was reached. Therefore, in line with this data saturation

procedure, together with the census sampling for PHC clinics, a minimum sample size of 18 nurses was targeted for the entire study.

3.8 ORIENTATION OF THE PROSPECTIVE PARTICIPANTS ABOUT THE STUDY

Once the researcher had received ethical approval from the DUT Institutional Research Ethics Committee (IREC) and permission to collect data from the relevant gatekeepers (KZN provincial research unit at eThekwini District office, Manager for PHC services South Sub-District and Operational Managers for the 18 PHC clinics), the researcher organised through the Manager for PHC Services a slot to brief the operational managers about the study at their sub-district management meeting. Thereafter, a meeting was scheduled telephonically through the operational managers to meet with all the nurses in each of the 18 PHC clinics to conduct an information-giving sessions and recruit them to participate in the study. During the information-giving session, the researcher attempted to establish rapport and to develop a trusting relationship with the prospective participants, introduced the study, and addressed all questions and concerns by the prospective participants. All prospective participants were given information letters in case they wished to read more about the study (Appendix 8). They were also given consent forms (Appendix 8) to sign as soon as they had decided to take part in the study either that same day or later. The consent form included an additional one-page attachment (Appendix 9) to provide contact details (telephone number), the preferred time to be phoned and the information that was to assist the researcher to ensure that the participant met the inclusion criteria such as the type of clinic where the person was working, the staff category and the duration (period) that the person had worked in that fixed PHC clinic. A sealable envelope was also issued to all prospective participants in which to put all the completed documents before depositing them in a sealed box that was left at a strategic point in the clinics for the participants who decided to return the consent forms later. These boxes were made available for two weeks in each fixed PHC clinic or up until data saturation was reached and confirmed.

An interview date, place and time was scheduled with each participant based on availability but ensuring minimal or no disruption to the normal functioning of the PHC

clinic. All interviews took place in the PHC clinics. The researcher arranged a private room in each PHC clinic to ensure that there was privacy and no disruption during the interview.

3.9 DATA COLLECTION

According to Grove, Burns and Gray (2013: 523), data collection is the process of selecting subjects and gathering data from these subjects. The actual steps in collecting the data are specific to each study and depend on the research design and measurement methods. The current study used one-on-one semi-structured interviews to collect data from the participants.

3.9.1 Data collection instrument

The interviews were guided and semi-structured using an interview guide (Appendix 10) to ensured uniformity of interviews for all participants. A similar interview guide which was developed by the researcher was used for all the categories of nurses. The guide consisted of five main questions each of which was aligned to particular research objectives (Table 3.1). Furthermore, probing questions which were not predetermined but were dependent on the need for clarity or more information required based on responses by the participants to the research question were asked. The probing questions were based on the three broad elements of the model guiding the study which were structure, process and outcome. Some of the probing questions included but were not limited to the following:

1. Structure: material resources
   Would you say you have been supported with adequate resources to facilitate the implementation of ICP?
2. Process: activities performed in the PHC
   In your opinion which processes have you struggled to implement in your endeavour to implement ICP?
3. Outcome: Achieving the ideal clinic status
   How would you rate the performance of your PHC, would you say you have achieved ideal clinic status?

Table 3.1: Alignment of the interview questions to the study objectives

RESEARCH OBJECTIVE	INTERVIEW QUESTION
Explore and describe the experiences of nurses regarding the implementation of an ideal clinic project in eThekwini district, KZN.	What has been your experience regarding the implementation of the ICP in your clinic?
Determine the perception of nurses regarding the implementation of an ideal clinic project.	What is your perception regarding the implementation of an ICP?
Describe the support, if any, received by the nurses during the implementation of the ideal clinic project.	What support, if any, have you been receiving during the implementation of the ICP?
Determine the challenges, if any, experienced by nurses during the implementation of an ideal clinic.	What challenges, if any, have you experienced during the implementation of an ICP?
Determine the strategies that can be instituted to facilitate successful implementation of an ideal clinic project.	In your opinion what strategies could influence successful implementation of an ICP?

3.9.2 Data collection process

Data was collected using one-on-one, face-to-face interviews with the nurses working in the fixed PHC clinics. Data collection only commenced after full ethics approval had been granted by the DUT IREC (Appendix 1) and permission granted to conduct the study by relevant gatekeepers (Appendices 2 to 7).

The interviews were conducted by the researcher in English and each interview session lasted for 30 to 45 minutes. The researcher alternated data collection events between PHC clinics in order to ensure that all 18 PHC clinics were included. When it was the turn for a particular fixed PHC clinic, the researcher visited the clinic, opened the box to pick up one envelope with a signed consent form and established if the participant met the inclusion criteria using the form attached to the consent form. If the participant and the situation at the clinic allowed, the interview session was conducted the same day, otherwise the researcher returned for the interview as agreed upon with the participant. Random selection of signed consent forms allowed for different categories of nursing staff to be included allowing for in-depth and wide ranging information to be gathered, as different categories of nurses have different scopes of

practice and therefore different experiences of implementation of the ICP. All interviews took place in the PHC clinics.

The researcher arranged a private room in each PHC clinic to ensure that there was privacy and no disruption during the interview. The researcher who is a registered nurse and therefore well conversant with the use of personal protective equipment ensured that the room was big enough to allow distancing according to the COVID-19 prevention precautions were adhered to with regards to the seating arrangement, ventilation, use of sanitiser and the wearing of protective devices such as face masks during each interview session.

One interview was conducted per clinic per day to allow concurrent data analysis so as to keep track of data saturation before gathering more data and also to ensure that all 18 PHC clinics were included. All interviews were voice recorded with consent from the participants. Field notes were also be taken in order to substantiate the recorded information and to capture non-verbal cues.

3.10 DATA HANDLING AND STORAGE

Data was collected and has been stored in a manner that ensures that participants' confidentiality and anonymity is maintained throughout the research and the dissertation writing process and also during the entire storage period which is to extend up to five years post completion of the study. No participants' personal details or any information that could directly link the participants was recorded on the interview sheets, field notes or audio recordings. A code assigned to the participant was recorded on the interview sheet and the field notes and was pronounced by the researcher to get it audio recorded onto the audiotape at the onset of each interview session. The researcher refrained from calling the participant by name while the interview was being audio recorded. Because the consent forms contained personal information of the participants these were placed in a sealed envelope immediately after verification and are stored in a locked cupboard. The collected data was kept in a safe, secure area for the research duration and will be stored in this locked cupboard for five years should they be required for audit trail. All electronic data has been

secured by a secret code that is only known to the researcher. Immediately after all voice recorded data was transcribed and confirmed, it was removed from the audio recorder into a disc and completely wiped off from the audio recorder. The disc is stored securely with all other hard copies of research material in a locked cupboard for the entire duration of the study and five years thereafter. The hard copies will be destroyed by shredding, the disc burnt and the soft copies will be wiped off after five years.

3.11 DATA ANALYSIS

Data analysis was done concurrently with data collection in order to monitor data saturation. According to Polit and Beck (2017: 517), analysis of the content of narrative data is done to identify prominent themes and patterns among the themes in qualitative studies. The researcher ensured that all interviews were analysed immediately, the same day or within a day or two and before moving to the next PHC clinic to conduct more interviews. This was done to monitor data saturation and to ensure a better comprehension of the information gathered while the interview session was still fresh in the mind.

The first step during data analysis was to listen to the voice recorded information, read the field notes and compare these two data sources several times until both were fully understood. This assisted the researcher to get a clearer understanding of the information. The audio-recorded information was transcribed into a written format and again compared and read against the field notes for clarity. The transcribed interviews were captured onto a master file through Microsoft Word and thereafter Tesch's (1992: 141) open coding approach was used to analyse the information, which involved the following eight steps:

1. Reading through all the transcripts to get a general impression of the collected data.
2. Writing in the margin thoughts that emerge from the data.
3. Organising all topics by clustering similar topics together and organising them as major topics unique topics and leftover topics.
4. Coding data: assigning codes to the corresponding segments of the data.

5. Rewording of the topics into most descriptive wording for the topics so as to have organised sub-categories.
6. Grouping together of the related topics and emerging list of categories was done.
7. Preliminary analysis of data was accomplished by assembling data that belong to each category from which themes emerges.
8. Existing themes and subthemes were identified and grouped together.

3.12 RESEARCH RIGOUR

Research rigour refers to openness, relevance, and thoroughness in data collection, data analysis processes and the researcher's self-understanding (Grove, Burns and Gray 2013: 126). It is measured by how well the researcher has attended to the fundamental characteristics of the method (Streubert and Carpenter 2011: 317). Assurance of trustworthiness was the main consideration regarding research rigour for the study. Trustworthiness is defined as the ability to be trusted and reliable (Oxford Dictionary n.d). In the research context, trustworthiness is the extent to which a research study is worth paying attention to / worth taking note of, and the extent to which others are convinced that the findings are to be trusted (Babbie and Mouton 2001: 276). Credibility, dependability, confirmability, transferability and authenticity are the five essential criteria for establishing the trustworthiness in a qualitative inquiry (Lincoln and Guba 1985; Guba and Lincoln 1994). All five criteria were used to ensure the trustworthiness and validity of data in the study as detailed below.

Credibility refers to the confidence in the truth of the data and interpretation thereof (Lincoln and Guba 1985). Throughout consultation with the participants, the researcher presented himself in a professional and dignified manner to all the participants to develop a sense of trust with the participants. Credibility was also ensured during data analysis by double-checking through repeated reading of transcripts and comparing the audio-recorded information with the field notes to ensure accuracy of data. During the interviews the interviewer now and again paraphrased the information shared by the participant. At the end of each interview session, member checking was done in order to confirm with the participant that the

information was captured correctly. Furthermore, the research supervisor checked on the accuracy of the information by comparing the transcription with the original data.

Dependability refers to stability of data over time and over conditions (Lincoln and Guba 1985). The researcher used one interview guide for all participants throughout data collection in order to ensure that the same main questions were asked of all the participants interviewed on different dates and at different sites and for all categories of staff. Probing was also standardised as much as possible. This assisted the researcher to ensure that the measure was stable when used on different participants. Donabedian's structure process and outcome model that was used as a framework for the study assisted in this regard. The interviews were recorded and in addition the researcher captured field notes and personal and reflexive notes to promote an audit trail. This makes it possible for other researchers to be able to trace the methods used to provide a thick description of the data collected.

Confirmability is the potential for congruence between two or more independent people about the accuracy of data and its relevance and meaning (Lincoln and Guba 1985: 156). As previously detailed in the section on dependability, the researcher strived to develop and maintain an audit trail to ensure confirmability of data by reporting and describing the entire research process and ensuring that data is securely stored for availability should s arise. Verbatim reporting of data was done to show objectivity and neutrality of the data.

Transferability refers to generalisability of data, i.e., the extent to which the findings can be transferred to have applicability in other settings or groups. Although there are reservations about transferability of findings of qualitative studies, the researcher ensured that other researchers could build on the findings of the proposed study when performing further research by providing a thick description of the research setting and research processes. This process also ensured authenticity of the study.

Authenticity means the extent to which a qualitative researcher fairly and faithfully shows a range of different realities in the collection, analysis, and interpretation of data (Polit and Beck 2017: 720). The researcher ensured authenticity by adhering to

principles of research throughout the study, using direct narratives from the study participants for presentation of data, and being truthful when analysing and interpreting data.

3.13 ETHICAL CONSIDERATIONS

Ethics is the theory or discipline dealing with principles of moral values and moral conduct. This definition is consistent with the nurses' role as a patient advocate, whether functioning as a researcher, caregiver, or research consumer (LoBiondo-Wood and Haber 2014: 255).

3.13.1 Non-maleficence

The researcher waited for DUT IREC to clear the research proposal and issue full approval before commencing with the study. Full ethics approval (IREC 085/20) was received on 11th September 2020 (Appendix 1). The researcher also waited for approval by the Provincial Department of Health Research Committee, eThekwini District Manager and the PMMH Hospital Manager before commencing data collection (Appendices 3, 5 and 7).

3.13.2 Justice

An information-giving session was held for all the prospective participants in order to answer any queries and to recruit them to take part in the study. The prospective participants were also given an information letter to read at their leisure to get more understanding about the study (Appendix 8). Contact details for the researcher and the supervisor were included in the information letters should the prospective participants require any further details or clarification about the study and their environment.

3.13.3 Beneficence

The participants were informed of their rights to autonomy in the study, meaning that they had the right to choose to withdraw from the study at any given time should they wish to do so. In order to maintain confidentiality of the participants the data collection tools were only identified by numbers and not the name and surname of the participants (Appendix 8). The participants were informed that the information given by them was to be used solely for the planned research purposes.

3.14 CHAPTER SUMMARY

This chapter focused on a detailed description of research design and methods that were employed for the study. The chapter also presented the researcher's worldview, a theoretical framework that guided the study, and how ethical consideration and research rigor were assured in the study. Findings from data analysis are presented in the next chapter.

CHAPTER 4: PRESENTATION OF THE FINDINGS

4.1 INTRODUCTION

Chapter 4 presents the findings obtained from the analysis of in-depth individual interviews conducted with nurses who were the key role players in selected PHC clinics at the time of the study. The intended purpose of any data analysis is to guide and give order to the vast amount information that has been collected so that conclusions can be drawn. Data collection in qualitative research is ongoing, emergent and interactive (Polit and Beck 2017: 383). Thus, in the current study data collection and analysis were employed concurrently and yielded the findings presented below, all of which aided in achievement of the study objectives which were to:

- Explore and describe the experiences of nurses regarding the implementation of an ideal clinic project in eThekwini district, KZN.
- Determine the perception of nurses regarding the implementation of an ideal clinic project.
- Describe the support if any, received by the nurses during the implementation of the ideal clinic project.
- Determine the challenges if any experienced by nurses during the implementation of an ideal clinic.
- Determine the strategies that can be instituted to facilitate successful implementation of an ideal clinic project.

4.2 SAMPLE REALISATION

4.2.1 Primary Health Care (PHC) clinics included in the study

All 18 fixed PHC clinics that were under PMMH in eThekwini Health district in KZN at the time of the study were included in the study as they met the inclusion criteria and this was also in line with the researcher use of census sampling of all PHC clinics in order to gain a complete picture regarding the implementation of the IPC in this setting. The PHC clinics were assigned codes from A to R which were used throughout the

study and reporting in order to maintain confidentiality and anonymity. Data saturation which was monitored concurrently for all 18 PHC clinics was reached after 15 interviews. Nevertheless, the researcher continued with the interviews till all 18 PHC clinics were included. Furthermore, considering that by the time data saturation was reached the researcher had only conducted one interview per PHC clinic, another round of interviews was conducted to ensure that no new information emerged as subsequent and different participants were interviewed from the PHC clinics. During this second round, the researcher was convinced and confirmed after the 6th interview that saturation of data was reached because up until this point no new information emerged and in total the researcher had already done nine interviews after having reached data saturation point. Therefore, in total 24 interview sessions were conducted in 18 PHC clinics where one interview was conducted per clinic in 12 clinics and two interviews per clinic were conducted in six clinics. Table 4.1 presents the number of PHC clinics that were included in the study.

Table 4.1: Total number of PHC clinics that were included in the study

PHC clinics		Interviews conducted		
Total in the study site	Number included in the study	Interviews before data saturation	Interviews after data saturation	Total interviews for the study
18	18	15	9	24

4.2.2 Number of participants included in the study

Data was collected using one-on-one semi-structured interviews with nurses as the key drivers of the ICP in PHC clinics. These nurses were identified during the preselection phase based on being exposed to ICP implementation and having been working in the selected PHC clinic for more than three months. (Appendix 9). Although there were varying categories such as operational manager, professional nurses, enrolled nurses and enrolled nursing assistants, sampling and data collection did not take into consideration the categories. A minimum of one interview was conducted per day and analysed before conducting further interviews either the very same day or within the next two days in order to monitor data saturation which was monitored concurrently for all PHC clinics that were included in the study and was evident after 15 interviews. As detailed in section 4.2.1, a further nine participants were interviewed

in order to ensure that all 18 PHC clinics were included and to monitor data saturation. In total, 24 interviews were conducted. The interviews were conducted over a period of four weeks (15 September to 25 October 2020). In total, 24 days were used for data collection. No specific sequence was followed in conducting interviews in the PHC clinic but this was guided by availability of staff for the interview session in each of the PHC clinics. Table 4.2 presents the date and number of interviews conducted for the entire study.

Table 4.2: Dates and number of interviews conducted

Date		Number of days Spent	PHC Clinics	Total Number of Clinics	Number of interviews
From	To				
15/09/2020	15/10/2020	18	A-R	18	18
19/10/2020	25/10/2020	6	A, D,G,J, M & P	6	6
Total	----	24	----	18	24

4.3 DEMOGRAPHIC DATA OF THE STUDY PARTICIPANTS

Data regarding demographic characteristics of the study participants were collected before each interview session. The findings of this data were quantified in order to facilitate interpretation and better understanding of it. The results gathered were as follows: All the participants who participated in the study were females. The majority of the participants (67% [n = 16]) were above 35 years of age and 33% (n = 8) were between the ages of 25 and 35 years. The majority of the participants (88% [n = 21]) participants were Black, 4% (n = 1) was Coloured and 8% (n = 2) were Indian. There were 17% (n = 4) of the participants who were Operational Managers, 50% (n = 12) of the participants were professional nurses, 25% (n = 6) were enrolled nurses and 8% (n = 2) were enrolled nursing assistants. All the participants (100% [n = 24]) had two years and above nursing experience and had been working for more than three months in the selected PHC clinic. The demographic characteristics of the study participants are presented in Table 4.3.

Table 4.3: Demographic characteristics of the study participants (n = 24)

Demographic characteristic	Total number of participants per category				Total
Gender	Male:0	Female: 100% (n = 24)			100% (n = 24)
Age	<25: 33% (n = 8)	25-35: 67% (n = 16)			100% (n= 24)
Ethnicity	Black:88% (n = 21)	Coloured:4% (n = 1)	Indian:8% (n = 2)	White: 0	100% (n = 24)
Category/Rank	Operational Manager:17% (n = 4)	Professional nurses:50% (n = 12)	Enrolled nurse:25% (n = 6)	Enrolled nursing assistant: 8% (n = 2)	100% (n=24)
Duration in this clinic	0-3 months: 0	> 3 months: 100 % (n = 24)			100% (n = 24)
Experience as a nurse	< 2years: 0	> 2 years: 100% (n = 24)			100% (n = 24)

4.4 THEMES AND SUBTHEMES

Two samples of interview transcriptions are attached as appendix 11a and 11b. In addition, a sample of data analysis report reflecting emergence of themes and sub-themes is attached as appendix 12.

4.4.1 Themes

Six themes emerged from interviews. These were:

1. Structural limitations
2. Processes involved in the running of the clinic
3. Support offered to the PHC clinics
4. Communications and staff involvements
5. Staff training
6. Administration of ideal clinic

4.4.2 Subthemes

Several subthemes emerged in line with each of the themes. The subthemes are presented in relation to each theme in Table 4.4.

Table 4.4Themes and subthemes

Themes	Subthemes
1. Structural Limitations	1.1 Staffing of the facility 1.2 Infrastructure 1.3 Equipment issues
2. Processes involved in the running of the clinic	2.1 Guidelines and policy issues 2.2 Too much paperwork 2.3 Discrepancies between registers and tally sheets 2.3 Service delivery issues
3. Support offered to PHC clinics	3.1 Support from each other and fellow clinics 3.2 Support from management and the District office
4. Communication and staff involvement	4.1 Clear communication on what is expected 4.2 Staff members as part of the ideal clinic project
5. Staff training	5.1 Staff training on ideal clinic 5.2 Staff training academically
6. Administration of ideal clinic implementation	6.1 Continuously changing ideal clinic tool 6.2 Assessment of the ideal clinic status

4.5 PRESENTATION OF FINDINGS

4.5.1 Theme 1: Structural limitations

The participants verbalised that the main hindrance in their endeavour to implement the ICP were structural concerns related to their facility buildings which were too old and on the brink of collapse, or were too small and did not allow them to deliver service according to ideal clinic standards. They went as far as mentioning the size of consulting rooms that they work under, that these consulting rooms were too small and therefor affected the privacy that was supposed to be given to patients during care. All these concerns had a bad influence on ICP implementation. Examples of their responses are:

> The biggest challenge with the ideal clinic implementation is that the infrastructure is congested and sometimes patients wait in the queue outside the facility for a long-time awaiting service delivery. (C: 3)

> The challenge we face is infrastructure, it is too small therefore not conducive for ideal clinic. Also, the attitude of staff towards ideal clinic creates a challenge. (G: 2)

4.5.1.1 Sub-theme 1.1: Staffing of the facility

Some of the participants stated that their clinics were not adequately staffed, thereby predisposing them to work overload and burn out. All this in turn exposes them to skip a lot of fundamental elements which comprise ICP implementation. This causes negative impacts on ICP implementation. This was evident in the following statements by some of the participants:

> The ideal clinic has been ideal for all the PHC clinics, however there has been a few glitches when it comes to availability of resources and staffing in order for the programme to run. (A: 2)

> My experience with the ideal clinic has not been good since we are short staffed, other nurses have to go as far as to pulling off files which is a duty that is intended for admin clerks. (C: 3)

> Since ideal clinic has been implemented it has put us under extreme conditions since we are short staffed and working with limited resources there by subjecting us to increased workload. (B: 2)

4.5.1.2 Sub-theme 1.2: Infrastructure

A lot of participants raised concerns that the infrastructure they work under is old, and therefore not meeting the ICP status so that the three streams that are set by the ICP not being met. Some of the infrastructure was too old and on the brink of collapse posing dangers to both staff and patients. Other factors that fall under this are lack of

even basic needs such as running water. All these factors further influence ICP implementation negatively. Their responses were as follows: -

> The ideal clinic project is a frustrating initiative as our infrastructure does not allow for the three streams to run accordingly. (C: 2)

> There are many challenges that we are facing, for example infrastructure is not conducive towards the implementation of the ideal clinic. (A: 4)

> The challenge is infrastructure, for example the consulting rooms are too small. (A: 3)

4.5.1.3 Sub-theme 1.3: Equipment issues

Some participants explained that there were a lot of issues with equipment that they used on a daily basis. The issues ranged from the actual availability of equipment, for example shortage of some of the equipment, meaning that they had to skip some aspects of nursing care. The repairs of equipment was also a problem as it took a lot of time when equipment went for repairs, and sometimes the equipment came back having not been repaired or serviced the reason being that the mother hospital did not know how to repair or service certain equipment. Their responses were as follows: -

> Since we are ideal clinic, we are facing challenges such as shortage of equipment in the facility which gives us huge problems because patients expect service delivery in time which cause a lot of frustration. (G: 2)

> There is lack of needed equipment for service delivery, therefore there is stagnation in ideal clinic implementation. (D: 2)

4.5.2 Theme 2: Processes involved in the running of the clinic

There are quite a few processes under the ICP that are required to be adhered to for the ideal clinic to become a reality. The participants responded that these processes are not always achievable nor in place in the clinics that they work for a number of reasons. They mentioned that either staff members are clueless of what is expected

of them, or staff numbers are short, or the equipment required for implementation of these processes are not available. Again, all these factors impacted negatively on ICP implementation. The participants stated the following in this regard:

> The pre-pulling of files before the patient comes to the clinic is not doable because the patients do not honour their set appointment dates and we end up with a pile of files of patients who did not come on their appointment dates. (E: 1)

> Sometimes the admin clerks do not fill in the demographic data accordingly, and completely on the files, and sometimes the junior staff do not do all the required vital signs which are required on the new files which all becomes a problem for the professional nurse who is consulting with the patient. (F: 1)

> As the name suggests, it is an ideal concept but too good to be true when it comes to practice, because the standards that has been set are too high e.g. the three streams are not achievable and lead nurses to become frustrated and stressed. (C: 4).

4.5.2.1 Sub-theme 2.1: Guidelines and policies issues

Some of the interviewed participants stated that the new guidelines intended to guide them in delivering care, that were promised to them by the district office, were sometimes not delivered in the clinics and they ended up downloading them at their expense. If these guidelines are not downloaded, they ended up using old and outdated ones which might be different than what is intended by current practice. This shortfall further negatively affects the ICP. Their responses were as follows:

> We do not have guidelines that we are supposed to have in the facility but we end up downloading them with our phones instead. (J: 2)

> The guidelines that we are using are old and outdated as the current ones that were promised to us were never delivered to us. (A: 2)

4.5.2.2 Sub-theme 2.2: Too much paperwork on patient files

Some participants mentioned paperwork as being too much to bear as they mentioned that with the ICP there are a lot of registers and a lot of information that needs to be added in patients' files that sometimes results in duplication of information. The main issue regarding files that was raised by the participants was the fact that sometimes files are found to be missing when it is time to pull them out for patient consultation, and that files have a lot of unnecessary information and duplication of information. All these mentioned factors slow down the successful implementation of the ICP. Their responses were as follows:

> The new registers and records require a lot of writing which becomes a repetition of information. There is also a segment in the new records which ask questions like1). If the patient has enough food at home 2). If the patient has a flushing toilet system at home, with these questions I really do not know what is intended because after the patient responds you if they have those things or not, you do not get to intervene afterwards. (H: 2)

> There is a lot of paperwork as opposed to nursing the patient, for an example there are now a lot of registers and duplication of information thus resulting in a long waiting time for the patient. (H: 2)

> I think the reduction of paperwork can really help improve reduction in waiting times, thus help in patient satisfaction and service delivery. (F: 2)

4.5.2.3 Sub-theme 2.3: Discrepancies between registers and tally sheets

The participants raised their concerns regarding the discrepancies between the registers and the tally sheets that they were using to record selected patient information, saying that some of the elements that are in the registers and tally sheets do not correspond and other elements do not appear on registers as compared to tally sheets and vice versa. These discrepancies resulted in a lot of confusion and distortion of information especially when it is time to summarise statistics for reporting. In addition, the confusion caused by these discrepancies result in slowing down of daily

operation as the staff struggle to ensure accurate completion of these documents. These concerns were evident in the following views by some of the participants:

> The challenge we have is with the tally sheet as they do not correspond with the tick registers that we use on a daily basis. (I: 2)

> Since the beginning of the year, we have been receiving different tally sheets almost every 3 months and they are not always in line with the elements that are stipulated in the tick registers that we use for stats, we then end up not reporting on some elements as they may not appear on the other document while they are there on the other. (H: 2)

4.5.2.4 Sub-theme 2.4: Service delivery

Service delivery, which is the pivotal issue in the ICP, was seen as be improved by the ICP. A number of the participants made this comment, saying that they could see that the ICP brought with it some sort of order. They mentioned that although there is a lot that still needs to be worked on, the desired service delivery seems to be achievable due to the one-stop-shop effect that comes with the ICP. The following points were expressed by the participants in this regard:

> My experience with ideal clinic implementation is that patients do not move from queue to queue when they come for more than one service. Each patient is able to receive complete service at one point which is very good and convenient for the client and it facilitates holistic approach and integration (B: 3)

> My experience with ideal clinic is that although this project has brought in much improvement to the quality of care, there is however still a lot to be done especially with regards to waiting times; patients tend to wait much longer than the actual stipulated waiting times as the staff are trying to adhere to the stipulated guidelines when consulting with and managing patients. This makes other patients and staff members very frustrated and impatient. (C: 3)

4.5.3 Theme 3: Support offered to PHC clinics

The participants commented a lot on the support that they get and the support that they should be getting in the ICP. Some participants mentioned that they do receive support from upper management and the district office, but others differed from this statement, stating that they either do not get enough support or no support at all. These mixed responses from different clinics mean the clinic experience is uneven and unequal in the ICP. The responses from the participants were as follows:

> I have not seen any adequate support being offered by the Department of Health, instead they come to look for loopholes and faults. (B: 2)

> Not much support has been offered leading to most issues that are beyond facility level to remain unachieved. (E: 1)

> When it comes to support from management and the mother hospital there is some support that we get, but there has been not much support from the district office. (E: 3)

4.5.3.1 Sub-theme 3.1: Support from each other and from fellow clinics

Some participants raised the concerns that the only support they get is from each other as staff members in the facility. In addition, the support sometimes comes from fellow neighbouring clinics. Thus, this is not good for the ICP because staff members can only do so much in support of ICP, so the ideal clinic status cannot be achieved. Their responses were as follows:

> The only support we receive is from other clinics but not district office. (F: 2)

> There is no support from the district office or mother hospital in such a way that we even sometimes use our own money to get what is needed. (H: 2)

> I have encountered support from the district office with regard to elements of an ideal clinic project. (A: 4).

4.5.3.2 Sub-theme 3.2: Support from upper management and the district office

The participants' responses on support received from management and the district were mixed; some acknowledged getting support while others mentioned that although they get support, they feel that the support is partial or not enough. These mixed responses further raise the challenge of the ICP not being implemented successfully in some PHC clinics. Their responses were as follows:

> The support from district office has been good since implementation of ideal clinic. (B: 3)

> Yes, we do get support from our district office. (K: 2)

> With regard to support we have not been receiving much support from district as some of the things that are implemented by district are not feasible and they do not come and support and tell us for example if you experiencing such and such problems this is how you can challenge them or face them. (F: 1).

4.5.4 Theme 4: Communication and staff involvement

Some of the participants stated that the communication between them and upper management is not clear regarding what is expected from them. They also mentioned that there was no staff involvement or introduction to them of the ICP from the start, so in turn they felt like the ICP was imposed to them. This impacts negatively on ICP implementation. Their responses were as follows:

> The ideal clinic project would have benefited far much if the implementers of the ideal clinic project involved nurses on the ground and got ideas and opinions from them before the implementation. (C: 2)

> I would have liked the implementers of the ideal clinic project to more democratic on their decision-making, involving staff opinion together with community to make conclusive decisions. (J: 2).

4.5.4.1 Sub-theme 4.1: Clear communication on what is expected

Other participants expressed views that there is no clear communication from upper management regarding what they are expected to do and they end up running around like headless chickens. These opinions do not place the ICP in a good light. Their views were as follows:

> Poor communication from Department of Health/District to us in PHC settings are a big challenge. High staff shortages which causes burnout and poor productivity. (A: 2)

> The biggest challenge is poor communication from upper management as of what is expected from us who are implementing the ideal clinic. (A: 3)

> Staff buy-in is not easy and has not been fully achieved yet as the ideal clinic implementation looks like it has a lot of work. Another challenge is that the ideal clinic was not properly introduced to the staff but it was rather imposed to them. Ideal clinic also needs well skilled staff to run the programme. (D: 1).

4.5.4.2 Sub-theme 4.2: Staff members as part of the ideal clinic project

Some participants in some of the PHC clinics stated that since the ICP is a team effort, they felt that it has brought them together to act as a team. Other participants in other PHC clinics felt that there was no staff involvement from the initiation of the ICP, so they do not feel involved in the ICP. Their views were as follows:

> My perception with ideal clinic is that it has brought every staff member together to work as a team, because every staff member has their own responsibilities. (I: 2)

> I think the ideal clinic initiative would have really benefited from member involvement from it very initial conceptualisation, because the way I see it a lot of staff members do not like ideal clinic due the fact that it was just imposed to them, rather than being introduced to them properly. (A: 2)

4.5.5 Theme 5: Staff training

Some participants stated that there is no staff training either on ICP or staff training to improve the rank that the staff member is at. Some participants felt that the lower ranks that they hold sometimes are a hindrance when they want to perform certain tasks due to the scope of practice that limits them. They also touched on the training of staff members on the ICP, as they were of the view that this could help in putting a team in place that can be the drivers of the ICP. This lack of trained personnel impacts the ICP negatively because it feels like the blind leading the blind. Their responses were as follows:

> I would have been good to have employees trained on ideal clinic project and those employees will form an ideal clinic committee as to give us support and direction at facility level. (D: 2).

> If we can have more trained staff to come and assist us on a day to day basis that could help as the ideal clinic implementation is a day to day thing. (C: 1).

4.5.5.1 Sub-theme 5.1: Staff training in regard to the ICP

Some participants expressed the view that there is no staff training on the ICP. Participants further attested that there is a need for staff training on ICP so as to improve ICP implementation. Trained staff can act as champions in ICP implementation and other staff members can soon follow. Their views were as follows:

> Training of personnel with required skills e.g. computer literacy can really help improve ideal clinic implementation improvement of infrastructure and addition of more consulting rooms. Ordering and maintenance of furniture for patients. (F: 2)

> The ideal clinic project could really benefit from the training of staff on quite a number of ideal clinics' elements and processes, just having someone in the facility who would be clued up from A up to Z can really help. (F: 1)

4.5.5.2 Sub-theme 5.2: Staff training academically

There were participants who felt that as they hold lower categories in the nursing status ladder, this further impacted the ICP implementation negatively as they can only do as much as their scope of practice allows them to do, which is not much in the lower categories they hold. Their views were as follows:

> The development of staff is very slow; you will find that us as junior staff have done with our part which is vital signs but now our hands are tied as we cannot help professional nurses since our scope of practice does not allow us to. (I: 3)

> Staff training in order to raise their categories can really help improve ideal clinic status in a sense that the nurses who holds higher ranks are able to do more work according to scope of practice. (F: 1)

4.5.6 Theme 6: Administration of the ideal clinic

There were administrative factors that were mentioned by participants which hinder ICP implementation. Their responses were as follows:

> The biggest challenge with the ideal clinic project is that there is nobody allocated to cater for processes of the ideal clinic, someone who will act like an ideal clinic project champion. (D: 2).

> There is no dedicated team or committee that will be held responsible for the administration of the ideal clinic project. (K: 2)

4.5.6.1 Sub-theme 6.1: Continuously changing ideal clinic assessment tool

Some participants expressed opinions regarding the ever-changing ICP assessment tool. They expressed concerns that whenever it is time for assessment the tool seems to have changed and there are new elements for them to be assessed on. This in turn causes set-backs as it makes it difficult to attain and maintain the ICP status. Their views were as follows:

> Since the implementation of an ideal clinic project I have experienced a lack of cooperation between different departments, both clinical and non-clinical, shifting of blame as of who is responsible to perform certain tasks e.g. maintenance issues. There is also a lot of frustration with the ever-changing assessment tool that is used to assess the ideal clinic standard, its changes on yearly basis making it difficult for us to achieve an ideal clinic status. (E: 1)

> The biggest challenge I have seen personally is that the tool that is used to assess the ideal clinic status is amended every time, every time there is a new element that we must be assessed on, this does not help us at all as we must keep on improving at short notices just to attain and maintain the ideal clinic status. (C: 2).

4.5.6.2 Sub-theme 6.2: Assessment of the ideal clinic

Other participants raised concerns about the assessors of the ideal clinic implementation. They mentioned the fact that sometimes the assessors of the ideal clinic are people who are not in the medical profession which makes it difficult in a lot of things like medical jargon etc. Their views were as follows.

> There has also been a discrepancy with the fact that we are sometimes assessed by non-clinical staff during the assessment of ideal clinic status, with this being said for an example I remember when we were being assessed for ideal clinic and this non-clinical assessor was clueless when I mentioned the GM machine as an HGT machine, not knowing that both these terms are interchangeable. Another not so good experience is lack of control over staff training which makes it difficult control which staff are adequately trained or not, furthermore leading to not getting other elements correct on the ideal clinic assessment tool. (E: 1)

> When I recall very well, there was a time when there was an ideal clinic assessment in our facility, what I remember about this time is that one of the assessors was not of a nursing profession and he kept being lost in the medical terminology we used, with this being said I think the ideal clinic could really benefit from having people of nursing profession in its ranks. (A: 2)

4.6 CHAPTER SUMMARY

Chapter 4 presented the findings and data analysis. Six themes and subthemes emerged from data analysis. The themes were subsequently grouped into categories based on the Donabedian model which was the theoretical model that guided this study. Discussion of the study findings is presented in the next chapter.

CHAPTER 5: DISCUSSION OF FINDINGS

5.1 INTRODUCTION

Chapter 6 presents a discussion of the findings in relation to the relevant literature. The discussion of findings focuses on the objectives of the study and the themes and the corresponding subthemes that emerged from data analysis.

5.2 DISCUSSION OF FINDINGS BASED ON THE SIX THEMES AND SUBTHEMES THAT EMERGED FROM THE STUDY

The six themes that emerged from the interviews were structural limitations, processes involved in the running of the clinic, support offered to the PHC facilities, communication and staff involvement, staff training and other factors. There were also several subthemes that emerged under these themes.

5.2.1 Structural limitations

The participants of the study responded by saying that the infrastructure poses a major problem in ICP implementation. Tshililo et al. (2019: 2) stated that since the integration of services in the PHC facilities there has been a great initiative in promoting holistic care. The government is trying to integrate all services at the PHC level but the infrastructure remains a problematic issue in this regard. The integration of services like ART and other programmes in the PHC facility is meant to offload from hospitals the burden they carry of the high number of patients they have, but the human resources and facility infrastructure to carry this out remains a challenge (Tshililo et al. 2019: 2).

Adequate infrastructure is needed for any existing health care system to provide service delivery timeously. There are many requirements in addition to a good infrastructure, including complementary technology, human resources, water supply, electricity, functional road networks etc. However, many of the accessory

requirements for a good infrastructure are absent in many developing countries. Proper maintenance of old infrastructure, and inability to provide sufficient funds in order to replace old structures are some of the factors that contribute to poor infrastructure (Oyekale 2017: 2).

5.2.2 Processes involved in the running of the clinic

The participants of the study mentioned that there were processes involved in the running of the clinic that were not currently in place or not fully functional which made it difficult to implement ICP successfully. During the interview sessions the participants mentioned processes like guidelines and policies which are supposed to be in place according to the ICP standards, but in many facilities they did not have these in place. This then made it difficult for them to keep up with the CP standards. Too much paperwork was also mentioned as a big issue, as well as information gathering being repetitive which wastes a lot of time during consultations. Another obstacle that they mentioned as being a problem was that of the discrepancies between registers and tally sheets; participants mentioned that these cause big distortions during the reporting of the elements that they need to report on. The biggest process that was running slow according to their experience regarding ICP implementation was the one of service delivery. They mentioned service delivery as being slow due to factors such as staff shortages.

According Anon (2018) health care workers expressed different views when it comes to paperwork with some seeing its importance e.g. nursing care plans which is crucial in-patient care. However, some administrative aspects that are expected from nurses on a daily basis mean that nurses have to stop actual patient care and focus on paperwork. Paperwork is not only time consuming; it also does little to improve patient care. Often basic administrative duties are taken over by highly skilled nurses, who are then taken away from their nursing duties (Macphee and Dahinten 2017: 7). In the long run this is one of the elements that pushes nurses away from the profession.

Innovations in modern technology such as tablets, smartphones etc. that nurses can use on the go to refer and report on patients can really help in reduction or paperwork.

The health system can also improve the issue of too much paperwork by having guidelines in place that will help identify non-essential documents. The removal of non-clinical nursing documentation from the nursing remit can also be of great assistance in dealing with the problem. Unifying of all patient documents into one patient document that can be functional for all health care providers is also another strategy in tackling the problem. Finally, the implementation of an electronic system to reduce paperwork can be of great help (Holroyd, Baron and Bade 2018: 11).

5.2.3 Support offered to the PHC facilities

Mixed responses were gathered from the interviews with regard to the support that participants perceive that they receive from management, tilting the scales unevenly among the participating clinic facilities. Some participants mentioned that they do get support but their main form of support is from fellow clinics rather than the district office or mother hospital. Other participants went as far as saying they get support from each other as colleagues, while others said that they do get support from upper management and district office but even when they do, this support is not enough.

Oyekale conducted an assessment study on primary health care facilities' service readiness in Nigeria posts the year 2015 and discovered that there was reemphasis on equity and efficiency in health care delivery which was achieved through technical and financial support to health care facilities. The support which was offered was directly related to realisation of several health-related targets in line with the sustainable development goals. The world's major policy players like the World Health Organizations (WHO) and World Bank had given support with regard to the resources to assist in some of these set goals (Oyekale 2017:13). Nevertheless, this author cautions that at times significant economic developments and the state of health care facilities in some countries is not aligned to global health development agendas (Oyekale 2017: 2).

5.2.4 Communication and staff involvement

The participants mentioned that there was no staff involvement in the ICP implementation, especially initially during the conceptualisation phase. The participants also raised the issue of communication, more specifically clear communication on what is expected of them. They mentioned that the lack of communication leads to confusion regarding what they are expected to do.

Kelly and MacDonald (2019: 432) stated that certain leadership styles have been shown to improve upward and downward communication in the workplace, thereby improving group collaborations and team context. Good communication between subordinates and supervisors has been shown to perpetuate desirable workplace outcomes. Furthermore, workplace communication impacts the psychological wellbeing of the employee (Kelly and MacDonald 2019: 432).

A relationship between a supervisor and subordinate that manifests good communication results in subordinates who are more content than those who do not share a relationship with their supervisor where communication is good. Positive outcomes are associated with good, clear supervisor-subordinate communication according to recent studies. Subordinates are usually more motivated in their work and show a positive intrinsic work disposition when there is subordinate-supervisor communication as this fosters psychological connection (Kelly and MacDonald 2019: 433).

5.2.5 Staff training

The participants expressed their views by saying that there was either no staff development, or that the staff development was too slow. This had negative impact on ICP implementation. Amde et al. (2019: 2) stated that the sub-Saharan Africa region faces huge capacity challenges regarding service provision and governance of their resources. African countries often face staff shortages which usually lead to poor performance of the healthcare workforce. Many human resource departments in developing countries have used training of staff as a means of improving health care

workers performance especially among frontline workers (Amde et al. 2019: 2). Disproportionate in-staff development is a big issue in the whole of systems level issues. With regard to on the job training, Amde et al. (2019: 2) advises on the importance of identification and selection of individuals to prepare for leading the process. According to Amde et al. (2019: 2), it is important to recognise those who have potential and therefore will be able to spearhead change so that focus of training is on them.

5.2.6 Administration in ideal clinic

Administration of the ICPs were not on a par with the set standards of the project as a whole. Participants mentioned that the ICP assessment tool was continuously changing which made it difficult for them to maintain a set standard. They also raised the fact that sometimes during the assessment of the ideal clinic status they were assessed by non-clinical staff resulting in poor communication because of their lack of familiarity with medical/nursing jargon.

Macarayan et al. (2019: 2) were of the view that any facility that is adequately managed will end up producing quality PHC performance. There is also substantial evidence regarding the correlation with good management and improved facility performance (Macarayan et al. 2019: 2). In most high-income countries, management in hospital settings are strongly linked with good clinical outcomes, while in low- and middle-income countries there is poor quality of service (Macarayan et al. 2019: 2).

Facilities which are better managed are also said to have higher essential drug availability (Macarayan et al. 2019: 2). These facilities with good management also have better performance which includes setting targets, and monitoring of those set targets (Macaraya et al. 2019: 12).

5.3 DISCUSSION OF FINDINGS BASED ON THE STUDY OBJECTIVES

The five objectives of the study were to explore and describe the experiences of nurses regarding the implementation of an ideal clinic project, determine the perception of

nurses regarding the implementation of an ideal clinic project, describe the support if any, received by the nurses during the implementation of the ideal clinic project., determine the challenges, if any, experienced by nurses during the implementation of an ideal clinic and to determine the strategies that can be instituted to facilitate successful implementation of an ideal clinic project.

5.3.1 Explore and describe the experiences of nurses regarding the implementation of the ideal clinic project in eThekwini district, KZN

Some of the participants expressed that they have experienced a huge workload since the implementation of the ICP because there are a lot of changes that need to be made while at the same time experiencing staff shortages. According to Fagerström, Kinnunen and Saarela (2018: 9), increased workload in the health care sector consists of nurses performing duties which can be directly or indirectly linked to patient care. These duties vary from institution to institution according to many factors such as physical layout of the facility or work processes. There are a lot of negative factors associated with workload such as errors in administration of medication, falls and deaths. Therefor it is essential to identify factors that increase workload. Dimunová, et al. (2020: 130) stated that nurses' workload is a global phenomenon and it impacts on both the health of nurses and that of the patients. The environment that nurses work in predisposes them to various mental, physical and behavioural risk factors and stress which is linked to the workload that they deal with from time to time. The stress that these nurses experience from increased workload further reduces the quality of their professional performance, resulting in stagnation in personal development and absence from the work environment.

5.3.2 Determine the perception of nurses regarding the implementation of the ideal clinic project

The majority of the participants mentioned that they perceived the ICP to be a good concept due to the integration of services, while others perceived it not to be a good concept because of the challenges they face on a daily basis that are beyond their control. According to Maharaj et al. (2018: 189) a PHC approach requires a

multidisciplinary approach which will integrate services offered by different teams. The integration of nursing services in the facility usually comes with a lot of transformations that need to occur in the facility.

There are barriers to the integration of services; these barriers include individual level barriers such as unfamiliarity with the roles of other team members. There are also organisational barriers in the integration of services such as sufficient leadership that encourages inter-professional collaboration, lack of appropriate facilities and equipment. Facility managers can assist new team members to understand their roles (Maharaj et al. 2018: 190).

According to Kalonji and Mohamed (2019: 5), infrastructure can present challenges regarding the integration of some programmes in some facilities, especially when TB is involved in that integration. Another challenge in integration of services is staff availability in the sense that staff will not willingly rotate due to preference or work experience.

5.3.3 Determine the support if any, received by the nurses during the implementation of the ideal clinic project

Some participants stated that they did get support on the implementation of the ICP, some stated that the support they received was not enough, while others stated that they received no support at all. According to Keller et al. (2017: 40), a supervisor should have an interactive relationship with their subordinates in order to foster a relationship that the subordinates can draw on in the course of their treatment of clients. Clients provide resources to the organisation in exchange for something of value such as service delivery. When there is meaningful training of employees, good communication, and exchange in information, the environment will be conducive for customer impact. For a manager to be deemed successful they need their subordinates to be successful as well at their designated departments. Assisting employees to set goals for achievement aids co-working relationships (Keller et al. 2017: 41).

5.3.4 Determine the challenges if any experienced by nurses during the implementation of the ideal clinic

There were numerous challenges faced by the participants on the implementation of the ICP, ranging from poor infrastructure to unavailability of equipment, staff shortages and poor filing systems. Macaraya et al. (2019: 2) state that the operation of a PHC facility or any facility will run smoothly when there are good administrative processes in place. Good facility management is associated with better clinical outcomes including mortality rate, shorter waiting times and reduced staff turnover.

5.3.5 Determine the strategies that can be instituted to facilitate successful implementation of an ideal clinic project

Some participants mentioned that they feel that the strategies that can aid successful implementation of an ideal clinic would be staff involvement on the implementation of the ideal clinic, improvement of infrastructure, employment of staff and the training of staff on the ICP and academically.

For the organisation to be a success, staff motivation and involvement should be at the forefront (Szelagowska-Rudzka 2019: 185). Staff involvement can be advantageous in the form of improved work efficiency and development of staff efficiency (Szelagowska-Rudzka 2019: 190). Involvement of health care workers in the decision-making process in healthcare institution is a good strategy to prevent the turnover of personnel because of the positive work environment resulting from healthcare worker involvement and empowerment (Ndikumana, Tubey and Kwonyike 2019: 2). Some of the disadvantages of staff none or poor involvement can include lack of knowledge on the part of the employee and short-sighted approach on the issues of the organisation (Szelagowska-Rudzka 2019: 190).

5.4 CHAPTER SUMMARY

The study findings presented in this chapter were supported by peer journal and articles reviews. The next chapter discusses the summary of findings, limitations and conclusion of the study.

CHAPTER 6: SUMMARY OF FINDINGS, LIMITATIONS, RECOMMENDATIONS AND CONCLUSIONS OF THE STUDY

6.1 INTRODUCTION

This chapter discusses the summary of findings, limitations, recommendations and conclusions of this study.

6.2 OVERVIEW OF THE STUDY

A qualitative research design using an exploratory descriptive approach was used to conduct the study. One-on-one semi-structured interviews were conducted with 24 nurses who are drivers of the ICP in 18 PHC clinics in eThekwini district, KZN. The aim of the study was to explore and describe the experiences of nurses regarding the implementation of ICPs in the eThekwini district, KZN. The study focused on answering the following five research questions:

- What has been your experience regarding the implementation of the ICP in eThekwini district, KZN?
- What is your perception regarding the implementation of an ICP?
- What support if any have you been receiving during the implementation of the ICP?
- What challenges if any have you experienced during the implementation of an ICP?
- In your opinion what strategies could influence successful implementation of an ICP?

6.2.1 How the research objectives, the theoretical framework and the themes and subthemes were aligned and used to better understand the study findings

The study was guided by the Donabedian model which is a conceptual model that provides a framework for assessing or critiquing health services and evaluating of quality of care thereof. According to this model, the categories “structure”, “process”, and “outcomes” all provide information about quality of care (McDonald et al. 2007).

In the current study it was evident that there is a strong relationship between the six themes and the several subthemes that emerged from the three categories of the Donabedian model and the research objectives that were laid out. The relationship between the study objectives, the themes and subthemes and the characteristics of the Donabedian model is discussed below and presented in Table 6;1

6.2.1.1 Structure

This category of the Donabedian model was seen as a major negative factor by the participants because of the lack of infrastructure or their infrastructure being too small to be able to handle the ICP status demands. In the current study the participants mentioned that they had knowledge and perceived the ICP implementation to be difficult to achieve due to the structural limitations that they had to work under on a daily basis. The structural limitations that they were exposed to, gave rise to problems with staffing, problems with the infrastructure itself, and equipment issues. All these factors that were raised on the interviews impacted negatively on the day-to-day implementation of the ICP.

6.2.1.2 Process

Participants communicated that there was a lack of process in that there was a lack of support in the implementation of the ICPs, and poor administration.

On the processes involved in the running of the ideal clinic, the participants expressed the negative impact of lack of availability of guidelines and policies for running the clinic. They also mentioned the volume of paperwork as being a problem, saying that they spend too much time on paperwork as opposed to actual nursing duties which they are there for to begin with. Furthermore, the discrepancies with tally sheets and tick registers was raised as a hindrance in their day-to-day ICP implementation saying that this usually led them to distortion of a lot of data. Nevertheless, participants mentioned that somehow the service delivery was improved especially with regards to quality of service and cooperation amongst staff members. They mentioned that there was teamwork and support from each other as they all strived to attain and maintain the ideal clinic status for their respective PHC clinics

Participants had a mixed reaction to the issue of support from management, with some participants saying that they received adequate support and others saying they received little or no support. These mixed responses revealed that the PHC facilities are not adequately supported, making the ICP implementation uneven across the clinics.

6.2.1.3 Outcome

The participants expressed views that the strategies that can positively influence ICP implementation was communication and staff involvement. They said that communication needed to be clear regarding what was expected from them and that the staff needed to be involved more in the ICP implementation. They felt that these strategies would improve ICP implementation or any other programme that that needed to be implemented in the future.

Table 6.1: Relationship between the study objectives, the themes and subthemes and the characteristics of the Donabedian model

Research Objectives	Themes	Subthemes	Categories of the Donabedian model
• Explore the perception of nurses regarding ideal clinic implementation. • Explore the knowledge nurses possess regarding ideal clinic implementation.	Structural limitations	• Staffing of the facility • Infrastructure • Equipment issues	Structure
• Determine the challenges nurses face during the implementation of an ideal clinic project.	Processes involved in the running of the facility	• Guidelines and policies • Too much paperwork • Discrepancies between registers and tally sheets • Service delivery issues	Process
• Explore the support if any received by nurses during the implementation of the ideal clinic	Support offered to the PHC clinics	• Support from each other and fellow clinics • Support from management and the District office	Process
To explore strategies that can influence successful implementation of an ideal clinic	Communication and staff involvement	• Clear communication on what is expected • Staff members as part of the ideal clinic project.	Outcome
To explore strategies that can influence successful implementation of an ideal clinic	Staff training	• Staff training on ideal clinic • Staff training academically	Structure
To determine the challenges nurses face during the implementation of an ideal clinic project.	Administration of the ideal clinic	• Continuously changing ideal clinic assessment tool • Assessment of the ideal clinic status	Process

6.3 SUMMARY OF FINDINGS

6.3.1 Experiences of nurses regarding the ideal clinic implementation in eThekwini district

Exploring and describing the experiences of nurses regarding the implementation of an ideal clinic project in eThekwini district, KZN was the main aim of the study. This also one of the objectives of the study that needed to be achieved in order to achieve the aim of the study. The participants shared various views with regard to their experiences in implementation of the ICP which were presented in the Chapter 4 as themes and subthemes. All six themes and their corresponding subthemes represent the experiences of nurses regarding the implementation of an ideal clinic project in eThekwini district, KZN. In summary the nurses who are the drivers of the ICP had varied experiences from clinic to clinic, with some experiencing burnout and stress due to the high demands of the ICP, while others experienced smooth and quick service delivery due to the ICP being systematic and orderly.

6.3.2 Perception of nurses regarding the ideal clinic implementation in eThekwini district, KZN

The perceptions of nurses regarding the ideal clinic implementation in eThekwini district, KZN, were good and bad, varying from clinic to clinic. Some participants expressed that they perceived the ICP as a stressful initiative since not all the components that needed to be in place were in place in order for the ICP to run successfully. Other participants perceived the ICP to be a good initiative since it guided them on how to carry out duties because of the protocols and principles that were in place.

6.3.3 Support if any received by the nurses during the ideal clinic implementation in eThekwini district

Some participants expressed that they received support during the implementation of the ideal clinic, while others responded saying that either the support was not adequate or it was non-existent.

6.3.4 Challenges experienced by nurses regarding ideal clinic implementation

The participants mentioned a lot of challenges that they face on a daily basis in their endeavour to ensure that their facilities are ideal. They mentioned challenges such as shortage of staff, shortage of equipment, and poor or small infrastructure, all of which inhibited their work ethic during ICP implementation. They also mentioned too much paperwork causing a lot of writing thus wasting a lot of time, and discrepancies between registers and tally sheets because of the information not always corresponding. They further mentioned the unavailability of policies and guidelines that are needed to implement ICP standards, which was a big challenge.

6.3.5 Strategies that can be instituted to facilitate successful implementation of the ideal clinic project

There were various takes in this regard. Some participants were of the opinion that if there was staff involvement during the implementation, and staff training on the ICP and academically, the ideal clinic could be successful. Other participants mentioned the need to hire more trained staff, the lack of availability of functional equipment, the need for a reduction of paperwork and improvement of the poor infrastructure. Their view was that if these things were improved then the ICP implementation would also improve.

6.4 LIMITATIONS

The study was conducted in one district and therefore the findings cannot be generalised to the whole of KZN or South Africa. Resource constraints regarding the research was one of the reasons the study was only conducted in one district.

The study did not include the non-nursing staff members, their inclusion could have enriched the data pool.

6.5 RECOMMENDATIONS

The recommendations made from this study are based on strategies that can be instituted to improve ICP implementation. The recommendations are made with special reference to the employment of more trained staff, improvement of infrastructure of the facilities, staff involvement in the implementation of any programmes, and adequate support of staff members in the implementation of the ICPs.

6.5.1 Employment of more trained staff

There is a need to employ more trained staff in order for the programme to run smoothly. This also involves training the staff academically but also on the ideal clinic programme as well. This will help ICP implementation be successful as nursing staff will be trained to treat patients holistically and they will also be clued up on running the ideal clinic programme. The recommendations are made with special reference to policy implementation and development, service delivery, and nursing education and research, as laid out below.

6.5.2 Policy implementation and development

Policies and protocols must be formulated in regard to the support of nurses who are at the grassroot and who are drivers of the ICPs, stipulating who should support these

nurses, when, how often, and how. Also, policies on staffing of the facilities and the adequacy of infrastructure should be formulated.

6.5.3 Service delivery

Service delivery can be up scaled through employment of more staff and staff that are adequately trained in line with the ICP needs. This will assist in improving service delivery as service delivery is often stagnant due to staff shortages. Improvement of infrastructure across all the satellite clinics can assist in service delivery as well because structural limitations were revealed in this study as a major problem.

6.5.4 Nursing education and research

There is a big gap regarding studies investigating the ICP in South Africa, as revealed in the literature review. More studies on the implementation of ICPs need to be undertaken in all areas in South Africa using various methodologies to gain further in-depth knowledge.

6.5.5 Improvement of infrastructure of the facilities

This study found that participants experienced the clinic infrastructure as being old, small and non-conducive for ICP implementation. Improving or rebuilding the infrastructure of PHC facilities will help improve implementation and running of the programme. The presence of well-built and modern infrastructure will assist in better accommodation of all three streams and improve the flow of patient queues during service delivery.

6.5.6 Staff involvement in the implementation of any programmes

Staff involvement in any new programmes that are implemented can assist the programme on a larger scale because staff members can contribute useful inputs on things that need to be in place how things need to be done considering that they are the ones that are at grassroots level. Furthermore, if staff are involved in decision-

making this can uplift ICP implementation because if they feel that they are involved so they will feel motivated to go the extra mile in making it successful.

6.5.7 Adequate support of staff members on the implementation of the ideal clinic project

Offering of adequate support from either higher management or the district office can improve ICP status as gaps and loopholes can be identified timeously and be attended to as soon as possible. This can also boost staff morale because they will see the concern from upper management regarding the whole ICP initiative.

6.6 CONCLUSION

The aim of the study was to to explore and describe the experiences of nurses regarding the implementation of ICPs in the eThekwini district, KZN. Participants revealed both positive and negative experiences and raised some challenges that they come across on a daily basis in the implementation of the ICPs.

The findings of the study confirmed that the nurses who are the drivers of the ICP have many negative experiences that make it difficult for them to fulfil the ICP standards. It was evident from the study that there was little support offered to them when it came to ICP implementation. However, the study also revealed that there are a number of actions that could be instituted in order to bring the ideal clinic status to fruition such as improvement of infrastructure, training of staff, addition of staff, and involvement of staff in decision-making in the ICP as a whole.

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APPENDICES

Appendix 1: University ethics clearance certificate

Institutional Research Ethics Committee
Research and Postgraduate Support Directorate
2nd Floor, Berwin Court
Gate 1, Steve Biko Campus
Durban University of Technology

P O Box 1334, Durban, South Africa, 4001

Tel: 031 373 2375
Email: lavishad@dut.ac.za
http://www.dut.ac.za/research/institutional_research_ethics

www.dut.ac.za

11 September 2020

Mr M Zulu
2506 Johnross House
20 Margaret Mncadi
Durban
4001

Dear Mr Zulu

Experiences of nurses regarding the implementation of an ideal clinic project in eThekwini District, KwaZulu-Natal.
Ethical Clearance number IREC 085/20

The Institutional Research Ethics Committee acknowledges receipt of your gatekeeper permission letters.

Please note that FULL APPROVAL is granted to your research proposal. You may proceed with data collection.

Any adverse events [serious or minor] which occur in connection with this study and/or which may alter its ethical consideration must be reported to the IREC according to the IREC Standard Operating Procedures (SOP's).

Please note that any deviations from the approved proposal require the approval of the IREC as outlined in the IREC SOP's.

Yours Sincerely

Dr M A Sathar
Deputy Chairperson: IREC

Appendix 2: Permission letter to KwaZulu-Natal Department of Health Research and Knowledge Management Component

Department of Nursing Studies
Durban University of Technology
Durban
16 August 2020

The Provincial Department of Research
The Provincial Department manager
Private Bag x9051
Pietermaritzburg
3200

Dear Sir/Madam

RE: REQUEST FOR PERMISSION TO CONDUCT A STUDY

I am presently registered as a student at the Durban University of Technology in the Department of Nursing doing Masters in Nursing Science. The proposed title of my research project is : Experiences of nurses regarding the implementation of an ideal clinic project in eThekwini District, KwaZulu-Natal.

The aim of the study is to explore and describe the experiences of nurses regarding the implementation of an ideal clinic project in eThekwini district, KwaZulu-Natal. The objectives of the study are to: 1) Explore and describe the experiences of nurses regarding the implementation an ideal clinic project in eThekwini district, KZN. 2) Determine the perceptions of nurses regarding the implementation of an ideal clinic project. 3) Describe the support if any, received by nurses in the implementation of an ideal clinic project. 4) Explore the strategies which according to the nurses can influence successful of an ideal clinic project.

The study sites will be the 18 satellite clinics, which are attached to the Prince Mshiyeni Memorial Hospital. The participants will be all the nursing staff members, who are working in these clinics with whom semi structured interviews will be conducted. COVID 19 transmission, all the necessary precautions to protect the participants from COVID19 transmission will be ensured such as distancing, room ventilation, sitting arrangement, protective devices such as masks and disinfecting at no cost to the clinic or the participants. However, the researcher will request, if available, a private room that is well ventilated and that will allow proper seating arrangement and distancing between the researcher and the participant.

I hereby request your permission to conduct a research project at Prince Mshiyeni Memorial Hospital satellite clinics. My research proposal and ethical clearance certificate is attached.

Your support and permission to conduct the study at your facility will be appreciated.

Yours sincerely

.....

Mr Mthokozisi Zulu (Researcher)
Contact no. 073 999 1141 Email: sikhwama@gmail.com

Appendix 3: Permission letter from KwaZulu-Natal Department of Health Research and Knowledge Management Component

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address: 330 Langalibalele Street, Pietermaritzburg
Postal Address: Private Bag X9051
Tel: 033 395 2805/ 3189/ 3123 Fax: 033 394 3782
Email:
www.kznhealth.gov.za

DIRECTORATE:
Health Research & Knowledge Management

NHRD Ref: KZ_202008_091

Dear Mr M. Zulu
(DUT)

Approval of research

1. The research proposal titled **'Experiences of nurses regarding the implementation of an ideal clinic project in eThekwini District, KwaZulu-Natal'** was reviewed by the KwaZulu-Natal Department of Health (KZN-DoH).

   The proposal is hereby **approved** for research to be undertaken at primary health care clinics under Prince Mshiyeni Memorial Hospital (Daganya, Ekuphileni, Folweni, KwaMakhutha, Magabheni, Mfume, Nkwali, Nsimbini, Odidini, Osizweni, uMbumbulu, Umlazi D, K, N, U21, H H (Umzomuhle), Umnini and Prince Mshiyeni Gateway clinic.

2. You are requested to take note of the following:
   a. *All research conducted in KwaZulu-Natal must comply with government regulations relating to Covid-19. These include but are not limited to: regulations concerning social distancing, the wearing of personal protective equipment, and limitations on meetings and social gatherings.*
   b. *Kindly liaise with the facility manager BEFORE your research begins in order to ensure that conditions in the facility are conducive to the conduct of your research. These include, but are not limited to, an assurance that the numbers of patients attending the facility are sufficient to support your sample size requirements, and that the space and physical infrastructure of the facility can accommodate the research team and any additional equipment required for the research.*
   c. *Please ensure that you provide your letter of ethics re-certification to this unit, when the current approval expires.*
   d. *Provide an interim progress report and final report (electronic and hard copies) when your research is complete to* ***HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200*** *and e-mail an electronic copy to hrkm@kznhealth.gov.za*
   e. *Please note that the Department of Health shall not be held liable for any injury that occurs as a result of this study.*

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely

Dr E Lutge
Chairperson, Health Research Committee
Date: 08/09/2020

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 4: Permission letter to eThekwini District Manager

Department of Nursing Studies
Durban University of Technology
Durban
14 August 2020

The eThekwini District
The District Manager of eThekwini
P/bag X54318
Durban
4000

RE: REQUEST FOR PERMISSION TO CONDUCT A STUDY

Dear Sir/Madam

I am presently registered as a student at the Durban University of Technology in the Department of Nursing doing Masters in Nursing Science. The proposed title of my research project is: Experiences of nurses regarding the implementation of an ideal clinic project in eThekwini District, KwaZulu-Natal.

The aim of the study is to explore and describe the experiences of nurses regarding the implementation of an ideal clinic project in eThekwini district, KwaZulu-Natal. The objectives of the study are to: 1) Explore and describe the experiences of nurses regarding the implementation an ideal clinic project in eThekwini district, KZN. 2) Determine the perceptions of nurses regarding the implementation of an ideal clinic project. 3) Describe the support if any, received by nurses in the implementation of an ideal clinic project. 4) Explore the strategies which according to the nurses can influence successful of an ideal clinic project.

The study sites will be the 18 satellite clinics, which are attached to the Prince Mshiyeni Memorial Hospital. The participants will be all the nursing staff members, who are working in these clinics with whom semi structured interviews will be conducted. COVID 19 transmission, all the necessary precautions to protect the participants from COVID19 transmission will be ensured such as distancing, room ventilation, sitting arrangement, protective devices such as masks and disinfecting at no cost to you, the clinic or the participants. However, the researcher will request, if available, a private room that is well ventilated and that will allow proper seating arrangement and distancing between the researcher and the participant.

I hereby request your permission to conduct a research project at Prince Mshiyeni Memorial Hospital satellite clinics. My research proposal and ethical clearance certificate is attached.

Your support and permission to conduct the study at your facility will be appreciated.

Yours sincerely

.....

Mr Mthokozisi Zulu (Researcher)
Contact no. 073 999 1141 Email: sikhwama@gmail.com

Appendix 5: Permission letter from eThekwini District Manager

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

DIRECTORATE:
Physical address: 83 King Cetshwayo Highway, Highway House, Mayville 4091
Postal Address: private Bag X 54318, Durban 4000 eThekwini District Office
Tel: 031 240 5308 Fax: 031 240 5555 Email: Ntombenhle.Ngcobo@kznhealth.gov.za
www.kznhealth.gov.za

Enquiries: Mrs. N. P. Ngcobo
Date: 20/08/2020

Dear Mr. M. Zulu
Durban University of Technology
Health Sciences

RE: SUPPORT FOR RESEARCH STUDY IN "EXPERIENCES OF NURSES REGARDING THE IMPLEMENTATION OF AN IDEAL CLINIC PROJECT IN ETHEKWINI DISTRICT, KWAZULU-NATAL"

I have pleasure in informing you that the District is granting you support to conduct the research study entitled **"Experience Of Nurses Regarding The Implementation Of An Ideal Clinic Project In EThekwini District, KwaZulu-Natal"** Under satellite clinics of Prince Mshiyeni Hospital.

Please note the following:

1. Please ensure you adhere to all the policies, procedures, protocols and guidelines of the department of health with regards to this research
2. This research will only commence once this office has received confirmation from the provincial health research committee in the KZN department of health.
3. Please ensure this office is informed before you commence your research.
4. The District office/facility will not provide any resources for this research.
5. You will be expected to provide feedback on your findings to the district office/facility.

Thanking you.
Sincerely,

Mrs. N.P. Ngcobo
(P, Monitoring and Evaluation Manager)
EThekwini Health District

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 6: Permission letter to Prince Mshiyeni Memorial Hospital Manager

Department of Nursing Studies
Durban University of Technology
Durban
12 August 2020

The Hospital Manager
Prince Mshiyeni Memorial Hospital
P/Bag X07
Mobeni
4060

RE: REQUEST FOR PERMISSION TO CONDUCT A STUDY

Dear Sir/Madam

I am presently registered as a student at the Durban University of Technology in the Department of Nursing doing Masters in Nursing Science. The proposed title of my research project is: Experiences of nurses regarding the implementation of an ideal clinic project in eThekwini District, KwaZulu-Natal.

The aim of the study is to explore and describe the experiences of nurses regarding the implementation of an ideal clinic project in eThekwini district, KwaZulu-Natal. The objectives of the study are to: 1) Explore and describe the experiences of nurses regarding the implementation an ideal clinic project in eThekwini district, KZN. 2) Determine the perceptions of nurses regarding the implementation of an ideal clinic project. 3) Describe the support if any, received by nurses in the implementation of an ideal clinic project. 4) Explore the strategies which according to the nurses can influence successful of an ideal clinic project..

The study sites will be the 18 satellite clinics, which are attached to the Prince Mshiyeni Memorial Hospital. The participants will be all the nursing staff members, who are working in these clinics with whom semi structured interviews will be conducted. To safe guard against COVID 19 transmission, all the necessary precautions to protect the participants from COVID19 transmission will be ensured such as distancing, room ventilation, sitting arrangement, protective devices such as masks and disinfecting at no cost to the clinic or the participants. However, the researcher will request, if available, a private room that is well ventilated and that will allow proper seating arrangement and distancing between the researcher and the participant.

I hereby request your permission to conduct a research project at Prince Mshiyeni Memorial Hospital satellite clinics. My research proposal and ethical clearance certificate is attached.

Your support and permission to conduct the study at your facility will be appreciated.

Yours sincerely

.....

Mr Mthokozisi Zulu (Researcher)
Contact no. 073 999 1141 Email: sikhwama@gmail.com

Appendix 7: Permission letter from Prince Mshiyeni Memorial Hospital Manager

health
Department:
Health
PROVINCE OF KWAZULU-NATAL

Physical Address: Mangosuthu Highway, Umlazi, Durban
Postal Address: P/B X01, Mobeni, 4060
Tel: 031 907 3259 Fax: Email: 086 527 4724 email: Sphesihle.mpanza@kznhealth.gov.za
www.kznhealth.gov.za

DIRECTORATE:
PHC –South Service Area
(Prince Mshiyeni Memorial Hospital)

Enquiries: S.R. Mthembu -Mpanza

Date: 20/8/2020

To: Mr Zulu
Durban University of Technology
Health Sciences

SUPPORT FOR RESEARCH STUDY IN "EXPERIENCES OF NURSES REGARDING THE IMPLEMENTATION OF AN IDEAL CLINIC PROJECT IN SATELLITE CLINICS UNDER PRINCE MSHIYENI MEMORIAL HOSPITAL"

I have pleasure in informing you have been granted permission to conduct research study entitled "EXPERIENCE OF NURSES REGARDING THE IMPLEMENTATION OF AN IDEAL CLINIC PROJECT IN ETHEKWINI DISTRICT , KWAZULU –NATAL"

Please note the following:

1. Please ensure that you adhere to all the policies, procedures, protocols and guidelines of the Department of Health with regards to research.
2. This research will only commence once this office has received the confirmation from the Provincial Health Research Committee in the KZN Department of Health.
3. Please ensure this office is informed before you commence your research
4. The Facility / Clinic will not provide any resource for this research
5. You will be expected to provide feedback on your findings to the Hospital.

Yours faithfully

Assistant Nurse Manager (PHC) South Service Area

Fighting Disease, Fighting Poverty, Giving Hope

Appendix 8: Letter of information and consent form

LETTER OF INFORMATION

Dear Participant

Thank you for voluntarily agreeing to participate in the study

Title of the Research Study: Experiences of nurses regarding the implementation of an ideal clinic project in eThekwini District, KwaZulu-Natal.

Principal Investigator/researcher: Mr Mthokozisi Zulu (MHSc: Nursing Student)
Supervisor: Prof. Thembelihle Ngxongo (D: Nursing)

Brief introduction and purpose of the study: An ideal clinic is defined as a clinic with good infrastructure, adequate staff, adequate medicine and supplies, good administrative processes, and sufficient adequate bulk supplies. The ideal clinic initiative was developed to address gaps in primary health care clinics and establish an algorithmic approach to change all the PHC facilities to adhere to the NHI standards. The aim of the study is to explore and describe your attitude, experiences and perceptions regarding the implementation of an ideal clinic project in eThekwini District, KwaZulu-Natal.

Outline of the procedures: The researcher will conduct a brief focus group discussion for 20 to 40 minutes with a group of nurses working within each clinic who will agree to participate in this study to attitude, experiences and perceptions of nurses regarding the implementation of an ideal clinic project in eThekwini District, KwaZulu-Natal.

Risks or Discomfort to the Participants: There are no potential risks associated with this study.

Benefits: This study is hoped to benefit you as a nurse working in the PHC clinic together with other nurses by identifying the challenges that you experience and the factors that could facilitate implementation of the ideal clinic project all of which will assist in successful implementation of the ideal clinic project and improve patient care.

Reason/s why the participant may be withdrawn from the study: You can choose to withdraw from participating in the study at any time without any consequences.

Remuneration: You will not receive any monetary or any other form of remuneration for taking part in the study.

Costs of the study: There is no monetary cost that will be incurred on you for participating in the study.

Confidentiality: Confidentiality and anonymity will be assured throughout the study and the distribution of results. Code numbers instead of your personal identity such as name will be used for data recording and reporting. The consent forms with the personal details will be kept in a locked cabinet only accessible to the researcher and will be destroyed by shredding after five years.

Researcher – related injury: The nature of the study does not pose any potential risk of injury to you and other participants.
Persons to contact in the event of any problems or queries:

Researcher: Mthokozisi Zulu Tel: 0739991141
Supervisor: Prof TSP Ngxongo Tel: 0313732606
Departmental HOD: Dr TSP Ngxongo Tel: 0313732606
Institutional Research Ethics administrator: Tel: 0313732900
Complaints can be reported to the DVC Rie: Prof S. Moyo on 031-373 2576 or moyos@dut.ac.za)

CONSENT

Statement of Agreement to Participate in the Research Study:

- I hereby confirm that I have been informed by the researcher **Mthokozisi Zulu** about the nature, conduct, benefits and risks of the study- Researcher Ethics clearance number…IREC 085/20……
- I have also received, read and understood the above written information (Participant Letter of information) regarding the study.
- I am aware that the results of the study, including personal details regarding my sex, age, date of birth, initials and diagnosis will be anonymously processed into a study report.
- In view of the requirements I agree that the data collected during this study can be processed in a computerised system by the researcher.
- I may, at any stage, without prejudice, withdraw my consent and participation in the study.
- I have had sufficient opportunity to ask questions and (of my own free will) declare myself prepared to participate in the study.
- I understand that significant new findings developed during the course of this research which may related to my participation will be made available to me.

……. …….. ……
……
Full Name of Participants Date Time Signature/Right thumbprint

I, **Mthokozisi Zulu** herewith confirm that the above participant has been fully informed about the nature, conduct and the risks of the study.

…….. …….. ……

Full Name of Researcher Date Signature

…….. …….. …….

Full Name of Witness (If applicable) Date Signature

…… …… ……

Full Name of Legal Guardian (if applicable) Date Signature

Appendix 9: Pre-selection tool

Appendix 6: Information to identify suitable participants meeting inclusion criteria

To be completed by the researcher

PHC clinic code: | | **Participant code:** | |

TITLE: EXPERIENCES OF NURSES REGARDING THE IMPLEMENTATION OF AN IDEAL CLINIC PROJECT IN ETHEKWINI DISTRICT, KWAZULU-NATAL.

To be completed by the participant

Please provide the following information

Type of Health Establishment:

Fixed PHC clinic	Health Post	Mobile Clinic

Category:

Nurse	Not a Nurse

Number of Years Working in the current PHC clinic:

0-3 Months	More than 3 months

Personal Contact number: ..... *Alternative Contact Number*.....

Preferred time when to be contacted: ..... Alternate Time: .....

Appendix 10: Interview guide

TITLE: EXPERIENCE OF NURSES REGARDING IDEAL CLINIC IMPLEMENTATION IN ETHIKWINI DISTRICT, KZN.

PHC clinic code: ☐ **Participant code:** ☐ **Date:** .....

SECTION A: DEMOGRAPHIC INFORMATION

Please indicate with a tick (√) against the appropriate column for all the statements below

Age:

<25	
25-35	
>35	

Category/Rank:

Operational Manger	
Professional Nurse	
Enrolled Nurse	
Enrolled Nursing Assistant	

Gender:

Female	
Male	
Not willing to state	

Ethnicity:

African	
Coloured	
Indian	
White	
Other	

If other please specify: ----------

Years of Experience as a Nurse

<2years	
>2yeras	

Duration working in this clinic

<2years	
>2years	

Appendix 11(a): Example of transcript

Interviewer	Good Day participant 1, How are you?
Participant	Good Day, I am fine thank you, and you?
Interviewer	I am fine as well, thanks.
Participant	Good.
Interviewer	My name is Mthokozisi Zulu, a Master's degree student studying at the University of Durban. I am doing a study on Experiences of nurses regarding the implementation of ideal clinic project in eThekwini district, Kwazulu-Natal. I would like to mention that your name would not be mentioned any-where in the study but you would simply be referred to as a code. I would personally keep the information you provide me with today solely for this study and this information will be kept in a safe ethical manner for the further 5 years just in case it is needed for audit trail. Do you agree with that?
Participant	Yes, I agree.
Interviewer	Before we begin, I would like to say this facility is clean and well managed, wow nice.
Participant	Thank you very much, we try.
Interviewer	Ok, as I have mentioned before, I would ask you 5 questions and we should be done, unless I feel that you did not answer these questions successfully then I will have to move on to 3 more questions which I call probing questions.
Participant	Ok.
Interviewer	Ok, then let us begin. My first question to u is: - What has been your experience regarding the Ideal clinic project?
Participant	My experience with this whole ideal clinic project is that it gives us clear directions as what is expected of us. There are also policies that are in place that guide us as of what is expected of us. It has also shown good team work involvement and including multidisciplinary teams.
Interviewer	By team work in multidisciplinary team what do you mean?
Participant	If you can remember very well, in the olden days we never used to have NGO's supporting us at the clinics, we never even used to have doctors who come to visits us. Since the ideal clinic implementation there has been a lot of changes in the multisectoral support and multidisciplinary teams.
Interviewer	You also mentioned policies and guidelines.
Participant	Yes, I did, in that regard I meant that in the olden day there were never strict rules on when should we have guidelines when treating patients in our consulting rooms, but now it is by law that we treat patients when we have these tried and tested reference policies and guidelines.

Interviewer	I hear you loud and clear, thanks for that elaborative explanation. Lets us move on to the next question which is: - What is your perception regarding the implementation of an Ideal Clinic Project?
Participant	It is good in a sense that it is a vehicle for quality improvement of service delivery and cater for staff distribution indicators needs.
Interviewer	Care to elaborate please?
Participant	By quality improvement I mean that we get to be assessed at list twice a year for maintenance of the standard of care by both our peers and by Office of standard compliance. These assessments keep us on our toes and makes us to amp u the standard of care.
Interviewer	You also mentioned something about staff distribution indicators?
Participant	Yes, I did, that is what we call “WISN” it is some sort of an indicator that measure the work load that the facility is up against and the need for staff distribution that is needed. With this the number of nurses which are supposed to be allocated in a facility are established. I mentioned this because it is a new thing that comes with the ideal clinic project as we never used to have it before, which is indeed a good thing as it guides against workload and burnout.
Interviewer	Wow thanks that was so informative and clearly stated. Now lets please move on to the next question. What support if any have you been receiving during the implementation of the ideal clinic project?
Participant	There is a lack of support from the principals. Infrastructure is not meeting the ideal clinic standard. Maintenance is very poor since there is no maintenance hub. There is no ideal clinic team committee that is visiting and giving mentorship. Programme coordinators are not visiting the clinics and reviewing the programme at facility level.
Interviewer	You have mentioned a lot of ways in which there is lack of support, for instance you said there is lack of support from principals, what did you mean by that?
Participant	By lack of support from principals I meant that there is lack of support from both management and the district office.
Interviewer	What kind of support are you looking for from both these entities or shall I say what kind of support is lacking from them?
Participant	For example the district office should come from time to time to offer us support on things like policies, offer us support on any changes in the quality and way of care or any new developments that should be implemented but

	they do not, they instead come to only bit us down like we did something wrong.
Interviewer	I hear you loud and clear, you also mentioned the infrastructure not meeting the ideal clinic standard, what does that have to do with support?
Participant	The infrastructure not meeting the ideal clinic standard has a lot to do with support because if we were adequately supported the infrastructure will be up to date in terms of the layout as a whole for example the flow of the three streams will be well set and organized by now.
Interviewer	What about the maintenance, as you also mentioned it as being poor and you also mentioned a maintenance hub, what did you mean by this maintenance hub?
Participant	Maintenance of the facility is a big part of support as well, but we are not receiving much support on the maintenance side of things in the facility. You will find yourself having reported a broken door or window or anything for that matter and it will be attended after a long time if it will be attended at all. By the word maintenance 'hub' I meant that there are no in-facility maintenance people that are ready to give us a hand right there and then on the sport when something needs their attention.
Interviewer	What about the ideal clinic team/committee that you also raised as part of support that is lacking, can you please expand on that?
Participant	If we did have people who are trained and continuously updated on this ever-changing ideal clinic project, if we did have these people as a committee or team inside the facility then the support given to us will be amped up, but unfortunately no such team exit.
Interviewer	Your last consent on the support was the lack of programme co-ordinaters of whom you said are not visiting the clinic facility for them to review the programmes, what did you mean by this?
Participant	The ideal clinic has a lot of programmes that are always introduced to us, you will find that every year they introduce a new programme but they do not then follow up on that programme if it is sustainable or not… there for you find your facility having a lot of programmes that are not functioning and let alone that these programmes should be run by the very staff that is short.
Interviewer	Thanks for all that information, can we please move on to question number 4, which is: - what challenges have you experienced if any during the implementation of the ideal clinic project?
Participant	There are a lot of challenges that I can mention but I will just mention a few that are common in my facility: -

	Buy-in of staff is not easy because the staff members view the ideal clinic as having a lot of work involved. The ideal clinic concept was not clearly introduced from the get go, it was just imposed to the workers. The ideal clinic project needs properly trained staff to perform certain duties. The infrastructure is not accommodative of all the programmes that should be in place and the filing system is a challenge on its own.
Interviewer	What do you mean about the by-in of staff members?
Participant	That statement means to get the staff members to be on the side of the ideal clinic project is hard as they view the ideal clinic as something that is packed with unnecessary workload.
Interviewer	By properly trained staff what do you mean, don't you have properly trained staff members?
Participant	Yes, I do not have properly trained staff, for example the ideal clinic needs professional nurses that are specialized the ones that are called 'Clinical Nurse Practitioners', and those Clinical Nurse Practitioners must have multiple short courses for example NIMART. With all this said you will find that your facility has professional nurses that are not specialized let all having these short courses which are a requirement therefore it becomes difficult for the facility to function adequately.
Interviewer	The point about infrastructure and filing system, care to expand on that?
Participant	The infrastructure is one of the biggest problems of all. These facilities were built a long time ago and are not conducive to the ideal clinic at all, meaning not even the three streams can be fully fitted in these facilities. The issues of filling is one of the worst ones, the filing cabinets are small and now have become full because ideal clinic requires us to open files for everyone who came for care even if that person is not from our catchment area and was just a passer-by who came for minor help and we will never see them again in future. There are also no filling clerks to pull out and return files.
Interviewer	So, what do you do in case where there are no clerks at all?
Participant	Anyone is available goes and assist in the filling cabinet, and when that happens it mean that particular person is taken away from their designated post and does what is not intended by his or her job description?
Interviewer	Oh, my word, you sure have a lot of challenges.
Participant	Yes, we do but what can we say, one has to do what one has to do.

Interviewer	Last question of the day. In your opinion what strategies can influence successful implementation of the ideal clinic project?
Participant	I think there are a lot of strategies that can be put in place to enable successful implementation of the ideal clinic.
Interviewer	Which are?
Participant	First of all, I truly believe that the ideal clinic can benefit from well staffing of the facilities with trained personnel. Improvement of the infrastructure. There should also be a vibrant functional ideal clinic committee from the district and subdistrict facility that will give frequent support and mentorship which will act like an ideal clinic knowledge hub. Community to be informed of the ideal clinic and the developments of the ideal clinic and what is expected of them when they come to the clinic for care.
Interviewer	What do you mean by a vibrant ideal clinic team that should be in place, and how do think this team will benefit the ideal clinic project?
Participant	A team or committee that will be knowledgeable about the ideal clinic and its frequent changes, this team or committee could be really beneficial in the ideal clinic setting as they will be always one step in front of us in terms of new developments in the ideal clinic project.
Interviewer	What about the community involvement that you also mentioned, how will this help?
Participant	I really think community involvement can be beneficial as a lot of community members when they come to the clinic are not sure what is expected of them and they are sometimes confused by all these changes that are always implemented at facility level.
Interviewer	Thanks a lot for this rich input you just given me, it will really help a great deal in my dissertation as you just laid out very really crucial information without being biased but you really spoke to the core of your daily reality in attaining and maintaining the ideal clinic standard.
Participant	But I think the person that needs to thanked is you, because the publication of your work will really show and reflect what we as nurses who go through on the implementation of this project on a daily basis.
Interviewer	Unless there are any questions or additions on your part, this marks the of our interview. Thank you very much for your contribution on this study.
Participant	I have no more questions nor do I have any additions. Thank you and good luck with everything.
Interviewer	Thank you.

Appendix 12(b): Example of transcript

Interviewer	Good Day participant 3, How are you?
Participant	Good Day, I am fine thank you.
Interviewer	My name is Mthokozisi Zulu, a Master's degree student studying at the University of Durban. I am doing a study on Experiences of nurses regarding the implementation of ideal clinic project in eThekwini district, Kwazulu-Natal. I would like to mention that your name would not be mentioned any-where in the study but you would simply be referred to as a code. I would personally keep the information you provide me with today solely for this study and this information will be kept in a safe ethical manner for the further 5 years just in case it is needed for audit trail. Do you agree with that?
Participant	Yes, I agree.
Interviewer	Ok we are going to start with the questions. My first question for you is what has been your experience regarding the implementation of the ICP?
Participant	My experience with the Ideal clinic project has not been a good one, for example the waiting times according to the ideal clinic standard is too short which makes the staff and patients to become frustrated as they are waiting for a quick service.
Interviewer	So, you are trying to tell me that the waiting times are not conducive to the workload that you face on a daily basis at all.
Participant	Not at all, and this is because the patient ratio to our is to big, patients are too many and we are short staff, let alone that some of us are supposed to go on leave, some of us have to be off duty while others are on duty. And oh, before I forget, not many nurses here are specialized, let alone the fact that the senior nurses who are supposed to perform

	highly skilled procedures like diagnosing and treating patients and delivering babies are not that many.
Interviewer	Ok, thanks for that answer, I hear you. Moving on to question number two. What is your perception regarding the ideal clinic implementation?
Participant	My perception with Ideal Clinic Project implementation is that it is a good concept in paper but when it comes to practicality of it is not doable, for example the pre-pulling of files patients that are due for those particular appointments that given day is not practical as patients usually do not their scheduled appointment dates.
Interviewer	I hear you, but is the pre-pulling of files the only example that you can give me as a bad example or is there more to this?
Participant	There is more, the whole concept of the ideal clinic is just good but as I have mentioned it is often not practical, for example even the three streams that we are required to keep to is not quite doable because these facilities were built a long time ago when the concept of ideal clinic was not even born in mind. By this I mean that the three streams cannot fit within the infrastructure that we work in, all in all making us not be able to keep up with the ideal clinic standards.
Interviewer	I hear you loud and clear, thanks for your answer. Moving on to question number 3. What support if any have you been receiving during the implementation of the Ideal Clinic Project.
Participant	There is no support at all, they only come when they are doing assessments only.
Interviewer	What do you mean, can you please elaborate further?
Participant	I mean exactly that. The district office and management only come with a dictatorship mentality when its only time

	for Ideal Clinic assessment. The support that we expect from them from time to time through-out is not seen at all.
Interviewer	Ok, I hear you, thanks for elaborating on that. So, can we move on to the fourth question?
Participant	Yes, we can.
Interviewer	Ok, the here is the fourth question. What challenges if any have you experienced during the implementation of the ideal clinic?
Participant	There are a lot of challenges with the Ideal Clinic Project, but the biggest challenge that is obvious is the with the infrastructure of the facility, the infrastructure is too congested and patients turn to stand outside the facility for a longtime, coursing frustration and stress.
Interviewer	Do u care to explain further on the congestion part of your statement.
Participant	By congestion of the facility I mean that some rooms are too small to be even call consultation rooms, while other clinicians even go as far to share the rooms for the consultations.
Interviewer	So, you mean to tell me that the privacy of the patient is compromised in that manner?
Participant	Yes, the privacy of the patient is very much so compromised but we have got used to it because we cannot change how our facility was built in the first place, but just have to go with it.
Interviewer	Eish I see.
Participant	Yes, it is what it is.
Interviewer	My final question for you to day is, what strategies can be instituted to influence successful implementation of the ideal clinic project?
Participant	I think they are quite a few to be frank.
Interviewer	Like what?

Participant	First of all, the district office should give us support.
Interviewer	Support?
Participant	Yes, support.
Interviewer	Care to elaborate on that?
Participant	The district office should offer us more support, the reason I say this is because they do not offer us enough support as they should. My understanding is that the district office should give us support on timely basis, despite if there is going to be an ideal clinic assessment or not. But the district office only come when there is going to be an ideal clinic assessment, and when they come, they come with a propaganda of point out the wrongs, they do not come to offer support as they should
Interviewer	Ok, I hear you, but when you began your statement you said “firstly” like you were going to mention another strategy that can influence successful implementation of the ideal clinic project.
Participant	Yes, I do have another strategy in mind.
Interviewer	And what is that?
Participant	It has to do with infrastructure.
Interviewer	What about it?
Participant	The ideal clinic project can really benefit from the improvement of the infrastructure of the facility. The facility that we work under is not conducive for ideal clinic implementation. If for example there were bigger consulting rooms to allow the clinicians to work on a conducive environment, I am saying this because other consulting rooms do not even have examination beds for you to examine the patients. Not only the size of consulting rooms needs to be worked on but also the quantity of the consulting rooms needs to be looked at, as I said before sometimes the sisters here need to share a consulting

	room therefore that affect the privacy of the patients that needs to be maintained.
Interviewer	Thanks for that very descriptive answer you just shared with me, it has really made me understand the situations you work under.
Participant	No, thank you. I really feel like that you research the experiences of us as nurses in these conditions we work under is really going to have some impact or change.
Interviewer	Let us hope so.
Participant	So, we are done right? Because you said that was my last question.
Interviewer	Yes indeed, this marks the end of our interview. Thank you very much for your input on my study, thank you very much for taking your time and come sit for this interview it will really help my study.
Participant	Good luck.

Appendix 12: Sample of data analysis report

Interview 6 Participant: F.1

Interviewing Questions	**Responses**	**Themes**	**Analysis**	
			Major Themes	**Sub-themes**
What has been your experience regarding the Ideal clinic project?	My experience with this whole ideal clinic project is that it gives us clear directions as what is expected of us. There are also policies that are in place that guide us as of what is expected of us.	Clear directions on wat is expected	Communication and staff involvement	Clear communication on what is expected
		Policies that are in place	Processes involved in the running of the clinic	Guidelines and policies
	It has also shown good team work involvement and including multidisciplinary teams.	Good team work involvement	Communication and staff involvement	Staff members as part of the ideal clinic project
What is your perception regarding the implementation of an Ideal Clinic Project?	It is good in a sense that it is a vehicle for quality improvement of service	Vehicle for quality improvement	Processes involved in the running of the clinic	Service delivery issues

	delivery and cater for staff distribution indicators needs.			
What support if any have you been receiving during the implementation of the ideal clinic project?	There is a lack of support from the principals. Infrastructure is not meeting the ideal clinic standard. Maintenance is very poor since there is no maintenance hub. There is no ideal clinic team committee that is visiting and giving mentorship. Programme coordinators are not visiting the clinics and reviewing the programme at facility level.	Lack of support. Sub- standard infrastructure Poor maintenance	Support offered to PHC clinics. Structural Limitations Structural limitations.	Support from management and the District office. Infrastructure. Infrastructure.

What challenges if any have you experienced during the implementation of the ideal clinic	There are a lot of challenges that I can mention but I will just mention a few that are common in my facility: - Buy-in of staff is not easy because the staff members view the ideal clinic as having a lot of work involved. The ideal clinic concept was not clearly introduced from the get go, it was just imposed to the workers. The ideal clinic project needs properly trained staff to	Properly trained Staff.	Staff training.	Staff training academically.

	perform certain duties. The infrastructure is not accommodative of all the programmes that should be in place and the filing system is a challenge on its own.	The infrastructure is not accommodative of all the programmes.	Structural Limitations.	Infrastructure.
In your opinion what strategies can influence successful implementation of the ideal clinic project?	First of all, I truly believe that the ideal clinic can benefit from well staffing of the facilities with trained personnel. Improvement of the infrastructure. There should also be a vibrant functional ideal clinic committee	Training of staff personnel Trained personnel Team/Committee in place	Staff training Staff training Staff training	Staff training academically Staff training academically Staff training on ideal clinic

	from the district and subdistrict facility that will give frequent support and mentorship which will act like an ideal clinic knowledge hub. Community to be informed of the ideal clinic and the developments of the ideal clinic and what is expected of them when they come to the clinic for care.			

Appendix 13: Editing certificate

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EDITING CERTIFICATE

Re: **Mr Mthokozisi Zulu**
Master's dissertation: **Experiences of nurses regarding the impleme ntation of an ideal clinic project in eThekwini district, KwaZulu-Natal**

I confirm that I have edited this dissertation and the references for clarity, language and layout. I returned the document to the author with track changes so correct implementation of the changes and clarifications requested in the text and references is the responsibility of the author. I am a freelance editor specialising in proofreading and editing academic documents. My original tertiary degree which I obtained at the University of Cape Town was a B.A. with English as a major and I went on to complete an H.D.E. (P.G.) Sec. with English as my teaching subject. I obtained a distinction for my M.Tech. dissertation in the Department of Homoeopathy at Technikon Natal in 1999 (now the Durban University of Technology). I was a part-time lecturer in the Department of Homoeopathy at the Durban University of Technology for 13 years.

Dr Richard Steele
2020-12-27
per email