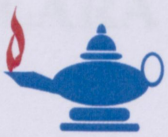
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FACTORS AFFECTING QUALITY NURSING DOCUMENTATION OF PATIENT INFORMATION AT SELECTED PRIMARY HEALTH CARE FACILITIES IN VHEMBE DISTRICT, LIMPOPO PROVINCE

by

Rhulani Caroline Shihundla

Student Number: 9624007

Dissertation Submitted in Fulfillment of the Requirements for the Degree:

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Department of Advanced Nursing Science

School of Health Sciences

University of Venda

Supervisor

Prof M.S.Maputle

Co-Supervisor

Prof. R.T.Lebese

30 April 2015

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DECLARATION

I, **Rhulani Caroline Shihundla**, declare that the dissertation "**Factors Affecting Quality Nursing Documentation of Patient Information at Selected Primary Health Care Facilities in Vhembe District, Limpopo Province**" hereby submitted by me for the degree—**MCur**—is my own work, that all sources that I have used or cited herein have been indicated and acknowledged by means of complete references, and that this work has not been previously tendered by me for any degree at this or any other institution.

R.C.Shihundla : .....

Date Signed : 30/04/2015

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DEDICATION

I wish to convey this special dedication to my family who supported me throughout my study. Special thanks to my husband for all the emphasis, support, love and advice he gave. I also wish to pay my heartfelt thanks to my children for their assistance and encouragement, especially my last born daughter, Khanyisa Jade Nemandalale. I also dedicate this work to my late father (German West) Mahatlane Petrus John Shihundla.

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I thank Almighty God, for giving me life free of charge and super protection day and night, and the strength to pursue this study.

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- My fellow colleagues in the Department of Health, for giving me the information which I needed concerning my research topic.
- The University of Venda, for giving me opportunity to acquire valuable skills and knowledge.
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- All my colleagues, especially professional nurses at PHC facilities, who encouraged me to go for it.
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ABSTRACT

Nursing documentation arises from actual happenings or events where a true picture of an incident that has happened is recorded. However, for nursing documentation to serve their provision of reliable evidence, patient information must be complete, accurate, legible and comprehensive. This study explored and described factors affecting quality nursing documentation of patient information at selected Primary Health Care (PHC) facilities in Vhembe District, Limpopo Province.

The study sought to achieve the following objectives: explore factors affecting quality nursing documentation of patient information on Antiretroviral Therapy (ART) files, forms, and registers; describe factors affecting quality nursing documentation of patient information on ART files, forms, and registers. The research design in this study was qualitative, explorative, descriptive and contextual in nature. The study population consisted of professional nurses working at PHC facilities in Vhembe District, Limpopo Province.

Non-probability purposive sampling was used to select PHC facilities and professional nurses. The objectives of the study were met during data collection which was conducted through the use of individual face-to-face, in-depth interviews. Permission to conduct study was obtained from relevant stakeholders. The ethical considerations adhered to were confidentiality maintained and informed consent obtained from participants. Trustworthiness was ensured throughout by employing the principles of credibility, dependability, conformability and transferability.

Data collection was done up to 10 participants as no new information was forthcoming from professional nurses. Professional nurses were 3 males and 7 females. Their ages ranged from 24 to 49 years. Tesch's open-coding methodology was used to analyze data. Data from participants were collated into themes and sub-themes. The following themes emerged from raw data: increased professional nurses' workload, knowledge deficit, lack of resources and unavailability, illegible and incomplete documents.

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It is recommended that health care executives develop responsible actions for delivering quality patient care through working towards ensuring good supply of professional nurses to PHC facilities, by recruiting, attracting and thriving to retain required staff to deal with issues of professional nurses' workload. Professional nurses should undergo sufficient (comprehensive) short course training in relation to quality nursing documentation of patient information. It is recommended that quality nursing documentation of patient information be fully presented and emphasized in the nursing workshops. It was proposed that each individual professional nurse should receive full support and mentoring after workshop training at his/her respective facility by programme supervisors and managers. Each patient's document at PHC facilities must be assessed with a tool designed for that programme.

Research should be conducted in other districts in Limpopo Province in order to compare the findings. The study suggested that dates for ordering and delivery of stationery should be drafted, agreed upon and adhered to between supervisors and facilities' staff members. Facilities' infrastructures should be modified and maintained continuously. The study also suggested that policy in relation to PHC facilities' documents must include control measures to be followed if documents are not well created and updated by individual professional nurses.

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KEYWORDS

- Factors affecting quality nursing documentation
- Patient information
- Primary health care
- Professional nurse

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ACRONYMS

ART	Antiretroviral Therapy
BANC	Basic Antenatal Care
CCMDD	Central Chronic Medicines Dispensing and Distribution
CHC	Community Health Centres
DHIS	District Health Information System
DHMIS	District Management Information System
DoH	Department of Health
EMS	Emergency Medical Services
HCT	HIV/AIDS counselling and testing
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
MDG	Millennium Development Goals
NCSS	National Council of Social Services
NDoH	National Department of Health
NIMART	Nurse-Initiated Management of Antiretroviral Therapy
PHC	Primary Health Care
PMS	Performance Management System
PMTCT	Prevention of Mother-to-Child Transmission
SANC	South African Nursing Council
STI	Sexually Transmitted Infection(s)
SOP	Standard Operating Procedure(s)
WHO	World Health Organization
TB	Tuberculosis

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 Introduction

Quality nursing documentation is complete, accurate, legible and readable patient information kept in health care facilities needed for control purposes, provide evidence and serve as an important communication tool among health professionals. Quality nursing documentation is always a fundamentally important part of a professional nurse's role in health care. That is because of the importance of communication in ensuring consistent patient care (Meyer, Naude, Shangase & van Niekerk, 2011:33).

Properly completed, accurate and readable records are the only sources of patient information that clearly indicate quality patient care rendered in health care facilities. Quality nursing documentation is required and created, received, maintained and used by organizations, public or private sectors or individuals to pursue legal obligation of which it forms or provides evidence (Records Management Policy, 2006:07). Nursing documentation arise from actual happenings where a true picture of an event that happened is written.

In order for created patient information to serve their provision of reliable evidence, quality nursing documentation has to be practiced through completeness, accuracy and comprehensive by professional nurses. At PHC facilities, there are two types of records; namely, physical (paper-based) and computerized. A report on these elements indicated that patient information found on the electronic system, amongst others, was only for one programme—patients on Antiretroviral Therapy (ART)(Records Management Policy, 2006:09).

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In this study, quality nursing documentation of patient information meant physical documented information on the ART programme. Patient's physical records that were used in different programmes available at PHC facilities, were registers, books and forms for the following programmes like Tuberculosis (TB), Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) counseling and testing, Sexually Transmitted Infections (STI), ART, reproductive health, antenatal care, maternal and newborn, child health, chronic diseases, geriatric services, mental health care, Emergency Medical Services (EMS), outreach programmes and tick registers for minor ailments.

When nursing documentation is complete and accurate, they also yield accurate data for the health care facilities, which determine the future plan of those facilities. It enables proper future planning for the facilities by higher authorities. Availability of quality nursing documentation makes it possible for the integration of services, provision of material resources and maintenance of infrastructure, as health facilities records are important part of the practice (Rigby, Roberts, Williams, Clark, Savill, Lervy & Mooney, 1998:579).

Lugte and Mbatha (2007:02) explained that the Government did not have the vehicle for the collection, storage and utilization of data relating to PHC infrastructure for the country. Without such data, future planning for the provision of PHC services at facilities was unlikely to be practical or effective. The vehicles for collecting the required information were all professional nurses employed by the DoH (South African National Health Act, 2003:50).

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1.2 Background and Rationale of the Study

The background of a study was the relevant informal information about the nature of the problem (Akinsola, 2005:47). Quality nursing documentation are tools used by the DoH to measure facilities' performance, public needs and as a way of communication among health professionals.

According to the Australian Governments Department of Human Services, Medical Care Item (701-707:2 of 3), nursing documentation was required by professional nurses to use as a guide on assessment of patients' health status and well-being. It was further indicated that nursing documentation allowed professional nurses to consider prevention of new diseases among patients, and to give health education to promote health. It is the essential duty of every professional nurse to complete patient records immediately after providing the service or after the incident had happened.

Failure to document patient information led to omissions of important facts (DoH and Social Development Record Management Policy, 2006:07). In case omissions of information to be recorded on the patient's file, where any harm could occur to the patient, the patient's relatives or next of kin might lay charges against the professional nurses or DoH. On the other hand, professional nurses may be charged for misconduct by the South African Nursing Council (SANC).

According to South African National Health Act (2003:50), professional nurses were held responsible for their acts and omissions in relation to records. Patient information was created and kept safe by professional nurses every time when treating patients and while performing their daily activities in the workplace. That was the reason why quality nursing documentation was called a collective responsibility by DoH and Social Development Record Management Policy (2006:06).

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Abbreviations are not allowed on patients information records, except those approved by SANC. SANC is the only body to approve abbreviations used in the nursing profession. Patient records should be updated by the professional nurses at all times to ensure that they are complete, accurate and readable. On behalf of the DoH, nursing documentation was called public records and remained the DoH's property (South African National Health Act, 2003:50).

According to Muller (2011:41), the public is becoming more aware of human rights, including the patient's rights charter. Therefore, professional nurses have to be able to provide proof of every duty they perform through quality nursing documentation of nursing care provided to patients. In the National Patient's Right Charter (2002:03), a patient has the right to complain about health care services received; this must be done in writing. Written complaints unlike verbal ones are easy to investigate and the progress followed; hence, investigation procedures are done in writing.

Every person had the right to request for referral for a second opinion by other health professionals. This referral system is done following the referral system of the facility kept in the records. When a professional nurse refers a patient, written information should be issued to enable the one receiving the patient to understand the history of the patient (National Patient's Right Charter, 2002:03). That implies that quality nursing documentation is a means of communication amongst professionals and a requirement in rendering quality patients care.

Record keeping research was done in two referral hospitals in the North West Frontier Province and Punjab in Pakistan (Mary, 2009:15). Their indicators were maternal morbidity and mortality. Their study focused on United Nations Emergency Obstetric Care Units. The study found nursing documentation in all facilities in the two Provinces was undesirable. Recorded patients information was inadequate, incomplete, inaccurate and illegible. In one of

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those facilities, there were no records at all. Some records were marked in duplicate, which might be a problem that contributed to inadequate recording. Health policies and planning in any country emphasize the issue of correct, complete legible patient information. There was shortage of specially designed forms for collection of information which might be due to administration of their Government (Mary, 2009:15).

In those two Provinces such guidelines and policies were available, but not properly followed. Even in the Vhembe District, guidelines to be followed during nursing documentation and management of patient information were available. There are guidelines like South African National Health Act (2003:50), DoH and Social Development Record Management Policy (2006:06), District Management Information System (DHMIS) Policy issued in 2011 and the (DHMIS) Standard Operating Procedure (SOP) issued in November 2012, which elaborated how documents are to be completed and responsibility of individual employee indicated.

When a professional nurse was found to have failed to record interventions and observations done, she/he could be charged with negligence. That was due to inadequate, absence or missing information on the record source (Mary, 2009:15). Mann and Williams (2003:329) indicated that there were many mistakes on hospital documents in England and Wales. Mistakes were the following: documented patient information was invisible and incomplete and unavailability of documents was experienced (Mann and Williams, 2003:329).

In South Africa, similar studies were done in urban areas, in hospitals. However, Olivier and Kyriacos (2011:01) conducted a study in Cape Town titled, "Record keeping: Self-reporting attitudes, knowledge practice, behaviors of nurses in Cape Town Public and Private Hospitals." In their study, different categories of nurses, namely, registered nurses, enrolled nurses and enrolled nursing auxiliaries were interviewed. The results of the study indicated that registered nurses had the relevant knowledge pertaining to different records in their work

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areas. Enrolled nurses and enrolled nursing auxiliaries had the deficiencies of required knowledge towards records in their workplaces.

Those deficiencies might have implications for nurses and their employer (DoH), as nurses exhibited serious problems on attitude, bad practice behavior and knowledge deficit on quality nursing documentation. Bad practice behavior, attitude and poor record keeping were due to interruption during nursing documentation of patient information. Professional nurses exhibited lack of confidence when creating documents, leading to incomplete record keeping in the hospitals (Olivier & Kyriacos, 2011:01).

Inadequate recording of information might lead to litigations which could possibly be a cost to the employer and employee. Pellagrino (2000:148) indicated that litigations were charges that an employee or the institution, public or private, could face if the records created indicated malpractice against a patient. Patient information might be needed to answer queries from stakeholders, including family, funders, donors or courts. Important evidence can be provided if malpractice claims or office inquiries arose concerning care given to patients (Borglund & Oberg, 2008:06). Patients might experience medico-legal problems, mismanagement and complications (Olivier & Kyriacos, 2011:01).

In Vhembe District, Limpopo Province, a research study on nursing documentation was done by Rampfumedzi (2006:08) titled "Quality control of obstetric nursing records in selected Regional Hospital." The study focused on auditing obstetric nursing records. However, no participants were included. The findings of the study showed that the patient records were partially complete. Rampfumedzi (2006:08) further indicated that some aspects on the patients' documents were not recorded at all, even though space to record information was provided.

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In all the nursing documentations that were screened, no single record was found to be completely filled in. In most cases, recording was done for less than eighty percent (Rampfumedzi, 2006:08). Whereas, according to the DoH and Social Development Record Management Policy (2006:06), all employees should be aware of the record keeping requirements, as it affected performance of their duties and that of the DoH. Rampfumedzi (2006:07) explained that professional nurses are required legally to record clear and accurate information of the progress of pregnancy, labour, puerperium including all duties done for the newborn and the mother.

Rampfumedzi (2006:01) added that quality record keeping included documenting all information, writing reports and statistics as are fundamental to delivering health services and to quality care at health facilities. Thus, professional nurses have an obligation to create records and register information in a record keeping system, transfer records to appropriate record keeping systems and made sure that records are not destroyed without authorization. Rampfumedzi (2006:37) further indicated that her study cannot be generalized as it was done in only one Regional Hospital in Vhembe District.

SANC Regulation No.169 (2013) states that health professionals have to be competent in order to protect the health status and well-being of patients through keeping accurate, complete records about patient care and observations done every time. Pellagrino (2000:147) indicated that records were kept in facilities for up to six years and twenty five years depending on the type of records. Maternal records were kept for twenty five years. Such records were destroyed by the Director General concerned. Destroying evidence by anyone else, might serve as evidence in a court of law, as no health professional was authorized to do so (Pellagrino, 2000:147).

The rationale of a study, as defined by Allen and Delahaunty (2006:507), means a fundamental reason of the study. Babbie and Mouton (2009:103) further defined the rationale

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of a study as the way the researcher explains the reasons for selecting the topic under study. In this study, the researcher, as one of the professional nurses working at PHC facilities, noticed several times that quality nursing documentation of patient information on relevant forms and books was often incomplete. Some of the information on these forms and books was illegible and incomplete. Therefore, the fundamental reason for this study was to explore and describe factors affecting quality nursing documentation of patient information at PHC facilities in Vhembe District, Limpopo Province.

The researcher wanted to make professional nurses aware of the implications on incomplete, incorrect and illegible documents on patient care at PHC facilities in Vhembe District, Limpopo Province. All records at PHC facilities had to be complete and legible to enable good communication, clear rapport amongst professional nurses and the smooth-running of health care facilities. Therefore, relevant patient information had to be documented accordingly on the provided forms and books (DoH and Social Development Record Management Policy, 2006:13).

Good record keeping is the cornerstone of all efficient, transparent and accountable administration in the public health setting, according to DoH and Social Development Records Management Policy (2006:03). Research studies on quality record keeping were done in different settings, more especially in public hospitals. Around the world, research studies on quality nursing documentation were also done in public hospitals (Mann and Williams, 2003:329)

In South Africa, such studies were carried out in urban areas, in public hospitals. However, no such studies had been done in Vhembe District, Limpopo Province in a rural setting pertaining to quality nursing documentation. However, the researcher recommended that further research studies on quality nursing documentation be done in the rural areas at PHC facilities in Vhembe District, Limpopo Province.

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1.3 Problem Statement

According to Brink (2012:61) and Creswell (2009:38), a problem statement is a concise description of how big and dangerous the problem to be investigated is for the beneficiaries, and solutions needed to solve that problem. Most of the PHC facilities located in the rural areas of Vhembe District render comprehensive, integrated PHC services seven days a week. That meant all special forms and books designed by DoH and other support services for collection of information were available.

The researcher, as one of professional nurses working at a PHC facility in Vhembe District, Limpopo Province, noticed that quality nursing documentation of patient information of the ART programme is often inconsistent. The problem was further pointed out during a Provincial Record Audit from 18 to 22 February 2013. During this audit, PHC facilities, Community Health Centre's (CHC) and the hospitals' patient information on ART programme were audited. Other programmes linked to the ART programme (like TB) were also checked to assess the flow of patient information and integration of services.

In the entire facilities audit, results were fatally undesirable. That was because patient information was disorganized, incomplete and illegible. It was difficult to retrieve patient records indicating unavailability of patient information. Furthermore, it was found that some of the patients' forms did not tally according to what was expected. In addition, figures on the Input Forms, on District Health Information System (DHIS) forms and on facilities, where patient information was extracted, were different (Provincial Record Audit at selected facilities in Vhembe District, 2013).

In some institutions those registers and input forms were not available, meaning that the required data were never collected or documented at facilities or reported to the Provincial Office. In other words, professional nurses in those facilities failed to create and provide patient information, which was one of their obligations according to the Nursing Act (Act 33 of 2005).

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National Health Act (2003:50). The Vhembe District plans might be irrelevant to what was needed by such facilities due to under-reporting of information.

The Vhembe District, Provincial and National Offices did not have reliable and real data of what was happening in Vhembe District due to under-reporting. The end result of those actions was poor health care services and compromised patients' care. Furthermore, during the data review meeting on 18-19 August 2013 in Polokwane, the Prevention of Mother-to-Child Transmission (PMTCT) Deputy Manager indicated that ART programme statistics exceeding 100% were from the Mutale Sub-District where Mutale Local Area is located.

Again, even during maternal outreach programme which was attended monthly at a community hospitals, Donald Fraser, and quarterly at the District hospital; namely, Tshilidzini where maternal and newborn health services were reviewed. The documents that were frequently reviewed were the antenatal cards or maternity case records. The issue of incomplete, inaccurate and illegible recording of information had been of great concern. Those always led to mismanagement of patients, complications and death of mothers and newborn babies, as reported by the District hospital.

The researcher was motivated to research about the aforementioned issue to alert professional nurses that justice was not done for patients. Professional nurses had to go back to basics, think more about the recording of patient information. Availability of quality nursing documentation at health facilities is evidence that professional nurses are skilled and patients' safe. The Vhembe District designed special evaluation tools used on a monthly basis, during support visit done by Assistant Managers at PHC facilities. However, those tools did not cater for all available records at facilities. That led other records to be neglected by professional nurses, especially the ART programme.

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1.4 Purpose of the Study

The purpose statement contains information about the central phenomenon explored in the study. It also directs the emerging design and uses research words drawn from the language of qualitative research (Creswell, 2009:112). The purpose of this study was to explore and describe factors affecting quality nursing documentation at selected PHC facilities in Vhembe District, Limpopo Province.

1.5 Research Objectives

A research objective is a clear, simple and declarative statement and it use an action verb in the present tense (Brink, 2012:55).

The objectives of this study were to:

1. Explore factors affecting quality nursing documentation of patient information on ART files, forms, and registers.

2. Describe factors affecting quality nursing documentation of patient information on ART files, forms, and registers.

1.6 Research Question

According to Brink (2012:55) a research question is an interrogative statement which focuses on the topic understudy in a question form and worded in the present tense, including one or more variables. A research question is a broad overall question to which the researcher seeks answers (Creswell, 2009:227). The research question that guided this study was:

> ***"What are the factors affecting quality nursing documentation of patient information at PHC facilities in Vhembe District, Limpopo Province?"***

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1.7 Significance of the Study

The study significance is associated with a study's importance to the body of knowledge for the people or different stakeholders (Creswell, 2009:234). According to de Vos, Strydom, Fouche` and Delport (2011:107), the significance of a study is the important contributions the study would make after it had been completed—in this study, to the DoH, PHC facilities, participants (professional nurses), policy makers, researchers, community members and students.

From the findings of the study, the DoH, managers and the professional nurses might be aware of factors affecting quality nursing documentation at PHC facilities. Recommendations might be used by the DoH to improve ways of collecting and recording accurate information at PHC facilities. That might enable the Vhembe District to plan properly for its facilities in terms of its budget.

Following clear understanding about quality nursing documentation by professional nurses, the facilities might reflect the true image of typical PHC facilities with complete, accurate statistics and legible records which met the required standards of the DoH. Even facilities' staff establishment may be increased and relevant resources needed to improve continuous quality patient care can be supplied to the facilities by the DoH.

Recommendations of the study might influence participants (professional nurses) to change their attitudes towards quality nursing documentation, understand the reasons for keeping accurate documents and gain knowledge to implement patients' care following the South African National Health Act (2003:50).

The results of the study might be used by Policy-makers to improve policy guidelines, specifically on quality nursing documentation. The DoH might also provide health facilities

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with relevant policy documents about quality nursing documentation and reasons for keeping accurate patient information.

Different researchers might use the recommendations for further research to improve and lift the standards of the nursing profession. The literature from this study could also be used in different projects as reference material. Researchers might also gain knowledge on how to bring about quality nursing documentation of patient records at PHC facilities.

To the programmes, when records were updated, accurate and complete all the time, there would be a high standard of patient care. Also, community members might receive improved quality patient care with enough resources. When facility staff establishment was increased, workload would be reduced in the health care facilities, resulting in reduced patient waiting time and long queues, leading to improved patient satisfaction (National Core Standards for Health Establishments in South Africa, 2011:06). Moreover, the mission of the DoH, was committed to provide the best quality patient care, focusing on promoting the well-being of all people and rendering good quality services in Limpopo Province (National Core Standards for Health Establishments in South Africa, 2011:02).

Students could access the literature during training in research studies. They might complete their curriculum with relevant knowledge about quality nursing documentation. Lastly, they might gain some knowledge on how to manage and up-date patient information in health care facilities.

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1.8 Paradigm Framework

Paradigms can be defined as a shared set of rules on how a discipline functions, including what counts to be knowledge, how it could be generated and by whom it could be generated (Machet & Maepa, 2004:42).

1.8.1 Meta-Theoretical Assumptions

These are the researcher's beliefs about the topic understudy. The researcher believed that patient information had to be written completely, correctly and legibly as it is a communication tool among health professionals. Accurate patient information is needed for the continuity of patient care as it informs the next professional nurses about the previous care rendered to a particular person in a health care facility.

The researcher also believed that accurate, readable and complete nursing documentation were means of improving the quality of nursing care. They also reported to the DoH about facility performance, assisted on issues of maintenance and resources. The researcher assumed that professional nurses did not understand the importance of quality nursing documentation of patient information because no strong measures were taken against them when information is not well-documented in the workplace.

1.8.2 Theoretical Framework

Henning, van Ransburg and Smit (2004:25) indicated that a theoretical framework positions the research study in the subject in which one is working. It helps the researcher to show clearly assumptions about the interconnectedness of the way things are related in the world. The theory to support this study is a Modern Paradigm for improving health care quality, as quality nursing documentation of patient information at health facilities is the evidence quality patient care. A research paradigm is a broad view or perspective, the standards or principles that guide the researcher's actions and beliefs (Taylor, Kermode & Roberts,

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2007:258). The researcher has chosen a modern paradigm to support the study because it focused on quality assurance and improvement in health care quality (Massoud, Askov, Reinke, Franco, Bornstein, Knebel, & MacAulay, 2001:03). Massoud et al., (2001:03), defined quality assurance as all acts and duties needed to be done to improve health care.

In this study, factors affecting quality nursing documentation at PHC facilities in Vhembe District were the relevant actions to be taken into consideration by professional nurses to bring about quality recorded patient information. The philosophy behind quality assurance recognized both the resources (input) and activities carried out (process). These must be addressed together to ensure quality care (outcome). In this study, professional nurses were expected to do their work activities in their facilities, utilizing the available resources to bring about quality care.

They were expected to record all information on the cards, to document all events that happened in facilities. However, in this modern paradigm, activities contain two major components—what was done (content) and how it was done (process of care). To improve quality nursing documentation at PHC facilities, the paradigm outlines that these two major components need to be addressed simultaneously (Massoud et al., 2001:04).

Professional nurses in this study, were required to organize their thoughts and actions to record the correct and relevant information on documents. Information must be recorded immediately after the occurrence of an event (content). Late documentations led to omission of important facts of the event. Early recording can improve records as the first recorded information had laid a greater foundation of what was done and what was to be followed in future to improve patient care (Pullen & Loudon, 2006:280).

The paradigm emphasizes the importance of looking at the content of care, review and updates of the clinical patient's records. In this study, factors affecting quality nursing

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documentation of patient information at PHC facilities, professional nurses' work was following recorded information on patient documents that remained in facilities or carried by patients were investigated. It was the nurses' duty to review the patient's previous records to follow proper direction and orders in rendering care, which was continuity of care. That showed good communication amongst professional nurses during provision and improvement of quality patient care. In relation to the modern paradigm for improving quality health care that was referred to as evidence-based medicine (Massoud et al., 2001:05).

There are different quality improvement approaches in this paradigm, of which the researcher selected the systemic team problem-solving approach. The present researcher's reason for selecting that approach was that it was often used for complex or recurring problems that require detailed analysis. Also, inadequate record keeping at PHC facilities was a persistent problem observed by the researcher, in facilities, during data reviews and in meetings.

The paradigm clearly supported the study as there should be data collection, to identify the factors affecting quality nursing documentation of patient information. This research study included data collection and required time and resources to function effectively (Massoud et al., 2001:05). The systemic team problem-solving approach was chosen to support this study because professional nurses in their PHC facilities work as team.

Even when applying this approach, professional nurses needed to share the activities that bring them to the required or proposed solutions. This approach can be used in any setting, including rural villages where this study was conducted. Even though quality improvement approaches are complex, each approach follows the same basic four-step sequence. However, In this study, the researcher followed three steps only, which were step one-identify, step two-analyze and step three-develop (Massoud et al., 2001:05).

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1.8.2.1 Step 1: Identify

The main aim of Step 1 was to clearly establish what to improve, entailing problems that needed solutions. That is the opportunity for development that required clear definition of the systems to be followed to bring about improvement. Step 1 involved recognizing the chronic complex and recurring problems (Massoud et al., 2001:33). In this study, the problems are inadequate, incomplete, illegible inaccurate patient information on ART programme forms and books at PHC facilities in Vhembe District, Limpopo Province.

Problems were identified as follows: The researcher as one of the professional nurses working at a PHC facility in Vhembe District, Limpopo Province, noticed several times, that quality nursing documentation of patient information on ART programme was unsatisfactory. Problems were further identified during a Provincial Record Audit from 18 to 22 February 2013. During that provincial audit, PHC facilities, Community Health Centre's (CHC) and the hospitals' patient information on ART programme were audited. Other programmes (TB) linked to ART programme were also checked to assess for the flow of patient information and integration of services.

In all the audited facilities, the records were disorganized, incomplete, and illegible; some were difficult to retrieve, indicating unavailability of the required information. However, even during the maternal outreach programme, which was attended quarterly at the Tshilidzini District Hospital, where maternal and newborn health services were reviewed. The records that were frequently reviewed were the antenatal cards or maternity case records. The concern had been incomplete, inaccurate, and illegible records indicating inadequate nursing documentation of patient information.

The PHC facilities are sometimes called telephonically by Local Area Supervisors and Vhembe District Officials to clarify some of the statistics sent to them on a monthly basis. That was a problem as the Provincial officers that deal with statistics were complaining that

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the information sent to them did not tally with the records from which the information was extracted. The effects of that problem were indicated by the Provincial officers.

It was said that the true picture of what was happening at different PHC facilities was not reflected due to under-reporting of information by the PHC facilities in Vhembe District. The present researcher would know when the problem of inadequate nursing documentation has been resolved as there would be quality record keeping at PHC facilities meaning that correct data is sent to Vhembe District and to the Provincial offices.

1.8.2.2 Step 2: Analyze

The main objective of Step 2 in Systematic Team Problem-Solving was to discover the major causes of the problem in order to select a suitable solution. Analysis may be done very fast if the problem was simple and the cause understandable. It involved analyzing of what must be known or understood before changes were considered (Massoud et al., 2001:34). The analysis to discover major causes of a problem required a creative and chronological examination process of information making sense of the findings and meaning of the data collected.

Professional nurses are the ones involved, as their work deals with documentation of patient information at facilities on a daily basis. When records are inadequate they affect patient care and service delivery in the facilities, including professional nurses' expected performance. The Vhembe District, Limpopo Province and National performance were affected too. Inadequate nursing documentation was happening daily at PHC facilities in Vhembe District. Patient care was compromised and their health was affected.

The problem occurrence might be due to professional nurses' knowledge deficit and poor quality nursing documentation. It might also be due to unavailability of material resources required for compiling quality records. As well as inadequate training about documents used

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for the programmes and limited support by programme supervisors. This step involved data analysis and it was continued after data collection as data were part of problem analysis (Massoudet al., 2001:34).

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1.8.2.3 Step 3: Develop

The main aim of Step 3 in Systematic Team Problem-Solving was to develop solutions to solve identified problems through avoiding the causes. When developing such solutions the researcher kept in mind that it was not always a simple task, as many attempted solutions were unsuccessful because they were not vigilantly thought through before performance. Massoud et al. (2001:36) emphasized that this is not the time to rush to solutions; critical thinking and rethinking were needed here.

After specifying all the effort that has been invested in selecting and analyzing the problems, then solutions can be selected. The best approach was to be open and think productively, first to develop a list of possible solutions then to assess each carefully before choosing one. The results found had to address the original causes identified. Choosing sound solutions required a good list of options. That was where creativity was important (Massoud et al., 2001:36).

In this study, solutions to solve identified problems were developed focusing on Vhembe District Programme Managers, Assistant Managers, Operational Managers and all Professional Nurses at PHC facilities. The primary aim of recording information on patient records was to support the delivery of good care, clinical decision-making, communication between health care professionals and continuity of care to reach the goals of the DoH.

The developed solutions were as follows:

- The best way was to start by reviewing previous successes and failures as there might be helpful lessons that could be learned from those. Other people's experiences could be useful if well examined. Benchmarking together with brainstorming could encourage creativity. Benchmarking included exploring a comparable process that may work well and taking into consideration ways others

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had tried when they had similar problems and investigate thoroughly what succeeded.

- Vhembe District could nominate members from PHC facilities to visit other Provinces to learn the way documentation of patient information was done. They consider engaging others to work together with the team in suggesting feasible solutions. It could be helpful if invited members were those who had been working on similar problems within the health facilities. However, it was vital to have a comprehensive understanding of one's own process before attempting any benchmarking (Massoud et al., 2001:36).

- Moreover, professional nurses needed to understand the importance of recording patient information on relevant registers at workplace on time. They had to know that quality records were important tools used during communication amongst health professionals. They must acknowledge their duty to keep patient information updated at all times and ensure that they were complete, accurate and readable. The DoH must conduct record audits and staff training on quality nursing documentation on regular basis. In-service training, workshops, mentoring, couching and supervision had to be done constantly for government employees to ensure that all health professionals understand importance of quality nursing documentation in health facilities.

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1.8.2.4 Step 4: Test and Implement

Systematic Team Problem-Solving depended on successfully testing and implementing the appropriate solution. Even a well-chosen solution will not resolve the problem if it was poorly planned, implemented, and monitored. In this study, Step 4, Test and its Implementation were not done as indicated above.

1.9 Definition of Key Concepts

1.9.1 Factors Affecting

Factors affecting are circumstances or behaviors that influence a difference or change in behavior pattern of a person or people and bring desired or undesired results (Allen & Delahunty, 2006:10 & 217). Factors affecting in this study, refer to knowledge, skills, and attitudes of professional nurses, situation or circumstances at workplace that influence them towards quality records keeping.

1.9.2 Quality Nursing Documentation

Quality nursing documentation is creation and maintenance of patient records that contain complete, accurate and readable patient information in specially designed forms or books by professional nurses (Hornby, 2010:430 & 1009).Quality nursing documentation In this study, refers to all correctly, legible and complete recorded information on ART forms and books used to record patient care found at PHC facilities in Vhembe District.

1.9.3 Patient Information

Patient information is important documented details about a person receiving medical treatment in a public or private health institution kept on special designed permanent forms (Hornby, 2010:770). According to the DoH and Social Development Records Management Policy (2006:07), patient information is all recorded facts in different books and forms regardless of form or medium. In this study, patient information shall mean all documented

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information about people who receive treatment and health-related matters in primary or secondary health facilities.

1.9.4 Primary Health Care

In the 1978 Declaration of Alma-Ata PHC was described as: "important health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of the country's health system, of which it is the central function and main focus, on the overall social and economic development of the community (WHO, 1978:08).

PHC in this study, refers to the first level to make contact with the individuals, family, and community in the health system—it includes the provision of incorporated, reachable health care services by different health professionals in the PHC facilities. It involves care given on first contact and in ambulatory settings. Primary health care services cover preventative, promotive, curative, and supportive, and rehabilitation services. These services provided by health professionals from different disciplines, attempt to enhance the individual's physical, mental, emotional and spiritual well-being, and address factors that influence their health. The services are usually designed to deliver services in union with community service providers.

1.9.5 Professional Nurses

Professional nurses are DoH employees who are connected with their jobs after a special training, acquired high level of education and skills, for that matter with relevant professional qualifications and are registered with SANC (Hornby, 2010:1170).Professional nurses. In this study, are all DoH employees whose daily work and perform activities directly involving

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the creation and updating of patient information which contribute towards quality patient care.

1.10 Research Design and Methodology

Research design used in this study, was qualitative, explorative, descriptive and contextual because the participants explaining their work experience in relation to quality nursing documentation of patient information. This is the research method which tried to gather full information in a real setting, in order to develop understanding of everything being answered by participants and observations made by the researcher. Data collection and analysis had occurred simultaneously; the researcher was intensively involved in taking field notes (de Vos et al., 2011: 269). A detailed description of research methodology is provided in Chapter 3.

In this study, an explorative, descriptive and contextual research design was chosen because of the following reasons:

- This type of design is flexible, unique and involved throughout the research process; the design has no fixed steps to be followed and cannot be easily replicated.
- It allows for merging various data collection strategies (triangulation) and requires the researcher to be intensively involved, or remain in the field for a long period, and become a research instrument; the unity of analysis in this design is holistic, striving for an understanding of the whole.
- The design ensures that the study is done in the natural setting where participants narrate their work experience in relation to quality nursing documentation of patient information.

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1.10.1 Study Population and Sampling

1.10.1.1 Population

Accessible populations are the cases that conform to eligibility criteria that are easily reachable by the researcher (Polit & Beck, 2008:338). In this study, the easily reachable population is Nurse Initiated Management of Antiretroviral Therapy (NIMART) trained professional nurses, their daily work and activities, involved issuing treatment and creating nursing documentation of patient information of ART programme, and compiling monthly statistics and send it to the Vhembe District.

1.10.1.2 Sampling Method

Sampling is defined as a process of selecting a small portion or number of participants required to participate, from the total population to represent the whole (Maree, 2007:79). In qualitative research, non- probability sampling is used. This sampling approach also involves non-random sampling since each element does not have an equal chance to be selected and researcher does not know members of the population (Polit & Beck, 2008:40). Non-probability sampling involves several types including purposive, snowball, theoretical and volunteers. In this study, purposive sampling method was used. Non-probability sampling is a method where each participant does not have an equal chance of being selected for a particular study, for example, participants can be selected purposely (Creswell, 2009:178; de Vos et al., 2011:231). The researcher had purposively selected the PHC facilities and NIMART trained professional nurses as participants based on the characteristics needed for this study.

In this study, sampling was done in two stages:

1.10.1.2.1 Sampling of Sub-District and Institution

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The PHC facilities which render PHC services including ART programme seven days a week. Undesirable, incomplete, inaccurate nursing documentation and unavailability of ART programme documents during Provincial Record Audit in February 2013 were from Mutale Local Area found in Mutale Sub-District in Vhembe District.

1.10.1.2.2 Sampling of Professional Nurses

Professional nurses with two or more years of experience working at PHC facilities at Mutale Local Area and who were NIMART trained, their daily work and activities directly involve nursing documentation, creation, maintenance and keeping of patient documents.

1.10.2 Research Setting

According to de Vos et al. (2011:223), setting is defined as a set of geographical boundaries of the study area. In this study, the geographical boundary was the selected PHC facilities for professional nurses' workplace, namely, Thengwe, Matavhela, Shakadza, Tshiungani, Rambuda Clinics and Mutale CHC at Mutale Local Area in Vhembe District, Limpopo Province.

1.10.3 Data Collection and Analysis

In-depth face-to-face interviews were used to collect data form professional nurses to explore and describe factors affecting quality nursing documentation of patient information. The researcher was the main primary gathering instrument. The researcher used reflexivity, intuition and bracketing to exclude preconceptions of the phenomena in order to enter the world of the participants with an open mind. Permission to record the interview with a voice recorder was obtained from the participants. The researcher conducted the interviews until data saturation was reached. The data collected included field notes, transcripts from the

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interviews and were analyzed qualitatively using the Tesch's eight steps of open-coding methodology (Creswell, 2009:186).

1.10.4 Trustworthiness

Trustworthiness constructs and criteria of Lincoln and Guba's model (Lincoln & Guba, 1985 page; Babbie & Mouton, 2009:277) considered for this study included credibility, transferability, dependability and conformability (Table 1.1).

1.10.5 Ethical Considerations

Ethical clearance was obtained from the University of Venda, Health, Safety and Research Ethics Committee and permission to collect data were arranged with the DoH Limpopo Province, Vhembe District, Management of Mutale Sub-District and PHC facilities operational managers. Informed consent was obtained from the participants (Annexure C). Participants were informed that participation was voluntary and that they could withdraw at anytime if they felt threatened, without penalty or punishment.

Table 1.1: Trustworthiness criteria, strategies and applications

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Criteria	Strategy	Application
Credibility	Reflexivity and bracketing	The researcher had critically reflected her own biases preferences and preconceptions. Bracketing was achieved by identifying and holding back any preconceived beliefs and opinion about the phenomenon understudy.
	Prolonged engagement	During data collection, the researcher ensured that there were adequate resources and time to stay in the field to establish rapport with the participants.
	Member check	The transcribed data were shared with the participants to ensure that ideas were not twisted.
Transferability	Stepwise replication	The data and analysis were then checked for compatibility and similarity: discrepancies were resolved through member checking with the participants.
	Sampling	The researcher had selected participants purposefully: suitable participants with required knowledge and experience were selected.
	Dense description	A detailed description of methodology was done and the research context or setting was sufficiently provided.
Dependability	Audit trail	The researcher had detailed the decision made before and during the research. Non-verbal communication during interviews was documented to enrich data.
Conformability	Inquiry audit This occurred with: Credibility Transferability and Dependability	The data were scrutinized by an external reviewer to determine dependability and conformability. The researcher had ensured trustworthiness and rigour, and proved conformability through credibility, transferability and dependability. The conclusions and interpretation had been derived directly from the data.

1.10.6 Limitations of the Study

Like most qualitative studies, transferability of research findings of this study may not be possible. The researcher had conducted the study at one site, namely, the District Vhembe, at Mutale Sub-District, in Mutale Local Area.

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1.10.7 Dissemination of the Study Findings

The research report will be submitted to the Limpopo Province DoH, Vhembe District office, Mutale Sub-District office and PHC facilities. The results will be submitted to journals for publication. Oral presentations or posters may be presented at organized conferences.

1.11 Organization of the Chapters

Chapter 1: Overview of the Study

Chapter 2: Literature Review

Chapter 3: Research Design and Methodology

Chapter 4: Data Analysis, Discussion and Literature Control

Chapter 5: Recommendations, Limitations and Conclusions of the Study

1.12 Summary

This chapter provided an overview of the study and included the introduction, background and rationale of the study which outlined challenges encountered by regions and countries that are needed to improve practices of quality nursing documentation of patient information. The significance and purpose of the study were also described to give a sense of the expected outcomes of this study. The research question, objectives and definition of terms were also explained. Theory selected to support this study, "Modern paradigm for improving health care quality" was also discussed. The next chapter encompasses the literature review.

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CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

An overview of the study was presented in Chapter 1. The objective of this chapter was the process to review pertinent literature in the area of investigation. That process covered a large area of information according to the plan, through reading, understanding and modelling extrapolations from all relevant publications related to the topic being investigated (Akinsola, 2005:55; Babbie & Mouton, 2009:565). According to de Vos, et al., (2011:109), a literature review enables the researcher to understand issues in relation to the topic under study. It showed differences and similarities between the topic under study and previous studies; it also indicated concepts used throughout the studies. In this study, the researcher focused on factors affecting quality nursing documentation of patient information on the ART programme at PHC facilities in Vhembe District, Limpopo Province. However, quality nursing documentation entails creating and maintaining of patients' records that contained complete, accurate and readable information, in specially designed forms or books by professional nurses (Hornby, 2010: 430 & 1009). Hence, those complete accurate and legible records at PHC facilities had a fundamental need for control purposes, and to provide evidence and serve as an important communication tool among health professionals (Meyer et al., 2011:33).

2.2 Classification of Patient Documents

Records were categorized into two types: physical and electronic. Physical or paper-based records can be touched and occupied physical space. Electronic or digital documents were

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generated with and used technology devices (Borglund & Oberg, 2008:01).

2.3 Contents of Patient Documents

Patient records contained sufficient information that identify the patient's history, subjective data, examination and test results, treatment plans, report of consultation or hospitalization, records containing information on drugs prescribed, administered or dispensed and patients' needs. The health record, whether electronically stored or traditional paper files, contained proper identification regarding the patient's case history by a particular health professional. Those records also contained assessment information that was sufficient to support the diagnosis indicated and justification of treatment issued. Furthermore, information varied with the individuals' medical history (Meyer et al., 2010:336). Services rendered, outcomes and minutes of meetings were also indicated. Records also contained statistics (total number) of patients seen in that facility per day, weekly or monthly (NCSS, 2007:04).

2.4 Purposes for Keeping Patient Information

Patient information was kept in health care facilities for the following reasons: continuity of care, accountability, service improvement, record audit, risk management, monitoring and evaluation Meyer et al., 2010:332). Whereas Borglund and Oberg, (2008:04) identified only three purposes for keeping documents in an organization which are business, accountability and cultural purposes. To guarantee the services rendered the organization employees might create and up-date the documents always at work place (Borglund & Oberg, 2008:05. The information contained in the records allowed professional nurses to determine the patient's medical history and provide the informed care. Records served as the central repository for planning patient care and documenting communication among patient and professional nurses which, in turn, contributed to the patient's care. An additional purpose of records was to ensure documentation of compliance with institutional, professional or governmental regulations (Borglund & Oberg, 2008:07; Meyer et al., 2010:332).

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2.4.1 Continuity of Care

The aim of continuity of care process should be patient-centred (Casey & Wallis, 2011:01). There was a need for continuity of care for patients who utilized more than one level of facility in order to achieve the health care outcome. Meyer et al., (2010:330) asserted that the referral system should be made an effective process during the patient's journey in and out of different facilities. The important contribution of health professionals was through communication using quality nursing documentation in all facilities to enable patients to have potential benefits of reduced re-admissions and average length of stay in hospitals.

Relevant documented information during transfer in and out enabled health professionals to empower patients with useful information for self care. A comprehensive record keeping enabled efficient transfer of medical information between health professionals. That was essential in ensuring that patients received a continuum of care. Smooth referral and continuity of care was effective through improving and maintaining relationship between health professionals within and between institutions (Meyer et al., 2010:330).

Casey and Wallis (2011:01) highlighted that communication was a preferred central human interaction, as without it people cannot work effectively and productively as they cannot relate information to others. Communication among health professionals should also be very effective as there were patients being cared for. Health professionals shared patient information actively, consistently and confidentially through giving or taking reports, managing incidents, complaints or concerns (Meyer et al., 2010:330; Casey & Wallis 2011:01).

Effective methods should be used to enable patients and home-based carers to communicate effectively. Accessible, acceptable and accurate information necessary for patients' needs should be shared actively and confidentially by health professionals. Staff verbal communication must be effective to ensure continuity, safety and quality health care for

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patients. Documentation, communication during handover of patients, information sharing, managing complaints, and reporting incidents and concerns were the more formal aspects of communication (Casey & Wallis, 2011: 01).

The National Patient Safety Agency (2007:page) identified communication difficulties as major factors affecting patient outcomes. Particular concerns included unclear nursing documentation and nurses not being clear and confident in their reporting as cited by Casey and Wallis (2011:01). Professional nurses read patient's previous records to continue giving and integrating patient care. Health professionals communicated by exchanging information stored on patient records thereby enhancing, promoting and maintaining patient safety (Wang, Hailey & Yu, 2011:10). When rendering services in the workplace, health professionals were able to make an informed decision if information needed was available (Wang et al., 2011:13).

Meyer et al., (2010:330) stated that documents contain important patient information, such as history, examination performed, diagnosis and treatment given. So it allowed a follow-up of services and approaches to help patients cared for by different health professionals. That was especially for patients with complex needs or those who required multiple services. Accurate and updated information was important when there was an emergency and the person who knew the patient well was not around. Patients were also transferred from one facility to the other with their records to enable continuity of care (NCSS, 2007:04). Patient transfer facilitated effective communication among health professionals. Patient information was used by different health professionals and used in the provision or continuity of care (Meyer et al., 2010:330).

2.4.2 Accountability

At PHC facilities, patient information were compiled in a consultation with the patient or when certain duties were performed, like after providing health education to patients. Those

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records were checked by an operational manager in a facility for completeness, legibility and accuracy. When recorded information was relevant, it was possible for health professionals and their facilities to respond to the patient's needs (Meyer et al., 2010:330).

Patient information was the last part of the patient's assessment and a very important part thereof. All the information gathered must be documented within normal boundaries. Information provided a baseline to assess changes in the patient's condition later on. Carefulness and accuracy was vital to enhance the possibility of diagnosing a patient's needs accurately, and to be able to nurse the patient with a scientific knowledge baseline as guidance. Apart from the importance of perfect nursing documentation in enhancing the quality of patient care, records were legal documents and recording was a legal and professional responsibility of every nurse. Documents should be kept to make it possible for each health professional to use them in rendering comprehensive quality health care (Meyer et al., 2010:33).

Patient information served as sources when anything goes wrong in the facility as they form a permanent account of the individual's considerations and reasons for decision making (Borglund & Oberg, 2008:06). Patient information may be needed to answer queries from stakeholders, including family, funders, donors or courts. Important evidence can be provided in cases of malpractice claims or office inquiries concerning care given to patient. Patient information give a clear picture of care rendered and forms the nature of professional relationship with clients (Borglund & Oberg, 2008:07).

Statistics South Africa is responsible and accountable for informing users (community members) about what is happening in the country, using patient information that was consolidated from all health facilities in South Africa (Open Society Foundation for South Africa, 2007:10).

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2.4.3 Service Improvement

Quality nursing documentation helped to improve services rendered to clients by assisting health professionals to organize their thoughts on how to help clients. Well-documented patient information also facilitated improvement through service planning, development and reviews. Such information could help to form primary data to conduct evidence-based research (NCSS, 2007:04).

Statistics South Africa indicated that the NDoH needed reliable and updated information for effective planning and supply of resources to facilities following statistics (data) reported. The DoH was able to measure the facility performance, knew community needs, supplied recourses and maintained infrastructure through facility quality nursing documentation. Similar populated facilities in different areas might be supplied with different resources relevant to data reported to Vhembe District on a monthly basis.

Different diseases could be dealt with by the directorate concerned, following previous well-kept quality records (Open Society Foundation of South Africa, 2007:09). Quality documents are necessary as a means through which PHC facilities statistics were generated, served as the eyes and ears of the Vhembe District Administrator. Records are of importance to the health facilities for the evaluation of its services for better patient care. They also serve as a resource for education and training of health professionals and others, also being a basis for clinical research.

For research studies to be effective recorded explanation as reflected in the patient information must be complete. The importance of quality documentation for legal purpose would be well established (Singh & Seema, 2014:01). Statistics South Africa had a bigger challenge as the Department responsible for Health had weaknesses of information collection system at Provincial level. It was noticed that there were no records on public servants who have been disciplined within the DoH (Open Society Foundation of South Africa, 2007:09-

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10).The mission of Statistics South Africa was to provide relevant and accurate body of statistics to inform users (community) on the dynamics in the economy and society through the application of international practices. Health professionals were therefore required to record correct figures about the data they are collecting on daily basis at their facilities (Open Society Foundation of South Africa, 2007:10).

2.4.4 Record Audits

Record audit was an official inspection done by responsible officers to check health care facility documents to see if they were in order, following the DoH requirements. WHO (2010:06) defined a record audit as a quality improvement process that seeks to maintain quality record keeping, hence improving patient care, outcome and health professional practice. Nursing and Midwifery Council (2007:03) defined an audit as one component of risk management process through assessing availability and quality of records kept in health facilities aimed at promotion of quality services, delivered to patients.

The Auditor General of South Africa is held responsible and accountable for auditing the performance of health data in the public health sector (NDoH, 2011:03). It is through kept quality nursing documentation that the Auditor General is able to audit the information at health care facilities (NDoH, 2011:03). Audit is an important tool used by the DoH to assess documents in facilities. The reasons for audits were to improve the standard of nursing documentation at facilities and to give advice to professional nurses on conditions under which documents were managed (DoH and Social Development Records Management Policy 2006:12).

Fundamental reasons for records audit were for quality record keeping, improvement of patient care and health professional practice in the health care facilities around the world (Nursing & Midwifery Council, 2007:03). Inspection of records in health facilities must be done on a regular basis and managed in line with DoH and Social Development Records

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Management Policy of 2006 by the Head Department concerned. Written inspection reports had to be available at all times and well-managed by the DoH (DoH and Social Development Records Management Policy, 2006:12).

In Nigeria, a study was conducted in Ibadan at nine PHC facilities. Available data were tested for correctness and completeness. Findings were inaccuracy of data documentation leading to lack of stable proof in all the facilities. The study showed that the Department of Health in Nigeria was receiving inaccurate information from the nine PHC facilities in Ibadan (Salami & Brieger, 2007:01). In South Africa, the National Health Care Facility Baseline Audit 2012 was conducted in order to strengthen health system effectiveness through improving health care, patient satisfaction and accreditation of health establishments (Visser, Bhana & Monticeli, 2012:06).

Record audits can be done by facility staff, Sub-District, District, Provincially or at National level depending on issues to be checked. The present researcher further observed the Provincial Record Audit in Vhembe District from 18 to 22 Feb 2013, where two hospitals Siloam and Tshilidzini, two CHC's, Mutale and Makhado, five clinics, Matavhela, Shakadza, Tshiungani, Tshikundamalema, Thengwe, were audited on record keeping. A similar audit form was used in all these facilities to check the records and information documented.

The results of the audit were unsatisfactory as most facilities performed badly. Only one facility was better. Four hospitals did not have PMTCT registers, which suggests that the information needed on PMTCT was never recorded nor reported to Vhembe District since the programme has started. The information on the DHIS, input forms and registers where information was extracted did not tally in almost all the facilities. Good record keeping was the cornerstone of efficient, transparent and accountable administration in the public health setting, according to DoH and Social Development Records Management Policy (2006:03).

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2.4.5 Risk Management

According to ArcMesa Educators (2014:05), nursing documentation could be a best friend or worst enemy against health professionals in any malpractice claim. Quality nursing documentation served many purposes at PHC facilities. Patient information was crucial for all health professionals concerned with a patient's care and for any subsequent new provider who assumed responsibility for the patient. In disciplinary or peer review matters, kept documents could justify the need for a particular treatment.

In damages and utilization disputes, documents could contain what services were rendered and whether they were medically necessary or not. The patient information was the single most important evidence for the providers whenever a malpractice claim, or other inquiry, arose concerning patient care (ArcMesa Educators, 2014:04). Gold and John (2013:07) argued that the Sub-Saharan Region was lagging behind in achieving the United Nations Millennium Development Goals (MDG's), particularly those which were directly health related due to failure in delivering adequate data because of the widespread under-reporting in the region.

While the region lagged behind, that did not give overall global reflections as there have been incredible achievements in health care. Health systems have significantly addressed most of its challenges of communicable diseases across the Sub-Saharan Region and met the basic health needs of humans and accelerated health care delivery, but there was no documented information illustrating that. Additionally, that might be due to health system management and administrators failing to understand the fundamental role played by nursing documentation of patient information in health care delivery.

However, Sub-Saharan Africa needed to be on par with the rest of the world through timely recording and reporting of data. That necessitated an accelerated empowerment to strengthen quality nursing documentation in the existing weak health systems in the region. The overall

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national picture was inevitable, i.e., incomplete due to under-reporting data from many health facilities in Sub-Saharan Africa (Gold & John, 2013:07).

2.5 Factors Affecting Quality Nursing Documentation

According to the DoH and Social Development Record Management Policy (2006:06), quality nursing documentation of patient information was a collective responsibility for employees and documents should be kept updated by employees at all times to ensure that they were complete, accurate and readable. The inability, improper behaviour and attitude of professional nurses at PHC facilities contributed strongly to incomplete and illegible documents. Factors affecting quality nursing documentation of patient information in PHC facilities included increased workload, knowledge deficit, and unavailability of resources and professional nurses' attitude towards quality nursing documentation.

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2.5.1 Increased Workload

Increased workload meant that one person was expected to do multiple duties as far as documentation of information was concerned. Recording of information on different books increased professional nurses' responsibilities and workload during working hours. There were multiple registers and books at PHC facilities on which one patient's information had to be recorded for different services during one visit by one health professional. Antenatal patients coming for the first visit needed to be recorded on the tick register, PMTCT register and; counselling and testing register also needed to be completed, TB suspect register, blood specimen register, maternity case record book and Basic Antenatal Care (BANC) checklist had to also be completed.

According to the Australian Government, clients were eligible under the Safety, Rehabilitation and Compensation Act 2011, which said that when patients were started on treatment they should be recorded in different relevant registers called Treatment Plan. Those findings indicated that nurses were faced with increased workload as they were required to record information on different relevant records according to their Departmental requirement. The Australian Government stipulates that clients eligible under the Safety, Rehabilitation and Compensation Act 2011, strongly support what was done at PHC facilities in Vhembe District in the Limpopo Province, the use of multiple records.

According to the American College of Health Care Executives (2012:03) in many countries around the world record systems were unable to cope with the growing mass of unmanaged records due to insufficient financial and administrative resources. The growing complexity of programme forms and registers needed relevant staff with enough stationery in order to manage the duties required. Availability of financial and administrative resources was the answer.

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Therefore, challenges encountered at PHC facilities in Vhembe District about complexity of records were also found in many countries around the world. The unavailability of the required (staff) number of professional nurses at PHC facilities clearly affected quality nursing documentation on a daily basis as few professional nurses were expected to work productively through completing different books and registers for quality nursing documentation.

According to the American College of Health Care Executives (2012:03) the effect of shortage of professional nurses was felt acutely in health facilities globally. Moreover, those clearly support shortage of health professional nurses as a major crisis at PHC facilities in Vhembe District, Limpopo Province in South Africa and around the World.

In Vhembe District at PHC facilities staff establishments were not yet filled as per facilities' requirements. All the facilities were operating with incomplete staff. In addition, there were no data-capturers to assist in documentation of patient information as all duties were done by professional nurses. Health professionals who work during the night (taking calls) were also expected to work as day staff members without rest. No night-staff was available at PHC facilities. As a result, they render twenty four hours services in a call system.

The American College of Health Care Executives (2012:03) recommended that health care executives had to develop responsible actions for delivering patient care. They had to work towards ensuring good supply of professional nurses, by recruiting, attracting and thrive to retain required staff to deal with issues of shortages. Health care executives had to treat staff members with respect and provide fair compensation for both normal hours and overtime worked to enable them to work productively.

According to Agency for Health Care Research and Quality in United States (2008:04) professional nurses were experiencing heavy workload than before due to increased demand

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of such professionals in the health care system. It was due to reduced staffing and increased overtime. The issue of nurses being overworked was a crisis throughout the world, even the Department of Health Locally, Provincially and Nationally in South Africa was fully aware of nurses being overworked through working long hours per day and night trying to manage workload. REF

An overworked person might fail to maintain quality nursing documentation of patient information or even use the wrong stationery or misplace the completed documents. Those led to poor recording. Hence, the Basic Employment Act (2002:08) as amended indicated that an employer might not allow an employee to work for more than 09 hours per day or for more than 45 hours per week. At PHC facilities two nurses who work during the night (taking calls) were also expected to work during the day which increased their working hours, even though paid they got tired.

The outcome of increased health professionals' working hours could increase patient mortality and morbidity in both primary and secondary facilities (University of Maryland, 2012-2013). Professional nurses' working hours might be increased to compensate decreasing physician working hours in hospitals because medical profession has taken steps to limit their working hours (University of Maryland, 2012-2013).

Even at PHC facilities in Vhembe District, health professionals were experiencing increased working hours as there was a shortage of physicians at referring hospitals. Both the studies conducted in different facilities yielded similar results on duration of working hours as a point of concern. According to a study by Pullen and Loudon (2006:280) "Advances in Psychiatric Treatment, Improving standards in clinical record-keeping", nursing documentations was inadequate and incomplete.

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Health professionals had lack of understanding about the importance of quality nursing documentation at health facilities. They postponed documentation of patient information after the incident had occurred which cause incomplete documents. According to a study by Pullen and Loudon (2006:280) some professional nurses wrote patient's notes long after the event had occurred and they were being investigated. Entry of patient records should be done as soon as possible after an event had occurred before the relevant staff go off. Inadequate record keeping might lead to medico-legal risks where patient's treatments could be omitted or duplicated (Meyer et al., 2010:330).

2.5.2 Knowledge Deficit

There was a lack of knowledge with regard to what was it that one had to record in different books and registers. That might be due to lack of training of health professionals in relation to quality nursing documentation at facilities. PHC facilities are the first point where data collection took place and that was the lowest level where quality information had to be improved (DHIMS) Standard Operating Procedure, 2012:01). According to a study done by Pullen and Loudon (2006:280), health professionals also lacked awareness of the importance of quality record keeping in health facilities. Documenting notes long after the incident has happened clearly showed that health professionals lacked important information with regard to record-keeping because that might lead to omission of facts.

Pullen and Loudon (2006:280) also indicated that professional nurses lacked information sharing amongst each other as they had a tendency to treat patient information as a personal issues rather than a cooperate assets. Patients' documents were seen as other professional nurses' or manager's property, thereby giving low priority to documents management by health professionals. McGeehan (2007:58) stated that a senior member of the nursing team in an Acute Trust was faced with a problem, of poorly recorded information in a patient's document when answering a complaint in a meeting with the family members. The health

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professional was embarrassed at the poor condition of the notes written by one of her staff members, due to negligence.

Employee training and development were continuous life processes and were imperative as they bring about a change in human behaviour; also improving the management process (The President Obama's Nursing Report 2012). Staff members did not understand some of the information to be recorded on registers and fail to ask others who had information.

According to The President Obama's Nursing Report 2012 the NHSC had been supporting nurse practitioners, certified nurse midwives and psychiatric nurse specialists, as well as other primary care providers, for 40 years. By offering nurses scholarships and loan repayment to pay down educational debt, those health care professionals were able to work in underserved communities where they were needed most. Training for nurses was very important to make them understand reasons for accurate record keeping as it was done in United State of America.

Staff members lacked relevant experience towards quality nursing documentation in Vhembe District. Vhembe District was also one of the Districts that were sending incorrect data on a monthly basis to the Provincial Office. According to Data Management meeting held at Landmark Protea Hotel in Polokwane 18-19 August 2013 involving three Districts, Mopani, Sikhukhune and Vhembe, professional nurses lacked experience for quality nursing documentation of patient information. Most of the numbers of data collected about indicators on Maternal and child-health were very low than expected, some were more than 100% in all the Districts.

That was a reflection that the indicators used in the DHIS did not communicate with health professionals who were collecting data in their respective facilities, and they did not understand the reasons for reporting the data on a monthly basis. The Deputy Manager of

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PMTCT programme reported that in Vhembe District the large numbers that exceeded 100% are from Mutale Sub-District.

According to South African National Health Act (2003:50) professional nurses were held accountable and responsible for their acts and omissions in relation to patients' records. The Australian Standards ISO 15489-2002 Record Management Act was developed for employers and employees to work responsibly and accountably in the working situation through proper management of patient information. However, both the comments supported the importance of accurate record keeping at health facilities.

2.5.3 Limited Resources

Limited resources referred to inadequate materials, equipments and poor infrastructure involved in the provision of quality patient care. The monthly report sent to the Vhembe District reflected that basic equipment available at facilities were of poor quality, but budget estimate for quality equipments are submitted on November every year. Much of the infrastructures at PHC facilities are inadequate with no store rooms and no cupboards to store equipments and stationery.

At PHC facilities cupboards were filled with old books and also on top there were books. Records were not retrievable and there was no planned disposal of old records at PHC facilities. That might be also due to inadequate planning of infrastructure with insufficient space for storing records. Moreover according to (DHIMS) Standard Operating Procedure (2012:09) health professionals were required to keep patient clinical records and all data collecting tools used at PHC facilities in a safe secured and lockable area. According to a study on record keeping in Universities in African countries by Ugwunyenga (2009:111), there were weak record-keeping and storage cupboards for stationery. Those were not suitable and unacceptable as there was little or no planned disposal of old records.

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Thus, financial records remained buried and inaccessible in the old cupboards. For example, two huge cupboards were full up to the brim with such records in one of the Universities under study. There was serious shortage of stationery at PHC facilities, where health professionals experienced a serious problem while executing their job. Research done by Baloyi (2009:57) revealed the serious shortage of non-medical supplies such as stationery, in all of the Limpopo Municipalities.

Supporting what was happening at PHC facilities, there was a shortage of medications, stationery and other important equipments required for effective service delivery. Baloyi (2009:57) further indicated that the functioning of PHC facilities without those supplies (stationery) posed a problem to health professionals providing services. Even though some of them were trained it was difficult for them to make a difference in the workplace due to shortage of stationery (Baloyi, 2009:57). According to Booyens (2005:173), stationery was the second most important part of health care, as all duties performed need to be recorded. Baloyi (2009:59) explained that even patients expressed their dissatisfaction with the unavailability of supplies such as stationery in the health facilities where they receive the services.

According to the National Health Care Baseline Audit Report by Visser, Bhana and Monticeli (2012:12) Vhembe District had inadequate and poor infrastructure at PHC facilities which had a major impact on the functioning of services and patient satisfaction. Visser et al., (2012:12) further indicated that PHC infrastructure management needed the most and urgent improvement. According to a Situational Analysis at PHC facilities infrastructure by Lugte and Mbatha (2007:06), poor infrastructure had been cited in a number of studies conducted primarily in middle and low income countries, and that displayed as undermining health service delivery worldwide.

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Burnout following infrastructure shortage made it difficult for health professionals to perform daily duties to meet the targets set by different programme managers, e.g., target for sputum collected per month is 60% of headcount of above five years and each nurse had to counsel and tests three clients daily [PMDS]. A study by specialized projects backed by international donors to improve reproductive health services and HIV/AIDS programmes by Lugte and Mbatha (2007:07) failed, as health professionals did not achieve their targets due to poor infrastructure, where services were delivered.

Poor infrastructure had shown significant effects on patients' perception on quality of care and health professionals' satisfaction with their poor working conditions. Lugte and Mbata (2007:07) further indicated that it was also difficult for professional nurses to collect data required if they did not know the criteria for collection and importance of such data. That was why only the Western Cape and Limpopo were the only provinces in South Africa to have the relevant data required for the improvement of the infrastructure. When health professionals understood the indicators used for data collection, the required information was found and reported on time (Lugte & Mbata, 2007:08).

2.5.4 Professional Nurses' Attitudes Towards Quality Nursing Documentation

Professional nurses' negative attitude towards quality nursing documentation affected patient documents and hence compromised the services rendered. Employees sometimes did record information which they did not understand or fail to record information because they were not sure about what was to be recorded. Process principles indicated that documented information should not include many abbreviations, jargons, value judgments and irrelevant words, as the meaning of the statement could be lost (Pullen & Loudon, 2006:281).

According to McGeehan (2007:60), quality nursing documentation of patient information should not be seen as a distraction from caring for patients because it was considered as a fundamental part of nursing, midwifery and specialist in community health practice. Hence it

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protected the welfare of patients by ensuring high standards and continuity of care. That clearly indicated that failure of health professionals at PHC facilities to record information on patients' records might be the negative attitude towards quality record keeping and also shown by low standards of patient care rendered at the facilities.

Professional nurses' negative attitude towards quality record keeping might lead to sluggishness among nurses even when there was work to be done, thinking that someone would do it shifting responsibilities, which might lead to litigation. Litigation was regarded as an occupational hazard for professional nurses. Law courts adopted the attitude that if something was not recorded it did not happen. Therefore, health professionals had a professional and legal duty to keep quality records. It had been stated that professional's documentation should demonstrate a full account of professional nurses' assessment and care planned, provided for the patient (Nursing & Midwifery Council, 2007:02).

Changing staff attitude was an important key to service delivery in both public and private institutions. One of the most important core standards set by the DoH for professional nurses was correcting employees' attitudes. As quality nursing documentation of patient information was a basic requirement in that noble profession and at PHC facilities, the responsibility and accountability had to come from within nurses themselves (Nursing Update, May, 2014:24).

Carla (2008:01) clearly indicated that motivation was something inside people that influenced certain behaviours to happen. Motivation was also influenced by a person's morale and attitude. It came from within such as thoughts, beliefs, ambitions, and goals that drive them to action, was willingness to work at high level of effort. Overwriting and illegible handwriting were parts of health professionals' negligence on their work. Human motivation was complex and important for successful management development (Carla, 2008:01).

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Theoretical and practical education about the types of motivation, their sources, their effects on performance, and their susceptibility to various influences had to be dealt with. Health professionals are the DoH's best assets. If health professionals were not well-motivated, it would have negative effects on service delivery and consequently, incomplete and unreadable records at the health care facilities. The DoH's overall efficiency would therefore deteriorate under unmotivated employees and poor reporting of data (Carla, 2008:17).

Carla (2008:17) believes that employees' emotions also affect motivation. An employee who was easily emotional about situations might lack the strength to perform optimally. Based on previous research done, under regular conditions, employees tend to work at only about two-thirds of their capacity. Motivation might also be influenced by the manager's management style. If a manager was not liked, employees might function minimally.

To be a successful manager one had to be a people mover, who motivated employees to increased productivity. Get to know your people well! Motivation was the most critical factor in productivity, quality service provision. Motivation is the key towards quality record keeping Carla (2008:18).

Lack of motivation results in failure of health professionals to account for nursing care rendered to patients (Meyer, Naude, Shangase & van Niekerk, 2010:333). What, in turn, posed a challenge amongst health professionals hindering proper communication, as the other member cannot read what was written on patient's record meaning failing continuity patients' care? According to Nursing and Midwifery Council (2007:02), the principle of good record keeping number one was that handwriting should be legible all the times. Incomplete information meant that health professionals did not record information on provided spaces on patient's files, booklets or registers.

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Following a study done on quality record keeping in (2006:20) at selected Regional hospital, by Rampfumedzi the findings were that obstetric nursing records were inadequate and described as incomplete. Moreover on the records some of the provided spaces were left unattended by health professionals, documentation was unclear. According to McGeehan (2007:60) every entry in the patient's records should reflect the date, time, signed by the person who made an entry. Name and designation of the nurse who recorded information had to be written legibly against signature.

On the other hand, employees who felt motivated to work were likely to be persistent, creative and productive, turning out high quality work that they willingly undertook. Employers needed to get to know their employees very well and use different tactics to motivate each of them based on their personal needs. Employees' motivation had always been a central problem for leaders and managers in different organizations. Unmotivated employees were likely to spend little or no effort on their jobs and avoid the workplace as much as possible (The President Obama's Nursing Report, 2012:01)

The President Obama's Nursing Report (2012:02), the growth of health professionals caring for the nation was supported to encourage them to continue in this profession. The Affordable Care Act had also allowed the programmes to evolve and motivate nurses to be innovative at their workplace. Provisions in the Affordable Care Act allowed the National Health Service Corps to offer a part-time option and increased credit towards fulfilling the service commitment for providers working at Teaching Health Centres, offering flexibility for those interested in the nursing profession. Those innovations provided more flexibility to programme participants – they could pursue additional nurse training, balance a desire to teach and serve patients, or spend more time with family, ultimately supporting retention at their health service site and within their community (The President Obama's Nursing Report, 2012:02).

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2.6 Summary

This chapter dealt with the literature review relevant to the topic under study. Issues discussed were classification of documents, content of documents, purposes for keeping documents and factors affecting quality nursing documentation of patient information at PHC facilities in the Vhembe District, Limpopo Province. The following chapter outlines the research methodology of this study.

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CHAPTER 3

RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

The previous chapter outlined the literature relevant to this study. This chapter deals with the research methodology which refers to the different techniques, methods and procedures that were used to collect and analyze data in this study. The research design is described in relation to the following: setting, population, sampling, data collection and data analysis. Measures to ensure trustworthiness of data are also described with regard to four principles, namely, credibility, dependability, conformability and transferability.

3.2 Research Design

Research design is a set of guidelines and instructions to be followed in addressing a research problem throughout a study, from identification of the problem to the end results (Babbie & Mouton, 2009:74). Research design is also defined as a plan on how the researcher conducted the study following relevant design methods which, in this study, were qualitative, explorative, descriptive and contextual in nature. Designs followed by the researcher depend on the purpose of the study, nature of research question and researcher skills (de Vos et al., 2011: 269).

3.2.1 Qualitative Design

According to Creswell (2009:16) the purpose of qualitative research is to gather full information in a real setting, in order to develop an understanding of everything being answered by participants and observation by the researcher. According to Babbie & Mouton (2009:278), qualitative research concentrates on qualities of human actions, behaviors and

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attitudes that people exhibited during the study and that were written to cover a large scope of collected information. In this study, the researcher used a qualitative research design, which is a systematic and subjective approach to explore and describe factors affecting quality nursing documentation of patient information. The interviews with participants were recorded and field notes were used to document non-verbal cues. A voice recorder was used to record what the participants were saying to help the researcher to remember what has been said during the interview (Babbie & Mouton, 2009:278). Participants were interviewed in their own settings which are the PHC facilities. Probing and paraphrasing were used to avoid influencing the participants' responses.

3.2.2 Exploratory Design

According to Babbie and Mouton (2009:79), an exploratory study is aimed at finding new knowledge. Therefore, an exploratory study develops preliminary ideas and moves towards refining research questions, focusing on the "what" questions. An exploratory study thus seeks to investigate what is happening in the environment and ask more questions about it (Brink, 2012:113). The researcher used an exploratory design because it made it possible to look at factors affecting quality nursing documentation of patient information. It assisted in finding new knowledge the researcher was unaware of. A detailed description of factors affecting quality nursing documentation of patient information has been achieved through in-depth face-to-face interviews with professional nurses. New knowledge has been acquired because participants have freely explained their own ideas of factors affecting quality nursing documentation of patient information in their facilities (Brink, 2012:113).

3.2.3 Descriptive Design

Brink (2012: 11) defined a descriptive study as the type of research method which provides a real picture of the situation or phenomenon being investigated. He further described it as a study that aims to lay out complete readable data about a phenomenon through observation,

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classification and description. In this study, participants' non-verbal cues like attitudes, gestures, tone of voices and behavior were observed, and well-described in full to give the real picture of what was happening during the interview.

Neuman (2011: 35) defined a descriptive study as the research in which the primary purpose was to "paint a picture" with the use of numbers or words in order to present a profile. The purpose of this study was to provide a picture of a phenomenon as it occurs naturally, and the researcher described participants' subjective information and non-verbal cues. A study done in Pakistan in two referral hospitals, on record keeping used the descriptive method to describe professional nurses' attitudes and behaviors towards quality nursing documentation of patient information (May, 2009:15).

3.2.4 Contextual Design

A context is a set of conditions within which interactions take place. Attention to a social context means that the researcher noted what surrounds the focus of the study (Neuman, 2011:331). In this study, the researcher gathered information from participants at selected PHC facilities where patient information was documented and kept. That enabled the researcher to understand the behavior and attitudes of participants through interacting with them in their own environment.

3.3 Research Setting

According to de Vos et al., (2011:223) a research setting is defined as a set of geographical boundaries of the study area. The present study was conducted at selected PHC facilities at Mutale Local Area in Vhembe District, Limpopo Province. Limpopo Province consists of five districts, including Vhembe District. Limpopo Province is located in the North-Eastern part of South Africa where most people live in rural areas and have low literacy levels. [ref] The majority of people speak Venda; other languages spoken in the Vhembe District are

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Tsonga/Shangaan and Northern Sotho. Vhembe District has four sub-districts which are Mutale, Thulamela, Makhado and Musina. Figure 3.1 shows the Vhembe District map with four Sub-districts. The facilities where the research was conducted are situated in the Mutale Sub-District, Mutale Local Area namely, Tshiungani, Shakadza, Matavhela, Tshikundamalema, Rambuda and Thengwe Clinics, Mutale Health Centre. The maps in Figure 3.2 indicated the Limpopo Province, Vhembe District and selected PHC facilities.

The PHC facilities render primary health care services seven days per week. Clinics do a call system, CHC render 24-hour services. Shortage of staff of all the different categories of nurses was a similar challenge encountered at all selected facilities. The services rendered were outreach, TB, HIV/AIDS counseling and testing (HCT), ART, ANC, maternal and newborn care, child-health, reproductive health, minor ailments, mental health, emergency services, geriatric and chronic diseases. Professional nurses rendered different services on a daily basis, where different forms and registers were used. Each person may be registered on more than one form or registered for one service. For example, when one patient was coming for HIV/AIDS counseling and testing, s/he must be registered on a tick register, consent form and HCT register. That led to incomplete nursing documentation, as professional nurses might forget to record the same information on different multiple registers.

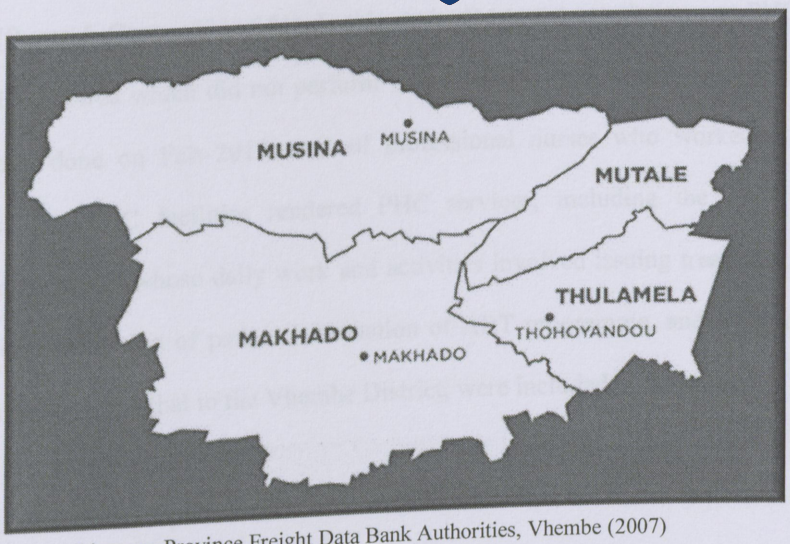
3.4 Study Population and Sampling

3.4.1Study Population

According to de Vos et al., (2011:223) population refers to sets of boundaries, in the study unit where individuals with similar characteristics are chosen. Population for a study is that group of people from which inclusions are drawn (Akinsola, 2005:93). In this study, population referred to professional nurses working at PHC facilities at Mutale Sub-District in Vhembe District, Limpopo Province.

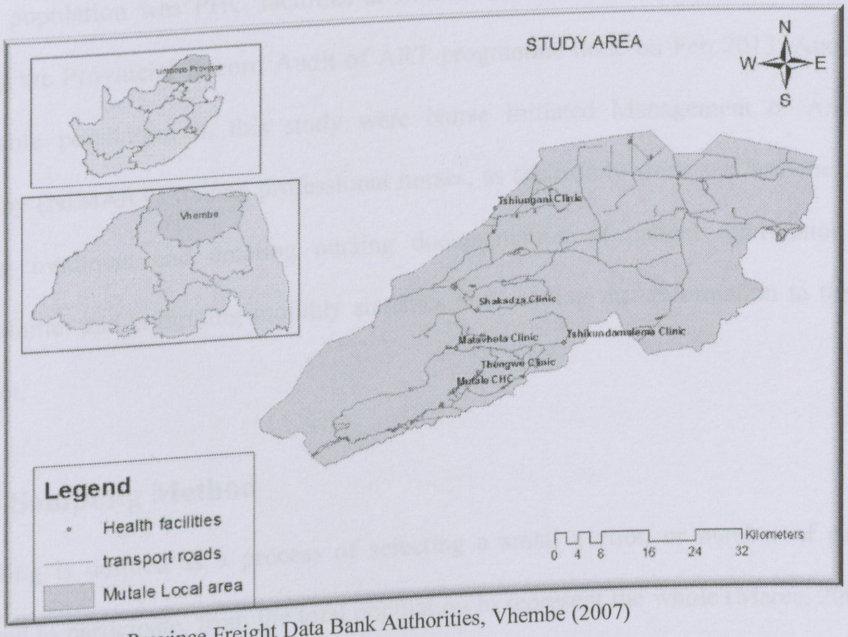
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Source: Limpopo Province Freight Data Bank Authorities, Vhembe (2007)

Figure 3.1: Vhembe district map indicating four sub-districts



Source: Limpopo Province Freight Data Bank Authorities, Vhembe (2007)

Figure 3.2: Maps indicating South Africa, Limpopo Province, Vhembe District and selected PHC facilities in Mutale Sub-District

3.4.2 Target Population

Target population refers to the entire set of individuals or participants who meet the sampling

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criteria (Burns & Grove, 2013:351). In this study, the target population was PHC facilities at Mutale Local Area which did not perform well during the Provincial Record Audit of ART programme done on Feb 2013, and all professional nurses who worked at those PHC facilities. The PHC facilities rendered PHC services, including the ART programme. Professional nurses whose daily work and activities involved issuing treatment and creating nursing documentation of patient information of ART programme, and compiling monthly statistics and sending that to the Vhembe District, were included in the study.

3.4.3 Accessible Population

Accessible population refers to those cases that conform to eligibility criteria that are easily reachable by the researcher (Polit & Beck, 2008:338). In this study, the easily reachable nurse population was PHC facilities at Mutale Local Area as they did not perform well during the Provincial Record Audit of ART programme done on Feb 2013. Another easily reachable population in this study were Nurse Initiated Management of Antiretroviral Therapy (NIMART) trained professional nurses, as their daily work and activities, involved issuing treatment and creating nursing documentation of patient information of ART programme, and compiling monthly statistics and sending that information to the Vhembe District.

3.4.4 Sampling Method

Sampling is defined as a process of selecting a small portion or number of participants required to participate, from the total population to represent the whole (Maree, 2007:79). In qualitative research, non- probability sampling is used. This sampling approach also involves non-random sampling since each element does not have an equal chance to be selected and the researcher does not know members of the population (Polit & Beck, 2008:40). Non-probability sampling involves several types of participants, including purposive, snowball, theoretical and volunteers. In this study, the purposive sampling method was used. Non-

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probability sampling was a method where each participant did not have an equal chance of being selected for a particular study, for example participants can be selected purposely (Creswell, 2009:178; de Vos et al., 2011:231).

3.4.4.1 Sampling of Sub-District and Institution

Purposive sampling was used to sample the sub-districts and PHC facilities. Mutale Sub-District was selected for the study due to its inaccurate, incomplete and unavailable ART documents in its PHC facilities [ref]. PHC facilities selected were those in Mutale Local Area found in Mutale Sub-District in Vhembe District. The reasons for those choice was that they render PHC services including ART programme seven days a week, undesirable, incomplete, inaccurate nursing documentation and unavailability of ART programme documents during Provincial Record Audit in February 2013 were from Mutale Local Area found in Mutale Sub-District, PHC facilities. Secondly, during the 18-19 August 2013 data review meeting in Polokwane, the PMTCT Deputy Manager indicated that ART programme statistics/numbers exceeding 100% were from the Mutale Sub-District where Mutale Local Area is located.

3.4.4.2 Sampling of Professional Nurses

Professional nurses were selected purposively. The reasons for selecting professional nurses were that they were NIMART trained, they worked at PHC facilities, at Mutale Local Area, in Mutale Sub-District in the Vhembe District, their daily work and activities directly involved nursing documentation, creation, maintenance and keeping of patient documents. All the PHC facilities shared a common challenge, namely, shortage of staff—especially professional nurses who were faced with a challenge of multiple registers, books and forms in which they had to create, maintain and keep patient documents.

3.4.4.3 Inclusion Criteria

According to Neuman (2011:230), inclusive criteria are used to clearly show inclusions of

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participants following their characteristics of interest. In this study, the inclusion characteristics for PHC facilities were the following: they were found at Mutale Local Area; and the undesirable, incomplete, inaccurate nursing documentation and unavailability of ART programme documents during Provincial Audit in February 2013 were at Mutale Local Area, PHC facilities. Secondly was that on the 18-19 August 2013 during data review meeting in Polokwane, the PMTCT Deputy Manager indicated that the ART programme statistics exceeding 100% were from Mutale Sub-District in which Mutale Local Area was located.

The inclusion characteristics for professional nurses was that they were NIMART trained, worked at PHC facilities at Mutale Local Area in Vhembe District, their daily work and activities involved nursing documentation of patient information of different programmes, including ART, and compiling statistics and sending these to the Vhembe District on a monthly basis. Professional nurses should at least have two or more years' work experience at PHC facilities at Mutale Local Area, and must be aged 24-49 years.

3.4.4.4 Sample Size

Neuman (2011:240) defined sample size as how large a sample should be. According to de Vos et al., (2011:358) there are no stipulated rules in qualitative research design, it depends on what the researcher wants to know, the purpose of the study, what it takes, what is helpful, what credibility it has and what is done with the available resources and time. In this study, there were two samples. Firstly, all PHC facilities at Mutale Local Area were purposely selected. There are 07 facilities, Tshiungani, Thegwe, Tshikundamalema, Matavhela, Shakadza, Rambuda clinics and Mutale CHC. Secondly, all professional nurses were selected as follows: three per PHC facility, both males and females who had two years or more work experience at Mutale Local Area PHC facilities in Vhembe District, Limpopo Province. A total number of 10 NIMART trained professional nurses were selected based on data

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saturation. A sample of professional nurses was reached when there no new data or information was emerging as participants were repeating the same information given previously by others. In a qualitative design, data saturation occurs when participants repeat the same information.

3.5 Data Collection

de Vos et al., (2011:335) defined data collection as a way of gathering information through asking questions, observations, voice recordings and taking field notes to answer rising research questions. According to Polit and Hungler (1995:655-656), data collection is finding unknown information through interacting with participants and asking questions related to the topic under study. In this study, a trusting relationship was established by developing rapport with professional nurses through visiting them on the agreed upon appointment date. Appointment dates were secured for data collection. Data were collected on Saturdays and Sundays during lunch time in February 2015.

In-depth face-to-face interview was the technique/method the researcher used to collect different kinds of information from participants (Maree, 2007:87). According to Maree (2007:87), an in-depth face-to-face interview is a two-way communication where the researcher asked participants questions, in order to learn more about their ideas, opinions, and beliefs about the topic under study. Polit and Beck (2008:372) defined an in-depth interview as a one-to-one interview between the interviewee and researcher, a method where the researcher asked participants questions without preconceived opinions regarding the phenomenon and specific content.

3.5.1 Question for Professional Nurses

In this study, the researcher asked participants the following question:

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"Explain in your own words what could be the factors affecting quality nursing documentation of patient information at your facility."

The researcher wrote field notes, word by word and used a voice recorder to avoid omitting participants' experiences. Participants were given an informed consent form to allow the researcher to use a voice recorder. A research assistant was hired to assist the researcher during data collection (Polit & Hungler, 1995:271-272).

An in-depth face-to face interview method was used by the researcher as it was flexible and allowed participants speak for themselves. The researcher was able to make follow-up on the information given by participants through communication skills, like probing, encouraging, paraphrasing and observing non-verbal cues. These techniques were used to facilitate the interview and gather more information. The venue for the interview was any unoccupied office, as there were no extra offices that could be used at the facilities (Polit & Beck, 2008:372). The interview lasted for about 35 to 45 minutes.

The researcher first identified participants by visiting the selected facilities and introduced herself to the participants. Then appointments were made with participants to meet at a venue that was comfortable and free from distractions. The researcher arranged a meeting with each sampled participant. Explanations about the nature, purpose and methods of the research were outlined. Participants were further requested to participate in the study and were assured about ethical measures such as confidentiality, anonymity, voluntary participation and the right to withdraw without penalties.

3.5.2 A Voice Recorder

A voice recorder was used during interviews, after permission to use voice recorder was obtained from participants and informed consent forms signed by the participants. Participants were informed that a voice recorder will be used so that information can be

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captured accurately. The researcher created an environment that was favorable for the interview. The voice recorder was checked before use to ensure that it was in a good working condition (Polit & Beck, 2008:372).

3.5.3 Field Notes

Field notes were written during interviews and were temporary key words, cues or drawings that assisted to trigger the memory of the researcher about what happened during data collection. The notes represent the observer's efforts to record information and also to synthesize and understand the data (Polit & Beck, 2008:372). Participants were informed about the purpose of taking field notes and requested their permission to take notes during the interviews. The researcher recorded notes in a two-quire book in the presence of the participants.

3.6 Data Analysis

Data analysis is a creative examination process of information making sense of the findings and meaning of the collected data, during a research process. The researcher used qualitative data analysis methods to evaluate data. The researcher considered Tesch's eight steps when analyzing data (Tesch, 1990; Creswell, 2009:186). The steps were as follows:

3.6.1 **Get a sense of whole**— researcher read all written versions from original material and wrote down ideas coming to her mind.

3.6.2 **Pick one document**— the researcher picked one short interesting document or the one on top of other documents. The researcher reviewed it and asked herself the question, "what is that about."

3.6.3 **Make list of topics** — researcher made a list of thoughts and wrote them in the margin; similar topics were grouped.

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3.6.4 Abbreviate topics as codes — researcher listed topics taken from information gathered, and wrote them as segments of text.

3.6.5 Describe wording for topics - categories were reduced by grouping them and draw lines between categories.

3.6.6 Make final decision - the researcher decided on the abbreviation for each category, and arranged codes alphabetically.

3.6.7 Group information- material that belonged to each group categorized.

3.6.8 Revisit existing information — the researcher revised records

3.7 Measures to Ensure Trustworthiness

According to de Vos et al., (2011:419-421), trustworthiness denotes how the researcher persuaded her participants that the findings of the study was worth paying attention to or taking account of. The term trustworthiness was also used to evaluate qualitative information using the criteria of credibility, transferability, dependability and conformability (Babbie & Mouton, 2009:277). Lincoln and Guba's framework (1985:318), as cited in Polit and Beck (2008:539), outlines 4 criteria for developing trustworthiness:

3.7.1 Credibility

The goal of credibility is to illustrate that research was conducted in a way that participants were appropriately identified and described. Lincoln and Guba (1985:318), as cited in Polit and Beck (2008:539), pointed out two aspects: first, carrying out the study in a way that enhances the believability of the findings and, second, taking steps to demonstrate credibility to external readers. Credibility answers all the questions regarding how truthful the information was reported from the participants (Babbie & Mouton, 2009:277). By prolonged engagement, the researcher works together with the participants, spending more time with

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them, through continuous interaction explaining the reasons for the study in order to gain trust and relationship. Thus, in this study, persistent observation was maintained during interactions and interview sessions (Babbie & Mouton, 2009:277).

3.7.2 Triangulation

Triangulation refers to the use of multiple methods in order to reach the conclusion about the truth (Babbie & Mouton, 2009:277). In this study, methodological triangulation was applied to attend to the research topic under study, through conducting interviews, observing participants' non-verbal cues like facial expressions or gestures and voice recording participants during interview sessions (Babbie & Mouton, 2009:277). Data triangulation was applied through the use of multiple sources of data, by interviewing multiple participants (Babbie & Mouton, 2009:277). In this study, the researcher was hoping to interview 18 participants depending on data saturation.

3.7.3 Referential Adequacy

The researcher kept field notes — written on everything that happened during interviews and all non-verbal gestures for reminding purposes. A voice recorder was used to capture detailed information during interviews, and thus not to omit information given (Babbie & Mouton, 2009:277).

3.7.4 Member Check

Member check was done by providing feedback to the participants after the interview to ensure that the researcher has captured the true meaning of the participants' experiences and to allow validation by the participants (Babbie & Mouton, 2009:277). That strengthened the trusting relationship; the researcher has built with participants and allowed her to rectify mistakes if any.

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3.7.5 Peer-Debriefing

Peer review to discuss the findings was done with colleagues of similar educational level at university. A peer review was done to check information gathered and how the researcher analyzed the information. An independent data auditor was asked to analyze the information. Data and methods of analysis were discussed with colleagues who share an interest in the subject (Babbie & Mouton, 2009:277).

3.7.6 Transferability

Transferability means that the findings of the study can be movable or applicable in another setting or group of people and give similar findings (de Vos et al., 2011:42; Babbie & Mouton, 2009:277). This methodology provided dense backward information about participants, research context and setting in order to allow the peers to check how transferable the findings were. The sample in this study was purposively chosen to ensure that maximum and specific data can be derived from the context and participants.

3.7.7 Dependability

Dependability answers the question about how one can be sure that the findings would be the same in case the study was repeated with similar participants in the same setting (Babbie & Mouton, 2009:278; de Vos et al., 2011:420; Brink, 2012:172). The methods used to collect data were consistent. The researcher provided her audience with evidence that if the study was repeated in the same setting with similar participants, similar results should be obtained. The researcher has conducted a literature review to check previous studies on methods and techniques used on the same or related topics like the one under study. The methodology used in this study was described in full by the researcher. The proposal was presented for peer review and examination. An independent coder was requested to assist with coding

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during data analysis (Maree, 2007:186). Field notes and information from the voice recorder were used. That displayed consistency of information gathered before and during an interview (de Vos et al., 2011:420).

3.7.8 Confirmability

Confirmability means answering a question on how the researcher ensured that the findings reflect the participants and the interview itself rather than creating researcher's biases (Babbie & Mouton, 2009:278; de Vos et al., 2011:42) — that is, to clearly indicate that the findings were a product of the concern and focus of the interview, not biased by the researcher. The researcher planned and followed the research methodology of previous studies, that is, how others conducted their studies. The researcher examined and identified herself to avoid bias.

3.8 Ethical Considerations

When a research study involves people as participants, serious consideration should exercise to ensure that their human rights are protected (Polit & Hungler 1995:32). The following ethical principles were followed in this study:

3.8.1 Protection of Human Rights

The researcher had an ethical responsibility to protect the rights of human research participants. That was done to preserve their self-respect, dignity and health. The human rights that required protection in this research were: right to self-determination, right to privacy, right to anonymity and confidentiality, right to fair treatment, protection from discomfort and harm. Because this study involved people, the researcher avoided risks that could cause harm to participants. However, security of the participants was paramount. Participants were treated as strictly confidential by numbers instead of using their names. That was done to preserve anonymity and confidentiality. Information collected would be

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used for research purpose and is kept under lock and key.

3.8.2 Rights of Institution Where Research Was Based

Ethical clearance was obtained from the University of Venda Research Ethics Committee (Annexure B). Permission to carry out the study was sought from the School of Health Sciences Higher Degrees Committee, Senate Committee of the University of Venda and from Limpopo Provincial Department of Health and Social Development and the Vhembe District Executive Manager, PHC Operational Managers. Every participant had an individual informed consent form read and explained to them in order to give consent before data were collected.

3.9 Summary

This chapter described the detailed process on how the study was conducted in order to achieve objectives of the study. The study design was qualitative, explorative, descriptive and contextual in nature. Ethical considerations and trustworthiness were also described. Processes followed in data collection and analysis was outlined. The following chapter focuses on the analysis and discussion of the research findings.

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CHAPTER 4

DATA ANALYSIS, DISCUSSION AND LITERATURE CONTROL

4.1 Introduction

A discussion of the research methodology was presented in the previous chapter. The objectives of this chapter were to analyze raw data and reduce it into themes and sub-themes to reflect participants' views on factors affecting quality nursing documentation of patient information. The results reveal ideas from professional nurses who are involved in creating, maintaining and keeping patient information at PHC facilities in the Vhembe District. Professional nurses who participated in this study have two years or more work experience at PHC facilities in the Vhembe District. Relevant literature was used against the findings whilst incorporating the modern paradigm for improving health care quality.

4.2 Demographics of the Participants

Data were collected from 10 professional nurses working at PHC facilities with 2 or more of years' experience at Mutale Local Area in the Vhembe District (Table 4.1). Participants were NIMART trained professional nurses whose daily work involved nursing documentation of patient information and compiling statistics.

4.3 Presentation of the Findings: Themes and Sub-Themes

Data presented were collected from NIMART trained professional nurses.

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4.3.1 Theme 1: Factors Related to Professional Nurses' Increased Workload

Table 4.2 shows the themes and sub-themes that emerged for data analysis of raw data collected from NIMART professional nurses whose daily work involved nursing documentation of patient information and compiling statistics for submission to the Vhembe District office. The participants expressed different views about factors affecting quality nursing documentation of patient information. Appropriate quotations drawn from the raw data were contextualized with the relevant literature to substantiate the themes. Professional nurses explained that they experienced an increased workload in that one person was expected to do multiple duties, collecting information from patients, assessment, prescription and issuing of treatment as far documenting patient information was concerned.

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Table 4.2: Themes and sub-themes that emerged from the data analysis

Themes	Sub-Themes	
1. Factors related to professional nurses' increased workload	1.1	The use of multiple documents at PHC facilities
	1.2	Availability of multiple services daily at PHC facilities
2. Factors related to knowledge deficit	2.1	Lack of understanding of the importance of quality nursing documentation
	2.2	Insufficient training periods
	2.3	Negligence and laziness
3. Factors related to lack of resources	3.1	Shortage of staff
	3.2	Poor stationery supplies
	3.3	Inadequate infrastructure and poor maintenance
4. Factors related to unavailability, illegible and incomplete documents	4.1	Staff attitude towards nursing documentation
	4.2	Lack of motivation

Participants said they work three or four in a group instead of six staff members due to a shortage of staff, thereby increasing professional nurses' workload. The few staff members were expected to perform duties — even for those staff members who were not yet employed. Professional nurses' workload is increased as they render multiple services in their facilities, including everyday emergency cases. The few professional nurses were also expected to attend workshops while on duty. In case there is a workshop to be attended, it means one of the four staff members have to vacate the facility leaving the staff members being three or two thereby increasing pressure of work to those remaining behind.

New programmes were being introduced at the facility where the DoH reported that they were trying to reduce workload at facilities, but, in turn, such programmes increased professional

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nurses' workload as no new staff members were employed to execute such extra duties. When the CCMDD programme was introduced, the DoH said this programme would reduce workload as there will be pick-up points where patients will collect their ART treatment from without visiting the clinics. Patients will only visit the facilities after a period of six months for assessment, blood reviews and renewal of their ART chronic treatment forms.

Up to this time such pick-up points were not yet allocated for all PHC facilities. Patients are still visiting the facilities to collect their ART treatment. That has increased professional nurses' workload as they were still responsible staff members to issue CCMDD treatment to patients. They were therefore faced with multiple forms and registers used in this programme, adding on the ones they were using for ART.

The immunization schedule has also changed because of new immunization vaccines introduced, like the oral rotavirus vaccine, pneumococcal vaccine and the Pentaxim vaccine. In terms of the ANC there is the BANC programme with its new maternity case book, antenatal register and the newly involved Mom-Connect programme. Then Mom-Connect is done after booking the ANC patient coming for her first visit. The completion of recording information for a first visit ANC patient takes more than an hour as she must also undergo HCT if she is not a known HIV-positive patient.

The counseling and testing issue also takes long time — more than an hour because the programme manager for HCT wants ANC patients to be counseled and tested by a midwife and not other categories of staff. That poses pressure on the professional nurses and that is a lot of work to be done by one professional nurse while other patients are waiting outside. As they render multiple services every day, the woman coming to clinic for her first ANC visit came for consultation on minor ailments and brought her child for immunization. All the three services are to be rendered in one cubicle by one professional nurse thereby increasing the pressure of the work done by one person.

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One male participant said, *"The next issue is pressure of work, in English I can say increased workload when working. As a junior professional nurse checking on my experience, when a patient comes there is a lot to be done for him/her. There is too much work to do facing one professional nurse; one is expected to collect information from patient, take vital signs, do patients' assessment and record health education, return date, and record information in the different registers. Similar information is recorded on patient's booklet, in the tick register, in the chronic register, and specimen registers if specimens are collected."* I start with the names, address, contacts, age and sex, then nursing care rendered in all these registers.

One female participant said, *"When they start introducing CCMDD they said they will create a station where patients will collect treatment. The station will be like a post office or Doctor's pharmacy where none of clinic staff members will be involved. They said at the clinic we will be left with few patients who are on ART. It was said that in such stations patients will no longer be taken vital signs like at the clinic. Now, staff members are still issuing treatment for patients on CCMDD at the facility, no station has been identified yet. The DoH has failed to create a station and employ new staff members to work on this CCMDD programme."*

One female participant said, *"There are multiple registers in the facility on which one patient needs to be recorded in for one service, e.g., antenatal patient coming for the first visit need to be recorded on the tick register, prevention of mother to child register, maternity case record book, specimen register, TB suspect register, counseling and testing consent form, counseling and testing register and if found to be HIV/AIDS positive, to be also documented ART blood specimen register, initiated on ART, maternity case record book and BANC check list must be completed."*

One male participant said, *"Those two nurses who remain at facility render different*

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services like under five clinic, reproductive health, antenatal care, minor ailment, child health, maternal and newborn, NIMART, HCT, TB, STIs' and chronic patients include, mental health, diabetes, hypertension, epilepsy, asthma, ART, emergency services, and others will be coming for collecting follow-up treatment and must recorded on booklets, data book and files so you can so a nurse can miss some of patient information."

One female participant said, "*Yes, there are a lot of forms which are used for CCMDD programme. For example, delivery forms signed by the nurse, other forms signed by patients. CCMDD patients treatments are not kept alphabetically are just mixed in the box because there is no enough space in the clinic to keep them. It takes long time for us to look for patient's parcel in the box in another room."*

One female participant said, "*Immunization schedule has also changed because there are new immunization vaccines introduced, like the oral Rota virus vaccine, pneumococcal vaccine and the Pentaxim vaccine. On the antenatal care there is the BANC programme with its new maternity case book, antenatal register and the newly involved Mom-connect programme. Mom-connect are done after booking antenatal care patient coming for first visit. The completion of recording information for first visit antenatal care visit patient takes more than an hour as she must also undergo HIV/AIDS counseling and testing if she is not known HIV/AIDS positive patient.*"

According to the Australian Government Safety, Rehabilitation and Compensation Act 2011, when a patient is started on treatment s/he should be recorded in different relevant records called the treatment plan. In these records all the information about the patient will be recorded. These findings indicate that nurses were faced with increased workload as they were required to document information on different relevant records according to their Department. There is a greater similarity between the findings on the study done outside South Africa and the findings at PHC facilities in Vhembe District. From theme 1 — factors

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related to increased professional nurses' workload, two sub-themes emerged, namely, the use of multiple documents at PHC facilities and availability of multiple services daily at PHC facilities.

Borglund and Oberg (2008:03) indicated that the knowledge about how to utilize records is crucial for those who create and manage records in an organization in their investigation on how records are used, while this study focused on exploring factors affecting quality nursing documentation of patient information at PHC facilities.

4.3.1.1 Sub-Theme 1.1: The Use of Multiple Documents at PHC Facilities

Professional nurses have reported a common problem of increased workload due to multiple registers following different services rendered at PHC facilities. Each service rendered at these facilities has its own multiple registers wherein one patient must be documented if consulted. They indicated that most of the information on the multiple documents is duplication. It happens that a patient who consulted for one service will have his/her information recorded in more than one document.

Even patients do complain about too much documentation as you will hear one saying, "Just give me what I'm here for" and you will remain documenting the information. The documents used at PHC facilities are not standardized according to the participants' understanding. They reported that it is not an easy task to take a patient's history, do assessment, record information on the tick-register, patient's booklet, specimen book, laboratory form and more depending on the patient's complaint of that day. The documents used are interconnected and if completely recorded, the flow of the information will be clear, that is the reason they are bound to record in all those documents.

One female participant said, *"Similar information is recorded on patient's booklet, in the tick register, chronic register, and specimen registers if specimens are collected. In the tick*

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register, specimen register, different forms I start with the names, address, contacts, age and sex for every patient I consult. Then follow the required information depending on the register in which the information is being documented."

One male participant said, *"I experience heavy pressure workload due to lot or registers and books in which information is to be documented in the facility. Multiple registers are to be written by one professional nurse during consultation with a patient for one services rendered and staff members do forget to document information in some of this registers."*

Another male participant said, *"The growing complexity and changes of different programmes, forms and registers in the clinic makes it too demanding for those fewer health professionals to manage all documents to be completed daily e.g. when you consult a patient, you record on patient's booklet, on the tick register and on different registers used during screening or diagnostic procedures as required by different programmes."*

Ten participants (males and females) indicated that, *"A newly diagnosed HIV-positive patient must be documented in all different documents used for this programme, in the tick register, ART file, Indian cover file, specimen books, ART register, care register and patient's booklet. It takes more than an hour to complete these documents properly thereby increasing patients waiting time."*

At PHC facilities in Vhembe District, the ART files are not assessed by Local Area Managers during their monthly supervision visit as they are not trained for that. They do not have ideas on how to assess those documents as there is no tool either to assist during evaluation. Professional nurses may be leaving blank spaces on the ART files as they know their supervisors do not check them. Law, Akroyd and Burke (2010:07), in their study titled "Improving nurse documentation and record keeping in stoma care in large London Hospital," revealed that the forms used in stoma care were partially completed by the nursing staff —

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reason being that such form lacked standardization and were not viewed by other health professionals.

According to International Records Management Trust of July (2000:02), in many countries around the world, record systems are unable to cope with the growing mass of unmanaged documents due to insufficient financial and administrative resources. The growing complexity of programme forms and registers need relevant staff with enough stationery in order to manage the duties required. Availability of financial and administrative resources is the answer. Therefore, challenges encountered at PHC facilities about complexity of records are also found in many countries around the world.

4.3.1.2 Sub-Theme 1.2: Availability of Multiple Services Daily at PHC Facilities

During interviews most professional nurses mentioned that PHC facilities render integrated services daily following the supermarket approach. In one cubicle one professional nurse is expected to render multiple services one by one, depending on the needs of the patient who enters the cubicle. There is no specific cubicle for specific services as the requirement by DoH is that services must be integrated, and they do not focus on patients on ART only, but in all patients coming to the facilities for different services including emergency services. The participants indicated that multiple services also increase patients' waiting time in the facilities as one patient may consult for more than one service at a time. Our patients are happy about availability of multiple services as they do receive different services in one visit, but they keep on complaining that others take long period of time being consulted in the cubicle. It seems they forget that the cubicle is a supermarket as it sells all the services needed.

Four participants, one male and three females explained, "*The facilities render multiple services available on daily basis namely; reproductive health, child health, antenatal care,*

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chronic diseases, outreach, geriatric, mother and child, minor ailment, ART, STI and TB. We do not focus on one service, each service has its own respective multiple registers and as we render different services daily we turn to forget to record patient information in all those multiple registers and books."

One female participant said, "*Now we render services like immunization of under fives, all chronic diseases like diabetes, hypertension and epilepsy, minor ailment, geriatrics, mother and child, postnatal, ART, reproductive health, TB, emergencies, outreach and deliveries. All these people must be attended to by professional nurses where we must record information for chronics on three documents, on patients' booklet, data book and patients' files. All chronic patients have chronic files to be written on each visit. If only one professional nurse is on duty s/he cannot record all information required. That is where we are losing lot of information it won't be possible as such as the pressure of work is increased hence more workload.*"

One female participant said, "*The facility does not render ART programme only, but all different services are rendered. When I'm still busy with another patient, an emergency one can arrive and I must run to attend emergency case first. When I come back from that scene I might have forgotten about the information to be documented for the previous patient*."

The findings of the study "*Factors influencing successful implementation of the basic antenatal care approach in primary health care facilities in eThekwini district, KwaZulu-Natal" by* Ngxongo and Sibiya (2013:03) indicated that integration of services was also done in other districts in South Africa for patients to access all multiple services every day in a week. It was explained that patients are able to serve time as they may use one day per month to visit the clinic and receive all the services required.

The literature maintains that the PHC facilities are always overcrowded due to the

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implementation of free integrated PHC services, and contributed to the deterioration of facilities management due to professional nurses' strain, stress and burnout. In the Bronkhorstspruit area, that resulted in complaints about long waiting hours, which affected the easy accessibility of health services by patients. It was found that patients were unhappy with the time spent queuing at PHC facilities in some of the rural communities in Limpopo Province. Similarly, some patients were frustrated with long waiting times as consultations were done without securing an appointment in the Taung District of North-West Province (Baloyi, 2009:55).

Vawda and Variawa (2012:09) confirmed that professional nurses at PHC facilities were faced with the daily integration of PHC services, including the ART programme, well-being, and safety in order to build and maintain a health of their patients. They further indicated that PHC services are accessible to everyone because even those who work six days per week are able to attend the clinics on weekends for similar services that are available during week days.

4.3.2 Theme 2: Factors Related to Knowledge Deficit

Knowledge deficit can be described as a person's lack of information regarding the way tasks are to be executed. Knowledge also refers to a person's state of being, with respect to somebody with information which includes ignorance, awareness, familiarity and understanding. During the interviews professional nurses indicated that some co-workers lacked knowledge with regard to what is it that one has to document in different books and registers. This may be due to lack of training of professional nurses in relation to quality nursing documentation of patient information at facility. It may also be due to inadequate training attended for short period of time mean while the information allocated is more than the days.

They also explained that professional nurses who have insufficient information as to what is to be documented, they are sometimes shy to ask others thinking that they will look down

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upon them. Some professional nurses should be ready to learn more information from their co-workers through teaching each other about the issues they understand better on ART documents. They reported that new forms are delivered to their facilities from different programmes without information as to how they are to be completed. As professionals they try to do the work they were employed for but in such cases they fail to record exactly what is required as no direction was provide.

It was also reported that information to be documented on patients' documents by professional nurses include full physical examination, the findings of the examination (diagnosis) the health education given, the treatment issued and advices about treatment, and the follow-up date of that patient. The participants explained that there are FPD staff members who seem to be the leaders of the ART programme and they complained that these staff members do not rain them at facilities on the issues they do not understand

One male participant said, "*Yes, lack of knowledge happen to professional nurses who think they know everything and are doing the best but they are failing as they leave recorded documents in a poor condition. There is no person who knows everything at workplace; we need to work together for quality nursing documentation as the key indicating quality patient care.*"

One female participant said, *"There is insufficient training of staff members in relation to quality nursing documentation of patient information at facilities. Sometimes we receive forms for different programmes which are to be completed without explanation on how to complete them as the changes approaches the programmes. These affect nursing documentation as we are not trained on how to complete such documents but as professionals we try to complete such documents."*

Another female participant said, "*NIMART training duration was only one week, I think it*

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should be one month training, where we will be taught in detail about everything including all the conditions available in the manual book issued to us during training. The training should include stationery used on ART programme which are files, forms and registers, maybe it would be enough. We may come back fully informed of what is expected from us as far as documentation of patient information on ART documents is concerned.

One female participant said, "*Here at the facility there are some of NIMART trained people who have better understanding about the files, forms and registers used for the ART programme. There are FPD staff members who are leading this programme who can teach us to improve our understanding on the ART documents.*"

One male participant said, "*Professional nurses do not know what is to be written they leave blank spaces where it is a must to record patient information. For example there is a space for notes on continuation form but you find it blank as the professional nurse does not know what is to be written. We must write information on how the patient looks like today losing weight or pale, also document health education about the condition or treatment given and the return date thereof as to when the patient should come for review. Professional nurses do not write relevant information as they do not know exactly what is to be documented.*"

The literature clearly indicates that professional nurses must be knowledgeable about the reasons for availability of recorded information as the PHC facilities are the entry points of patient information. Patients visit PHC facilities before they are referred to the hospital with a referral letter which should be readable so that the receiving professional nurse will be able to understand what is to be done next to assist the patient (DIHMS) Standard Operating Procedure, 2012:01).

Additionally, Joubert and Gerber (2011:10) argued that knowledge is a very important tool

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for professional nurses regarding their daily work of documenting services rendered to patients and is important for the organization's evidence and development. Lack of the relevant knowledge at the workplace will affect the efficiency and effectiveness of service delivery at facilities. Therefore, professional nurses have responsibility to develop knowledge at workplace, ability to re-use the knowledge they developed and ability to share that knowledge with co-workers for effective work execution.

A study done by Pullen and Loudon (2006:280) also indicated that professional nurses lacked information sharing amongst each other as they have a tendency to treat patient's documents as a personal thing rather than cooperation's assets. Professional nurses need to understand that patients' documented information must be shared confidentially for the benefit of the patients in the improvement of service delivery. Pullen and Loudon (2006:280) further indicated that there is low priority given to nursing documentation management by health professionals.

The sub-themes that will be discussed below emerged from factors related to knowledge deficit and are three, namely, lack of understanding importance of quality nursing documentation, insufficient training period, and negligence and laziness.

4.3.2.1 Sub-Theme 2.1: Lack of Understanding of the Importance of Quality Nursing Documentation

Professional nurses voiced some of the staff members lacked understanding why patient information should be recorded and kept at the facility. It was illustrated by the behavior of co-workers who did not mind issuing treatment to patients without documenting the information on the relevant documents. Professional nurses mentioned that when patients' ART files are checked they sometimes find that patient information for the month is not recorded, e.g., visits to the facility, would not be documented. They complained that it poses a

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great challenge as it clearly indicates that the patient missed the follow-up visit appointment date. Participants complained that amongst them there were lazy people not interested in documenting nursing care rendered to patients who came to the clinic for services. They complained that such professional nurses were fully aware that patient information needed to be documented as evidence of work done, but they just issued treatment to patients without recording the information.

They further indicated that issuing treatment to patient without recording was not permitted because when the patient comes back it would be difficult to ascertain the type of treatment given as it was not documented, but patient may use other treatments from which side effect may develop and the nurse may be charged with medico-legal hazards. It was also reported that if the previous nurse who consulted the patient did not record the information, the present nurse will not be able to continue with relevant patient care. Continuity of patient care is then interrupted and the delay would be a problem trying to ask the patient as to what happened the last day he came to clinic.

One male participant indicated, *"Lack of knowledge by some of our colleagues, they do not ask others who are informed. When checking on patient's ART file we find that patient information for that month is not recorded as if the patient has missed return dates but on patient's book the information is documented."*

One male participant said, *"Laziness and carelessness. Sometimes you find a nurse being lazy to write the nursing care rendered to patients meanwhile they are aware that the truth is to document patient information. That is professional nurses' laziness, not taking care of their work and don't care about what he or she was employed for. Professional nurses just give patients treatment without documenting required patient s' information."*

One female participant said, *"It is not allowed to give patient treatment without*

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documenting the care given as patient may develop side effects from treatment given or taken. When patient comes back you won't know type of treatment you gave him or her as it was not documented the day treatment was given. Remember you can give treatment to patient and he can use other treatments from which side effect may develop. As you have not documented patient information when issuing treatment previously, you can be caught around a corner because of that.

One female participant said, "*There are lots of effects as when patient visit the facility in the absence of the previous nurse, patient will not receive quality nursing care accordingly as the information which was not be documented by the previous professional nurse. Continuity of care will not exist in this sense and delay will be a problem trying to ask patient as to what happened the last day he came to clinic.*"

Professional nurses are urged to be vigilant enough when dealing with patients' records as quality documented patient information might be needed to answer queries from stakeholders, including family, funders, donors or courts and the DoH. Important evidence can be provided if malpractice claims or office inquiries arose concerning care given to patients (Borglund & Oberg, 2008:06).

Another study done by Pullen and Loudon (2006:280) revealed that professional nurses also lacked awareness of the importance of good nursing documentation in health facilities, some of the professionals write their notes long after, when they are then suspected and the case being investigated. This information clearly shows that health professionals lacked important information with regard to quality nursing documentation because writing information very late after an incident may lead to omission of facts.

Findings in the study done by Pullen and Loudon (2006:280) also indicated that health professionals lacked information sharing amongst each other as they had a tendency to treat

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patient records as a personal thing rather than a corporate asset, there is low priority given to records management by health professionals. In support of the findings, Meyer et al., (2011:106) indicated that there is a need of available professional nurses to facilitate proper integration of services whilst Singingtree (2006:01) pointed out those competent professional nurses will employ their basic skills together with their clear written information in doing their nursing duties.

4.3.2.2 Sub-Theme 2.2: Insufficient Training Periods

In the process of the interviews professional nurses outlined the issue of short periods allocated to training sessions they attended. They indicated that they attended workshops for very short periods, but the information given is more than the allocated time. It is difficult for them to understand and apply the information upon their return to their normal course of duties as there is no time at work to sit down and read books as they are faced with their workload.

Participants mentioned that during NIMART training professional nurses are taught when to initiate an HIV-positive patient, treatment used, baseline blood samples to be collected and opportunistic infections and other conditions interconnected to HIV/AIDS. They further complained that stationery used during initiating patients were not included in the training, that is why is very difficult for them to utilize stationery at the facility. They only see these ART documents at the facilities when initiating HIV/AIDS patients.

Professional nurses suggested that facility operational managers should take responsibility to teach every staff member so that they have knowledge about information to be documented on the ART documents. Even though they were not trained to train others, such practices would benefit the facility. Professional nurses also remarked that they were not trained on the newly introduced CCMDD programmes — only one professional attended the meeting introducing this programme and it was indicated that they would have to report to others at facilities. Now, participants hope that every employee should be trained in order to work effectively as there would be no one shifting

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responsibility to others.

One female participant said, *"There is NIMART training undergone by professional nurses, who I think is not enough. During training professional nurses are taught about when to initiate a positive HIV/AIDS patient, treatment used, baseline bloods to be collected and opportunistic infections. Stationery used during initiating patients is not included in the training. That is why is very difficult for us to utilize stationery at facility."*

One female participant said, *"You will find that many times, clinic managers, take responsibility to teach every staff member so that they have knowledge on these. Even though they did not receive training to train others we do it together, as there is no one who would like to see her facility rated under performance. Every manager want to see his or her facility praised for good performance. She try by all means even though she do not understand some of the information to be documented she do call others for clarity. Until we feel that we are now used to document the required information."*

One female participant said, *"I think the NIMART training is not enough. Time allocated for the training is not enough. The information taught is too much and the documents used are too many also. You find that to have time to read those documents at work is not available. Except when I have a patient and just want to check information is then that I can open those documents. Training period allocated for NIMART was very short."*

One female participant said, *"Professional nurses are not trained on CCMDD programme, only one professional nurse attended a meeting where this programme was introduced and they said we must give report to others. It was not a full training as such but just one day short notice information. It was said during that meeting that there will be trainings for professional nurses but it is not yet implemented."*

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One female participant said, *"Haa! That is impossible. Nurses trained on NIMART must be enough so that we can be able to work effectively. So that every staff member in both groups must be NIMART trained and there would be no shifting responsibility will be done. In fact I was thinking all categories must be NIMART trained so that we can work together with relevant knowledge."*

One female participant said, *"Professional nurse are trained on NIMART but information taught during NIMART is too much as we start at 08h00 to 18h00 on top of that we are also given self-study work to do after hours. Information is just forced into professional nurses' heads and they fail to understand all the information given."*

One male participant said, *"No! The ART files, forms and registers are not included during NIMART training."*

One female participant said, "*I think it is not enough, the FPD staff members should have enough time with us and train us on how these forms and files are completed, so that we nurse our patients in totality."*

One male participant said, *"They taught us about when to initiate patients, baseline blood observations and treatment side effects, and types of treatment which may suit different categories of patients, no ART files, forms and registers were shown during training. Professional nurses see these files at clinics."*

One male participant said, *"The NIMART training should to be improved. Length of training must be increased so that we come back with enough information. The training should also include ART files and forms so that we are orientated on how to document information on then at the clinic."*

One male participant said, *"NIMART training I attended was one week I think it should be*

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one month training, where we will be taught in detail about everything and practice documenting information before we go back to our workplace, may be it would be enough."

The literature maintains that in order to address the need for occupational training it is crucial to decide the future training needs of facilities and districts, especially in the disadvantaged rural areas. To develop and implement appropriate training programmes to address skills deficits, programme managers must improve on support of professional nurses during and after training at their respective facilities (Bester & Engelbrecht, 2009:01). Additionally, regular professional auditing of patients records at facilities provide greater chances for training and development needs for staff members (Nursing & Midwifery Council, 2007:08).

According to The President Obama's Nursing Report (2012:02) the NHSC has been supporting nurse practitioners, certified nurse midwives and psychiatric nurse specialists, as well as other primary care providers for 40 years. By offering nurses scholarships and loan repayment facilities to pay down educational debt, these health care professionals were able to work in underserved communities where they were needed most. Training for nurses is very important to make them understand reasons for accurate record keeping as it is done in United State of America. The literature corroborates that there is shortage of trained professional nurses in South Africa, especially in rural areas and that entails the training of lesser-qualified professional nurses to perform tasks which they were previously not qualified to do, or tasks that were beyond the scope of their practice (Vawda &Variawa, 2012:09).

According to Ngxongo and Sibiya (2013:05), their study participants indicated that in-service education and workshops on the BANC (Basic Antenatal Care) programme were used by programme supervisors and managers as the means of communication to empower professional nurses at PHC facilities in eThekwini District, KwaZulu-Natal. Supervisors were

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trained on BANC in eThekwini Districts that was the reasons they were able to give good support to professional nurses at their workplace with full understanding as to what they were to monitor regarding the performance and progress of the programme. In the Vhembe District supervisors were not trained on the ART programme as they did not check patients' ART files remaining at PHC facilities, during the monthly support visits they conducted.

Booyens (2005:370) argued that employees should be observed for the need for training by allowing them to give inputs and suggestions to improve their skills and knowledge. Intentionally planned in-service training assisted professional nurses to be efficient and effective at work. The eThekhwini District is trying by all means to improve health care for the patients through professional development to empower nurses by continuous in-service training and workshops done once per month for a newly started programme. Following the paradigm selected by the researcher to support the study, it indicated that eThekwini District has used step one of the paradigm. It involves identifying the repeated chronic complex and recurring problem at the PHC facilities that needed to be addressed by following the strategies utilized by other countries (Massoud et al., 2001:33). Even in Vhembe District, step one of the paradigms must be adopted to bring about change at the PHC facilities.

4.3.2.3 Sub-Theme 2.3: Negligence and Laziness

During interviews, participants described why some of the information was not documented on the patients' documents, including negligence and laziness by professional nurses who did not care about patients. Some of the professional nurses did not care for documents to be complete as they just left blank spaces, even if they were aware of the information required to fill out the document.

One male participant said, "*Professional nurses themselves have ignorance or are lazy to write on ART files. You find a professional nurse telling a patient coming for the service that, I'm relaxing I will write on your booklet only and give you treatment then you go, I will*

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record on your ART file later when not busy. In that way patient information is getting lost due to nurses' laziness and information is not documented."

One male participant said, *"I associate that with nurses' attitude towards quality nursing documentation of patient information, I think when I see such a person I see a lazy type of a person in the facility. I do not mean I am a better person from others but I think we are here to do what is expected from us as workers who need to follow protocols. Such professional nurses are misbehaving as they know exactly what is to be done and expected from them on facility documents."*

One male participant said, *"Ten percent of available nurses in the clinic are lazy to maintain record keeping, but all of us are professionally trained and well orientated about available records/ stationery used in the clinic on daily basis."*

According to Pullen and Loudon (2006:280), some health professionals wrote patient's notes long after the work had been done and even when their work were subject to be investigated for correctness or queries to be answered — that also indicated negligence and laziness. The study done by Mc Geenhan (2007:58) illustrated that a senior member of the nursing team in an Acute Trust was faced with a problem of poorly documented information in a patient's folder when answering a complaint in meeting with the family of a patient. The health professional was embarrassed at the poor condition of the notes written by one of her staff members, due to negligence. Entry of patient information on documents should be done as soon as possible after an event has occurred before the relevant staff goes off. Studies done by BJM (2011:20) on the quality of patient record keeping showed that nursing records were inadequate and were described as incomplete records.

4.3.3 Theme 3: Factors Related to Lack of Resources

Professional nurses described lack of resources as the main major problem at PHC facilities

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that negatively impacted their working situation, especially quality nursing documentation of patient information. Participants cited the overwhelming shortage of nurses, inadequate infrastructure and poor maintenance and lack of stationery in their facilities that made it difficult to document, update and store patient documents. They voiced concerns over inadequate space, small consulting rooms and lack of cupboards to keep the documents. They walked around while on duty to look for patient documents as there were no spaces in the consulting rooms where such documents can be kept. Bester & Engelbrecht (2009:01) reinforced that the continuous shortages of resources at PHC facilities caused frustration and affected the ability of staff members to deliver quality services and that these issued needed urgent attention.

4.3.3.1 Sub-Theme 3.1: Shortage of Staff

Participants expressed that they experienced staff shortages in their respective facilities because vacant posts in their facilities were not filled by the DoH. The unavailability of the required (staff) number of professional nurses at PHC facilities clearly affected quality nursing documentation of patient information on a daily basis as nurses are faced with different services to be rendered daily. They are also expected to work effectively through consulting patients, managing emergency cases daily and completing different documents, files, forms and registers for quality assurance purposes.

Participants raised the issue that most of the facilities' documents were incomplete because when working they rush to comply with patient waiting time and they happen not to record information required. They raised concern that the DoH may plan inappropriately for their facilities due to under-reporting of data following inadequate documentation of patient information at their respective workplace. They reported that as they were faced with multiple services when staff members conduct outreach activities it increased the burden of shortage of staff at facilities because very few members remained to consult patients.

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One female participant nurse said, *"There are lots of causes that affect quality nursing documentation, you find that there are little staff members, there is no staff. When you are working being very few, the facility is full of patients. When consulting patients we do it in a hurry to comply with our waiting time and to assist them in order to serve them in time. The other thing you will hear patient grumbling. These contribute to incomplete documentation of patient information as we will be running to comply with waiting time and because we are very few. We are short staffed but there are many services to be rendered. You will find that some are to visit schools to render school health services and home visits. Those nurses remaining in facility must render different services and patients will be many. When consulting one patient there are lots of documents to be recorded patient information."*

One female participant said, *"I mean that today we are only three professional nurses on duty, no other category of nurses and according to the staff establishment we should be four professional nurses, one enrolled nurse and one enrolled nursing assistant. That is the reasons we experience high pressure of work as there is lot of work to be done by few workers, then we happen omit more information to be documented. Sometimes we try hurry to work in order to serve our patients on time to reduce unnecessary waiting time but it is difficult to manage the work even for those missing."*

One female participant said, *"I think shortage of professional nurses is also affecting quality nursing documentation of patient information in this clinic. You find that there are little staff members; there are shortage staff members to do the work. When you are working being very few, the facility is full of patients. When consulting patients we do it in hurry to comply with our waiting time and to assist them in order to serve them in time."*

The other male participant said, *"Every professional nurse is struggling to keep quality nursing documentation but the main problem hindering is shortage of professional nurses as few nurses fail do execute increased workload effectively. There will be poor planning for our*

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clinic by the Department of Health following poor recording and underreporting of information (data) on monthly, which will increase patient's waiting time because few professional nurses fail to document required information correctly in their workplace."

Another female participant said, *"Shortage of staff is serious we work being four members today and we were supposed to be six. Sometimes two professional nurses have to attend different workshops. You find that only one professional nurse and one enrolled nurse or enrolled nursing assistant remain working, it means one will take vital signs and one consult patients. It will be difficult for one nurse to document patient information as the clinic provides multiple services; patients may leave the facility during sunset."*

The PHC facilities in eThekwini District were well staffed by professional nurses according to the recommended staffing norm in the Saving Babies Report (DoH, 2005:15) of one professional nurse is to thirty patients per day. In Vhembe District almost all PHC facilities visited for interviews complained of working being understaffed due to shortage of manpower. Bester & Engelbrecht (2009:01), in their study in the Free State Province, supported that the South African PHC services are faced with severe shortages of nurses due to high patient volumes, unpredictable work overload, movement of nurses to private institutions, to other countries and poor working conditions.

According to Ethical Issues Related to Staff Shortages November 2012, the effect of shortages on health professionals were felt acutely by hospitals and other health care organizations globally. Moreover, these clearly supported the notion that shortage of health professionals is a major crisis in many facilities in South Africa and around the world. Vawda and Variawa (2012:09) indicated that the single most major barrier to attaining public health goals is the lack of adequate human resources, especially at the PHC facilities where professional nurses are issuing ART.

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In support to what participants said, a WHO report indicated that it is widely accepted that there is serious need for health workers in many parts of the country. Shortage of professional nurses is due to low throughput of nurses by universities and colleges and the increasing burden of diseases in the country. Globally, there is an alarming shortage of skilled nurses of all categories to meet the demands of their customers, patients (WHO, 2006:19). Booyens (2005:48-49) explained that the higher authorities of DoH responsilities for employing new staff members might recruit professional nurses to reduce staff shortages. Recruiting officers should focus on employing new individuals for the post who have required qualifications, qualities and potential for specific jobs. The recruiting officers should be able to choose the relevant employees who will be productive to improve quality patient care. Management should be able to provide staff members with job security which might assist in staff retention thereby reducing transfers and migration of workers to other countries.

Furthermore Booyens (2005:50) argued that each department should be organized and develop strategies to deal with reasons why professional nurses leave the institutions, in order to retain workers required for the job.

4.3.3.2 Sub-Theme 3.2: Poor Stationery Supplies

The participants complained of serious shortage of stationery at facilities where they experienced a huge problem while executing their job. They indicated that they do not receive stationery from responsible suppliers on time, even when they have ordered. They struggled to photocopy stationery from the nearby schools and sometimes they use money from their pockets to pay for such supplies. In some instances, they do request books from nearby schools in order for them to document patient information. The participants indicated that the shortage of stationery disturbs them as sometimes they failed to record information because prescribed forms were not available.

One female participant said, "*First thing that I can indicate as an important thing following*

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my experience as a junior professional nurse working at PHC facility is shortage of stationery to be used for documenting information. The problem is from the top, our supervisors or whether is the logistics followed I do not know. In the files there are forms called continuation sheets in which information should be recorded about patient care rendered, if stationery is not available information is lost. We need to document work done for the patients. Lack of relevant forms to be used for this ART programme disturbs nursing documentation process."

One female participant said, *"Shortage of stationery, shortage of stationery disturbs us. When patient's file is full you look for continuation sheets and you find is not there, then you skip without recording the information that day the patient visited the clinic. If the information is lost, the facility statistic is affected and the patient will be like is not attending the clinic regularly for follow-up, it inconveniences the services rendered. The information is for the benefit of facility, patient and professional nurse's work."*

One female participant said, *"No, the files are not well completed. They are not complete as such because sometimes there is shortage of stationery. We do photocopy some where you find is not like the original copy where some of the information will not be documented. We request books like two quires' from nearby schools in order to record some of the information as there is no enough supply."*

One female participant said, *"I will write on data book only as we do not have photocopy machines at facility to make copies we can use, in patient's file there will be no information recorded for that visit and will indicate that patient did not come this month. That leaves the patient's document being incomplete and required information unavailable."*

According to a research study done by Baloyi (2009:57) in Limpopo Province on the PHC facilities, there was a severe unavailability of non-medical supplies such as stationery in all

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the municipalities. Supporting factors affecting quality nursing documentation at PHC facilities, Baloyi further indicated that functioning of PHC facilities without these supplies (stationery) poses a problem to staff members providing services, because even though they were trained it was difficult for them to make a difference at the workplace due to shortage of stationery (Baloyi, 2009:57). Booyens (2005:173) further indicated that stationery is the second most important part of health care — without it there would be no evidence of the work done by staff members.

Further support of the problem encountered at PHC facilities, in her findings (Baloyi, 2009) outlined that even patients expressed their dissatisfaction about the unavailability of supplies such as stationery at PHC facilities where they receive health care services. Singh and Seema (2014:04) in their study "Medical Record Department: An analytical study, "argued that facility supervisors and officials responsible for delivering stationery must ensure that there is a smooth and continuous supply of well-designed files, forms and registers for well-organized quality documentation of patient information at health facilities.

4.3.3.3 Sub-Theme 3.3: Inadequate Infrastructure and Poor Maintenance

Professional nurses described their facilities as being very small making it very difficult to work properly as they walked around in order to assist their patients. There was no space in cubicles to store documents that are in use and the cubicles were untidy and sub-standard. The researcher observed that the facilities visited for interviews were very small with two small consulting rooms; especially the clinics had no offices and store rooms. Participants explained that there were no lockable cupboards to store patient documents. Professional nurses also indicated that patients were dissatisfied about the issue of lack of space wherein services were rendered. During the interviews participants indicated that they walked from one cubicle to the other to look for patients' documents in order to record the required information.

One female participant said "*The clinic is small without proper space for keeping*

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documents which lead to misplacement of some registers and protocols in use, that is the reason we walk up and about the clinic to look for patients' files from other rooms and unlock able cupboards. This is because the only two consulting rooms in the clinic are very small with no extra apace to can accommodate cupboards where documents in use can be placed."

One male participant said, "*Because of lack of space to keep patients' files, books, registers and other documents some of the required documents are imbedded in the old cupboards due to limited space to keep them accordingly. I think you may also have observed that our clinic is very small with only two small cubicles which interfere with our daily work. We have to move from one cubicle or rooms to the next fetching patients' documents and books we are using to record the work we are doing. It is too much for us we walk more kilometers on daily basis unfortunately we have not tried to calculate them for others to can see."*

One female participant said, *"There is no lockable space or shelves to keep important documents, which lead to poor effectiveness of records in the clinic. Even some available rooms and cupboards in the clinic are not lockable."*

One male participant said, "*The burnout following infrastructure makes it difficult for health professionals to perform daily duties and makes it difficult for them to meet the targets set by different programme managers e.g. each facility has its own target for sputum collected per month and each nurse must counsel and test three clients daily."*

A study on specialized projects backed by international donors to improve reproductive health services and HIV/AIDS programmes by Lugte and Mbatha (2007:) failed as professional nurses had not achieved their targets due to poor infrastructure where services are delivered. Poor infrastructure has been shown to exert a significant effect on patients' perceptions on the quality of care and on professional nurses' dissatisfaction with their poor working conditions. The literature also confirmed that the physical environment and buildings of the PHC

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facilities where the ART programme is rendered were not in good order at all due to poor maintenance (Vawda & Variawa, 2012:11).

Findings of the study on record keeping in universities in African countries by Ugwunyenga (2009) confirmed ineffective record keeping and storage, such as storage cupboards for stationery which were not suitable and unacceptable; there was hardly any indication of planned disposition of old records. Thus, important documents remained buried and inaccessible in the old cupboards. For example, two huge cupboards were full up to the brim with such records in one of the universities under study. Therefore, the findings in these two studies strongly support what is happening at PHC facilities in Vhembe District as important documents remain buried in the old cupboards and were not retrievable.

According to the National Health Care Baseline Audit Report by Visser (2012:12) in the Vhembe District, inadequate and poor maintenance of infrastructure at PHC facilities was evident; this had a major impact on functioning of services and patient satisfaction. Visser (2012:12) further indicated that PHC infrastructure management needs the most improvement. Similarly, according to a situational analysis on the infrastructure of PHC

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facilities by Lugte and Mbatha (2007:), poor infrastructure has been cited in a number of studies conducted principally in middle and low income countries, and that displayed as undermining health service delivery worldwide.

Borglund and Oberg (2008:08) argued in their study titled "how are records used in organizations" employees found it easy to retrieve previous documents in order to make informed decision in their work place. Through that they were able to report for maintenance of the facilities where work is done thereby solving problems quickly. Up-dated information is the key for quickly and reliable decision making in the work place.

4.3.4 Theme 4: Factors Related to Unavailability, Illegible and Incomplete Documents

Nurses indicated during the interviews that due to lack of space to store the documents in use in the facilities, some of the documents got misplaced and lost in the old cupboards. There was no plan of disposing old documents at PHC facilities as some of the clinics still had documents used when the facilities started operating. That caused misplacement of useful documents in the facilities as the same cupboards where old documents were placed. Illegible and incomplete information on the documents were also cited by the participants as a major challenge in the facilities.

They explained that professional nurses failed to record clear, readable patient information due to carelessness and, sometimes, fatigue. They explained that as they worked 24 hours daily in a call system, one may be overworked during the night and forget to document relevant patient information on the correct form or file. They even articulated that you can even find blank spaces on the files, forms and registers left out due to tiredness, forgetfulness and increased workload. These factors contributed significantly to the unavailability of patient

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information. Due to overwork, someone may fail to answer queries when documented information is illegible and incomplete. They also elaborated that some professional nurses had the tendency of recording information later, after the incident has occurred and with the patient long gone. It leads to missing relevant information of how patient care was rendered. Professional nurses complained that for a long time they have been reporting the necessity of relevant staffing in order to overcome problems of illegible and incomplete documents.

Trained professionals at their workplace have the ability to identify the challenges they encounter and the way of resolving them. Participants explained during interviews that due to being overworked they tended to write illegible information. They even voiced that some documents had gone missing because of lack of space to store them for later retrieval. Some of the required documents were imbedded in old cupboards due to limited space to keep them.

One female participant said, "*Another point is space where we keep our documents; clinics in rural areas have no adequate buildings. Sometimes we walk from one place to another to fetch patients' documents. The facility is very small; that even the cubicles are small there is no space or cupboards to keep the documents on daily use."*

Another male participant said, *"No! Somewhere in the facility I mean in the postnatal ward which is also congested with equipments and treatment in use. There is no enough space; cubicles are very small and untidy as they are congested with books and equipments in use, according to the nursing profession the cubicles should not look like that. There are no cupboards in the cubicles where documents can be kept."*

One male participant said, *"According to the Department of Health an employee must work 08hours per day and 40 hours per week regarded as normal working hours. Two nurses who work during the night (taking calls) are also expected to work during the day which increases*

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their working hours, even though paid we get tired. When one has overworked during the night may forget to document required relevant patient information on the correct form or file."

Singh and Seema (2014:04) confirmed in their study "Medical Record Department: Analytical study" that there were a serious limitations that included the need for large storage areas for manual documents at health facilities because professional nurses experienced difficulties in the retrieval of documents in use. Failure to find the documents by the officials contributed more too unwritten documented, thereby loosing much needed information. Nursing and Midwifery Council (2007:07) disposing and retention of old documents at facilities depend on the number of pieces of policies and legislations by the government health policies of the country in which people are practicing. It is the duty of such departments to inform the employees about what might be done in relation to retaining and disposing such documents.

Even in Jordan hospitals, in the Middle East, the results of a study done on nursing documentation were the same as those of hospitals in England and Wales where documented patient information was invisible, incomplete and thus an unavailability of documents was experienced (Gilson, 2012:444). According to a research study conducted by Pullen and Loudon (2006:07) in the United Kingdom, nursing documentation was accorded low priority. Documents were poorly maintained and some of the required records were not available in facilities. Furthermore, the authors explained that standards of nursing documentation have been criticized by public bodies and official enquiries into deficiencies of care in hospitals. The above findings indicate that globally more research on quality nursing documentation in public hospitals and PHC facilities needed to be done.

Moreover the study done by Borglund and Oberg (2008:07) "on how are records used in organizations" the employees are the once to provide the proof that they are able to manage

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their work effectively, no information on documents should be missing. The primary aim of quality nursing documentation of patient information is that, it is an essential source of information required for research studies. Unavailability, illegible and incomplete patient information made it difficult for researchers to identify the adverse events as there was no enough data to trace from. Inadequate documented patient information on the records might indicate compromised patient care at facilities concerned (Zeger, et al., 2011:02). The results of the study titled "Quality of patient record keeping: an indicator of the quality of care?" by Zeger, et al., (2011:02) revealed that there were missing components of documented patients' information in both the nursing records and medical records. Nursing documentation was found to be inadequate, illegible, incomplete, unclear and in disorderly manner.

4.3.4.1 Sub-Theme 4.1: Staff Attitude Towards Nursing Documentation

Our attitudes help us to interact with other people in the world around us. This is important for the manager because our attitudes towards our work bring about the way we perform. The professional nurses during the interviews communicated that some of their colleagues' displayed behaviors of negative attitude towards quality nursing documentation of patient information at the workplace; they recorded information which they did not understand or failed to record the required information. It was reported that personal pride did affect quality nursing documentation of patient information as one failed to ask those who were knowledgeable in order to write relevant information.

One male participant said, *"There is health professional's negative attitude and behavior towards quality record keeping as they also fail to keep information recorded in registers e.g. gossiping about patient's conditions on records."*

One female participant said, *"Employees sometimes do record information which they do not understand or fail to record information because they are not sure about what is to be recorded."*

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One male participant said, " *I think that is professional nurses' attitude towards quality documentation of patient information, as others display failure to ask from those informed about information to be recorded due to undermining, or inferiority complex, it fall under lack of knowledge. That's where a nurse thinks s/he is doing well and does not care about other personnel's opinions. Sometimes professional nurses' do not write required information due to behavior like laziness, when asked one say is forgetfulness.*"

One male participant said, "*Professional nurses' attitude can be displayed in different ways at work place one can remain seated even when there is work to do thinking that someone will do it, shifting responsibility. That is a clear behavior of attitude towards work that must be dealt with by managers to improve documentation of information.*"

Joubert and Gerber (2011:10) indicated that it was the responsibility of the service provider to ensure that the customer is receiving quality services that can be exhibited by quality documented information elaborating the types of services rendered. Professional nurses should be urged to understand that patients form an essential part of PHC facilities as they are the ones who obtain the services. Thus, availability of quality documented patient information matches with customer satisfaction and that is an indication of general improvement of an organization (Joubert & Gerber, 2011:13).

According to McGeehan (2007:60), nursing documentation of patient information should not be seen as a distraction from caring for patients because it is regarded as a fundamental part of nursing, midwifery and specialist community health care practice. Hence, it protects the welfare of patients by ensuring high standards and continuity of care. This was clearly indicated in the failure of professional nurses at PHC to record information on patient documents, perhaps a negative attitude towards quality nursing documentation of patient information and also a manifestation of low standards of patient care rendered at the facilities.

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The negative attitudes of professional nurses rendered them incompetent for the work they were trained for. This incompetency may be linked with the factors related to lack of resources and lack of commitment at work. These are issues that lead to mismanagement, complications and death of patients in some other aspects of life (Saving Mothers Report, 2008-2010: IV). That may lead to litigation which, according to the National Audit Office (2002), is regarded as an occupational hazard for health professionals. Law courts adopt the attitude that if something is not recorded it did not happen, therefore nurse have a professional and legal duty to keep records. The Nursing Midwifery Council (2002) stated that professional documentation should demonstrate a full account of nurses' assessment and planned care provided for the patient.

4.3.4.2 Sub-Theme 4.2: Lack of Motivation

Professional nurses described that they were not equally motivated to comply with the documentation of the information as their supervisors did not motivate them, even when they tried to do better work. Nurses at clinics rendered 24-hour services in a call system, which contributed towards an increased workload, as there was no night staff. DoH employees must work 8hours per day and 40 hours per week — regarded as normal working hours — but to those who were taking calls, the working hours increased. In each of the two groups of nurses working at the clinic, two nurses (one professional nurse and one enrolled/assistant nurse) worked during the night rendering emergency services in a call system. They worked after hours only when there was a patient requiring emergency care. Patients visited the clinic after hours for non-emergency services as they knew that there were always nurses at the facilities to assist, even those trying to abuse the services.

These contributed to nurses' being overworked. When nurses work at the clinic several times at night they became tired and overworked — yet, the following morning they were expected to report for duty on time. They lacked motivation to start working without rest even though

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they were paid for overtime. They reported that money paid for overtime was not enough — moreover, it was not even paid on time. They sometimes worked overtime for more than three months without receiving the stipends — that negatively impacted on staff motivation, as they complained. The way their facilities looked like with the limited space also did not motivate them to work effectively.

One female participant said, *"Two nurses who work during the night (taking calls) are also expected to work during the day which increases their working hours, even though paid the money is too little, we get tired then lack motivation required for the work. The patients we attend to during the night were supposed to be emergencies only but as patients know that there are always nurses to assist during the night, they abuse the services. Even minor cases do visit the clinic for services and as trained professional nurses we do not turn them back we give the service they want and explain to them what is meant by emergency."*

One participant said, *"The growing complexity of new documents of the multiple services increased our workload and we always forget to record some of these registers."*

Law, Akroyd and Burke (2010:07), in their study titled "Improving nurse documentation and record keeping in stoma care in large London Hospital, "reported that professional nurses were not motivated to record information required as most of the information recorded was repetitive and stationery used was not well-organized and lacked standardization. Poorly motivated professional nurses turned out to be candidates for medico legal hazards at the workplace as everything they did lacked focus.

According to Carla (2008:01), motivation is something inside people; it comes from within us such as thoughts, beliefs, ambitions and goals, and drives people to action with the willingness to work at a certain level of effort. On the other hand, employees who feel motivated to work are likely to be persistent, creative and productive, turning out high quality

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work that they willingly undertake. Employers need to get to know their employees very well and use different tactics to motivate each of them — based on their personal wants and needs.

Employee motivation has always been a central problem for leaders and managers in different organizations. Unmotivated employees are likely to spend little or no effort in their jobs, avoid the workplace as much as possible. Poor motivation on the part professional nurses at PHC was identified. Almost all health professionals interviewed at PHC seemed to lack motivation in their daily work. Working conditions can pose a stressful situation to professional nurses as they are not comfortable (Carla, 2008:01).

Lack of motivation at work may be the result of absence and inconsistency of motivation policies. Both motivation and the ability of a person are important mechanisms for the successful performance in an organization. There should be fairness and equality in the distribution of incentive packages of an organization to produce higher performance from workers, as it has a significant influence on workers performance (Gana & Bababe, 2011:02).

Moustaka and Constantinidis (2010:01) in their topic "Sources and effects of Work-related stress in nursing, "confirm that daily increased workload at workplace increases chances of poor motivation even before nurses' start with their duties in the morning. They further argued that nurses are subject to decreased motivation which arises from the physical, psychological, and social aspects of the work environment.

According to President Obama's Nursing Report, 2012, in addition to supporting the growth in the number of nurses caring for the nation's underserved communities, the Affordable Care Act has also allowed the programme to evolve and motivate nurses to be innovative at their workplace. Provisions in the Affordable Care Act allowed the National Health Service Corps to offer a part-time option and increased credit toward fulfilling the service commitment for providers working at Teaching Health Centre's, offering flexibility for those interested in the

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nursing profession. These innovations provide more flexibility to programme participants – they can pursue additional nurse training, balance a desire to teach and serve patients, or spend more time with family, ultimately supporting retention at their health service site and within their community.

4.4 Summary

This chapter analyzed the data collected from professional nurses selected for the study. Four themes were identified, namely, factors related to increased professional nurses' workload; factors related to knowledge deficit; factors related to lack of resources; factors related to unavailability, illegible and incomplete documents. The next chapter will discuss the recommendations, limitations and conclusions of the study.

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CHAPTER 5

RECOMMENDATIONS, LIMITATIONS AND CONCLUSIONS OF THE STUDY

5.1 Introduction

Chapter 4 discussed the analysis of the data in relation to the relevant literature on the factors affecting quality nursing documentation of patient information in the Vhembe District, Limpopo Province. This chapter will focus on recommendations, limitations and conclusions in association with the purpose and objectives of the study. Recommendations that might influence policy and service delivery with regard to improvement of quality nursing documentation of patient information will be described. Conclusions based on the findings of the study will also be outlined. This chapter includes an appraisal of whether the objectives of the study were met.

5.2 Overview of the Study

The purpose of the study was to explore and describe factors affecting quality nursing documentation of patient information at selected PHC facilities in the Vhembe District, Limpopo Province. The objectives of this study were as follows:

- To explore factors affecting quality nursing documentation of patient information on ART files, forms, and registers.
- To describe factors affecting quality nursing documentation of patient information on ART files, forms, and registers.

The objectives of the study were met during data collection which was conducted through the

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use of in-depth individual face-to-face interviews with participants, followed by data analysis. The research design used in this study was qualitative, exploratory, descriptive and contextual in nature. In this study, the population consisted of professional nurses working at PHC facilities at Mutale Local Area in Vhembe District, Limpopo Province.

Data saturation occurred at the 10th professional nurse because it became apparent that no new information would be forthcoming from the remainder of the professional nurses sampled. Three of the professional nurses (participants) were males and seven females. The ages of the participants ranged from 24-49 years. All the participants were permanent employees of the DoH. Tesch's open-coding methodology for qualitative research was used to analyze data in this study.

Data analysis of the verbal descriptions from professional nurses during interview revealed the following themes and sub-themes. Themes: - factors related to increased professional nurse's workload, - factors related to knowledge deficit, - factors related to lack of resources, and - factors related to unavailability, illegible and incomplete documents. Sub-themes: -the use of multiple documents at PHC facilities, availability of multiple services daily at PHC facilities, -shortage of staff, -poor stationery supply, -inadequate infrastructure and poor maintenance, -staff attitude towards nursing documentation and -lack of motivation.

5.3 Recommendations Based on the Themes And Sub-Themes

5.3.1 Professional Nurses' Increased Workload

It is recommended that professional nurses' workload be reduced through standardizing the types of files, forms, registers and books used at PHC facilities, to avoid duplication of patient information. The detailed information required in the registers should be minimized. The health care executives may develop responsible actions for delivering quality patient care through working towards ensuring good supply of professional nurses, by recruiting,

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attracting and striving to retain required staff to deal with issues of professional nurses' workload.

5.3.2 Knowledge Deficit

Professional nurses should undergo sufficient (comprehensive) short course training in relation to quality nursing documentation of patient information. The duration of training must be equivalent to the amount of work to be covered in the training. Each individual professional nurse should receive full support and mentoring after training at his/her respective facility by programme supervisors, managers and each document PHC facility must be assessed with a tool designed for that programme.

5.3.3 Lack of Resources

It is recommended that facilities staff-establishment should be filled as per facilities' requirement by health care executives through recruiting, attracting and striving to retain required staff. Dates for ordering and delivery of stationery should be drafted, agreed upon and adhered to between supervisors and facilities' staff members. Facilities infrastructure should be modified and maintained continuously to enable professional nurses to execute their duties effectively.

5.3.4 Unavailability, Illegible and Incomplete Documents

Professional nurses should be made aware that nursing documentation, up-dating and keeping patients' documents is their obligation and requirement in the nursing profession. Health care executives had to treat staff members with respect and provide fair compensation for both normal and overtime hours worked to motivate them to work productively.

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5.4 Recommendations On Nursing Education

The study revealed that there is lack of knowledge about patient information to be documented on the ART documents by professional nurses at PHC facilities. There is doubt about the duration of workshop training in relation to the way in which information is given during such events. Therefore, it is recommended that quality nursing documentation of patient information be fully presented and emphasized in the nursing workshops. Also, the period allocated for the workshop training must cover the scope of the work to be done. This will assist professional nurses to acquire the requisite knowledge about importance of quality nursing documentation of patient information at workplace.

5.5 Recommendations For Further Research

The finding of this study revealed that there is inadequate nursing documentation of patient information on ART documents at PHC facilities.

Recommendations for further research include:

- Research should be conducted in other districts in Limpopo Province in order to compare the findings.
- Professional nurses' attitude towards nursing documentation of patient information must be dealt with more effectively to improve the standard of patients' documents at PHC facilities.

5.6 Recommendations on Policy Making

Health policy makers should review the policies regarding quality nursing documentation of patient information at health care facilities. Unavailability of documented patient information and relevant registers at PHC facilities showed that quality nursing documentation is not taken into consideration, and control over the creation, up-dating and keeping of documents

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was reduced. Therefore, policy in relation to PHC facilities' documents must include control measures to be followed if documents are not well created and updated by individual professional nurse.

5.7 Limitations of the Study

There were challenges in the recruitment of the professional nurses as some participants thought that the researcher wanted to find faults about patients' documented information in their respective facilities. The study was conducted at Mutale Local Area, Mutale Sub-District in Vhembe District, Limpopo Province. The study did not include professional nurses who were not trained on NIMART and other lower categories.

5.8 Conclusions

The conclusions that follow are discussed in relation to the objectives of the study.

5.8.1 Objective 1: Explore Factors Affecting Quality Nursing Documentation of Patient information on ART Files, Forms and Registers

Professional nurses described the factors affecting quality nursing documentation of patient information in their respective primary health care facilities. Quality nursing documentation of patient information is affected by increased professional nurses' workload due to the use of multiple documents and availability of multiple health care services daily at PHC facilities. It is also affected by knowledge deficit, lack of resources and unavailability, illegible and incomplete documents.

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5.8.2 Objective 2: Describe Factors Affecting Quality Nursing Documentation of Patient information on ART Files, Forms and Registers

The factors affecting quality nursing documentation of patient information at PHC facilities were described. It was noticed that factors affecting quality nursing documentation of patient information at PHC facilities are common. It was also noted that communication amongst nurses was not efficient when some of the patient information was found to be missing or eligible due to failure of professional nurses to document information correctly and on time. The study revealed that there was no proper follow-up and mentoring of the professional nurses done by programme Managers, Local Area Managers and Non-Governmental officers (responsible for ART programme) at PHC facilities. There was also no tool used to assess ART documents during the supervisory visits at PHC facilities.

5.9 Summary

This chapter covered the recommendations, limitations and conclusions based on the objectives of the study. Recommendations based on the themes and sub-themes that emerged from data analysis in this study have already been outlined in the previous sections. Programme and Area managers in the Vhembe District, Mutale Sub-District and Mutale Local Area must find ways to reinforce and help professional nurses understand the importance of quality nursing documentation of patient information, at PHC facilities. Standardized, well-designed registers, files, books and forms must be used for all different programmes to avoid duplication of information. Therefore, availability of quality nursing documents would enable health professionals to communicate, understand community problems, and plan for patients, improve patient satisfaction, service delivery and report relevant statistics to the Vhembe District.

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ANNEXURE A

REQUEST TO CONDUCT THE STUDY

I am **Rhulani Caroline Shihundla**, a Masters student at the University of Venda. In this degree we are expected to complete a full dissertation.

The study title: "**Factors Affecting Quality Nursing Documentation of Patient Information at Selected Primary Health Care Facilities in Vhembe District, Limpopo Province**"

The objectives of this study are:

- To explore factors affecting quality nursing documentation of patient information on ART files, forms, and registers.
- To describe factors affecting quality nursing documentation of patient information on ART files, forms, and registers.

The study wants to determine the factors affecting quality nursing documentation of patient information at selected Primary health care facilities in Vhembe District, Limpopo Province.

Participants will be protected against any harm or discomfort by taking into consideration the following issues: anonymity, informed consent, right to privacy and confidentiality.

I therefore request an approval for the collection of data from professional nurses who will be identified through the primary health care facilities.

I hope that my request will be taken into consideration

Regards

_____

Shihundla R.C.

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ANNEXURE B

ETHICAL CLEARANCE CERTIFICATE

RESEARCH AND INNOVATION
OFFICE OF THE DIRECTOR

NAME OF RESEARCHER/INVESTIGATOR:
Ms RC Shihundla

Student No:
9624007

PROJECT TITLE: FACTORS AFFECTING QUALITY NURSING DOCUMENTATION OF PATIENT INFORMATION AT SELECTED PRIMARY HEALTH CARE FACILITIES IN VHEMBE DISTRICT, LIMPOPO PROVINCE.

PROJECT NO: SHS/15/PDC/01/1901

SUPERVISORS/ CO-RESEARCHERS/ CO-INVESTIGATORS

NAME	INSTITUTION & DEPARTMENT	ROLE
Prof MS Maputle	University of Venda	Supervisor
Dr RT Lebese	University of Venda	Co-Supervisor
Ms RC Shihundla	University of Venda	Investigator - Student

ISSUED BY:
UNIVERSITY OF VENDA, RESEARCH ETHICS COMMITTEE

Date Considered: January 2015
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
PRIVATE BAG X5050, THOHOYANDOU, 0950, LIMPOPO PROVINCE, SOUTH AFRICA
TELEPHONE (015) 962 8816/8313 FAX (015) 962 9060
"A quality driven financially sustainable, rural-based Comprehensive University"

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ANNEXURE C

CONSENT FORM

1. I am a master's student at the University of Venda. I am presently engaged in a research study entitled "Factors affecting nursing documentation of patient information at selected Primary health care facilities in the Vhembe District, Limpopo Province".

2. The study is conducted under the supervision: Prof M.S. Maputle as supervisor, Prof R.T. Lebese as co-supervisor, of the Department of Advanced Nursing Science.

3. The interviews will be conducted within 35-45 minutes and will be audio taped for verification of the findings by my supervisors and an independent coder.

4. The name and dignity of each participant will be preserved by observing the following ethical standards throughout the interview process:

   - Voluntary participation and freedom to withdraw without any penalty
   - Informed consent signed
   - Raw material will be kept under lock and key to ensure confidentiality
   - Information related to the interviews will only be accessible to my supervisors, Department of Health and the independent coder.
   - Field notes will be destroyed and the audio tape recorder be erased as soon as possible.
   - The summary of the research will be made available to the participants if they wish to have it.
   - No names of participants will be mentioned during discussions.

I hereby understand the content of this research after the researcher's explanation.

Thank you

Shihundla Rhulani Caroline

Researcher:.....

Participant: .....

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ANNEXURE D

RESEARCH INSTRUMENT

Interview Guide for Professional Nurses

1. **Biographic Information:**

   Age: .....

   Gender: .....

   Working experience in years: .....

2. **What are the factors affecting quality nursing documentation of patient information at your facility?**

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ANNEXURE E

INFORMATION SHEET

1. Introduction

Good day

My name is Shihundla R.C., a master's Curationis degree student of the University of Venda, doing research study. Research is part of fulfillment required for MCUR degree. The main aim of this study is to identify factors affecting quality nursing documentation of patient information at PHC facilities. I am requesting you to be a key participant in my study. The duration of my interview will be 35 to 45 minutes. I will ask you a few questions on your knowledge, regarding quality nursing documentation of patient information.

The questions are not for examination meaning there is no right or wrong answers. Your ideas are important for the study. My role as a researcher is to listen and understand your opinion, without judgment. If you feel uncomfortable in answering some of the questions, feel free to say so; you will not be penalized.

2. The following measures will be followed in order to respect and protect human rights:

2.1 Informed Consent

Brink (2012:38) defines informed consent as information given to participants before the study is conducted, that involves participant's decision to participate or not. Researcher will comply with principles of informed consent through giving full information to participants, about what the study is all about. Participants will be informed that is it their will to participate in the study. This will be explained using their local language. The participants will be informed about the benefits of the study (Brink, 2012:38).

2.2 Confidentiality

Researcher will inform participants that all information they give will only benefit the study. The study is not for publicity the information will be kept under lock and key where only the researcher have access the participants need to be threatened by researchers assistant as she is part of the study, no information will leak (Brink, 2012:38).

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2.3 Voluntary Participation

Participation will be voluntary to any member involved. Participants can terminate his/her involvement in the study at any time as he or she wishes. The participants will sign a concern form if they agree to participate in the study (de Vos et al., 2011:115).

2.4 Anonymity

Participants will be provided with numbers or codes to avoid using their names. No one's name will appear anywhere in the documents of the study. If possible participants can suggest their own pseudonyms (de Vos et al., 2011:115).

2.5 Avoidance of Harm

All participants will be protected from harm at all cost during the study. Vulnerable participants will be identified and removed before commencing with the study. The researcher will weigh the risks versus benefit of the study (de Vos et al., 2011:115).

2.6 Avoidance of Deception of Participants

The researcher will never mislead the participants in the study. All information given will be true at all times. Incorrect information will not be used at all (de Vos et al., 2011:118).

2.7 Denial of Treatment

Participants should never be denied for treatment for a purpose of the study or after they refused to participate in the study or terminated before study is completed. This is in case where participants are patients in the study (de Vos et al., 2011:121).

2.8 Compensation

In case where participants can benefit from study through compensation, everyone may need or even volunteer to participate in order to get incentive (de Vos et al., 2011:121).

2.9 Confidentiality

The information that you give will be treated as confidential matter. All participants will be given code and those codes will be used when doing interviews. These codes will only be known by the researcher. I undertake that all information provided by you will be used only for the purpose of the study. Everything you say will be treated as private and confidential. No one will know how you answered the question apart from the researcher. The answers

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given by participants will be combined and analysed according to common themes and categories. The combined information will be written in the form of report.

2.10 Consent

Ethical clearance will be obtained from the University of Venda Ethical Committee. Permission to carry out the study will be sought by the School of Health Science Higher Degree Committee, Senate Committee of the University of Venda and from Limpopo Provincial Department of Health and Social Development and Vhembe District office. I will ask you to sign an informed consent form, both to participate in the study and to conduct the interview if you are willing to consent. The researcher will appreciate your participation and the information that you will provide.

2.11 Benefits Under Risk of Participation

Please note that participation in this study is voluntary and there will be no direct benefits to anyone who participates. There will be no penalties if you want to withdraw from the study or if you do not want to answer some of the questions if you feel I'm violating your rights. However, I would really appreciate if you share your thoughts and feelings on the question asked.

2.11 Recording the Interviews

I would like to ask your permission to audiotape the interviews because it is not possible to write all the answers quickly enough to capture all the important information. This will prevent misinterpretation of your responses to some of the questions that you will be asked if recording is not done. It is important for you to know that, digital voice data and notes will remain confidential and your identity will not be disclosed.

I am only interested in your honest responses to the questions. Taped and digital data will be listed by the researcher. Tape and digital voice data of interview will be transcended and the transcript of the interview will bear the codes and not the name of the interviewee. The information will be analyzed and organized into a report according to the themes. The voice recorder and digital data files will be kept in locked safe requirements, the voice recorder and voice digital data will be kept for two years old after the publication of the research findings.

2.12 Contact Details

I will be happy to answer any question or clarity you have about this study. This study will be approved by Research Ethics Committee of the University of Venda. If you have any questions about your rights or any aspect of the study you may contact Prof Maputle M.S. at 015 962 8000. If you have further questions about the research or interview contact: Shihundla R.C. at Cell: 073 844 9222

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ANNEXURE F

INTERVIEW TRANSCRIPT FOR PROFESSIONAL NURSES

KEY:

Researcher: R

Professional nurse number one: PA

Good day!

PA: Good day!

R: How are you?

PA: I am fine

R: Explain in your own words what could be the factors affecting quality nursing documentation of patient information at your facility?

PA: First thing that I can indicate as an important thing following my experience working at PHC is shortage of stationery to be used for documenting information. The problem is from the top, our supervisors or whether is the logistics followed I do not know. In the files there are forms called continuation sheets in which information should be recorded about patient care, if stationery is not available information is lost. We need to document work done for the patients. Lack of relevant forms to be used for this ART programme disturbs nursing documentation process.

R: I heard you saying there is shortage of stationery, who supply you or where do you get this stationery?

PA: There is a team or FPD staff allocated to supply us with such stationery but the supply schedule is not reliable ever.

R: From your local area do they supply you with such stationery?

PA: There is a unit at local area where we request in case we are stranded. From the unit at local area we get stationery from the CHC Mutale, sometimes they give us, or fail but mostly we rely on FPD staffs who supply all PHC facilities. The FPD staff does not utilize the schedule to deliver such stationery, sometimes they wait for us to request telephonically as they do not have an order form. When they have enough stationery utilized on ART programme they supply from one facility to the other. They sometimes make copies for us when possible to try and supply us.

R: What is the next issue that affects nursing documentation?

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PA: The next issue is pressure of work, in English I can say increased workload when working. As a professional nurse checking on my experience, when a patient comes there is a lot to be done for him/her. There is too much work to do facing one professional nurse; one is expected to collect information from patient, do patients' assessment and record health education and return date, and take vital signs and record information in different registers. Similar information is recorded on patient's booklet, in the tick register I start with the names, address, contacts, age and sex, chronic register, and specimen registers if specimens are collected.

R: As you write on data book and files, is there a person to assist you collecting such documents from different offices, or….

PA: No! There is no one to assist us by collecting the files, forms and registers as we are already short staffed at our facility. We walk to and from different rooms inside the facility to collect files, document the information then again take back the file to avoid getting lost in the mixed-up cubicle.

R: Is the documented information similar in all documents?

PA: Yes, same information is recorded in the different books files and registers as required, even in the data book is the same. That is duplication of information increasing our workload. That is because if you do not record this duplicated information some of the documents will remain unattended, thus rendering our facility documents to e incomplete.

R: Another factor?

PA: Because of lack of space to keep patients' files, books, registers and other documents some of the required documents are imbedded in the old cupboards due to limited space to keep them accordingly. I think you may also have observed that our clinic is very small with only two small cubicles which interfere with our daily work. We have to move from one cubicle or rooms to the next fetching patients' documents and books we are using to record the work we are doing. It is too much for us we walk more kilometers on daily basis unfortunately we have not tried to calculate them for others to can see.

R: Another issue

PA: Professional nurses' lack knowledge and skills as to what information is to be recorded, on provided stationery as you will find blank spaces on completed files. These render records to be incomplete and sometimes invalid. There is NIMART training undergone by professional nurses, which I think is not enough. During training professional nurses are taught about when to initiate a positive HIV/AIDS patient, treatment used, baseline bloods to be collected and opportunistic infections. Stationery used during initiating patients is not included in the training. That is why is very difficult for us to utilize stationery at the clinic.

R: Its means they do not show you the forms during training, they just talk about medication.

PA: Yes, they teach us about when, and which blood need to be collected, patient reviews, treatment and its side effects. We see stationery files and forms when coming back to the clinic, but not trained on that. That is why it becomes so difficult to complete these records properly as we sometimes do not know what is expected from us. In such case we sometimes even record information we are not sure whether is relevant or not in those files. In that way we are just trying to keep the files to be fully completed in the facility.

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forgetfulness.

R: When you see a professional nurse who does not ask others continuing to make mistakes and leaving blank spaces on written records, what does that mean to you?

PA: I associate that with nurses' attitude towards quality nursing documentation of patient information, I think when I see such a person I see a lazy type of a person in the facility. I do not mean I am a better person from others but I think we are here to do what is expected from us as workers who need to follow protocols. Such professional nurses are misbehaving as they know exactly what is to be done and expected from them on facility documents.

R: They know what is to be done?

PA: Yes! I think everyone of know exactly what is to be done at workplace more especially in relation to documentation of patient information. The fact that we all know that we are expected to record the information is that staff members do record information everyday but we still have blank spaces on our documents. I mean we are all adults who were employed with the understanding that we are here to work productively for the benefit of our patients, service delivery and that of the DoH.

R: I heard you saying they do malpractice, what is malpractice?

PA: They do what is not expected from them, they do what is not allowed on recording of patient information as everything done for, or given to patient need to be recorded to be an evidence of what is happening at the clinic. That will form part of statistics communicating clinic performance which is the requirement by the DoH on monthly basis.

R: Can we proceed to another factor affecting quality nursing documentation?

PA: Hmm, I can include shortage of staff, if we were enough in facility we would work hand in hand and it would be easy for us when recording patient information and other required data information. It would be possible to allocate personnel to deal with specific programmes, and information would be recorded well without the challenges encountered now, of incomplete and inaccurate information in some of the patients' documents.

R: When you say shortage of staff what do you mean? How many personnel should be at work today?

PA: I mean that today we are only three professional nurses on duty, no other category of nurses and according to the staff establishment we should be four professional nurses, one enrolled nurse and one enrolled nursing assistant. That is the reasons we experience high pressure of work as there is lot of work to be done by few workers, then we happen omit more information to be documented. Sometimes we try hurry to work in order to serve our patients on time to reduce unnecessary waiting time but it is difficult to manage the work even for those missing.

R: Are the higher authorities busy working on shortage of staff to fill in the staff establishment of the facility?

PA: I really do not know exactly as the Local Area supervisors sometimes say there is no shortage of staff, sometimes say they know we are short staffed they have reported to the District. They say different information in different day depending on how is their mood on that day.

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R: Tell me what are the services you render daily?

PA: Now render services like immunization of under fives, all chronic diseases like diabetes, hypertension and epilepsy, minor ailment, geriatrics, mother and child, postnatal, ART, reproductive health, TB, emergencies, outreach and deliveries. All these people must be attended to by professional nurses where we must record information for chronics on three documents, on patients' booklet, data book and patients' files. All chronic patients have chronic files to be written on each visit. If only one professional nurse is on duty s/he cannot record all information required. That is where we are losing lot of information it won't be possible as such as the pressure of work is increased hence more workload.

R: Hmm, the forms that you write are they audited on time or do they have a tool they use to check ART documents.

PA: Those people (FPD staff) have a schedule in facility they have to follow; they come twice a month to check the documents, patients' files forms and registers. They do not have specific time to visit the clinic but just arrive at anytime of the day, and do not have specific time to spend with us. Most of the time they do not finish more than an hour in the clinic with us as they always tell us that they not visiting one clinic per day.

R: Are the ART files written by NIMART trained nurses or even those untrained nurses can write.

PA: These files must be written by NIMART trained nurses only, but you find that there is only one NIMART trained nurses on duty and there are many patients waiting for services even untrained nurses do write due to shortage of staff. This does contribute to loss of information as they are not NIMART trained as they do not know exactly the information to be recorded.

R: It means that if that was followed patients would be turned back when there is no NIMART trained nurse to render the service.

Participant: Yes! If that was followed they should be turned back as there are meetings to be attended by NIMART trained nurses only and facility remains without such category. It would mean that day such service would not be available for the patients coming to the clinic, and patients do not know who is trained and who is not trained. When patients come to the clinic they only request the service they want without even checking the qualifications of a person as they do not want to wait too long at the clinic.

PA: Yes, to nurses themselves they have ignorance or are lazy to write on ART files. You find a professional nurse telling a patient coming for the service that, I'm relaxing I will write on your booklet and give you treatment then you go. Information is getting lost due to nurses' laziness and information is not documented.

R: As you say nurses are lazy is it found that patient was told such information?

PA: Yes! It is found by the next nurse as the patient s' information for last month is not recorded; patient will say that the previous nurse said information will be recorded during my absence but on my booklet it was recorded.

R: You can still add more information if possible

PA: Professional nurses sometimes document information that the next person cannot read as it will be

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overwritten, writing illegible information. Hence, they know we are supposed to write readable information for audit purposes, and clinic statistics. That even leads some documents information to be invalid thereby missing statistics.

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ANNEXURE G

CONFIRMATION BY LANGUAGE EDITOR

UNIVERSITY of the WESTERN CAPE

FACULTY OF NATURAL SCIENCES

DEPARTMENT OF MEDICAL BIOSCIENCES

Donavon C. Hiss
University of the Western Cape
Private Bag X17
Bellville 7535
South Africa

Tel: 021 959 2334
Cell: 0722001086
Fax: 021 959 1563
E-mail: dhiss@uwc.ac.za or hiss@gmx.us

21 February 2015

To Whom it May Concern

This serves to confirm that I have edited the language, spelling, grammar and style of the MCur dissertation by **Rhulani Caroline Shihundla**, titled: "**Factors Affecting Quality Nursing Documentation of Patient Information at Selected Primary Health Care Facilities in Vhembe District, Limpopo Province**."

Sincerely Yours

Dip. Freelance Journalism, Dip. Creative Writing, MSc (Medicine), PhD

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LIMPOPO
PROVINCIAL GOVERNMENT
REPUBLIC OF SOUTH AFRICA

DEPARTMENT OF HEALTH

Ref:4/2/2

Enquiries: Latif Shamila

Shihundla RC
University of Venda
Private Bag X5050
Thohoyando
0950

Greetings,

RE: Factors affecting quality nursing documentation of patient information at selected primary health care facilities in Vhembe 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.
   - In the course of your study there should be no action that disrupts the services.
   - After completion of the study, a copy 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.

Your cooperation will be highly appreciated.

Head of Department

25/02/2015
Date

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

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