An Evaluation of Hospitality within a Provincial Hospital in the Southern Area of Durban, KZN

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DECLARATION

I, Anisah Deen 20152611 declare that this dissertation is my own work and has not been submitted previously for any degree at any one university.

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A. Deen

DEDICATION

I dedicate this dissertation to the following persons: -

- My grandmother, the late Rabia Kader for her inspiration and faith in me even in her last days;
- My grandfather, Abdul Kader for his unconditional love;
- My father, the late Abbas Deen, whom I know would have been proud;
- My Papa, the late Ebrahim Paruk, who blessed me with his presence in the years that he spent with me;
- My mother, Farida Kader, who has always guided and protected me; and
- My sisters Zaheeda Deen, Fathima Sadak and Tasneem Hussain.

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ABSTRACT

It has been accepted that health care within provincial hospitals has deteriorated. For most it has become routine to visit provincial hospitals and wait for majority of the day for basic treatment. Service delivery in provincial health care are confronted with challenges such as staff shortages, inadequate medical supplies and reduced budgets. The media contributes with letters and articles about poor patient treatment, the increase in deaths and diseases due to poor service delivery and weak hospital management. However, with the growing rate of poverty and unemployment, resources have become scarcer hence, adding to an already crippling economy.

The rationale behind this research is to evaluate the role of hospitality within a Provincial Hospital in the southern area of Durban KZN that's offering treatment to patients with more than just basic health care. And to establish a more effective and efficient delivery of services offered with scarce resources which enhances patient encounters within a provincial hospital. The aim of this research is to evaluate the current legislation around provincial hospitals for the efficient and effective practise of hospitality. In the form of a literature review a theoretical perspective was formulated around the study and an operational chapter detailing the Provincial Hospital in the southern area of Durban, KZN. The rationale was tested by research in the form of questionnaires and interviews with the Provincial Hospital. A target sample was selected with managers, senior management and patients.

The major findings may be gravitated towards serious service delivery issues. The Provincial Hospital should therefore, consider the introduction of a hospitality approach in its attempts to improve the delivery of patient care. The study also found that hospitality management influences may improve employee output which impacts on the delivery of patient care.

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LIST OF ABBREVIATIONS

CEO	Chief Executive Officer
CFO	Chief Financial Officer
ANC	African National Congress
FORKK	Friends of RK Khan
PRO	Public Relations Officer
QA	Quality Assurance
HR	Human Resources
CADPAA	The Chatsworth and District partnership against AIDS
HIV	Human Immunodeficiency Virus
AIDS	Acquired Immune Deficiency Syndrome
OPD	Outpatients Department
SPSS	Statistical Package for Social Science
PFMA	The Public Finance Management Act
CCG	Concerned Citizens Group
KZN	Kwa Zulu-Natal

CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION

According to the KwaZulu Natal Department of Health annual report (2005-2006) KwaZulu Natal can be seen as one of the most densely populated provinces in South Africa. This report further highlights that this over population is accompanied by serious socio-economic challenges such as high levels poverty, illiteracy and poor infrastructure. The department of Health is one of the departments that are affected. The difficulties relating to health cannot be viewed in isolation and the government as a whole has to streamline its efforts and interventions dealing with those factors responsible for the crippling economy.

Provincial hospitals in South Africa are under pressure due to staff shortages, unmanageable workloads and management failure resulting in poor service delivery which is particularly evident in KwaZulu Natal. Ndebele (2008) outlines that many institutions in the public sector suffer from inadequate infrastructure. The lack of space compromises a patient's rights to privacy, and inadequate staffing impacts on service delivery, thus resulting in patients having to wait in lengthy and exhausting queues at dispensaries. Some may not have the opportunity to receive treatment and patients are often not aware of their rights.

Ndebele (2008) further states that the provincial government's responsibility is that of confronting the challenges within the public sector and of committing itself to the improvement of its citizens' lives (i.e. to ensure a better life for all).

Nezifo, Nobubha, & Ithemba (2007) identify that the Provincial Department of Health constitutes basic principles of citizen health care. The "Batho Pele Principles" which means "People First", constitutes principles that ensure citizens are entitled to courtesy, consideration, transparency and value for money when they are provided with health care.

At its most basic, the hospitality industry comprises organizations that offer guests courtesy, professional food and drink, and lodging services. However, Mullins (1995: 9) suggests that the hospitality industry offers more than just the basics, it signifies that efficient and effective service delivery is vital to customer satisfaction. Cetron, Demicco & Davies (2006: 3) insist that service does not happen in a vacuum, it grows out of complete mastery of the basics. They continue by defining the basics as the strengths and weaknesses of any business, it is understanding what is necessary and doing it well Cetron *et al* (2006: 3).

Brotherton (2003: 6) explains that the human aspect of hospitality has an important social dimension, as well as meeting physiological requirements of shelter and body comforts. The mission of The Batho Pele Principles is to create a people-centered and people-driven public service that is characterized by equity, quality, timeliness and a strong code of ethics (Batho Pele Vision and Mission 2007).

Williams (2003: 8) supports Brotherton's notion of hospitality by stating that every employee who is in contact with the external customer affects customer satisfaction. According to Kandampully (2007: 13), hospitality is a service enterprise and a people-based business. Both Mullins and Brotherton stress that hospitality outlines the importance of efficient and effective service delivery and customer satisfaction. This is the primary focus of the Batho Pele Principles.

1.2 PROBLEM STATEMENT

The right to health care is an important and critical right, without which other fundamental rights cannot be exercised which is highlighted by the right to life in the Bill of Rights. One cannot live without the accustomed need to be healthy. Therefore, the right to health care needs to be clarified and further defined in practice.

Ntuli (date unavailable) states that the Batho Pele Principles are transparent policies that guide the services of health care, but they are lacking and unequal application of human rights tends to be the norm.

The Minister of Health has noted the concerns of over spending of budget allocations and ineffective or wasteful use of funds in provincial hospitals, and until recently the

allocation of budget funds between provincial hospitals was based on historical allocations and patient head counts (Assessment of The Ministry of Health Division of Provincial Hospitals as a possible, 2008).

Ntuli (date unavailable) believes that most complaints made within provincial hospitals relate to service delivery in the health care system in all the provinces. These information sources point to the poor state of many hospitals in the country; the shortage of trained health care workers; shortage of drugs in clinics; long waiting periods for treatment; poor infrastructure; disregard for patients' rights; the shortage of ambulance services and poor hospital management.

The primary challenges, which are continuously emphasized, are budget constraints, staff shortages and unmanageable workloads; however the absence of hospitality and its practice may have critical implications on service delivery in provincial hospitals.

The concept of hospitality epitomizes the delivery of courteous services efficiently. According to Hemmington (2007) hospitality is about the customer perspective which is essential to the effective delivery of products; as customers do not buy service delivery, they buy experiences.

There is a significant role to be played by hospitality in hospitals in terms of the importance of efficient service and effective service delivery in achieving customer satisfaction. Existing health care services ought to be receptive to change, in order to meet the standards of the provision of health care prescribed in the South African Constitution.

1.3 RESEARCH OBJECTIVES

1. Locate theory and practice of hospitality within provincial hospitals;
2. Evaluate hospitality practice within the broader context of provincial hospitals;
3. Examine and evaluate current legislation for the efficient practice of hospitality within provincial hospitals; and
4. Evaluate the operational practices of a provincial hospital in the southern area of Durban within the context of hospitality;

1.4 RATIONALE OF THE STUDY

Most complaints made within provincial hospitals are with regard to poor service delivery in the health care system in all the provinces. Problems such as poor conditions of provincial hospitals, lack of trained health care workers, disregard for patients' rights and poor hospital management have also been highlighted (Ntuli, date unavailable).

The purpose of this study is to evaluate the role of hospitality within a provincial hospital, identifying that the reception of, and treatment of patients should offer more than just the basic health care. This study aspires to inform the provision of health care with the concept of hospitality. The South African Constitution of 1996 contains a Bill of Rights which enshrines the rights of all people in our country and affirms the democratic values of human dignity and equality.

Nezifo *et al* (2007) highlight that the Provincial Department of Health constitutes basic principles in Batho Pele, which emphasize that citizens are entitled to courtesy and consideration, which is spirited for improving patients' conditions and a delivery of service that benefits the customer.

Kotas (1996: 259) supports that efficient service and effective service delivery are the vital keys to customer satisfaction, which is relevant to the provision of health care that is ordained by the South African Constitution.

It is understood that the hospitality industry promotes services as their main product, and this study aims to highlight the concept of hospitality practice and 'service' within the health care system and its benefits to the patients.

1.5 RESEARCH METHODOLOGY

The research methodology within the context of this study had to take into account a number of factors that were peculiar to the Provincial Hospital. These factors were constraints of the respondents in respect of time and levels of understanding, fear of reprisal and availability of accurate information. This, therefore, necessitated a scientific methodological process. Methodological triangulation is seen within the

study as an overall approach as well as at a micro level in respect of the qualitative and quantitative approaches used in the framing of questions in the survey research.

A combination of quantitative and qualitative research techniques was applied in the study. This provided the researcher with the ability to gather in-depth information and data in a small space of time and at the convenience of the participant. Creswell (2008:14) indicates that the reasons for mixing methods have led writers from around the world to develop procedures for mixed method strategies of inquiry, and these take the numerous terms found in the literature such as multi method, convergence, integrated and combined methods and shape procedures for research.

1.5.1 THEORY SEARCH

A literature study was undertaken of available texts comprising relevant books, journals, dissertations, periodicals, official publications, papers and reports relating to the management of Provincial Hospitals and the Provincial Hospital of the study and "*hospitality*" as a concept and practice.

1.5.2 TARGET PERCENTAGE SAMPLE

The sample Provincial Hospital comprised patients, Department Heads and Senior Management. There are 14 departmental heads including:

1. Medical;
2. Nursing;
3. Quality Assurance;
4. Human Resources;
5. Public Relations;
6. Pharmacy; and
7. Systems.

Systems within the Provincial Hospital include departments of Maintenance; Catering; Admitting Outpatients; Housekeeping; Laundry; Security and Supply Chain Management.

A structured questionnaire was targeted at the department heads of the Provincial Hospital. A sample size of 100% was sought. A 93% return rate was achieved.

The Provincial Hospital has two managers at a strategic level whose job titles are the Chief Executive Officer and the Financial Manager. A structured interview was conducted with both managers.

There are approximately 500 patients that are cared for daily within the outpatients department of the Provincial Hospital (Chetty, 2010). A structured questionnaire was targeted to the patients within the outpatients department of the Provincial Hospital. A sample size of 65% of daily patients (325 patients) was sought. A 61% of daily patients (306 patients) return rate was achieved.

1.5.3. DATA COLLECTION AND ANALYSIS

The results of the study were organised thematically and were combined with relevant responses from the structured interview with senior managers of the Provincial Hospital. The survey questionnaires to the patients, Heads of Department and the structured interview conducted with the senior managers of the hospital were originally intended to be compartmentalised and organised into convenient sets of information to the relevant themes of the study respectively.

The data yielded through these mechanisms however, materialised in a very integrated and comprehensive way which became relevant to all three themes of the study at varied levels. In order to enhance the coherence of the presentation of results, data were triangulated and viewed as a whole.

1.5.3.1 RESEARCH THEMES

The concept of hospitality within a Provincial Hospitals emerged from the study through various themes. These themes surfaced as dominant components in enhancing hospitality within hospitals and are discussed as follows:

Service delivery a key theme served as a conduit between the organisation (hotel/hospital) and the customer (guest/patient).

Management practices and processes alluded to the basic functions of management which is a significant factor to effective practice and hospitality. A conscious effort therefore was made to structure this within the interviews of senior management.

Environmental impacts and influences refer to the environments immediate as well as those indirectly linked to the organisation. The essence of this theme was the interdependency between the organisation (hotel/hospital) and these environments.

1.5.4 LIMITATIONS OF THE STUDY

This study was an evaluation of a provincial hospital which is within the public sector of healthcare. Careful attention was needed for sensitive factors and criteria that had to be considered before and during the time that this research was carried out.

Factors that influenced the research study were as follows:

1. The study was limited to one Provincial Hospital;
2. The need to obtain consent to conduct the study on the Provincial Hospital;
3. The focussed area of study within the Provincial Hospital was limited to the areas that correspond to the hospitality industry;
4. There was an influx of interruptions of service within provincial health care due to unhappy staff and conditions of work. This made the study a further challenge as it limited the information gathered on the Provincial Hospital due to poor publicity through the media;
5. The availability of staff was limited due to the nature of their organization;
6. Surveys on patients were limited due to the conditions of the hospital such as peak and off peak days of visits; and
7. Surveys on patients did not include areas of casualty and wards due to the nature of these areas. Patients were unable to respond and answer questions in their conditions

1.6 DEFINITIONS OF TERMS

Service delivery is getting services as effectively and efficiently as possible to the intended recipient. The intended recipient maybe a guest, a patient or a customer.

Hospitality has a wider meaning, conveying the bestowal of friendship and trust, and even bearing within it hints of sacred duty (Baker & Huyton, 2001: 3).

Batho Pele Principles are a set of principles that were developed to serve as an acceptable policy and legislative framework regarding service delivery in the public service sector (White Paper on Transforming Public Service Delivery, 09/1997).

Drainage areas refers to the areas in and out of KwaZulu Natal the Provincial Hospital services (Chetty, 2009).

Legislation refers to the act of giving or enacting laws

Provincial Hospital signifies the hospital belonging to a particular province, and the Provincial Hospital which had to remain anonymous

1.7 OVERVIEW OF CHAPTERS

The study is divided into six chapters. The chapters are organized as follows:-

Chapter 1: **OVERVIEW OF THE STUDY**

This chapter entails an introduction into public health care and a background to the governments' responsibility within the provincial health care sector in conjunction with hospitality practices. The objectives, research methods and justification of the study are discussed.

Chapter 2 **LITERATURE REVIEW**

This chapter outlines the location of theory and concept of hospitality within hospitals. Evaluating hospitality in a broader context of service and service delivery in which hospitality established its roots. Health care, government in South Africa, and legislations are explained. Leading themes of service delivery, management practices and processes and environmental impacts and influences emerge from the literature. Specific reference is made to journals, published sources, internets sites and Acts of Parliament in support of the theory and practice of the concept.

Chapter 3 **OPERATIONS OF THE PROVINCIAL HOSPITAL IN THE SOUTHERN DISTRICT OF DURBAN AND ITS RELEVANCE TO HOPITALITY**

This chapter provides an understanding of the district of the Provincial Hospital with a history and background of Chatsworth. The organizational structure of the Provincial Hospital and the roles and responsibilities of staff are detailed. Similarities are drawn with an applied guest cycle and a flowchart of the patient process. Governance structures of the Provincial Hospital were outlined and an application of Jones & Lockwood's (1989: 111) model of management influence on service is made for the hospital which depicted the essentials for the patient encounter.

Chapter 4 **RESEARCH METHODOLOGY**

This chapter describes the methodology employed with a detailed progression, incorporating the objectives and theoretical approach of the study. An account of the qualitative and quantitative methods used in the study are described, the organization and administration of the research instrument, research design and the sample procedure are explained as well.

Chapter 5 **PRESENTATION OF FINDINGS AND DISCUSSION**

This chapter presents the results generated by each research instrument. The instruments are triangulated to provide constructive discussion and the results are presented under the three research themes namely; Service Delivery, Management Practices and Processes and Environmental Impacts and Influences.

Chapter 6 **CONCLUSIONS AND RECOMMENDATIONS**

This chapter details with conclusions, which are drawn based on the findings from the study. Based on the interpretations of the results, this chapter further offers a set of recommendations

pertaining to the Provincial Hospital and the role of hospitality within this context.

1.8 SUMMARY

This chapter has provided an outline for the study by introducing the challenges that a Provincial Hospital encounter during the delivery of healthcare. Some of these challenges include lengthy waiting periods for patients who seek treatment, only to receive treatment from difficult staff that are severely challenged in their respective working areas. The association with hospitality and healthcare was outlined and further drawing on the need for hospitality to be considered whilst delivering healthcare. Health care and hospital care delivers a service to the community and hospitality practices may enhance this delivery with the approach of hospitality management. The subsequent chapter will provide a detailed overview of the literature review of the study.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

Over the past two generations, the hospitality industry has evolved to accommodate explosive growth, radically changing consumer demand, and a substantially different social economic environment. The hospitality industry today is commonly associated within the private sector which includes five star city hotels, guest houses, pubs, spas, fitness clubs, heritage sites, outdoor sport events and cruise liners.

At its most basic, the hospitality industry comprises of organizations that offer guests courtesy, professional food and drink, and lodging services and it is understood that the hospitality industry fashions service as the product that they produce.

Hospitals are recognized primarily within the health care sector with a basic function of supplying health care to the consumer. Along with patient treatment and the provision of wellness is an extended product of service that is often disregarded. This service product is intangible and is experienced by each patient staying at a hospital.

Regardless of the styles of these two industries, good service is difficult to define, and both environments may offer a different expectation. However an impression of good, unobtrusive service is one that remains long after the service has been received.

The objectives of this chapter are:

- Analyse the evolution and expansion of the hospitality industry;
- Locate the theory and practice of hospitality within hospitals;
- Evaluate hospitality practice within the broader context of hospitals;
- Develop a legislative basis for the practice of hospitality within hospitals; and
- Profile hospitals within a national and provincial context.

2.2 THE EVOLUTION AND EXPANSION OF THE HOSPITALITY INDUSTRY

The Oxford Dictionary (2013) defines 'hospitality' as the generous and cordial reception of guests offering a pleasant and sustaining environment. Powers and Barrows (2009: 4) redefine hospitality as the friendly and generous entertainment of guests, visitors or strangers with liberality and good will.

Throughout history hospitality has been centered around security and physical comfort, all centering around offerings to others by a host. Clarke and Chen (2007: 5) support that hospitality is rooted in the relationships that develop between hosts and guests, a dynamic which has existed since the first human societies emerged.

Hospitality not only includes hotels and restaurants, but also refers to other kinds of institutions that offer shelter, food or both to people away from their homes (Barrows and Powers, 2009: 4).

When offering hospitality to a guest there is the implicit guarantee to take charge of his comfort, welfare, nourishment and lodging and Berger and Brownwell (2009: 4) support that a stay at a hotel should provide a comfortable experience away from home.

Traditionally hospitality happened in the home. This meant that the provision of hospitality was under the supervision of the homeowner. Jones (1996: 1) explains that hospitality should meet the basic human needs by the provision of sustenance and accommodation for people eating and staying away from their home.
The concept of hospitality is rooted deep in the history of humanity. Dittmer and Griffin (1993: 5) state that hospitality has ancient roots, dating from the earliest days of Roman civilization. Ever since humans felt the need and the desire to establish and maintain relationships with others, hospitality has been a central social phenomenon.

Hospitality is known as being a cultural construct, created by people, a learned behaviour that has been passed down by generation to generation. Chon and Sparrowe (2000:1) admit that the hospitality roots lie in social and cultural life.

Chappel and Lane (1998) argue that the hospitality industry is a product of the Industrial Revolution in Western Europe. Jones (1996: 2) suggests that the hotel and catering industry stemmed from the Standard Industrial Classification in 1948, and Jones further agrees that the hospitality industry developed in the United Kingdom. Dittmer and Griffin (1993: 4) observe that since the 1950's, the hospitality industry has been of growing importance to the economic life of the nation and has been leading the way in providing new opportunities for individuals from every age group, ethnic, racial and socioeconomic background.

The word hospitality as it is used today seems to imply no more than the exchange of a commercial service, and Baker and Huyton (2001: 3) point out that hospitality has a wider meaning, conveying the bestowal of friendship and trust, and even bearing within it hints of sacred duty.

2.3 TOURISM AND HOSPITALITY

According to George (2007: 3) tourism is the world's largest and fastest growing industry and it is a major economic, environmental, and sociocultural dynamic force. The basic relationship between hospitality and tourism can be seen in the roles that destinations and hospitality facilities play in motivating people to travel.

Dittmer and Griffin (1993: 8) highlight that hospitality and tourism are typically used together as an umbrella term to refer to those businesses providing primary services to travellers. Baker (2000: 2) states that the hospitality industry is influenced by the growing tourism industry and an expanding economy.

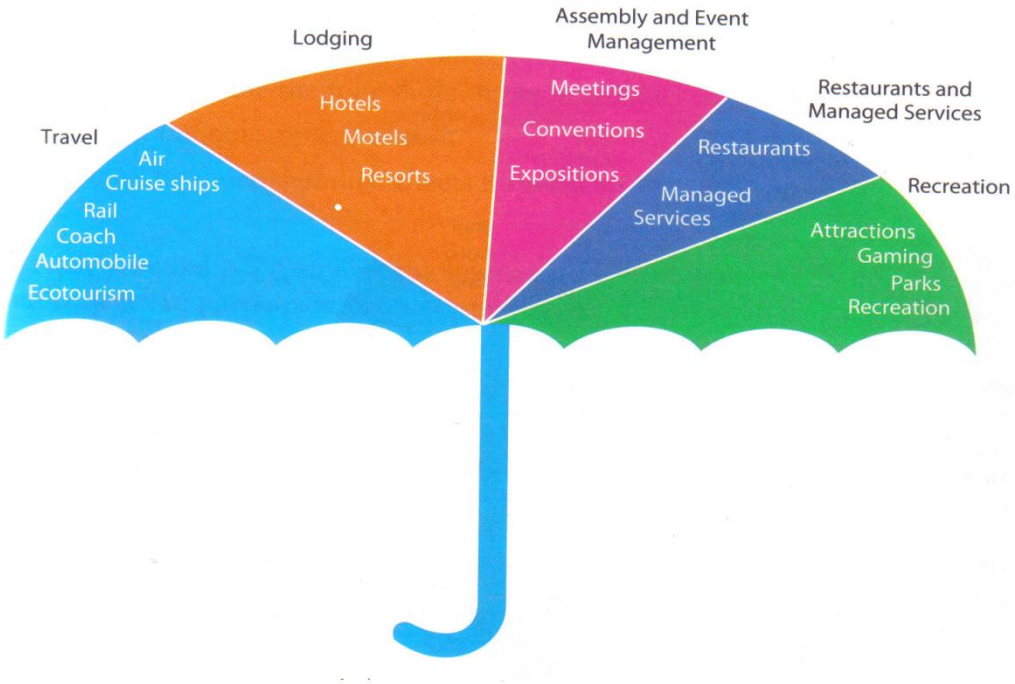

Figure 2.1 Scope of the hospitality and tourism industry (Walker, 2008: 7)

Figure 2.1 displays the scope of the hospitality and tourism industry. Walker (2008: 7) supports Dittmer and Griffin's concept that hospitality and tourism are used together as an umbrella term thereby providing the necessary services such as travel, lodging as well as associated services such as conventions, restaurants and recreation to travellers.

McIntosh, Goeldner, and Ritchie (1995: 15) define a tourist as someone who travels away from home and defines tourism as people taking trips away from home, which embraces the entire range of transportation, lodging, food service, and other activities relating to and serving the traveller which is outlined in **Figure 2.1.**

The scope of the hospitality and tourism industry in **Figure 2.1** identifies that the hotel industry is part and parcel of the tourism sector. The tourists are honoured guests and the hotels' management offer them the demanded hospitality. Mill and Morrison (1985: 4) reveal that tourists take vacations in the hope and belief that these vacations will satisfy various needs and wants, and further points out that it is the difference between

seeing a destination as a collection of palm trees and hotel rooms for the tourists and seeing it as a means for satisfying needs and wants.

Ahmed (2005: 2) suggests that the accommodation is a very important part of the tourism infrastructure and it plays an important contribution to the economy as a whole by stimulating economic development, social contacts and commercial activities.

Clarke and Chen (2007: 19) indicate that the touristic culture binds the experience of hospitality and tourism with its own set of expectations which promotes itself and further argues that guests should expect a high quality of service.

According to Barrows and Powers (2009: 416) tourism is central not only to the health of the hospitality industry but also to the economy worldwide. However Van der Wagen (1999: 3) observes that hospitality is included as a sector in the tourism and travel industry, and continues by saying that the hospitality industry should be regarded in its own right since it meets the needs of customers other than tourists.

Chon and Sparrowe (2000: 3) indicate that history reveals the strong relationship between the shape of hospitality industry and the needs and expectations of different societies and the range of businesses.

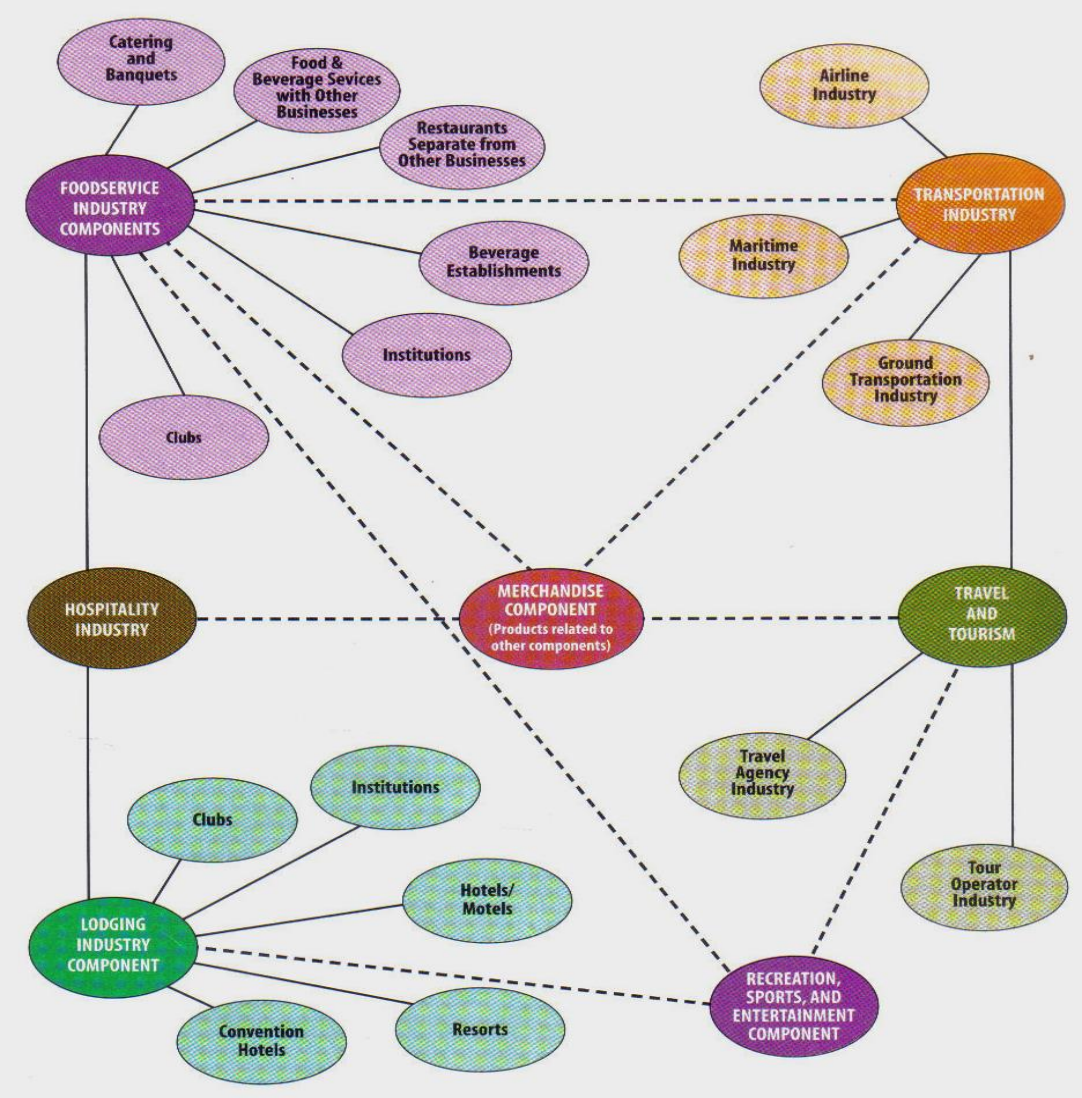

Figure 2.2 The hospitality and tourism network (Chon and Sparrowe 2000: 7)

Figure 2.2 illustrates that the network of the hospitality and tourism industry strongly affect each another. A network can be defined as a complicated interconnection of parts or components. Chon and Sparrowe (2000: 8) explain in **Figure 2.2** that the various components of the hospitality and tourism industry interrelate, and expand into other institutions respectfully. Institutions are the various organizations in which the food service and the lodging industry broaden their expertise, namely schools; universities; prisons and hospitals. Yu (2004: 4) supports that hospitality is an international business encompassing various economic, financial, and commercial activities conducted by both private enterprises and government entities. Within the government sector, hospitals may be recognized within the realm of the hospitality sector.

Mullins (2001: 17) admits that the hospitality industry is unique as it is a relationship between people. Dittmer and Griffin (1993: 27) agree that hospitality is a people oriented profession by understanding the varying needs and views of people from varied cultural, ethnic and religious backgrounds by means of communication and the social skills involved. Hospitality also means demonstrating consistent excellence and quality in people skills (staff and guests), product and ambiance (Hogan, 2008).

2.4 HOSPITALITY SERVICE AND SERVICE DELIVERY

Lashley and Morrison (2000), cited in Severt, Aiello, Elswick, and Cyr (2008: 664), indicate that hospitality provides a commitment to meeting guests' needs as the primary focus in commercial operations through a host and guest relationship. The host and guest relationship is further characterized by hospitableness typically extended by the host to the guests then reciprocated by the guest to the host.

Service is an integral part of the hospitality industry and according to Angelo and Vladimir (2004: 4) service is defined as 'work done for others'. Barrows and Powers (2009: 503) define service as all actions and reactions that customers perceive they have purchased. Olsen, Teare, and Gummesson (1996: 1) believe that in the decade of the 1990's, a renewed emphasis began where businesses thought about improving service quality to the customer.

The perceptions and understandings of hospitality are largely dependent on the attitudes of the giver and receiver. Barrows and Powers (2009: 26) inform that service is the difference, and continues by saying that service will be the difference between barely surviving and achieving success.

In hospitality, service is performed for the guest by people or systems. In the view of the guests, service is the performance of the organization and its staff. Guerrier (1999: 61) believes that the hospitality industry can be seen as the service industry providing a product that is intangible as it is difficult to measure the quality of a greeting.

Kotas *et al* (1996: 122) confirm that service industries essentially offer a psychological experience that is ultimately enjoyed or endured by the guest or visitor. Gee (1994) proposes that the cornerstone of the industry is hospitality in the form of service. He goes on to say that what constitutes hospitality is relative to the user, implying that the recipient measures the service offered.

Levitt (1972) points out,

> *"There are no such things as service industries. There are only industries whose service components are greater or less than those of other industries. Everybody is in service!"*

Levitt (1972) explains that any tangible product for sale is accompanied by the intangible element of service and all industries sell an extended product of service.

Jones (1996: 29) signifies that the hospitality experience is about much more than economics, global representation and sophisticated products and services, it is about the human element of service, and the fulfilment of the specific needs and wants of the customer.

Service is an intangible experience of performance that the guest or the customer receives along with the tangible side of the product purchased. A good service team is essential because service people are a part of the product. Ive (2000: 1) identifies that to develop the highest standards of service, a deep understanding of guests' needs, need to be established, and further explains that it is the understanding of the person or guest who is requiring the service.

Berger and Brownwell (2009: 3) conceive that quality service does not just happen by chance, it needs to be planned and managed, from the design of the service delivery system to maintaining efficient operations that ensure quality is both high and consistent.

Walker (2008:12) envisions that for success in service provision one needs to:

- *Focus on the guest;*
- *Understand the role of guest service;*
- *Weave a service culture into education and training systems;*
- *Anticipate guest needs is very important if we want to impress them; and win them as frequent guests;*
- *Emphasize high – touch instead of high – tech; and*
- *Thrive on change – constantly improving the guest experience.*

It is important to understand the consumer's perceptions and expectations because the service rendered is ultimately only as good as the customer perceives it to be. It is the attentiveness that is service. Hospitality is about increasing one's social capital, and the value of social capital comes from knowing the social artefacts and activities of the customer and knowing what to say about them. Ahmed (2005: 64) insists that the guest in the hotel should be treated as you would treat a guest in your house.

Hence Walker (2008: 12) states the focus should be placed on the guest, their needs, wants and their satisfaction. Berger and Brownwell (2009: 8) agree that the guest arrives with a set of needs and expectations about the service and the environment in which the service will be delivered.

Chon and Sparrowe (2000: 20) recommends some of the following principles for achieving guest satisfaction:

> *Recognize your guest: By personalizing interactions by using guest name.*

It's understood that remembering the guests' name is not always possible, however a sincere smile and warm interaction goes a long way.

> *Make a positive first impression: Guests judge your advertising claims against beliefs they already hold and accept only new information that matches those beliefs.*

The first impression is a lasting impression. Changing a negative first impression is challenging, if not impossible. Furthermore the guest has an expectation before their

visit to the establishment due their marketing to the customer. Ford and Heaton (2000: 15) verify that creating a guest expectation lies within the marketing department.

Reduce the effort required of the customer: Guests want to exert as little effort as possible in purchasing your service.

Make it easy for your customer. They are there to relax, and we are there to make that possible.

Focus on the customer's perception.

The guests' perception may not be accurate, however to them it is a reality.

Create memories the customer will want to recapture: Good times and memories of good times are what we really sell.

When customers leave the establishment all they take with them are memories of their service encounter and service received, and it is the good memories brings them back.

Expect your customer to remember bad experiences: Also expect your customer to tell about those bad experiences.

Customers would share their bad experiences to anyone who will listen. This results in poor impressions on people who have not yet patronized your establishment.

Chon and Sparrowe (2000: 20) explain in their principles that guest satisfaction is the fulfilment of a guest's needs and wants, ensuring that guests receive outstanding service which is a priority to the hospitality organization and Walker (2008: 29) agrees that the hospitality is a service industry, which means taking pride in caring about others as well as ourselves. Van der Wagen (1999: 15) further supports that in all service industries, positive customer contact is the key to running a successful operation.

The principles recommended by Chon and Sparrowe (2000: 20), including the vision of Walker (2008: 12), and the beliefs of Levitt (1972), all pave the way for the actual service encounter whereby customer and employee have their interpersonal interaction.

Ford and Heaton (2000: 12) specify that the service encounter is the person to person interaction between the customer and the person delivering the service. Ford and

Heaton (2000: 12) further acknowledges that the service encounter and interactions have critical moments within them which is of crucial importance to the guest's evaluation of service quality, and may make or break the entire guest experience.

Hence, Jones and Lockwood (1989:109) state that any service encounter is of prime importance in determining the customer's overall satisfaction with experience and further explains this importance in his model of management influence on service.

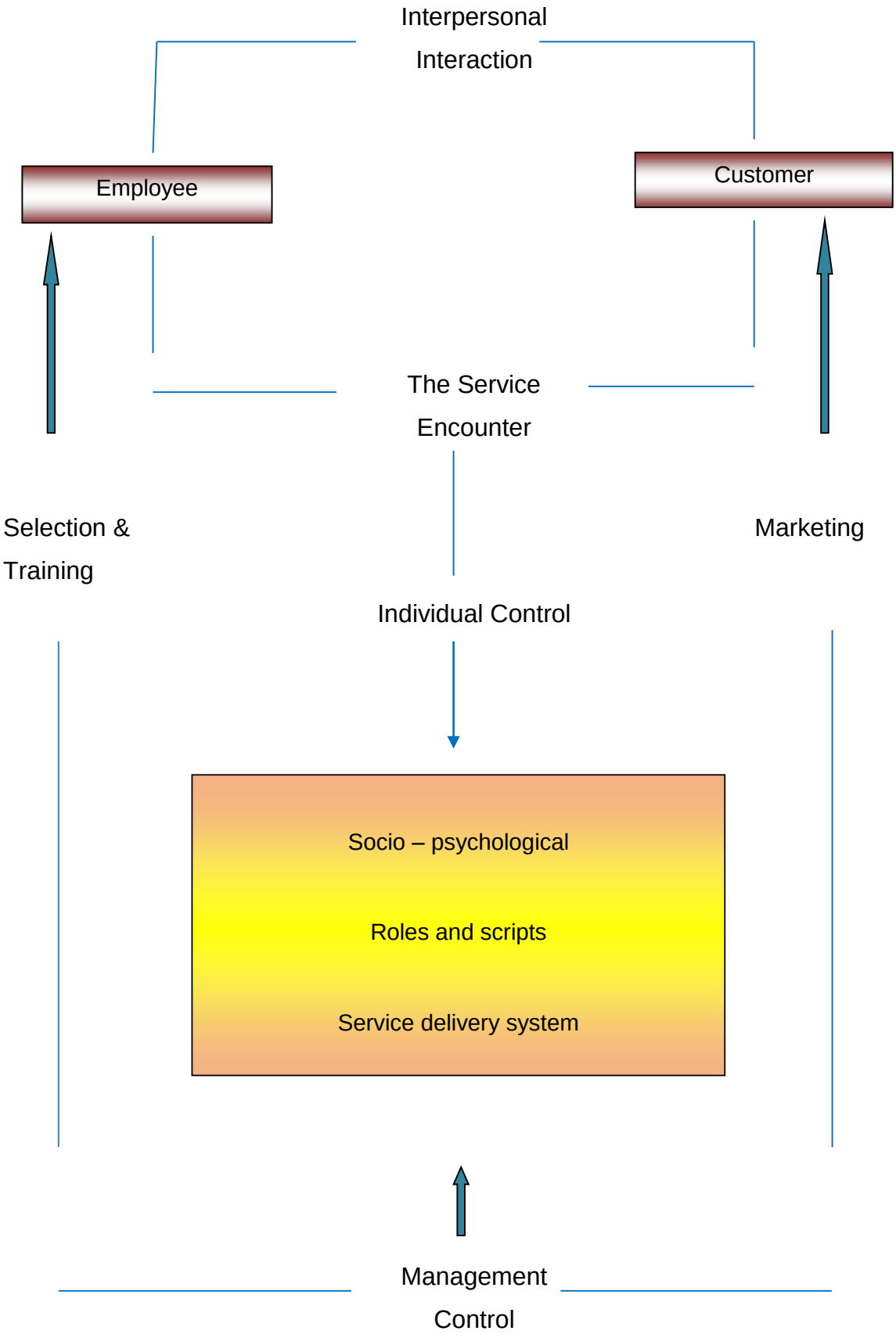

Figure 2.3 A model of management influence on service (Jones and Lockwood 1989: 111)

Figure 2.3 illustrates the influence that the manager has on service interaction and provides the framework for analysing and discussing the effective management of service. Jones and Lockwood (1989: 111) believe that a manager needs to take a proactive approach to this encounter or experience.

The model reveals that there is an interpersonal interaction between the employee and the customer which creates the service encounter. The model also depicts that management control includes the selection and training process of the employee which enhances the interpersonal action to the customer in terms of the quality of service, and marketing to the customer, which stimulates and creates the customer expectation.

Price and Jaffe (2008: 21) believe that service matters because customers who encounter bad service tell their friends and find other companies with which they would want to do business. In **Figure 2.3**, Jones and Lockwood (1989: 127) outline that a manager has direct control over influence through selection and training thereby influencing employee performance.

Ford and Heaton (2000: 142) argue that service effectiveness depends on everyone throughout the organization taking service responsibility seriously and organizations need not hire anyone who is unwilling or unable to provide and deliver outstanding service.

Jones and Lockwood (1989:112) are in support of Ford and Heaton's (2000: 142) service effectiveness and Berger and Brownwell's (2009: 3) quality service concepts in their illustration and outlines that the manager does have influence over the role employees play, the scripts they use, the design of the service delivery system, and the organization culture, which indirectly affect control over each interaction the employee is engaged in.

Mullins (2001: 155) admits that the function that distinguishes the manager above all others is the function no one but the manager can perform, which is the ability to give

others vision and the ability to perform, which is exhibited in Jones's model in **Figure 2.3**. Furthermore Walker and Miller (2010: 202) declare that if you want your employees to treat guests courteously and serve them well; your associates must be treated well and with courtesy.

2.5 MANAGEMENT

Management is an integral part of the hospitality industry. According to David (2005: 8) management is such an important element of the hotel industry that can make or spoil the industry and further defines it as a technique of getting things done through the efforts of others.

Mullins (1999: 169) states that management relates to all activities and at all levels of the organization and the overall responsibility of management can be seen as the attainment of the given objectives of the organization.

2.5.1 HOSPITALITY MANAGEMENT

Nelson and Economy (2005: 5) state the classical functions of management are planning, organizing, leading and controlling which are defined as follows:

> *Planning: its' the job of managers to develop plans that determine goals an organization will pursue, the products and services it will provide, how it will be manufacture and deliver them, to whom and at what price.*

A plan is the map that one uses to steer your business or organization to get it where you want to and in which direction.

Nelson and Economy (2005: 5) describe organizing as:

> *Organizing: After managers develop their plans, they have to build an organization that can put these plans into effect by designing organizational structures for execution, developing systems and processes to direct the allocation of human, financial and other resources.*

Once the map is developed, systems and structures needs put in place in order to accomplish the desired objectives and direction of the organization.
Nelson and Economy (2005: 5) define leading as:

> *Leading: Managers are expected to lead their employees, to motivate them to achieve the organization's goals - quickly and efficiently.*

Leadership is considered to be the most important ingredient for a manager's success, Nelson and Economy (2005: 5) motivates that great leaders can make great things happen, inspiring their employees to do extraordinary things and accomplish extraordinary goals.

Nelson and Economy (2005: 5) outline controlling as:

> *Controlling: To accomplish their goals and the goals of the organization, managers must establish performance standards based on the organization's goals and objectives.*

Controlling involves the basic principle if you can't measure it, you can't manage it. One must measure in order to manage.

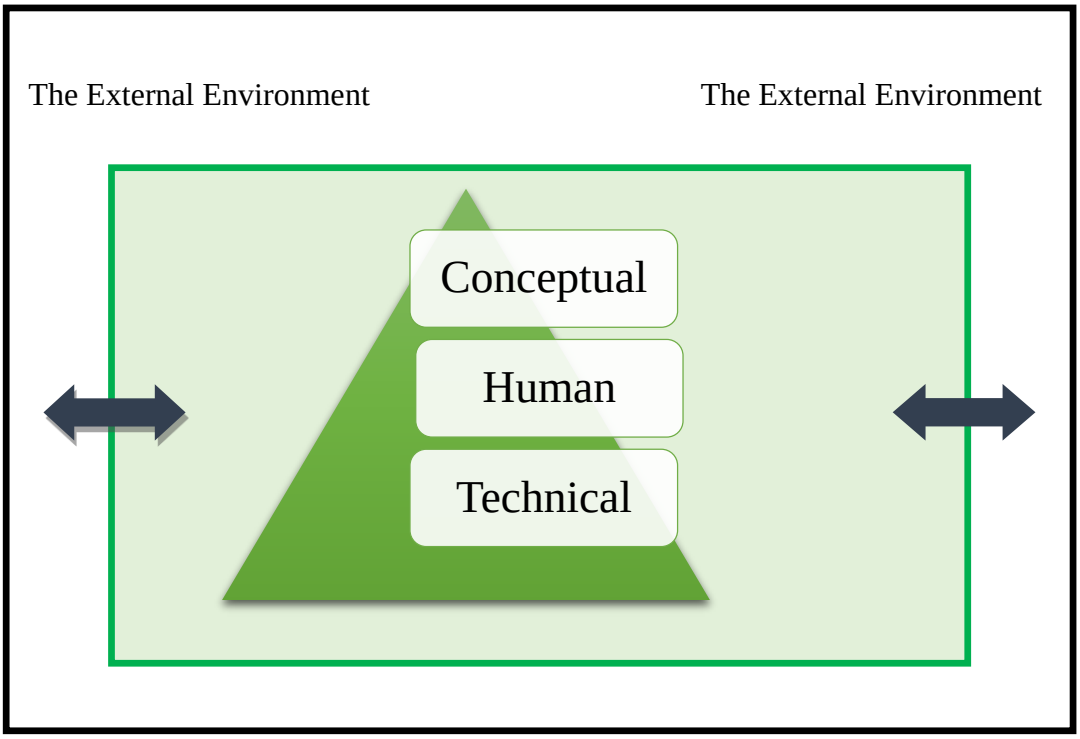

Figure 2.4 An applied approach to the relative skills needed for effective performance at different levels of management including the influence of the external environment (Stoner, Freeman and Gilbert, 1995: 18)

Figure 2.4 depicts an applied approach to the relative skills that are needed for effective performance at the different levels of management which includes the influence of the environment. Stoner *et al* (1995: 18) reveal that the peak of the triangle refers to top management, the centre being middle management and the bottom representing first line management.

The classical functions of management that is identified by Nelson and Economy (2005: 5) as planning, leading, organizing and controlling would be applied be in **Figure 2.4** and carried out at the different levels of management. At the peak of the triangle top management conceptualize their plans that would determine the goals of the establishment. According to Stoner *et al* (1995: 17) conceptual skills are the ability to coordinate and integrate all of an organization's interests and activities which involves seeing the organization as a whole. Stoner *et al* (1995: 17) further outline that conceptual skills is understanding how its parts depend on one another, and anticipating how a change in any parts will affect the whole.

Holt (1993: 19) supports that conceptual skill is the ability to solve long term problems and view the total organization as an interactive system.

Middle management is the stage whereby managers would organize and design structures, develop systems and processes and execute plans by leading and inspiring the relevant human resources. Stoner *et al* (1995: 17) state that human skill is the ability to work with, understand, and motivate other people as individuals or in groups. Holt (1993: 19) agrees that human relations is the ability to work effectively, lead and ensure harmonious interpersonal relations.

First line management is the stage whereby managers would now establish performance and productivity standards as a form of control to accomplish the goals and objectives at top management. Stoner *et al* (1995:17) describe the technical skill as the ability to use the procedures, techniques and knowledge of a specialized field. Holt (1993: 19) concurs that the technical skill is the ability to use tools, apply specialized knowledge, and manage processes and techniques.

Figure 2.4 also demonstrates the external environment which is an important factor that would influence managers and management in an organization. Stoner *et al* (1995: 63) identify that the external environment comprises of direct action and indirect action elements.

Stoner *et al* (1995: 63) further highlight that direct action elements include shareholders, unions, suppliers, government, customers, competitors, special interest groups and financial institutions which directly influence an organization and indirect action elements are identified as technology, economy, and politics of a society that affect the climate in which an organization operates and have the potential to become direct action elements. These elements create a climate, rapidly changing technology, economic growth or decline, changes in attitudes toward work in which the organization exists and to which it may ultimately have to respond Stoner *et al* (1995: 74).

Keiser (1979: 36) concurs that no management operates in a vacuum, and an effective and efficient manager must understand these external factors and be able to adapt to them.

Guests expect procedures to be designed to ensure a smooth flow of service which is tailored to meet their individual needs. Keiser (1979: 32) finds that industries where the product is service and tends to be handcrafted, management concerns itself with people.

Hospitality is a people industry and in **Figure 2.3**, Jones and Lockwood (1989: 111) envision the management of the service encounter with the application of the hospitality management functions in illustrated **Figure 2.4**. Keiser (1979: 32) points out that in a factory, management deals only with its employees as people; in a retail establishment, the customers are the primary people concerned; whereas the hospitality industry is different, both employees and customers are dealt with at the same time.

In the hospitality industry, employee commitment plays a major role in delivering a good customer experience, in turn leading to customer satisfaction, hence employees must understand the importance of service and its relationship with the customer. Mullins (2001: 137) outlines that the task of management is to make use of staff, and the responsibility of management is to manage as epitomized in the Jones and Lockwood's model (1989: 111) and **Figure 2.4** the applied approach to the relative skills needed for effective performance at different levels of management including the influence of the external environment (Stoner *et al* 1995: 18).

However, the efficiency of staff and their commitment to the aims and philosophy of the establishment are fostered by good human relationships and by the nature of sound managerial behaviour.

Williams and Uysal (2003: 8) concur that in any service industry the service role is basic and essential, and dependent on staff performance, and further explain (2003: 9) that every employee who is in contact with external customers affects customer satisfaction. Berger and Brownwell (2009: 83) indicate that the hospitality industry is a high; contact setting that places physical, mental and emotional demands on employees in terms of the socio and psychological factors as established in Jones and Lockwood's model (1989: 111).

Ford and Heaton (2000: 110) support Jones and Lockwood (1989: 111) in **Figure 2.3**, that managers of effective hospitality organizations understand the value of a strong culture applied in **Figure 2.3** through **Figure 2.4** the applied approach to the relative skills needed for effective performance at different levels of management including the influence of the external environment (Stoner *et al* 1995: 18) and do whatever they can to reaffirm and support what the organization values, and if the culture supports excellent service, then the members learn that providing excellent service is what they are supposed to do.

2.5.2 THE SERVICE EMPLOYEE

Ford and Heaton (2000: 67) elaborate that one of the characteristics of an excellent service strategy is to focus on the entire organizational effort on service.

Pienaar and Willemse (2008: 1053) cite Hochschild (1983) where front-line service industry employees are confronted with extremely stressful and demanding situations, like putting on a smile while dealing with a demanding and insulting customer, emotional labour is typically evident. Pienaar and Willemse (2008: 1053) further cite Pizam (2004) in his definition of emotional labour as associated with higher levels of perceived stress, distress and turnover, and lower levels of satisfaction in the service industries.

Mullins (1995: 5) observes that the particular features of services require an understanding of both internal and external customer behaviour and needs to focus attention on the actual delivery of service. Berger and Brownwell (2009: 7) suggest that understanding the customer proves essential for organizations that strive to deliver quality service.

Piernaar and Willemse (2008: 1054) cited Sandiford and Seymour (2007) who recognize service occupations with a high level of face-to-face contact with customers are significantly different from other types of work, since they contain emotional demands beyond the scope of traditional conceptualisations of work. Ford and Heaton (2000: 68) find that the service strategy commits the organization to hiring people who believe in service, employee training programs emphasize the commitment to service

quality, resources are allocated to serving the customer, the performance and reward systems to carefully designed to reinforce the workforce's commitment to service.

With reference to the Jones and Lockwood's (1989: 111) model in **Figure 2.3,** managers and staff need to know what behaviours they must adopt to deliver a good service experience. Olsen *et al* (1996: 41) suggest that to become and remain a leader in a highly competitive marketplace, a hospitality organization needs competent, well trained, highly motivated people who are dedicated to working together and supporting each other.

Berger and Brownwell (2009: 10) further state that effective hospitality managers understand the importance of staff recruitment, selection and training for the service experience which is highlighted in the Jones and Lockwood's (1989: 111) model. Furthermore, Stoner *et al* (1995: 7) agree that managers can set the tone, influencing attitude that employees have about their work.

Figure 2.5 Applied approach to the guest cycle (Abbott and Lewry 1999: 33)

Figure 2.5 identifies the applied approach to the guest cycle within the hospitality industry. The guest cycle represents the flow of business through a hotel identifying physical contacts, financial exchanges between guest and the hotel.

According to Bardi (2011: 197), guest hospitality begins at the arrival and registration process, as the front desk clerk begins the check-in process with a display of hospitality toward the guest, including eye contact and a warm smile. Bardi (2011: 198) continues by emphasizing the importance of a warm welcome to a guest as essential, as it is expected with a high quality product and a well-developed delivery system. Referring to the guest cycle in **Figure 2.5**, Dix and Baird (1998: 32) agree the reason we care for our customers, is because we want them to come back, and once they have experience a product or service they have enjoyed, they will want to repeat it.

Olsen *et al* (1996: 41) support by stating the quality of the service rendered to external customers (guests) exhibited in **Figure 2.5** depends on the quality of the service rendered to internal customers (staff). Essentially this requires that staff be seen as customers and their expectations understood, which can be identified in the Jones and Lockwood's model (1989: 111), specifically referring to management control, their persuasion of staff, and therefore influencing the service encounter. Referring to the Jones and Lockwood's model (1989: 111) in **Figure 2.3** and **Figure 2.4** the applied approach to the relative skills needed for effective performance at different levels of management including the influence of the external environment (Stoner *et al* 1995: 18)**,** Bardi (2011: 329) states that a hospitality manager needs to visualize the organization as dealing with the customer in terms of cycle of service.

Bardi (2011: 329) further states that the guest cycle is a repeatable sequence of events in which various people try to meet the customer's needs and expectations at each point which is illustrated in **Figure 2.5** the applied approach to the guest cycle (Abbott and Lewry 1999: 33).

Berger and Brownwell (2009: 11) observe that service within is a term for the concept of internal service and this philosophy holds that employees, supervisors and

managers must be treated well and given good service in the same way that customers are provided with excellent care.

Barrows and Powers (2009: 296) recognize the Marriot Corporation Philosophy,

> *Give to your employees and they will give back to you.*

Giving to your employees would encourage and motivate them to give back to the organization, and every employee has a direct or indirect responsibility of service quality and customer satisfaction which Jones and Lockwood (1989: 111) illustrate in **Figure 2.3.** Berger and Brownwell (2009: 11) support that employees who feel valued and appreciated will in turn provide service excellence to the guest.

The employee of the service organization engages in service encounters for a large part of their working day presented in the guest cycle in **Figure 2.5**, and these interactions with the customers are central to the employee's self-perception.

Hence, Mullins (2001: 86) identifies that managers need to understand the feelings of staff, their needs and expectations, together with a genuine concern for their welfare, which will go a long way in encouraging them to perform well (identified in the Jones and Lockwood's model in **Figure 2.3** applied through the management functions illustrated in **Figure 2.4** the applied approach to the relative skills needed for effective performance at different levels of management including the influence of the external environment Stoner *et al* 1995: 18).

2.5.3 MEASURING GUEST SATISFACTION

New hospitality organizations arise every day, and service may be the leading competitive edge in the hospitality industry, which gives the establishment an identity in the competing market. Hence, in connection with **Figure 2.3**, Jones and Lockwood (1989: 164) believe that following on from new product development and marketing customer's perceptions need to be analysed on an ongoing basis, and further states that guest satisfaction may be monitored in three main ways are as follows:

- Unsolicited complaints and compliments;
- Comment cards; and

- Customer surveys.

Ford and Heaton (2000: 370) support that acquiring feedback may allow recovery from service failures depicted in the service encounter and the interpersonal interactions in both the Jones and Lockwood's model (1989: 111) and the guest cycle (**Figure 2.5**). Ford and Heaton (2000: 370) further identifies that training also represented in **Figure 2.3** (the Jones and Lockwood's model 1989: 111), should therefore include service recovery techniques. Barrows and Powers (2009: 290) explain that quality service is consistently meeting and exceeding customer expectations and further agrees (2009: 291) that the true measurement rests with the individual customer, of which is exemplified in the Jones and Lockwood's model (1989: 111).

2.6 HEALTH CARE IN SOUTH AFRICA

Governments through ministries of health and other related ministries and agencies play an important role in the development of health, through the strengthening of health care systems with financial and other resources. This allows health care systems to achieve their goals of improving health, reducing health inequalities and financing and responding to the population needs.

After South Africa's first democratic elections in 1994, the dismantling of the country's race-based health system began. During the Apartheid era hospitals were assigned to particular racial groups and most were concentrated in white areas. Over the past few years the health sector has undergone rapid change to make it more equitable and accessible to the needy and since 1994, more than 1300 clinics have been built or upgraded (Health Care South Africa, 2009).

Health care is structured into private and public sectors. South Africa's health system consists of a large public sector and a smaller but fast growing private sector. Health care varies from the basic primary health care, offered free by the state, to highly specialized hi-tech health services available in the private sector for those who can afford it (South African Information, 2008).

The Constitution (1996) contains a Bill of Rights, which enshrines the rights of all people in the country and affirms the democratic values of human dignity, equality and freedom. This Bill applies to all law and legislature. It also embodies the principle that everyone has a right to life, a right to health care services and no one may be refused emergency medical treatment.

The Government plays a huge role in influencing the welfare of their citizens in both the private and public sectors, and Shah (2005: 1) stipulates that effective and efficient delivery of the basic services of health care to citizens has always been one of the yard sticks of good governance. With reference to The Hospitality and Tourism network in **Figure 2.2**, Du Toit *et al* (2002: 80) supports that public service delivery is a crucial responsibility of government and government institutions.

Ndebele (2008) acknowledges that the provincial Government has an obligation, commitment and responsibility to improve the lives of its citizens of the province and further states that it is the government's responsibility to ensure a better quality of life for all.

The mission of The Department of Health is to improve health status through the prevention of illness and disease through the promotion of healthy lifestyles and to consistently improve the health care delivery system by focusing on access, equity, efficiency, quality and sustainability (KwaZulu Natal Department of Health, Annual report 2007-2008).

South Africans live in a society in which reflects great disparities in wealth. Millions of people are living in deplorable conditions and in great poverty. There is a high level of unemployment, inadequate social security, and many do not have access to clean water or to adequate health services. The constitution provides a commitment to address these issues, and to transform our society into one in which there will be human dignity, freedom and equality (Constitutional Court of South Africa 1997).

The obligation of the Government is further defined in the Health Act (2000), by declaring the responsibility of the provincial health care providers which are the

hospitals within the public sector and the rights and entitlement of the health care users which are the patients (KwaZulu-Natal health act, No. 4 of 2000).
Mseleku (2007) states in the National Policy on Quality in Health Care that there are ways to improve the quality of care in both the public and private sectors. The policy sets out the main objectives of Government to assure the quality in health care and to continuously improve the care that is provided. The national aim includes addressing access to health care; reducing underlying causes of illness, injury and disability through preventative and health promotion activities; ensuring the appropriate use of health care services and reducing health care errors. The national aims also reflect the needs of specific vulnerable populations and geographical areas.

Referring to **Figure 2.4** the applied approach to the relative skills needed for effective performance at different levels of management including the influence of the external environment (Stoner *et al* 1995: 18), Mseleku (2007) further states that achieving the goal of a quality health care system requires a national commitment to measure, improve and maintain high-quality health care for all its citizens. This involves measuring the gap between standards and actual practice, and working out ways to close the gap between the spheres of government.

2.6.1 PROVINCIAL HOSPITALS IN SOUTH AFRICA

According to Kandampully (2007: 5) the national economy of every country depends on its service infrastructure including transport, communication, education, health care and various government entities.

Governance are the actions undertaken to improve the general welfare of a society by means of the services delivered (Du Toit, Knipe, Van Niekerk, Van der Walt and Doyle, 2002: 64).

Intergovernmental relations in a South African context concern the interaction of the different spheres of government.

The Constitution (1996) declares that government is comprised of National, Provincial and Local spheres of government which are distinctive, interdependent and interrelated (The Department of Provincial and Local Government, 2005).

Ministries of health oversee the development of health systems using their governance function, which includes policy analysis and formulation, regulating service delivery between partners, developing norms and standards for quality assurance and ensuring the implementation of agreed upon policies and strategies. Du Toit *et al* (2002: 12) corroborate that governance is the connections and interactions between national, provincial and local authorities and the public they serve.

Level of government and department	Output	Needs to satisfy
National government		
Department of Education	An educated (literate) society	To be trained and developed
South African National Defence Force	Safety and protection	To feel safe and protected
Department of Welfare and Population Development	Provision of welfare services	Help and support
Provincial government		
Department of Health	Health society	To be trained and cured
Department of Environmental Affairs	Healthy and clean environment	To live in a healthy environment
Department of Housing	Houses	To have a house to live in
Local government		
Health Department	Healthy and clean town	That refuse is removed
Roads	Roads	Opportunity to travel
Parks and Recreation	Parks and sports facilities	Recreational needs

Table 2.1 Examples of national, provincial and local government departments, their outputs and what needs such outputs satisfy (Du Toit *et al* 2002: 10)

Table 2.1 exhibits the three spheres of government which deliver certain services according to their priorities of importance. Du Toit *et al* (2002: 10) explains in **Table 2.1** the names of state departments, departments of provincial governments and the functional departments of local departments indicate the typical needs that sphered governments and government institutions have to satisfy.

Gildenhuys and Knipe (2000: 56) verify that governments, at all spheres, are to supply and deliver public goods and services to their communities. Goss (2001: 36) submits

that the most important relationship in governance is not between levels of government, but between government and people.

The Constitution (1996) spells out the powers and functions of the three spheres of government that form the bedrock for the division of functions within the national health system. Thus the national sphere has the power to make national legislation, set norms and standards, relate to international organizations and the Ministries of Health of other countries, monitor the delivery of services and take over this function when a province is incapable of providing services, and providing services which, because of economies of scale or financial constraints cannot be provided at provincial level. The provinces are charged with planning, regulating and providing health services with the exception of municipal health services. Local government or municipalities are responsible for the rendering of municipal health services (McCoy, Bennett and Pillay, 2001).

2.6.2 THE IMPACT OF LEGISLATION IN PROVINCIAL HOSPITALS IN SOUTH AFRICA

The Department of Health aims to ensure that all South Africans have access to affordable, good quality healthcare through a caring and effective national health system based on the primary healthcare approach (South African Government Information, 2008).

According to Balfour (date unavailable) the following pieces of legislation govern health services in South Africa:

- The Constitution of the Republic of South Africa;
- National Health Act 61 of 2003; and
- Health Act 63 of 1977

In connection with national sphere of government in **Table 2.1** The National Health Act, 2003 provides a framework for a single health system for South Africa. It highlights the rights and responsibilities of health providers and healthcare users, and ensures broader community participation in healthcare delivery from a health facility level up to national level. It establishes provincial health services and outlines the general

functions of provincial health departments (South African Government Information, 2008).

According to South African Government Information (2008), The National Health Act of 2003 also provides for the right of citizens in terms of the right to emergency medical treatment; the right to have full knowledge of one's condition; the right to exercise one's informed consent; the right to participate in decisions regarding one's health; the right to be informed when one is participating in research; the right to confidentiality and access to health records to complain about service; and the right of health workers to be treated with respect.

The provincial sphere of government in **Table 2.1**, the national department assists provincial health departments to develop service-transformation plans to reshape and resize the health services and develop appropriate, adequately resourced and sustainable health service-delivery platforms, which are responsive to needs (South African Government Information, 2008).

The South African Government Information (2008) states that the provincial health departments are responsible for providing or rendering health services;
formulating and implementing provincial health policy, standards and legislation;
planning and managing a provincial health information system; researching health services to ensure efficiency and quality; controlling quality of health services and facilities; screening applications for licensing and inspecting private health facilities; coordinating the funding and financial management of district health authorities and consulting effectively on health matters at community level ensuring that delegating functions are performed.

In connection within the local sphere of government in **Table 2.1**, Du Toit *et al* (2002: 11) identifies that local government is responsible for rendering the following:

- *Preventative and promoting healthcare, with some municipalities rendering curative care;*
- *Environmental health services, including the supply of safe and adequate drinking water, sewage disposal and refuse removal; and*

- *Regulation of air pollution, municipal airports, firefighting services, licensing and abattoirs.*

Along with Balfour's (date unavailable) stated pieces of legislation, there are necessary acts of labour relations, skills development, employment equity and the occupational health and safety which govern the way health care is provided.

In terms of health care and occupational health and safety, The Department of Labour (2011) declares that The Occupational Health and Safety Act: No 85 of 1993 aims to provide for the health and safety of persons at work and for the health and safety of persons in connection with the activities of persons at work and to establish an advisory council for occupational health and safety.

Furthermore, within health care this act is fundamental due to the nature of operations in delivering health care services to the public. Health care employees are constantly around patients who are ill. Tests including needles and blood are performed daily due to the nature of illness and diagnosis. Therefore precaution and safety regulations and procedures would be elementary in the practice and delivery of health care.

Further supporting legislation which are in place that govern the practise within health care services is:

- The Public Financial Management Act No.1 of 1999 amended by Act of 29 of 1999.

According to the Department of National Treasury (2010), The Public Finance Management Act (PFMA), as amended, is one of the most important pieces of legislation passed by the first democratic government in South Africa. The Act promotes the objective of good financial management in order to maximise service delivery through the effective and efficient use of the limited resources.

The National Treasury is responsible for managing South Africa's national government finances. The Department of National Treasury (2010) states that the efficient and sustainable public financial management is fundamental to the promotion of economic

development, good governance, social progress and a rising standard of living for all South Africans. The Constitution of the Republic (Chapter 13) mandates the National Treasury to ensure transparency, accountability and sound financial controls in the management of public finances.

With specific reference and application to **Table 2.1**, the key objectives of the Act may be summarized as being to modernise the system of financial management in the public sector; enable public sector managers to manage, but at the same time be held more accountable; ensure the timely provision of quality information; and eliminate the waste and corruption in the use of public assets (Department of National Treasury, 2010).

Contributing towards the legislations that steer the practice of health care is the current development of the National Health Insurance (NHI). According to van Eck (2011), the South African government is currently in the process of a major health sector of reform that is aimed at achieving universal access to good quality health care for all South Africans, whereby a National Health Insurance (NHI) has been proposed as the fundamental component of this reform process.

The National Health Insurance (NHI) is a financing system that will make sure that all citizens of South Africa (and legal long-term residents) are provided with essential healthcare, regardless of their employment status and ability to make a direct monetary contribution to the NHI Fund (The Department of Health, 2011).

It is understood that the healthcare is a human right stipulated by the Constitution, and The Department of Health (2011) is aware that people continue to die prematurely and suffer unnecessarily from poor health in the country which is mainly caused by a skewed health care financing system, hence the Green Paper process of the National Health Insurance (NHI).

According to The Department of Health (2011) the purpose of the Green Paper is to outline the broad policy proposals for the implementation of the NHI and the document is published for public comment and engagement on the broad principles.

After the consultation process the policy document or White Paper will be finalized. Thereafter draft legislation will be developed and published for public engagement. After public engagement the legislation will be finalized and submitted to Parliament for consideration. Once Parliamentary approval, the Bill has to be approved by the President of the Republic (Department of Health, 2011).

According to The Department of Health (2011), the purpose of this health insurance is due to the consideration of a combination of factors such as the district's health profile, demographics, income levels and other social factors impacting on health, health delivery performance, management of health institutions, and compliance with quality standards.

2.6.3 SERVICE FUNDAMENTALS IN PROVINCIAL HOSPITALS

Nezifo *et al* (2007) asserts that the Provincial Department of Health in **Table 2.1** constitutes basic principles to citizen health care called the "Batho Pele". It constitutes principles that citizens are entitled to courtesy, consideration, transparency and value for money when they are provided with health care, similarly pointed out with guests and the service encounter represented in **Figure 2.3** (Jones and Lockwood's 1989: 111).

Fraser-Moleketi (2007) defines the Batho Pele, a Sotho translation for "People First", as an initiative to get public servants to be service orientated, to strive for excellence in service delivery and to commit to continuous service delivery improvement. It is a simple and transparent mechanism, which allows citizens to hold public servants accountable for the level of services they deliver.

The Batho Pele principles drive an approach which is typical to the concept of hospitality. Du Toit *et al* (2002: 109) emphasize the similarities with hospitality in the following headings:

> ***Service standards***: *citizens must be informed about the level and quality of the services they will receive in order for them to know what to expect.*

This implies that public servants must deliver the level and quality of services they have undertaken to provide. Failing to do so means that citizens have a

right to complain and demand quality services. In the hospitality industry, Kotas *et al* (1996: 272) emphasize the importance of meeting customer needs, and when there are no gaps between what the customer expects and what the customer gets, quality is present, and demonstrated in **Figure 2.3** (Jones and Lockwood's model 1989: 111).

Du Toit *et al* (2002: 109) emphasizes further:

> ***Access:*** *citizens have a legitimate right to equal access to services, and public servants must not withhold that right from them*.

This asserts that all citizens should have equal access to the services to which they are entitled. Whitney (1990) suggests in the principle of rights, that right is not based so much on the individual guest's status as it is upon the fact that the guest is a human being, and life itself is a moral entitlement.

Du Toit *et al* (2002: 109) defines:

> ***Courtesy:*** *citizens should be treated with courtesy and consideration.*

According to this principle, public servants must treat every citizen with courtesy and consideration, irrespective of the social status of the person. Brownwell and Berger (2009: 12) believes every employee's activities, no matter what position they hold, affect the customer, and epitomized in **Figure 2.3** (Jones and Lockwood's model 1989: 111).

Du Toit *et al* (2002: 109) further defines:

> ***Value for money****: citizens have the right to demand that the services they receive are real value for money paid for them.*

This makes public servants responsible for providing efficient, effective and economic services – value for money. Ford and Heaton (2000: 11) highlights the most important component of service delivery in the hospitality industry, are the people in the organization that interact with customers or guests, and it is attitude, friendliness and genuine concern of the organization staff that determine both the value and the quality of the experience of the guest which is demonstrated in **Figure 2.3** (Jones and Lockwood's model 1989: 111).

The Batho Pele Principles represent the people, and they emphasize their right to how they should be treated when receiving health care, and these fundamental principles

are in conjunction with the Bill of Rights within the Constitution, the rights of citizens which can be recognized by management illustrated in **Figure 2.4** (the applied approach to the relative skills needed for effective performance at different levels of management including the influence of the external environment Stoner *et al* 1995: 18) and applied in **Table 2.1** (Examples of national, provincial and local government departments, their outputs and what needs such outputs satisfy Du Toit *et al* 2002: 10) as it is applied **Figure 2.5** (the applied approach to the guest cycle Abbott and Lewry 1999: 33) within the hospitality industry.

The Batho Pele is not an "add-on" activity. It is a way of delivering services by putting citizens at the centre of public service planning and operations. It is a major departure from a dispensation, which excluded the majority of South Africans from government machinery to the one that seeks to include all citizens for the achievement of a better-life-for-all through services, products, and programmes of a democratic dispensation (Fraser-Moleketi, 2007).

According to Nzimakwe and Mpehle (2012) the aim of introducing these principles was not only to transform the culture of public service delivery, but also to prescribe citizens' service packages, set service standards that can be benchmarked against international standards. Nzimakwe and Mpehle (2012) further state that the Batho Pele Principles aims to ensure that citizens are the central focus in service delivery, and therefore are put first.

2.6.4 NATIONAL, PROVINCIAL AND LOCAL CHALLENGES THAT IMPACT ON SERVICE DELIVERY IN HEALTH CARE IN SOUTH AFRICA

As mentioned in **Chapter 1** of this study, with a population of over 9.5 million people, the province of KwaZulu Natal can be seen as one of the most densely populated of the nine provinces. Accompanying the over population are some of the most serious socio-economic challenges such as high levels of poverty; poor infrastructure, as well as high levels of illiteracy and innumeracy. One of the departments affected is The Department of Health. The difficulties relating to health cannot be viewed in isolation and that the government as a whole has to streamline its efforts and interventions dealing with those factors responsible for the crippling economy (KwaZulu Natal Department of Health, Annual report 2005-2006).

The Department of Health has allocated a health budget which grew from R, 7 billion in 2003/04 to R15, 2 billion in 2009/10, representing a growth rate of 11, 9% annually. The Department's budget grew by 14,4% annually between 2004 and 2007. South Africa spent an extra R5,3 billion over the following three years on improving the salaries of doctors and nurses, and boosting recruitment levels in the public health sector (South African Government, 2008). Osborne and Gaebler (1992: 3) argue that government budgets encourage managers to spend money, reason being that if they don't spend the entire budget by the end of their fiscal year, three things may happen: they lose money they have saved; they get less the following year; and the budget director enquires to why so much was needed last year.

However, the public sector is still under-resourced and over-used, while the growing private sector, run largely on commercial lines, caters to middle- and high-income earners who tend to be members of medical schemes, which are a small amount of the population, and to foreigners looking for top-quality surgical procedures at relatively affordable prices. The private sector also attracts most of the country's health professionals (South African Information 2008).

According to Buthelezi (2009) the public health sector is seriously challenged by infrastructural, organizational and staffing shortfalls. Buthelezi (2009) submits that whether one blames this on the legacy of Apartheid or the last 15 years of ineffective leadership at the helm of the Department of Health depends on one's political lens. Buthelezi (2009) further highlights that high infant mortality rates, low life expectancy, the often appalling state of our health clinics and hospitals with their shortages of equipment and medication, the critical shortage of health professionals at public hospitals and the poor treatment of overworked and underpaid health professionals by the previous Minister and MEC for Health – the symptoms are numerous and the diagnosis unmistakable, South Africa's health care system is failing.

The government is under pressure servicing a large portion of the population who are not on medical schemes within the public sector impacting the way service is delivered to the patients. Ntuli (date unavailable) agrees that the perilous growth of private health care providers in connection with the scarcity of resources, including finances and health personnel, inevitably impacts on access to health care for the majority of the

population, and this is a phenomenon worthy of further examination from a human rights perspective.

South African Information (2008) further states that public health consumes around 11% of the government's total budget, which is allocated and spent by the nine provinces. How these resources are allocated, and the standard of health care delivered, varies from province to province. This implies that difficulties begin from top level management and travels through the system ultimately impacting the consumer, which are the patients.

Ntuli (date unavailable) highlights complaints made within provincial hospitals relate to service delivery in the health care system in all the provinces which amounts to disregard for patients' rights; the shortage of ambulance services and poor hospital management, whereas Mfusi (2009: 3) and Premdev (2009: 1) agree that staff lay blame on poor hospital management by CEOs and hospital management claims that the root of the problem lies in the fact that provincial hospitals are understaffed and overcrowded.

Attwood (2008: 1) headlines that state hospitals are in crisis and KZN's health care is on the verge of collapse. State hospitals are complaining that staff are working under intolerable conditions. Conditions such as staff shortages and lack of equipment are leading to the death of patients. Local provincial hospitals indicate their resources are running on empty. Along with the staff shortages and the lack of life saving equipment, basic hygiene tools such as antiseptic soap, towels, scrubs and even cotton wool are in short supply.

Ndebele (2008) and Mbonambi (2009: 1) agree that the local problems of the public sector are attributed to many institutions suffering from inadequate infrastructure. Mbonambi (2009: 1) highlights the lack of space compromises patients' rights to privacy, inadequate staffing impacts on service delivery, resulting in patients waiting in lengthy and exhausting queues at dispensaries. Some may not have the opportunity to receive treatment and patients are often not aware of their rights. Patients lay on beds and on benches in corridors, wrapped in dirty blankets. There is a shortage of

beds and some patients receive treatment in wheel chairs, and some are left unattended with their medical records lost (Mbonambi 2009: 1).

The doctors of these state hospitals claim that these detrimental conditions are damaging service delivery in health and patient care caused by the KZN Department of Health, attempts to recover a budgetary overspend of R1.2 billion in the past financial year by freezing posts and not ordering essential equipment (Attwood, 2008: 1).

Mfusi (2009: 3) reveals that the eThekwini Health Department district manager expresses that public hospitals caters for 88% of the population including the unemployed and those who cannot afford private health care, and this percentage is growing due to the economic crisis. He goes on to say that the current disease burden and patient profile that is faced requires another level of care, but is impossible because of the congestion and the constant sick people that visit provincial hospitals (Mfusi, 2009: 3).

Doctors, general surgeons, specialists, registrars and interns take a stand with threats of strike and abandoning patients, in effort to force the government into adjusting salaries, improving working conditions, opening up currently frozen doctors posts and staffing in all public hospitals. These hospital staff express their doubts of lack of funds, when millions are spent on presidential inaugurations and other official functions (De Boer, 2009: 3).

Along with the challenges that provincial hospitals are undergoing, are allegations of fraud, nepotism and seeking sexual favours for jobs. Allegations extend to bribery, abuse of authority, mendacious qualifications and securing additional salaries for “ghost employees”, employees who are no longer on the payroll of the hospital (Da Costa, 2009: 1).

Accompanying the above allegations, Attwood (2009: 1) discloses that a forensic audit commissioned by the Department of Health has revealed that one of the province’s biggest state hospitals has been looted of millions of Rands over an 18-month period. The audit, which indicates that millions might have been misappropriated between

October 2007 and April 2009, was launched to investigate the allegations of fraud, supplier payment irregularities and intimidation of employees. Attwood (2009: 1) further outlines that this comes against the backdrop of a crippling R1.2 billion budget overspend in the provincial health department last year.

According to Teke (2013: 1) there has been debate around the closing of the 103 year old hospital in the Durban area which is seen as a landmark institution. Teke (2013: 1) states that although McCord hospital's attempts to fight the Apartheid government to close their doors as it defied the Groups Areas Act No.41 of 1950 with treating people across the racial divide. However, Teke (2013: 1) verifies it is not about colour, but accessibility of health services to all.

The imminent closing of this hospital may have a pressuring rippling effect to supporting provincial hospitals in the area and the community they serve. West (2013) indicates that it is likely that McCord will close, the government may buy it and offer free services, or it will become an acquisition opportunity for a private hospital group.

Along with the misfortune of landmark hospitals possibly closing, KwaZulu Natal is further facing a chronic shortage of doctors, with 49% of public health jobs which are not filled (Rondganger, 2013: 1).

2.7 HOSPITALITY AND HOSPITALS

A hospital is an institution for the treatment, care, and cure of the sick and wounded, for the study of disease, and for the training of physicians, nurses, and allied health care personnel (Medical Dictionary, 2012).

A hospital can be defined as a hospitality organization as it offers people food, shelter and security to those away from their home with the addition of health care. Barrows and Powers (2009: 4) distinguish that the word "hospitality" is derived from "hospice" clearly related to hospital, also referred to an early form of what is also known as a nursing home.

A person visiting a hospital is not from a desired choice, but from a need to improve health. Pizam, Lewis, and Manning (1982: 4) indicate that the sector of the economy termed “hotels and other lodging places” serves as a source of livelihood for a significant proportion of the labour force. Pizam *et al* (1982: 8) continues by saying that a growing number of people view their vacations away from home as a necessity rather than a luxury.

In connection with the hospitality and tourism network (**Figure 2.2**), Soumya (2001) suggests that the most popular role of hospitality within the hospital sector is the supporting of back of house areas. Singh (2006) questions whether it's through the avenues of food and beverage or facility management that hospitals are outsourcing these vital components of their new business models to the players with core competencies in this field - the hospitality industry.

Front of house may be considered as the areas that patients have direct contact with doctors, nurses and the general health care personnel, such as the area where patients are checked in, settle their accounts, how they are directed to their wards, and the personnel responsible for afterhours treatment. These are the primary interactions between patient and health care personnel which establishes the element of service in hospitals (Blom, 2006).

Many medical facilities in hospitals are mimicking hotel environments. Singh (2006) certifies that hospitals are now taking the phrase 'being hospitable' to a new level, and believes who better to turn to than the hospitality industry itself for assistance.

According to Singh (2006) the trend towards enhanced quality of services started when Dr Naresh Trehan, an executive director and chief cardiac surgeon, who worked in the US came and retuned to India in 1988, was keen on maintaining the standards he had witnessed and experienced in the US. All this meant a rigid clean and hygiene policy and exceptional Food and Beverage guidelines.

Fottler, Ford, Roberts, Ford and Spears (2000: 91) agree that over the last ten years the health care industry has recognized that the physical environment is a valuable resource that can affect all of its customers.

The accepted differences between that clientele that visit these two establishments are that hospitals refer to their customers as patients and the hospitality industry refer

to their customers as guests. Reasons being that people visit hospitals because they are ill therefore they are classified as patients.

However, both patients and guests have a common goal in mind when visiting either a hospital or hotel, is the constant quest for comfort and security, and it can be argued that patients require more comfort, security and kindness due to the fact that they are ailing and The Patient's Rights Charter (date unavailable) states that there should be a continuity of care, where no one shall be abandoned by a health care professional worker or a health facility which initially took responsibility for one's health.

Whitney (1990: 58) explains that hospitality is one of the noblest words in the English language, connoting welcome, friendship, comfort and gracious service. He goes on by clarifying that hospitality is distinguished by expressions of kindness, treating others as we would like to be treated and ensuring the provision of comfort. According to Ford and Heaton (2000: 5) hospitality is different, as it is a challenge because the hospitality product is the experience that is delivered.

Fottler *et al* (2000: 91) highlight a significant statement that although most service organizations give some thought to setting, its importance that the service experience has been most thoroughly understood by those who view and treat their customers as guests.

It is understood that the hospitality industry is a people industry and the main product that is sold is service. The intangibility of service makes the hospitality business a different organization. Service is the integral part of the hospitality experience. To be of service means to attend to someone's needs, involving helping, giving and meeting needs to both patient and guest, and Srinivasan (2008: 177) positions that a hospital is in the service industry with a noble cause.

According to the Batho Pele Principles, these principles educate the public sector that health care should also be provided to the people in the way they would want to be treated and Nzimakwe and Mpehle (2012) state that the main aim of The Batho Pele Principles was to provide good customer service to citizens.

Kotas *et al* (1996: 259) authenticates by stating that the vital importance of providing customers with excellent service and consistent service delivery is to generate customer satisfaction which is found in the Batho Pele Principles.

According to Clarke and Chen (2007: 5) a hospitality relationship was defined in terms of honour and respect within a reciprocal framework, and The Batho Pele Principles enforce that patients are entitled to be treated with courtesy and consideration. They highlight the significance of service and service standards which should meet the expectations' of the patient. It also points out the importance of improving service delivery and customer satisfaction. These are common values that steer the hospitality industry succeeded through the application of hospitality management identified in **Figure 2.4** and applied in **Figure 2.5** the applied guest cycle.

Ford and Heaton (2000: 11) agree that the element of service is what brings the client to the organization in the first place. Cetron *et al* (2006: 3) insists that service does not happen in a vacuum, it grows out of complete mastery of the basics. Cetron *et al* (2006: 3) continues by defining the basics as the strengths and weaknesses of any business, understanding what is necessary and doing it well, which supports Keiser's theory of hospitality management not operating in vacuum.

According to Randall and Senior (1994: 68), the National Health Service (NHS) in the United Kingdom, has a support service which is often referred to as "hotel services" and the standards of these services are a key determinant of the overall perception that patients have of the quality of their experience while in the care of the NHS.

The KwaZulu-Natal Citizens' Charter in 2005 made a pledge for the creation of an environment that is characterized by a culture of service excellence that starts with treating citizens as customers (Ndebele, 2008).

Srinivasan (2008: 173) agrees that customers in a hospital context would not only include those who are direct recipients of the service but also those who come into contact with the hospital are its potential customers. And further outlines (2008: 174) that internal customers would comprise of:

- *Doctors;*

- *Nurses;*
- *Patient care service staff; and*
- *Non patient care service staff.*

Srinivasan (2008: 174) highlights that the external customers would comprise of:

- *Patient;*
- *Consumers of the hospital service;*
- *Patient attendants; and*
- *Patient visitors.*

Similarly within hospitality, Williams and Uysal (2003: 1) emphasize the importance that customer satisfaction has become an essential business issue, as organizations have realized the significant outcomes achieved when providing effective customer service. It can make the difference between a company's survival and failure. Van der Wagen (1999: 195) supports that good service is about understanding customer needs and perceptions that needs to be attended to with effectiveness and efficiency by the hospitality organization and its staff that is obtained through **Figure 2.3** (the Jones and Lockwood's model) and accomplished through hospitality management assisted with **Figure 2.4** (the applied approach to the relative skills needed for effective performance at different levels of management including the influence of the external environment Stoner *et al* 1995: 18).

Efficiency becomes important if we take into consideration that the resources available to deliver services are far less than what the public demands in terms of service delivery. Because of the continuous shortage of resources, the efficiency and economy of government institutions and public officials is crucial. Apart from this, the public also expects efficiency, effectiveness and economy from government institutions and public servants (Van der Walt and Du Toit, 1999: 107).

Hospitality is referred to as an industry that takes care of people who are away from their home and Mullins (1995: 9) confirms that efficient service and effective service delivery is paramount to a successful hospitality operation and customer satisfaction. In health care Du Toit *et al* (2002: 109) upholds the following:

- *Government institutions' obligation to deliver services efficiently, effectively and economically;*
- *The public's legitimate right to receive efficient, effective and economic services; and*
- *The public's legitimate right to demand quality services if standards drop.*

Du Toit *et al* (2002: 109) state that it is the governments' responsibility to provide service to the public which is effective, efficient and economical. The public are entitled to receive and demand quality services which are also highlighted in the Batho Pele Principles. Nzimakwe and Mpehle (2012: 279) recognize that in order for the Batho Pele Principles to be implemented successfully and excellence in service delivery is achieved, public servants need to be service-orientated, accountable and be committed to continuous service delivery improvement with a sense of duty. Nzimakwe and Mpehle (2012: 279) further state that all this can be achieved if public servants have a sense of belonging, and feel appreciated and important in an organization.
Hospitality is more than the extended service product that is provided by hotels and restaurants. It is evident that hospitality and hospitality management has its place within the health care environment, and it constitutes a significant role as it outlines the importance of efficient and effective service delivery and customer satisfaction represented in **Figure 2.3** (Jones and Lockwood model 1989: 111).

The Batho Pele Principles pertains to efficient service and service delivery which is key to the government's obligation of achieving their objectives that is defined within the Health Act (2000) and the Bill of Rights.

Mader (2003) suggests,

> *"There is a real trend in the industry for the health care environment to move from being institutional to being much more inviting with a gentle touch and a warm smile."*

It is clear that hospitals offer more than just health care where hospitals may be considered as an establishment providing healing hospitality. Hence, Ahmed (2005: 37) points outs that the hospitality industry provides a significant service to all who are away from their home. This establishes that hospitality plays a considerable role in

front of house areas, associating with people providing a service that promotes a recovery within the realm of hospitality as it is to those who are away from their home searching for comfort and security.

Furthermore, and with reference to Jones and Lockwood's (1989: 111) model in **Figure 2.3**, the delivery of consistent quality service hinges on the versatile employees who are knowledgeable and skilled in their respective positions and who understand and gain satisfaction from their positive impact to each guest's visit and in health to each patient's visit.

2.8 SUMMARY

The literature review discussed the evolution of the hospitality industry and explained the beliefs of service and service delivery in which hospitality established its roots. This chapter further focuses on health care and the role of government in South Africa explaining legislation involved and how health care is governed.

The leading challenges experienced by provincial hospitals were also highlighted. Emerging from the literature are the leading themes of the study of management practices and processes where service delivery emanates, environmental impacts and influences specifically focusing on the entities which guide and manage health care within South Africa. The chapter concludes with similarities of hospitality and hospitals where the Batho Pele Principles are found to have parallel standards in the way that service is delivered within the hospitality industry. The Operations **Chapter 3** follows, researching the designated area of study which is the provincial hospital in the southern area of Durban, KwaZulu Natal.

CHAPTER 3

OPERATIONAL PERSPECTIVE OF THE PROVINCIAL HOSPITAL IN THE SOUTHERN DISTRICT OF DURBAN AND ITS RELEVANCE TO HOSPITALITY

3.1 INTRODUCTION

Hospitals are primarily for those who need in-patient care, although all have out-patient departments, casualty and emergency care. During the Apartheid era, there were huge inequities in the quality of care between hospitals in formerly black areas, and hospitals in urban areas to serve white patients. These inequalities still exist today.

According to the National Health Plan for South Africa (2008), the South African government, through its Apartheid Policies, developed a health care system which was sustained through the years by the circulation of racist legislation and the creation of institutions such as political and statutory bodies for the control of the health care professions and facilities. These institutions and facilities were built and managed with the specific aim of sustaining racial segregation and discrimination in health care.

Furthermore, the challenge that South Africans face is the design of a thorough programme to redress the social and economic injustices, to eradicate poverty, reduce waste, increase efficiency and promote greater control by communities and individuals. The National Health Plan for South Africa (2008) states that within the health sector, a complete transformation of the health care delivery system is needed.

The objectives of this chapter are:

- Trace the existence of the Provincial Hospital in the southern area of Durban, KZN;
- Explore the operational practices of the Provincial Hospital in the southern area of Durban, KZN;
- Provide an analysis of the customer/patient that the makes use of Provincial Hospital services;
- Examine the relevance of the customer cycle within the Provincial Hospital in the southern area of Durban, KZN; and
- Develop an applied service model to the functioning of the Provincial Hospital of research.

3.2 BACKGROUND

The focussed area of this study is within a provincial hospital in the southern area of Durban, KwaZulu Natal and has grown to be one of the prominent hospitals within the community which depends on the vital service that it renders.

Hence this chapter includes the history to date of the area of study, Chatsworth, and the history to date of the provincial hospital. It is important to understand the geographical information of Chatsworth and how it impacts on service delivered at the Provincial Hospital. Along with the history, the Provincial Hospital operations, vision and mission, with the various departments are discussed in detail. This clarifies the similarities between the hospitality industry and health care in **Chapters 2** and **3**.

Furthermore, a model is adapted from the hospitality industry provided in the literature review and is enhanced and adapted at the close of this chapter.

3.2.1 HISTORY OF THE DISTRICT OF CHATSWORTH

Chatsworth is a large township in Durban, South Africa. This area was created as a result of the Apartheid Government and the Group Areas Act in the late 1960s. It was designated for use by the Indian population only and by those who were removed from their initial areas of occupation due to racial segregation and the implications of the Group Areas Act.

Because of this, parts of Chatsworth are still characterised by extreme poverty separated from the developed resort areas of Durban. However there are also large middle class and wealthy areas.

Mathuray (2005) conveys that Chatsworth is world-renowned for its diversity in culture, religion and society. Mathuray (2005) supports that consisting of a population of approximately 450 000, this suburb is considered to be the heart of the Indian community and created by the Old Apartheid Regime of White dominance in South Africa

As a consequence of its history, Chatsworth is still a predominantly Indian population growing rigidly, with many economic interests in favour of Indians. It boasts many of the Indian cultures that were acquired from their ancestors from India, and is home to the Temple of Understanding.

According to Freund (1995) and Horrel (1956) The Pegging Act, 43 of 1942, and the Ghetto Act of 1946 gave the government the right to remove and destroy shacks and small self-made shelters with the intention of improving sanitary conditions.

This led to the Group Areas Act of June 1950, which designated certain areas for the Whites and other areas for Indians, Coloureds and Africans. Indians were removed from areas such as Mayville, Cato Manor, the Clairwood and Magazine Barracks, and the Bluff, and were placed in areas like Riverside, Prospect Hall, Duikerfontein and Sea Cow Lake. By 1950, there were advertisements in the papers of an exclusively Indian suburb, Umhlatuzana. Later, Silverglen and Red Hill were also developed (Freund,1995 and Horrel,1956).

Then in the early 1960s Chatsworth was planned, opening in 1964 and consisting of eleven neighbourhood units. Modern day Chatsworth has 64 suburbs that fall within its region. Chatsworth was deliberately built to act as a buffer between white residential areas and the large African township of Umlazi (Freund,1995 and Horrel,1956).

According to Desai (2002) “the poors” was established when Nelson Mandela was elected president of South Africa in 1994, where freedom-loving people around the world hailed a victory over racial domination. The end of Apartheid did not change the basic conditions of the oppressed majority. Material inequality has deepened and new forms of solidarity and resistance have emerged in communities that have forged new and dynamic political identities Desai (2002).

The Chatsworth area is now a fully-fledged suburb of Durban and boasts industrial development with strong infrastructure and has contributed to the growing intellectual capital and business environment of Durban.

In May 1999, Professor Fatima Meer, hero of the struggle against Apartheid, arrived in Chatsworth with a small organisation called the Concerned Citizens Group (CCG). CCG's mission was to persuade the 250,000 voters in this community to vote for the ANC rather than the "white parties" in the coming general elections. The business and professional elite embraced her call but the poor told her that they were "not concerned about their former oppressors but were angry at their present oppressors" (Pithouse, 2000).

According to Pithouse (2000), Meer threw her energy into the compilation of a research report that she intended to present to the government to show that people were not able to pay their rates and rent and to argue that poverty was not grounds for eviction and disconnection.
Pithouse (2000) further highlights that Meer submitted her report to the ANC and was horrified that after the elections ANC councillors were "among the most vociferous in insisting that electricity and water cut-offs and evictions be visited on the poor". She found that the "disciples of a better life for all were behaving as if poverty itself were a crime" (Pithouse, 2000).

3.2.1.1 CHATSWORTH CURRENTLY

Chatsworth, as a result of its history, is still predominantly Indian today, although there is a healthy mix of African, Indian, White and Coloured residents (www.SA-Venues.com).

Chatsworth has currently a mixed population with diverse cultures and extreme economic backgrounds. There are low income earners, middle income earners and high income earners. However there is little hope for low income earners to become top earners due to the nature of competition in the Chatsworth area.

Dawad, Dalal and Gibbs (2009) found that Chatsworth currently has an approximate population of 750 000, with informal settlements providing housing for refugees and other black urban residents as well. Informal settlements including Luganda, Bottlebrush and Welbedacht now have their place within the surrounding Chatsworth area. According to an overview report by Crossmoor (2009), the people in the formal areas often leave due to the escalating crime levels which are attributed to the high levels of unemployment and drug abuse.

However, it is not all gloom and doom for Chatsworth, it is also an area which thrives on cultures of sports and strong sense of community. Although Chatsworth remains a predominantly Indian population, the diverse cultures which inhabit this area have a strong community setting. Neighbours support and assist each other irrespective of differing beliefs.

3.2.2 HISTORY OF THE PROVINCIAL HOSPITAL

The Provincial Hospital is a District and Regional Hospital in line with the policy of the Provincial and National Departments of Health (Patient information booklet). It has 543 beds and is located in Chatsworth, a suburb in the eThekwini health district (Chetty, 2009). It bears the name of the renowned Indian philanthropist and humanitarian who founded the hospital and the Dispensary Trust which donated 50% of the initial capital costs of building the core block of the hospital.

The doors of the Provincial Hospital were opened on 3 March 1969. The first patient, an Indian male, was directed to the consulting rooms with all categories of staff in attendance for the historic occasion and privileged to be present (Govender, Maharaj, Mannadiar, Naidoo, Naidoo, Nobin, Pillay, Pillay, and Rajput,1969). According to Subban (2009), the hospital has grown from being a minor district level hospital to one of the major hospitals in the Ethekwini District providing the full package of services expected from a regional/district hospital.

Govender *et al* (1969: 15) explain that the professional staff compliment were only a handful at that time, were enthusiastically committed to the success of the new community based hospital, and further indicate (1969: 19) that the Provincial hospital attracted patients from a wide area, not only from Chatsworth and the Durban metropolitan complexes but also from the northern and southern coastal towns, and the inland regions.

Subban (2009), further states that the Hospital Board has been active throughout the existence of the hospital and in November 2002 Friends of R.K.Khan (FORKK), an organization that recruits volunteers to assist the hospital and raises funds to undertake various projects in the hospital, was formed. Subban (2009) identifies that religious groups like the Sri Sathya Sai Organization and Tea for Africa have worked with the hospital over many years in assisting patients. The hospital is also involved in an initiative of using community facilities and organizations to dispense medication to patients in an effort to decongest the hospital pharmacy and improve patient waiting times (Subban, 2009).

3.3 VISION AND MISSION OF THE PROVINCIAL HOSPITAL

Chetty (2009) states that the hospital vision is:

> *To see The Provincial Hospital as a leading health care facility in KwaZulu-Natal. This vision is supported by the hospital's mission, objectives and core values of the KwaZulu-Natal Department of Health.*

The mission of the Provincial Hospital is to deliver a comprehensive mainly curative health service of a high standard to all people in their region, with compassion and empathy, in a cost effective manner (Patient Information Booklet).

This mission is endorsed by the KwaZulu-Natal Department of Health (2001) as their mission is to develop a sustainable, co-ordinated, integrated and comprehensive health system at all levels, based on the primary health care approach through the district health system.

The Dispensary Trust donated 50 percent of the initial capital cost of building the core block of the hospital. The site on which the hospital stands is 44.9459 acres in extent; originally prime farming area, earmarked for housing purposes. The provincial hospital has grown from being a community hospital to one of the four major hospitals in the Durban region. It is a referral hospital for St. Mary's Hospital and KwaDabeka Clinic (Chetty, 2009).

According to the KwaZulu-Natal Department of Health (2001) the core values of the provincial hospital are:

- *Trust built on truth, integrity and reconciliation;*
- *Open communication, transparency and consultation;*
- *Commitment to performance; and*
- *Courage to learn, change and innovate.*

These core values are in conjunction with the Batho Pele Principles explained in **Chapter 2**, describing that these Principles constitute that citizens are entitled to courtesy, consideration, transparency and value for money when they are provided with health care. Fraser-Moleketi (2007) further emphasizes

that it is a simple and transparent mechanism, which allows citizens to hold public servants accountable for the level of services they deliver.

3.3.1 DRAINAGE AREAS OF THE PROVINCIAL HOSPITAL

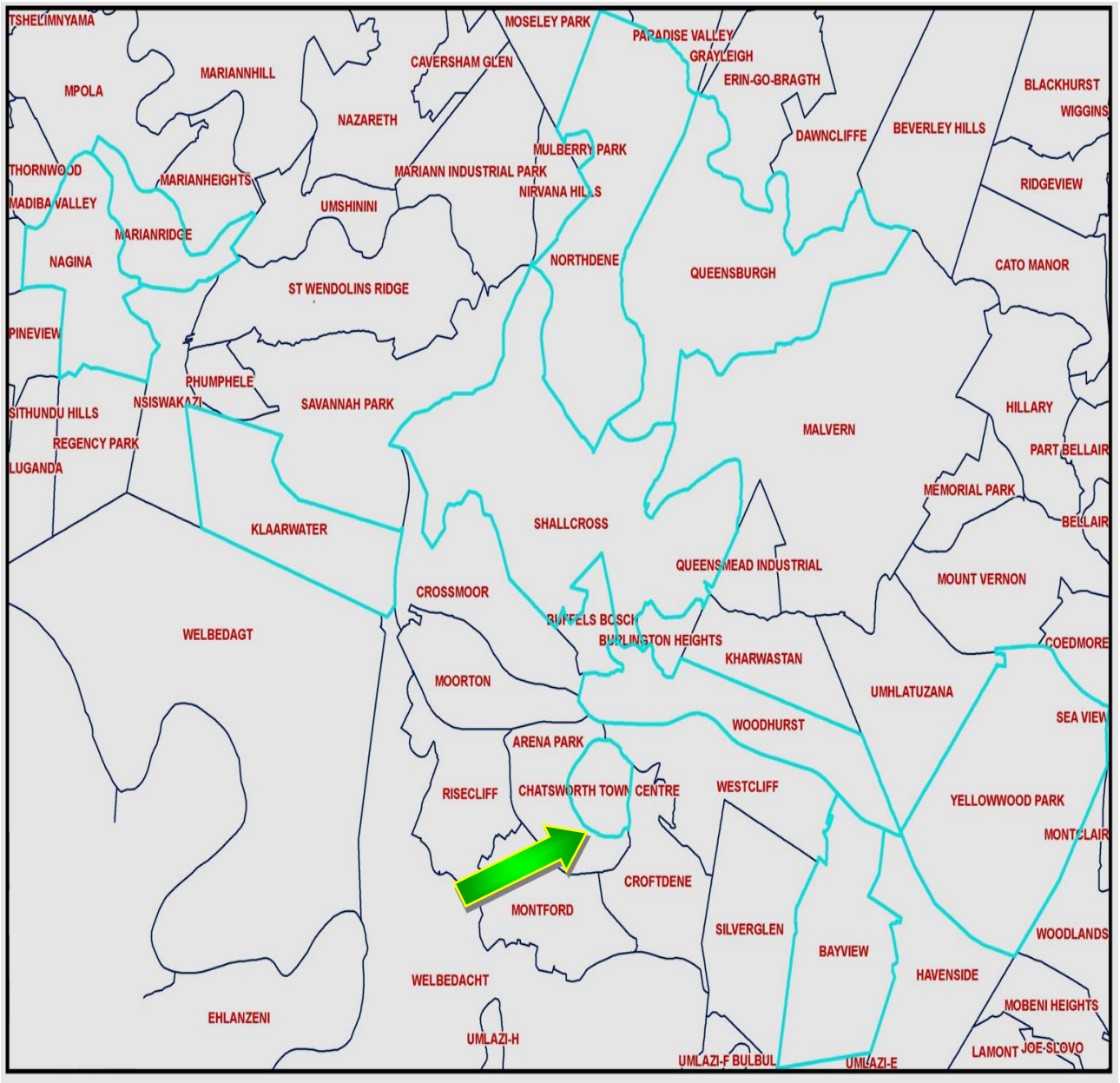

Figure 3.1 Drainage areas of the provincial hospital eThekwini Municipality (2011)

Figure 3.1 identifies the area of Chatsworth where The Provincial Hospital is situated including the hospital's drainage areas. The green arrow in **Figure 3.1** points to the exact location of Chatsworth. The highlighted areas in blue depicted in **Figure 3.1** are

the drainage areas of The Provincial Hospital. The drainage areas refer to areas in and out of KwaZulu Natal that the hospital services.

The drainage areas of The Provincial Hospital highlighted in **Figure 3.1** include:

- Chatsworth township center & Bayview;
- Yellowood Park & Woodhurst;
- Shallcross & Klaarwater;
- Nagina & Marionridge; and
- Queensburgh & Northdene.

As mentioned, the Provincial Hospital is designated a District and Regional hospital. Therefore the Provincial Hospital has to provide support to health workers in clinics the surrounding area of Chatsworth, provide community services, both in terms of clinical care and public health expertise. The Provincial Hospital has to also provide first level hospital care for the district and be the place of referral from clinics, community health centres in the southern region and be responsible for referring patients to higher levels of care when necessary (Chetty, 2009).

Therefore, the Provincial Hospital is also a referral hospital for St. Mary's Hospital which services areas outside their drainage areas including:

- Pinetown & Tshlemnyama;
- Motala Heights & Mzamo;
- Mpolo & Kwadabeka;
- Wyebank & New Germany;
- Halley Stott & Kloof;
- Molweni & Waterfall;
- Msinduzi & Ngcolosi;
- Fredville & KwaNdengezi;
- Ntshongweni & Zwelibornvu; and
- Hlengiswe & Mpumalanga.

All of these areas are not depicted in **Figure 3.1** as they reach beyond the southern area of Durban and out of KwaZulu Natal. Although the Provincial Hospital has a limited amount of beds, it is bound by The Constitution (1996) and the Bill of Rights which details the principle that no one may be refused emergency medical treatment.

3.3.2 OPERATIONAL PRACTICES OF THE PROVINCIAL HOSPITAL

An unstructured interview with Chetty (2010) informs that patients arrive as early as 4am at the Provincial Hospital to wait patiently to receive treatment within the Outpatients Department. The patients are allowed to enter the hospital from 5am. There are no designated parking facilities available to the public within the grounds of the Provincial Hospital, however there are two disabled bays available. To the day existent poverty is present in the community of the Chatsworth area, most patients depend on the public transport available to them such as taxis, buses and trains. There is security at the entrance of the hospital assisting and directing patients to their destination, providing information of visiting hours, screening the cars that enter and general safety and security (Chetty, 2010).

Chetty (2010) further clarified that patients identify the staff of the hospital by their uniforms; nurses have on their sister's uniform; doctors are recognized by their white coats. Staff members also have identity badges that point out their name and designation. The hospital also has volunteers from the community supporting the hospital and patients in basic operations. Queue marshals assist the hospital in queue management, and directing patients to their destination. Volunteers and marshals are identified by their bright orange aprons.

According to Melamed (2005), Apartheid might have ended in 1994 but the struggle has not ended, it has merely changed its shape as new forms of community solidarity and resistance have emerged to fight for rights to housing, water and electricity, and workers' rights. Material inequality has deepened. In addition to the poverty and effects of post-Apartheid, recession has also affected the community, their culture, as well as the hospital itself.

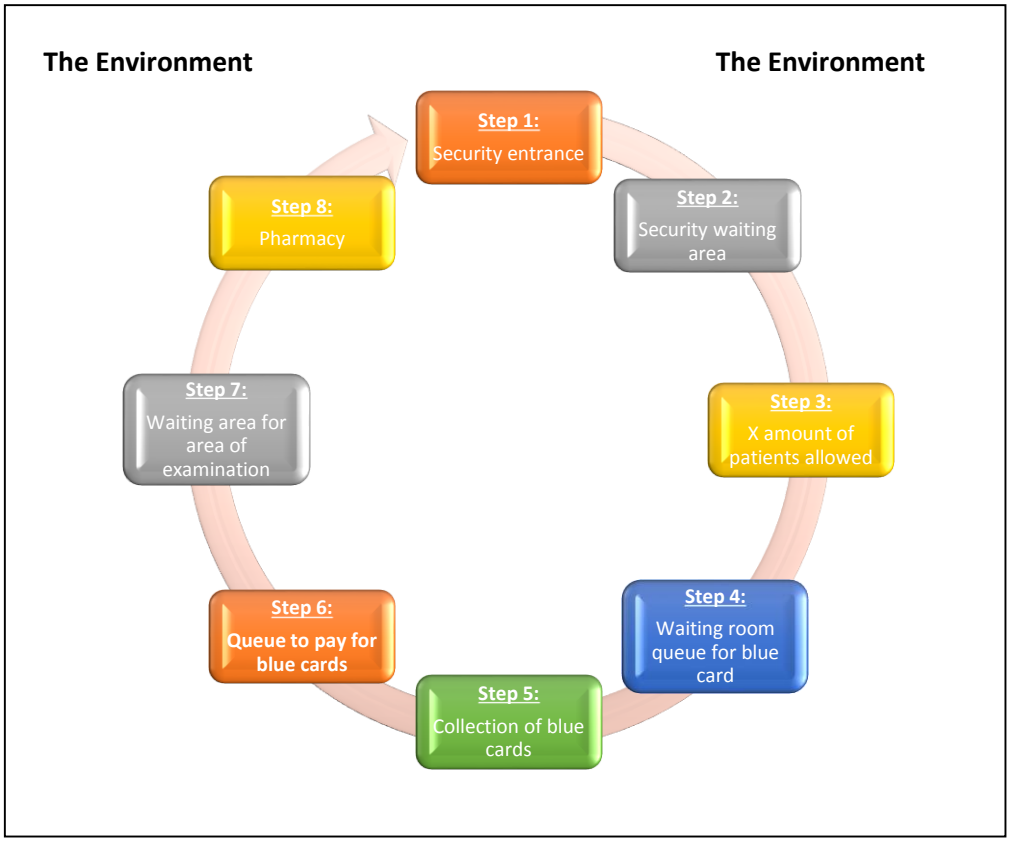

Figure 3.2 A flowchart depicting the patient process at the Provincial Hospital in the southern area of Durban, KZN (Unstructured interview Chetty, 2010)

Figure 3.2 represents an applied flowchart depicting the process that patient experiences when treatment is sought at the Provincial Hospital in the southern area of Durban, KwaZulu Natal.

This flowchart is similar to the applied guest cycle (**Figure 2.5**, the applied approach to the guest cycle Abbott and Lewry, 1999: 33) found in **Chapter 2** of the study. **Figure 3.2** the applied flowchart depicts that there are 8 steps that a patient has to follow when seeking treatment illustrating the actual points of contact with hospital.

Figure 3.2 also includes the environment influenced by the economic climate of the Chatsworth area, the transport system and effects of Post-Apartheid. Stoner *et al* (1995: 74) highlight in the literature review that these environmental elements create a climate, rapidly changing technology, economic growth or decline, changes in attitudes toward work in which the organization exists and to which it may ultimately have to respond.

As identified in **Figure 3.2,** Chetty (2010) states that the patient enters the Provincial Hospital at the security entrance and is directed by the security guards into the waiting area of the Outpatients Department. Thereafter the Security directs a certain number of patients at a time into the waiting room whereby patients queue in the waiting room for approximately an hour before proceeding on to their next step. The patients start their day to seek treatment when they are sick. To have a regular check up with an appointment or just to collect medication begins with long hours of waiting (Chetty. 2010).

This is tiresome for the patient or any human. Furthermore, when a patient is sick and waiting with others who are also ailing may promote further ailment. Patients then collect their respective blue cards. The blue card system assists the Provincial Hospital in tracking patients' activities. According to Chetty (2010) unfortunately, the blue card system is an outdated system that does not contribute to efficiency and effectiveness of the delivery of health care to the public. Once the blue cards are collected they proceed to another queue to pay.

The patient then waits for treatment. A patient may wait for approximately 2-3 hours depending on treatment and tests required. The final point of the patient process as illustrated in **Figure 3.2,** is where the patient collects their medication from the pharmacy and then exits the hospital via Security. **Figure 2.5** (the applied approach to the guest cycle Abbott and Lewry, 1999: 33) in **Chapter 2**, represents the flow of business through a hotel identifying physical contacts and financial exchanges between guest and hotel. This is further illustrated **Figure 3.2** which is relevant to the Provincial Hospital, as the patient undergoes a similar procedure in their physical contacts and financial exchanges at the hospital.

Verified in the literature review with reference to **Figure 2.4** (an applied approach to the relative skills needed for effective performance at different levels of management)**,** Stoner *et al* (1995: 18) identifies the external environment with economic, political, social and technological variables. These variables are highlighted in **Chapter 2**, where KwaZulu Natal is seen as one of most densely populated out of South Africa's nine provinces and with the over population are serious challenges of poverty, illiteracy and poor infrastructure. These variables directly impact on the provincial hospitals in

KwaZulu Natal, which are the existing external environment presented in the flowchart of the patient process (**Figure 3.2**).

Hence, according to Chetty (2010) a patient should seek treatment at the preferred clinic in the area, and only once the patient receives a letter of referral then the next step should be a visit to the Provincial Hospital. The patient must be prepared to wait up to 8 hours in the queue for treatment at the Provincial Hospital. The external environment is also emphasized in the history of Chatsworth in terms of the political climate and struggle through the years and to date.

Furthermore, this patient process as outlined in **Figure 3.2**, similar to the applied guest cycle identified in **Figure 2.5**. It is established that within this process, there are interpersonal interactions between patient and the hospital employee, therefore initiating the service encounter, both identified by Jones and Lockwood's (1989: 111) model (**Figure 2.3**) in **Chapter 2**.

According to Srinivasan (2008: 189) the needs of a patient can be identified within the following requirements:

> ***Attention:*** *The patient requires immediate attention or at least the assurance that he would be attended to within a particular time frame;*
>
> ***Information:*** *The customers of hospital services require information about treatment, facilities and regular updates on patient's health and progress;*
>
> ***Listening:*** *The patient, though unwell, has the deep desire to be listened to; and*
>
> ***Delivery of promised services: E****xpectations are built on promises. The customer must be given all that is promised and more.*

All of Srinivasan's (2008: 189) requirements are the common values that pilot service delivery within the hospitality industry and pointed out in the literature review illustrated in Jones and Lockwood's model (1989: 111) in **Figure 2.3**, assisted with the hospitality management functions identified in **Figure 2.4** (an applied approach to the relative skills needed for effective performance at different levels of management**,** Stoner *et al*

1995: 18) and executed in **Figure 2.5** (the applied approach to the guest cycle Abbott and Lewry, 1999: 33).

Hence, these values should be executed in the patient flowchart (**Figure 3.2**) taking into consideration the interpersonal interactions of patient and hospital employee and ultimately the service encounter pointed out in Jones and Lockwood's model (**Figure 2.5**) in the literature review.

To every patient that enters the Provincial Hospital, a patient information booklet is distributed. This booklet educates the patient about the Provincial Hospital, their rights and the services offered, which influences the patient's process exemplified in **Figure 3.2**. The vital information is as follows:

- Vision and Mission of the provincial hospital;
- Patients' rights;
- Patient responsibilities;
- Services provided at the provincial hospital;
  - Casualty – 24 hours emergency services;
  - General outpatients – Monday to Friday 08:00 – 16:00;
  - Inpatient services;
  - Primary health care clinic;
  - HIV/AIDS clinic;
  - Voluntary testing and counselling;
  - Anti-retroviral therapy;
  - Prevention mother to child transmission; and
- Requirements of the patients and the Batho Pele Principles

This allows the patient to be aware of the services provided by the Provincial Hospital with their rights and requirements as a patient.

This process can be identified as the marketing practice of the hospital's services to the patient, also identified in **Figure 2.3** (Jones & Lockwood's model 1989: 111) in

Chapter 2 of the study, whereby Jones depicts that managers market to the customer therefore creating a customer expectation.

Hence, this booklet markets to the patient the services they can expect, accompanied by the type of service delivery pointed out in The Batho Pele Principles, and additionally influencing the patient process in **Figure 3.2**.

3.4 ORGANOGRAM OF THE PROVINCIAL HOSPITAL

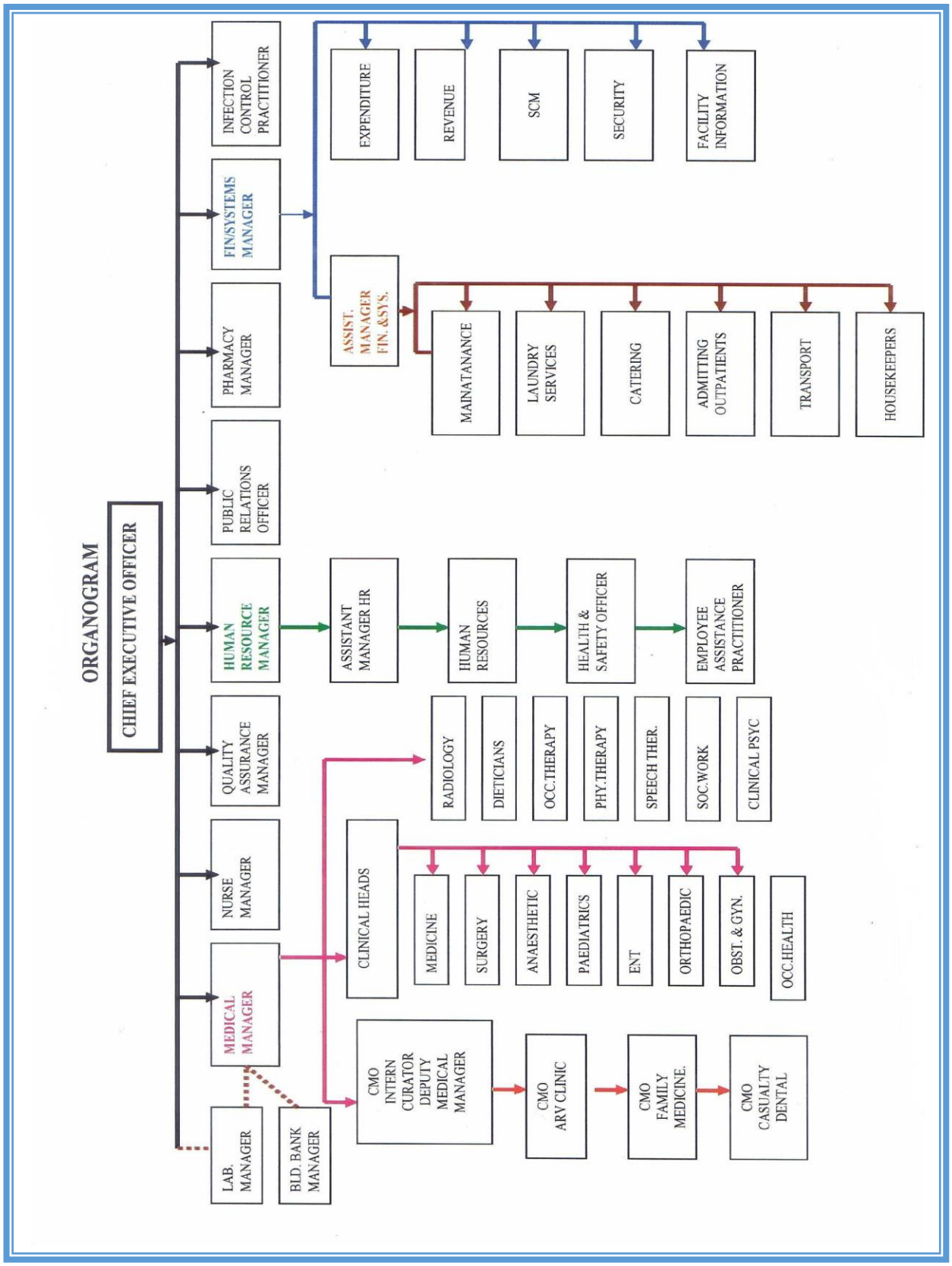

Figure 3.3 The organogram of the provincial hospital in the southern area of Durban, KZN Chetty (2009)

Figure 3.3 illustrates the organogram of the Provincial Hospital in the southern area of Durban, KZN (2009). Part of the responsibilities of line managers is to handle complaints. These are varied and relate to various operational processes and are from different sources, therefore, **Figure 3.3** depicts that the provincial hospital has a Chief Executive Officer that manages all departments of the hospital through the various line managers respectively, corresponding to **Figure 2.4** in **Chapter 2** of the study, in terms of the various levels and functions of management respectively.

Srinivasan (2008: 53) believes that an organizational structure is a managerial tool that aids in guiding the organization towards its goals, and assessing **Figure 3.3**, the highest manager is the Chief Executive Officer. This is consistent with **Figure 2.4** (the applied approach to the relative skills needed for effective performance at different levels of management including the influence of the external environment Stoner *et al* 1995: 18) in the literature review, where top management conceptualize their plans that would determine the goals of the establishment.

Following the Chief Executive Officer in **Figure 3.3** are the various line managers that assist in the hospital operations are, a medical manager, a nurse manager, a quality assurance manager, a human resource manager, a public relations officer, a pharmacy manager, a financial and systems manager and an infection control practitioner. This resembles the middle management stage in **Figure 2.4** (the applied approach to the relative skills needed for effective performance at different levels of management including the influence of the external environment Stoner *et al* 1995: 18) in **Chapter 2** of the study whereby managers would organize and design structures, develop systems and execute plans by leading and inspiring the relevant human resources.

The CEO has two staff meetings in a week. Monday begins with issue and review feedback from staff in the relevant departments for the week ahead, and on a Friday to issue and review feedback for the weekend ahead. This management practice supports staff with their daily responsibilities and promotes interdepartmental cooperation, which ultimately assists in the patient encounter within the hospital.

3.4.1 ROLES AND RESPONSIBILTIES

3.4.1.1 THE CHIEF EXECUTIVE OFFICER

The CEO's role, in the organogram (**Figure 3.3**), is to ensure all departments of the hospital run smoothly, oversee all operations and meet the requirements of the eThekwini District, The Provincial Department of Health and The National Department of Health. Similarly pointed out in the management functions identified in **Figure 2.4** in the literature review, the manager at the top of the triangle has the ability to coordinate and integrate all of the organization's interests and activities, analysing the organization as a whole with the understanding of how all the respective departments in **Figure 3.3** depend on each other and their way forward in terms of their strategic policy.

3.4.1.2 THE LABORATORY MANAGER

In **Figure 3.3** the arrow in the organogram is broken beneath the Chief Executive Officer which leads to is The Lab Manager. This department services the provincial hospital in terms of the provision of the blood tests, results and the blood bank.

3.4.1.3 THE MEDICAL MANAGER

The Medical Manager in **Figure 3.3** is responsible for all the medical staff in the provincial hospital. He manages both staff and patient queries, transfers, facilitates reports, and oversees staff performance. As seen in the **Chapter 2** of the study in **Figure 2.4** (the applied approach to the relative skills needed for effective performance at different levels of management including the influence of the external environment Stoner *et al* 1995: 18) where middle management would execute plans set out by senior management, they inspire and lead the relevant human resources in the respective departments.

3.4.1.4 THE NURSE MANAGER

Following the Medical Manager is the Nurse Manager in **Figure 3.3**, who is responsible for the entire nursing staff in the provincial hospital. Her duties include personnel management and deployment of nurses in the respective departments, nursing operational matters and concerns, also falling into the middle management

stage of **Figure 2.4** in the literature review, planning and leading her staff in departments respectively.

The Medical Manager and the Nurse Manager contribute to the service encounter depicted in the applied patient process identified in **Figure 3.2** in terms of their management functions and control with planning and leading staff, similar to Jones and Lockwood's model (1989: 111) in **Figure 2.3** in **Chapter 2**.

3.4.1.5 QUALITY ASSURANCE MANAGER

Rugnandhan (2010) stated in an unstructured interview that the Provincial Hospital follows the stipulated quality assurance procedures set out by the requirements of the hospital and District Office. There are evaluations and surveys in place that both patient and staff are required to complete which is carried out by the QA Manager.

According to Rugnandhan (2010), on every patient departure, there is a discharge evaluation that the patient may complete regarding the service received, general care and facilities with amenities rendered at the hospital. Similarly displayed in the hospitality industry and pointed out in **Chapter 2** of the study where Walker states that the focus should be placed on the guest, their needs and wants and their satisfaction. Also pointed out is Berger and Brownwell's (2009: 8) agreement that the guest arrives with a set of needs and expectations about the service and the environment in which the service will be delivered.

Rugnandhan (2010) further outlines that if there is a complaint that is lodged, it is referred to as a negative incident and an investigation is proceeded to ascertain faults and a report completed and submitted to management. Monthly statistics are reconciled pertaining to the role players associated to the negative incidents to facilitate improvement.

The eThekwini District Office further regulates evaluations such as:

- Waiting time survey
    - This is an annual survey focussed on the patients and their waiting period at the pharmacy and outpatient departments.

- Minimum standard survey
    - This survey is conducted every quarter and is also focussed on the patient. This survey is the minimum requirement that a patient would require to complete during their stay.

Rugnandhan (2010) conveys in the unstructured interview that these surveys facilitate improvements in the wards for better patient stays. Accompanying the survey are nursing audits, internal cleaning audits, monitoring of absenteeism, and quality improvement programmes encouraging staff and department to provide solutions to any deficiencies that they may have.

Following the audits are motivational practices of open day Quality Day that displays the improvements of their programmes in respective departments. Similar to the hospitality industry as confirmed in literature review, Jones and Lockwood (1989: 164) specify that guest satisfaction may be monitored by unsolicited complaints and compliments, comment cards and customer surveys.

Furthermore, Barrows and Powers (2009: 290) explains in **Chapter 2** that quality service is consistently meeting and exceeding customer expectations and therefore, Barrows and Powers (2009: 291) agree that the true measurement rests with the individual customer, of which is exemplified in Jones and Lockwood's model (1989: 111) in **Figure 2.3**.

The Quality Assurance department assists the hospital with the improvement of the patient process highlighted in **Figure 3.2**, and ultimately with the interpersonal interactions between patient and hospital employee.
The hospitality industry is distinguished as a people industry and health care can also be identified as a similar type of industry, which can be supported with Jones and Lockwood's model (1989: 111) in **Figure 2.3** assisted with the hospitality management functions in **Figure 2.4** in **Chapter 2**.

Furthermore, Keiser (1979: 32) discloses that in a factory, the management deal with only with its employees as people; in a retail establishment, the customers are the

primary people concerned; whereas the hospitality industry is different, where both employees and customers are dealt with at the same time.

3.4.1.6 HUMAN RESOURCE MANAGER

The HR Manager in **Figure 3.3** is responsible for the training and development, recognized in Jones and Lockwood's model in **Figure 2.3**, therefore contributing to the patient service encounter through interpersonal interaction between patient and hospital employee. Responsibilities include the induction process of staff, all areas of concern in terms of labour, recruitment and appointment.

Every employee that enters the Provincial Hospital is given an updated KwaZulu Natal Department of Health Employee Handbook (Unstructured interview with Sahadeo, 2010). The Employee handbook is a complete guide to the vision of the Department of Health and the requirements of being a public servant. Sahadeo (2010) further states that the Provincial Hospital has a total staff compliment of 1280 as per July 2010.

According to the organogram in **Figure 3.3**, the Health and Safety Officer reports to the Human Resource Manager. Health and Safety responsibilities include health safety of both staff and patient, ensuring all areas of the hospital are hygienic, the use of utensils and equipment are correct and hygienic. This is essential as the patient encounter and stay is dependent on the unfailing health care service of the hospital.

3.4.1.7 PUBLIC RELATIONS OFFICER (PRO)

The PRO plays a vital role in the Provincial Hospital as this deals with the management of patient complaints and ensures that the Batho Pele Principles are carried out amongst staff. The PRO liaises closely with the CEO and the eThekwini District Office, and refers back to the relevant staff in terms of human and technical abilities.

The PRO is further responsible for the marketing aspect of the Provincial Hospital in terms of updating websites, organizes events and promotions that support hospital, and closely involved with the communications department, which is not presented in the organogram in **Figure 3.3**, for media releases and statements. The PRO is also responsible for the provincial hospital's newsletter and is very closely involved with

Minimum standard survey in Quality Assurance, in terms of the practice of the Batho Pele Principles which promotes improvement for the applied patient process pointed out in **Figure 3.2**.

3.4.1.8 PHARMACY MANAGER

The Pharmacy Manager, illustrated in **Figure 3.3**, is liable for the dispensary and the distribution of medication in the pharmacy ensuring that patients receive their medication. However this is one of the areas influencing the patient process depicted in the applied patient process in **Figure 3.2**, as this epitomises a considerable amount of time spent at the hospital. Patients wait in winding queues until it is their number that is called to collect medication. This process is long and agonizing for the patient hence affecting the patient service encounter.

3.4.1.9 FINANCE AND SYSTEMS MANAGER

According to the HR Manager (Sahadeo, 2010) of the Provincial Hospital, this individual is responsible for two posts, both Systems and Finance. Pointed out in **Figure 3.3**, finance including expenditure, revenue and supply chain management. Systems grouped with security, facility information, maintenance, laundry service, catering, admitting outpatients, transport and housekeeping, are all part of the responsibilities.

3.4.1.9.1 FINANCE

An unstructured interview with Myeza (2010) revealed the following when reviewing revenue and expenditure:

- Existing health services;
- Existing personnel;
- Expansions of services ;
- New services to be initiated;
- Inflation rate (market related prices);
- General salary increases and pay progression;
- Filling of vacant posts; and
- Expenditure trends for each item.

It is understood that the Provincial Hospital is in a financial crisis and has severe staff shortages which compromises patient care (Naidoo, 2010). However Myeza (2010) distinguishes that with the limited budget allocated by the Department of Health, these criteria are considered, it is guided by the necessary plans of the provincial hospital including; the vision and mission statements; strategic, operational and activity plans respectively.

Myeza (2010) further advises that the main challenges in his financial management are:

- Limited funding;
- Workload increasing;
- Over spending;
- Service delivery may be compromised in some areas;
- Poor quality;
- Staff demotivated; and
- Wastages particularly from staff.

According to Myeza (2010) these challenges make it difficult for the Provincial Hospital to operate in terms of quality service as limited funding affects all facets of the hospital. With continuous workload increasing and a constant decrease in funding, staff feel demotivated to perform hence, quality in service delivery is affecting not only in the tangible products that hospitals provide but the intangible elements of health care which are the encounters that patients experience with staff.

This is in conjunction with **Figure 2.4** (the applied approach to the relative skills needed for effective performance at different levels of management including the influence of the external environment Stoner *et al* 1995: 18), the middle management stage in the triangle found in the literature review, whereby managers would organize and design structures, develop systems and processes and execute relevant plans in order for the establishment to operate effectively.

Furthermore, this finance function makes it possible for the provincial hospital to operate, in terms of **Figure 3.2**, the patient process and **Figure 3.3** the organogram, where all departments are dependent on each other.

3.4.1.9.2 SYSTEMS

Systems include the areas of Security, Maintenance and Transport. It further includes Catering, Laundry Service and Housekeepers with Admitting Outpatients and Facility Information, and Supply Chain Management.

3.4.1.9.2.1 SECURITY

The Security Department ensures the safety of both staff and patient, regulating patient visiting times, and the overall security of the hospital in terms of theft and general misdemeanour. An unstructured interview with Gumede (2010) reveals that security is managed in-house and the guards are outsourced. A business plan is compiled and submitted regarding necessary staffing requirements, infrastructure and improvement for the provincial hospital.

Gumede (2010) states that a walkabout is performed daily and an incident report completed. Gumede (2010) further states that the volume of patients makes it difficult for security as their staff compliment remains the same, and are also on call to the wards when needed. Hence the safety areas are compromised.

3.4.1.9.2.2 MAINTENANCE

The Maintenance Department ensures that the hospital functions smoothly in terms of general maintenance including plumbing, preservation of wards and equipment. It is understood that there are limited resources in terms of budget allocated to the hospital, however in an unstructured interview, Perumal (2010) states that a business plan is drawn up every financial year regarding the projects that have to be undertaken in order to maintain the Provincial Hospital. This enables the Finance Department to distribute funds effectively and in order of priority.

The training of the Maintenance Department falls under the Occupational Health & Safety Act: No 85 of 1993.Therefore, the HR department of Provincial Hospital ensures that staff are sent on their required training. The daily challenges that the

Provincial Hospital experiences are in the volumes of patients that visit the hospital daily. Hence, Perumal (2010) states that the breakdown and repairs are the running costs daily. Theft is also an issue that is endured to the poverty in the community. Furthermore Perumal (2010) accepts that times change and vandalism does occur, however, the maintenance department and the Provincial Hospital itself are providing a service, and it is part and parcel of the responsibility.

3.4.1.9.2.3 TRANSPORT

The Transport Department assists staff in transfers for workshops and training, collection of equipment from eThekwini District, and providing transport if medical staff are on call.

These are operating departments which will fall in the first line management as depicted in **Figure 2.4** (applied approach to the relative skills needed for effective performance at different levels of management Stoner *et al* 1995: 18), whereby the technical skill would be applied and managed within the relevant processes within the respective departments. Therefore, in connection with the flowchart of the patient process (**Figure 3.2**) and **Figure 3.3** (the organogram), these departments impact on the conditions of the service and its delivery of the Provincial Hospital.

3.4.1.9.2.4 CATERING

The Catering Department is responsible for patient meals, nutrition and dietary requirements. This Department has a designated Catering Manager, who manages staff, as well as the cleanliness and hygiene of operations and equipment in the kitchen. Although the Provincial Hospital is under constraints in terms of budget allocation, the catering manager ensures that food cost and budgets are adhered to without interference to service delivery.

In an unstructured interview with Dorasamy (2010), every new financial year the Catering Manager is required to prepare a business plan in terms of the Catering Department’s needs and requirements. This business plan stipulates the amount required for the Catering Department to operate. It also provides an opportunity for the Catering Manager to voice new ideas in terms of lowering food cost, improving

efficiencies and productivity that assist The Provincial Hospital in service delivery in their limited budget allocation.

Dorasamy (2010) states that together with the Catering Manager there is a dietician, that assists with patient specific nutrition and dietary requirements. Referring to organogram in **Figure 3.3**, there is a meeting every quarter with the CEO and the catering department analysing quality and service delivery. Along with the quarterly meeting there is a meeting every month with the assistant Finance and Systems Manager, in terms of productivity, concerns and budget of the catering department.

Complaints and compliment cards are completed by the patient, to obtain feedback regarding food preparation, taste and quality (Dorasamy, 2010). Similar to the quality assurance department in terms of their patient surveys and the hospitality industry pointed out in **Chapter 2**.

3.4.1.9.2.5 LAUNDRY SERVICES

The laundry service department has two areas that are managed, the soiled linen department and the unsoiled linen department. Soiled linen are sent from the wards, washed first for hygiene purposes, and then sorted to be sent through to an outsourced laundry. Turnover time for laundry must be timeous to ensure that the hospital has clean linen for operation.

The control method that is used is one for one, or dirty for clean. This method assists the Provincial Hospital to manage the loss and turnover of their linen. In an unstructured interview, Nokhutula (2010) declares that the responsibility of the linen room is to ensure that clean linen is supplied to 14 wards and 17 departments on a daily basis. There are 2 seamstresses onsite that sew table cloths and belts for the maternity wards. The seamstresses also mend and sort linen in terms of utility and quality. These functions also impact on the conditions of service delivered in the Provincial Hospital.

Departmental training is performed in-house and external experts are called in to further improve staff skills. A business plan also has to be drawn up in terms of the

department's overspend, purchasing, and staff requirements. Regular department meetings are held for the management of concerns and compliments. Nokhutula (2010) further states that the challenges of the Linen Department are staffing, as staff on sick leave affects service delivery. Hence, the Department protocol to assist in control, in terms of staff policies and code of conduct. Therefore, both internal and external auditing is performed to improve department efficiencies and ad-hoc meetings with the Finance section takes place for departmental requirements and concerns.

3.4.1.9.2.6 HOUSEKEEPERS

According to an unstructured interview, Dorasamy (2010) advises that housekeepers within the provincial hospital are referred to as General Attendants. The General Attendants are responsible for the general upkeep of the ward and assisting nursing personnel. The allocation of General Attendants are dependent on the number of patients in the ward. The nurses supervise the housekeepers to ensure that the ward is maintained.

Supervision includes the making of patient beds, ensuring the floors, bins, toilets and furniture are clean and hygienic. In performing these duties the General Attendants have a considerable amount of exposure to the patients. This necessitates training which includes diseases, hygiene and infection control and inspections are essential for HIV and diseases. Once every quarterly the General Attendants undergo "Batho Pele Principles" workshops with the nurses.

This function and role in the Provincial Hospital is extremely important and at the same time most unpleasant to do. It is, however, vital for the hospital operations and key to enhancing hospitality within health care. The General Attendants assist significantly in uplifting the comfort levels of the patients.

3.4.1.9.2.7 ADMITTING OUTPATIENTS AND FACILITY INFORMATION

According to Dorasamy (2010), patient admittance takes approximately 10 minutes. This Department is also responsible for the discharge of patients which is only done in the afternoons after 3pm. This department functions 24 hours every day, 7 days a week.

Nurses are the point of contact at the clinic where patients are treated for minor ailments and a common cold. The patients who require a doctor are then sent to outpatients after their blue card is obtained as seen in the applied patient process in **Figure 3.2**. The doctor then examines and determines if the patient needs to be admitted into the Provincial Hospital. The Admitting Outpatients Department is responsible for this function.

The admitting of outpatients is similar to the front desk in a hotel specified in the literature review. This process is similar to the registration process illustrated and explained in **Figure 2.5** (the applied guest cycle). In the hospitality industry the customer experience and their service encounter is epitomised in Jones & Lockwood's model in **Figure 2.3.** As per Dorasamy (2010) there is minimal in-house training that is performed in this department, however the staff are trained on The Batho Pele Principles and "Counter Personal Courses" to facilitate patient service and service delivery. It must be noted that large volumes of patients hampers the service delivery as the staff compliment remains the same.

3.4.1.9.2.8 SUPPLY CHAIN MANAGEMENT

The Supply Chain Management Section is the department that assists all departments of the hospital in terms of purchasing and stores. Anything that is required by the hospital in terms of catering, maintenance, stock, equipment, Supply Chain Management puts out the relevant tenders and obtains three quotes, thereafter selecting the most reasonable option.

3.5 SPECIFIC LEGISLATIONS AND THAT SUPPORT THE PROVINCIAL HOSPITAL

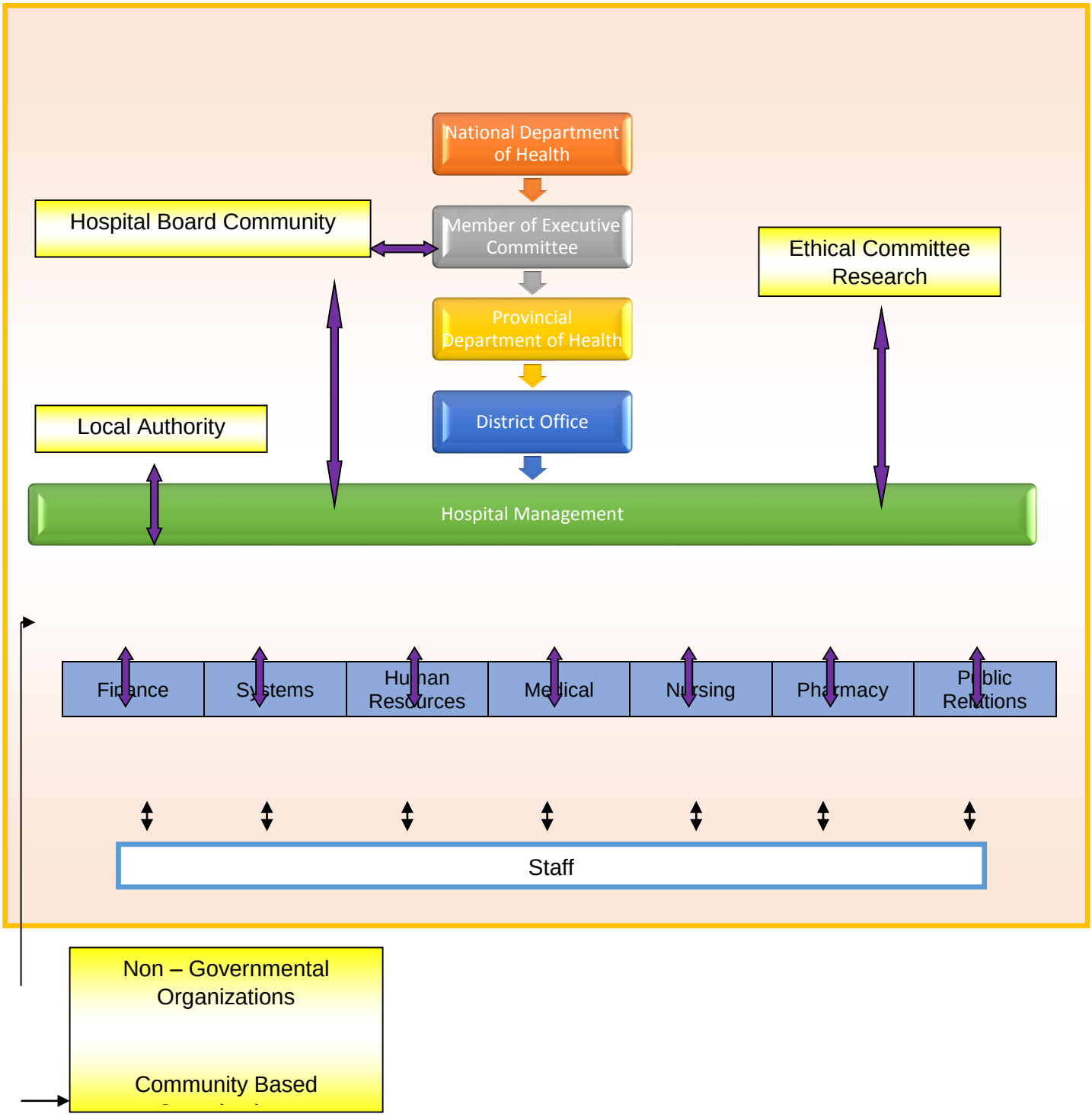

Figure 3.4 Governance structures and Lines of Communications (Unstructured interview with Sahadeo, 2010)

Figure 3.4 represents the governance structure and lines of communication within the Provincial Hospital in the southern area of Durban, KZN. According to **Figure 3.4** the

Provincial Hospital is supported and lead by the District Office which is the eThekwini District office, The Provincial Department of Health, Members of Executive Committee, and The National Department of Health.

According to Dorasammy (2010) the Hospital Board, depicted in **Figure 3.4**, are comprised of nominated members and is the direct liaison with the community. To date, their functions and powers are in an advisory capacity. However, future intentions are for this board to have a greater influence in which the community would be directly involved in hospital management, where responsibilities may even include budgeting and recruitment.

The Local Authorities in **Figure 3.4** include the eThekwini Municipality, the Local Board, and the local clinics. These organizations provide services to assist the hospital, in terms of public health care provided at local clinics which should be the patient's first point of contact before being referred to the provincial hospital. Therefore, the Local Authorities advise the community to visit the clinics first through the local papers and tabloids. This may be considered as a marketing tool for the provincial hospital highlighted by Jones and Lockwood's in their model (1989: 111) in **Figure 2.3** of the literature review. The Ethical Committee assists the CEO, with medical research, work ethics all of which assists in the medical operations of the hospital denoted in **Figure 3.3** (the organogram of the Provincial Hospital).

According to Dorasammy (2010) The Non–Governmental Organizations or the Community Based Organizations are the Happy Arts Club, Friends of RK Khan (FORKK), The Chatsworth and District Partnership against Aids (CADPAA) and the People's Church of God. The Happy Arts Club and FORKK assist the hospital in raising funds for necessities such as, linen, blankets and pillows. The CADPAA provides awareness to the community regarding essential understanding of HIV and AIDS awareness and prevention. The CADPAA facilitates their awareness programs through workshops at the provincial hospital which educates the community. This function is similar to the role of marketing in Jones and Lockwood's model (1989: 111) in **Figure 2.3** in **Chapter 2**, as this process is a management tool, which informs the patient of their responsibilities of good public health.

FORRK also supports the hospital in their systems with volunteer work, with extra hands in the hospital, queue management, and lecture presentations on good health care and hygiene. FORRK also provides media assistance in advising the community to visit their local clinic for minor ailments before visiting the Provincial Hospital.

Together with The Happy Arts Club and FORRK, The Ministry of People's Church of God, who is the on the hospital board depicted in **Figure 3.4**, also assist the Provincial Hospital with raising funds to purchase required items that aid in hospital operations.

According to Sahadeo (2010) other legislation also govern the way the Provincial Hospital operates, such as the Occupational Health Safety Act: No 85 of 1993. This Act assists Human Resources and the Health and Safety Officer in the organogram in **Figure 3.3** and further assisting Human Resources are the Employment Equity Act: No 55 of 1998, and the Labour Relations Act: No 66 of 1995.

3.6 THE PATIENT SERVICE ENCOUNTER

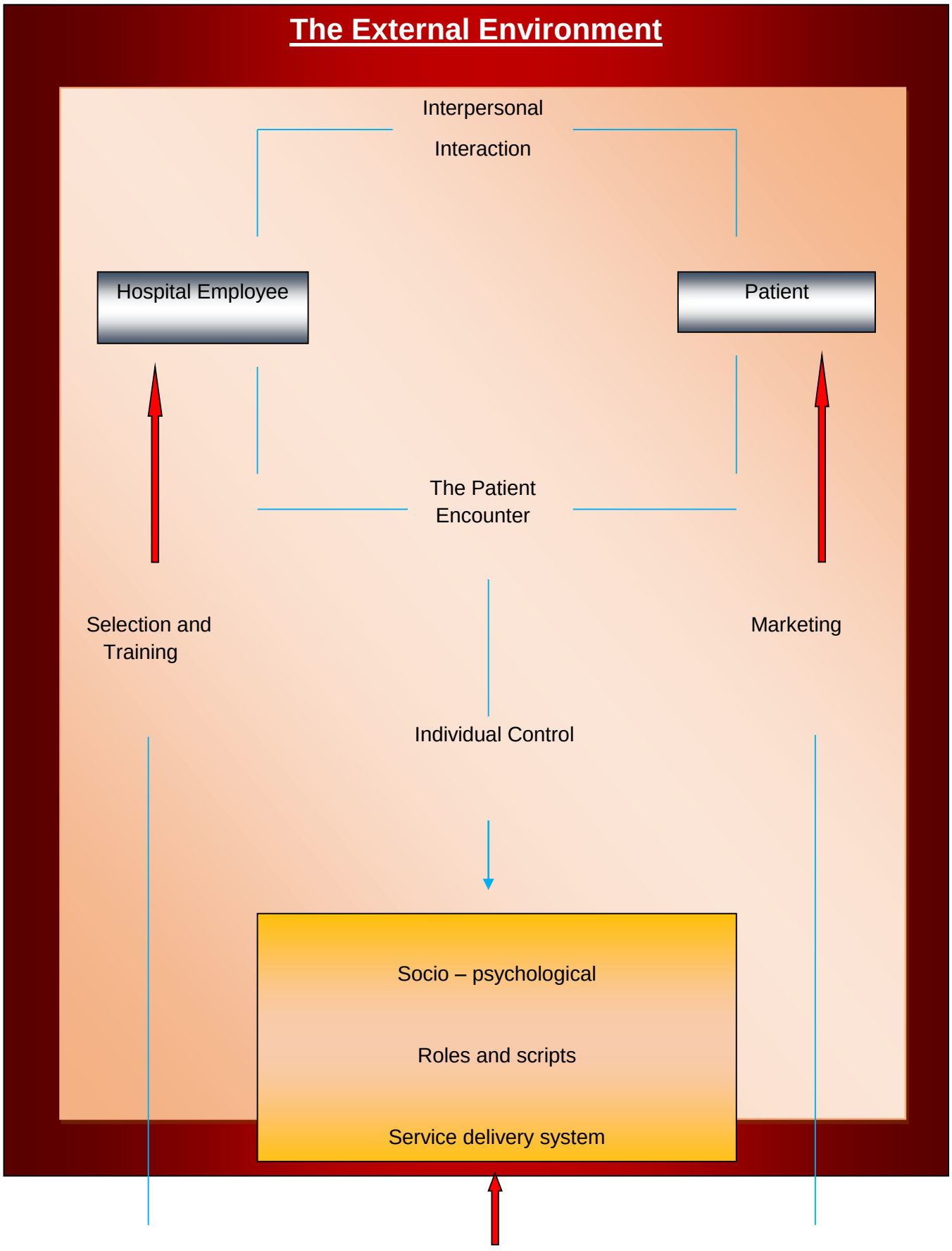

Figure 3.5 An applied model of *management influence on patient service* of the provincial hospital (Jones and Lockwood 1989: 111)

Figure 3.5 displays an applied model of Jones and Lockwood's approach to management influence on patient service within the Provincial Hospital. Similar to the model of **Figure 2.3** in the literature review, Jones and Lockwood (1989: 111) illustrate the influence that the manager has on service within the interpersonal interaction.

The applied Model (**Figure 3.5**) was adapted for the Provincial Hospital involving hospital management and front-line employees for service quality improvement opportunities. This, therefore, provides the framework for analysing and understanding the effective management of service whereby Jones depicts the service encounter between the employee and the customer. The applied model advances the service encounter as "patient encounter" between the hospital employee and the patient.

This Model may be applied to all customer exposed departments within the Provincial Hospital together with its interdependent departments. Ultimately Jones and Lockwood (1989: 111) advance that management control has influence in the manner in which employees perform. Hence, their psychological and social skills create an organizational culture which promotes or demotes the manner an employee delivers service.

The Provincial Hospital may not be selling a leisure stay as do the hospitality industry, however, the principles in the way that service is delivered behind both of these organizations are related and of vital importance to both customer and patient.

Hence, Jones and Lockwood's applied Model (1989: 111) explains simply the necessary steps and the importance of management influence on staff and their attitude in their work, which is essential to both hospitality and health care.

Chapter 2 of the study, Soumya (2001) suggests that the most popular role of hospitality within the hospital sector is the supporting back of house areas. Singh (2006) proposes that it's through the avenues of food and beverage or facility management, that hospitals are outsourcing these vital components of their new business models to the players with core competencies in this field, i.e. the hospitality industry. However, it is clear that this role extends further than the tangible similarities of these establishments. There are parallel fundamental systems within the hospitality and health care environment and they are encapsulated in the way these establishments both deliver their respective services offered.

3.7 SUMMARY

An understanding was given of the district of the Provincial Hospital with a history and background of Chatsworth. The operations chapter finds that the Provincial Hospital of study is the cornerstone for health care in the southern area of Durban, and for the referral drainage areas out of Durban irrespective of the lack of resources and bed space. The organizational structure of the Provincial Hospital and the roles and responsibilities of staff are detailed. Similarities were drawn with the applied guest cycle and the flowchart of the patient process. Governance structures of the Provincial Hospital were outlined and an applied to Jones and Lockwood Model of management influence on service, which depicted the essentials for the patient encounter.

This chapter continued to focus on the themes which were detailed in the literature review. These themes of management practices and processes and service delivery, environmental impacts and influences and the similarities of hospitality and hospitals were specifically focussed on the Provincial Hospital of study. **Chapter 4** follows where the research methods and collection of information will be discussed.

CHAPTER 4

RESEARCH METHODOLOGY

4.1 INTRODUCTION

The literature review discusses the areas around hospitality and provincial hospitals. The operations chapter describes the provincial hospital of study therefore, a questionnaire and an interview schedule were formulated to test the theory and hospitality within hospitals. This chapter discusses the research methodology and design that has been used to carry out this study. It identifies the techniques and approaches that were applied in the study.

The objectives of this chapter are:

- Identify methods of research and data collection techniques that will be utilized;
- Describe the research design; and
- Explain the organization, design and administration of the questionnaire.

4.2 RESEARCH METHODOLOGY

The research methodology within the context of this study had to take into account a number of factors that were peculiar to the Provincial Hospital. These factors, some of which have been previously highlighted, were time constraints of the respondents in respect of time and levels of understanding, as well as fear of reprisal and availability of accurate information. This therefore necessitates a scientific methodological process. Fox and Bayat (2007: 2) advance the following as fundamental to a scientific approach:

> *You should be able to formulate basic research questions, collect data, process the data into information, organise the information into a rational whole, draw acceptable conclusions, document them, and make them known in an acceptable way by using these tools and this methodology your results should, on the whole be far more accurate in order to make decisions, write scenarios and plan strategically.*

Fox and Bayat (2007) further indicate that in order to ascertain information for the purposes of resolving practical day to day issues, one would need a clear understanding of the actual problem at hand, and establish the relevant questions and conduct the relevant research to produce acceptable findings when using scientific based approach. Research is conceptualised by Fox and Bayat (2007: 5) as:

> *A study or investigation in order to discover facts or gain information. It is a universal activity by which a specific phenomenon in reality is studied objectively in order to create a valid concept of that phenomena. The process of research simply constitute the formulation of a problem, from which may flow a question or questions and methods used to gain the information needed to answer it or them.*

They further state that Science may be defined as *a system of concepts, results and methods accepted by a number of scientists*. This indicates that the concept of Science refers to the system of scientific knowledge, while research refers to the process by which such a system is created Fox and Bayat (2007). Triangulation enhances the scientific system or method of research. David and Sutton (2011:296) state that:

> *Triangulation seeks convergence, corroboration, correspondence of results from different methods. Used to increase the validity of the results by counteracting or maximising the heterogeneity of relevant sources of variance attributable especially to inherent method bias but also to inquirer bias, bias of substantive theory, biases of inquiry context.*

Neuman (2006: 149) supports the view that triangulation is the observation of something from different angles or viewpoints to get a fix on its true location whereby researchers take multiple measures of the same phenomena.

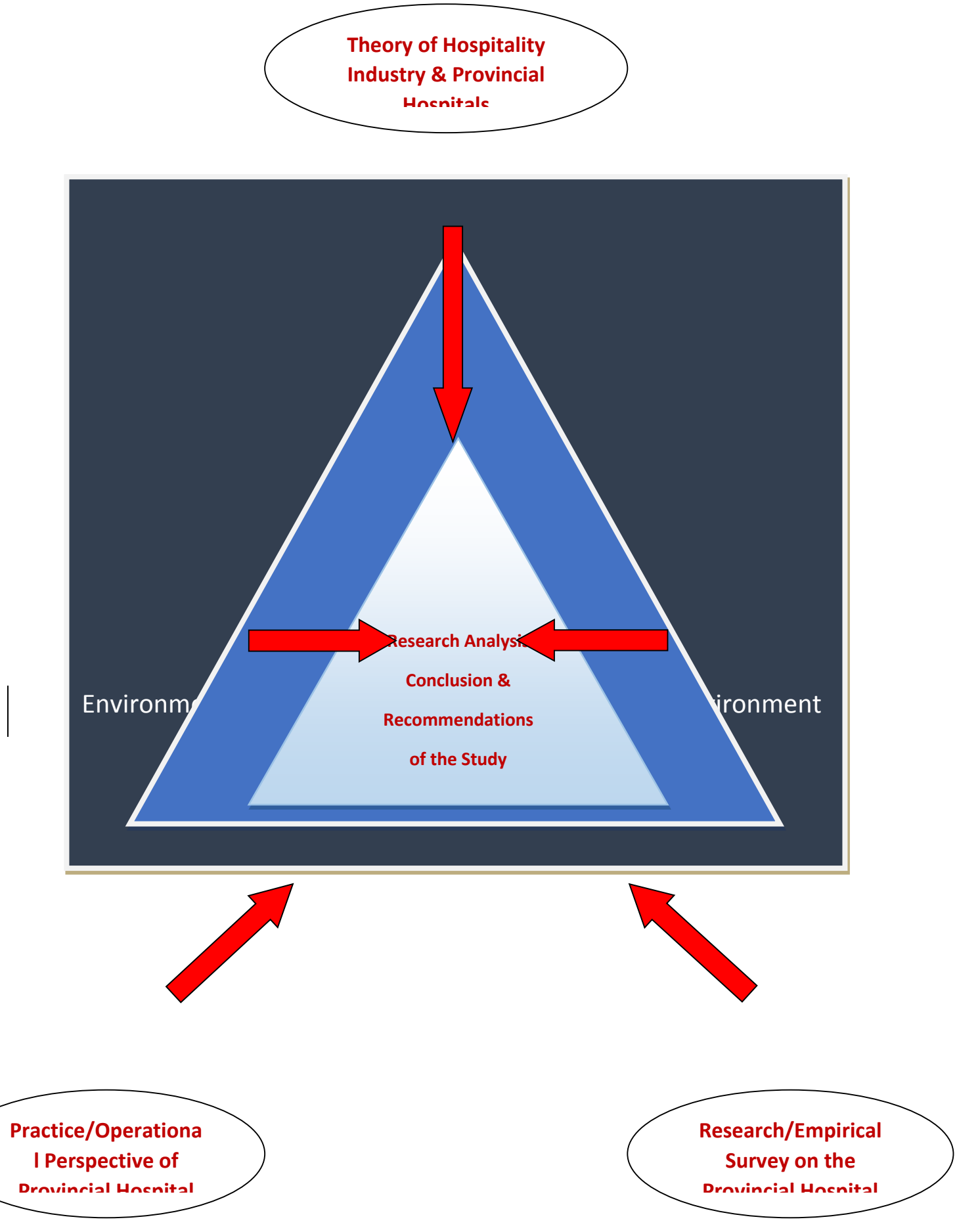
Theory of Hospitality Industry & Provincial Hospitals
Research Analysis
Conclusion &
Recommendations
of the Study
Practice/Operational Perspective of Provincial Hospital
Research/Empirical Survey on the Provincial Hospital

Figure 4.1 An applied Aspects of Validation through Triangulation (Woollard, 2007)

Figure 4.1 illustrates the aspects of validation of the study through triangulation. According to Woollard (2007), the validation process of research includes a consideration of sources of information and the degree of saturation of the data. Therefore, in support of the validation process the full methodology will also possess a degree of triangulation. Hence, Woollard (2007) states that the major components of the triangle are the literature review, interview data and analysis and the focus group reflections. Therefore, within this process of validation through triangulation, **Figure 4.1** identifies the holistic areas of which the study is carried out. The research begins with the theory of hospitality and the hospitality industry. Health care and provincial hospitals are discussed in detail followed by an operations chapter pointing out the practice and operational perspective of the Provincial Hospital.

De Vos, Strydom, Fouche and Delport (2005: 362) identify four types of triangulation which are data triangulation, Investigator or observer triangulation, theory triangulation and methodological triangulation. Relevant to the study are the following:

- *Data triangulation denotes the use of more than one data source (interviews, archival materials, observational data ,etc); and*
- *Methodological triangulation denotes the use of multiple methods to study a single topic, for example combining quantitative and qualitative methods in a single study.*

Data triangulation within the context of this study refers to the use of the multiple applications of questionnaires and structured interviews to the patients, heads of department/ managers, and senior management of the Provincial Hospital. These survey instruments will triangulate dense data between the different groups of respondents and to provide verification and support in respect of areas that are sensitive in nature.

The methodological triangulation is seen within the study as an overall approach as discussed in **Figure 4.1** as well as at a micro level in respect of the qualitative and quantitative approach used in the framing of questions in the survey research.

Adapted to Woollard's (2007) validation process, **Figure 4.1** points out that the study develops a theoretical framework around the hospitality industry, health care and the role of governance is also discussed within healthcare in the literature review. **Chapter 2** establishes the essence of hospitality management emphasizing the delivery of soft services consistently. It further outlines that hospitality management represents effectiveness and efficiency by emphasizing the importance of customer satisfaction. Furthermore, the research establishes a basis for hospitality practices within healthcare for the purpose of assessing its relevance and impact.

Figure 4.1 also depicts the operational perspective of the area of study which is identified in **Chapter 3** focussing on the operational practises of the Provincial Hospital. Within this chapter the link between hospitality and health care are established. **Chapter 3** of the study further identifies that there are parallel fundamental systems of the Provincial Hospital and the hospitality industry. Therefore Jones and Lockwood's model of management influence on service illustrated in **Chapter 2** of the study was applied, developed and applied for the Provincial Hospital in **Chapter 3**.

The research and empirical survey on the provincial hospital illustrated in **Figure 4.1** will conceive the possible emergence of gaps in the provision of healthcare and will serve as a basis for the development of sound recommendations. The use of qualitative and quantitative techniques may be applied to a relevant sample size to collect information and data. This process serves to identify the potential gaps derived from the foundation of **Chapter 2** and **3**.

Figure 4.1 includes the environment in which the research was carried out and represents the factors that both hindered and promoted the study. Stipulated in the literature review of the study, Stoner *et al* (1995: 64) identify that the external

environment comprises the social, technological, economic and political variables. These elements create a climate, with rapid changing technology, economic growth or decline, changes in attitudes toward work in which the organization research process exists and to which it may ultimately have to respond.

4.2.1 METHODS OF RESEARCH

There are various types of data collecting techniques for acquiring knowledge, such as telephonic interviews, personal interviews, participant collecting, and the use of field workers who are trained to go out and collect the required information (Moore, 1983: 9). This research focuses on a provincial hospital in the southern area of Durban, KZN, and data was collected through a survey using questionnaires and structured interviews. Operational information in the Provincial Hospital were collected through unstructured interviews.

The research approach within organisations like hospitals needs to be dynamic and flexible enough to accommodate for the fluidity of the business. Alasuutari, Bickman and Brannen (2009: 323) highlight that in deciding which data collection technique is best in a certain situation, as it is often complex and depends on many factors such as population under investigation, topic, types of questions to be asked, available times and funds. When one considers these factors in the context of the study one finds direct relevance to the availability of patients and Heads of Department of the Provincial Hospital and the types of questions to be asked of the respondents.

Service organizations like hotels are not scientific laboratories with controlled conditions. Hospitals have a similar environment lacking in controlled conditions with specific reference to patients in need of care and both staff and patient are not always willing to participate in research projects. Therefore, research projects must have contingency plans and especially within the hospital service organization which is labour intensive, employees are constantly engaged in delivering services and treatment to patients directly. The availability of employees and hospital staff are usually very scarce as mentioned in the

environmental factors and pointed out in **Figure 4.1**, and the need to be flexible becomes critical.

Questionnaires are one of the most widely used social research techniques. Blaxter, Hughes and Tight (2006: 58) explain that the idea of formulating precise questions, for those whose opinions or experience the researcher is interested in, is an obvious strategy for finding answers to the questions related to the research. Alasuutari *et al* (2009: 325) contend that face to face interviewing has the highest potential to accommodate different types of questions as well as complex questions. In order to achieve this one needs to have well trained interviewers and well tested questionnaires.

4.2.2 QUALITATIVE RESEARCH

Qualitative research is more open to and responsive to its subject. Blaxter *et al* (2006: 64) states that qualitative research is harder, more stressful and more time consuming than other methods. However, Hakim (2000: 34) suggests that qualitative research is concerned with individuals' own accounts of their attitudes, motivations and behaviour. Gray (2009:201) believes that qualitative researchers contend that the truth and meaning do not exist in some external world, but are constructed through peoples' interactions with the world therefore for the same phenomenon, two people could construct two quite different meanings.

Creswell (2009: 175- 176) identify amongst others qualitative research to have the following characteristics:

- *Researchers typically gather multiple forms of data such as interviews, observations and documents, rather than rely on a single data source;*
- *Researchers build their patterns, categories, and themes from the bottom up, by organising the data into increasingly more abstract units of information;*
- *The entire qualitative research process. The researcher keeps a focus on learning the meaning the participants hold about the problem or issue, not the meaning that the researchers bring to the research or writers express in the literature;*
- *Is a form of interpretative enquiry in which researchers make an interpretation of the way they see, hear, and understand; and*

- *Researchers try to develop a complex picture of the problem or issue under study. This involves reporting multiple perspectives, identifying the many factors involved in a situation, and generally sketching the larger picture that emerges.*

Hakim (2000: 34) claims that although qualitative research is about people as the central unit of account, it is not about particular individuals per se; reports focus rather on the various patterns, or clusters, of attitudes and related behaviour that emerge from the interviews.

David and Sutton (2011:130) indicate that qualitative interviewing requires the researcher to pay great attention to the nature of the questions they ask and the place and time in which they set their interactions. This attention is to ensure a balance between the researcher's focus of attention and the priorities and interpretations of those being interviewed.

The fieldworkers were B-Tech students who were studying Research Methodology for the first time, and became actively involved in the qualitative nature of the empirical survey on the Provincial Hospital.

The qualitative approach proved to be constructive as in depth interviewing allowed the researcher to collect a considerable amount of data in the interview process which contributed to both the **Chapter 3** and the empirical surveys of the research methodology identified in **Figure 4.1**.

4.2.3 QUANTITATIVE RESEARCH

Quantitative research consists of those studies in which the data concerned can be analysed in terms of numbers. Blaxter *et al* (2006: 64) points out that quantitative research is based more directly on its original plans and its results are more readily analysed and interpreted. It tends to emphasize relatively on large scale and representative sets of data. Blaxter *et al* (2006: 65) further explains that if the researcher wants to finish their dissertation quickly and easily, hence with respect of this study, both qualitative and quantitative research techniques would be taken to gather information.

Welmam, Kruger and Mitchell (2005: 8) emphasise the measurement and analysis of casual relationships between variables within a value- free context. The purpose is to evaluate objective data consisting of numbers while qualitative research deals with subjective data that are produced by the minds of respondents or interviewees. Welman *et al* (2005: 8) states that qualitative data are presented in language instead of numbers. The researcher tries to understand the significance which respondents attach to their environment.

The quantitative approach assisted the researcher to obtain and complete the large sample size that was targeted for the study. Relevant information was gathered efficiently given the limited time. Had the results of research can only be become meaningful if the techniques used are appropriate to the research situation.

Leedy and Ormrod (2010: 187) indicates that survey research involves acquiring information about one or more groups of people – perhaps about their characteristics, opinions, attitudes, or previous experiences – by asking them questions and tabulating their answers. The survey design makes critical demands on the researcher that, if not carefully respected, may place the entire research effort in jeopardy.

A combination of quantitative and qualitative research techniques was applied in the study. This provided the researcher with the ability to gather in-depth information and data in a small space of time and to the convenience of the participant. Creswell (2008:14) indicates that the reasons for mixing methods have led writers from around the world to develop procedures for mixed method strategies of inquiry, and these take the numerous terms found in the literature such as multi method, convergence, integrated and combined methods and shape procedures for research.

4.3 RESEARCH DESIGN

Creswell (2008: 3) identifies research design as plans and procedures for research that span the decisions from broad assumptions to detailed methods of data collection

and analysis. Goldenberg (1992: 129) believes that research design fundamentally involves an attempt to isolate and assess the relevant factors in a study. David and Sutton (2011: 27) advance that validity, reliability and generalizability are all criteria by which the truth of research can be judged.

This study embraced qualitative and quantitative techniques in the data collection process. Historical and documentary research on related issues was used and largely dominated the theoretical and conceptual framework of the study. The quality of the selected sample in relation to the population in question, as well as the quality of the data collection instruments, will determine the depth and scope of the findings. Some research seekers not only to know the world, but also to help change it (David and Sutton, 2011: 27).

Babbie (2010: 254) highlights that surveys may be used for descriptive, explanatory and exploratory purposes. They are chiefly used in studies that have individual people as the units of analysis. Survey research is probably the best method available to the social researcher who is interested in collecting original data for describing a population too large to observe directly. They are also excellent vehicles for measuring attitudes and orientations in a large population Babbie (2010: 254). A structured questionnaire to the patients and department heads of the provincial hospital was applied (**Appendix1** & **2)**.

Gray (2009: 233) states that interviewer-administered questionnaires are expensive and time consuming. However, responses are usually higher than methods such as telephone interviews, particularly if a letter can be sent in advance, explaining the purpose of the structured interview. They are also more suitable for asking open questions and for eliciting more detailed responses Gray (2009: 233). This technique worked well with the fieldworkers and this provided training for their own upcoming research.

A structured interview was conducted with strategic level management of the Provincial Hospital (**Appendix 3**). According to Neuman (2006: 304) interviews to gather information occur in many settings. Neuman (2006: 304) continues that employers interview prospective employees, medical personnel interview

patients, mental health professionals interview clients, social service workers interview the needy, reporters interview politicians and others, police officers interview witnesses and crime victims, hence a survey research interviewing is a specialized kind of interviewing. Neuman (2006: 304) further states that as with most interviewing, its goal is to obtain accurate information from another person.

4.4 SAMPLE PROCEDURE

The sample Provincial Hospital comprised patients, Department heads and Senior Management.

Department heads were illustrated in the organogram of the Provincial Hospital (**Figure 3.3**) in the **Chapter 3** of the study. There are 14 departmental heads of including:

- Medical;
- Nursing;
- Quality Assurance;
- Human Resources;
- Public Relations;
- Pharmacy; and
- Systems including: Maintenance; Catering; Admitting Outpatients; Housekeeping; Laundry; Security and Supply Chain Management.

A structured questionnaire was targeted at the department heads of the Provincial Hospital. A sample size of 100% was sought. A 93% return rate was achieved.

Figure 3.3 in **Chapter 3** also depicts 2 strategic level managers which are the Chief Executive Officer and the Financial Manager. A structured interview (**Appendix 3**) was conducted with both of these individuals.

According to Chetty (2010) there are approximately 500 patients that are cared for daily within the outpatients department of the Provincial Hospital. A structured questionnaire (**Appendix 2**) was targeted to the patients within the outpatients department of the Provincial Hospital. A sample size of 65% of daily patients (325

patients) was sought. A 61% of daily patients (306 patients) return rate was achieved.

A population is a group of cases such as people, managers and organizations. A target population can become extremely costly and time consuming if one has intentions to cover the entire population. Hence, a sample would be the next option. Hansen, Hurwitz and Madow (1993: 4) define a sample as a subset of a population selected to obtain information concerning characteristics of the population

Goldenberg (1992: 153) suggests that specification of the sampling frame translates a rather abstract idea of the purpose and orientation of the research into a far more grounded or concretely spelled out set of rules concerning how data will be gathered and what basis there would be for generalisation from them to the relevant population. Hence, Johns and Lee-Ross (1998: 85) outline that sample as a smaller group that represents the whole population.

4.5 ORGANIZATION AND ADMINISTRATION OF QUESTIONNAIRES

Contact with the respective persons and patients need to be made for permissions to undertake a study at their institution and decide on an appropriate time to distribute and collect questionnaires. Johns and Lee-Ross (1998: 76) recommend that questionnaires should be designed carefully so that the respondent is not confused or misled.

Leedy and Ormrod (2010:194) warn that questionnaires seem so simple, yet in their experience they can be tricky to construct and administer. One false step can lead to uninterpretable data or an abysmally low return rate.

Gray (2009: 243) indicates that unskilled, untrained, or inexperienced interviewers can also be a source of error due to the way in which they handle the interview.

The administration of the structured questionnaire (**Appendix 1**) to the department heads of the Provincial Hospital was scheduled for a period of two months. This involved the setting up appointments with respective heads and

conducting of interviews. Each structured questionnaire took approximately an hour to complete.

A structured questionnaire followed to the patients at the Provincial Hospital and scheduled over a period of four months. The structured interview with the Chief Executive Officer and the Financial Manager were the last to be conducted post survey of both department heads and patients respectively. The structured interview required a minimum of an hour per subject. Appointments of an hour duration were made with both the CEO and the Financial Manager of the Provincial Hospital.

The sequence of the surveys to the Provincial Hospital were important as the information obtained was utilized to get a better understanding as well as a more informed approach in the survey which followed.

4.6 ORIENTATION OF THE FIELD RESEARCH ASSISTANTS

Assumptions about the skills and procedures of conducting interviews and or questionnaires are that it is part of the research process and everyone has the ability to do it regardless of the nature of the research question or approach. De Vos *et al* (2005: 20) state that the quality of the interview depends mainly on the skills of the researcher as an interviewer. It is, therefore, advisable to use highly skilled interviewers if researchers do not feel competent to do the interviewing themselves. Thorough training, including familiarisation with the project and its goals, is important. Poor interviewing skills, poor phrasing of questions, or inadequate knowledge of the participants' culture or frame of reference may result in a collection that obtains few useful data.

Simons (2009:53) suggests that during an interview the interviewer or researcher makes clear why their response is being sought to ensure that the information reported is accurate, that perspectives are reported fairly in context, to seek further data, and/or to establish or reaffirm co-operation.

The field workers who assisted in the administration of the structured questionnaire to the patients of the Provincial Hospital were B-Tech Hospitality

Management final year undergraduates. They were chosen as they were most suitable for the task and as mentioned it provided training for their respective research studies. The field workers were briefed on the content of the questionnaire and were given information on the nature and content of the research.

4.7 DESIGN OF THE QUESTIONNAIRE

Johns and Lee-Ross (1998: 77) agree that as the number and complexity of questions, it becomes less likely that respondents will complete and return it. Therefore, the survey instrument must contain enough questions to be of value to the researcher, but not so many as to be ill – favoured to respondents.

Surveys are particularly useful in describing the characteristics of a large population. A carefully selected probability sample in combination with a standardised questionnaire offers the possibility of making refined descriptive assertions about a student body, a city, a nation, or any other large population (Babbie 2010: 287).

Babbie (2010) asserts that questionnaires are utilised in various modes of observation in social research. Although structured questionnaires are essential to and most directly associated with survey research, they are also widely used in experimental field research, and other data collection activities.

The confidentiality of the questionnaire had to be ensured to patients, employees and management. Another aspect that needs to be considered in terms of De Vos *et al* (2005:170-171) is the covering letter which should be accompanied to all questionnaires. A covering letter serves to introduce and explain the purpose of the questionnaire to the respondent.

De Vos *et al* (2005) state that the covering letter should incorporate areas around the length of time for the completion of the questionnaire and the assurance of anonymity and confidentiality, as well as a deadline for returning the questionnaire.

The format and layout of the questionnaire is just as important as the nature and wording of the questions asked. Questionnaire should be clear, neat and easy to follow. An inadequately laid out questionnaire can lead respondents to miss questions, confuse them about the nature of the data desired and, in the worst case, lead them to throw the questionnaire away (De Vos *et al* 2005: 170).

Babbie (2010: 426) highlights that one should be able to tailor ones questionnaire in accordance with the particular program or data source one is using. Coding of questionnaires for easy data capturing was done in advance of the administration of the questionnaire.

In all cases it is essential that newly-constructed questionnaires, those in their semi-final form, be thoroughly pilot-tested before being utilised in the main investigation. This ensures that errors of whatever nature can be rectified immediately at little cost De Vos *et al* (2005:171-172).

Babbie (2010: 257) states that questionnaire items should be precise so that the respondent knows exactly what the researcher is asking. The possibilities are endless and no researcher is immune.

The approach taken was to distribute the questionnaires to patients, and wait to collect them once finished. Although this may be more time consuming, it provided the respondents with the privacy and security of exercising their views.

The approach for the questionnaire to the department heads was similar. However, the questionnaires were forwarded in advance of the appointment made to provide the respondent an opportunity to read the questionnaire at leisure. Thereafter, the researcher completed the questionnaire whilst the respondent answered during the scheduled appointment.

4.8 QUESTIONNAIRE COMPLETED BY THE PATIENT OF THE PROVINCIAL HOSPITAL (APPENDIX 2)

Bailey (1994: 115) finds it common to introduce the questionnaire by stressing that it will not take long to complete. Bailey further stresses that urging the prompt return of the questionnaire as the results could improve the respondent's health care. This approach was adapted in the study.

The questionnaire was designed for the patients of the Provincial Hospital. The target respondents were the patients that visited the outpatients department where the provincial hospital accommodates the largest number of patients as

compared to other departments on a daily basis. The outpatients department includes the following areas:

- Pharmacy;
- Clinic;
- Medical outpatients;
- Card office; and
- Casualty.

The questionnaires were pre-coded in order for the researcher to easily analyze and interpret the data. The questionnaires were also carefully constructed to ensure easy understanding by the patient. These questionnaires were administered by the researcher and the research field assistants. Due to the nature of the casualty area, questionnaires could not be administered to these patients as they were in no capacity to answer them.

4.8.1 STRUCTURE AND CONTENT OF PATIENT QUESTIONNAIRE (APPENDIX 2)

The questionnaire directed to the patients of the provincial hospital included the areas of:

- Covering Letter;
- Biographical information;
- General information of the patient; and
- Scope of hospital service.

The various sections within the patient questionnaire comprised core themes that were explored.

The covering letter in **Appendix 2** was included with the questionnaire that explained the following areas:

- Topic of the research;

- Reasons for the questionnaire;
- Aims of the research;
- Instructions on completion of the questionnaire;
- Assurance of confidentiality; and
- Details of researcher.

The questionnaire also made provision for additional general comments. This provided an opportunity for the patient to express further views and comment on the research undertaken and other related issues.

4.9 QUESTIONNAIRE (APPENDIX 1) FOR DEPARTMENT HEADS AT THE PROVINCIAL HOSPITAL

The target respondents were the department heads or the line managers depicted in **Figure 3.3** presented in **Chapter 3,** who were similar to managers found within the hospitality industry.

The questionnaire was pre-coded for easy analysis and interpretation of data collected. The questionnaire was carefully constructed to ensure easy reading and understanding. All the questionnaires were administered by the researcher.

4.9.1 STRUCTURE AND CONTENT OF QUESTIONNIARE FOR DEPARTMENT HEADS OF THE PROVINCIAL HOSPITAL (APPENDIX 1)

The questionnaire was directed to the department heads of the Provincial Hospital identified in the organogram in **Figure 3.3** in **Chapter 3** of the study which included the areas of:

- Covering letter;
- Section A;
    - Biographical information;
- Section B;
    - Service delivery;
        - Management and Leadership;
    - Complaints;

- Human resources;
- Performance management;
- Batho Pele Principles / Patient care; and
- Hospitality practices.

The various sections within the questionnaire comprised core themes that explored in detail the various issues that were emphasized throughout the study. The thirty – nine questions including sub-questions were a mixture of open-ended and close-ended questions. Much of the questions were formulated from the gaps that emerged in **Chapter 3** and the literature review.

The questionnaire was accompanied by a covering letter which identified and explained the same areas covered by the questionnaire to patients.

The questionnaire also made provision for additional general comments. This provided an opportunity for the Departments Heads to express further views and comments.

4.10 DESIGN OF STRUCTURED INTERVIEW WITH SENIOR MANAGEMENT OF THE PROVINCIAL HOSPITAL (APPENDIX 3)

Neuman (2006: 304) states that interviews are used to gather information in multiple settings. Bailey (1994: 186) identifies a structured interview as a special case of social interaction between two persons. The intention of the structured interviews was to create a relationship with the interviewees to gain access for the study.

Neuman's (2006: 305) views are consistent with Bailey's (1994: 186) where the survey interview is a social relationship involving social roles, norms and expectations. Neuman (2006: 305) further states that the interview is a short term, secondary social interaction between two strangers with the explicit purpose of one person obtaining specific information from another, where the information is gathered in a structured conversation in which the interviewer asks prearranged

questions and records answers. Interviews with Senior Management included an interview schedule and permission was sought to record sessions.

Alasuutari *el al* (2009: 316) advise that a questionnaire is more than a collection of questions, It contains instructions and texts to keep the flow of information going and to keep the respondents motivated. It also should be pleasant, to avoid unnecessary routing errors, and correctly guide respondents from question to question.

The structured interviews had set themes emanating from the literature review and **Chapter 3** of the study. This provided a guide line for the interview conducted to ensure all relevant aspects pertaining to the study were covered.

4.11 STRUCTURED INTERVIEW (APPENDIX 3) WITH SENIOR MANAGEMENT OF THE PROVINCIAL HOSPITAL

A questionnaire was designed as the instrument for the structured interview targeting the senior management of the Provincial Hospital. The target respondents of the structured interview were the Chief Executive Officer and the Finance and Systems Manager identified in the organogram in **Figure 3.3** of the study.

Figure 3.3 points out that the CEO is at the head of the organizational structure and the Finance and Systems Manager is responsible for both the finance and systems of the Provincial Hospital. The Finance and Systems Managers were selected for the structured interview and senior management since they were responsible for finance and budgets, and the allocation of those budgets through to the various system departments depicted in **Figure 3.3.**

The structured interviews were conducted by the researcher. Appointments with these respondents had to be made well in advance because of their lack of availability due their demanding positions at the Provincial Hospital.

4.11.1 STRUCTURE AND CONTENT OF STRUCTURED INTERVIEW WITH THE SENIOR MANAGEMENT OF THE PROVINCIAL HOSPITAL

The structured interview was directed to the CEO and the Finance and Systems Manager of the provincial hospital. The interview schedule was drawn up using the advice of Leedy and Ormrod (2010) which are as follows:

- Covering letter;
- Introduction of topic;
    - Biographical information;
    - Area of expertise and experience;
    - Hospital management functions;
        - Planning;
        - Leadership;
        - Organization;
        - Controlling;
    - Service delivery;
    - Challenges;
    - Hospitality practises; and
    - Batho Pele Principles / Patient care.

The various areas within the structured interview comprised core themes that explored in detail the various issues that were emphasized and integral to the study. The twenty – one questions including sub-questions were a combination of open-ended and closed-ended questions. Much of the structured interview questionnaire was based on the information gathered from the **Chapter 2** and particularly **Chapter 3**. Furthermore the structured interview was planned to be undertaken post the surveys of the Departmental Heads and patients of the Provincial Hospital. The purpose of this approach was to provide a basis on triangulation and verification.

The questionnaire was accompanied by a covering letter which identified and explained the same areas covered by the questionnaire to patients. The structured interview was also accompanied by a covering letter which identified and explained the same areas covered by the questionnaire to patients and departmental heads.

4.12 PRE-TESTING

Simons (2009:38) highlights that one should plan well ahead of the first field visit. Simons (2009:38) indicates that one should pilot/pre-test the schedules or questionnaires and to ensure that recording equipment is also checked and tested. Staying open to changes to design and methods is strongly advised as the understandings of the field grew.

The questionnaires directed to the patients of the provincial hospital were carefully constructed. A pilot questionnaire was conducted among members of family who were patients of another provincial hospital. Changes made to the piloted questionnaire were minimal, however necessary to the overall impact of the data collected.

The structured questionnaire to department heads was pretested using friends and work colleagues as interview subjects. This method proved useful to the structure of the questions, duration of the questionnaire and grammatical errors. However there were limitations, as the pre-test was conducted among individuals who were not from a provincial health care background. Therefore limitations included the following:

- Difficulty in checking the relevancy of questions;
- Uncertainty as to whether respondents understood all the questions; and
- Inability to establish if answers were in line with expectations.

The structured interview was pretested with field research assistants and fellow work colleagues. The instrument questionnaire for the structured interview was carefully constructed as information obtained from patient questionnaire and questionnaire with department heads of the Provincial Hospital were notably considered.

4.13 CODING AND EDITING DATA

According to Bailey (1994: 340) the point of coding the data is to make it suitable for analysis via computer and modern electronic data processing equipment. The sample size of the study was extensive therefore coding was necessary to easily capture the

results on the computer programme Statistical Package for Social Science, (SPSS) version 20.0.

Johns and Lee-Ross (1998: 135) state that the objective of coding is to produce theories which are grounded in empirical data are conceptually dense, that are related to the data through many justifiable generalizations, are well integrated, and that are to have common themes that support one another.

The questionnaires had to be checked for completeness and this was carried out by the researcher. The line management questionnaire and the structured interview schedule were complete as the researcher administered them. The patient questionnaires that were administered by the field research assistants were checked thoroughly for errors and completion by the researcher.

Edwards and Talbot (1996: 105) highlight that categories and their sub-categories or coding can develop from the data and therefore become completely data driven. Boyatziz (1998: 31) points out that a good thematic code is one that captures the qualitative richness of the phenomenon.

The data that was collected from the patient questionnaire, the line management questionnaire and the structured interview were set into themes in order to code for analysis. Furthermore, the themes that were formulated ensured the correct data capture and analysis of results with specific reference to qualitative research. The coding process paved the way for the data capturing to take place. Data capture was completed by the researcher along with the research field assistants who were familiar with the statistical package and then further given to a statistician to produce findings in graphical representation.

4.14 SUMMARY

This chapter focussed on the research methodology employed in this study. The research methodology of the study comprised a detailed progression incorporating the objectives and theoretical approach of the study. The approach involved the theory of the literature review and the operational chapter pertaining to the Provincial Hospital of study. An account of the qualitative and quantitative methods to be used in the study was described. The organization, administration

and design of questionnaires and interviews were discussed. The research design as well the sampling procedure were explained and implemented. A detailed description of the questionnaires for department heads and patients were included. The necessity of pre-testing and coding was described in the methodology. The presentation of the findings of the study will follow in the next chapter.

CHAPTER 5

PRESENTATION OF FINDINGS AND DISCUSSION

5.1 INTRODUCTION

This chapter presents the results and details the findings obtained from the questionnaires in this study. The information obtained from the survey questionnaires and structured interviews, responded to the critical areas of the study which were grouped into three fundamental themes. Descriptive statistics were used to summarise, organise, express graphically and in general analyse the information quantitatively. The data collected from the survey questionnaires were analysed with SPSS version 20.0.

5.2. RESEARCH OBJECTIVES OF THE STUDY

The research objectives of the study may be summarised as follows although specific sub-objectives within the various chapters are specified:

1. Analyse the evolution and expansion of the hospitality industry;
2. Locate the theory and practise of hospitality within provincial hospitals;
3. Evaluate hospitality practise within the broader context of hospitals; and
4. Evaluate hospitality practise within the specific context of the Provincial Hospital within the southern district of Chatsworth, Durban.

The first three research objectives were discussed in the literature review (**Chapter 2**) of the study in which an extensive theoretical account of these aspects were covered. It was important to explain and understand how dynamic and similar these two industries, hospitality and health care, are and yet how differently they are perceived.

The literature provides the relevant content and puts perspective on the similarities of these industries and this may be seen in the first layer (**A**) from the bottom in **Figure 5.1.**

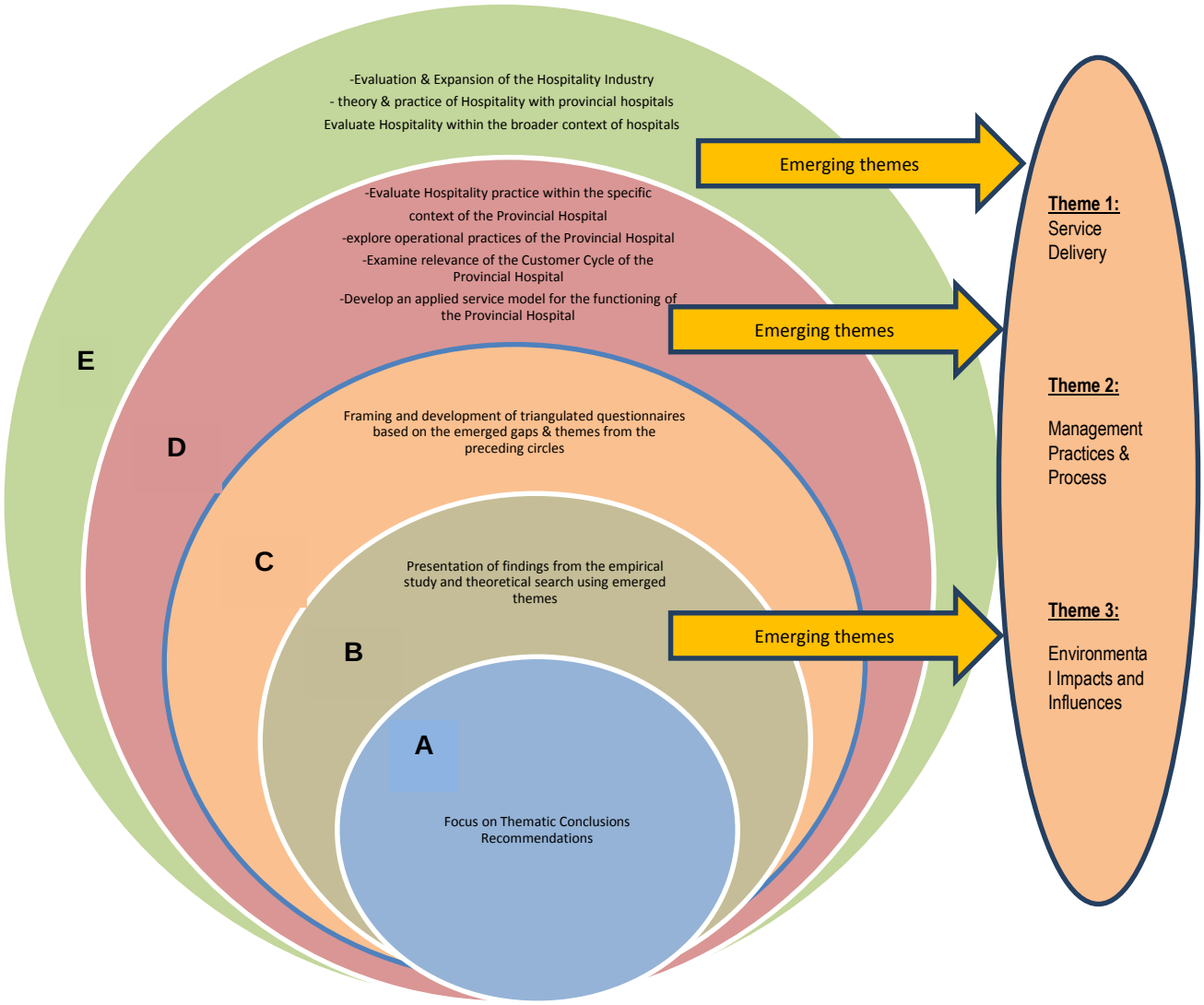

Figure 5.1 Methodological approach to the establishment of Findings

The fourth objective of the study was to evaluate hospitality practise within a specific context of the Provincial Hospital within the southern district of Chatsworth in Durban, which was researched and covered within **Chapter 3** and appears in **Figure 5.1** (second layer from the bottom - **B**). A complete background, history and account of the operational practices of the Provincial Hospital were discussed. Within this discussion, existing similarities between the hospitality and hospitals were identified.

This chapter will serve to bring out, crucial gaps and similarities that were studied within the literature review. This assisted in the framing and development of the triangulated questionnaires and structured interviews conducted at the Provincial Hospital. This is evident in the third layer (**C**) in **Figure 5.1** of **Chapter 5,** where the process of triangulation will present findings collectively from the respective empirical data.

5.2.1 RESULTS OF THE STUDY

The results of the study were organised thematically (**Figure 5.1**) and were combined with relevant responses from the structured interview with senior managers of the Provincial Hospital. The survey questionnaires to the patients, Heads of Department and the structured interview conducted with the senior managers of the hospital were originally intended to be compartmentalised and organised into convenient sets of information to the relevant themes of the study respectively.

The data yielded through these mechanisms however, materialised in a very integrated and comprehensive way which became relevant to all three themes of the study at varied levels. In order to enhance the coherence of the presentation of results, data were triangulated and viewed as a whole. The interviews were recorded, transcribed, and read to establish a sense of familiarity with the data. Veal (2011: 143) states that in research, the triangulation method involves the use of more than one research approach in a single study to gain a broader or more complete understanding of the issues being investigated. Veal (2011: 143) further identifies that the methods used are often complimentary in that the weaknesses of one approach are complimented by the strengths of another.

In providing a description of the experiences of the senior managers in the Provincial Hospital it was necessary to classify related ideas and concepts into the respective themes of the study. Some of the information went beyond these parameters. **Figure 5.1** demonstrates the layered approach from which data was yielded.

5.2.2 THEMES OF THE STUDY

The concept of hospitality within hospitals emerged from the study through various themes. These themes surfaced as dominant components in enhancing hospitality within hospitals and are discussed as follows:

Service delivery as espoused in **Chapter 2** emerged as a conduit between the organisation (hotel/hospital) and the customer (guest/patient). The applied model of Management Influence on Patient Service of the Provincial Hospital (**Figure 3.5**) is the mechanism that represents this conduit which is directed to service delivery.

Management practices and processes are proved to be an integral point of discussion both in the literature search and in **Chapter 3** of the study. This further alluded to the basic functions of management which is a significant factor to effective practise and hospitality. An intentional effort therefore was made to structure this within the interviews of senior management.

Environmental impacts and influences refer to the environments immediate to the organisation and those that are indirectly linked to the establishment. The essence of this theme was the interdependency between the organisation (hotel/hospital) and these environments. **Chapter 2** highlights the socio, political economic and technological influences as well as those such as legislation and competition.

5.2.3 RELIABILITY

Joppe (2000) in Golafshani (2003) identifies reliability as the extent to which results are consistent over time and an accurate representation of the total population under study is referred to as reliability and if the results of a study can be reproduced under a similar methodology, then the research instrument is considered to be reliable. This is significant as the study undertook a sample which represented the population that frequented the Provincial Hospital.

Golafshani (2003) further observes that triangulation is used in quantitative research to test the reliability of the research. A methodological triangulation has been practised within the study and explained in **Chapter 4**. Patton (2001) cited by Golafshani (2003) supports that triangulation strengthens a study by combining methods using both quantitative and qualitative approaches, which is parallel within the study.

5.2.3.1 CRONBACH'S COEFFICIENT ALPHA

Cronbach's coefficient alpha was used to measure reliability in the study.

Cronbach's Alpha	N of Items
0.699	118

Table 5.1 Cronbach's Coefficient Alpha

Table 5.1 represents Cronbach's coefficient alpha test which reflects that the number of items in management questionnaire is 118. It is evident from **Table 5.1** that Cronbach's coefficient

alpha is 0.699. This estimate is close to unity and it can be concluded that the measuring instrument has a high degree of reliability.

Leech, Barret & Morgan (2008: 50) indicate that whist Cronbach's coefficient alpha is above.07, it is common to find journal articles where scales have lower alphas such as 0.60 and 0.69. This is mainly in instances where there are few items in the scale and items may not necessarily be repetitious.

5.2.4 BIOGRAPHICAL DATA RELATING TO THE DEPARTMENT HEADS OF THE PROVINCIAL HOSPITAL

The findings below are a reflection of the general questions that appeared in the questionnaires in respect to the Provincial Hospital.

This section presents the descriptive statistics based on the demographic information of the study targeting all participants of the study within the Provincial Hospital. The results are presented using tables and graphs.

5.2.4.1 RACE AND GENDER OF THE PARTICIPANTS IN THE STUDY OF THE PROVINCIAL HOSPITAL

	Gender		Race							
Survey Instrument	**Male %**	**Female %**	**Black %**		**White %**		**Indian %**		**Coloured %**	
			M	**F**	**M**	**F**	**M**	**F**	**M**	**F**
Questionnaire to HOD's of the Hospital	**53.8**	**46.2**	**7.7**	**15.4**	**0**	**0**	**46.42**	**30.08**	**0**	**0**
Questionnaire to Patients of the Hospital	**27.1**	**72.9**	**13.1**	**32**	**0**	**0.7**	**13.1**	**38.9**	**1**	**1.3**
Structured interview Senior Managers	**100**	**0**	**50**	**0**	**0**	**0**	**50**	**0**	**0**	**0**

Table 5.2 Cross tabulation of Race and Gender of all participants at the Provincial Hospital

Table 5.2 indicates that in respect of the Heads of Department, more than half of the respondents (53.8%) were male. The racial profile of the sample was approximately in the ratio of 3:1 for Indian: African (76.9% : 23.1%). Nearly half (46.2%) of the respondents were Indian males.

A serious factor to be considered here is the history of the Provincial Hospital as outlined in **Chapter 3** and the impact of this on the racial imbalance that currently remains. The Provincial Hospital in the past was intended to service the Indian community of Chatsworth as the Chatsworth District was a legislated zone for Indian settlement. The current position in respect of the various communities the Provincial Hospital services are diverse in respect of race, gender and religion.

Senior Management comprised only males and 50% (n1) are Indian and 50% (n1) are African.

Table 5.2 reflects the race and gender of the sample. A little more than a quarter of the respondents (27.1%) were male and 72.9% were female respondents. This also reveals that only 3% of the sample belonged to other race groups other than Black or Indian. More than half of the respondents (52.0%) were Indian and 45.1 % of the respondents were Black.

Table 5.2 indicates that 13.1 % of the respondents were black males and 32.0% of the respondents were black females. 13.1% of the respondents were Indian males and almost 39% of the respondents were Indian females. White female respondents comprised 0.7% of the sample. The sample also included 1.0% of coloured males and 1.3% coloured females.

5.2.4.2 YEARS OF SERVICE OF STAFF WITHIN THE PROVINCIAL HOSPITAL

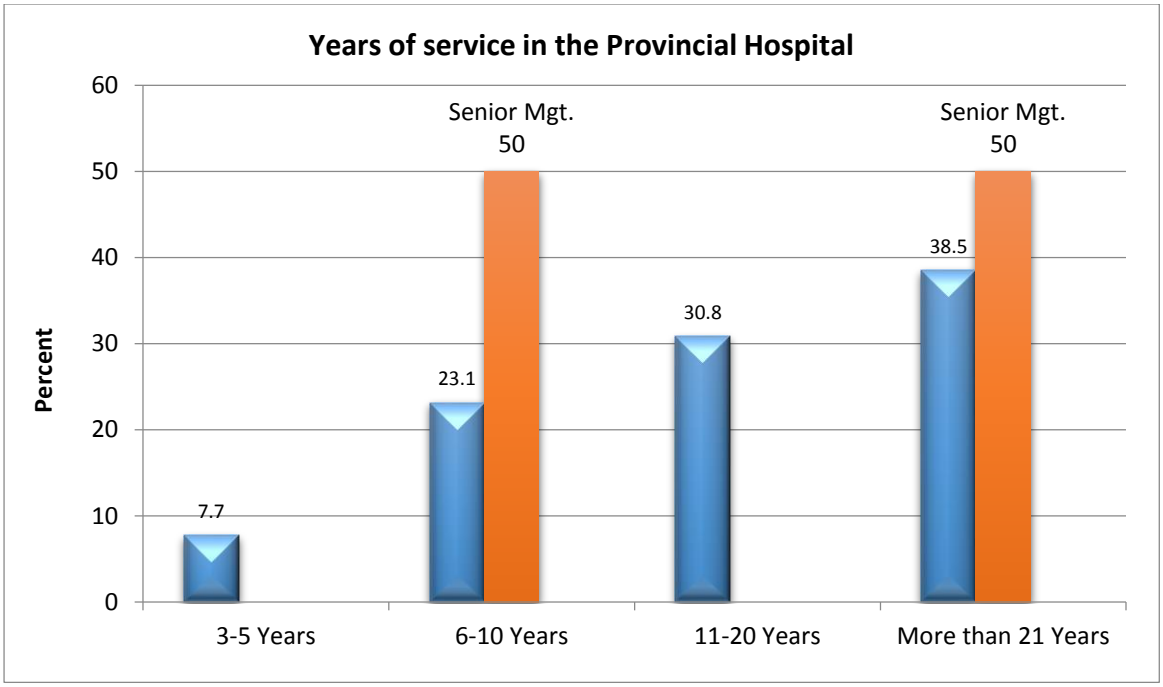

Figure 5.2 Staff years of service within the Provincial Hospital

Figure 5.2 indicates that more than two-thirds of the respondents (69.3%) had more than 10 years of experience at the hospital. This is useful as it indicates that the sample has many years of experience and that the responses should be an accurate source of information. Senior Management identified in **Figure 5.1** reveals that 50% (n1) have between 6-10 years of experience and the other 50% (n1) have experience in excess of 21 years.

5.2.4.3 QUALIFICATIONS OF DEPARTMENT HEADS

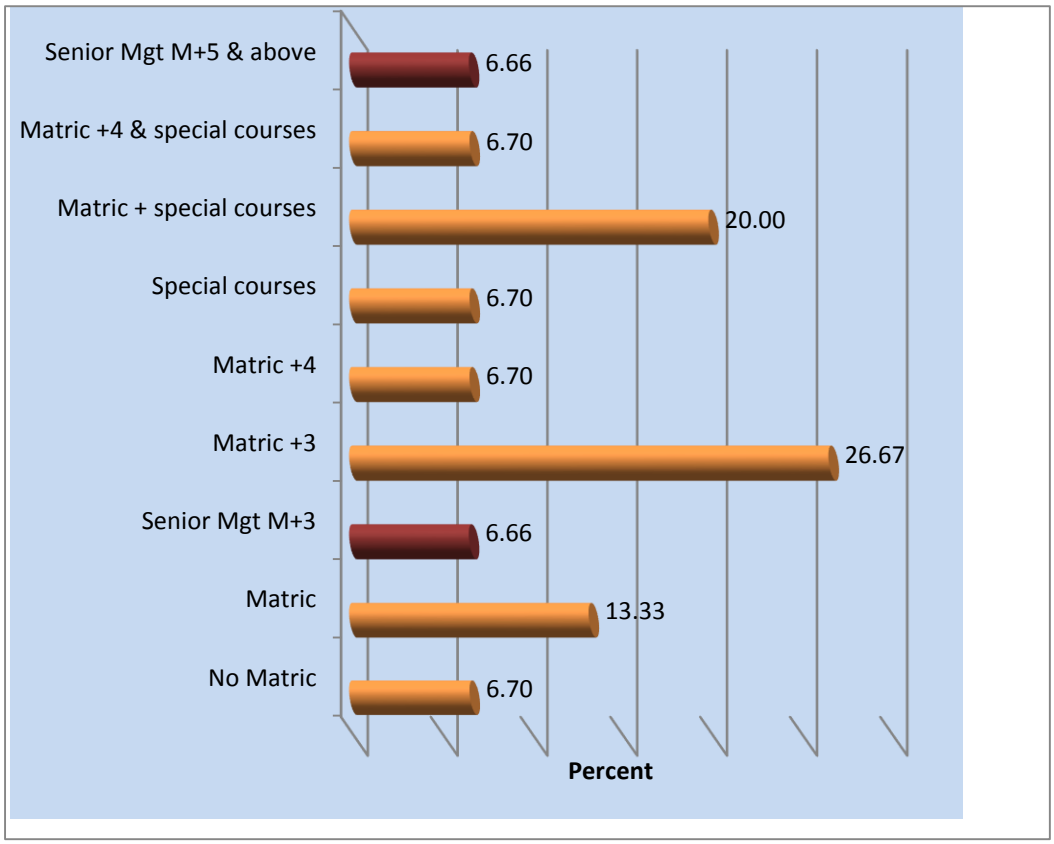

Figure 5.3 The qualifications of the department heads

Figure 5.3 indicates that nearly a third of the respondents (30.8%) had a diploma as their highest qualification (Matric +3). A further 23.1% had a Matric with other Special Courses.

Nearly 8% had not completed high school. Almost 8% of the respondents had only special courses with and the same percentage had a degree with special courses respectively.

This is a strong indicator that the department heads have some tertiary management knowledge but not all. **Chapter 2** reveals that management is such an important element of the hotel industry that can make or spoil the industry and further defines it as a technique of getting things done through the efforts of others David (2005: 8). Senior management qualifications range from medical degrees to diplomas. The Financial Manager who was interviewed holds a diploma in public management. His role as identified in **Chapter 3** is to oversee the entire financial operation of the Provincial Hospital. The CEO who holds a medical degree is responsible for the operations of the entire Provincial Hospital.

5.2.4.4 DEPARTMENTS EMPLOYED IN AND JOB TITLE

			Job title			Total
			Manager	Supervisor	Sister	
Department you are employed in	Admitting outpatients	Count	1	0	0	1
		% of Total	7.7%	0.0%	0.0%	7.7%
	Maintenance	Count	1	0	0	1
		% of Total	7.7%	0.0%	0.0%	7.7%
	Security	Count	1	0	0	1
		% of Total	7.7%	0.0%	0.0%	7.7%
	Catering / Kitchen	Count	1	0	0	1
		% of Total	7.7%	0.0%	0.0%	7.7%
	Human resources	Count	1	0	0	1
		% of Total	7.7%	0.0%	0.0%	7.7%
	Housekeeping	Count	0	2	0	2
		% of Total	0.0%	15.4%	0.0%	15.4%
	Quality Assurance	Count	0	0	1	1
		% of Total	0.0%	0.0%	7.7%	7.7%
	Nursing	Count	1	0	0	1
		% of Total	7.7%	0.0%	0.0%	7.7%
	Linen	Count	0	1	0	1
		% of Total	0.0%	7.7%	0.0%	7.7%
	Pharmacy	Count	0	1	0	1
		% of Total	0.0%	7.7%	0.0%	7.7%
	Systems & Finance	Count	1	0	0	1
		% of Total	7.7%	0.0%	0.0%	7.7%
	Public relations	Count	1	0	0	1
		% of Total	7.7%	0.0%	0.0%	7.7%
Total		Count	8	4	1	13
		% of Total	61.5%	30.8%	7.7%	100.0%

Table 5.3 Cross tabulation of the department employed in and job title

Table 5.3 indicates the job title and department of the respondents and reveals that more than 60% of the respondents were managers. **Table 5.3 is resonant** with the organogram in **Figure 3.3 of Chapter 3**, which details the various heads of department of the Provincial Hospital. The departments above are critical to the delivery of services and to the enhancement of Hospitality as espoused in **Chapter 2**.

5.2.4.5 AREAS OF THE PROVINCIAL HOSPITAL MOST VISITED BY PATIENTS

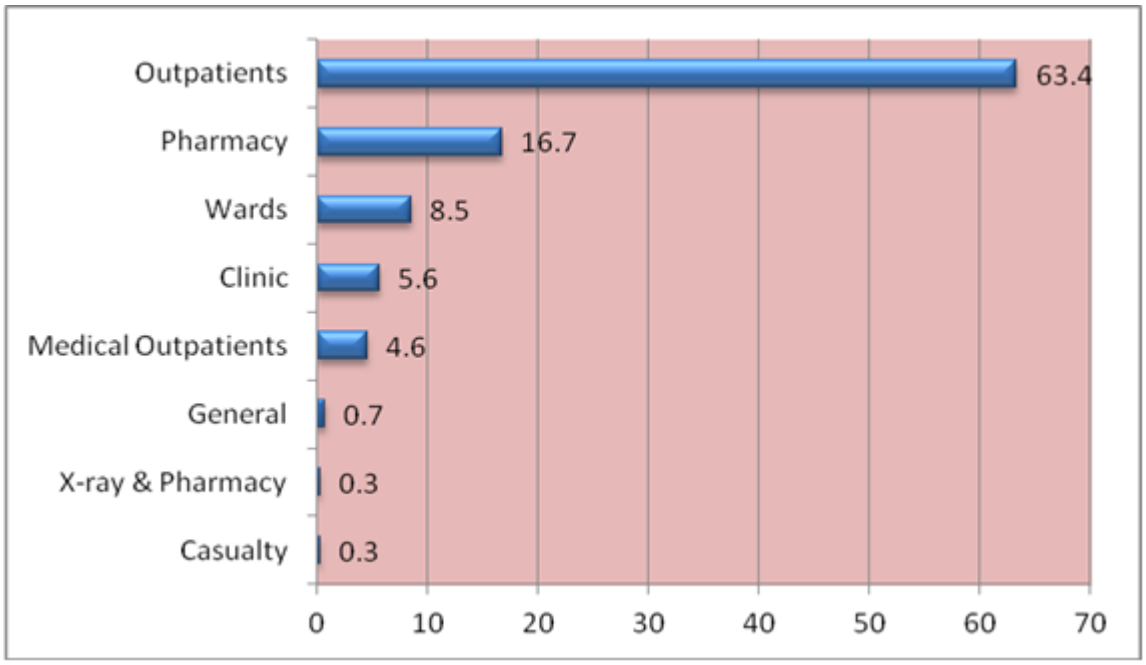

Figure 5.4 Areas most visited in the Provincial Hospital

Figure 5.4 indicates the most common areas that were visited by the respondents of the Provincial Hospital. Nearly two-thirds of the respondents (63.4%) indicated that their primary location (of visit) was outpatients. A quarter of the respondents visited the pharmacy (16.7%) and 8.5% of the respondents were from the wards. The respondents that visited the clinic amounted to 5.6%, where 4.6% of the respondents visited the medical outpatients department and only 0.7% of the respondents visited the provincial hospital for a general query.

5.2.4.6 AREA OF RESIDENCE OF THE PATIENT

	Frequency	Percent
Margate	2	0.7
Shongweni	2	0.7
Nagina	3	1
Umhlatuzana Township	3	1
Botha's Hill	4	1.3
Klaarwater	4	1.3
Silverglen	4	1.3
KwaNdengezi	5	1.6
Kharwarstan	6	2
Newlands	6	2
Savannah Park	6	2
Hammersdale	7	2.3
Woodhurst	19	6.2
Welbedacht	9	2.9
Montclaire	9	2.9
Havenside	10	3.3
Arena Park	11	3.6
Crossmoor	13	4.2
Croftdene	17	5.6
Shallcross	18	5.9
Moorton	19	6.2
Bayview	23	7.5
Montford	23	7.5
Marianhill	26	8.5
Westcliffe	27	8.8
Pinetown	30	9.8
Total	306	100

Table 5.4 Area of residence of the patient

Table 5.4 indicates the patients' area of residence. The areas are made up of immediate subsections which have been highlighted in yellow, and 68% of the respondents reside in these areas combined.

Table 5.4 reveals that over 37% of the respondents reside in the north western region of Chatsworth which include Marianhill, Shallcross, Crossmoor, Hammersdale, Savannah Park, Botha's Hill, Nagina, Pinetown, KwaNdengezi and Klaarwater. Almost 7% of the respondents reside in Montclaire and Havenside combined which is east of the Chatsworth area.

These findings confirm that the Provincial Hospital provides hospital care for not only their respective district but also from referrals from clinics, community health centres in the southern region and outside their respective drainage areas (Chetty, 2009). A considerable number of patients travel a distance to reach the Provincial Hospital, as pointed out in **Figure 3.1** in **Chapter 3**. Along with the distance that patients travel, **Chapter 3** also draws attention to the patient arrival times as early as 4.00 am at the Provincial Hospital to wait to receive treatment and are only allowed to enter the hospital at 5.00 am.

5.2.5 STUDY THEME 1: SERVICE DELIVERY AS AN ELEMENT TO HOSPITALITY

Chapter 2 and **Chapter 3** have alluded to the service delivery as a key component to hospitality. The following are findings presented from the empirical research that are pertinent to service delivery as an element to hospitality.

5.2.5.1 DEPARTMENTAL COMPLAINTS

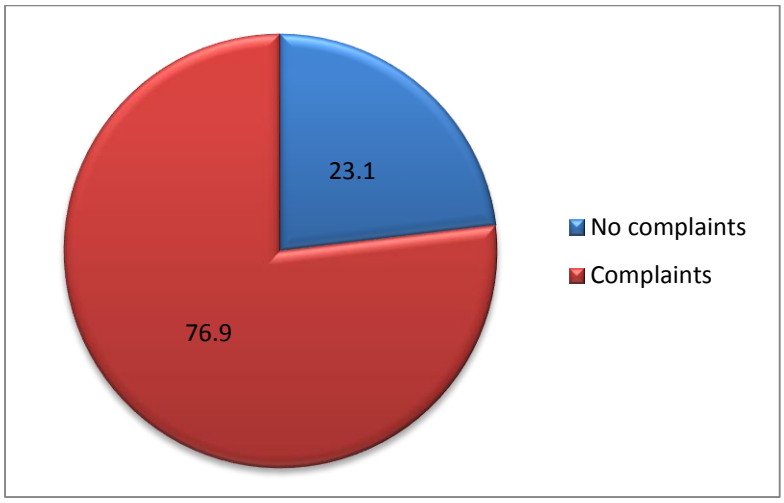

Figure 5.5 Complaints on department's performances

Figure 5.5 identifies the complaints on performance received by the respective department head. A majority of the respondents (76.9%) received complaints regarding their departments' performance and 23.1% of the respondents indicated that they received no complaints on their department's performance.

Chapter 2 reviews that in the hospitality industry, employee commitment plays a major role in delivering a good customer experience, in turn leading to customer satisfaction. Uysal & Williams (2003: 8) confirm that in any service industry the service role is basic and essential, and dependant on staff performance. They further explain (2003: 9) that every employee who is in contact with external customers, affects customer satisfaction.

Mullins (2001: 137) attests that the task of management is to make use of staff and the responsibility of management is to manage which is illustrated in the model of management influence.

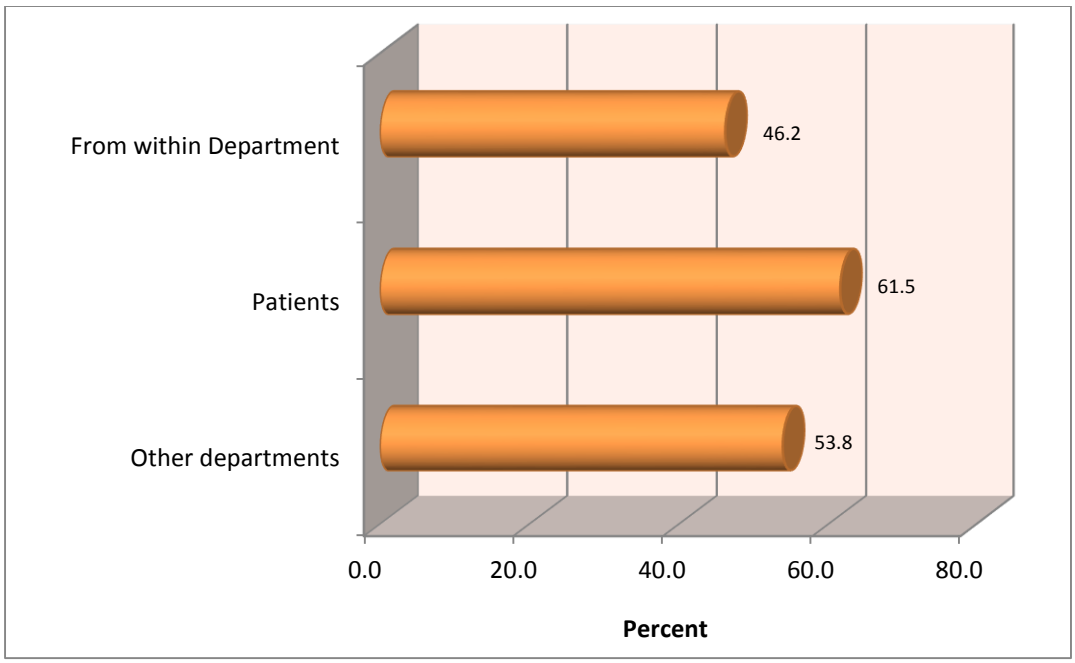

Figure 5.6 Origin of Complaints

Figure 5.6 show complaints received in the Provincial Hospital and where they originate. Multiple responses were possible for the options in the figure above. The figure represents only the positive results.

The highest level of complaints were from patients (61.5%), 53.8% of complaints emerged from other departments and 46.2% complaints are from within the department. The purpose of this analysis was to ascertain where the complaints originate. These findings are consistent with **Figure 5.5** which relates to complaints on departments' performance.

5.2.5.2. DEPARTMENTS THAT PATIENTS INDICATED THEY WERE UNHAPPY WITH

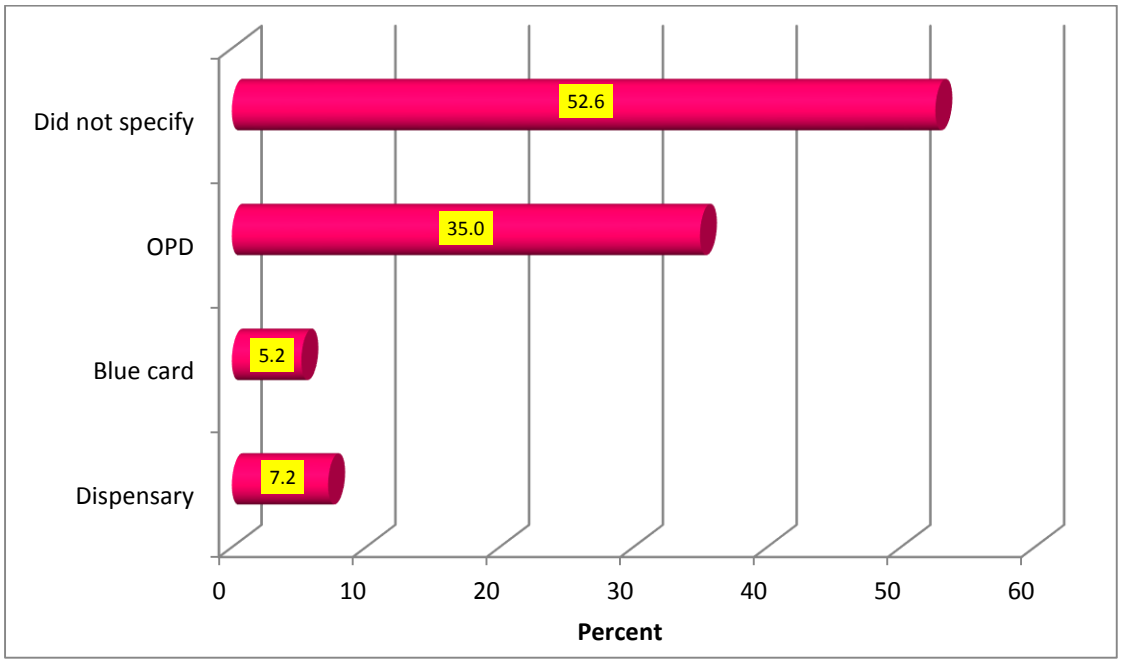

Figure 5.7 The specified departments that patients indicated that they were unhappy with

More than half of the respondents (52.6%) did not specify the area that caused the longest delays in **Figure 5.7**. However, others (35.0%) indicated that the OPD was the leading department of dissatisfaction followed by the dispensary (7.2%) and the blue card area (5.2%).

The purpose of this analysis was to display a consistency with the management survey and patient survey**.** The findings reveal that of those respondents who did specify that OPD was the leading department of dissatisfaction. **Figure 5.7** indicates that this department is also the most frequented department by the patient.

5.2.5.3 THE EXTENT OF SATISFACTION OF THE PATIENT AND THE DEPARTMENT THEY ARE UNHAPPY WITH

			To what extent are you happy with the service at the hospital?					Total
			Very unhappy	Unhappy	Average	Happy	Very Happy	
If you were unhappy, which department you were most unhappy with?	Long waiting periods: Dispensary	Count	5	9	6	2	0	22
		% of Total	1.6%	2.9%	2.0%	0.7%	0.0%	7.2%
	Long waiting periods: OPD	Count	35	52	13	6	1	107
		% of Total	11.4%	17.0%	4.2%	2.0%	0.3%	35.0%
	Long waiting periods: Blue card	Count	4	9	3	0	0	16
		% of Total	1.3%	2.9%	1.0%	0.0%	0.0%	5.2%
	Did not specify department	Count	5	30	81	44	1	161
		% of Total	1.6%	9.8%	26.5%	14.4%	0.3%	52.6%
Total		Count	49	100	103	52	2	306
		% of Total	16.0%	32.7%	33.7%	17.0%	0.7%	100.0%

Table 5.5 Cross tabulation with the extent of satisfaction of the patient and the department they are unhappy with

Table 5.5 indicates the extent of satisfaction that the patient has with the Provincial Hospital and which department the patient was dissatisfied with. It indicates that the OPD, the area for blue card, and the dispensary are the leading departments (37.1%) of unhappiness of the respondents and only 3% of the respondents are happy with these departments respectively.

Srinivasan (2008: 173) highlights in the literature that customers in a hospital context would not only include those who are direct recipients of the service but also those who come into contact with the hospital are its potential customers. Ndebele (2008) supports this by referring to the KwaZulu Natal Citizens' Charter in 2005 where a pledge was made for the creation of an environment that is characterized by a culture of service excellence that starts with treating citizens as customers.

These findings further reveal that management has an influence on staff performance and Jones and Lockwood (1989: 111) support this with their model of management influence in **Figure 2.3**, which draws an association to the interpersonal interaction between the employee and the customer which creates the service encounter.

5.2.5.4 PATIENTS IDENTIFIED COMPLAINTS

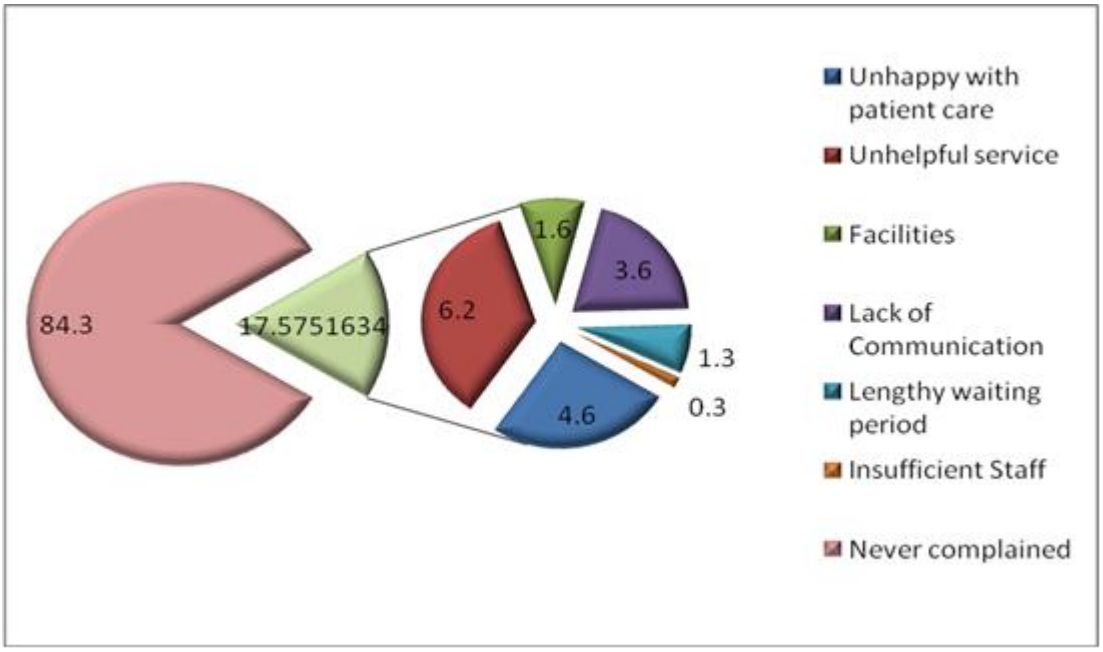

Figure 5.8 Patient Identified Complaints

Figure 5.8 indicates the actual complaints levelled from patients. The majority of the patients (84.3%) have indicated that they have never complained previously. The remaining 18.2% complained about matters pertaining to poor patient care (4.6%),

unhelpful service (6.2%), facilities (1.6%), lack of communication (3.6%) and lengthy waiting periods (1.3%).

It was highlighted in the structured interview with Senior Management, staff skills in terms of clinical people have a can do what we want attitude.

5.2.5.5 MANAGEMENT VIEW ON CHALLENGES FACED WITH PATIENT VISITORS

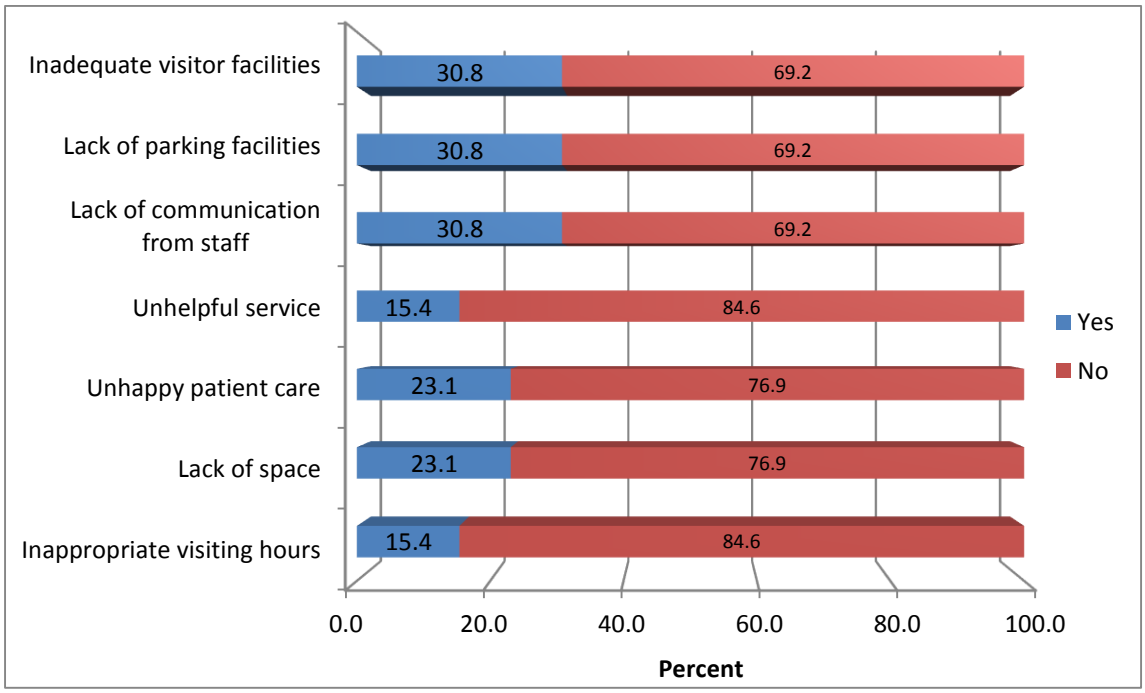

Figure 5.9 Management view on challenges faced with patient visitors

Figure 5.9 represents the challenges encountered by the patient visitors reported by the departmental managers. Department heads were required to select from the options reflected in **Figure 5.9** various categories of problems that patient visitors may have experienced. The key challenges faced by patient visitors were inadequate patient facilities (30.8%), parking facilities (30.8%) and lack of communication (30.8%). Patient visiting hours are limited and therefore require sufficient infrastructure.

Other dominant areas of complaints centred on unhappy patient care (23.1%) and lack of space. A fair measure of consistency may be observed between **Figures 5.8** (questions patients' response) and **Figure 5.9** (management response) in respect of poor communication, unhelpful service and poor patient care.

5.2.5.6 THE NATURE OF PATIENT COMPLAINTS REPORTED FROM HOD's

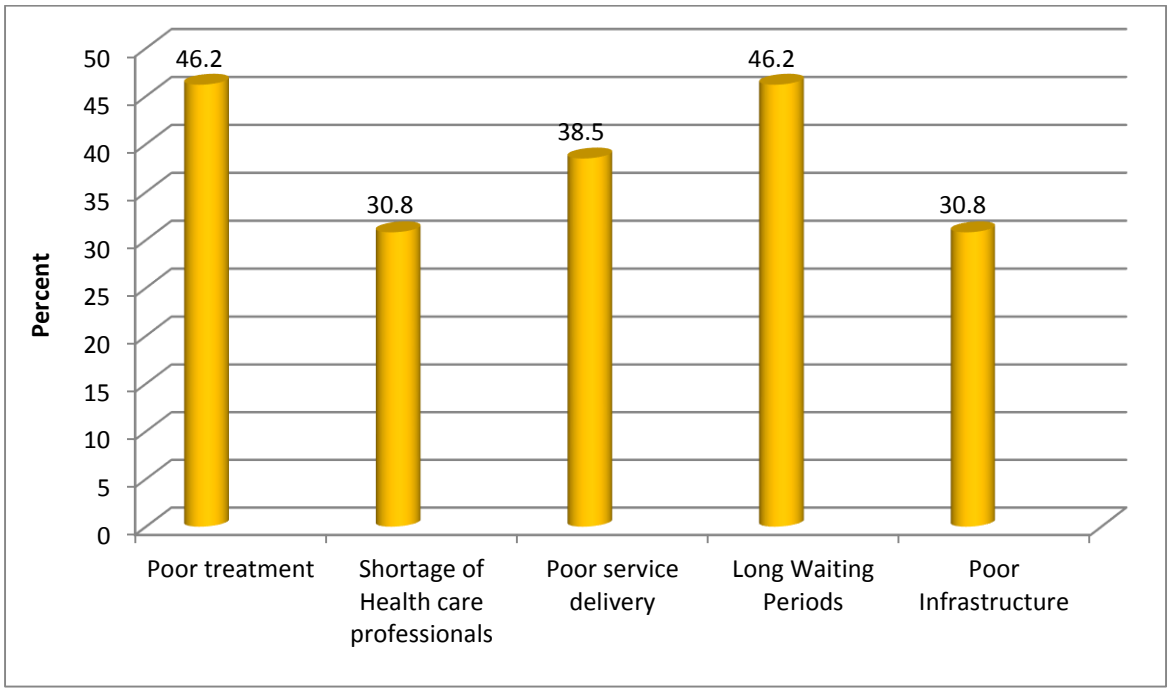

Figure 5.10 The Nature of patient complaints reported from HOD's

Figure 5.10 indicates the nature of the patient complaints. Multiple responses were possible for this section. The figure represents only the positive results.

Nearly half of the patients (46.2%) indicated that the two most serious problems experienced as patients were the poor treatment that they received and the long waiting periods associated with being attended to. The next leading complaint from patients relates to poor service delivery (38.5%), followed by poor infrastructure and the shortage of health care professionals at 30.8%.

Arising from the senior interview with Senior Management, it has been highlighted that the needs for infrastructure to be put in place in respect of mental health care has not been made provision for.

The purpose of this analysis was to prove that management has an influence on staff performance which supports Keiser's (1979: 32) view that in a factory, the management deals only with its employees as people; in retail establishments, the customers are the primary people concerned; whereas the hospitality industry is different, where both employees and customers are dealt with at the same time.

These findings further confirm the views expressed by Jones & Lockwood (1989:109) that any service encounter is of prime importance in determining the customer's overall satisfaction with experience and further explains this importance in his model of management influence on service as set out in **Figure 2.3** of this study. **Chapter 4** outlined that there are approximately 500 patients that are cared for daily within the outpatients department of the Provincial Hospital (Chetty, 2010). A total of 306 patients were sampled.

5.2.5.7 SERVICE EXPERIENCED BY THE PATIENTS

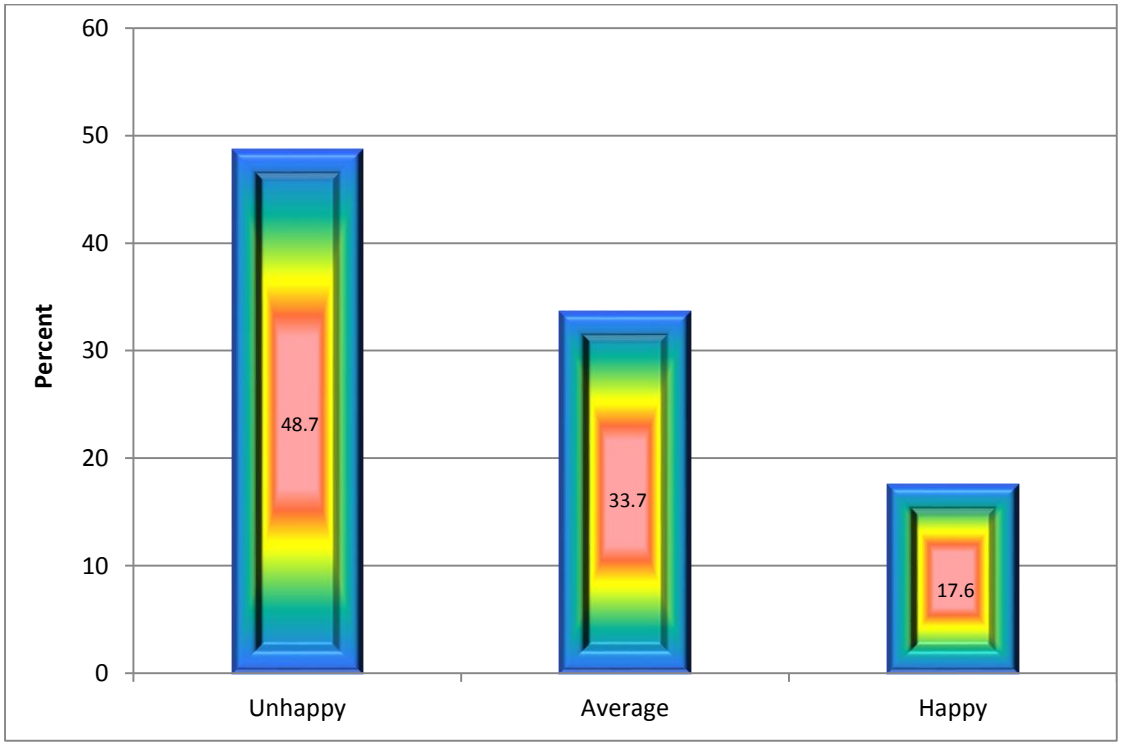

Figure 5.11 The service experienced by the patients

Figure 5.11 indicates perceptions of patients who visited the provincial hospital regarding the service experience. There are nearly 3 times as many respondents who were unhappy (48.7%) with their hospital experience than there were those who were happy (17.6%).

Kotas *et al* (1996: 122) confirms that service industries essentially offer a psychological experience that is ultimately enjoyed or endured by the guest or visitor. This analysis further confirms that management has an influence on staff performance and Jones and Lockwood (1989: 111) offer support for this view with their model of management influence (**Figure 2.3**) which draws an association to the interpersonal interaction between the employee and the customer which creates the service encounter.

5.2.5.8 PATIENT MODE OF TRANSPORT AND THEIR DEPARTURE TIME FROM PLACE OF RESIDENCE

			What was your mode of transport?						Total
			Bus	Taxi	Train	On foot	Own vehicle	A friend	
What time did you leave the hospital?	2pm-3pm	Count	1	29	1	0	7	7	45
		% of Total	0.3%	9.5%	0.3%	0.0%	2.3%	2.3%	14.7%
	3pm-4pm	Count	1	30	0	0	7	3	41
		% of Total	0.3%	9.8%	0.0%	0.0%	2.3%	1.0%	13.4%
	4pm-5pm	Count	0	57	0	2	12	4	75
		% of Total	0.0%	18.6%	0.0%	0.7%	3.9%	1.3%	24.5%
	Later than 5pm	Count	4	104	2	5	22	8	145
		% of Total	1.3%	34.0%	0.7%	1.6%	7.2%	2.6%	47.4%
Total		Count	6	220	3	7	48	22	306
		% of Total	2.0%	71.9%	1.0%	2.3%	15.7%	7.2%	100.0%

Table 5.6 Cross tabulation of the patient's mode of transport and the time they left the hospital

Table 5.6 emphasizes the time that patients leave the hospital and their mode of transport. Findings reveal that almost 75% of the respondents use public transport for the trip to the hospital and 36% of respondents leave the hospital after 5pm. Almost 19% of respondents who leave the hospital between 4pm and 5pm use public transport to get to the hospital. Only 9.8% of the respondents who leave between 3pm and 4pm use public transport and 10.1% of the respondents who leave between 2pm and 3pm use public transport.

The purpose of this analysis was to demonstrate that the majority of the community that visit the Provincial Hospital rely on public transport. Along with the effort of public transport, patients travel late once their day is complete at the provincial hospital.

Chapter 3 elaborates on the struggles of the Chatsworth area and the impact on the community. Melamed (2005) states that Apartheid might have ended in 1994 but the struggle has not, it has merely changed its shape as new forms of community solidarity and resistance have emerged to fight for rights for housing, water and electricity, and workers' rights. Material inequality has deepened. In addition to the poverty and effects of post-Apartheid, recession has also affected the community their culture as well as the hospital itself.

5.2.5.9 PATIENT ARRIVAL AND DEPARTURE TIMES

			At what time did you get to the hospital?					Total
			4am	5am	6am	6am-7am	Later than 7am	
What time did you leave the hospital?	2pm-3pm	Count	1	4	7	17	16	45
		% of Total	0.3%	1.3%	2.3%	5.6%	5.2%	14.7%
	3pm-4pm	Count	0	3	4	10	24	41
		% of Total	0.0%	1.0%	1.3%	3.3%	7.8%	13.4%
	4pm-5pm	Count	2	4	16	20	33	75
		% of Total	0.7%	1.3%	5.2%	6.5%	10.8%	24.5%
	Later than 5pm	Count	1	10	21	41	72	145
		% of Total	0.3%	3.3%	6.9%	13.4%	23.5%	47.4%
Total		Count	4	21	48	88	145	306
		% of Total	1.3%	6.9%	15.7%	28.8%	47.4%	100.0%

Table 5.7 Cross tabulation with the time the patient left the hospital and the time that they arrived at the hospital

Table 5.7 illustrates the time between the patient arriving at the Provincial Hospital and the time the patient left. Almost 24% of the respondents arrived between the early parts of 4am and 6am. Findings reveal that nearly 11% of these respondents left the hospital after 5pm.

These findings indicate that a patient may spend up to 12 hours at the provincial hospital. Chetty (2010) states that a patient's start to their day to ascertain treatment when they are sick, having a regular check up via appointment or just to collect medication, begins with long hours of waiting.

Chapter 3 identifies that the patient enters the provincial hospital at the security entrance and is directed by the security guards in to the waiting area. Thereafter, security directs a certain amount of patients at a time into the waiting room whereby patients are now queuing in the waiting room for approximately an hour to proceed to their next step (Chetty, 2010).

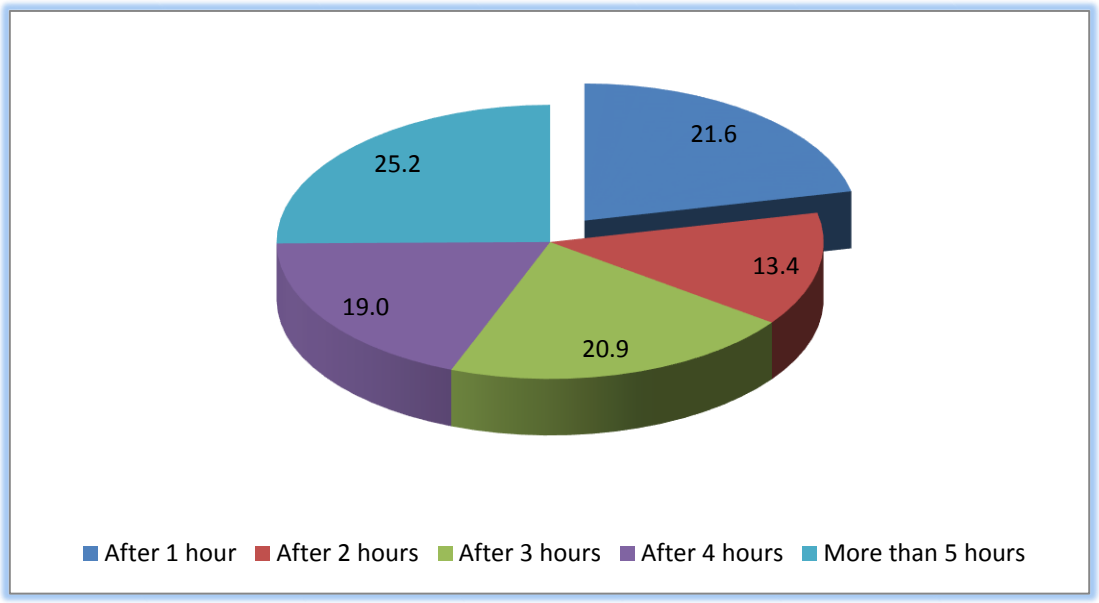

Figure 5.12 Time Lapse for treatment after Patient Arrival

Waiting for treatment is an extremely stressful experience and **Figure 5.12** reveals the waiting times where 25% of the patients wait for more than 5 hours to be treated. Another 19% receives treatment after 4 hours of waiting, 20.9% after 3 hours of waiting. The remaining patients (13.4%) receive treatment after 2 hours of waiting and 21.6 % of the patients after 1 hour of waiting.

5.2.5.10 PATIENTS' VIEW OF STAFF ATTITUDE

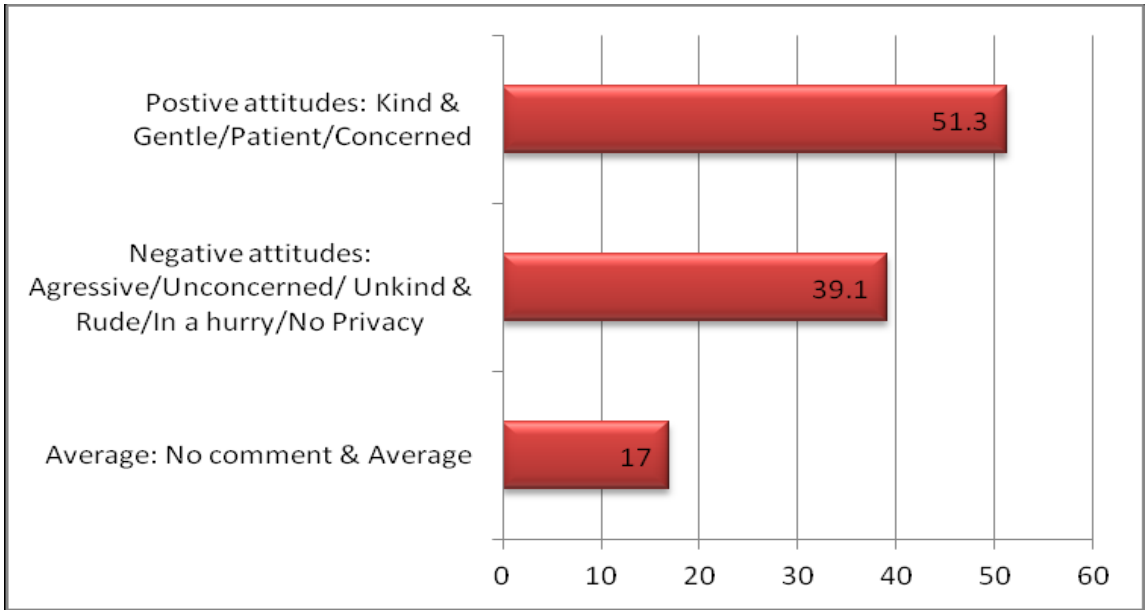

Figure 5.13 Patients' views of staff attitude

Figure 5.13 describes the attitude of staff experienced by the patient when they visit the hospital. Multiple responses were possible for the options in the **Figure** above. These multiple responses were grouped into 3 categories which reflected positive attitude of staff, negative attitudes of staff and a category which depicted neutral comments.

In respect of the positive attitudes 51.3% of the respondents agreed that staff were kind and gentle (15.4%), patient (11.4%) and concerned (24.5%). In respect to the negative attitudes, 39.1% of the respondents believed that staff were aggressive and unconcerned (9.5%), unkind and rude (19.2%) and no privacy (0.3%). The remaining respondents (17%) chose to be neutral.

5.2.5.11 REPORTED COMPLAINTS FROM PATIENTS AND HOD's

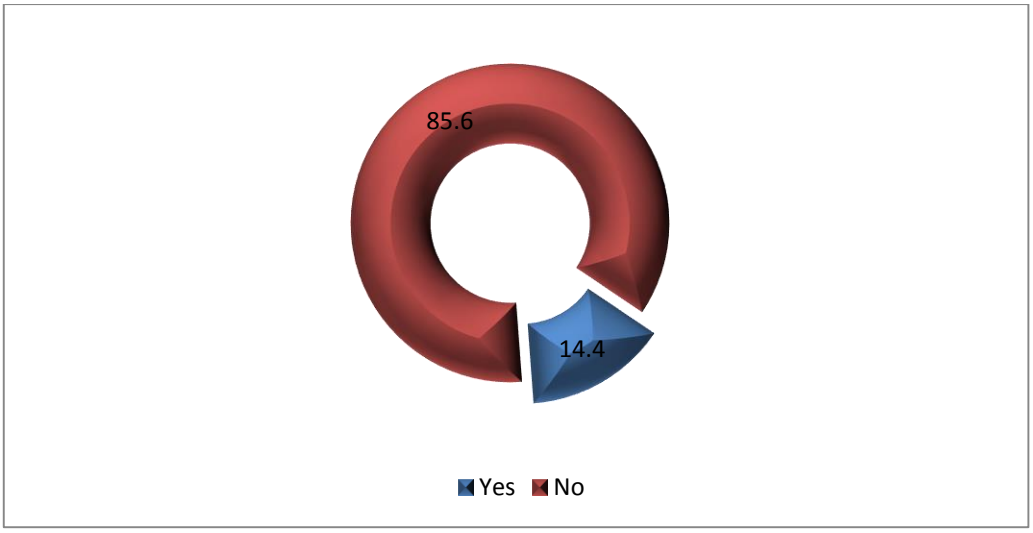

Figure 5.14 Patients reporting on Complaints Experienced

Figure 5.14 indicates the extent to which patients have complained in respect of services delivered by the Provincial Hospital. This reveals that 85.6% of the patients have complained about services received.

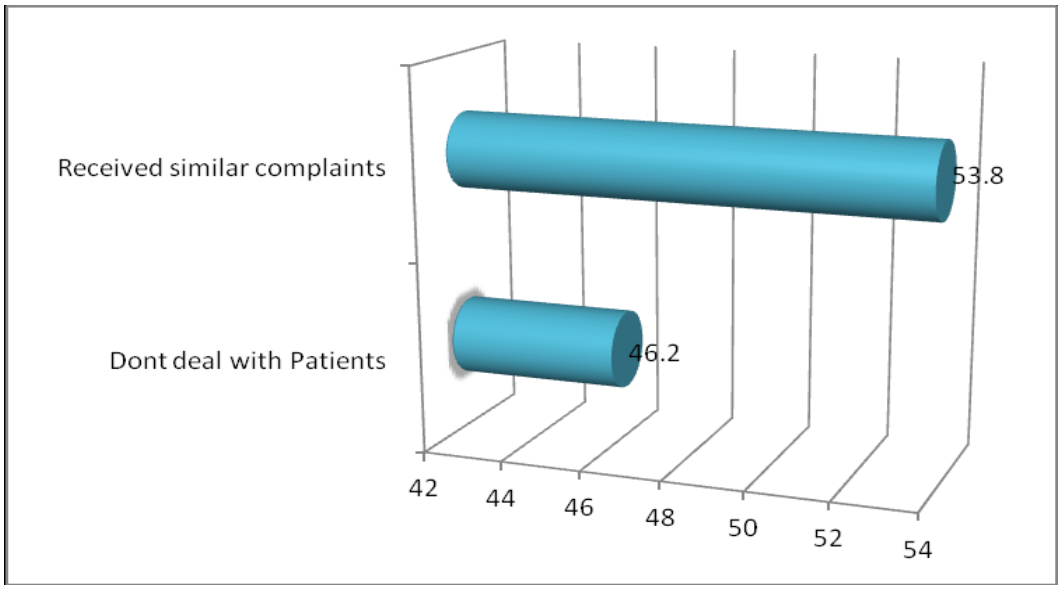

Figure 5.15 Complaints received by Management from Patients

Figure 5.15 indicates that a little more than half of the respondents (53.8%) indicated that they received complaints of a similar nature often (without specifying the nature of the complaints).

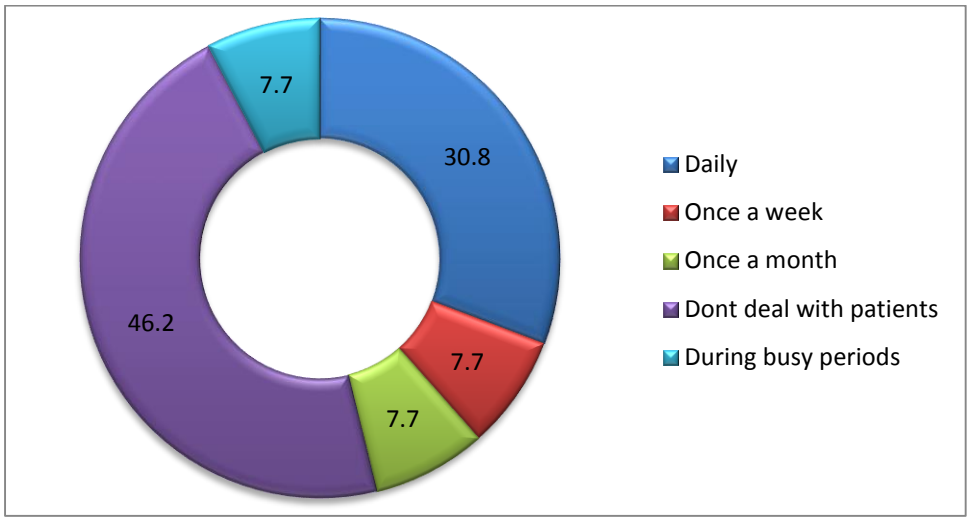

Figure 5.16 Repeat complaints reported by HOD's

Figure 5.16 indicates the managers' response to patient complaints within the respective departments. This makes particular reference to the repeat complaints that have emerged from patients. A significant proportion of the respondents (38.8%) stated that the patients complained on a daily basis. This indicates a clear lack of attention to the problems areas. A collective of 23.10% of respondents indicated repeat complaints from patients that may be spread over busy periods, daily and monthly.

5.2.5.12 CHALLENGES WHEN DEALING WITH PATIENTS

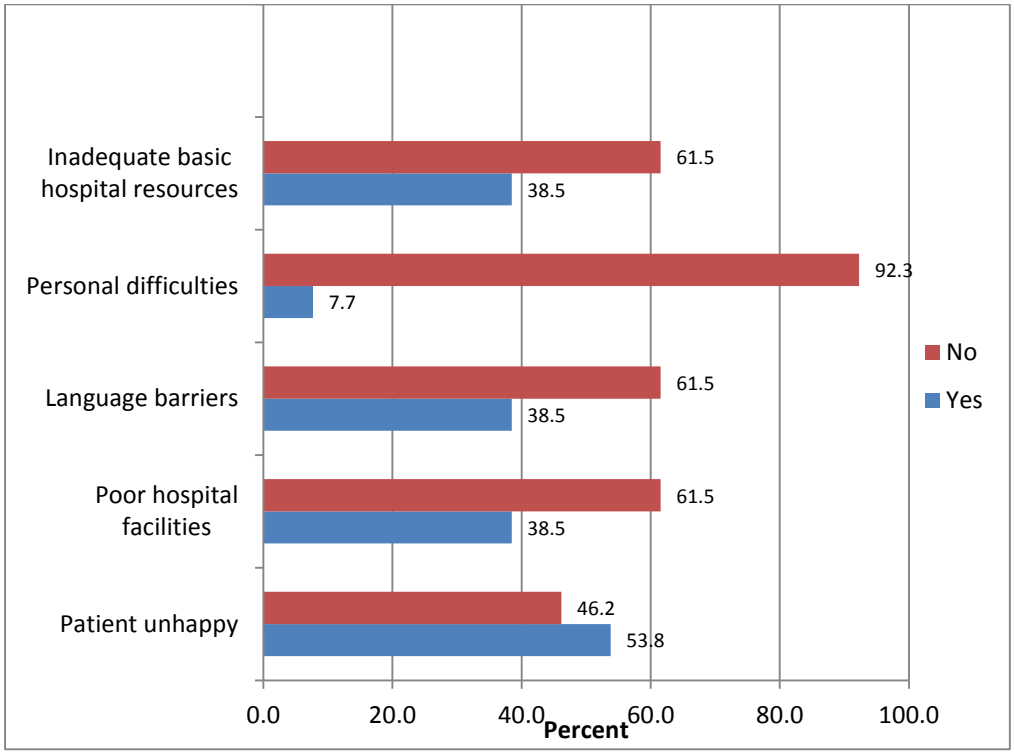

Figure 5.17 Challenges when dealing with patients

Figure 5.17 outlines the challenges that department heads experience in their encounter with patients. Patients that are unhappy with some aspect of the hospital service amount to 53.8%. This in itself creates a challenge for the hospital as the patient initiates their experience from an unhappy state of mind. A significant proportion of patients experience inadequate basic hospital resources (38.5%), language barriers (38.5%) and poor hospital facilities (38.5%).

Arising from the structured interview with Senior Management, it has been highlighted that there are departments which are so busy and the infrastructure is totally inadequate. In some departments doctors are relatively junior and staff turnover is high as they don't want to remain in a specific department for too long as the workload becomes difficult.

5.2.5.13 COMPLIMENTS

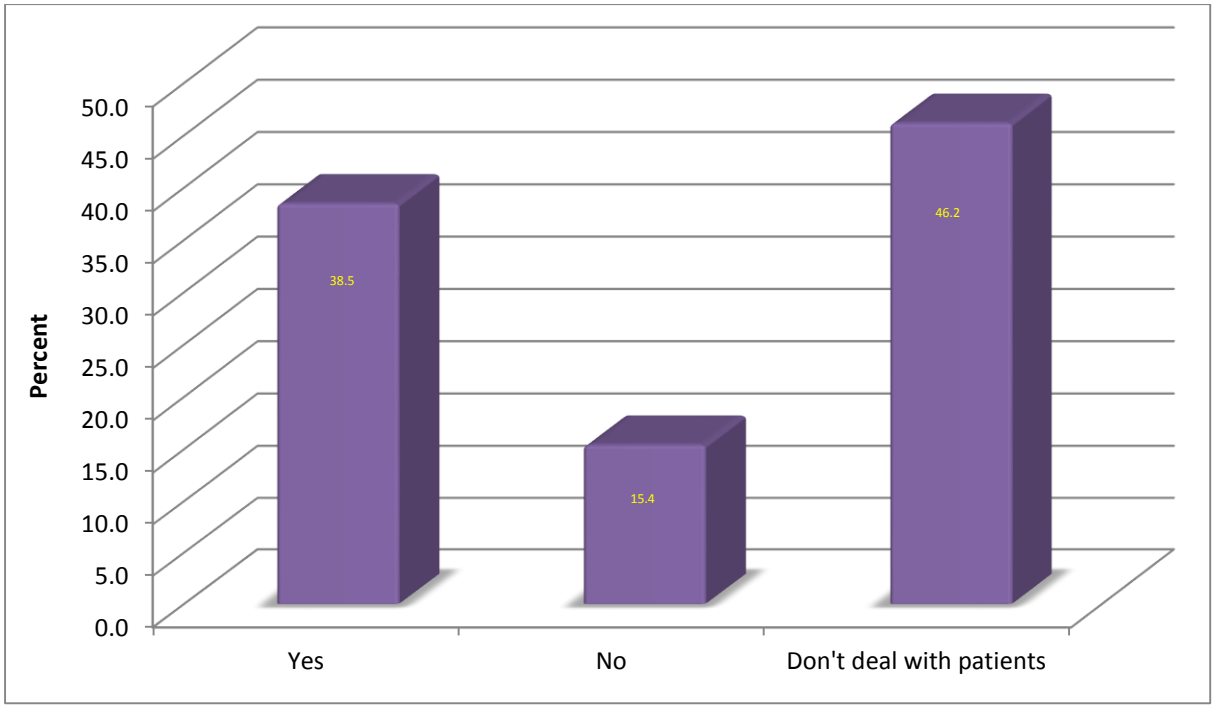

Figure 5.18 Compliments received from patients

A little less than 40% of the respondents indicated that they received compliments. Whilst 46.2% of the respondents may not have dealt with patients directly, a significant proportion of their efforts may have impacted positive comments given by patients.

It was highlighted in the structured interview with Senior Management that the Provincial Hospital is achieving its goals and clients are happy.

5.2.5.14 DISCUSSION ON FINDINGS THEME 1: SERVICE DELIVERY

Service delivery as previously discussed, emerged as a conduit between the organization (Hotel / Hospital) and the customer (Guest / Patient). The results presented under this theme reflect vividly the status of service delivery within the Provincial Hospital. Reference has been

made in **Figure 3.5** of **Chapter 3** to the applied model of Management Influence of Patient Service of the Provincial Hospital.

The intention behind the application of this model was to demonstrate the extent to which effective and efficient service delivery has had an impact on the patient encounter. The findings confirm that there is a clear relationship between management influence and staff performance. Staff performance directly affects the patient encounter when they visit the Provincial Hospital. Levitt (1972) confirms in the literature review that there is no such thing as service industries, there are only industries whose service components are greater or less than those of other industries and everybody is in service.

Jones & Lockwood (1989: 111) validates that a manager needs to take a proactive approach to this encounter or experience and explains in **Figure 2.3** that the influence that the manager has on service interaction provides the framework for analyzing and discussing the effective management of service. The model also further depicts that management control includes the selection and training process of the employee which enhances the interpersonal action to the customer in terms of the quality of service.

This implies that ineffective and inefficient services would result in a poor patient encounter which would indicate the absence of the hospitality concept as espoused in the literature review. The following areas have clearly elucidated the extent to which service delivery is effective within the Provincial Hospital: complaints on departments' performance (**Figure 5.5**); origin of patient complaints (**Figure 5.6**); patient comments on hospital departments that they were unhappy with (**Figure 5.7** and **Table 5.4**); patient identified complaints (**Figure 5.8, Figure 5.11, Figure 5.13, Figure 5.14, Figure 5.15**); challenges faced by departmental managers with patient visitors (**Figure 5.9** and **Figure 5.10**); time lapse for treatment upon arrival of patient (**Figure 5.12**, **Table 5.6**, **Table 5.5**) and complaints and compliments received by management from patients (**Figure 5.16**, **Figure 5.17** and **Figure 5.18**).

The extent of service delivery may also be corroborated with Senior Management in respect to the challenges experienced in implementing the Batho Pele Principles. High workload of staff featured as a prominent element from the structured interview with Senior Management.

Upon triangulation of the 3 surveys the following elements featured as dominant areas of concern in respect to service delivery: lengthy waiting periods for patient care; poor attitude of staff; high workload of staff; poor patient care and inadequate facilities.

It must be noted that good practise has also been identified by patients and management, and this extends to the attitudes of staff and the compliments received from patients.

5.2.6 STUDY THEME 2: MANAGEMENT PRACTICES & PROCESSES

Management practises and processes is a theme that has emerged from the conceptual framework of the study and its importance has been highlighted by various experts within the hospitality and health care sectors.

Findings in respect of this theme are presented as follows.

5.2.6.1 LEVEL OF SATISFACTION OF DEPARTMENT HEADS' WITH THEIR STAFF

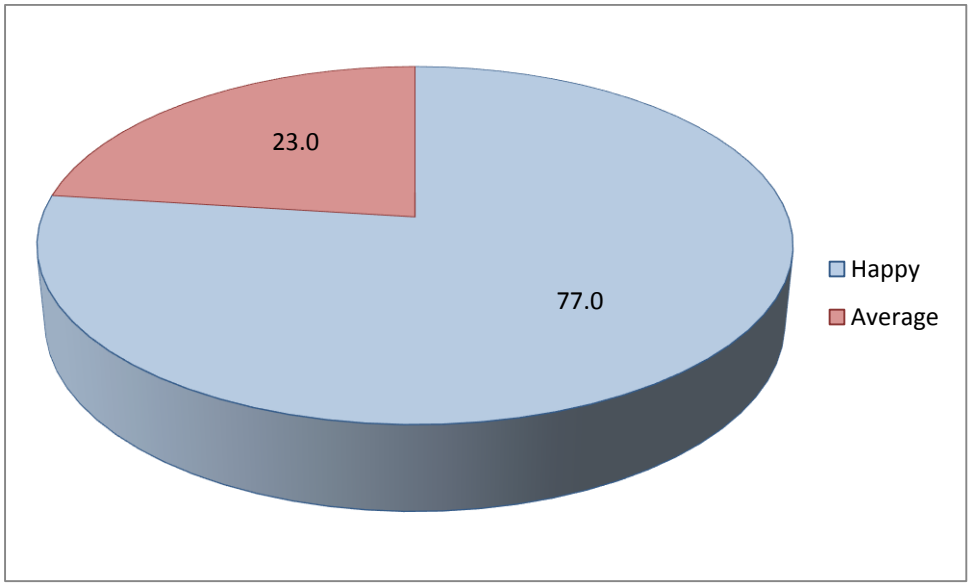

Figure 5.19 The level of satisfaction of department heads' with their staff

Figure 5.19 indicates the level of satisfaction that managers have with their staff. The pie chart above indicates that 77% of the department heads are happy with their staff.

These findings reveal that majority of management are happy with their staff and is consistent with Olsen *et al* (1996: 41) **who** suggest that to become and remain a leader in a highly

competitive marketplace, a hospitality organization needs competent, well trained, highly motivated people who are dedicated to working together and supporting each other.

5.2.6.2 DEPARTMENTAL COMPLAINTS

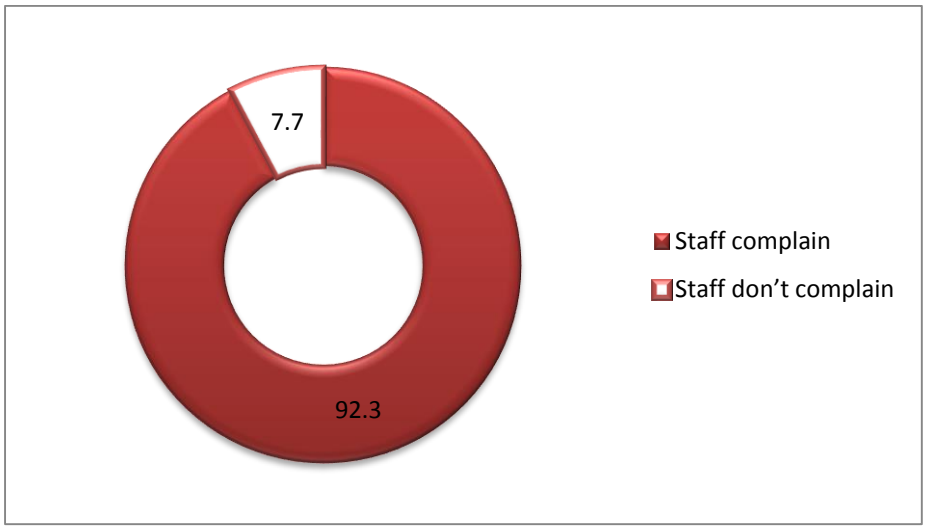

Figure 5.20 Staff complaints from within the department

Figure 5.20 highlights staff complaints from within their department. The majority of staff (92.3%) had complaints within the department and 7.7% had no complaints.

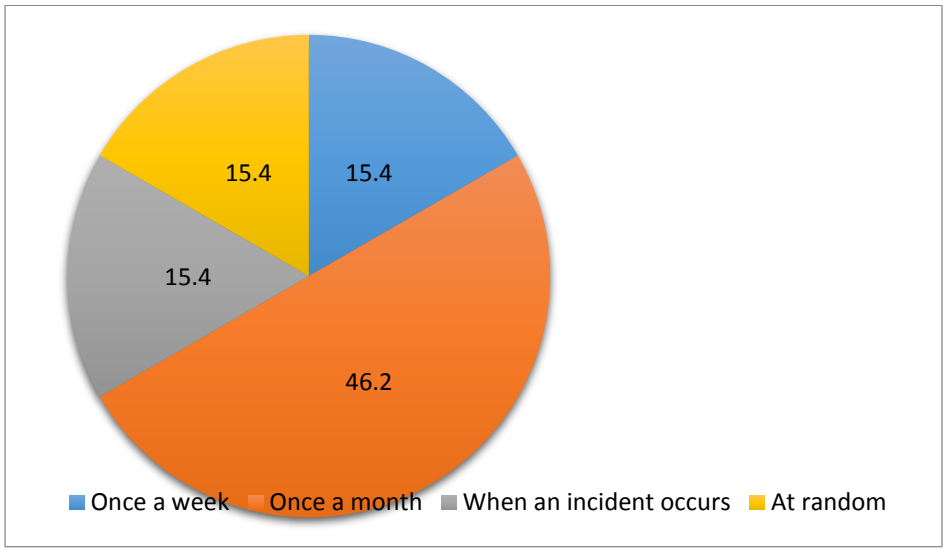

Figure 5.21 Frequency of staff complaints

Figure 5.21 reflects the frequency of staff complaints. The majority of staff (46.2%) complains once monthly. The frequency of other complaints comprise, once a week (15.4%), when an incident occurs and at random (15.4%).

Arising from the structured interview with Senior Management, it was highlighted that Senior Management met with their department heads once or week or when they require.

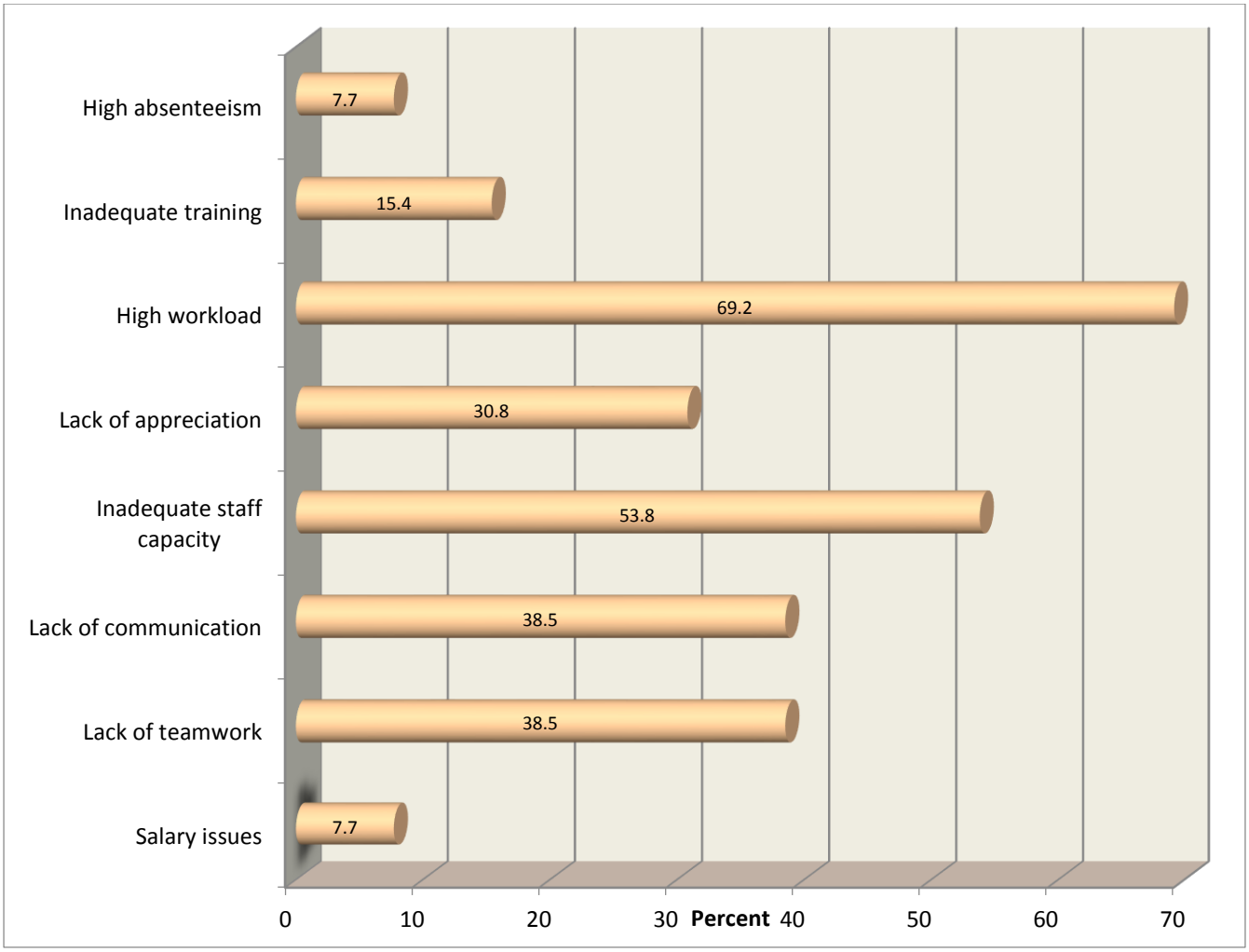

Figure 5.22 Nature of staff complaints

Figure 5.22 highlights the nature of staff complaints within their department.

Multiple responses were possible for this section. The figure represents only the positive results. The dominant complaints within the department comprised high workload (69.2%), inadequate staff capacity (53.8%), lack of communication (38.5%) and lack of team work (38.5%). Other internal complaints were inadequate training (15.4%), high absenteeism (7.7%) and salary issues (7.7%).

Chapter 3 discloses that staff lay blame on poor hospital management by CEO's and hospital management claims that the root of the problem lies in the fact that provincial hospitals are understaffed and overcrowded (Mfusi, 2009 and Premdev, 2009).

The purpose of this analysis was to ascertain the reasons why staff complain. Hence, further proving that management have influence on staff performance. This is supported Uysal &

Williams (2003: 8) who concur that in any service industry the service role is basic and essential, and dependant on staff performance, and they further explain (2003: 9) that every employee who is in contact with external customers affects customer satisfaction.

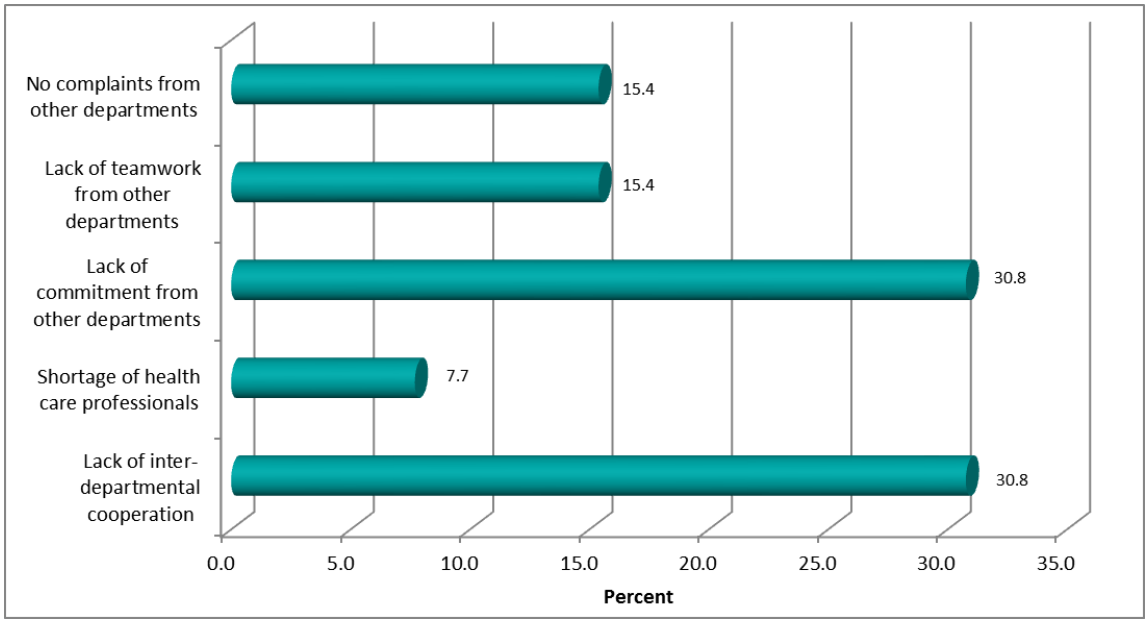

Figure 5.23 Nature of Inter-departmental Complaints

Figure 5.23 represents the nature of complaints between departments. The dominant areas that pertain to complaints between departments comprise the following: lack of commitment from other departments (30.8%) and lack of inter–departmental cooperation (30.8%). Other complaints between departments relate to lack of teamwork (15.4%) and shortage of health care professionals (7.7%).

It is interesting to note that **Figure 5.21** indicates similarities in respect of the lack of teamwork and shortage of staff. The structured interview with Senior Management informs that department heads meet once a week or when they require as highlighted in **Figure 5.21**.

5.2.6.3 STAFF APPRAISALS

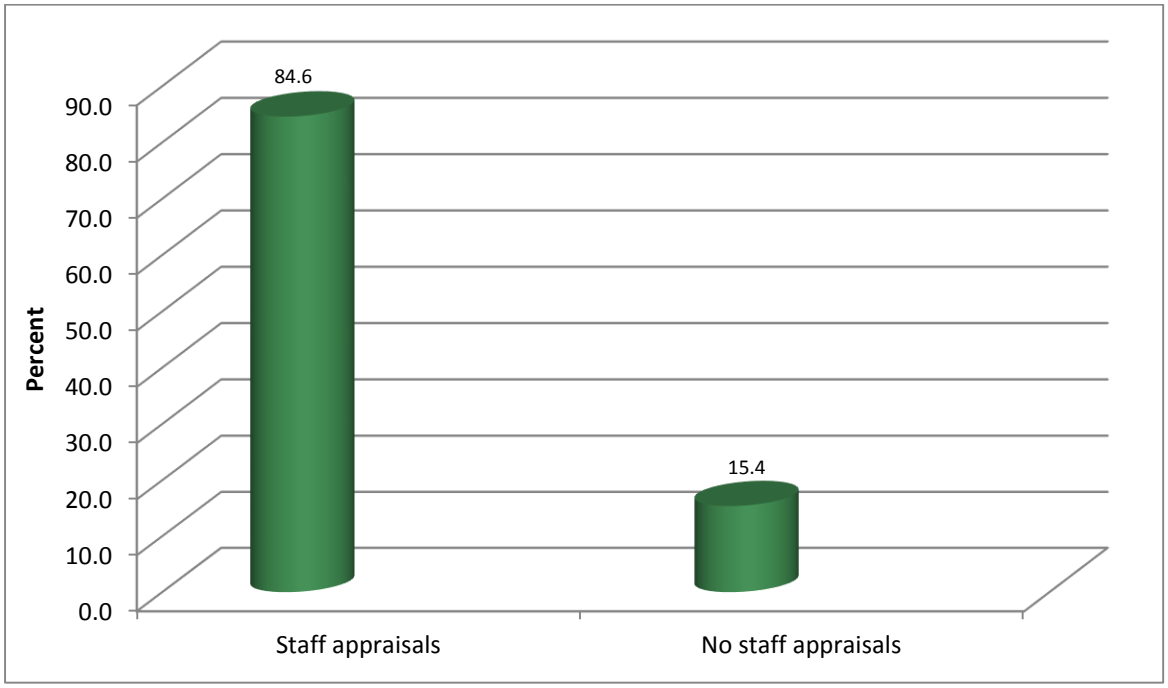

Figure 5.24 Staff appraisals

Figure 5.24 highlights the extent to which staff appraisals are practised within the provincial hospital. The majority of the respondents (84.6%) indicate that staff appraisals are implemented within the Provincial Hospital.

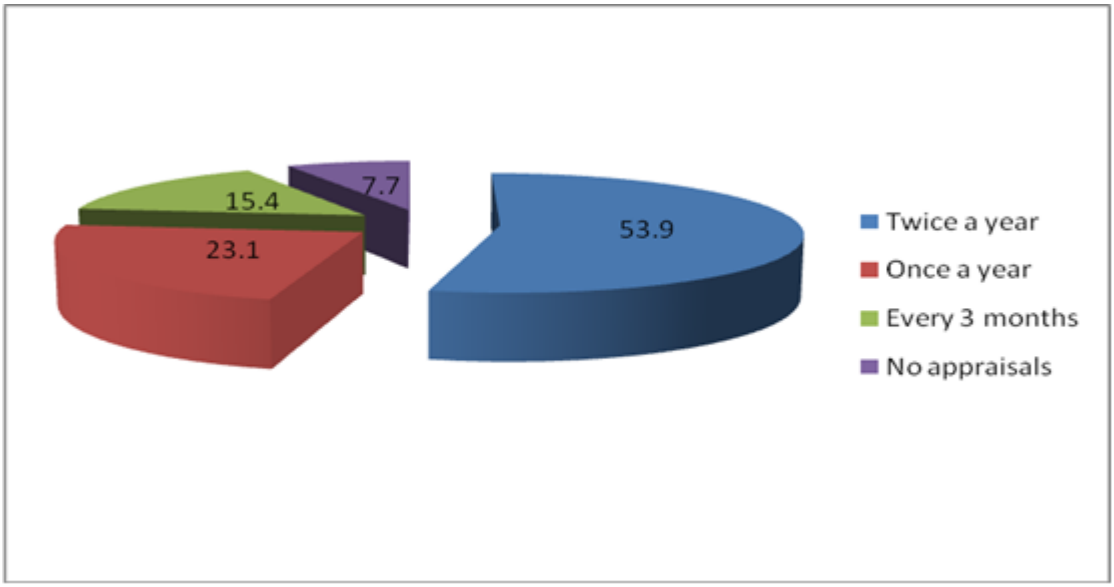

Figure 5.25 Frequency of staff appraisals

Figure 5.25 highlights the frequency of staff appraisals. The majority of the respondents (53.9%) indicate that staff appraisals occur twice a year. Staff appraisals occur on an annual basis to 23.1% of the respondents. Other responses were no appraisals (7.7%) and every three months (15.4%)

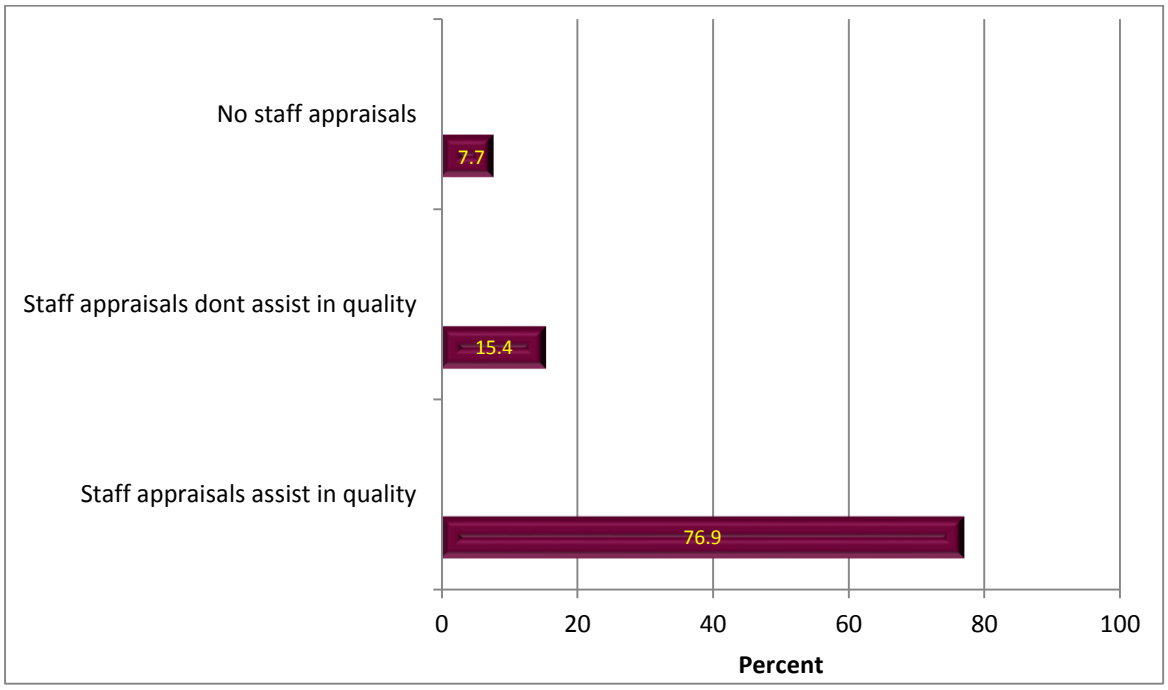

Figure 5.26 Managers representation of the assistance of staff appraisals in quality

Figure 5.25 indicates the extent to which staff apparaisals are useful to managers. The majority of managers (76.9%) agree that staff apparaisals assist in improving in the quality of work whilst 15.4% of managers disagreed that staff apraisals assist in improving quality of work. The remainder of the managers (7.7%) indicated that they do not have staff appraisals.

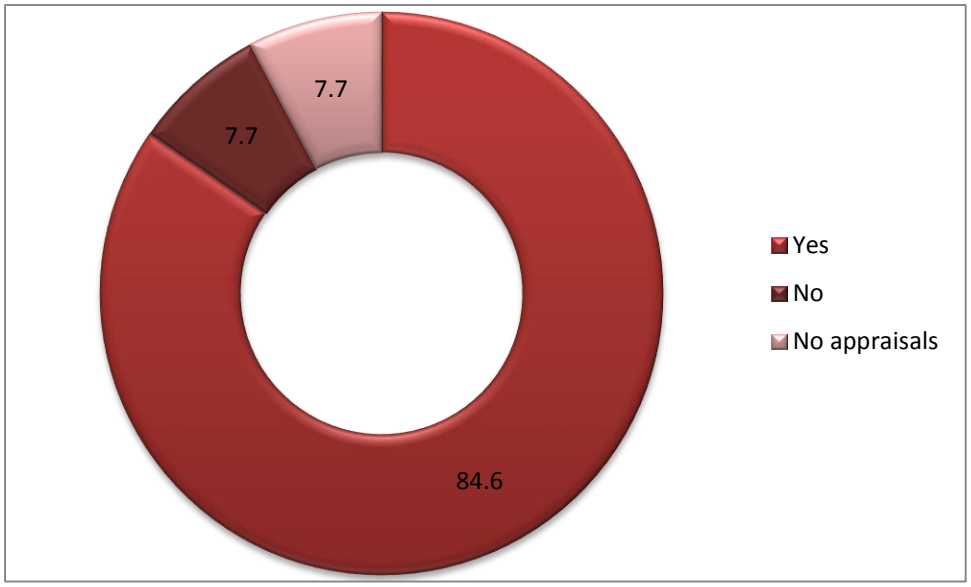

Figure 5.27 Staff appraisals helpful to staff

Figure 5.27 reflects the extent to which staff appraisals are useful to staff themselves. The majority of managers (84.6%) agree that staff appraisals are useful to staff and 7.7% of managers disagreed that staff appraisals are useful. The remainder 7.7% of managers indicated that they do not have staff appraisals.

Chapter 2 highlights that the efficiency of staff and their commitment to the aims and philosophy of the establishment are fostered by good human relationships and by the nature of managerial behaviour.

5.2.6.4 QUALITIES THAT THE DEPARTMENT HEADS SHOULD HAVE

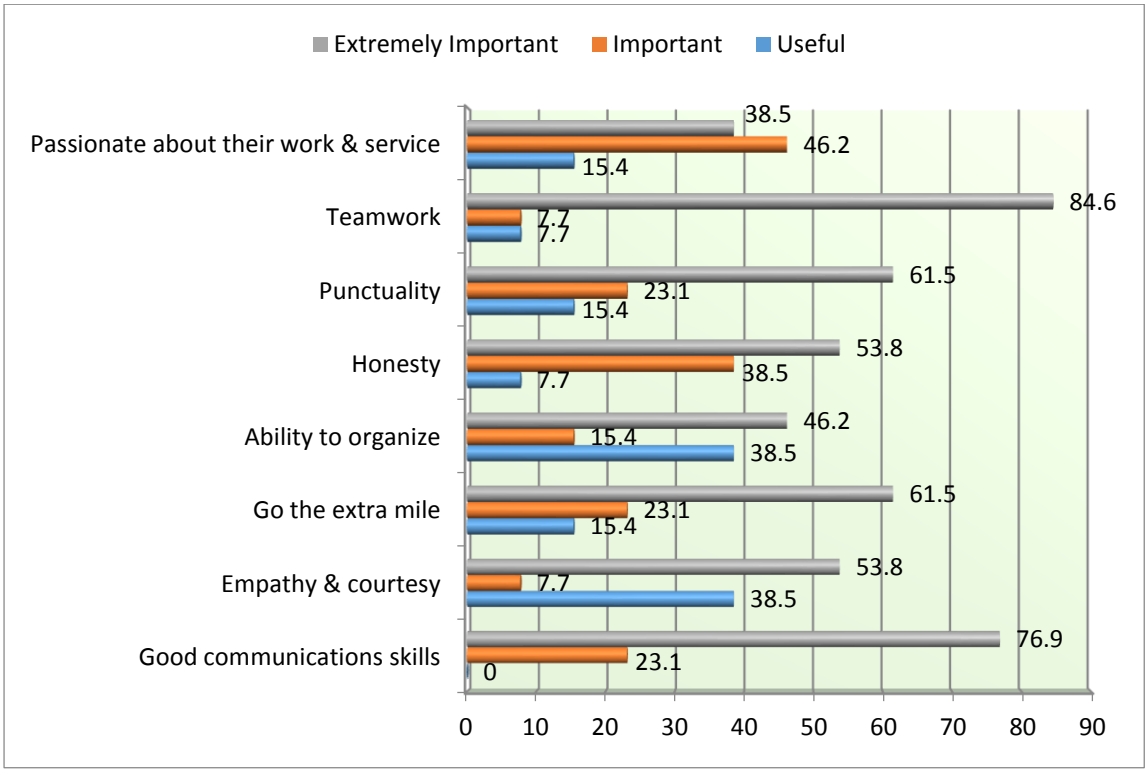

Figure 5.28 Qualities that the department heads should have

Figure 5.28 highlights the two top rated qualities which stand out as being the most extremely important, which are teamwork (84.6%) and having good communication skills (76.9%). A second grouping of extremely important rated qualities include: punctuality and going the extra mile (61.5%). Other areas that were selected as extremely important pertained to honesty, empathy and courtesy (53.8%), the ability to organize (46.2%), and being passionate about their work and service (38.5%).

The two salient categories that were indicates as important were passionate about their work and service (46.2%) and honesty (38.5%).

Findings reveal that the department heads have a modest amount of management knowledge. **Chapter 2** details Stoner *et al's* (1995: 18) approach to the relative skills needed for effective performance at different levels of management which also includes the influence of the external environment which are not present in **Figure 5.28**.

Arising from the structured interview with Senior Management, it was highlighted that managers are not managers to where they manage their designated department and their

subordinates. Department heads only look at their position and overlook the department as a whole.

5.2.6.5 MAJOR CHALLENGES THAT MANAGERS ENCOUNTER DURING SUPERVISION OF STAFF

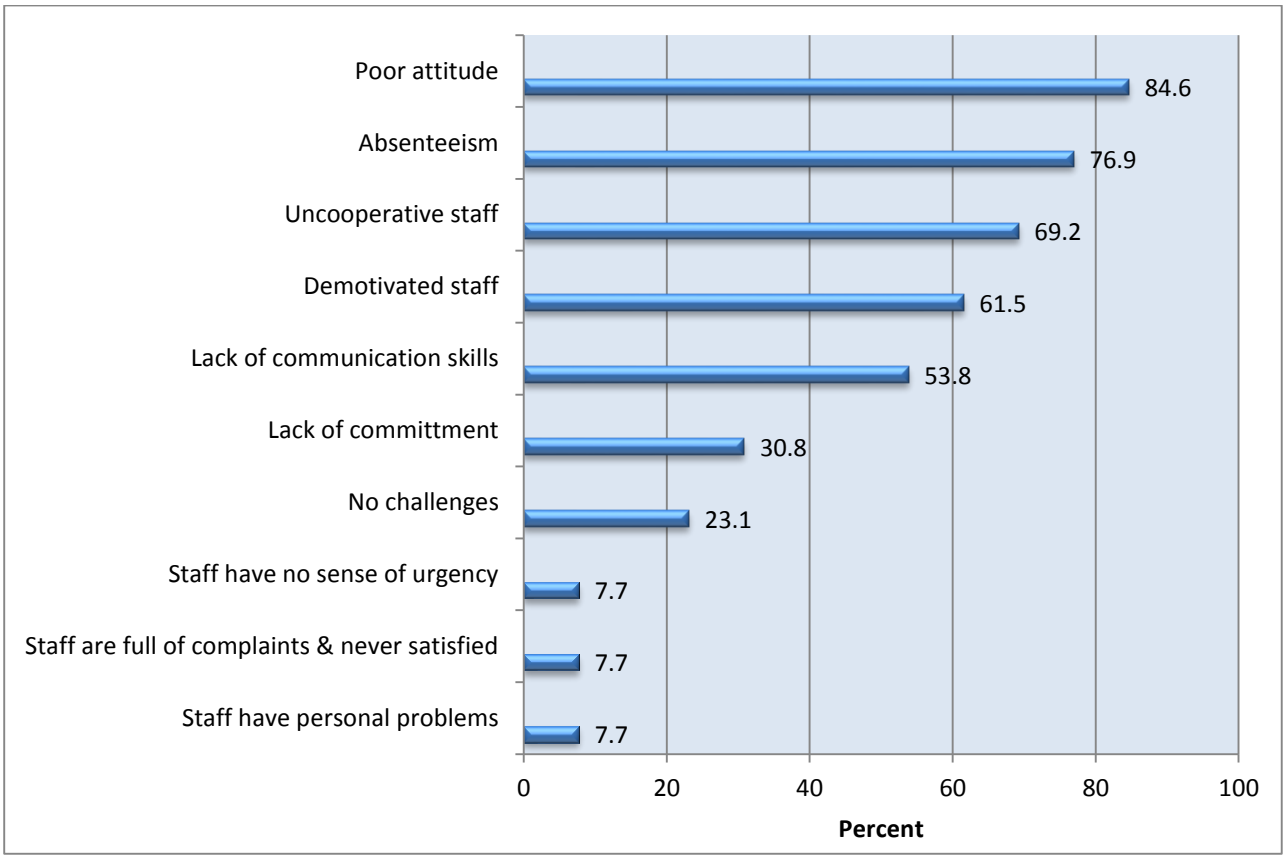

Figure 5.29 Major challenges that managers encounter during supervision of staff

Figure 5.29 indicates some of the major challenges that managers in the Provincial Hospital encounter whilst supervising staff. Multiple responses were possible for each option. The two major challenges of supervision refer to poor attitude (84.6%) and absenteeism (76.9%). The second grouping of challenges which stand out are uncooperative staff (69.2%), staff are demotivated (61.5%), lack of communication skills (53.8%) and lack of commitment (30.8%).

The findings reveal that attitude of staff within the provincial hospital is a major concern. Ford (2000: 142) points out that service effectiveness depends on everyone throughout the organization taking service responsibility seriously and organizations need not hire anyone who is unwilling or unable to provide and deliver outstanding service.

The findings further reveal that the major challenge of poor attitude leads to the added challenges that emanate from this attitude. **Chapter 2** explains Jones & Lockwood model of management control and influence of the employee which enhances the interpersonal action to the customer in terms of the quality of service in **Figure 2.3**. These findings also confirm that the model of management influence in **Chapter 2** draws an essential point of the qualities that a good manager should have which are directly related to employee performance.

5.2.6.6 JOB SATISFACTION OF DEPARTMENT HEADS

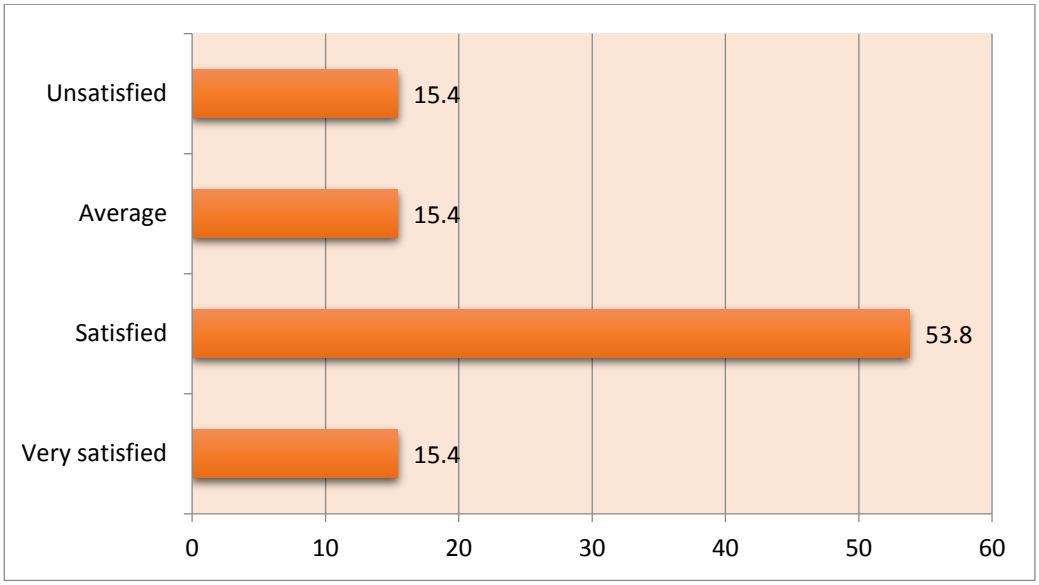

Figure 5.30 Job satisfaction of departments heads

Figure 5.30 identifies the extent to which department heads are satisfied with their job. The majority of managers (53.8%) indicate that they are satisfied with their jobs. Managers that were unsatisfied with their job comprised 15.4%, a further 15.4% were very satisfied with their job.

The literature review highlighted that giving to your employees would encourage and motivate them to give back to the organization, and every employee has a direct or indirect responsibility of service quality and customer satisfaction which Jones & Lockwood illustrate in **Figure 2.3** (the model of management influence) and Berger & Brownwell (2009: 11) support where employees who feel valued and appreciated will in turn provide service excellence to the guest.

5.2.6.7 PLANS DEVELOPED BY DEPARTMENT HEADS

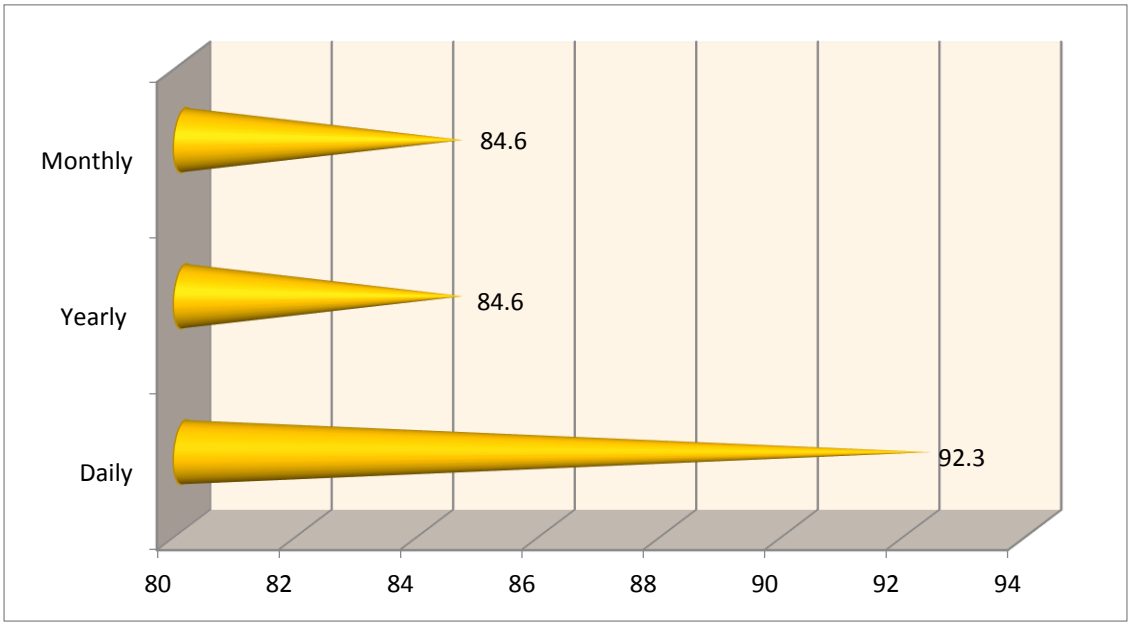

Figure 5.31 Frequency of plans developed by department heads

One of the duties of a manager is to develop plans for their departments. These plans are developed over different time periods. Hence, **Figure 5.31** indicates the frequency with which plans are developed by the department heads. Multiple responses were possible for each option.

The majority of respondents (92.3%) indicated that planning was done daily. The graph also indicates that a large measure of the managers (84.6%) engage in planning on a monthly and yearly basis. The literature review highlights Berger & Brownwell (2009: 3) who explain that quality service does not just happen by chance, it needs to be planned and managed, from the design of the service delivery system to maintaining efficient operations that ensure quality is both high and consistent.

5.2.6.8 WORKLOAD SATISFACTION

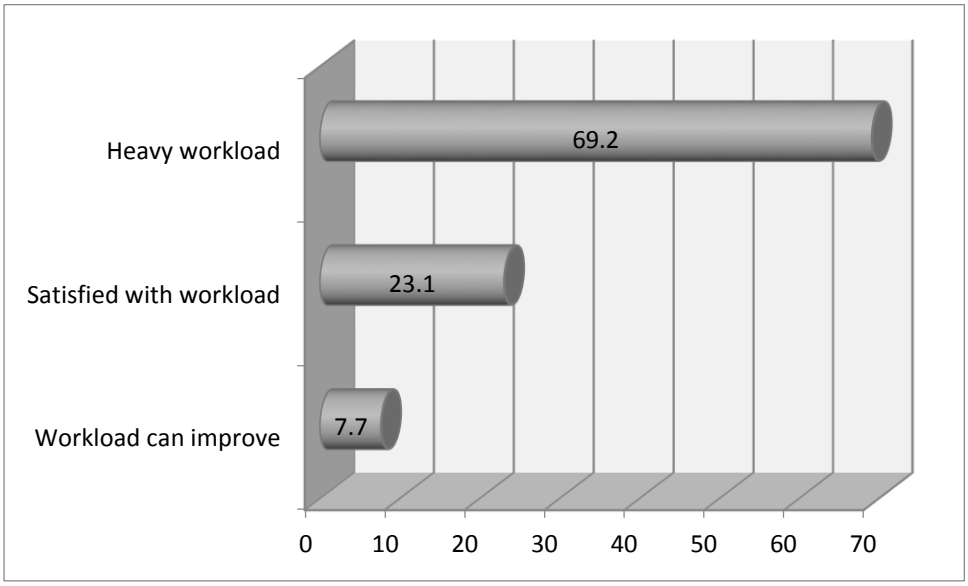

Figure 5.32 Workload satisfaction

Figure 5.32 represents the extent to which managers are satisfied with their workload. The majority of managers (69.2%) reflect that they have heavy workloads. The remaining respondents (7.7%) indicated that workload could improve and they were satisfied with their workload (23.1%).

It is interesting to note that staff have made managers aware of the high workload represented in **Figure 5.32**.

The survey that was conducted with Senior Management highlighted that the most challenging Batho Pele Principle was courtesy. It was interesting to note that Senior Management noted that this principle was most challenging as staff felt overworked with their workload and they subsequently take it out on the patients.

			Workload satisfaction			Total
			Heavy workload	Workload can improve	Satisfied with workload	
Job satisfaction	Unsatisfied	Count	2	0	0	2
		% within Job satisfaction	100.0%	0.0%	0.0%	100.0%
		% within Workload satisfaction	22.2%	0.0%	0.0%	15.4%
		% of Total	15.4%	0.0%	0.0%	15.4%
	Average	Count	2	0	0	2
		% within Job satisfaction	100.0%	0.0%	0.0%	100.0%
		% within Workload satisfaction	22.2%	0.0%	0.0%	15.4%
		% of Total	15.4%	0.0%	0.0%	15.4%
	Satisfied	Count	4	1	2	7
		% within Job satisfaction	57.1%	14.3%	28.6%	100.0%
		% within Workload satisfaction	44.4%	100.0%	66.7%	53.8%
		% of Total	30.8%	7.7%	15.4%	53.8%
	Very satisfied	Count	1	0	1	2
		% within Job satisfaction	50.0%	0.0%	50.0%	100.0%
		% within Workload satisfaction	11.1%	0.0%	33.3%	15.4%
		% of Total	7.7%	0.0%	7.7%	15.4%
Total		Count	9	1	3	13
		% within Job satisfaction	69.2%	7.7%	23.1%	100.0%
		% within Workload satisfaction	100.0%	100.0%	100.0%	100.0%
		% of Total	69.2%	7.7%	23.1%	100.0%

Table 5.8 Cross Tabulation of Managers Job Satisfaction and Workload

Table 5.8 highlights the relationship between the levels of job satisfaction and the levels of workload of the departmental managers of the Provincial Hospital. This relationship will be discussed further in under **Figure 5.33**.

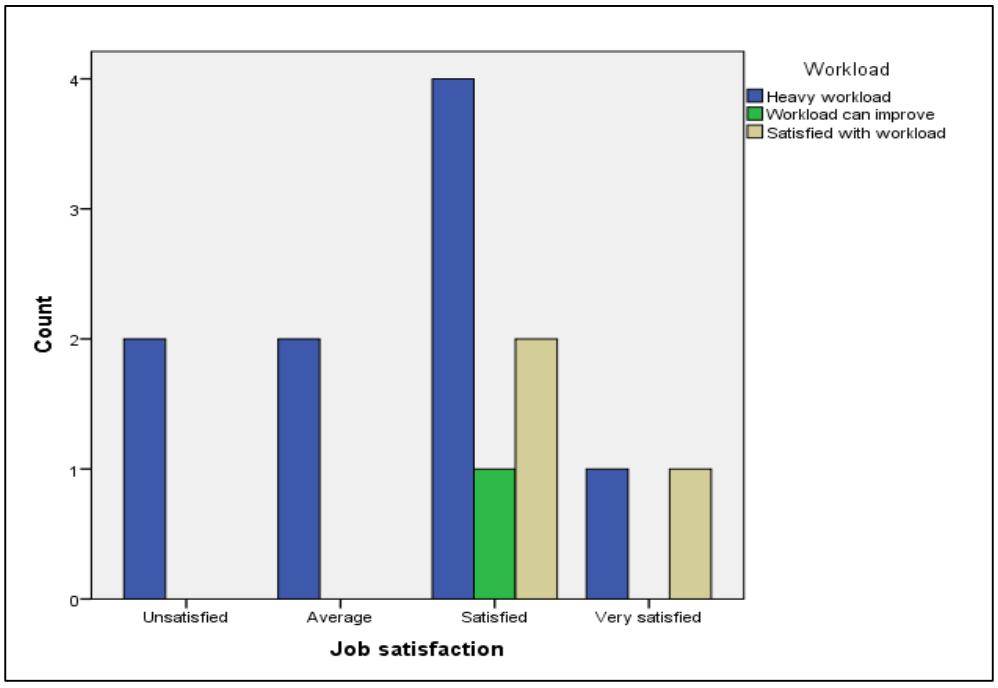

Figure 5.33 Cross tabulation: Job Satisfaction with Workload

The graph in **Figure 5.33** together with **Table 5.7** represents the extent of the relationship between Managers job satisfaction and their workload.

These variables have been tested individually in **Figures 5.30** and **5.32.** The cross tabulation reveals that 15.4% of managers that were unsatisfied with their jobs had declared that they had heavy workloads. Those that were satisfied with their jobs declared their workloads as follows: heavy workloads (30.8%), workload requires improvement (7.7%) and satisfied with their workload (15.4%). Of the managers that were very satisfied with their jobs, 7.7 % had indicated that they had heavy workloads and 7.7% were satisfied with their workload.

			Are you happy with you conditions of employment?				Total
			Unsatisfied	Average	Satisfied	Very satisfied	
Job satisfaction	Unsatisfied	Count	2	0	0	0	2
		% within Job satisfaction	100.0%	0.0%	0.0%	0.0%	100.0%
		% within Are you happy with you conditions of employment?	100.0%	0.0%	0.0%	0.0%	15.4%
		% of Total	15.4%	0.0%	0.0%	0.0%	15.4%
	Average	Count	0	2	0	0	2
		% within Job satisfaction	0.0%	100.0%	0.0%	0.0%	100.0%
		% within Are you happy with you conditions of employment?	0.0%	40.0%	0.0%	0.0%	15.4%
		% of Total	0.0%	15.4%	0.0%	0.0%	15.4%
	Satisfied	Count	0	3	4	0	7
		% within Job satisfaction	0.0%	42.9%	57.1%	0.0%	100.0%
		% within Are you happy with you conditions of employment?	0.0%	60.0%	80.0%	0.0%	53.8%
		% of Total	0.0%	23.1%	30.8%	0.0%	53.8%
	Very satisfied	Count	0	0	1	1	2
		% within Job satisfaction	0.0%	0.0%	50.0%	50.0%	100.0%
		% within Are you happy with you conditions of employment?	0.0%	0.0%	20.0%	100.0%	15.4%
		% of Total	0.0%	0.0%	7.7%	7.7%	15.4%
Total		Count	2	5	5	1	13
		% within Job satisfaction	15.4%	38.5%	38.5%	7.7%	100.0%
		% within Are you happy with you conditions of employment?	100.0%	100.0%	100.0%	100.0%	100.0%
		% of Total	15.4%	38.5%	38.5%	7.7%	100.0%

Table 5.9 Cross Tabulation of Managers Job Satisfaction and Workload

Table 5.9 highlights the relationship between the levels of job satisfaction and conditions of employment of the departmental managers of the Provincial Hospital. This relationship will be discussed further under **Figure 5.34**.

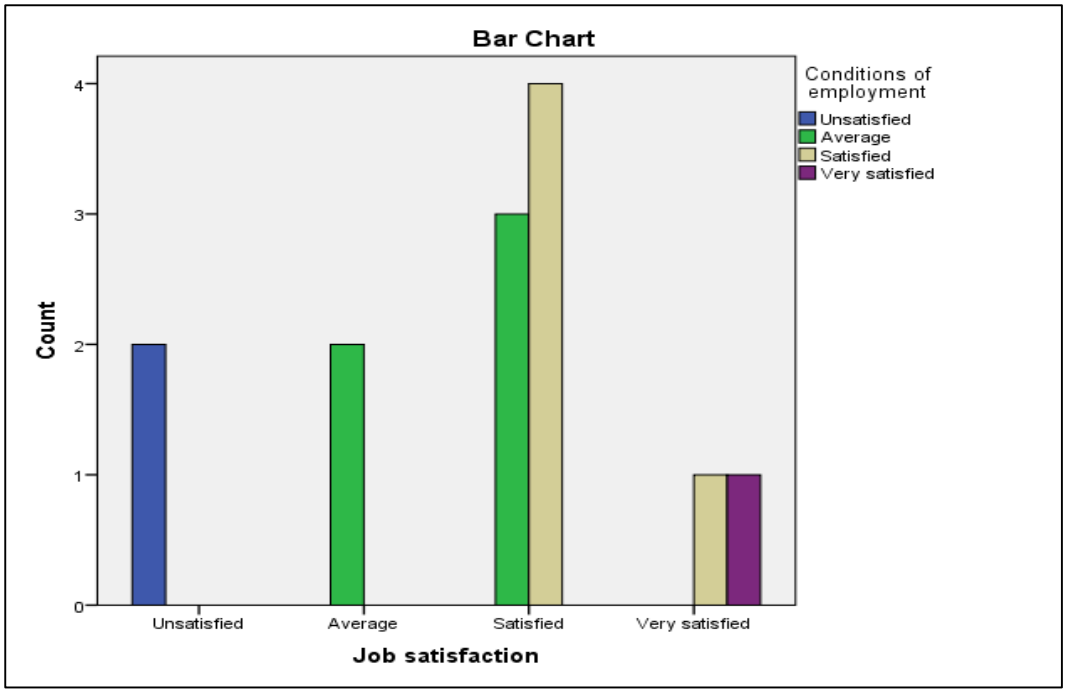

Figure 5.34 Cross tabulation: Job Satisfaction with Conditions of Service

The chart in **Figure 5.34** together with **Table 5.8** represents the extent of the relationship between Managers job satisfaction and their conditions of employment.

The variable in respect of job satisfaction was tested individually in **Figure 5.30**. The cross tabulation reveals that 15.4% of managers that were unsatisfied with their jobs, were also unsatisfied with their conditions of service. Those that were satisfied with their jobs declared their conditions of service as follows: average (23.1%) and satisfied (30.8%). From the managers that were very satisfied with their jobs, 7.7 % had indicated that they were satisfied with their conditions of employment and another 7.7% indicated that they were very satisfied.

5.2.6.9 STAFF MEETINGS

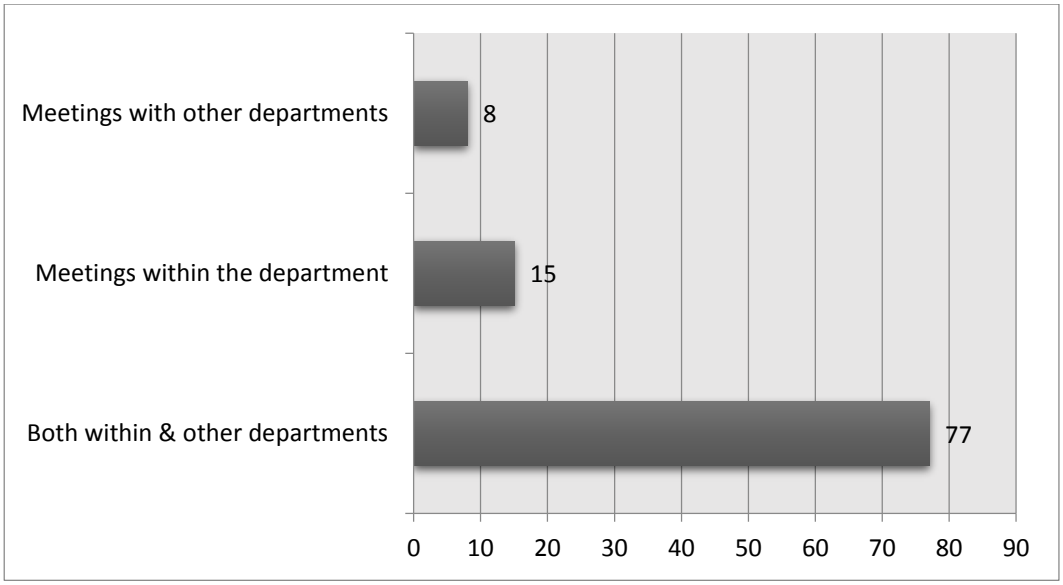

Figure 5.35 Nature of staff meetings held

Figure 5.35 indicates the extent to which departments' conducts meeting. The majority of managers (76.9%) conduct meetings within and between departments.

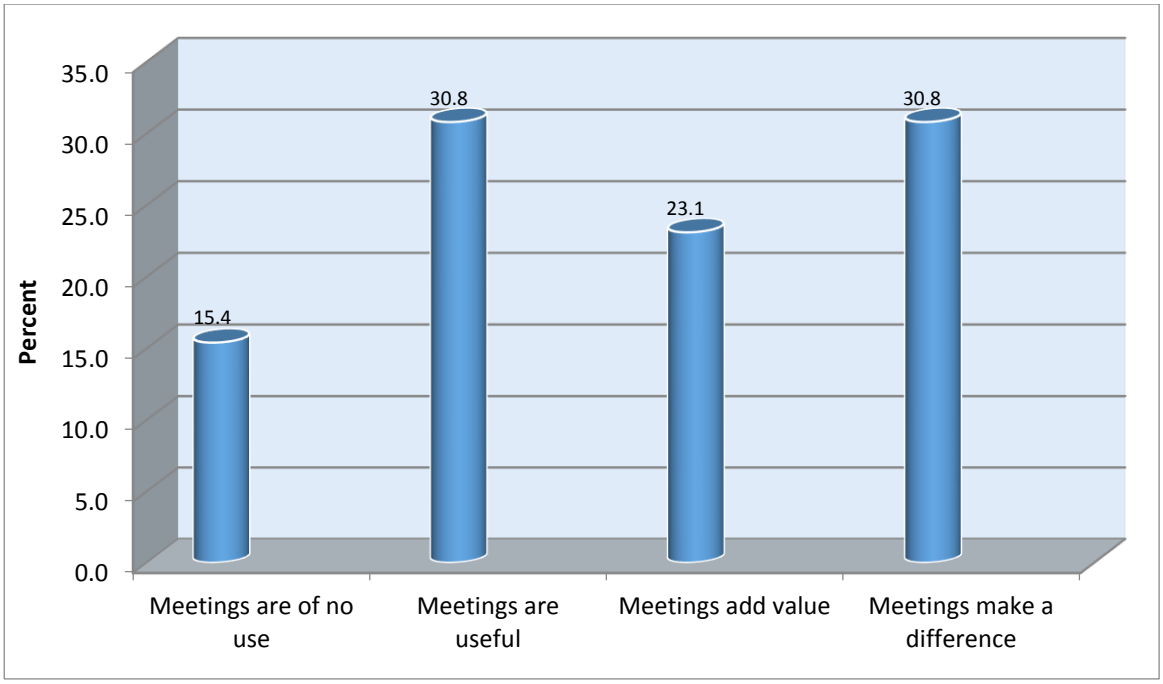

Figure 5.36 Usefulness of meetings

Figure 5.36 highlights the usefulness of meetings held by managers. The majority of respondents agree that meetings are useful (30.8%), meetings add value (23.1%) and meetings make a difference (30.8%).

The survey conducted with Senior Management highlighted that department heads don't express what their concerns are at management meetings. Meetings are too lecture based and some department heads feel that if they inform Senior Management of an issue or concern, it would come back to them.

5.2.6.10 THE EXTENT OF ASSISTANCE FROM QUALITY ASSURANCE

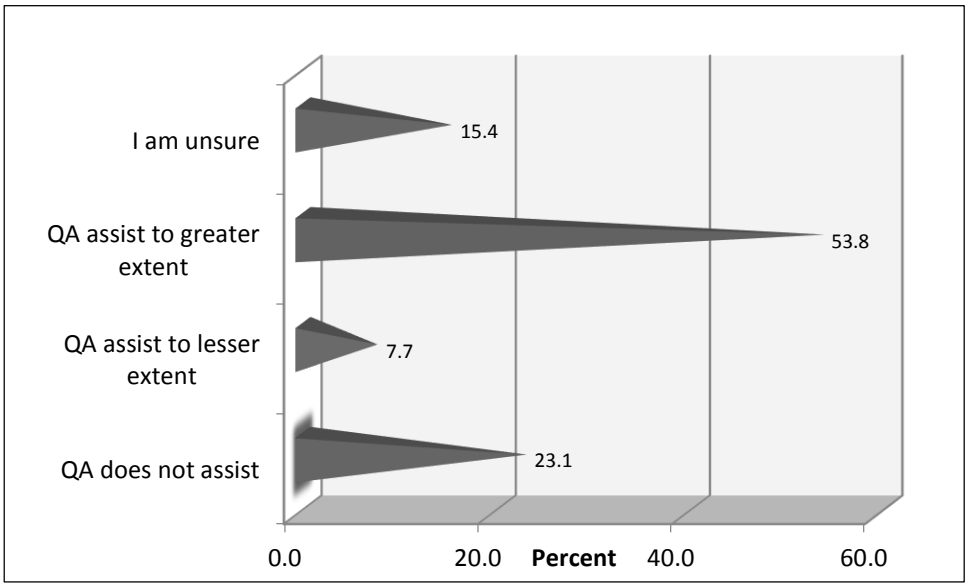

Figure 5.37 The extent of assistance from Quality Assurance

Figure 5.37 indicates the extent of usefulness of quality assurance to managers. Majority of managers (53.8%) agree that quality assurance does provide assistance to a greater extent. Managers have also indicated (23.1%) that quality assurance provides no assistance.

5.2.6.11 SIMILARITIES OF HOSPITAL OPERATIONS TO HOTEL OPERATIONS

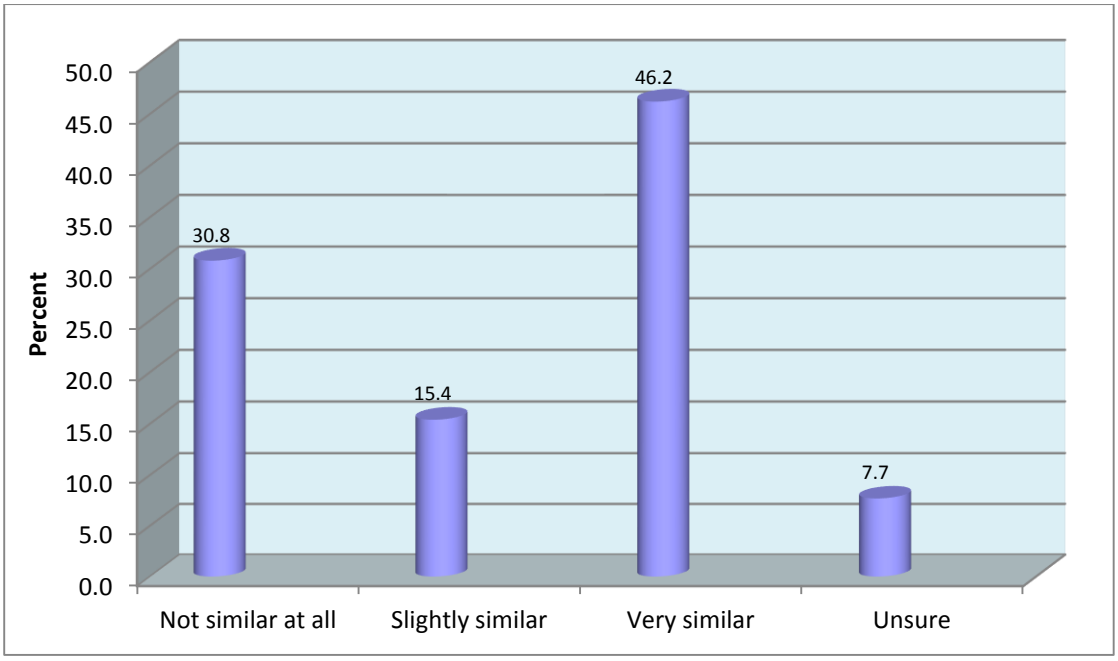

Figure 5.38 The similarities of hospital operations to a hotel operation by department heads

Figure 5.38 highlights the department heads' view of whether operations are similar to a hotel operation. The majority of the managers (46.2%) indicated that the operations are very similar while 30.8% of the respondents indicated they are not similar at all. The remaining respondents (15.4%) further indicated that they are slightly similar to a hotel while 7.7% of the respondents indicate that they are unsure.

The purpose of this analysis was to ascertain the outlook of line management within hospitals, and if the environments are similar to that of hospitality. The literature review draws an association with hospitals to hotels and the Batho Pele Principles to hospitality. Srinivasan (2008: 177) confirms that a hospital is in the service industry with a noble cause.

The KwaZulu-Natal Citizens' Charter in 2005 made a pledge for the creation of an environment that is characterized by a culture of service excellence that starts with treating citizens as customers (Ndebele, 2008). This is supported by Srinivasan (2008: 173) who agrees that customers in a hospital context would not only include those who are direct recipients of the service but also those who come into contact with the hospital as its potential customers.

The survey that was conducted with Senior Management highlighted that the concept of hospitality and the practise of hospitality in hospitals are similar to the Batho Pele Principles which includes patients receiving good food, clean linen and shorter waiting times.

5.2.6.12 QUALITIES WHICH MANAGERS FEEL THAT REPRESENTS HOSPITALITY

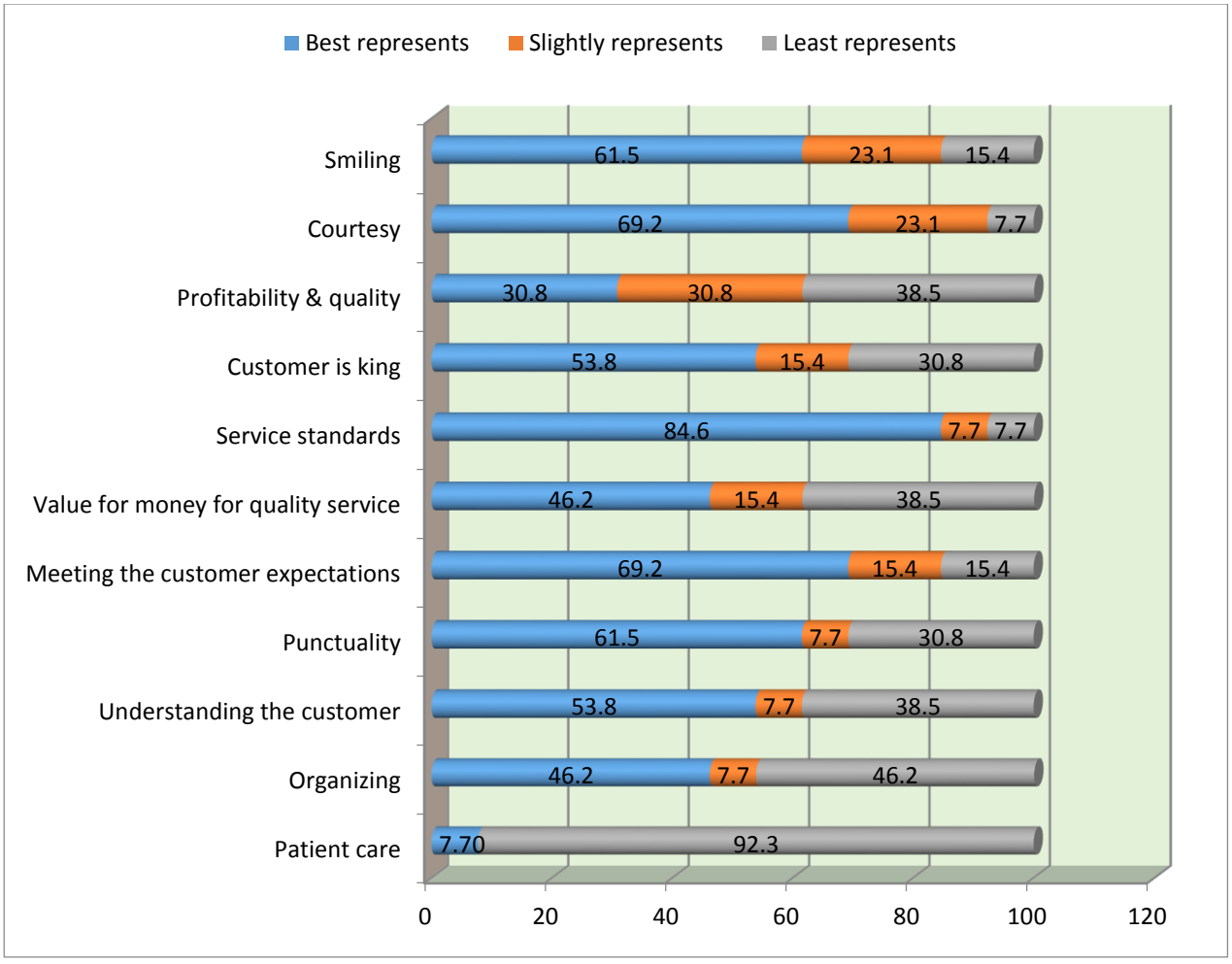

Figure 5.39 Qualities which managers feel represent hospitality

Figure 5.39 indicates by rank order the qualities that best represent hospitality. This question was premised with the phrase "*It is understood that hospitality includes hotels and restaurants, however also referring to other kinds of institutions that offer shelter, food and comfort to people away from their homes"*. The dominant areas chosen comprised of service standards (84.6%), meeting customer expectations (69.2%), courtesy (69.2%), punctuality (61.5%), a pleasant disposition (61.5%), and view that customer is king (53.8%).

5.2.6.13 TOP RATED QUALITIES THAT MANAGERS CHOOSE FOR PROVISION OF GOOD SERVICE

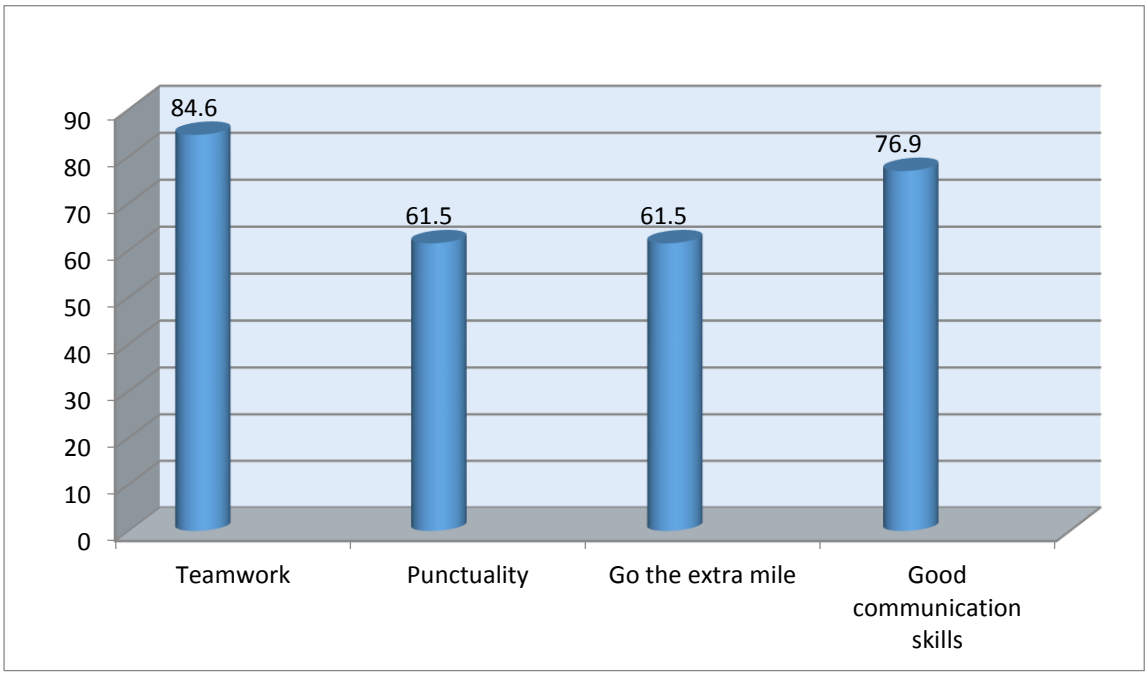

Figure 5.40 Top rated qualities that Managers choose for provision of good service

Figure 5.40 indicates in order of importance the qualities that are essential for the provision of good service. The majority of managers highlight that teamwork (84.6%) and good communication skills (76.9%) are essential qualities for the effective delivery of services. The other two areas pertain to punctuality and going the extra mile (61.5%).

These findings are consistent with **Figure 5.28** which relates to the qualities that managers should have. **Figure 5.28** also highlights the qualities of teamwork, punctuality and good communication skills indicated in **Figure 5.40**.

The survey conducted with Senior Management highlighted that it was vital to have good communication skills and that hospitals are always clinical and sterile. Big things happen at the Provincial Hospital, example death and birth.

5.2.6.14 MANAGERS CHOICE OF HOSPITALS

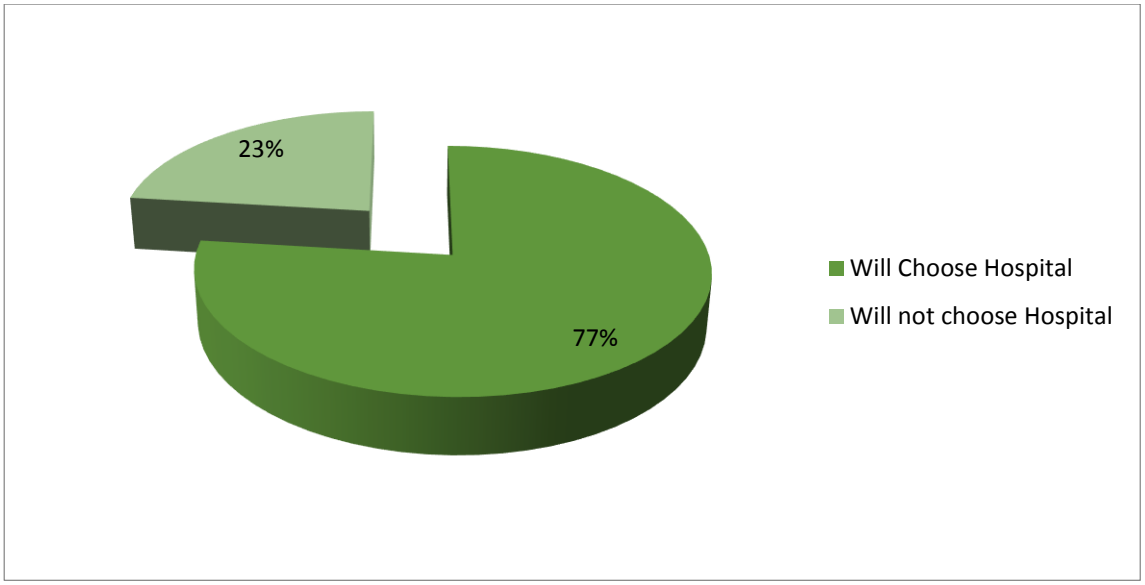

Figure 5.41 Managers choice of Hospital for themselves

Figure 5.41 identifies the extent to which managers would choose the Provincial Hospital as their hospital of choice. The majority of managers (77%) have chosen their Provincial Hospital as a hospital of choice for themselves.

5.2.6.15 DISCUSSION ON FINDINGS THEME 2: MANAGEMENT PRACTISES AND PROCESSES

Chapter 3 highlights to a large extent the management practises and processes involved within the provincial hospital. **Chapter 2** underlines the theoretical management practises and processes which provides the foundation for effective service delivery. It has been argued in the study that effective management practises and processes results in effective service delivery which in turn implies sound hospitality principles within hospitals.

To this end the applied model of management influence in **Chapter 3** was highlighted. The figures and tables represented under this theme focussed on key elements within management practises and processes. These elements encompassed the department heads, senior management and the patients of the Provincial Hospital.

The theme focussed on several areas of management practises and processes and these areas revolved around supervision of staff, staff appraisals, job satisfaction levels, workload implications, complaints to and from staff, staff meetings and communication and challenges faced by managers.

When triangulated with the senior management survey, firm support can be aligned to the findings of **Figure 5.9** (Management view on challenges faced with patient visitors with HOD's), **Figure 5.11** (Service experienced by patients), **Figure 5.20** (Staff complaints from within the department), **Figure 5.28** (Qualities that department heads should have) **Figure 5.29** (Major challenges that managers encounter whilst supervising staff), **Figure 5.32** (Workload satisfaction), and **Figure 5.39** (Qualities that managers feel that represent hospitality).

5.2.7 STUDY THEME 3: ENVIRONMENTAL IMPACTS AND INFLUENCES

Chapter 2 highlights the social, political, economic, and technological influences as follows those such as legislation and completion. This in essence refers to the environmental impacts and influences that the Provincial Hospital is exposed to. The following are findings represented from the empirical research that are pertinent to this theme. Reference will also be made to the relevant aspects which appear in the biographical information.

5.2.7.1 REASONS WHY PATIENTS VISIT THE HOSPITAL

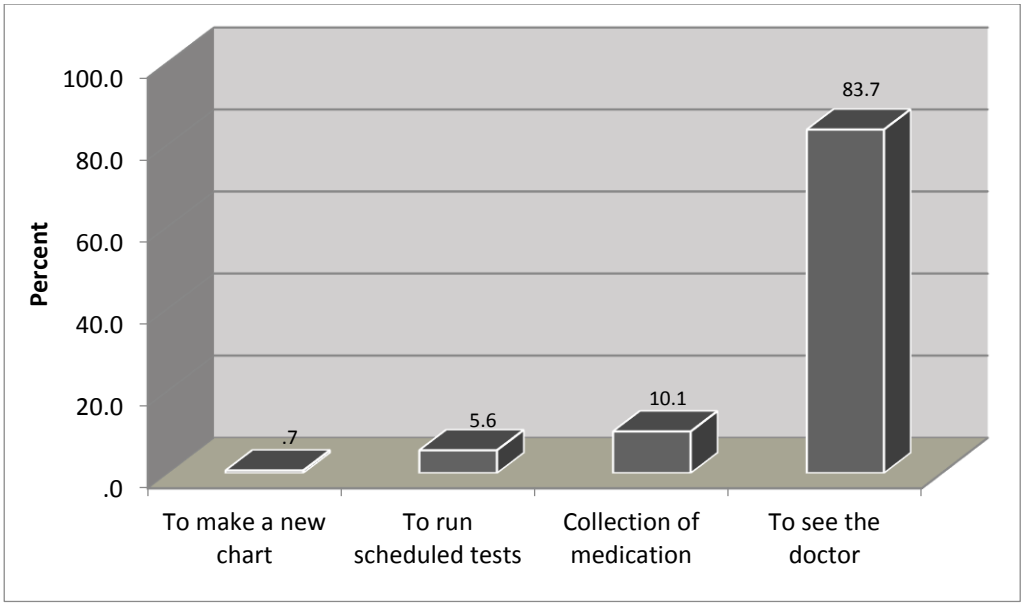

Figure 5.42 Reasons why Patients visit the Hospital

Figure 5.42 indicates the reasons why patients visit the Provincial Hospital. Majority of the respondents (83.7%) indicated that their primary reason for visiting was to see a doctor. The remaining respondents who visited the Provincial Hospital were to collect medication (10.1%), to run scheduled tests (5.6%) and to make a new chart (0.7%).

Chapter 3 highlights that Chatsworth currently has a mixed population with diverse cultures and extreme economic backgrounds. There are low income earners, middle income earners and high income earners. However there is little hope for low income earners to be become top earners due to the nature of competition in the Chatsworth area. **Chapter 3** highlights further with Dawad *et al* (2009) emphasising that Chatsworth currently has an approximate population of 750 000, with informal settlements providing housing for refugees and other black urban residents as well. Informal settlements including Luganda, Bottlebrush and Welbedacht now have their place within the surrounding Chatsworth area. According to an overview report of Crossmoor (2009) the people in the formal areas often leave due to the escalating crime levels which are attributed to the high levels of unemployment and drug abuse.

5.2.7.2 MODE OF TRANSPORT AND GENDER

			Gender		Total
			Male	Female	
What was your mode of transport?	Bus	Count	2	4	6
		% within What was your mode of transport?	33.3%	66.7%	100.0%
		% within Gender	2.4%	1.8%	2.0%
		% of Total	0.7%	1.3%	2.0%
	Taxi	Count	53	167	220
		% within What was your mode of transport?	24.1%	75.9%	100.0%
		% within Gender	63.9%	74.9%	71.9%
		% of Total	17.3%	54.6%	71.9%
	Train	Count	2	1	3
		% within What was your mode of transport?	66.7%	33.3%	100.0%
		% within Gender	2.4%	0.4%	1.0%
		% of Total	0.7%	0.3%	1.0%
	On foot	Count	2	5	7
		% within What was your mode of transport?	28.6%	71.4%	100.0%
		% within Gender	2.4%	2.2%	2.3%
		% of Total	0.7%	1.6%	2.3%
	Own vehicle	Count	16	32	48
		% within What was your mode of transport?	33.3%	66.7%	100.0%
		% within Gender	19.3%	14.3%	15.7%
		% of Total	5.2%	10.5%	15.7%
	A friend	Count	8	14	22
		% within What was your mode of transport?	36.4%	63.6%	100.0%
		% within Gender	9.6%	6.3%	7.2%
		% of Total	2.6%	4.6%	7.2%
Total		Count	83	223	306
		% within What was your mode of transport?	27.1%	72.9%	100.0%
		% within Gender	100.0%	100.0%	100.0%
		% of Total	27.1%	72.9%	100.0%

Table 5.10 Cross Tabulation Mode of Transport & Gender

Table 5.10 represents the relationship between the patients' mode of transport and gender. The race and gender of patients has been tested in **Table 5.2**. The majority of patients (71.9%) travel by taxi to the Provincial Hospital. Females comprise 54.6% of the total patients that travel by taxi.

With the exception of the train travel, the other modes of transport were dominated by females. These modes of transport are as follows: bus (female, 1.3%), on foot (female 1.6%) and friends and own vehicle (females, 12.6%)

5.2.7.3 MANAGEMENT REPRESENTATION OF THE APPLICATION OF BATHO PELE PRINCIPLES

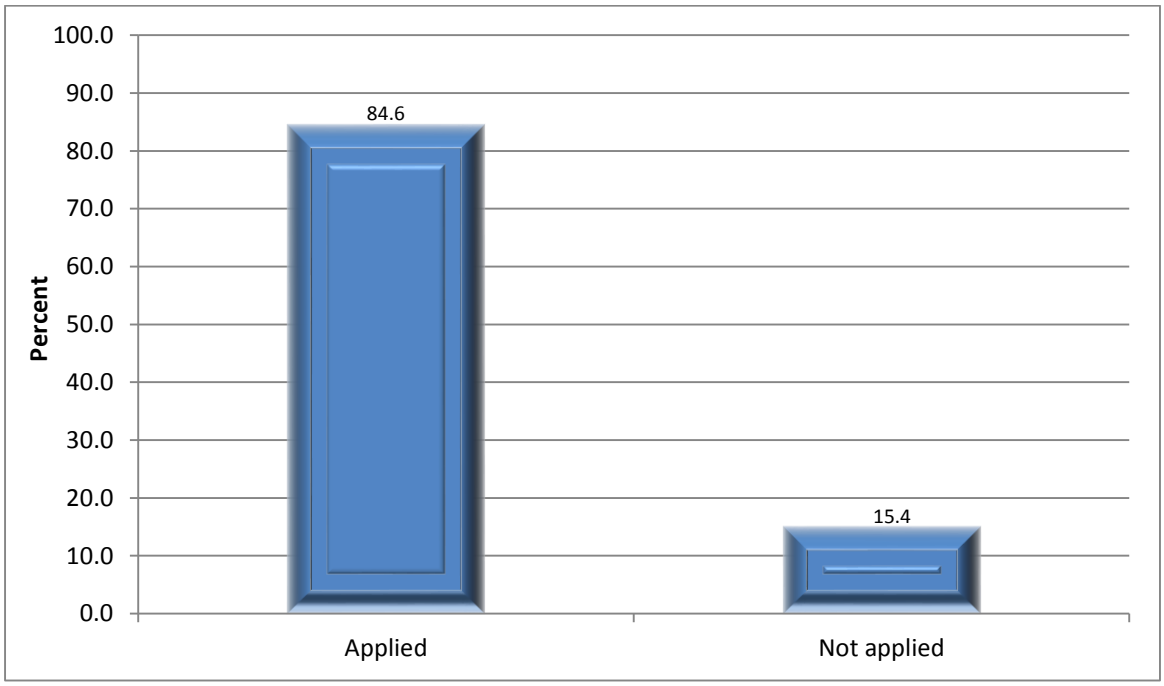

Figure 5.43 Management representation of the application of Batho Pele Principles

Figure 5.43 highlights the managers' representation of their application of the Batho Pele Principles. The majority of the respondents (84.6%) indicated that the Batho Pele Principles are applied whilst 15.4% of the respondents indicated that the Batho Pele Principles were not applied.

The survey conducted with Senior Management highlights that the Batho Pele Principles are difficult to practise due to workload. Senior Management further point out that if you are a health care worker, medicine is not only given, it is the art and way of the administered.

5.2.7.4 DISCUSSION OF FINDINGS THEME 3: ENVIRONMENTAL IMPACTS AND INFLUENCES

The essence of impact of the environmental influences both indirect and direct o the Provincial Hospital can have devastating consequences. The Provincial Hospital in terms of the empirical data is exposed to a number of environmental influences that may be observed in the various figures and tables outlined in this chapter. The following representation includes a summary of figures together with the environmental influence.

Figure & Tables	Environmental Influence/s
Figure 5.3 Qualifications of HOD's	Staff capacity within the hospital (Forms the integral part of the internal environment of the organization)
Table 5.3 Area of residence of patients	Districts and towns that patients come from (Physical environment surrounding the hospital)
Figure 5.7 Specific departments that patients indicated that they were unhappy with	Departments within the Provincial Hospital that require attention (Dedicated operations of the Provincial Hospital which is the core structure of the organization)
Figure 5.8 Patient identified complaints	Complaints that the Provincial Hospital are exposed to (Complaints emanating from the customers which comprise the specific / direct action environment of the Provincial Hospital)
Table 5.5 Cross Tabulation of patients' mode of transport and time they left the hospital	Demonstrates the infrastructure that surround the Provincial Hospital (The mode of transport may be a constituted as the specific environment of the Provincial Hospital)

Figure 5.42 Reasons why patients visit the hospital	Demonstrates patients' needs (These needs are influenced by general/indirect action environment)
Table 5.9 Cross tabulation of mode of transport and gender;	Demonstrates the sensitivities around sound infrastructure (The mode of transport may be a constituted as the specific /direct action environment of the Provincial Hospital)
Figure 5.43 Management representation of the application of Batho Pele Principles	Demonstrates the role of government (Government and legislation are the specific/ direct action environments that influence the Provincial Hospital

Table 5.11 Figures representing environmental influences

Table 5.11 highlights the role of the specific/direct actions environments and the general/indirect action environments. These environments are enunciated in **Chapter 2.** Stoner *et al* (1995: 63) in the literature review make reference to the direct action environments as elements which include shareholders, unions, suppliers, government, customers, competitors, special interest groups and financial institutions, which directly influence an organization.

The indirect action environment elements are identified as technology, economy, and politics of a society, affecting the climate in which an organization operates and have the potential to become direct action elements. These elements create a climate, rapidly changing technology, economic growth or decline, as well as changes in attitudes toward work in which the organization exists and to which it may ultimately have to respond (Stoner *et al,* 1995: 63-74). The Provincial Hospital and its operations are directly influenced by these environments which provide a challenge in effective and efficient delivery of services.

5.3 SUMMARY

Chapter 5 detailed the results generated by each research instrument. These instruments were triangulated to provide constructive discussion. The results were presented under the three research themes namely; Service Delivery, Management Practices and Processes and Environmental Impacts and Influences. The presentation of the findings culminated in a detailed discussion around the various themes that emanated from the study.

This discussion creates a sound platform for the development of conclusions and recommendations. The conclusions and recommendations will follow in **Chapter 6** of the study.

CHAPTER 6

CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

The previous chapter discussed the findings of the research instruments and established links to the conceptual framework and operations chapter of the study. This chapter presents the conclusions that were drawn from the study. It further presents recommendations and provides a summary based on the interpretation of results.

6.2 SUMMARY OF STUDY

The overall purpose of the study was to evaluate the role of hospitality within a provincial hospital, identifying that the reception of, and treatment of patients should offer more than just basic health care.

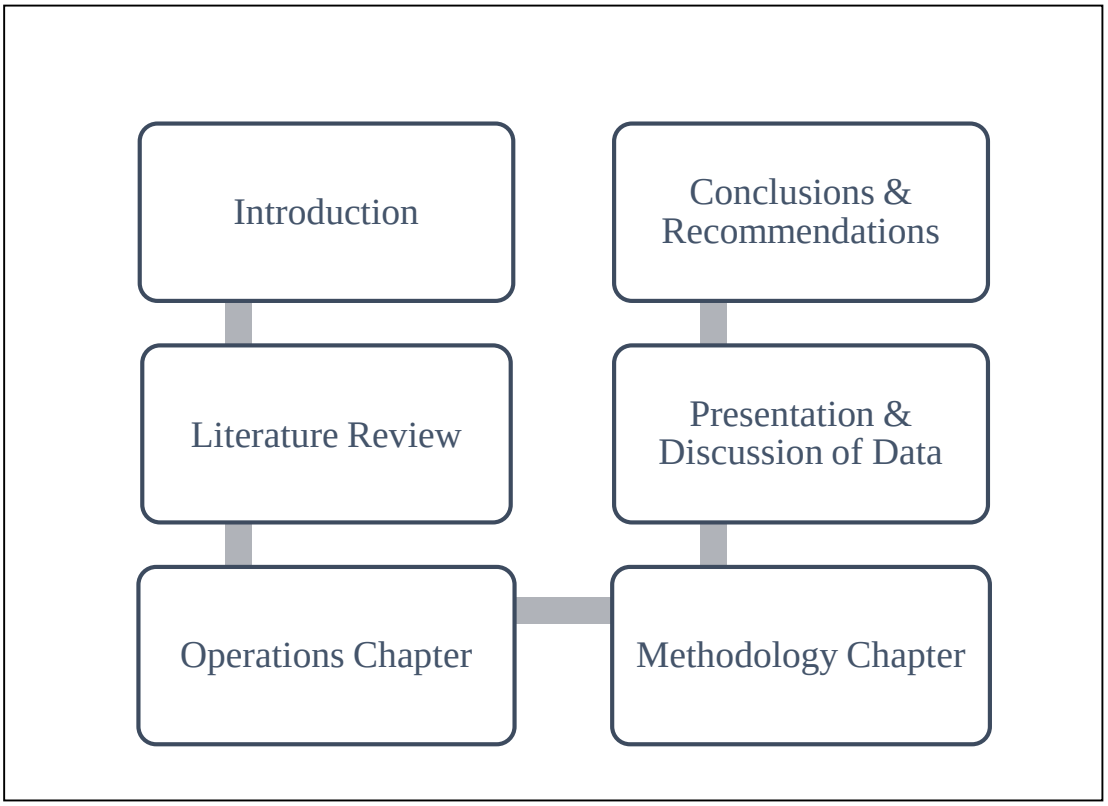

Figure 6.1 Flowchart of the study

Figure 6.1 identifies the flow and steps that were completed in which the research was set out.

The introduction chapter presented the approach of study introducing the problem statement and rationale of the research which identifies the areas of concern around the delivery of health care, and the aspirations to provide health care with the concept of hospitality. The research objectives are explained which maps out the focal areas that would be covered to establish that hospitality practices have a role within health care services and identifies the area of the Provincial Hospital of study.

The literature review was the foundation of the theoretical aspect which generated a discussion on the evolution and expansion of the hospitality industry, the development of service and service delivery which highlights the Jones & Lockwood's model of management influence and its impact on service. Hospitality management was explained as well as the service employee. An understanding of Governance and Intergovernmental relations was described along with the service fundamentals in hospitals were highlighted. A grasp of the challenges that provincial hospitals experience which impact on the delivery of health care is accounted for. The chapter concludes with the similarities of hospitality and hospitals revealing that the Batho Pele Principles which steer the delivery of health care resembles the essence of hospitality.

The operations chapter discussed the succinct history of the Chatsworth area and the Provincial Hospital of study. The vision and mission and the drainage areas of the Provincial Hospital were highlighted. An extensive explanation was given of the hospital's operational practices along with a detailed organizational structure with the roles and responsibilities of hospital staff and the support structures of the Provincial Hospital was outlined. An applied Jones & Lockwood model of the management influence on service was introduced which depicts application to hospital management.

The methodology chapter detailed the methods of research and the process of triangulation of the study was explained. The research design and the types of research that the researcher undertook were described. An explanation of the sampling procedure, organization and administration of questionnaires to both patient and department head, with the design and description of these questionnaires

was given. The description and structure of the structured interview to senior management was discussed. An account for the need for pre-testing, coding and editing of the questionnaires was identified. The use of field research assistants was justified. The chapter concluded with limitations of the study.

The presentation and discussion of data chapter identified the core themes of service delivery, management practices and processes and environmental impacts and influences, and the research objectives were reintroduced. The majority data analysis revealed that the application of Jones and Lockwood's model of management influence proved to be useful in hospital management in terms of quality patient service delivery. Data analysis also revealed that patients are unhappy with hospital care. The data analysis further revealed that there are similarities with hospitality and hospitals in terms of the Batho Pele Principles and the concept of hospitality, and The Provincial Hospital and its operations are directly influenced by the direct action and indirect action environment which provides a challenge in effective and efficient delivery of services.

6.3 CONCLUSIONS

The aim of the study was to identify the need for hospitality practices to be included with the delivery of health care within a provincial hospital in the southern area of Durban. A sample of 306 patients, 13 department heads and 2 members of senior management were targeted. Based on this, the following section represents the conclusions of the study based on the objectives set out in **Chapter 1**.

6.3.1. Core research theme 1: Service delivery at the Provincial Hospital. Key conclusions in this respect are *inter alia*:

- The provincial hospital has a discontinuous level of service that is provided to patients.
- The area most frequented is the Outpatients Department and subsequently is the leading area of dissatisfaction among patients, followed by the Dispensary.
- A considerable amount of patients spend up to 12 hours at the Provincial Hospital.

- A large amount of patients spend up to 12 hours at the hospital travel with public transport.
- A substantial amount of patients have a poor impression of staff attitude of the Provincial Hospital.
- The leading challenges that management encounter with staff are poor attitude and absenteeism.
- A large amount of patients report that staff have a negative attitude.
- The majority of complaints received by management are on staff performance
- The Provincial Hospital receives compliments in various departments.
- Senior management recognize that The Provincial Hospital has poor infrastructure and cannot accommodate all the patient needs.

6.3.2 Core research theme 2: Management Practices and Processes. Conclusions in this respect are *inter alia*:

- Senior management have mixed views regarding their vision.
- The Provincial Hospital has significant challenges with budgeting and the allocation of budget to them.
- The lack of funding to the Provincial Hospital impacts on services delivered.
- Senior management have challenges with the performance of their department heads.
- Majority of department heads would choose the Provincial Hospital as their hospital of choice.
- The leading staff complaints that department heads receive are of high work load and inadequate staff capacity.
- Senior Management recognize that staff of the Provincial Hospital have high workloads which influence the delivery of patient care.

6.3.3 Core research theme 3: Environmental impacts and Influences. Conclusions in this respect are *inter alia*:

- Department heads are aware of the Batho Pele Principles.
- There is application of some elements of the Batho Pele Principles within the Provincial Hospital.

- Senior management have a committed approach to the application of the Batho Pele Principles within the Provincial Hospital.
- The Batho Pele Principles elements of The Provincial Hospital resemble the concept of hospitality and its practices and senior management identify that hospitality practices are existent within the Batho Pele Principles.
- Majority of the department heads find their respective departments similar to a hospitality environment.
- Majority of the patients who frequent Provincial Hospital travel by public transport (taxi).
- The Provincial Hospital and its operations are directly influenced by environmental factors which provide a challenge in effective and efficient delivery of health care.

6.4 RECOMMENDATIONS

The following recommendations may be considered at the Provincial Hospital:

6.4.1 The implementation of a mystery patient program

The Hospitality Industry has a similar program by which a mystery guest visits a hotel to test the service delivery of a particular establishment. A mystery patient program will be an effective way of measuring service that is delivered to the patients and can be applied in the various areas of the Outpatients Department. A candidate which is recruited by the Provincial Hospital, visits the areas of concern (Outpatients Department) of the hospital. The candidate will then provide complete feedback to the Provincial Hospital of the areas visited.

According to Nzimakwe and Mpele (2012) the Batho Pele Principles were seen as the instrument to revolutionize public service delivery in South Africa. The findings revealed that quality patient care and level of service are inconsistent within the Provincial Hospital. The implementation of a mystery patient program would therefore test the patient care and the level of service. This program may be done in a comprehensive way to test both service delivery and the hospital facilities.

The level of service and patient care is steered by the Batho Pele Principles which commit staff to continuous service delivery improvement. The mystery patient

program would be able to test on a regular basis the application of these principles. Furthermore, reveal which departments are weaker in their application of the principles and find remedies to strengthen the Batho Pele thread across the Provincial Hospital.

6.4.2 The application of the applied Jones and Lockwood model of management influence on service into departmental management at the Provincial Hospital

Service is an intangible experience of performance by hospital employees that the patient receives along with the tangible product of health care. Conclusions and findings revealed that hospitality management has a place within the delivery of health care and hospital management. A good service is essential because people are a part of the service product. In order for employees to perform well, an effective management system is required. The operations chapter presented an application of Jones and Lockwood's model of management influence on service designed for the Provincial Hospital and health care.

The applied model depicts the patient (**Figure 3.5**), the hospital employee and the patient encounter. The goal is to improve the patient experience and enhance patient care and further maintain good levels of service within the Provincial Hospital. Research and findings support that the use and application of this applied model may improve patient care within departments and ultimately promote effectiveness and efficiencies within the Provincial Hospital. Research supports Ford and Heaton (2000: 142) in stating that service effectiveness depends on everyone throughout the organization taking service responsibility seriously and organizations need not hire anyone who is unwilling or unable to provide and deliver outstanding service.

6.4.3 The introduction of a soft services training program with a university

In the view of the guest service is the performance of the organization and its staff, and service is the cornerstone of the hospitality industry. The findings revealed that the Batho Pele Principles are strongly aligned with the concept of hospitality practices and that hospitality management has a place within the delivery of health care and hospital management. The implementation of a soft services training program specifically with a university that offers hospitality management would create a long

standing a relationship and facilitate department outreach to the Provincial Hospital. This relationship would benefit both institutions. The Provincial Hospital would benefit as the members from the university would train all relevant personnel and staff in the various departments, which include all patient facing employees, regarding soft services which will include the application of the Batho Pele Principles to enhance patient care and the level of service and its delivery. The goal is not only to build new relationships but also to ensure that staff perform to the best of their ability. Hence, Berger and Brownwell (2009: 10) believe that effective hospitality managers understand the importance of staff recruitment, selection and training for the service experience.

6.4.4 The introduction of Hospitality Management in Medical Schools

Research has presented that hospitality management is more than just hotels and hotel rooms. Mullins (2001: 137) outlines that the task of hospitality management is to make the use of staff and the responsibility of management is to manage. However, the efficiency of staff and their commitment to the aims and philosophy of the establishment are fostered by good human relationships and by the nature of managerial behaviour. Hence, the introduction of hospitality management to medical schools would establish the association of soft services with the hospitality thread before entering a provincial hospital.

This initiative would also create new relationships between universities which will encourage further faculty outreach. The success of this initiative may improve and expand job opportunities for hospitality graduates as hospitality and health care would not be viewed in isolation.

6.5 POSSIBLE FUTURE DIRECTIONS

As a result of this study the following areas of research may be considered for future study:

- An introduction of hospitality management into schools of medicine and its relevance to hospital management and patient care;
- An investigation into the introduction of a soft services manager within provincial hospitals; and

- The role of clinics as a support mechanism to provincial hospitals.

6.6 SUMMARY

Health care in provincial hospitals has been one of the sectors which have been greatly affected with the increase of poverty and unemployment. Hospitals with the capacity of treating a limited number of patients have forced to take on more than they can accommodate. This study has endeavored to assist provincial hospitals to enhance their patient care, improve effectiveness and efficiencies amongst staff for improved service delivery. This study, therefore, not only strives to draw attention to the research problem but also paves the way to improve systems and create a new thread of healing hospitality.

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APPENDIX 1

HOTEL SCHOOL
7 Ritson Road
Durban
4001

RK KHAN HOSPITAL
Private Bag X004
Chatsworth
RK Khan Circle
Westcliffe
4030

20 December 2010

Dear Staff

RE: COMPLETION OF QUESTIONNAIRE

I am a student and currently studying towards my M-Tech Degree in Hospitality Management at the Durban University of Technology, Kwa Zulu-Natal. I am currently researching the area of hospitality within public health care. My research topic involves "*An Evaluation of Hospitality within a Provincial Hospital in the Southern area of Durban, KZN."*

The intention of this research is to provide this hospital and potentially other provincial hospitals with valuable information on enhancing service delivery.

To facilitate my research, I have attached a questionnaire for completion. This questionnaire should take approximately of 15minutes to complete. The questions will require you to choose an appropriate answer from the list provided. All the information obtained will be treated confidentially and you may remain anonymous. Both the findings and the recommendations will be made available to the hospital.

I anticipate your prompt response and thank you for your time and assistance. If you have any queries or require more information, please do not hesitate to contact me at 073 892 6780.

Yours sincerely

_____

Anisah Deen

M-Tech Student
Durban University of Technology

SECTION A

BIOGRAPHICAL INFORMATION FOR STATISTICAL PURPOSES ONLY

The following information is based on your personal details. Please be assured that it will remain confidential and anonymous. Codes that appear on the right hand side of the boxes are to be ignored. Please place a cross (x), in the correct answer box

1. Gender

Male		0
Female		1

2. Race (For statistical purposes only)

Black		0
Indian		1
White		2
Coloured		3
Other_____		4

3. Please indicate your years of service at this hospital?

0-2 years		0
3-5 years		1
6-10 years		2
11-20 years		3
21+ years		4

4. Education/Qualification/s

No Matric		0
Matric		1
Matric +3		2
Matric +4		3
Matric +5		4
Special Courses		5
Other_____		6

5. Please indicate your position /job title?

Manager		0
Supervisor		1
Sister		2
General assistant		3
Other_____		4

6. Please indicate the department in which you are employed in?

Admitting Outpatients		0
Maintenance		1
Security		2
Catering/Kitchen		3
Human Resources		4
General Wards		5
Housekeeping		6
Other_____		7

7. Identify very broadly your place of residence?

Chatsworth		0
Umlazi		1
Shallcross		2
Pinetown		3
Yellowood Park		4
Marion Hill		5
Other_____		6

SECTION B

SERVICE DELIVERY

8. Are you responsible for the supervision of staff in the department?

Yes		0
No		1

8.1 If yes, to what extent are you happy with your staff in your department?

0	1	2	3	4
Very Unhappy	Unhappy	Average	Happy	Very Happy

8.2 Please indicate in order of importance the qualities that members in your department should have in order to provide excellent service (1 being important and 7 being least important)

Good communication skills		0
Ability to be empathetic and courteous		1
Ability to go the extra mile		2
Ability to organize		3
Honesty		4
Punctuality		5
Ability to work as a team		6
Passionate about their work and service		7
Other _____		8

9. Indicate some of the challenges you face when supervising staff?

Absenteeism		0
Uncooperative staff		1
Lack of commitment		2
Poor attitude at the workplace		3
Lack of communication skills		4
De-motivated staff		5
None at all		6
Other_____		7

10. Do you develop plans on a daily basis?

Yes		0
No		1

10.1 If yes, indicate some of the plans you develop on a daily basis that assists in your departments operations?

_____

_____

_____

10.2 Do you develop plans on a monthly basis?

Yes		0
No		1

10.3 If yes, indicate some of the plans you develop on a monthly basis that assist in your departments operations?

_____
_____
_____
_____

10.4 Do you develop plans in your department that extend to more than a year?

Yes		0
No		1

10.5 If yes, indicate the nature of these plans?

_____
_____
_____
_____

COMPLAINTS

11. Do you receive complaints on the performance of your department?

Yes		0
No		1

11.1 Indicate where these complaints originate? (You may choose more than 1)

From other departments		0
Patients		1
From within the department		2
Suppliers		3
Other_____		4

PATIENT COMPLAINTS AND COMPLIMENTS

If your department does not deal with patients please ignore questions 12 to15.1

12. What are the natures of these patient complaints?

Poor infrastructure		0
Poor treatment		1
Shortage of health care professionals		2
Poor service delivery		3
Long waiting time periods		4
Other _____		5

13. How would best describe the nature of patient complaints?

_____
_____
_____
_____
_____

14. Do you receive complaints of a similar nature repeatedly?

Yes		0
No		1

14.1 If yes, how often does this occur?

Daily		0
Once a week		1
Once a month		2
Other _____		3

15. Do you receive compliments from patients?

Yes		0
No		1

15.1 If yes, please indicate the nature of the compliments?

_____
_____
_____
_____
_____

16. To what extent do you receive complaints regarding medical staff?

Never		0
To a little extent		1
To a large extent		2
I am unsure		3
Other_____		4

INTER - DEPARTMENTAL COMPLAINTS

17. Do you receive complaints from other departments of the hospital?

Yes		0
No		1

17.1 If yes, how often do you receive these complaints from other departments? However if your answer is no this question, please ignore 18 to 19.1

Daily		0
Once a week		1
Once a month		2
Other _____		3

18. Describe the nature of these complaints from other departments?

Lack of communication between departments		0
Shortage of health professionals		1
Lack of commitment from other departments		2
Lack of teamwork between departments		3
Other_____		4

18.1 How would you go about managing complaints from other departments?

_____
_____
_____
_____
_____
_____

19. Do you receive complaints from other departments of a similar nature repeatedly?

Yes		0
No		1

19.1 If yes, how often does this occur?

Daily		0
Once a week		1
Once a month		2
Other _____		3

COMPLAINTS WITHIN THE DEPARTMENT

20. Do you receive complaints from staff within the department?

Yes		0
No		1

20.1 If yes, how often do you receive these complaints? Should you answer “no” to this question please ignore questions 20.1 through to 20.5

Daily		0
Once a week		1
Once a month		2
Other _____		3

20.2 What are the nature of complaints from staff within the department?

Salary related issues		0
Lack of teamwork		1
Lack of communication		2
Inadequate staff capacity		3
Lack of appreciation		4
High workload		5
Inadequate training		6
Other _____		7

20.3 How would you manage these staff complaints?

_____
_____
_____
_____
_____
_____

20.4 Do you receive complaints within the department of a similar nature repeatedly?

Yes		0
No		1

20.5 If yes, how often does this occur?

Daily		0
Once a week		1
Once a month		2
Other _____		3

21. What do you think are the important qualities that a departmental head should have? (1 being important 8 being least important)

Strong leadership skills		0
The ability to manage		1
The ability to plan and coordinate		2
Good communications skills and listening skills		3
Have the ability to work in a pressured environment		4
Committed to one's department and staff		5
Punctuality		6
A manager that is trained in management		7
Other_____		8

HUMAN RESOURCES

22. Please indicate to what extent you are satisfied with your job?

0	1	2	3	4
Very unsatisfied	Unsatisfied	Average	Satisfied	Very Satisfied

23. Please indicate to what extent are you satisfied with your conditions of employment?

0	1	2	3	4
Very unsatisfied	Unsatisfied	Average	Satisfied	Very Satisfied

24. Do you deal with patients?

Yes		0
No		1

25. If yes, identify some of the challenges you face? If not ignore questions 25.1 to 25.2

Patient unhappy with something		0
Poor hospital facilities		1
Language barriers		2
Personal difficulties		3
Inadequate basic hospital resources		4
Other_____		5

25.1 When faced with these challenges do receive assistance from managers?

Yes		0
No		1

25.2 If yes, what kind of assistance do you receive?

_____
_____
_____
_____
_____

26. To what extent does the QA department assist with improving the quality of your department?

QA does not assist		0
QA assist to lesser extent		1
QA assists to great extent		2
I am unsure		3

27. How do you consider your workload to be in your department?

0	1	2	3	4
Very unsatisfactory workload	Heavy workload	Workload could improve	Satisfied with workload	Extremely happy with workload

28. Do you have staff meetings?

Yes		0
No		1

28.1 If yes, choose the nature of these meetings? If not, ignore questions 28.1 to 28.2

Meetings within the department		0
Meetings with other departments		1
Other_____		2

28.2 To what extent do you find these meetings useful?

0	1	2	3	4
Meetings don't make a difference	Meetings are of no use	Meetings are useful	Meetings add value	Meetings make a difference

PERFORMANCE MANAGEMENT

29. Do you have staff appraisals in your department?

Yes		0
No		1

30. How often do these appraisals take place?

Once a year		0
Twice a year		1
Other _____		2

31. Do staff appraisals assist in the quality of service of your department?

Yes		0
No		1

32. Are these helpful to your staff?

Yes		0
No		1

33. If not, explain reason for this?

_____
_____
_____
_____

BATHO PELE PRINICPLES / PATIENT CARE

34. Do you know of the Batho Pele Principles?

Yes		0
No		1

34.1 Do you see the Batho Pele Principles being applied t in your operations?

Yes		0
No		1

34.2 If you answered yes to question 31, how are the Batho Pele Principles applied?

_____
_____
_____
_____
_____
_____

35. Does your department deal with patient visitors? If not, ignore question 35.1

Yes		0
No		1

35.1 If yes, identify some of the challenges that you may encounter with patient visitors?

Inappropriate visiting hours		0
Lack of space		1
Unhappy patient care		2
Unhelpful service		3
Lack of communication from staff		4
Lack of parking facilities		5
Inadequate visitor facilities		6
Other_____		7

HOPITALITY PRACTISES

It is understood that hospitality includes hotels and restaurants, however also referring to other kinds of institutions that offer shelter, food and comfort to people away from their homes

36. In order of rank indicate the qualities that best represents hospitality?

Smiling		0
Courtesy		1
Profitability and quality		2
The customer is king		3
Service standards		4
Value for money for quality service		5
Meeting the customer expectations		6
Punctuality		7
Understanding the customer		8
Organizing		9
Other _____		10

37. In your view, how similar are the operations of your department to hotel?

Not similar at all		0
Slightly similar		1
Very similar		2
I am unsure		3

38. If you were a patient that required hospitalization, would you choose this hospital?

Yes		0
No		1

38.1 If not, why?

_____
_____
_____
_____
_____
_____
_____

GENERAL COMMENTS

39. Please provide further comments in general that you think may be relevant to this study. You may also provide comments on questions that had inadequate space for answers.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

END OF QUESTIONNIARE

THANK YOU

APPENDIX 2

HOTEL SCHOOL
7 Ritson Road
Durban
4001

RK KHAN HOSPITAL
Private Bag X004
Chatsworth
RK Khan Circle
Westcliffe
4030

15 March 2011

Dear Patient

RE: COMPLETION OF QUESTIONNAIRE

I am a student and currently studying towards my Masters of Technology Degree in Hospitality Management at the Durban University of Technology. I am currently researching the area of hospitality within public health care. My research topic is "*An Evaluation of Hospitality within a Provincial Hospital in the Southern area of Durban, KZN."*

The intention of this research is to provide this hospital and potentially other provincial hospitals with valuable information on enhancing service delivery.

To facilitate my research, I have attached a questionnaire for completion. This questionnaire should take approximately 10 minutes to complete. The questions will require you to choose an appropriate answer from the list provided. All the information obtained will be treated confidentially and you may remain anonymous. Both the findings and the recommendations will be made available to the hospital.

I anticipate your prompt response and thank you for your time and assistance. If you have any queries or require more information, please do not hesitate to contact me at 073 892 6780.

Yours sincerely

_____

Anisah Deen
M-Tech Student
Durban University of Technology

1. Gender

Male		0
Female		1

2. Race (For statistical purposes only)

Black		0
Indian		1
White		2
Coloured		3
Other		4

3. Are you the patient visiting the hospital?

Male		0
Female		1

4. Which section of the hospital are you visiting?

Outpatients		0
Wards		1
General		2
Pharmacy		3
Other_____		4

5. Which area are you from?

Chatsworth (indicate which unit) _____		0
Shallcross		1
Queensburgh		2
Woodhurst		3
Marionridge		4
Pinetown		5
Other		6

6. What was your mode of transport?

Bus		0
Taxi		1
Train		2
On foot		3
Own vehicle		4
Other		5

7. What time do you leave home?

3am		0
4am		1
5am		2
6am		3
Other		4

8. What time do you get to the hospital?

4am		0
5am		1
6am		2
7am		3
Other		4

8.1 What was the reason for visiting the hospital?

Collection of medication		0
To see the doctor		1
To run schedules tests		2
Other		3

9. What time do receive attention after you enter the hospital?

1 hour after arrival		0
2hours after arrival		1
3hours after arrival		2
4 hours after arrival		3
Other		4

10. What time do you leave the hospital after your day is complete?

4pm		0
5pm		1
6pm		2
7pm		3
Other		4

11. To what extent are you happy with the service at this hospital?

0	1	2	3	4
Very Unhappy	Unhappy	Average	Happy	Very Happy

11.1 If very unhappy or unhappy, please identify the department/area that you are unhappy with?

_____
_____
_____

12. At which department did you find it the longest waiting period?

Entrance waiting area		0
Clinic		1
Waiting area for blue card		2
Area of examination		3
Dispensary		
Other (must specify)		4

13. Describe the attitude of staff toward you?

Kind and gentle		0
Patient and concerned		1
Always willing to help		2
Aggressive and unconcerned		3
Unkind and rude		4
Always in a hurry		5
Other (must specify)		6

14. Have you ever complained before?

Yes		0
No		1

14.1 If yes, how many times?

Once		0
Twice		1
Three times		2
More than three times		3

15. What were the nature of these complaints?

Visiting hours		0
Unhappy with patient care		1
Unhelpful service		2
Facilities		3
Lack of communication from staff		4
Other		5

16 Please provide further comments in general regarding the hospital.

_____
_____
_____
_____
_____

APPENDIX 3

HOTEL SCHOOL
7 Ritson Road
Durban
4001

RK KHAN HOSPITAL
Private Bag X004
Chatsworth
RK Khan Circle
Westcliffe
4030

20 June 2011

Dear Senior Management

RE: INTERVIEW WITH EXECUTIVE MANAGEMENT OF PROVINCIAL HOSPITAL, DURBAN

I am a student and currently studying towards my Masters of Technology Degree in Hospitality Management at the Durban University of Technology. I am currently researching the area of hospitality within public health care. My research topic is "*An Evaluation of Hospitality within a Provincial Hospital in the Southern area of Durban, KZN."*

The intention of this research is to provide this hospital and potentially other provincial hospitals with valuable information on enhancing service delivery.

To facilitate my research, I have attached a structured interview schedule. The duration of the interview is approximately 1 hour. The findings and the recommendations will be made available to the hospital.

I thank you for your time and assistance. My contact details are 073 892 6780 if you have any further queries.

Yours sincerely

_____

Anisah Deen
M-Tech Student
Durban University of Technology

1. Gender

Male		0
Female		1

2. Race (For statistical purposes only)

Black		0
Indian		1
White		2
Coloured		3
Other_____		4

3. Please indicate your years of service at this hospital?

0-2 years		0
3-5 years		1
6-10 years		2
11-20 years		3
21+ years		4

3.1 Please indicate years of experience in total

_____

4. Please indicate your area of expertise/specialization?

_____
_____

5. Is RK Khan Hospital well positioned towards its vision?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

6. Do you find any serious challenges in complying with the Health Act or any other legislation?

7. How often do you focus on the strategic plan to ensure strategic alignment?

8. To what extent do you find the Hospital/Organization achieving its strategic goals?

9. How often does executive management engage in strategic planning for the hospital?

10. How long ago was the last strategic plan formulated by Executive Management?

11. Do you find the strategic plan useful to the hospital?

12. How often do you meet your heads/managers as a collective?

13. What are some of the challenges in these meetings? Eg: problems managers have that you have to deal with?

14. Do you have train managers to assist them in their day to day activities?

15. To what extent do you have contact time with patients?

16. What are some of the day to day challenges experienced by yourself?

17. Which section of the hospital has the greatest challenges at operational level?

18. To what extent does The Hospital Board have influence over the management of the hospital?

19. What is your view on the concept of hospitality and the practise of hospitality in hospitals?

20. Do you think it is realistic that the Batho Pele Principles are to be practised in a provincial hospital?

21.1 Which principle do you think is most challenging to the hospital

Service standards		0
Access		1
Courtesy		2
Value for money		3
Openness & transparency		4
Redress		5

21.2 Why do you think this is the case?