FACTORS INFLUENCING PATIENT WAITING TIME AT NTHABISENG CLINIC IN THE CAPRICORN DISTRICT OF LIMPOPO PROVINCE

By

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DECLARATION

I, SHANDUKANI SHONISANI TIKVA MASUTHA, hereby declare that this mini-dissertation titled: ***Factors influencing patient waiting time at Nthabiseng clinic in the Capricorn district of the Limpopo Province***, has not been submitted before for any degree or examination at this or any other institution; and that it is my own work in design and execution and all reference materials contained herein have been duly acknowledged.

Signature: …… Date: ……..…….

DEDICATION

This mini-dissertation is lovingly dedicated to my family. Thank you for continuously standing by me, your love and kindness keeps me strengthened. To my supervisors Prof. L. Nemathaga and Prof. A.K. Tugli, I am grateful for your time, guidance and on-going support. You remain my motivation.

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Thank you Lord for your Mercy and Grace. You remain a Sovereign God.

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ABSTRACT

Post-apartheid South Africa's healthcare system improved with many community members being able to easily access basic health care services. However, patient waiting time has remained a critical issue. Patients are well-known for arriving at healthcare facilities very early for the reason of avoiding lengthy queues. This, however, does not solve their problem.

The purpose of the study was to explore factors influencing patient waiting time in Nthabiseng clinic in the Capricorn district of the Limpopo Province. The study was conducted at Nthabiseng clinic in the Capricorn District.

A qualitative approach was adopted, and a sample was chosen from a targeted population through purposive sampling. Data were collected through a one-to-one semi-structured interview and analysed through the Thematic Data Analysis approach.

The study found out that the Department of Health does not have a patient waiting time specific policy or legislative framework and/or a guiding document. It also showed that healthcare professionals define and calculate patient waiting time differently. Moreover, what is an acceptable waiting time to one is an unacceptable waiting time to another.

The study recommended that a policy and Standard Operation Procedure be drafted to guide healthcare professionals on how to improve waiting time in their specific facilities.

Key Words: Factors, patients, patient waiting time.

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List of Abbreviations and Acronyms

Abbreviation/Acronym	
ACU	Ambulatory Care Unit
AR	Action Research
BCCA	British Columbian Cancer Agency
CC	Clinic Committee
CHBC	Community Home Based Carers
CNP	Clinical Nurse Practitioner
DoH	Department of Health
EN	Enrolled Nurse
HDC	Higher Degrees Committee
LAC/USC	Los Angeles Country/University of South California
MDG	Millennium Development Goals
NCS	National Core Standards
NHI	National Health Insurance
OPD	Out-Patient Department
OPM	Operational Manager
PN	Professional Nurse
QAM	Quality Assurance Manager
VC	Vancouver Centre
WHO	World Health Organisation

CHAPTER 1

INTRODUCTION

1.1. Background

The health and the ability of a community to access healthcare services without delay and hardship is important to the government. The standard of the healthcare services provided as well as the time taken to provide such services determines the viewpoint which community members will have towards their country's healthcare system. According to WHO (2007:15), health is a state of complete physical, mental and social well-being and not merely the absence of disease. The World Health Organisation (WHO) further refers to healthcare as a professional field concerned with the maintenance or restoration of good health and/or procedures and methods used to maintain or restore good health. WHO emphasises the universal coverage of healthcare as a significant aspect towards the provision of health care services to disadvantaged communities.

Globally, a total of one hundred and ninety countries' healthcare systems were scrutinised by the WHO. The WHO concluded that the worst performing countries in the provision of healthcare services is Myanmar, with France, Italy and San Marino leading the pack. Countries such as Canada, United States of America and Zimbabwe are rated in 30th, 37th and 155th position respectively. Of the 190, South Africa stands at 175. Part of the factors identified to have and continue to contribute towards failure in the provision of healthcare service is the excessive amount of patient waiting time in healthcare facilities (WHO, 2007:14).

Hall (2006:01) argues that a health system that functions properly experiences patients who flow in like a river, whereas one that does not function properly experiences patients who represent a reservoir as a result of chronic delays. This means that a good patient flow minimises patient queuing and the period spent by patients in a facility thereof. Hall (2006:2) states that a study titled *An evaluation on patient time at Los Angeles Country/ University of South California (LAC/USC) General hospital* was conducted after realising that LAC/USC hospital is

characterised by a multitude of patients and delays in healthcare service delivery. The study discovered that patient waiting time can be reduced through balancing room allocation with the amount of demand with each speciality need, synchronising the work done within various departments in order to avoid patients moving from one room to another.

A similar study titled *Reducing patient wait times and improving resource utilization at British Columbian Cancer Agency's (BCCA) ambulatory care unit through simulation* was conducted in Canada in a cancer centre named Vancouver Centre (VC). The VC's Ambulatory Care Unit/waiting area (ACU) is always populated with patients because all three cancer related programs (medical, radiation and surgical oncology) and all non-hospitalised patients, whether outgoing or incoming, assemble in the same area. The study recommended that a redistribution of clinic workload as well as adjustments to medical staff schedule needs to be made, that information technology solutions need to implement a flexible strategy whereby patients will know which room to go, medical staff will know which room to go to next as well as the occupancy status of each room. This would help in clearing confusion and delays experienced in VC's ACU (Santibanez, Chow, French, Puterman & Tyldesley, 2008:12).

In Tanzania, a study titled *Patient Satisfaction at the Muhimbili National Hospital in Dar Es Salaam, Tanzania* was conducted on patient satisfaction at Muhimbili national hospital where 61% patients waited shorter periods for medical assistance, 7.2% were assisted upon arrival and 26% experienced lengthy queues and were left dissatisfied. Muhimbili national hospital continues to address patient waiting times with an understanding that even a small proportion of those left dissatisfied is of concern for customers/patients treated in their hospital (Muhondwa, Leshabari, Mwangu, Mbembati & Ezekiel, 2008:69).

Similarly, in Nigeria a study titled *Time, Expectation and Satisfaction: Patients' Experience at National Hospital Abuja, Nigeria* was conducted with an aim to assess patient waiting time as well as patients' perceptions towards waiting time. Findings indicated that 84% of patients spend 2 to 7 hours in the outpatient department and

that there is a significant need to address waiting time in order to improve patient satisfaction and meet patients' expectations (Mora & Ogunfowokan, 2012:01).

South Africa (1996:13) states that everyone has the constitutional right to have access to healthcare services; that the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. The Department of Health (2014:15) specifies that the Department of Health in South Africa (DoH) continues to address such a clause in the constitution through developing reasonable legislative measures to improve the healthcare system of the country. Among these is the National Health Insurance (NHI), a measure that seeks to provide health services to communities without attaching any monetary value to an individual. The NHI also seeks to provide a particular universal healthcare standard across all its healthcare facilities regardless of whether the healthcare facility is a private or public healthcare facility. However, unlike the NHI, DoH still functions without a legislative paper or policy that addresses patient waiting time in healthcare facilities.

The Department of Health (2014:15) states that the constitution of the Republic of South Africa and other laws regarding health and healthcare services, have imposed various obligations on the Ministry of Health. Such obligations include actively promoting and improving the national health system hence the Ministry of Health committed itself to, among other things, achieving this through the Millennium Development Goals (MDGs) by the year 2015 and also developed various policies and national action plan such as The Ten Point Plan. The Ten Point Plan also includes its fourth (4) point titled *Improving quality of health services* which also cuts across improving the access and reducing the amount of time a patient spends in a healthcare facility.

In various health facilities within the Limpopo province, patients spend hours waiting to be assisted. It has become a trend that people would wake up before sunrise to queue at five o'clock in the morning at a health facility that only commences its duties at eight. In spite of such a strategy, patients would still wait for many hours in the waiting area for assistance. Such waiting times are perceived as a lack of quality service delivery by many community members (Health System Trust, 2012:17).

The DoH's Quality Assurance Manager (QAM) in the Capricorn district utilises a tool which was once known as the *Patients' waiting time survey* but is currently referred to as a *Time flow study* to determine the waiting period which a patient spends at a point of entry until an exit point in a healthcare facility. Consequent to this, DoH expects each individual healthcare facility to develop its own Developmental Plan to address patient waiting periods (Health System Trust, 2012:17).

1.2. Problem Statement

During daily door-to-door visits conducted by Community Home Based Carers (CHBC) attached to Nthabiseng clinic, CHBC reported that 13 community members indicated that they are reluctant to use the clinic because of unbearable queues. The Clinic Committee (CC) also noted waiting time related complaints from patients through suggestion boxes. Long waiting time is a problem to patients in that they are likely to experience fatigue, reluctance to consult the clinic, perceive Nthabiseng clinic as incapable of providing easy access and adequate healthcare services to communities. Furthermore, the expected maximum time allocated for a single patient to spend upon entering and leaving a clinic is four hours but the time flow study indicates that patients go beyond such time (Department of Health, 2014:15). This motivated the researcher to conduct this study in order to determine factors influencing patient waiting time in Nthabiseng clinic.

Nthabiseng, like all other Capricorn based clinics, does not have a policy to regulate patient waiting time. However, DoH utilises a Time Survey to assess the amount spent by a patient in a facility. A clinic is expected to draft its own Developmental Plan. The consequences of Nthabiseng clinic formulating its own development plan without a guiding legislative paper/policy are as follows; i.e. developmental plan format may differ from those of other clinics, the plan may not adhere to the National Core Standards, other crucial aspects may not be included within the plan, effecting aspects of monitoring and evaluation may prove problematic, time allocated to drafting the plan may inconvenience the normal working schedule and clinic staff may not have the skills nor the knowledge to formulate development plans.

1.3. Study Rationale

South Africa lacks a patient waiting time specific policy or legislative paper which serves as a guide on how healthcare facilities should formulate developmental plans which adhere to the National Core Standard. The DoH utilises a time flow study to calculate the amount of time spent by a patient in a clinic, however, such a study only assesses the time spent in a facility, it does not identify contributory factors to the amount of time spent nor does it introduce possible intervention measures. These are gaps which this research seeks to fill.

Nthabiseng clinic's CC members are concerned about the high number of patient waiting time related complaints raised by community members through suggestion boxes. CHBC are concerned about the number of cases of patients who are reluctant to consult healthcare facilities due to unbearable long queues.

A study titled *Quality Improvement Cycles that Reduced Waiting Times at Tshwane District Hospital Emergency Department* was conducted at Tshwane District Hospital after the hospital received continuous complaints of dissatisfaction from patients about prolonged waiting times (Rauf, Blitz, Geyser & Rauf, 2008:44). However, the study did not specifically focus on Primary Healthcare clinics nor did they make mention of any policy positions and measures currently implemented by government in solving such a challenge.

1.4. Significance of the Study

The results of the study may benefit DoH in the formulation of policy positions or regulatory paper that may serve as a guideline to the developmental plan on patient waiting time in healthcare facilities. It may also assist in furthering researches and widening literature on patient waiting time within the South African context and thus improving the South African Healthcare system. This may also help the community serviced by Nthabiseng clinic to easily access health services without delays and unbearably long queues.

1.5. Aim of the Study

To explore factors influencing patient waiting time at Nthabiseng clinic in the Capricorn district of Limpopo province.

1.6. Objectives

- To describe factors that contribute to long queues and slow patient flow in healthcare facilities as perceived by health personnel.
- To investigate patient waiting time related policy positions with the South African Department of Health.

1.7. Definition of Key Terms

- **Factors**

Conceptual definition: factors refer to a circumstance that influences a result (Barker, 2003:154).

Operational definition: for purposes of the study, factors refer to various circumstances or aspects which contribute to patient waiting time in Nthabiseng clinic, i.e. shortage of staff, shortage of consulting rooms, morning prayer and tea as an interruptive factor in delays in opening of new files and handing out existing files, etc.

- **Patient**

Conceptual definition: patient refers to a person receiving or registered to receive medical care or treatment (Hornby, Wehmeier, Montosh, Tumbul & Ashby, 2005:1475).

Operational definition: for purposes of the study, patient refers to any person waiting for medical and/or healthcare assistance at the waiting area in Nthabiseng clinic.

- **Waiting time**

Conceptual definition: waiting time refers to a period of time between when an action is requested or mandated and when it occurs (Hall, 2006:27).

Operational definition: for purposes of the study, waiting time refers to the amount of time a patient spends from a point of entry to an exit point in a healthcare facility.

1.8. Summary

This chapter covered the introduction and background to the study, its problem statement, rationale and significance. The chapter also elaborated on the aim and objectives of the study as well as providing both the conceptual and operational definitions for key terms used in the study.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

A literature review refers to a section of the research paper whose purpose is to present scholarly information, ideas, views and evidence about the study based on previous researches conducted, books, journals etc. related to the research topic (Gray, 2009: 578). Hence in this section, the researcher will define patient waiting time, discuss global and national views on patient waiting time, factors influencing patient waiting time as well as assessing the policy positions related to patient waiting times within the South African context.

2.2. Conceptualising Patient Waiting Time

Various authors define patient waiting time in different ways, the argument being whether one calculates the time a patient spends in a healthcare facility when that patient enters the main gate of the facility or when he/she starts queuing for healthcare assistance. For example, Sanmartin (2003:49) defines patient waiting time as a period when the waiting for care begins and ends, which is basically the point of queuing to the point when one leaves the consultation room. This definition therefore omits the time when a patient enters and leaves the consultation room and when he/she fetches drugs/medication at the facility's pharmaceutical area.

Rauf et al. (2008:43) defines waiting time as the time which a patient waits for medical assistance, meaning that such a time is recorded from the point of arrival in a healthcare facility to a point when the medical practitioner starts consultation. Taking into consideration the differences in the definition of patient waiting time, patient waiting time for the purposes of this study refers to the time a patient spends in a clinic from the point of entry to their exit point.

2.3. Global Perspective on Patient Waiting Time

Health refers to the total well-being of a person hence it is an obligatory aspect that a country has to carry out in accordance to the uniqueness of the needs of its people and its legislative capability. However, the universal coverage of healthcare is viewed as an integral part in the provision of health services hence such health service provisions must prove satisfactory to the patient (WHO, 2006:03).

Statistically, there are one hundred and ninety (190) countries whose healthcare systems were scrutinised by the World Health Organisation focusing on their ability to provide accessibility of healthcare services as well as the effectiveness of each country's healthcare system. Countries were rated in accordance with their performance and various common factors which impacted negatively on their healthcare systems.

South Africa and Zimbabwe were rated in position 155 and 175 respectively while Myanmar, France, Italy and San Marino were ranked in the first four positions. Countries such as Canada and the United States of America were each ranked position 30 and 37. Part of the common aspects which contributed negatively to the performance of a country's healthcare system was medication stock-outs, vast differences in standards of health services provided in public and private health facilities, unbearably long queues and/or patient waiting time (WHO 2006:03).

Countries such as the Netherlands indicated that to improve the health status of a country, a government must display both political and organisational will towards improving staff performance, availability, productivity, competence, responsiveness and assess factors within and outside the health institution which may affect health professionals including their living circumstances. The Netherlands is of the view that an effective management of institutional and environmental determinants will improve the attitude and rate at which health professionals operate and therefore benefitting the patient, in this case patient waiting time (Dieleman & Harnmeijer, 2006:13).

Canadian Health Institute (2012:08) indicates that the information they have on patient wait times is by far better, compared to one which they had in 2006 when

they last compiled their review report. The institute further acknowledges that their wait time performance is poor and thus gives an example of a 2010 comparison which was made alongside other eleven (11) countries where Canada was ranked the lowest in wait times when one needed to consult a doctor or nurse. Surprisingly, community members in Canada reported that their wait times are acceptable even though their country's healthcare system's waiting time performance was rated to be long by international standards. Instead, they raised concerns with wait times for seeing specialists. Canada's standard is that patients should not spend more than four (04) hours waiting for medical assistance but patients reach eight (08) hours waiting.

Countries such as Belgium conducted a study on patient waiting time wherein they constructed and applied different healthcare queueing models. They assessed the impact of service outages to calculate patient flow times. They also looked at interruptions in services and how this slows down patient flow times. For example, aspects such as the entire personnel going on lunch breaks at once were classified as interruptions and therefore a lunch breaks schedule was introduced in order to keep a provision of healthcare services flowing at all times (Creemers & Lambrecht, 2008:02).

The study speaks more on patient flow times as opposed to patient waiting time because they believe that in order for any healthcare system to successfully measure patient waiting time, one ought to focus on how slow or fast patient flow is. In their view, patient time flow reflects how effective and efficient a healthcare system is able to serve a greater number of patients over a small period of time (Creemers & Lambrecht, 2008:02).

Michael, Schaffer, Egan, Little and Prichadt (2013:53) indicated that the Florida Country Health Department's Adult Primary Care Unit utilises a "plan-do-study-act (PDSA)" in order to lower patient waiting time. The PDSA is a framework wherein the healthcare department identifies factors which contribute to long waiting time in both the waiting area and examination room, identify opportunities to improve on such factors and thus implement on such, evaluate the impact of such implementation

through focusing on patient satisfaction with waiting time pre and post implementation. Florida is confident that this system works.

African countries such as Nigeria conducted a cross-sectional descriptive study at the patients' department of the Usmanu Danfodiyo University where they assessed patient waiting times through focusing on the time spent by patients at both the waiting area and consultation room. Of the 384 patients, 31% (118) waited for more than an hour at the waiting area while 96% (211) were satisfied with rendered services. Nigeria argues that in order to measure and improve patient waiting times, a facility must assess the quality of healthcare services through responses provided by patients (Umar, Oche & Umar, 2011:78).

2.4. Cases and Strategies Utilised in South Africa

The South African healthcare system is structured into National, Provincial, District, Municipalities and Community based healthcare facilities. These structural segments are constructed to provide healthcare services to a total of twenty-seven (27) million people for which a greater portion of these are unable to access healthcare services at an acceptable rate. In an attempt to address this, DoH identified and placed five worst performing hospitals under the hospital revitalization plan, namely Umtata General – Eastern Cape, Rob Ferreira – Mpumalanga, Natalspruit – Gauteng, Cecilia Makiwane – Eastern Cape and Mahatma Ghandi Memorial hospital – Kwazulu Natal province. All these hospitals have lengthy queues as a common aspect which patients are subjected to (Adams, 2005:13).

The DoH conducted a National Facility Audit in the year 2011 where the national average score for patient waiting time across all facilities within South Africa was 68 percent. Later on in the year, the Minister of Health in South Africa - Dr Aaron Motswaledi focused on the reduction of time spent by a patient in a facility through focusing on reducing long queues and increasing patient flow. Thus patient waiting time was also included as a priority aspect in the National Core Standards (Health E-News, 2014:02).

Adherent to the National Core Standards, the DoH in the Western Cape Province indicated seven principles which will guide its 2020 strategy; the very first principle

being that healthcare will focus on 'patient centred quality of care'. According to the Western Cape DoH, this will build organizational cohesion, guide staff behaviour towards people/patients, improve patient experiences, strive for further operational efficiencies and improve waiting times (Western Cape Department of Health, 2011:12).

Patient waiting time remains a challenge that the South African healthcare system continues to deal with. For example, an elderly man died on queue at the Daveyton clinic, Gauteng Province in 2011 and this was followed by a protest. The Our Health Citizen journalist Mishack Mahlangu and a Limpopo Citizen journalist Surprise Nemalale were each sent by their news company to capture/monitor time spent by patients queueing for healthcare services (Health E-News, 2014:02). Although patients were of the view that the appropriate hours one spend queueing is five as opposed to four, Mishack queued at the Soshanguve block X clinic, Gauteng Province from 06h45 for services which are only provided at 07h00 but was still on queue at noon. Surprise on the other hand, queued at 07h30 at Thengwe clinic in Vhembe district, Limpopo Province where patients believe that the average waiting time is at least two hours but was still on queue at 14h15 (Health E-News, 2014:02).

A baseline audit on the National Health Care Facilities was conducted by the Health System Institute in 2011 where it focused on the compliance of the six ministerial priorities which included patient waiting time formed part (Health System Trust, 2012:14). Figure 1 below shows the compliance score to the six ministerial priority areas on vital measures per province in the year 2011 while Figure 2 shows the compliance score to the six ministerial priority areas on vital measures in the Limpopo province in 2011:

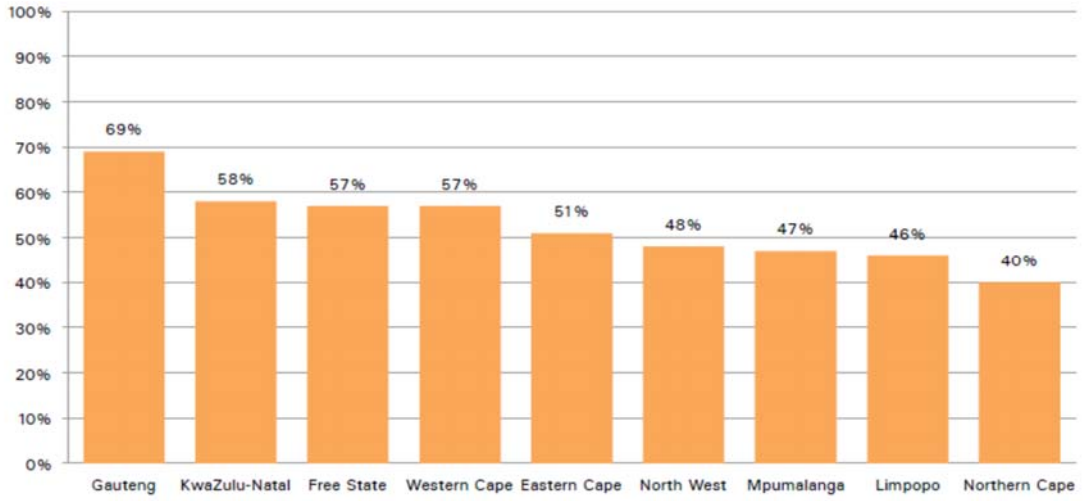

Figure 1: Compliance score to the six ministerial priority areas on vital measures per province, 2011 (Health Systems Trust, 2012:14).

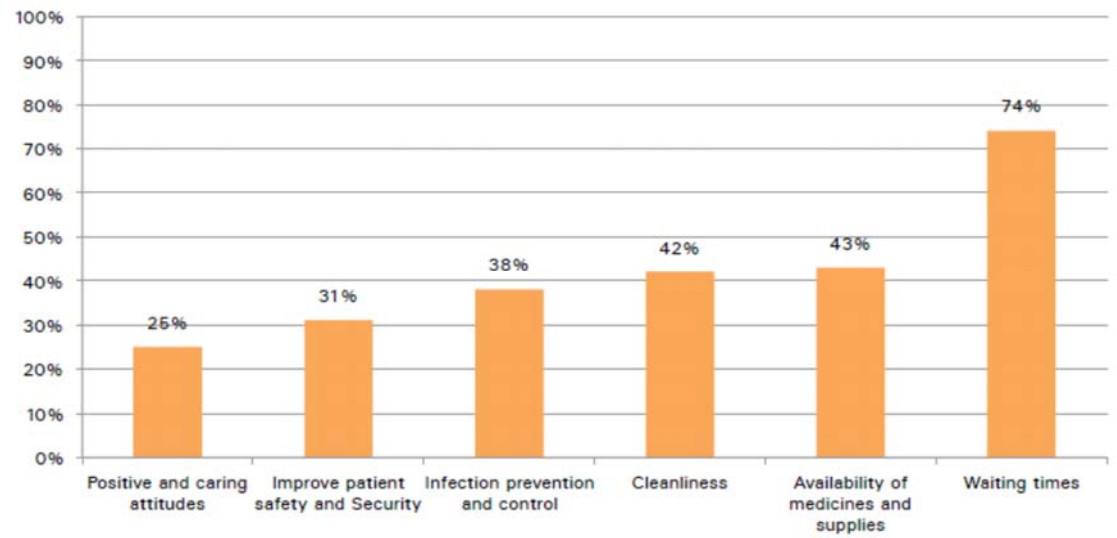

Figure 2: Compliance score to the six ministerial priority areas on vital measures in Limpopo province, 2011 (Health Systems Trust, 2012:14).

Figure 1 depicts that the overall compliance to the six ministerial priorities are led by Gauteng province with a compliance of 69%, followed by a 58% compliance of Kwazulu-Natal, whereas the Free State and Western Cape are both at 57%. The province with the lowest compliance is the Northern Cape with 40% compliance. Figure 2 on the other hand shows that the Limpopo province is at a 74% compliance when it comes to patient waiting time but all other remaining five ministerial priorities

are performing below 44% (Health Systems Trust, 2012:14). One wonders whether the remaining five ministerial priorities are in any way directly or indirectly contributory factors to patient waiting time.

Rauf et al. (2008:43) conducted a study at Tshwane District Hospital Emergency Department after the hospital received continuous complaints of dissatisfaction from patients about prolonged waiting times as and when they visit the hospital for consultations with medical practitioners. The study analysed and improved the situation through using quality improvement cycles that measured the improvement of patient waiting time.

The methodology of the study was that a quality improvement team be chosen to carry out two quality improvement cycles at two different time intervals, namely May to August and September to December 2006. The two cycles each evaluated a total of one hundred and fifty (150) waiting times. Furthermore, two surveys to identify factors which contribute to long waiting times were conducted in May and September respectively (Rauf et al., 2008:43).

Results from both quality improvement cycles as well as those from the two surveys indicated factors which contribute to prolonged waiting time. The quality improvement team then successfully utilised a number of aspects as a way of dealing with such circumstances. They improved on referral system, initiated a reference book and speaker phone which they used to locate/summon patients to the emergency department and relevant consultation rooms, improved on stock ordering and drug availability, reworked or reorganised their working rooster i.e. doctors rescheduled their lunch and break times in order to avoid going to lunch at the same time and thus allowing a provision of medical assistance flowing at all times. The study's conclusion shows that it is possible to improve on waiting time utilising quality improvement cycles in emergence departments without requiring any additional human and/or financial resources (Rauf et al., 2008:43).

Excessive amount of patient waiting time is a disadvantage in that it promotes an unbalanced workload for health professionals, limit the amount of time which a single healthcare professional dedicates to each patient, results in other patients returning

home just to come back to consult the following day or never, increases patient volumes, negatively influences staff and examination room availability, results in staff fatigue and patient dissatisfaction, causes confusion and nervous conditions in the waiting area and so forth (Santibanez et al., 2008:04).

The severity in the inability to address patient waiting time suggests that healthcare facilities provide services to communities at a rate that is not satisfactory, that community members in need of such care are unable to easily and reasonably access healthcare services and pose the possibilities of many patients turning back and/or not consulting government based health facilities at a slightest thought of spending unreasonable amount of time at the waiting area as well as other areas within a facility. This weakens the statistical coverage of patients who receive attention, the number of those who are left satisfied; and most disappointing, it impacts negatively on the state of the healthcare system in South Africa.

2.5. Policy Position in South Africa

The Republic of South Africa has always been a diverse nation both in its racial and class divide as well as in its cultural composition. During the apartheid government, a person's classification influenced to a greater extent the access and standard of healthcare services he or she was privileged to. The norm has always been that a few, white persons in particular, were the ones who could easily access private healthcare facilities and better conditions of healthcare services in comparison to the rest of the racial divide.

Post-apartheid, socio-economic factors such as class and income still influence the inequalities which South Africa as a country continues to face. However, the government has formulated and effected various policies and laws which are aimed at ensuring that all communities, regardless of racial and class divide are able to access quality healthcare services. The government also enacted it as a human right that such access to healthcare is respected, protected, promoted and fulfilled (Section 27, 2010:228).

According to Torjman (2005:03), a policy refers to a law that governs and directs actions towards a betterment of a particular phenomenon in society. The Department

of Health (2011:19) states that even though South Africa does not have a patient waiting time specific policy, the National core standards, has 'reducing delays in care' under its patients' rights domain which emphasizes the effective management of long queues in order to improve patient satisfaction. Some strategies indicated are the ability of a healthcare facility to monitor, evaluate and make improvements where necessary.

South Africa (1997a:24) states that the government must introduce remedial strategies and must apologise when a promised standard of service is not rendered to a patient. South Africa (1997b:13) further specifies that each person has the right to complain and hold the Department of Health accountable when he/she is mistreated in healthcare institutions and when he/she feels that his/her human rights, including easy access to healthcare are infringed upon. This however, does not speak directly to patient waiting times.

Section 27 (2010:231) also emphasises on this right by mentioning that it is a right of an end user to lodge a complaint as and when his/her right to access quality healthcare is demeaned. Patients and community members adhere to such a right and the duty that comes with it through providing feedback to their respective healthcare facilities through suggestion boxes, participating in various platforms such as community health meetings, speaking to healthcare personnel individually and forming part of various healthcare facility based units such as the clinic committee and community home based carers committees.

Based on the above mentioned information, South Africa has patient waiting times as a major factor that is also common amongst its various health facilities, be it clinics or hospitals at district, provincial or national levels, but does not have a patient waiting time specific policy or regulatory paper that seeks to improve such an aspect. However, South Africa only mentions patient waiting time in passing in its various strategic documents.

2.6. Summary

This chapter discussed various studies related to patient waiting time in healthcare facilities. Such a review was done through focusing on how numerous authors

conceptualised patient waiting time, their perspectives on strategies and tactics used in the healthcare systems of other countries, continents as well as globally. This chapter also looked at cases within South Africa which are related to patient waiting time, strategies used by the Department of Health and RSA government as well as its policy position.

CHAPTER 3

METHODOLOGY

3.1 Study Design

Maree and Pietersen (2007:50) define qualitative research as an approach used to collect in-depth descriptive data related to a particular phenomenon or content with the intention and/or purpose of developing an understanding of what is being observed or studied. The study adopted a qualitative approach that assumed an explorative design. The study was explorative because it sought to explore patient waiting time related factors through understanding the perceived views of health personnel in Nthabiseng clinic.

3.2 Study Location

According to Hornby et al. (2006:868), a location refers to a place where something happens or exists and/or the position of something. The study was conducted at Nthabiseng clinic situated in the Molemole municipality within the Capricorn district of the Limpopo province. The Limpopo province has five districts, namely Vhembe, Capricorn, Sekhukhune, Waterberg and Mopani district. Of the five, Capricorn district is the second largest and comprises a total of 109 441 community members who are located across its 09 main areas. The Capricorn district has five sub-districts or municipalities which are Molemole, Lepelle-Nkumpi, Blouberg, Polokwane and Aganang.

Molemole as a municipality has a total of seven clinics and one hospital, namely Nthabiseng, Dendron, Mohodi, Makgato, Matoks and Ramokgopa clinic as well as Bothlokwa hospital. Nthabiseng clinic is a government based healthcare facility which offers services such as preventive and curative healthcare for children, antenatal care, reproductive healthcare, mental healthcare, acute curative adult, ophthalmic eye services, youth friendly services, sexually transmitted infections and sexual violence related services, oral health services, etc. Nthabiseng clinic comprises a total of twelve (12) healthcare personnel as outlined in Table 1. The

twelve (12) healthcare personnel render healthcare services to a total population of approximately 9915. The clinic is based in a rural setting where the majority of its community members are mainly Sepedi speaking. Nthabiseng clinic was chosen as a study location because of the high number of patients waiting time complaints received in comparison to other clinics in the district.

Table 1: Nthabiseng Clinic Healthcare Personnel

#	Designation	Quantity	Category
1	Clinical Nurse Practitioner	03	Senior Management
2	Professional Nurse	04	Middle Management
3	Enrolled Nurse	02	Lower Management
4	Enrolled Nurse Assistant	01	Lower Management
5	Lay Counsellor	01	Subordinate
6	Data Capture	01	Administrative

3.3 Study Population

A population is a study object that consists of individuals, groups, organizations, human products and events or conditions to which they are exposed (Welman, Kruger & Mitchell, 2005). The targeted population of the study was healthcare personnel at Nthabiseng clinic. The criterion of inclusion focused on healthcare professionals who were in management positions and are working at Nthabiseng clinic.

3.4 Sampling Procedure and Methods

Sampling refers to a process of obtaining information or data through selecting a group of objects or subjects or events from which the actual information can be obtained (Mogorosi, 2009:18). Nthabiseng clinic was chosen based on the high number of patients waiting time complaints received in comparison to other clinics in the Capricorn District. The study adopted a non-probability purposive sampling approach. According to Maree (2007:79), purposive sampling is used when participants who most suitably embody the required traits per criteria of inclusion are

known. The total sample size was 05-08 based on the convenience and availability of research participants i.e. Nthabiseng had a total of five healthcare personnel who are in management positions as indicated in Table 1.

3.5 Research Instrument

Research instrument refers to a data collection tool chosen by the researcher to collect data to achieve the research objectives (Marlow & Boone, 2005:36). The researcher utilized a one-on-one semi-structured interview with open-ended questions to gather data. Maree (2007:87) defines an interview as a two-way conversation wherein a researcher asks questions and the participant responds. Maree (2007:87) further defines a semi-structured interview as one in which participants answer predetermined questions. The researcher used an interview guide when conducting a one-on-one semi-structured interviews in order to allow herself an opportunity to probe and also ask emerging questions. The open ended questions focused perception of healthcare personnel on patient waiting time as well as policy positions or lack thereof.

3.6 Pre-test

De Vos, Strydom, Fouche and Delport (2011:237) state that pre-testing is a procedure for testing and validating an instrument by administering it to a small group of participants from the intended population. The researcher pre-tested the instrument for purposes of measuring the possible research duration time and to see whether data collection instrument and methods will work out or not. The pre-test was conducted on 03 healthcare personnel who met the criteria of inclusion but based at Dendron clinic. The pre-test was done at Dendron clinic because it is also a clinic within Molemole municipality that also experiences long queues and slow patient flow.

3.7 Plan for Data Collection

Data were collected by a means of a one-on-one semi-structured interview with healthcare personnel at Nthabiseng clinic. The researcher established and maintained healthy rapport as well as utilizing English as a medium of communication well-understood by both the researcher and participants. Participants were asked predetermined questions which allowed emerging questions and further

probing. A research assistant was employed in order to assist with data collection techniques such as taking field notes, assisting with audio-recording and making observations. Consent to utilize such recordings was obtained from participants.

3.8 Plan for Data Management and Analysis

Babbie (2010:378) refers to data analysis as a process of systematically breaking down data, searching for codes and categories which form research themes. Qualitative data analysis refers to a non-numeric examination and interpretation of data in order to gain understanding of underlying meanings and patterns of a researched phenomenon. The researcher used a thematic data analysis to identify, analyse and report patterns through organizing and describing data by observing the following steps as indicated in Table 2.

Table 2: Phases of Thematic Data Analysis

Phase Name	**Phase Description**
Phase 1: Familiarizing yourself with data	Reading through responses several times to get an overall understanding
Phase 2: Generating initial codes	Categorizing responses/similar items into folders
Phase 3: Searching for themes	Looking out for recurring similar responses
Phase 4: Reviewing themes	Studying through and understanding recurring similar responses
Phase 5: Defining and naming themes	Analysing, interpreting and drawing conclusions
Phase 6: Producing report	Reporting on findings in text, tabular and graph form.

(Braun and Clarke, 2006:16-23)

3.9 Measures for Trustworthiness

Trustworthiness refers to the acid test of a research study's data analysis, findings and conclusions. This means that certain data analysis procedures ought to be kept in mind and effectively implemented. Such procedures include checking the credibility, transferability, dependability and conformability in data analysis (Maree, 2007:115). The researcher, University of Venda's Department of Public Health, research supervisor and co-supervisor as well as the Higher Degrees Committee (HDC) ensured trustworthiness through critically assessing the following:

Credibility: Credibility refers to the ability of the research instrument to produce information that is trustworthy and reliable (Lincoln & Guba, 1985:376). Credibility was ensured through using the most appropriate sampling method to identify and select participants who meet the criteria of inclusion. This includes selecting the most appropriate method for data collection and analysis and thus categorizing relevant themes and discarding irrelevant themes, presenting them to participants in order to verify whether their views are accurately captured and presented. One-on-one interviews using open-ended questions in order to promote thorough engagements which allowed participants to fully contribute towards the research topic. Ensuring credibility was a four weeks long process.

Transferability: Transferability refers to research findings that are able to be generalized to other settings or groups or circumstances (Lincoln & Guba, 1985:376). To ensure transferability, the researcher made it a point that participants met the criteria of inclusion so that descriptive data would be applicable to other settings. This is inclusive of explaining and providing verbatim quotes from focus groups.

Dependability: Dependability refers to the appropriateness of inquiry, decision and methodological changes or the stability of data over a period of time under various circumstances (Lincoln & Guba, 1985:376). To ensure dependability, the researcher ensured that her biases did not influence participants' responses through (i) thoroughly describing data collection and analysis, (ii) explaining research protocol to the research team, (iii) using data collection techniques such as an audio recorder in order to promote reliability of collected data.

Confirmability: Brink (2006:119) states that confirmability is a strategy used to ensure that the findings, conclusions and recommendations are supported by data and that the researcher's interpretation is correlated to actual evidence. To ensure confirmability, the researcher remained objective and maintained neutrality by making sure that findings are a result of participants' views. The researcher also conducted a substantial review of literature in order to compare and/or identify similarities and differences as well as verifying whether research findings were supported by literature. A voice recorder was also used to confirm whether the reported data is a true reflection of data collected.

3.10 Ethical Considerations

Ethical considerations are generally accepted rights of the participant or institution related to research which researchers or social scientists must respect (Bless and Higson-Smith, 1995). The following are ethical considerations which the researcher adhered to:

- **Permission**

A research proposal was presented to the University of Venda's Department of Public Health Research Committee, School of Health Sciences Research Committee. Permission to conduct the study was requested from the University of Venda's Health, Safety and Research Ethics Committee, Higher Degrees Committee for quality assurance purposes and Ethical Clearance, Limpopo's Department of Health, Capricorn District's Department of Health as well as Nthabiseng clinic.

- **Informed Consent**

Informed consent refers to the ability of a researcher to respect the participants enough through allowing them to or not to participate in the study (De Vos et al., 2011:117). Participants were fully informed of the study process, reasons for conducting the study, that participation was voluntary and those who agreed to participate were given consent forms to complete prior to their participation. The Operational Manager (OPM) of Nthabiseng clinic was be asked to give consent to the researcher conducting research at the clinic.

- **Anonymity**

People may feel more at ease to divulge sensitive or private information when they have the assurance that their names will not be attached to the information hence they remain anonymous (Bless & Higson-Smith, 1995:103). In this regard, participants were not requested to provide their names and their occupational titles. They were only requested to indicate whether they were patients or health personnel. Anonymity was ensured by not linking participants' responses to their individual identities.

- **Confidentiality**

According to Burns and Groove (2009:194), confidentiality is an assurance that participants' privacy will not be invaded and that data of research participants as given to the researcher is strictly confidential and will not be divulged to anyone without participants' permission. Participants were assured that the information they shared was confidential, that only the researcher and supervisors would access it. They were also assured that the audio-tapes will be out of unauthorised people's reach.

- **Protection from harm**

Participants should be given the assurance that they will be indemnified against any physical and emotional harm (Welman et al., 2005:201). For purposes of the study, the research topic, its aim, objectives and significance were well-outlined prior to participants partaking in the study. Emotionally sensitive matters and issues were not entertained during the course of data collection; instead, a conducive environment was created and healthy rapport was forged.

3.11 Plan for Dissemination and Implementation of Results

The study findings will be disseminated in the form of a final research report which will detail the findings, interpret such findings in both narrative and tabular form. The report will be distributed and discussed with various stakeholders who were, in one

way or the other, involved in the research, for example, Nthabiseng clinic, the Capricorn District's Department of Health (Quality Assurance Manager as a person who is directly responsible for patient waiting time), Foundation for Professional Development in Capricorn (Technical Advisor), University of Venda (Public Health Department).

Research results will also be disseminated to the general public through published articles in accredited journals, presentations in various conferences, seminars and other related platforms with an aim of fostering further engagements on the subject of research.

3.12 Work Plan

Table 3: Work Plan

Activities	Person Responsible	Time Frame	Deliverables	Status
Proposal presentation at the department seminar	Researcher	26 August 15	Submission of inputs and approval by the department to conduct research	Done
Proposal presentation at the school seminar	Researcher	10 March 16	Submission of inputs and approval by the department to conduct research	Done
Proposal presentation to the Higher Degree Committee	Researcher	March /April 16	Submission of inputs and approval by the committee to conduct research	Done
Proposal review	University of Venda's Ethics Committee	June 16	Written ethical clearance by the University of Venda	Done
Application for Ethical Clearance from Provincial DOH	Researcher	August 16	Written granted permission from DOH Limpopo province	Done
Application to conduct study from District DOH	Researcher	August 16	Written granted permission from DOH Capricorn	Done
Data collection, management and analysis	Researcher	January 17	Available and evident results of the study	Done
Report writing and submission	Researcher	February 17	Complete report as proof of evidence	Done
Final Submission (external examiner)	Researcher	February 17	Making it into May 2017 Graduation roll, MPH degree awarded to me	In Progres s

3.13 Summary

This chapter explained how the study was carried out, the location of the study and how the population was sampled. The chapter also elaborated on the research instrument, the pre-test, how data was collected, managed and analysed. Measures used to ensure trustworthiness, ethical considerations and a plan on how results would be disseminated was also outlined.

CHAPTER 4

DATA PRESENTATION AND ANALYSIS

4.1. Introduction

This chapter presents, interprets, discusses and analyses data collected on the factors influencing patient waiting time at Nthabiseng clinic in the Capricorn district of Limpopo province. Data were collected from five participants through interviews and analysed through Thematic Data Analysis. The purpose for analysing and interpreting data was to answer research questions and achieve research objectives set out in chapter one of the study. This chapter also presents data collected in the form of themes and sub-themes.

4.2. Data Analysis

As previously mentioned in Chapter 3, data analysis refers to a process where data is systematically broken down in search for codes and categories which form research themes (Babbie, 2010:378). Data collected from participants underwent a non-numeric examination and was interpreted in order to gain understanding of underlying meanings and patterns of the researched phenomenon. Audio recordings were repeatedly listened to, whereas transcripts were thoroughly analysed in order to generate initial codes, search, review, define and name themes as per the steps of Thematic Data Analysis as presented in Table 2 in Chapter 3.

4.3. Biographical Information

This section discusses aspects such as the sample description, designation and managerial level of participants. These are participants who met the criteria of sample selection and agreed to participate in the study through signing a participant's consent form.

4.3.1. Sample Description

Data was obtained from five healthcare professionals (nurses) working at Nthabiseng clinic. These healthcare professionals varied in their respective designation and managerial level. The sample assisted in getting different viewpoints

on the factors influencing patient waiting time at Nthabiseng clinic. The sample provides healthcare services to community members and/or patients served by Nthabiseng clinic. Furthermore, the sample is exposed to challenges and factors which contribute to patient waiting time.

4.3.2. Participants' Designation

The five interviewed participants consisted of healthcare professionals who, per their specific academic qualifications, were of varying designation. There were three (3) Clinical Nurse Practitioners (CNP) of which one (1) of them was Acting Operational Manager (OPM). Of the 5, the remaining 2 consisted of a Professional Nurse (PN) as well as an Enrolled Nurse (EN) as indicated in Table 4 below:

Table 4: Participants' Designation

Designation	**# of Participants**	**# in %**
Clinical Nurse Practitioners	3	60%
Professional Nurse	1	20%
Enrolled Nurse	1	20%

4.3.3. Participants' Managerial Level

Participants' designations were equivalent to their managerial level per the hierarchy of Nthabiseng clinic. CNPs who constituted 60% of the participants who participated were in senior management category whereas PNs and ENs who were each a minority of 20% were categorized in middle and lower management respectively, as indicated in Table 5 below:

Table 5: Participants' Managerial Level

Participants' Designation	Participants' Managerial Level	Percentage
Clinical Nurse Practitioners	Senior Management	60%
Professional Nurse	Middle Management	20%
Enrolled Nurse	Lower Management	20%

4.4. Organisation of the Process of Data Analysis

Data were analysed through thematic data analysis. In order to familiarise and gather overall understanding of the collected data, the researcher repeatedly listened to audio recordings and re-read transcripts used during one-on-one interviews. The researcher generated initial codes through categorising responses and/or similar items into folders. Such categorisation allowed the researcher to search for themes or recurring similar responses, study through and understand such themes, define and name themes into various sub-themes through analysing, interpreting and drawing conclusions.

Through applying the seven steps of thematic data analysis, the researcher was able to categorise responses into two main themes which are:

- Theme 1: Contributory factors to long queues and slow patient flow
- Theme 2: Patient waiting time policy position

4.5. Themes and Sub-themes

The identified themes are substantiated further through sub-themes. Sub-themes provide thorough information on factors influencing patient waiting time as collected from healthcare professionals working at Nthabiseng clinic. Table 6 summarises themes and sub-themes derived from participants' responses in this study. Sections written in italics are verbatim quotations used to directly narrate participants' responses. Such responses are substantiated further by literature.

Table 6: Themes and Sub-themes Emerging From Participants' Responses

Themes	**Sub-themes**
Theme 1: Contributory factors to long queues and slow patient flow	Sub-theme 1.1: A lack of a common definition of patient waiting time
	Sub-theme 1.2: Understanding contributing factors
	Sub-theme 1.3: Patients' reactions to waiting time
	Sub-theme 1.4: Challenges encountered when improving waiting time
Theme 2: Patient waiting time policy position	Sub-theme 2.1: RSA's patient waiting time specific policies and/or legislative framework
	Sub-theme 2.2: Clinic's specific developmental plan
	Sub-theme 2.3: DoH's assistance to the clinic

4.5.1. Theme 1: Contributory Factors to Long Queues and Slow Patient Flow

When the researcher conducted one-on-one interviews with participants, the researcher realised that participants provided different perspectives about factors influencing patient waiting time. Resultantly, participants also reacted differently to patient waiting time. This theme is supported by various sub-themes such as a lack of common definition of patient waiting time, understanding contributing factors, patients' reaction to waiting time as well as challenges encountered when improving waiting time.

4.5.1.1. Sub-theme 1.1: A Lack of Common Definition of Patient Waiting Time

Nthabiseng clinic operates from 07h00 to 16h30. The amount of time a patient spends in a clinic influences, to a greater extent, how a patient feels about visiting that particular clinic. Participant 1 and 3 indicated patient waiting time as the total period a patient spends in a clinic upon entering and leaving the premise. They said:

> "P*atient waiting time is calculated from the moment a patient arrives at the main gate's security personnel, to the waiting area, throughout the consulting room and pharmacy until exiting the premises".*

Different to the above response, participant 2 and 5 explained patient waiting time as calculated from the moment a patient gets to the waiting area waiting for the file to be retrieved, through to the consulting room and ends after collecting medication. Their argument was:

> *"One cannot calculate the time a patient spends before getting to the waiting area. If a patient decides to converse with the security personnel for 30 minutes before getting to the waiting area, that 30 minutes cannot be accounted for by the clinic; or if the patient who has already received medication decides to*

wait for their friend who is yet to receive healthcare service, such time cannot be accounted for by the clinic either".

Participant 5 further mentioned that one distributed time flow surveys to patients to record the time they spend in the clinic when they are at the waiting area, not at the gate. Meaning that the time patients spend between the gate and the waiting area is not recorded nor calculated towards the total time spent. The same applies to time spent within the premises of the healthcare facility post medication dispensary.

When asked how they define patient waiting time, participant 4 said the following:

"*Patient waiting time is the time spent by a patient in a clinic's designated waiting area waiting to be seen by clinic; for example, the outpatient department in a hospital, waiting area 1 and 2 in a clinic and time spent in a pharmacy waiting area in the hospital and some clinics which have a separate medication dispensary unit within its facility".*

Participant 4 further argued:

"*The amount of time a patient spends in a consultation room or receiving medication in a separate dispensary unit does not form part of patient* waiting time. *Therefore such times must not be calculated in the total waiting time of a clinic by virtue of the patient being attended to by the clinician and any other staff".*

The above-sited participants' responses indicate that participant 1, 2, 3 and 5 are in agreement that patient waiting time refers to the total amount of time a patient spends in a healthcare facility. Whereas participant 4 defines waiting time as a time spent by patients in a clinic's designated waiting area where clients are actually waiting to be assisted.

All participants also agree that one uses a time flow survey to calculate patient waiting time. However, participants differ in their understanding of the exact point when one ought to begin calculating the period of time a patient spends in a healthcare facility. Consequently, their conflicting views of the exact point when one

ought to start calculating waiting time may imply that what qualifies as long waiting period to one may be an acceptable period to another and may affect how they address waiting time.

A lack of a common definition of patient waiting time among participants working at the same healthcare facility raises questions on what is an acceptable waiting period for patients. Thus this conflicts the *Client Centred Quality of Care principle* found in the *Principles, Values and Vision for the Comprehensive Service Plan 2020* which states that waiting time should be acceptable at all times (Western Cape Department of Health, 2011:11).

Rauf et al, (2008: 02) agrees with participants that waiting time is and should be a measurable variable. However, Rauf et al's (2008: 02) definition of waiting time is similar to that of participant 4; that waiting time is a time from arrival of the patient in the unit (waiting area) until the beginning of the consultation.

4.5.1.2. Sub-theme 1.2: Understanding Contributing Factors

When asked what factors contribute to waiting time, all participants elaborated on how the clinic is often crowded during appointment days. Nthabiseng clinic does not have an in-house doctor specifically allocated to work fulltime in the clinic. Resultantly, patients for Tuberculosis, Antenatal Care (ANC) etc. are allocated Wednesdays since the doctor visits on such a day. Participants said:

> "*When patients come for doctor visits (Wednesday), the clinic experiences long queues and slow patient flow. All these patients are scheduled to be seen by one doctor and often is a hustle to get the line moving quicker*".

The above observation shows that even healthcare professionals are overburdened during appointment days and that the lack of frequent visits or the unavailability of a full time doctor at Nthabiseng clinic results in long queues and slows patient flow. One may argue that burdened healthcare professionals are easily fatigued which results in a decrease in working pace and inability to perform their jobs to the best of their abilities. Muhondwa, et al (2008:69) supports this argument indicating that

fatigued staff often try to service a patient quicker in attempt to cover more patients over a short space of time and that they are most likely to experience job dissatisfaction. On the other hand, Dieleman and Harnmeijer (2006:33) mentions that overburdened staff have a greater likelihood of experiencing fatigue, demotivation and may not necessarily provide patients with a great service.

Participant 1, 3 and 4 indicated being short-staffed as a contributory factor to patient waiting time. Representing the view of other two participants, one participant said:

> "T*here are times when three nurses are on call and more patients in the waiting area. Even though we (nurses) are not necessarily fatigued, it becomes almost impossible to assist all patients in time, hence others end up spending above 3 hours waiting to be assisted*".

This view is supported by Santibanez et al. (2008:04) who indicated that the nurse-to-patient ratio is important in that it identifies how many patients each nurse can sufficiently assist without rushing the consultation. He further indicates that the nurse is able to take his time to critically assess the patient, probe into the patient's medical related situation and prescribe accordingly. This also strengthens the quality of service given to patients.

All participants agreed with the comments below:

> *"Patients who presents at the clinic excessively bleeding or whose health condition require immediate attention are classified as emergencies. Such emergencies as well as female patients due to give birth are given immediate attention and do not have to necessarily follow the mainstream procedure into consultation. Such emergencies and baby deliveries contribute to long patient waiting times"*.

Participants further elaborated that when a pregnant woman is due for delivery, especially in unscheduled dates and/or prematurely, nurses who are in consultation rooms are compelled to redirect their focus to the pregnant woman. This means that

patients in the waiting area ought to patiently wait for the delivery to be completed before nurses can continue helping them. The same applies to other emergencies.

4.5.1.3. Sub-theme 1.3: Patients' Reaction to Waiting Time

When participants were asked about patients' responses towards waiting time, most indicated that they have never encountered a situation wherein patients complain about long queues to healthcare professionals. Neither have they ever heard fellow healthcare professionals giving an indication that a patient confronted them about having to wait for long hours.

Participant 4 said:

> "*Even though patients have not verbally complained to us (nurses) about waiting time, long queues and slow patient flow are mainly evident during appointment days or days scheduled for doctor's visits".*

Participant 2 also stated that during appointment days, patients often bear long queues and are subjected to waiting until the doctor is able to see them. Patients scheduled for the doctor's visits tend to avail themselves at the clinic very early in attempt to be amongst the first to be attended.

The above responses show that patients of Nthabiseng clinic, especially those who are scheduled for doctor's visits are not verbally communicating their satisfaction or dissatisfaction to healthcare professionals. This raises concern because Section 27 (2010:244) states that patients' health service rights include the right to participate in decisions about the health care system. This means that patients are and should be granted and have the responsibility to use the various opportunities and platforms granted to them to raise concerns regarding their clinics and healthcare system.

When the researcher probed further, participant 3 said:

> *"When I sat in a monthly meeting held by Community Home Based Carers (CHBC), the agenda of the meeting also includes discussing and attending to the contents of the suggestion box. Letters of complaints from patients indicated their*

> *dissatisfaction with having to wait long periods of time before getting assistance".*

The participant elaborated further by saying:

> *"CHBCs also shared with the meeting that other patients are reluctant to consult the clinic and would rather stay home than consult because of the amount of time it takes to get medical assistance"*.

The above response imply that patients are either afraid to verbally communicate their dissatisfaction about waiting time to healthcare professionals (nurses) or they just prefer communicating with CHBC and/or find it more convenient to use the suggestion box. However, the few patients who complained through the suggestion box have done so anonymously and also did not provide their contact details.

The realisation that other patients who are in need of medical attention would rather stay at home than consult the clinic negatively impacts the healthcare system. This also means that the Department of Health, through its clinics is unable to reach all patients since patients perceive clinics as inaccessible due to unfriendly hours spent waiting for assistance. Regrettably, this conflicts the *easily accessible, quality and patient-friendly healthcare services* which the Department of Health is striving to achieve.

De Silva (2013:03) states that making sure that people get the care they need quickly is a key component of providing safe and high quality healthcare. Based on aforementioned participants' responses, Nthabiseng clinic's inability to successfully manage its patient flow and queues have, to a certain extent generated a negative reaction from its patients.

4.5.1.4. Sub-theme 1.4: Challenges Encountered When Improving Waiting Time

All participants feel that there are various challenges they encountered when putting in measures aimed at improving patient waiting time. The following verbatim responses were made:

"The turn-around time for solving complaints made through suggestion boxes is 72 hours. Even though the clinic may attempt to instil measures aimed at reducing waiting time and improving patient flow, it is a challenge to conclude whether the patient who complained sees an improvement or not because patients do not leave contactable information in their letters".

"Complaints in the suggestion box made anonymously or without contacts makes it difficult for the clinic to provide direct feedback to the patient".

"If we do not understand the complaint received and the person complained anonymously, we are unable to seek clarity or engage complainants further, get their assistance and views on how to best improve as well as observing how they truly feel before and after the raised complaint is attended to".

Participants also stated the following regarding complaints raised to Community Home Based Carers:

"I personally appreciate that patients who are seen by CHBC during door-to-door visits communicate their concerns to CHBCs. This helps the clinic to be able to improve and relate better with its patients".

"I feel that we still lack a mechanism that is able to prove whether those who complained to CHBCs are linked back into the mainstream of the clinic or not. We know that they complain to CHBCs but what we do not know and are concerned about, is whether they, after communicating, consult the clinic ever again".

The above responses indicate the possibility that patients are still reluctant to consult the clinic because of unbearable queues. Furthermore, the responses raise

questions as to why none of the healthcare professionals have been directly approached by patients complaining about patient waiting time.

The Department of Health (2014:04) states that the ministry has already signed the service level agreements with development partners who will be key in achieving the outcome of the health sector. The Department of Health will assume a leadership role in this process by taking ownership of the strategies, activities on plans and review mechanisms. The Foundation for Professional Development (FPD) is one such development partner.

Participants indicated that Nthabiseng clinic is one of the ideal clinics in the Capricorn district and is supported by FPD as its DoH development partner. FPD sends in a team comprising a medical doctor, professional nurse, community champion, pharmacist, health information coordinator and ideal clinic coordinator to the clinic. Among some of its responsibilities, an ideal clinic coordinator ensures that quality assurance issues, inclusive of patient waiting time, are attended to in a satisfactory manner.

The ideal clinic coordinator assists Nthabiseng clinic through mentoring and assessing whether they appropriately administered a time flow survey in order to calculate the total amount spent by each patient in the facility as well as its patient flow. Participants outlined the process of administering a time flow survey:

> "*Patients are given a time flow survey which they use to note their arrival time, file retrieval time, consultation time and medication collection time. The noted times are used to calculate the total time a patient spent in the facility as well as a breakdown of times spent in specific venues within the facility, i.e. consultation room, waiting area etc. The total times from different patients are then used to calculate the average waiting time for patients within the clinic"*.

Some of the challenges encountered when administering a time flow survey is that it is difficult for patients to complete. This is especially so for those who do not have a watch as they have to constantly rely on asking other clients or healthcare workers

for time. Moreover, patients who can neither read nor write are unable to participate in the study. The time flow survey is usually drafted in English. This is also an impediment for those who are not fluent in the language.

Participants also outlined the following challenges:

> "*Some patients will agree to complete the study but will either leave without submitting their forms, or other spaces are not filled or times are not visibly indicated. This makes it difficult to be able to appropriately track the amount of time spent as well as making evident conclusions based on a vast number of patients. Consequently, calculating the total average may not be based on a fair representation of patients and thus the study will have to be conducted over a stretched period of time".*

All participants indicated that trying to manage long queues and slow patient flow while attending to consultations results in fatigue. Rauf et al. (2008:2) substantiates this by stating that overcrowding of patients creates anxiety and job dissatisfaction amongst healthcare providers. This is a challenge because it often results in clinicians having to deal with many patients in a limited time. This compromises the quality of service rendered.

4.5.2. Theme 2: Patient Waiting Time Policy Position

The Republic of South Africa enacted laws and policies aimed at ensuring that the rights of all people who need to access health care services are well respected, protected, promoted and fulfilled. These laws and policies are specifically aimed at improving quality and access of public health services within the country (Section 27, 2010:241). This theme specifically focuses on policies and/or lack of, used by the Department of Health to guide implementers on how to effectively and sufficiently address patient waiting time within South Africa.

Sub-themes included within this section are categorised into three, namely, RSA's patient waiting time specific policies and/or legislative framework, clinic's specific developmental plan as well as DoH's assistance to the clinic. Contents of these sub-themes will also include research verbatim substantiated further by previous studies.

4.5.2.1. Sub-theme 2.1: RSA's Patient Waiting Time Specific Policies and/or Legislative Framework

The Department of Health (DoH) does not have a patient waiting time specific policy or legislative framework or a guiding document on how healthcare facilities ought to address patient waiting time. When the researcher asked participants if they are aware of any official document that exclusively speaks on patient waiting time owned by DoH, participants responded:

> *"I am unaware of a policy or any other related guideline on patient waiting time. What I know is that the National Core Standard makes mention of the need to improve patient waiting time in clinics".*

> *"The National Health Plan talks more about improving quality and access in healthcare facilities, it does not directly point out to patient waiting time".*

> *"The department does not have a patient waiting time policy. What I am aware of is a time flow survey and that the Ten Point Plan partially alludes to improving waiting time".*

The above responses validate that South Africa does not have a patient waiting time policy and/or legislative framework and/or guiding document which guides implementers on how to successfully improve waiting time. However, the constitution of South Africa, as a superseding document indicates that everyone has the right to access quality health. Furthermore, the government has the responsibility of developing reasonable legislative measures to improve the healthcare system of the country (Department of Health, 2014:15).

WHO (2007:09) states that it is imperative to put in various measures and strategies aimed at improving the healthcare system. For example, a guiding document such as the eHealth strategy refers to the use of information and communication technologies to improve the system. These technologies include Electronic Health

Records (enabling sharing of patient data between points of care), Routine health management information (e.g. web-based surveillance systems, electronic disease registers, electronic district health information systems), mHealth (e.g. use of mobile devices such as cell-phones to share information or to collect aggregate or patient data) etc.

The eHealth strategy makes use of six domains to improve quality healthcare. Relevant to this study, is the domain of timeliness which refers to reducing waiting times and potentially harmful delays for both those who receive and those who give care (WHO, 2007:09).

A quality assurance system and accountability mechanisms are required to improve the quality of care at facility level. It is therefore imperative for a country to enact guiding documents, policies and/or legislative framework that outlines its plans on how to improve its systems. Such official documents are necessary in informing and setting a scope of work and parameters which implementers ought to operate within. The same is applicable to patient waiting time (Dieleman & Harnmeijer, 2006:20).

4.5.2.2. Sub-theme 2.2: Clinic's Specific Developmental Plan

Post conducting the time flow survey, the DoH expects each individual facility to draft its own patient waiting time related developmental plan which adheres to the National Core Standard (NCS). When asked whether they have drafted an NCS adherent developmental plan, participants mentioned the following:

> "*We have never drafted a developmental plan. The only strategy we use to decrease patient waiting time is through trying to assist patients as quick as possible".*

Participant 3 went on to ask:

> *"How does one write the developmental plan, what is its format?"*

The above question indicates that participants will require assistance drafting the plan. The fact that they are asking about its format is an indication that DoH's

expectation for clinics to draft their own developmental plan may not necessarily be feasible. One may question whether participants have the skills and knowledge on how to draft the plan; whether they will find time to perform such a task considering their workload; and whether they will align their plans with the NCS.

This shows that there is a significant need for immediate attention to the creation of a patient waiting time specific policy or framework that shall be used by clinics as an implementation guide. Government, particularly the Department of Health, its relevant stakeholders and partner organisations, need to assess the effects of waiting time in its healthcare facilities and assist in drafting policies, Standard Operating Procedures or frameworks which are waiting time specific.

4.5.2.3. Sub-theme 2.3: DOH's assistance to the Clinic

This sub-theme looks at the role of the Capricorn district DoH in ensuring that Nthabiseng clinic provides quality healthcare services to patients and that it is easily accessible and patient-friendly. South Africa (1997a:24) substantiates this further stating that the government must introduce remedial strategies and apologize when a promised standard of service is not rendered to a patient.

When asked how the Department of Health has assisted Nthabiseng clinic in reducing patient waiting time, participant 3,4 and 5 mentioned that quality assurance personnel from DoH visits the clinic to give feedback on their standard of service. Participants went on to say part of the issues emphasized are waiting time, appropriately conducting a time flow survey and attending to patients' queries and any other forms of complaints.

Participant 2 and 4 commended the Capricorn district DoH's decision to instruct healthcare facilities to allow partner organizations to assist in their clinics. They said:

> *"The assistance we get from partners such as FPD has made a great impact. For example, they trained our CHBC on how to effectively address patients who complain about waiting time and other healthcare related services. They also trained clinic committees on procedures they ought to follow when attending*

> *to complaints received through suggestion boxes and other related services. This makes it easier for us (nurses) to focus on clinical consultations while other healthcare workers assist in improving non-clinician tasks".*

This shows that DoH's decision to collaborate and urge cooperation from the clinics to work with partners, has allowed a variety of ideas to jointly help in strengthening the healthcare system. Evidently, strengthening relations with partner organizations benefits DoH and Nthabiseng as a clinic. For example, ideal clinic coordinators from partner organizations assists in quality assurance, time flow survey, training and mentoring CHBC and clinic committees to effectively attend to waiting time related complaints.

Among others, DoH assists Nthabiseng with improving patient waiting time through partnering with various personnel and partners to conduct an Action Research (AR) study. Participants elaborated:

> *"FPD teams and DoH personnel jointly undertake AR studies aimed at solving issues of concern within a clinic, e.g. late ANC bookings, lack of referral systems, patient waiting time etc. such studies have assisted our clinic in understanding that a lack of a legislative guideline on how to deal with waiting time is a hindrance. Further, such studies do not only explore factors contributing to long queues but also implement intervention measures, monitors progress made and establishes sustainability measures".*

In line with the above response, AR studies have become a tool which DoH uses to identify significant issues within its healthcare system, implement intervention measures and monitor whether such measures are improving their systems or not. Participants cited that it is advantageous for DoH to empower its employees with knowledge and skills on how to utilize AR to improve factors within its system. However, improvement is only evident after a long period of time.

> *"DoH calls us to attend provincial, district and sub-district quarterly reviews where clinics within the Capricorn district are able to share concerns and ideas on how to best improve the standard of service they give to patients"* stated four (4) participants.

The above quote shows that DoH is concerned about the performance of its clinics and has enacted measures aimed at reviewing whether clinics are performing as required. During reviews, clinics share ideas on performance, policy, operational issues as well as waiting time. Unfortunately, none of the reviews have managed to make recommendations to DoH to work on a patient waiting time policy framework.

4.6. Summary

This chapter presented, interpreted and analysed data collected from participants on factors influencing patient waiting times. The chapter gave a sample description as well as biographical data of participants. The analysis of data generated two themes and seven sub-themes which were used to structurally interpret and report the collected data. Such themes and sub-themes were identified from findings as a result of one-on-one interviews which followed an interview guide containing open-ended questions. Participants shared similar views and also differed in some of their perspectives. Open-ended questions made it easier for them to ask clarity whenever necessary. Verbatim sentiments were cited, while previous studies were used to further substantiate participants' views. Chapter 5 is a summary of findings, recommendations and general conclusion.

CHAPTER 5

Summary of Findings, Recommendations and General Conclusion

5.1. Introduction

This chapter presents a summary of findings of the study. It also provides recommendations as well as a conclusion of findings based on factors that influence patient waiting time at Nthabiseng clinic in the Capricorn District of Limpopo Province.

5.2. Overview of the Study

The study explored factors influencing patient waiting time at Nthabiseng clinic in the Capricorn District of Limpopo Province. It aimed at examining factors influencing patient waiting time through focusing on healthcare personnel's views on long queues, slow patient flow and patient waiting time related policy position in South Africa.

The study was conducted at Nthabiseng clinic in the Capricorn district. The study took a qualitative approach and data was collected through one-on-one interviews. Participants were Nthabiseng clinic's healthcare professionals and were selected through the purposive sampling method. The collected data was analysed through the Thematic Data Analysis approach.

The first objective of the study was to describe factors that contribute to long queues and slow patient flow in healthcare facilities as perceived by healthcare personnel. The study found factors such as appointment days (days scheduled for doctor's visits), lack of a common understanding of what patient waiting time is, lack of a patient waiting time specific developmental plan, emergency cases presenting in clinic as being significant.

The second objective was to investigate patient waiting time related policy positions within the South African Department of Health (DoH). The study found that the DoH does not have an existing policy and/or legislative framework, guide or even a

Standard Operation Procedure (SOP) used for patient waiting time in its healthcare facilities. However, the DoH calculates patient waiting time utilizing a time flow survey.

5.3. Discussion of the Study Findings

Based on the analysis of data done in this study, the amount of time a patient spends in a healthcare facility waiting for medical assistance determines to a larger extent, how the patient views the standard of service rendered to him/her. Through the mandate of the National Core Standards (NCS), government must strive towards the provision of quality healthcare, accessible and patient-friendly services. Below is a discussion of study findings relating to the study's focus areas:

Finding 1: Lack of Common Understanding of Patient Waiting Time

Healthcare professionals define patient waiting time in different ways. Others define it as a time a patient spends from the moment they enter the main gate to when they leave. Others define it from when a patient accesses the waiting area throughout to medication collection. This negatively influences patient waiting time because what is an unbearable waiting time is acceptable waiting to another. Furthermore, the same healthcare professionals are supposed to be the ones implementing measures aimed at improving patient waiting time.

Finding 2: Various Factors Contribute to Long Queues and Slow Patient Flow

The study showed that Nthabiseng clinic does not have a patient waiting time specific development plan which means that they do not have a strategy on how they can reduce long queues and improve patient flow.

The study also showed that Wednesdays are days which patients are scheduled for their doctor visits. This means that queues are unbearably longer on Wednesday, the waiting area is populated, patients wait to see the same doctor who likely experiences fatigue as a result of his or her workload.

Emergency cases such as a stabbed patient who is excessively bleeding and a woman who is due for premature delivery and/or miscarriage are attended to upon

arrival at the clinic. This increases waiting time in that patients who were already on the queue ought to wait until emergency cases are concluded.

The study showed that Nthabiseng clinic usually has three healthcare professionals on call. During days where there are many patients, the clinician to patient ratio signifies that the clinic is under staffed and therefore unable to maintain a higher patient flow.

Finding 3: Patients' Reaction to Waiting Time

The study revealed that patients are reluctant to consult the clinic because of unbearably long queues. They also prefer confronting CHBC about their dissatisfaction rather than nurses. Those patients who are frustrated with the system resort to anonymously utilizing suggestion boxes.

Finding 4: Improving Waiting Time and Challenges Encountered

The study discovered that DoH uses a time flow survey to calculate the amount of time a patient spends in a facility from entry to exit point. However, the time flow survey only calculates and records the time. It does not establish contributing factors to long queues and slow patient flow and therefore makes no recommendations for intervention measures.

The study also showed that patients do participate in the time flow survey. However, others do not clearly record the required times while others leave without submitting surveys. This results in inaccuracy when calculating the total time a patient spends in a clinic and in other sections within the clinic as well as the average waiting time for that particular clinic.

Finding 5: DoH's Assistance to the Clinic

The DoH deploys quality assurance officers to Nthabiseng clinic to assess its standard of service as well as evaluating whether time flow surveys are carried out or not. The study also showed that DoH urged its clinics to cooperate with partner organizations. Resultantly, FPD as a partner organization, partnered with Nthabiseng clinic to address patient waiting time through utilizing an AR study.

Finding 6: Patient Waiting Time Policy Position

The DoH does not have a standing policy on patient waiting time but makes mention of improving waiting time on its NCS and its Ten Point Plan.

Finding 7: Clinic's Specific Developmental Plan

The study showed that healthcare personnel are concerned about the format to follow should they resolve on drafting the plan because there is no policy position or a framework which will work as a guide to the plan. They are also not sure of how they will align it to the NCS.

5.4. Recommendations of the study

The findings of the study highlight a need for government, through the Department of Health, to focus on improving patient waiting time in its healthcare facilities. It also shows that patients are subjected to the consequences of unbearably long queues and slow patient flow. In assisting the DoH to intervene and improve patient waiting time, the following recommendations are suggested:

Recommendation 1: Policy formulation

The DoH should conduct a thorough assessment of patient waiting time within its healthcare facilities and formulate a nationwide policy that each healthcare facility could use as a guide. The DoH district departments should refer to the policy to draft an SOP that shall detail how facilities within its district ought to address waiting time, this should be inclusive of related tools. Facilities will use such guidelines to draft their facility-specific developmental plans responding to unique needs of their facilities.

Recommendation 2: Conduct an in-service and district reviews

Post-policy formulation, the DoH ought to in-service its healthcare personnel on what and how to appropriately define and calculate patient waiting time. The in-service should also elaborate on the standing policy positions, SOP and tools to be used as well as reporting procedures.

District reviews should be implemented on a quarterly basis to allow facilities within the district to share experiences, report on progress and challenges to date as well as brainstorming on possible intervention measures.

Recommendation 3: Host community/patient targeted awareness campaigns

Facilities and district departments should host campaigns aimed at making communities and patients aware of steps taken by clinics to improve waiting time. This includes informing communities about the proper use of a suggestion box, the turn-around time for the clinic to respond to complaints received through suggestion boxes as well as possible assistance that the clinic might require from communities in betterment of the standard of its service.

The campaigns must also aim at tracing, retaining and linking those patients who are reluctant to consult the clinic due to fear of bearing long queues. This means that CHBC, clinic committees and other stakeholders should participate in mobilising community members to attend such campaigns.

Recommendation 4: Increase supply of medication

Human Immunodeficiency Virus (HIV) and Tuberculosis (TB) patients who are referred for doctor visits (Wednesday) should be considered for an increased supply of medication. Similarly, HIV patients with two consecutive viral load suppression and are adherent to medication should be given two to three months medication supply. In this case, there would not be a need for them to visit the doctor every fourth Wednesday.

5.5. Conclusion

The NCS and the Ten Point Plan allude to improving the level of service rendered to patients. It makes mention of the need to improve patient waiting time. However, DoH lacks a patient waiting time policy position that gives a directive on how DoH expects its clinics to improve waiting time. The District DoH expect clinics to draft their individual developmental plan that adhere to the NCS.

This study found out that there is a need for the DoH to formulate a policy, in-service healthcare professionals on an approach they ought to take to address waiting time. The study also showed that it is necessary for the Department of Health to improve relations with patients and change how they perceive the healthcare system. The study also made recommendations on steps to take towards improving patient waiting time.

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ANNEXURE A1

REQUEST TO CONDUCT RESEARCH (Limpopo Province)

PO BOX 842
Dzanani
0955
01/08/2016

Department of Health (Limpopo Province)
Research Directorate
18 College Street
Polokwane
0699

Re: REQUEST TO CONDUCT RESEARCH AT NTHABISENG CLINIC

Dear Sir/Madam

This letter serves as an application for your approval and clearance regarding my proposal to conduct research at Nthabiseng clinic in the Capricorn district. This research project is a requirement towards the successful completion of my Masters degree in the Department of Health at the University of Venda. The title of the research project is: "*Factors influencing patient waiting time at Nthabiseng clinic in the Capricorn district of Limpopo province"*. The aim of the research project is to explore factors which influence patient waiting time at Nthabiseng clinic in the Capricorn district of Limpopo province.

The objectives of the research project are:

- To describe factors that contribute to long queues and slow patient flow at healthcare facilities as perceived by health personnel.
- To investigate patient waiting time related policy positions within the South African Department of Health.

Standard ethics of the research will be granted to participants as outlined in the research project proposal herein attached for your consideration. Attached is also an Ethical Clearance Certificate by the University of Venda.

Regards,

……

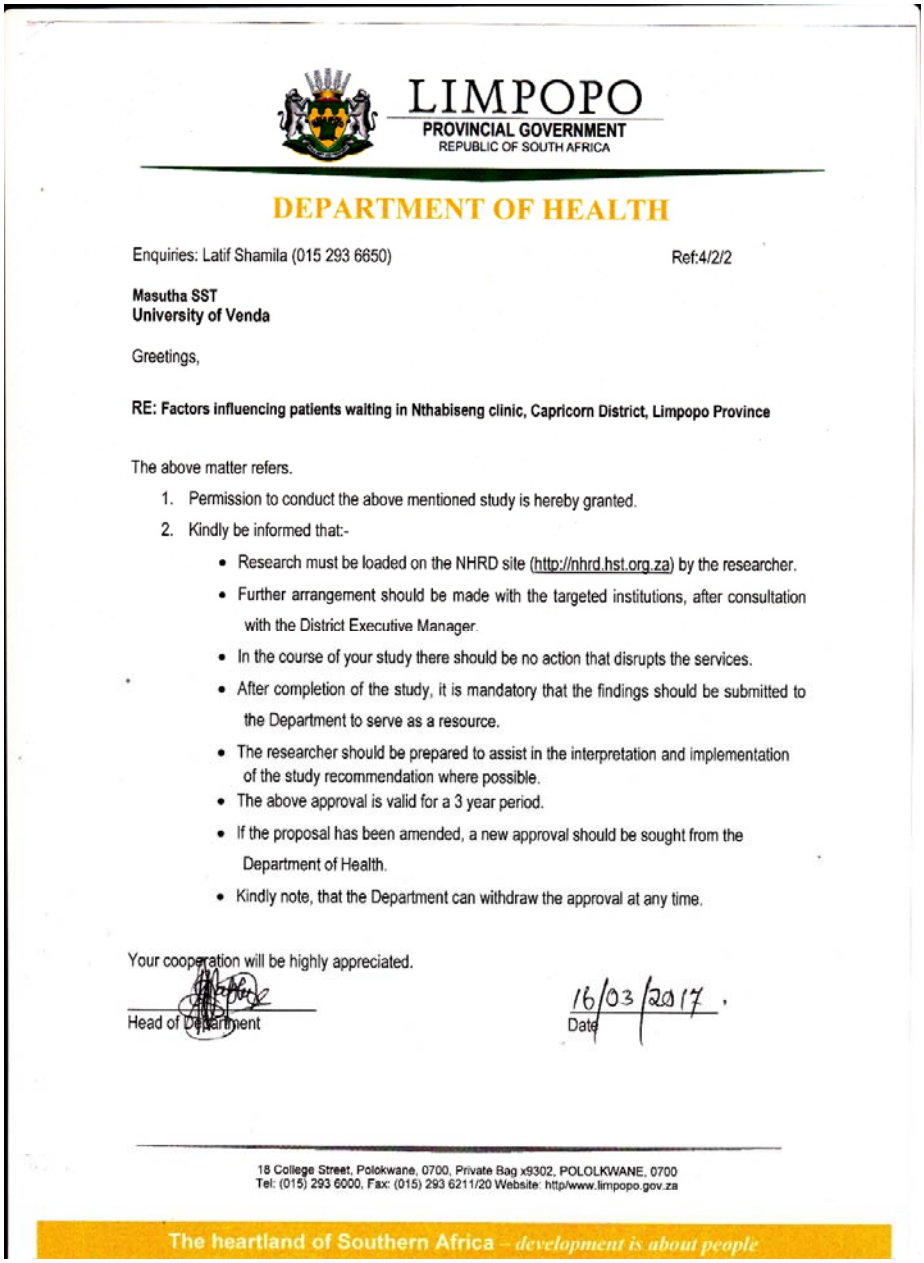
Masutha SST

079 376 1071

shonisst@gmail.com

ANNEXURE A2

PERMISSION TO CONDUCT RESEARCH (PROVINCIAL DOH)



LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Enquiries: Latif Shamila (015 293 6650) Ref:4/2/2

Masutha SST
University of Venda

Greetings,

RE: Factors influencing patients waiting in Nthabiseng clinic, Capricorn District, Limpopo Province

The above matter refers.

1. Permission to conduct the above mentioned study is hereby granted.
2. Kindly be informed that:-
   - Research must be loaded on the NHRD site (http://nhrd.hst.org.za) by the researcher.
   - Further arrangement should be made with the targeted institutions, after consultation with the District Executive Manager.
   - In the course of your study there should be no action that disrupts the services.
   - After completion of the study, it is mandatory that the findings should be submitted to the Department to serve as a resource.
   - The researcher should be prepared to assist in the interpretation and implementation of the study recommendation where possible.
   - The above approval is valid for a 3 year period.
   - If the proposal has been amended, a new approval should be sought from the Department of Health.
   - Kindly note, that the Department can withdraw the approval at any time.

Your cooperation will be highly appreciated.

Head of Department

16/03/2017
Date

18 College Street, Polokwane, 0700, Private Bag x9302, POLOKWANE, 0700
Tel: (015) 293 6000, Fax: (015) 293 6211/20 Website: http/www.limpopo.gov.za

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ANNEXURE A3

ETHICAL CLEARANCE – UNIVERSITY OF VENDA

UNIVERSITY OF VENDA

OFFICE OF THE DEPUTY VICE-CHANCELLOR: ACADEMIC

TO : MR/MS SST MASUTHA

SCHOOL OF HEALTH SCIENCES

FROM: PROF J.E. CRAFFORD

DEPUTY VICE-CHANCELLOR: ACADEMIC

DATE : 30 JUNE 2016

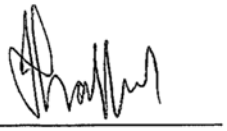
DECISIONS TAKEN BY UHDC OF 14TH JUNE 2016

Application for approval of Master's research proposal in Health Sciences:
SST Masutha (11594964)

Topic: "Factors influencing patient waiting time at Nthabiseng clinic in the Capricorn district of Limpopo province."

Supervisor:	UNIVEN	Dr. L.H Nemathaga
Co-supervisor:	UNIVEN	Dr. A Tugli

UHDC approved Master's proposal



Prof J.E. CRAFFORD

DEPUTY VICE-CHANCELLOR: ACADEMIC

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Ms SST Masutha

Student No:
11594964

PROJECT TITLE: **Factors influencing patient waiting in Nthabiseng clinic in the Capricorn District of Limpopo Province.**

PROJECT NO: SHS/16/PH/26/1811

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Dr L Nemaithaga	University of Venda	Supervisor
Prof A Tugli	University of Venda	Co- Supervisor
Ms SST Masutha	University of Venda	Investigator - Student

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: November 2016
Decision by Ethical Clearance Committee Granted
Signature of Chairperson of the Committee: .....
Name of the Chairperson of the Committee: Prof. G.E. Ekosse

UNIVERSITY OF VENDA
DIRECTOR
RESEARCH AND INNOVATION
2016 -11- 21
Private Bag X5050
Thohoyandou 0950

University of Venda
PRIVATE BAG X5050, THOHOYANDOU, 0950λ LIMPOPO PROVINCEλ SOUTH AFRICA
TELEPHONE (015) 962 8504/8313 FAX (015) 962 9060
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ANNEXURE B1

INFORMATION LETTER

Dear Participant (Healthcare Personnel)

1. Introduction

I am Shandukani Shonisani Tikva Masutha, a Masters student in Public Health at the University of Venda. As a requirement for the completion of my degree, I am conducting a research project for which I am humbly inviting you to participate. This information leaflet will assist you in understanding what the research project is about as well as whether or not you would like to participate. The topic of the research is as follows:

Factors Influencing Patient Waiting Time in Nthabiseng Clinic in the Capricorn District of the Limpopo Province.

2. Aspects Concerning the Research Project

2.1. Aim of the Research Project

To explore factors influencing patient waiting time in Nthabiseng clinic in the Capricorn district of the Limpopo province.

2.2. Data Collection Procedure

The research project will involve a one-on-one semi-structured interview with the researcher. A research assistant will be in attendance in order to assist with data collection. You will be required to answer open-ended questions and ask for clarity whenever necessary. Findings from the interview will be summarized in the form of a research report by the researcher.

2.3. Risks Involved

There are no risks involved in participating in this research project.

2.4. Possible Benefit

You will not directly benefit from the research project. However, your participation will enable the Department of Health in the Capricorn district to implement measures aimed at reducing patient waiting time, thus improving patient flow as well as easy access to healthcare.

2.5. Rights of Participants

Your participation in the study is voluntary. Deciding to discontinue participation with or without giving reasons, will not be used against you and your employment in any way possible.

2.6. Confidentiality

The information you will provide will be treated with confidentiality thus participation will not require you to provide your personal details such as name, identity number, date of birth, contact details, etc. Furthermore, the research project report which will be done by the researcher through analyzing, interpreting and reporting on the data you have provided, will not provide information that may enable any party/person/institution to identify you. Reports and articles in journals and conference presentations will not include information that may point to you.

2.7. Contact Person

The contact person for this research project is Ms Masutha SST. For further enquiries, kindly contact 079 376 1071.

ANNEXURE B2

LETTER OF CONSENT

FACTORS INFLUENCING PATIENT WAITING TIME AT NTHABISENG CLINIC IN THE CAPRICORN DISTRICT OF LIMPOPO PROVINCE.

I …….. confirm that the person requesting my consent to participate in the research project has thoroughly explained the nature and process of the research as well as its risks, possible benefits and my rights as a participant. I have received, read and understood the information leaflet and am aware that the results of the research and its final report will be anonymously processed. I had enough time to ask questions and therefore consent to participation. Furthermore, I understand that I will not be penalized in any way should I choose to discontinue participation. I have received and signed a copy of this informed consent agreement.

Participant's Name……..... (Please Print)
Participant's Signature…… Date…….

Researcher's Name……. (Please Print)
Researcher's Signature……..… Date…….

Witness's Name…… (Please Print)
Witness's Signature…… Date…….

ANNEXURE C1

CONFIRMATION OF LANGUAGE EDITING

Editing and Proofreading Report

22 February 2017

This letter serves to confirm that I, Dr I. Ndlovu of the English Department, University of Venda, have proofread and edited Masters dissertation titled "Factors Infuencing Patient Waiting Time at Nthabiseng Clinic in the Capricorn District of Limpopo Province" by Masutha Shandukani Shonisani Tikva (Student No. 11594964) to be submitted to the Department of Public Health in the School of Health Sciences at the University of Venda.

I carefully read through the dissertation, focusing on proofreading and minor editorial issues. The recommended suggestions are clearly highlighted in red ink.

Yours Sincerely

Dr Isaac Ndlovu, PhD
Lecturer: English Department
University of Venda
Private Bag X5050
Thohoyandou 0950
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Fax: +27 15 962 4749
E-mail: isaac.ndlovu@univen.ac.za

ANNEXURE D1

RESEARCH INSTRUMENT/INTERVIEW GUIDE

Bibliographical Data

Designation	Clinical Nurse Practitioner
	Professional Nurse
	Enrolled Nurse
Managerial Level	Senior Management
	Middle Management
	Lower Management

Objective 1: "To describe factors that contributes to long queues and slow patient flow at healthcare facilities as perceived by health personnel".

- What is your view on patient waiting time?
- What factors contribute to long queues and slow patient flow at your clinic?
- How do patients react to the amount of time they spend waiting to be assisted?
- What measures do you or the clinic implement in improving patient waiting time?
- What challenges do you encounter when implementing such measures?

Objective 2: "To investigate patient waiting time related policy positions within the South African Department of Health".

- Does your clinic have a developmental plan? What policy/legislative document do you use as a guide when formulating your clinic's development plan?
- What challenges did you encounter in formulating the plan?
- What improvements did DoH apply in assisting your clinic to improve the formulation of the development plan?