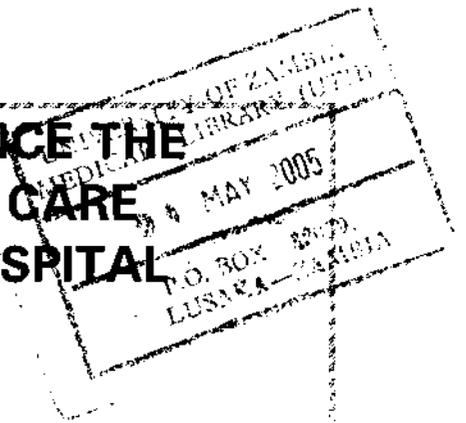


**FACTORS THAT INFLUENCE THE
QUALITY OF NURSING CARE
AT KAFUE DISTRICT HOSPITAL**



BY

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RN (LUSAKA 1990)**

UNIVERSITY OF ZAMBIA

**THE UNIVERSITY OF ZAMBIA
SCHOOL OF MEDICINE
DEPARTMENT OF POST BASIC NURSING**

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**A STUDY SUBMITTED TO THE
DEPARTMENT OF POST BASIC NURSING
SCHOOL OF MEDICINE,
UNIVERSITY OF ZAMBIA
IN PARTIAL FULFILMENT FOR
THE AWARD OF BACHELOR OF SCIENCE
DEGREE IN NURSING**

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I sincerely thank the Government of the republic of Zambia, through the African Development Bank for sponsoring me to undertake the Bachelor of Science Degree in Nursing at the University of Zambia.

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LIST OF ABBREVIATIONS

QOC	-	Quality of care
PHC	-	Primary Health care
WHO	-	World Health Organisation
KDH	-	Kafue District Hospital
NT	-	Nursing Times
AJN	-	American Journal of Nursing
UNICEF	-	United National International Children's Emergency Fund
CSO	-	Central Statistical office
CBOH	-	Central Board of Health
MOH	-	Ministry of Health
QA	-	Quality Assurance
AC	-	Quality circles
ANA	-	American Nurses Associations
TQM	-	Total Quality Management
IJM	-	International journal of Nursing
UAN	-	United American Nurses
RN	-	Registered Nurse
GNC	-	General Nursing Council

DECLARATION

I hereby declare that the work presented in this study for a Bachelor of Science in Nursing has not been presented either wholly or in part for any other Degree and is not being submitted for any degree.

SIGNED: *Rabdelo*

DATE: *11th April, 2005*

CANDIDATE

SIGNED: 

The stamp is circular with the text: UNIVERSITY OF ZAMBIA, DEPT. OF POST, 1st APP, LECTURER, BASIC NURSING, SCHOOL OF MEDICINE.

DATE: *April 11th 2005*

STATEMENT

I hereby certify that this study is entirely the results of my own independence investigation. Various sources to which I am indebted are clearly indicated in the context and in the reference.

SIGNED BY.....*Rabdim*.....

DATE:.....*11/04/05*.....

DEDICATION

I dedicated this work to my Loving Husband Maurice for his encouragement and standing up for me in my endeavour as I pursued my Degree. He tirelessly played the roles of both Mother and Father to our three children.

To my Three Children, Chooye, Mweemba and Munakabala for doing without their mother during the critical development stages.

Finally to my late father, Isaac and my late Mother Esther, who could not hold on to life to see me graduate and both passed away in my last year of competing my BSC Degree. May their souls rest in peace.

ABSTRACT

The study sought to determine the factors that influence the quality of nursing care at Kafue District Hospital.

The respondents were selected from four wards within the Hospital. A self-administered questionnaire was used to collect data from the nurses.

The data for the study was collected during the months of August and September 2004. A sample of 50 respondents from four wards was selected. A questionnaire with open and closed responses was used.

Literature review was based on some studies done Globally, Regionally and Nationally. Literature was also obtained from Pamphlets, books and from the Internet.

The collected data was checked for completeness. It was then coded, categorised and entered on the data master sheet and analysis was done manually.

Results from the study revealed that there is a relationship between the staffing levels and the quality of nursing care provided. Majority of the respondents (36%) reported that the quality of nursing care was poor due to poor staffing and the use of task allocation (50%). The other factors given were lack of motivation for the staff in order to put in as much as they can, some respondents attributed inadequate medical and surgical supplies for them to use to provide quality care to their patients and clients. The majority of the respondents (57%) preferred training of nurses in quality Nursing care, using patient allocation as a model of Nursing care and how to be cost effective in available resources. This they say could help them provide quality care to their clients and in so doing be able to satisfy and meet patients needs. Poor conditions of service have led to nurses to migrate to other countries in search of greener pastures and this has adverse effect on staffing.

In view of the above findings, recommendations to the Ministry of Health were written so that appropriate measures are taken to ensure quality Nursing care and how to be cost effect so as to make the make the Nurses technically competent. I was also recommended that the Ministry of Health should consider remuneration, to motivate and retain the Nurses

CHAPTER ONE

1.0 INTRODUCTION

1.1 BACKGROUND INFORMATION:

COUNTRY PROFILE

Zambia is a Landlocked Country situated in the Sub-Sahara Africa. It covers an area of 752.614 square kilometres, which is 2.5% of the total area of Africa. Zambia shares borders with eight countries which are Botswana to the South and Zimbabwe, to the North, there is Tanzania and the Democratic Republic of Congo Southwest there is Namibia and to the West Angola and lastly to the East it borders with Mozambique and Malawi.

The country is divided into Nine (9) Provinces, which are further divided into 72 smaller administrative areas called districts for easy management. There are 73 ethno linguistic groups with varied cultural practices. The country is densely populated along the line of rail, especially in Lusaka and the Copperbelt. The rest of the rural areas are sparsely populated. The total population for the whole country is 10,285,631 as of 2000 census of which 5,070,891 are males and 5,214,740 are females.

DISTRICT PROFILE

Kafue District is situated in Lusaka Province, it shares borders with Mumbwa and Chongwe District in the North Western and Northeastern respectively. On the South Eastern part, Kafue District borders with Mazabuka, the Kafue River makes the boundary between the two Districts.

Kafue District covers an area surface of 23,250 square kilometres representing 3% of the total country's surface area. The District is largely mountainous with Kafue River that

empties its waters in the Zambezi River at Chiawa. Though only 45 Kilometres from the Capital City (Lusaka) Kafue is largely rural with 49% of the population in the peri-urban area.

According to the 2000 Census, the population of Kafue is estimated to be 178,343. The level of development in Kafue is mainly industrial. Many residents are casual workers at Commercial Farms while some are engaged in Subsistence Farming. The nutrition status of the Community is also compromised since people have no economic power to purchase food. The little food that is grown is sold to enable people purchase other essentials of life. The population along the Kafue and Zambezi Rivers is involved in fishing and fish trading most of which is sold in Lusaka.

ZAMBIA'S HEALTH REFORMS

During the pre-Independence era, Mission and Mining Hospitals provide health care services that were limited to families living within the vicinity of the few missions and mining hospitals. As a result, majority of the population had no access to health care. Against a background of the erosion of health infrastructure, declines in quantity and quality of access of health services, rise in various morbidity and mortality indices, decrease in drug and other medical supplies, low staff morale and shortage of financial resources, the government of Zambia started reforming the health services.

In 1992, the Government of the Republic of Zambia through its National Health Policy introduced the Health Reforms to decentralise health reform process which aims at providing Zambians with equity of access to cost effective quality care as close to the family as possible. (Strategic Plan 1992). This was to be achieved through Primary Health Care (PHC) made universally accessible to individuals and families by means acceptable to them through their full participation and at a cost that the Country and Community can afford (WHO and Unicef 1978)

Through the introduction of PHC many hospitals and health centres were built to bring the health services as close to families and individuals as possible. Health services are

now available at Provincial, District and Community levels. Each District has a District Hospital and each Provincial Town has a General Hospital where District level facilities refer their cases. There are several health centres and health posts Kafue District but some areas still have no health institution, especially in the remotest areas.

THE IMPACT OF QUALITY CARE ON NURSES

The Quality care given to the patient is the primary goal of every institution providing health care services. The need to focus on improved standards of nursing care has been advocated for within the profession. In trying to improve the quality of care that is given to patients, the Nursing Profession have development approaches that have been used as instruments in the delivery of care.

There are two (2) widely selected approaches to Nursing Care, which have been prescribed. The two are Task Allocation and Patient Allocation. Patient Allocation looks at patient's problems in totality as an individual. The Nursing Care Plan is more appropriately used in Patient Allocation, as it looks at the patient's individual needs how to take the necessary measures to overcome the identified problems. According to a study conducted in some of the University Teaching Hospital and Kafue District Hospital, patient allocation is done only on patients in acute conditions.

Most of the care is done through task allocation, which is widely used in many hospitals. Task allocation is being practiced as an alternative to the worldly advocated for patient allocation. Task allocation ensures work is distributed evenly among the staff to avoid overlap of duties and to avoid leaving out some patients unattended to during shifts.

Though Nursing Care is being provided using task allocation, it is important to determine the quality care in both task and patient allocation. The need for quality of care has led many hospitals to look for ways and means of improving the quality so that in the end the care providers will find satisfaction in their job. Though there are many reasons as to why task allocation is used in different hospitals, there is also need for nurses to provide care using the most appropriate approach to the patients so that there is patient satisfaction.

This problem is reflected in the number of repeated admissions, increasing number of new admissions, long queues that are seen in the outpatient department. These circumstances lead to delivering poor quality care and consequently discourage patients from using the services and the health service providers feel no motivation for working in such an environment.

It is only through providing quality care that will minimize the need for medical attention and hence, reduce admissions, re-admissions and the long queues, which are a common occurrence. Quality nursing care entails that care providers communicate with their clients individually so that they understand their conditions better. **WHO (1983)**, states that communication should not only provide insight into what is needed to remain healthy, but it should also heighten or motivate individuals towards better health. This, therefore, means that nurses have to assess their situation and select or modify the type of care to be given to suit their environment. The Nurse is able to judge the quality of care she provides, not in terms of the type of approach used, but rather in relation to whether her/his commitment to the patient is continuous and that the identified needs of the patient are met.

Quality care is a central notion in nursing and awareness of this can help to lead nursing towards more patient-centred and participative care so long as its skills cover health promotion, restoration, rehabilitation and comfort. It is hoped that the results of this study will increase the Nurses' awareness of their responsibility in the delivery of effective quality care.

2 PROBLEM STATEMENT

In the 1980s' Zambia experienced deterioration in its health services due to economic decline. Health budgets were reduced and due to this the quality of services declined as staff became demoralised. The increase in disease burden due to increased levels of poverty among the Zambian people further demotivated the staff. The health reforms were designed to revert these trends through its vision of equal access to high quality of effective health care as close to the family as possible. This was to be achieved through the use of PHC, which entails that the services provided should be cost-effective, universally accessible and at a cost that the individual, family and community can afford.

The introduction of Health Reforms brought about the needs to evaluate the effectiveness of the services being provided to the patients by the Nurses or care provider. King, (1989) states that care is complex concept comprising of pictures of concern, compassion and comfort. It is, also, associated to supporting and cherishing. It carries values about individual worth, respect and dignity as well as acceptance, dependence and reciprocity, it is through this statement that we ask ourselves questions as to whether the care we provide is fulfilling and satisfying to the clients. There is therefore, need to evaluate the effectiveness of the services client receive from professional caregivers. Due to this awareness, the profession of nursing has moved through a number of stages in order to provide quality care and this has led to the development of different approaches to meet the standards of care. Approaches such as team nursing, task allocation, and patient allocation have been used to improve quality care including primary care systems to find ways of improving nursing care.

Though task allocation is widely practised, patient allocation is desirable but its implementation has met some difficulties due to a number of factors. These include shortage of staff, shortage of resources, time factor and negative attitudes from nurses. Patient allocations involve interaction with the patient, making decisions together and evaluating care being given. Patient allocation if fully implemented, will contribute to the quality of care given to patients and Nurses in the end may feel a sense of job satisfaction.

Patient Allocation looks at a patient as an individual who has different needs and therefore, needs individualised care. This calls for a lot of Patient-nurse interaction, hence promoting the nurse-patient relationship where patients will know the nurse attending to them and vice versa. This ensures that the nurse knows the name of the patient and not by his condition or bed number.

Many factors have led to patient allocation not been fully utilised such as shortage of staff and increased workload on the Nurse, while others saw no difference between task and patient allocation. Others thought that the introduction of Health Reforms have brought with it a lot of documentation which makes it difficult to implement patient allocation as a lot of time is spent on writing.

The alternative to patient allocation is task allocation, which entails that one Nurse, is able to look at many patients in a cubical or through allocation of tasks such as temperature taking and recording, giving of bed baths. Each Nurse is given responsibility to accomplish the task and is accountable for the outcome. Task allocation does not look at the patient as an individual. This entails that one patient is attended to by different Nurses at the same time hence reducing the chances of Nurse-patient relationship. The patients in this type of approach do not know the Nurses attending to them and neither do the Nurses know their patients by name. Most of the patients are known by their bed numbers and their conditions.

Task allocation has been practiced as a means to cater for staff shortages as this makes it easier for the Nurses to take care of every patient in the ward. Measures to improve the quality of Nursing care through task allocation such as documentation of the tasks performed, monitoring and evaluation cannot be implemented.

Patient allocation can be implemented so long as Nurses are given the support to fully deliver this approach. There should be an even field where all the Nurses practice patient allocation at Ward level and not only a section of staff like the registered Nurses. Nurses in countries such as America have introduced Essence of care which is seen to have

produced good results as it is not seen as time consuming or costly but beneficial to both patient and care giver. (Nursing times May 2004)

If patient allocation is to make a significant difference then all Nurses must be given the necessary time and resources to get involved. Otherwise there is a danger that Nurses will miss this opportunity to improve patient care. For it to have a greater impact it needs to be taken on by everyone within the multidisciplinary team. This will help us so long everybody takes it on board and doesn't think it's just another government initiative.

It has been observed that the shortage of staff and over crowding of patients makes it difficult for the Nurses to fully give the desired quality Nursing care. Providing quality Nursing care is likely to reduce the number of readmissions that are a common occurrence in the hospitals. This will motivate staff to give the best care to their clients.

3 FACTORS THAT MAY INFLUENCE THE QUALITY OF CARE

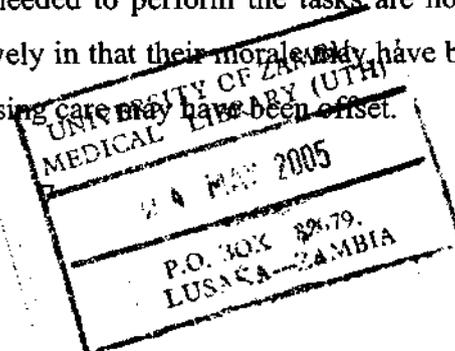
There are several factors that may influence the delivery of quality Nursing Care. These are:

a. STAFFING LEVELS

The introduction of voluntary separation and the movement of Nurses from Zambia to other countries in search of greener pastures have led to a critical shortage of nurses to cater for the influx of patient in the hospital. Because of this, the quality of nursing care may have been compromised due to that many who have left not have been replaced.

b. RESOURCES

Availability of medical and surgical supplies has been irregular to an extent that the delivery of nursing care may have been affected in as much as Nurses want to deliver quality care; the resources that are needed to perform the tasks are not available. This may have affected the Nurses negatively in that their morale may have been reduced and all their efforts to deliver quality Nursing care may have been offset.



c. CONDITIONS OF SERVICE

The Conditions of Service provided for Nurses may also affect the delivery of quality Nursing care in that Nurses are not provided with enough remuneration to motivate them. Due to lack of motivation the care the Nurses are delivering is of low standard as they feel they should work as they earn. "Little work for little pay."

d. KNOWLEDGE

Some nurses may lack the knowledge on how best they can provide care to their clients. It may be this lack of knowledge among nurses that may have affected the delivery of quality nursing care to clients, as they may not know the other best approaches to nursing care apart from task allocation.

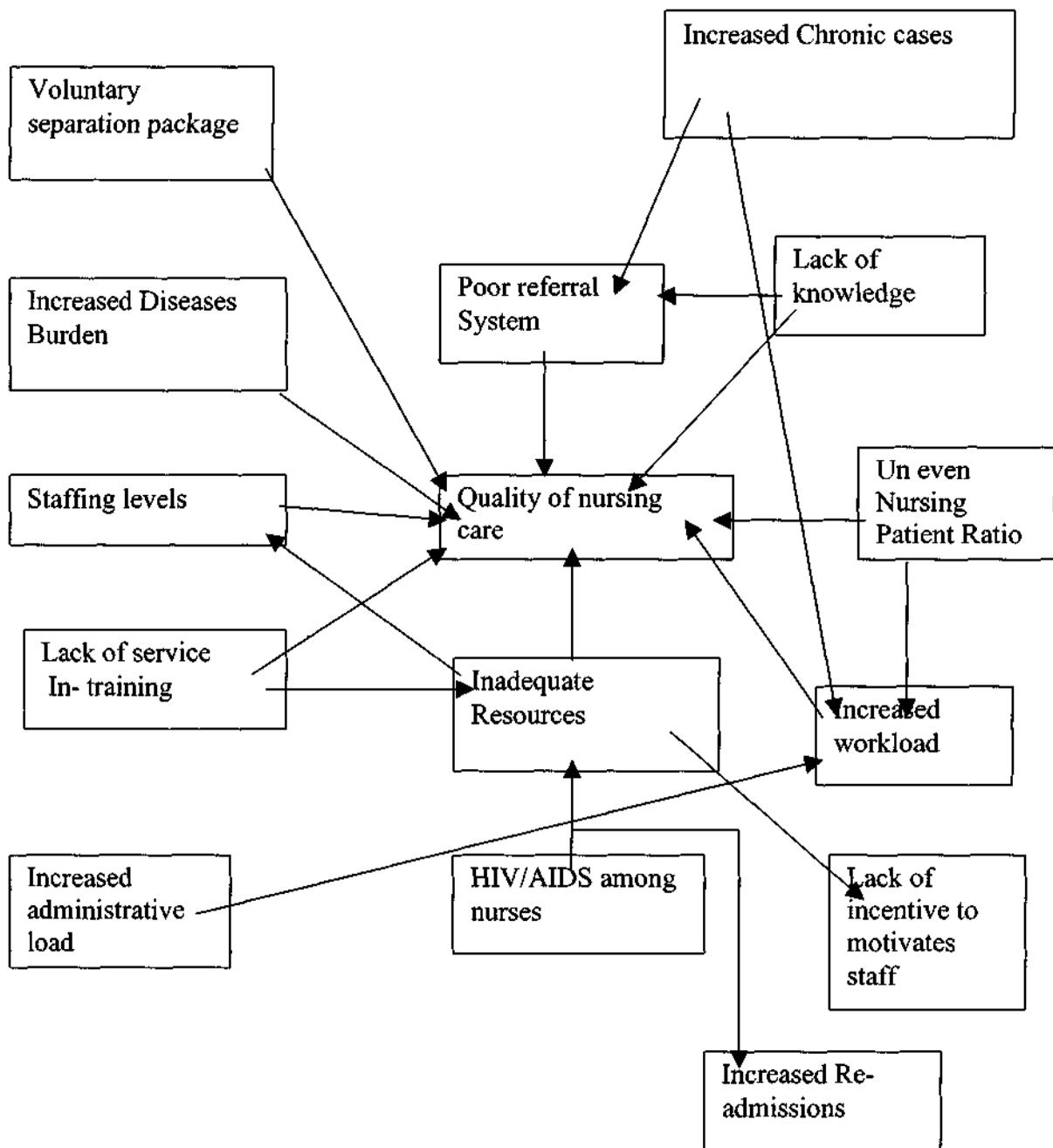
e. NURSE - PATIENT RATIO

The number of staff attending to clients may have affected the quality of nursing care in that the normal patient ratio of 1 to 6 has been overcome by the increase in the number of patients one nurse has to take care of. If the number of clients being cared for is higher than what the health provider can handle, this may have resulted in the nurse not providing quality care as recommended due to work overload. Hence, care will be compromised.

f. MOTIVATION OF STAFF

When the requirements for the care of patients are made available, the health provider will be encouraged to work extra harder. Also the provision of incentives to the nurse will assist in making the provider put in his/her best and provide quality care as recommended.

4 PROBLEM ANALYSIS DIAGRAM OF FACTORS AFFECTING QUALITY OF CARE



5. JUSTIFICATION

The quality of nursing care at Kafue District Hospital has been and is still being questioned for its effectiveness. The use of patient allocation can have its benefit if measures to implement it were to be looked into by relevant authorities.

There has been no study conducted in the district to assess the quality of patient care being provided. This study aim to show to what extent the care of clients meet the set standard of nursing care. It is important therefore, to estimate the cost of providing this care in terms of quality and resources. Providing quality care will give the nurses an opportunity to use the nursing process so that they are able to evaluate the care and use of the best approach in provide quality service.

- The information obtained would assist to work out strategies to help nurses improve the care of patients.
- The health care providers (nurses) will use the information to evaluate their services as well as find ways to improve.
- This information may help the institutions change the approach to care from task allocation to patient allocation

6 RESEARCH OBJECTIVES

6.1 GENERAL OBJECTIVES

To determine the quality of care being provided to clients of Kafue District Hospital.

6.2 SPECIFIC OBJECTIVES

- To establish the quality of care being provided at Kafue District Hospital.
- To gain information from the nurses on the care information provided to them.
- To determine whether nurses are aware of other approaches in nursing care.
- To examine the effectiveness of both task and patient allocation in nursing care.
- To determine factors influencing the quality of care
- To identify areas for further research
- To make recommendations

7 HYPOTHESES

- There is a relationship between the staffing levels and the quality of nursing care provided. .
- The use of task allocation has lowered the quality of nursing care

8 OPERATIONAL DEFINITION

1. **Quality:** A set standard of the highest possible attainment of patient care.
2. **Task allocation/Functional:** Nursing duties are divided among staff members according to task rather than patients. One nurse might be assigned to give all the medicines to all the patients, another might do the treatment and others might give the hygiene care.
3. **Patient Lease or Individual Allocation:** Nurses are assigned the total care of one or more patients for a working shift. They concern themselves with the total needs of the patient and work under the directives of the Charge Nurse, reporting their assessment interventions and evaluations during that period of time.
4. **Team Nursing:** A supervising nurse is responsible for the nursing care of patients. One nurse is assigned to supervise the performance of those involved in the direct care of patients.
5. **Quality Nursing Care:** Individualised and comprehensive measures are carried out by the nurse and they comprise of activities like pain reliefs, hygiene, nutrition and observations.
6. **Structural quality:** Address the professional qualification of staff of the safety and functional performance of equipment.
7. **Process Quality:** Address the features of performance, waiting times,

reception, nursing care and that medical procedures are based on appropriate indications.

8. Outcome Quality: Addresses survival, functional ability, frequency of side effects, quality of life.
9. Quality Assurance: Involves measuring and assessing quality when needed, correcting deficiencies and improving quality.
10. Efficiency: is the relation between outcomes (degree of goal attainment) and resource input
11. Readmission: Admission on more than one occasion with the same disease /condition.
12. Patient: Any person who is sick and has been admitted to hospital and is receiving medical and surgical nursing care.

9 VARIABLES

The main study variables are the independent and dependent variables. An independent variables is a variable that influences the dependent variable where as the dependent variable that is influenced by the independent variable.

1. Dependent variable
Quality of Nursing Care
2. Independent Variables:
 - Staffing levels
 - Resources
 - Knowledge

VARIABLE AND CUT OFF POINTS

VARIABLE	CATEGORY	CUT OFF POINT
Care	<ul style="list-style-type: none"> • Patient allocation • Team Nursing • Task allocation 	<p>Adequate</p> <p>Moderate</p> <p>Poor</p>
Staffing Level	<ul style="list-style-type: none"> • Number of Nurses per shift • 5-6 Nurses • 3-4 Nurses • 1-2 Nurses 	<p>Adequate</p> <p>Moderate</p> <p>Poor</p>
Knowledge	<ul style="list-style-type: none"> • Definitions Quality • Importance • Achievement of quality • Definitions of Quality • Importance 	<p>High</p> <p>Moderate</p> <p>Poor</p>
Resources	<ul style="list-style-type: none"> • All medical and surgical supplies available • All medical and surgical supplies not available 	<p>Adequate</p> <p>Inadequate</p>

CHAPTER TWO

2.0. LITERATURE REVIEW

2.1 INTRODUCTION

The goal for quality initiatives in many health care organisations has shifted from achieving accreditation to improving care and services. In several developing countries of the world, many lives have been lost due to poor quality of care provided. Maternal mortality rate, infant mortality rate and rate of malnutrition continue to be depressingly high 99% of maternal deaths due to complication of pregnancy take place in developing countries. The region with the largest discrepancy between births and infant deaths is Africa; which has 2% of births and 29% of deaths (Maine and Allman 1990).

Good quality care is defined to mean that care shall be adapted to the individual, assure a level of qualified resources which are commensurate with the problem, not intervene in the normal life of the patient more than absolutely necessary, and be based on scientific information and reliable experience and other norms of quality. Other characteristics include well qualified and experienced personnel in a well functioning organisation and suitable facilities, equipment, and material resources. The concept of quality also includes giving attention to continuity of care and care in a normal environment.

The health policy strategy of the World Health Organisation (WHO) includes the following target: "By 1990, all member states should have built effective mechanisms for ensuring quality of patient care within their health systems" the reasons given provide good arguments to dedicate more attention to quality in health care. The most urgent reasons are associated with what is referred to as the 'cost crisis' in health care.

Rapid medical and technological advancements and the changing age structure of the population over the last decades have contributed to the rapidly increasing demand for health care.

While demand has been increasing and the changing character of health care has created new demands on equipment and material, health services have also been burdened by sharp increases in personnel costs. Reduction in working hours and improved social benefits have particularly affected the health care sector since health services are staff-intensive and have relatively few options for rationalization and automation. The situation has become more complicated due to difficulties in recruiting and retaining staff. This in turn, has generated additional cost e.g. education and in-service training for new staff.

From this perspective it becomes clear that the quality of health care is important not only for patients, but even for the job satisfaction of personnel. In addition to job security and materials benefits, the sense of performing meaningful work and the opportunity for personnel development meaningful work and the opportunity for personal development are important factors for recruiting and retaining qualified personnel. To achieve this it is essential to safeguard a high quality of care and to clarify the concept of quality care to health personnel.

Discussions of quality in health care usually differentiate among three aspects of quality namely structure, process, and outcome. Structure refers to the organisation itself and the resources which are available such as personnel, equipment, facilities materials etc. Process refers to how the activity is carried out. Outcome refers to the change in the health or well-being of the patient which can be attributed to the structure and process of care.

Good quality of resources such as well educated and qualified personnel, safe and functional equipment, suitable facilities, a dynamic organisation create the conditions for good quality which in turn increases the opportunity for a good outcome of care.

Health services suffer from several setbacks due to insufficient planning, inadequate training and supervision of manpower, lack of communication with intended beneficiaries and subsequent poor utilisation of services, culturally inappropriate services and social economic constraints. (Durta, P.K. 1993)

Quality health care is the appropriate application of medical scientific knowledge to patient care while balancing the hazards associated with each intervention with the benefits resulting from the intervention (Dona-bedian, 1993).

Quality is defined as "proper performance (according to standards) of interventions that are known to be safe, that are affordable to the society in question and have the ability to produce an impact on mortality, morbidity and malnutrition or doing the right thing right, the first time (Romeme, WHO, 1993).

In quality assurance "quality means to provide care, the way you would like to receive it if you were seeking the same services" (Heath reforms, News Bulletin, 1998). The overall goal of quality assurance should be to improve the quality health care, within the framework of available resources. This includes assuring substandard quality and deficiencies in care, minimising complications and adverse outcomes, and preventing overutilisation and insuring that needed service is delivered in a timely, appropriate and efficient fashion.

Over the years, several appointments have been used to improve the quality of care. There are three (3) classic framework from which nursing care can be evaluated: structure, process, and outcome (carey and posavec, 1981).

During the 1980's many health agencies have adopted the philosophy of total quality management or continuous quality improvement, which has been used to improve productivity as it requires a massive shift in nursing efforts to improve the quality patient care (Juran, 1989).

Under earlier quality assurance programmes poor quality nursing care was thought to result from an individual nurse's lack of required knowledge skill, or attitude. With total quality management, the primary cause for nursing care problems is thought to be malfunction of the health care systems or organised work systems (Maclaughlin and Kgluzny, 1990).

Nursing as an involving scientific discipline is developing models and approaches to explain the phenomena of nursing. Nursing care models and theories provide guides for nursing practice research and curriculum development. There is also a

growing awareness among professional caregivers to evaluate the effectiveness of the services patients receive. As a result, there have been efforts to try to provide quality care to patients. Some of these approaches are patient and task allocation.

The use of the nursing process in nursing entails an in-depth knowledge of the physical and psychological needs of the patient so that problems may be identified, nursing objectives clearly stated and nursing care plans evaluated, this is more appropriately used in patient allocation where the quality of care can be evaluated and determined. In addition, nurses need theoretical knowledge of both the nursing science and nursing models in order to recognise patterns of deviation from normal and to be able to formulate a diagnosis.

Hamilton. I. (1991) pointed out that professionals are concerned with the gap between that which they know about nursing and what they should practice. But even though nurses have identified areas that need change, they have failed to develop, to change, or to promote the climate for change so that quality care is provided for. Nurses are still adhering to the traditional belief of nursing where routines are to be followed regardless of how much time is spent on the expense of giving quality effective care to a patient. Hamilton J. Questions whether professionals will continue to ignore the gap that currently exists between the perceived capacity of nursing and the recognised reality of practice, or whether nurses will be able to function from the basis of sound theoretical nursing knowledge. Hamilton concluded by saying that how nurses would adapt to their professional role under pressure of change will depend on what they value in nursing. Nurses, who value the skilled direct practice of nursing, will act to preserve what they value. Therefore nurses can no longer afford to let change happen by chance or they will no longer meet society's expectations.

Fuller. S. (1978) states that nurses have become more involved with developing the profession because nurses have realised that without much study, the practice of nursing will undoubtedly remain a process of common sense, intuition or trial and error. None of these factors will cause the profession to be efficient, economically or in the long run intellectually and emotionally satisfying to nurses in the practice unless the profession changes to a better practice to satisfy both the nurse and the patient.

From these discussions, conclusions can be that it is important for the nursing profession to develop models of nursing care that can better the services provided to clients. The professional nurse is advocating the need to change from routine or task oriented nursing practice to individual nursing practice where the needs of the patients are detected and resolved systematically, from routinized stereotype nursing to innovative practice and from dependency to accountability. This means that as nurses, standards of nursing practice must be set, monitored and evaluated to satisfy and exceed patients expectations. The use of patients allocation in the delivery of care is said to improve the quality of care. Some of the advantages of patient allocation are:- there is accountability because the nurse is answerable for the nursing care she gives to the patient, the needs of the patient are assessed and met systematically, rapport is established between the nurse and the patient, there is autonomy because the nurse is able to plan the care and to act upon her decisions, and the care as it is documented, it enhances the continuity of nursing care.

Bundoo. B. (1989) asserts that the use of care plans at the bedside encourages nurses to involve the patient and the family in making decisions concerning his care. The successes and failures of implementing patient allocation are effected by many factors like excessive documentation, high patient - nurse ratio, availability of resources and the support that nurses get from their immediate supervisors.

Tiery. A. (1988) says that documentation in nursing has become more complex because of the nursing care plans, which brings fear in nurses as they know that the care they are rendering to patients is being evaluated. Documentation entails that less time is spent with patients as most of the time is spent on documenting. Tiery argues that in the days of task allocation much time was spent taking temperatures and doing bed baths which are more important than spending time documenting. Shea, H. L (1986) states that nursing care plans are the operationalisation of the nursing process, which a nurse to use it effectively need appropriate degree of knowledge and skill in the use of the nursing process in order for her to translate the process into action. In a study she conducted, she found out that nurses had negative attitude about writing of nursing care plans. Nurses attached less importance on the use of the care plans, care plans were time

consuming and that there was lack of administrative support and minimal possible reinforcement about writing and using of care plans.

McMahon, R. (1988) also observed that care plans were rarely written or consulted in a consistent and nurses saw time spent on writing care plans as an administrative job rather than having a direct bearing on their practice. Bimdo, B also observed that nurses are reluctant to spend time away from patients writing lengthy and complicated care plans that are out-dated by the time they are finished; neither do nurses want to duplicate work that is already recorded elsewhere.

Wright, S (1986) supports the above statement as he asserts that the assessment may take long to complete depending on the patient's condition. He also states that nurses did not see the importance of writing care plans as they felt that no one was going to read or act on them and that nurses hardly had time to record care plans so they tended to rely on the patient who was the source of the information.

Shea, H. L (1986) argues that nurses strive to administer high quality care in spite of difficulties. She asserts that there is no proof as to whether lack of written care plans diminishes the quality of care. She pointed out that if nurses perceived that using care plans accomplished and contributed to the standards of care hospitalised patients received, then nurses would write and use care plans to accomplish the valued and deserved standards of care.

The use of care plans emphasizes on the giving of individualised care, which means that the nurse patient ratio has to be very low, i.e. 1 to 6 if the individualised care have to be achieved. Smith, G (1986) following the same line of thought, state that when there are only a few nurses on duty, each nurse becomes involved in meeting the needs of the patients on her ward. Smith outlines factors that contribute to under staffing, as: - high staff turnover and delays in replacing staff who had left the institution. High sickness and absence rates, very uneven distribution of staff over a long time, regular changes in patient allocation and the allocation of nurses to the least permanent patient and demands on the nurse by duties outside nursing, i.e. attending meetings, and accompanying patients to other departments.

Shortage of staff results in inadequacies of nursing care. Hamilton states that

heavy service commitment have often led to too much emphasis on getting the work done without reference to the quality of care. Hunt. J (1987) supported the statement and said that before implementing a nursing model, one must take into account the sophistication of the device, the environment in which it will be used, the availability of resources and the number of trained staff. Shea. H. L (1986) consolidates this fact as she stated that nurses feel that they are being expected to practice at a level, which they do not often understand.

Aydelotte. M. K (1985) asserts that any institution whose purpose is the delivery of health care is confronted with a difficult situation of establishing a relationship between staffing level and the quality of care given to patients. Therefore, low nurse - patient ratio or high nurse -patient ratio affects the quality of care, either positively or negatively. Aydelotte further says that in circumstances where there is few staffing levels, classification of patients and task analysis need to be carried out, to help in predicting the number of staff necessary to care for the patients in a particular unit. Aydelotte says that the testing of any staffing programme is not the quality of service produced but the effect upon the patient.

According to Donabedian (1980) he states that quality of care consist in the application of medical science and technology in a way that maximises its benefits to health without corresponding increasing it's risks. The degree of quality is, therefore, the extent to which the care provided is expected to achieve the most favourable balance of risks and benefits.

Quality is a comprehensive and manufactured concept such as technical competence, access to services, effectiveness, Interpersonal relations efficiency, continuity safety and amenities.

The purpose of literature review is to gain an in depth understanding of the magnitudes, factors, the efforts and effectiveness of nursing care

The content which literature review will be discussed will be based on the indicators of quality nursing care under global, regional and national perspective.

2.2 GLOBAL PERSPECTIVE

Countries all over the world have seen the need for the nursing profession to improve its care to a standard that is reasonable and affordable to its clients. Many countries advocated for changes in the type of care to ensure that clients and health providers are satisfied.

Over the years, health care has become increasingly expensive. The current health care delivery system provides consistent services only to those who are able to pay. Amid the fast paced changes in health care delivery, health care professionals remain responsible for ensuring quality client care. Quality client care is the outcome of the integrated health care system approach (Tatro 2001).

Edward W. Deming (1998) believed that 85% of all quality problems were as a result of harmful management practices. Hunt, 1992 said only 15% of the problems are said to be under a worker's control. Total quality management recognises that administrative policies and procedures can be as much of a buyer to quality as the attitude or performance of an individual staff member.

In view of this, nurses may be eager to provide quality care but due to lack of medical surgical equipment, finds it not easy to provide that care and hence to do things in a shortcut manner.

Quality assurance programmes are now an integral component of the strategy for every health authority in the United Kingdom. A quality assurance can be described as a process whereby standards of care are continuously objectively monitored and measured. American Regulatory bodies have introduced guidelines for different aspects of the quality health care, a model for the provision, evaluation and improvement of patient care. One of the methods that is increasingly being used for judging the quality of care on a ward is that known as MONITOR. This shows exactly where care is failing and where improvement should be focused (Slack 1985).

The system allows the manager (ward) to describe the quality (dependency) of each patient, the workload, the manpower required to achieve a prearranged level

of quality and the appropriate staff mix. It provides an object assessment or diagnosis of what is actually happening on a ward, and can demonstrate that change is required and the nature of that change (Birch 1986).

It has claimed that the implementation of MONITOR in a ward can have many beneficial spin-offs such as the identification of training needs, the development of better ways of organising the nursing care and the improvement of patient information (Goldstone 1989).

As part of the increasing emphasis on quality, a number of strategies have been devised to help improve quality as well as to measure it. One such method is that of quality circles. Quality circles are small groups of staff, usually from the same ward, unit or work area which meet voluntarily and regularly to identify and solve their own work-related problems in a systematic way. These report their findings to managers who decide on what action to take or sometimes the group has sufficient power and authority to take the action itself. It is a useful way of increasing commitment to total quality management and can have an effect on individuals' growth and commitment. This has been practised in the Warwickshire health authority, which resulted in significant improvements in quality of care to patients.

Nursing Audits are performed by peer through examining case records or through more direct observations of procedures. This is another way of improving the quality of work environment. It is therefore essential that everyone on staff participate in the process. This can help to diminish the feeling that the process is a means to 'check' performances. An important condition for assuring good quality care is a strong working relationship among all different professions who contribute to delivering care.

Quality conforming to the needs of the client when the outcome meets or exceeds the client's expectations (Carman et al 1996). In health care quality encompasses effectiveness, efficiency, optimality a balance between cost and effectiveness, accessibility, legitimacy (comfortable to social norms and ethical principles) and equity (Donabedian in Mark, Salyer and Geddis, 1997). In health care, we have a special obligation to strive for perfection because instead of making products, we

serve people anything less than for perfection is unjustifiable.

Carman Pushing, (1996) identified four (4) basic elements of continuous quality improvements.

(a) Team work

The ability to function as part of an interdisciplinary team is essential to effective continuous quality improvement.

(b) Patient perspective

In the past, the patient's point of view was often omitted from evaluations of health care services. Both patient outcomes and patient satisfaction should be considered in evaluating health care services.

(c) Measurement of work structures, processes and outcomes are essential elements of continuous quality improvements. It includes both baseline measures and measures after changes have been instituted.

- Structure includes the preparations and experience of staff process measures actions i.e. how many times a patient receives colostomy care instructions.
- Outcome measures the results i.e. patient's satisfaction with his/her ability to care for the colostomy at home.

(d) Adequacy of the resources available for implementation of any improvement i.e.

adequate staff, time to participate, adequate equipment, sufficient data to perform the evaluation, consultation about resolving a problem.

The above-mentioned elements are a key to a satisfactory quality care a nurse can deliver. Without these elements, nursing care becomes a kind of service delivery that does not meet the needs of the client. Hence it is important for every institution to take serious consideration in all these elements.

Essence of care a patient focus benchmarks for clinical governance was launched in 2001 setting out best practice in key areas of patient care. Essence of care has the clear objective of involving all health care professionals in improving the quality of care (Nursing times May 2004).

Essence of care has nine key areas of care that have been identified by patients as

needing attention:- continence, pressure ulcers, safety of people with mental health needs, record keeping, privacy, dignity and communication.

A snapshot survey of trusts revealed that nurses are using essence of care to improve care on the wards while others are concerned that it is yet another thing to add on their already heavy workload.

It is important to take on essence of care or patient focussed approach in order to improve the quality of care being provided patient focussed approach stresses the importance of effective communication as a way to ease the fears of patients who are feeling sick, tightened and powerless. This will enable patients to take part in their care and hence nurses will be left to do duties that call for their attention and improve the quality of care.

Over the last 20years at St. Vincent's Hospital Sydney, a variety of models for delivering nursing care have been used. These are Task Allocation, Team Nursing, Patient Allocation and more recently Primary Nursing. In February 1992, another model case management was commenced as a way of improving patient outcomes. This was brought on by an adverse complication suffered by a patient who resulted in substantially increasing this patient's length of stay. Other reasons for the commencement are:

- Low staff morale
- High rate of staff sick leave
- High patient acuity levels
- Other patients' complications i.e. pressure sores, pulmonary embolism and infection rates.
- Budget over run.

According to Zander's (1998) definition, case management is a model of patient care delivery which restructures and streamlines the clinical production process so that is it outcome based (Zander 1988:23). As a process, nursing care management mobilises, monitors and rationalises the resources that a patient uses over the course of an illness. In so doing, managing care aims at a controlled balance between quality and cost (Giuliano and Poirier 1991:52).

Giuliano and Poirier identified five (5) objectives for case management, which were adopted and modified by St. Vincent and are, to:

- Improve patients' outcomes.
- Enhance patient care through collaboration of health care providers.
- Ensure proper use of resources, both human and material in order to reduce wasted time, energy and materials.
- Ensure timely discharge using length of stay.
- Increase nurses sense of autonomy and to enhance their professional recognition.

This was implemented by allocation of three (3) nurses per shift to 12 - 18 patients and it proved to be more successful. Initially, there was some resistance from nursing staff to the idea of their team approach. This was overcome by including them in decision-making.

CRITICAL PATHWAYS

Critical Pathways are the main “tool” of Case Management. They show the critical or key incidents that must occur in a predictable and timely fashion to achieve an appropriate length of stay. The incidents of a critical pathway are categorised according to consults, diagnostic tests, activity, treatments, diet, medications, discharge planning and teaching (Woldum 1988:1)

These critical pathways have been developed by a multi-disciplinary team consisting of: physiotherapist, social worker, Nursing unit Manager and Case Managers who have been meeting weekly. These critical pathways have been based on existing clinical protocols, and the average expected length of stay.

Critical pathways look at events which are likely to happen within the patients 'stay in hospital and on what days these may happen. As these events occur, a tick is placed in the appropriate column.

If patients stray from critical pathways, for example, if a complication such as wound infection or pulmonary emboli develops or their recovery is slower than expected and events do not occur on the day they should, then this is called a

variance and is coded on the variance chart. As can be seen variances can be separated into four main categories and isolated to see if this particular area can be improved.

With the use of critical pathways, variances should be detected promptly and appropriate action taken. The critical pathway is individualised and is viewed by the Case Manager and staff looking after the patient each 24 hours. The Case Manager signs the appropriate box everyday. (See Appendix)

If nurses in a particular institution have well-developed specific objects of care, they will make a decision about the degrees to which they can meet the objective. This means that nurses in an environment must devise simple ways in which they can use the minimal staff to meet the objective of providing quality care.

Smith. G (1986) states that it will be profitable to traditionally allocate nurses on the basis of bed occupancy; however nurses must use their professional judgement to redeploy staff in the areas where there is more demand.

Seivwright. M.J (1989) points out that the deficiencies in the provision of health care facilities and service in un served and under-served areas of most countries are likely to get worse as more and more of these economies are under severe strains and constraints. Seivwright asserts that the manpower situation is not likely to improve to any appropriate extent in the near future as economic, social and political forces combine to draw away highly skilled health care personnel into other sectors.

It is thus concluded that before a nursing approach is implemented one has to take into consideration the factors that should be viewed in terms of what is best for that hospital and not what is best for the profession in general as this may lead to failure of implementation.

A study was conducted in California to seek improvement in the quality of health care as well as expand access to affordable health care in under served communities. Rating the nursing staff did this and it was found that nurse staffing to be the most important quality indicator, compared to other resources. It was

found out that facility in the highest range of staffing levels performed significantly better than facilities in both the lowest and mid range levels. Low staffing levels can cause serious harm to their residents and jeopardise their health (Charlene H. 2003)

According to a nationwide survey in November 2002 by United American Nurses (UAN) on staffing levels, 85% of nurses ranked reduced nurse-patients ratio as the most effective solution to the nursing shortage in order to provide quality care to patients and committed to minimum staffing ratios as an initiative toward excellence in nursing care. They concluded that the target ration for medical - surgical units is one licensed nurse (RN) to four patients and one nurse for every two patients on critical care units.

This indicates that for nurses to provide quality care there is need to look at the nurse patient ratio which should be reduced so that nurses are able to perform better and give that quality care to their patients.

A study was conducted in United Kingdom (UK) on the development of a classification system for clarification, understanding and measurement of nurses' work methods. This was done to distinguish between three common work methods: - primary, team and task nursing, the strength of opportunity for nurse-patient interaction in each method being determined as either "strong", "moderate" or "weak" according to how effectively they are practiced. The system was developed to determine the work method in a ward adopted and indicate changes that might be necessary to switch to another method, basing on the availability and organisation of manpower and resources so that quality care given to patients. The classification system reveals a number of components central to nurses, work methods, which can be used to classify the particular method actually being practiced.

1. The nursing assessment aims to establish work methods such as primary nurse which stipulate that it is the function of the nurse to assess, plan implement and evaluate care from admission to discharge are met holistically and provide quality care (Wright, 1987 a pearson 1988, reed 19988)

2. Bowlby (1981) asserts that a critical period of the nurse-patient occurs at the time of admission when the patient is vulnerable and want to be close to another human, especially one who appears to be helpful and in greater control. Bowlby says that in traditional work methods such as task nursing, interviews with patients are usually basic and aimed essentially at maintaining biological integrity. In team nursing care, decision-making is on a shared basis, all the members of the team share in communication with the patient and relatives in the evaluation of care while in primary nursing care is planned based on nurse 's own information gained from medical records.
3. The accountability for patient care in task nurse is fragmented, with each task treated with the seriousness of life and death intervention (Menzles, 1960). Under such condition accountability is difficult to establish Nurses work method that try to develop holistic care address the issues of accountability because of the greater involvement the nurse has with the patient and the decision making process, i.e. patient allocation team nursing suffers to some extent in the same way that task care does in that it is difficult to hold anyone accountable for anything (Hestlin, 1987) primary nursing incorporates accountability such as patient allocation (read 1988).
4. The responsibility for patient care in primary nursing positively encourages the individual nurse to take responsibility for care directly 24hours a day, seven days a week (Wright 1987, Lathlean 1988). The nurse is responsible for giving information to other nurses regarding the care of the patient and for ensuring that care is completed (Reed 1988) A hunt (1988) believes that, operationally, there should be one person responsible for the care of a patient seven days a week to provide that quality care. Reed, 1988 assets that the philosophy and structure within primary nursing helps to facilitate self- directing control of care, increase professional autonomy and provide authority for the nurse to use her knowledge and skills in away that the feels is right for an individual patient so that the best care is provided for. Total patient care is meant to encourage direct communication between the patient and the nurse taking care of the patient so patient- nurse relationship

is promoted and enhanced.

5. The method of allocating patients to nurse is simpler in task nursing because risks can be completed within a span of duty and can be given to one or more nurses (Chavasse, 1981) patient allocation works in much the same way as total patient care with staff being allocated patients either on a shift or a weekly basis (Marks - Maran, 1978).

The patient involvement with decision-making is designed more to suite rather than patient need in risk nursing. (Fretureu, 1980). There is blocks prescription of care with the results that the patient become a passive object with a one way process that discourage him from asking questions or contributing in any useful way. Lee 1979) claims that in risk nursing the nurse simply does not have the knowledge of the patient to help with his problems.

From an extensive review of the literature the various work method that exist (i.e. task nursing team nursing, patient allocates, total patients care, progressive patient care and primary nursing) it was clear that the salient features of each, could be incorporated into three major work method. Primary team and task nursing. The emphasises was made that these methods facilitate different types of nurse- patients interaction ranging from those between the patient and individual nurse and to those between the patient and all the nurses on the ward.

May (1990) asserts that although nurse - patient relationship are viewed as important by nurses, the evidence shows that verbal interaction is often poor, with nurses creating tactics that give them conversational control, responding negatively to patient cues and spending little time with the patient. The unsatisfactory nature of nurse - patient interaction is possibly of the ward has more status than interacting with the patient.

A study was carried out within the Primary Health Care (PHC) system in the state of madhya Pradesh, India by Kanani Khanna, (1995) it was evident from the extensive interview observation data that low priority

given to any component of the PHC programme adversely affected the quality of care. They conclude that inadequate human power development, poor monitoring which focused on quantity not quality are some of the factors that maybe the quality of care to be poor.

A study was conducted in Sweden by the Swedish health and Medical care act which explicitly charges the health sector with providing good quality health services to their populations. The deficiencies that were identified are reflected by too many occupied bed in hospitals due to insufficient post care resources, other by poor continuity in the patient-staff relationship and serious personnel problem accompanied by high staff turnover and vacancies.

The Swedish health sector adopted quality assurance as a key for measuring and evaluating quality of care in order to meet the set standards. Multiple perspectives, which reflect the interest of different parties, were considered to establish quality goals (Standards). A patient's perspective was considered to favour the highest possible quality while other viewpoints for example economic favoured different limitations on the level of quality. In this way it was found out that quality assurance primarily attempts to insure that existing methods are consistently performed in the best way. Quality assurance may also provide a knowledge base for technology assessment by identifying methods / technologies which are of doubtful value or in need of further assessment. *Health Care Quality Assurance in Sweden, (1990)*

A quality assurance process was used in order to identify deficiencies (see Appendix)

In another study in Gujarat India by Kanani and Saiyed (1995) stated that quality of care should be focused in all aspects of management such as training, Logistics of supplies, monitoring and supervision. Equally important, adequate financial resources should be available to make it possible to deliver good quality care.

A study by a group of registered nurses in Sweden described their perception of

the barriers to quality care as being due to that information was not readily available, inadequate facilities implement, lack of competent colleagues with whom to discuss quality care and lack of time and authority that nurses have in the organisation. It was concluded that nurses who had studied approaches in their basic nursing education seemed to perceive fewer barriers than those who had not

The discussion has shown that for quality care to be provided certain factors should be taken into account i.e. availability of resources, manpower (nurse-patient ratio) strengths and weakness of constrains of economic. These factors render the quality of care to be successful or fail. Studies done in developing countries show that quality care is essential for any health institution in order to have both patients and nurse satisfaction.

The expectations of clients on the quality of care given in the health sector is increasingly getting higher because of their due to cost sharing. In order to maintain credibility, attract and retain clients, in these days of competitive health care delivery, all areas of health care delivery need to meet their objectives of acquit of access to cost effective quality of care as close to the family as possible. This means provisions of better management for the individuals of services and holding patients in high esteem through their cooperative in their care.

4 STRATEGIES FOR KEEPING PATIENT SATISFIED

1. Recognise that you own the problem even if it's not your fault.
Being able to step back and recognise that you own the problem, even if you didn't create it, is a key first step in promoting patient satisfaction.
2. Don't just assess your patient's needs; reassess them as they can continuously change over the course of a shift. This helps not only to meet those needs but also to anticipate them. Patient satisfaction results when patient's needs are met time and time again not just once.
3. Try to exceed your patient's expectations- going that extra mile to deliver more than your patient's expect to receive from their nursing care is one of the surest ways to promote patient satisfaction. Keeping patient's family informed

is another way to ensure satisfaction.

4. Remember that patients are health care consumers and like all consumers, they want good services. Studies on patients satisfaction have repeatedly shown that what patients want most from their nurses is common courtesy- someone who treats them like a real person (not a disease), who really listens to their fears and concerns, who respects their privacy.

Patient satisfaction is a high priority goal of nursing care. When problems do arise, your ability to listen to your patients determines what needs to be done and acting quickly will help ensure that their hospital stay is as comfortable and therapeutic as possible.

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The researcher hopes to identify other factors influencing the quality of care by health care providers, which will be used to make further recommendations to relevant authorities on how to improve the quality of nursing care to patients.

CONCLUSION

Globally, the quality of care being provided has come into critical analysis by both the provider and the clients. Certain measures have been implemented to improve the quality of care such as quality circles, MONITOR and using the critical pathways.

Factors that influence poor quality of care have been identified as being poor staff morale, high rate of staff sick leave, poor staffing conditions.

The expectations of clients on the quality of care of care given is increasingly getting higher because of their due to cost sharing. In order to satisfy patient or client expectation, nurses should be able to enhance patient care through collaboration of health care providers. In order for the care to be continuous, ensure proper use of available resources, both human and material in order to reduce wasted time and increase Nurses' sense of autonomy and enhance their

professional recognition so that they are able to practice within the framework of the professional and not be too dependent on doctors.

The other barriers to quality Nursing care were perceived as being due to that information was not readily available, inadequate facilities to implement care and lack of competence among Nurses due to lack of training in quality.

2.3 REGIONAL PERSPECTIVE

In several developing countries of the world, quality of care has suffered many setbacks due to insufficient planning, inadequate training and supervision of manpower, lack of communication and subsequent poor utilisation of services and socio-economic constraints (Mooney, G, 1998).

These are challenges that are facing the developing countries, which has led to the quality of care to be compromised. Developing countries have to advocate for an environment, which supports quality care so that the best care is given to the patients.

According to Mensch (1993), in the years following the Alma Ata Conference, the concern regarding culturally appropriate care and community involvement in primary health care laid the groundwork for much of the ensuring work on quality of existing services (Mensch, 1993). Raceveano and Johansen have stated that in essence, continuous quality development involves setting and achieving goals for quality on a continuous basis (Raceveanu and Johansen, 1995). Health care of good quality encompasses the three areas of

- Structure (organisational setting of care).
- Process (skills, deployed in delivery of services).
- Outcome (effects of care given on health and well being of patients).

Saturno (1995) has highlighted the importance of voluntary commitment to quality, especially institutions where the government owns and provides most health care and where health personnel are salaried employees. Professionals delivering health care should be motivated and involved in qualitative assurance on a voluntary basis as a part of a clearly defined strategy (Saturno, 1995).

In view of this, it is found that training was the most strategic factor for success and the employees must be motivated to provide the care that clients will be satisfied with meeting client needs in a culturally appropriate manner is imperative to ensure utilisation of services by care givers.

The health system trust a non-governmental organisation based in South Africa

has been developed and its main challenge is to keep an eye on the quality of care in the public health sector.

Health facilities, medical equipment and transport represent vital investment for hospital. However, over the years, most of those have been in short supply or have deteriorated making effective delivery of health services impossible (WHO 2003) in the Sub-Saharan region.

It was noted in Sub-Saharan region that delivery of health services is grossly compromised due to lack or inadequate medical equipment and transport that a health worker can use to bring out that quality of care health providers may want to deliver quality care but find difficult to deliver as the constraints hinder them.

According to WHO Regional Office states that scarce resources are used in an efficient and effective way. Without quality there will be no trust in the effectiveness of the system. Institutions can improve quality through education, drawing research and evaluation.

Quality can therefore, inform planning by providing a knowledge base for evidence-based practice. As a result the amount of medications, the number of staff and the infrastructure needed at an acceptable level of quality (a level that is likely to produce desired outcomes) help to define the level of need that can be made with the available resources.

According to Anderson and Daigh (1991) poor quality can result in wastage as when errors are made or processes have to be repeated (over use) second, an absence of quality orientation may result in inefficiency as happens when two processes can produce the same outcomes but the more expensive one is selected (misuse). Third, waste occurs when subclinical dosages of medications are administered because treatment in question is unlikely to produce desired results (under use) some studies suggest that waste associated with poor quality accounts for 25-40% of all hospital costs

2.4 NATIONAL PERSPECTIVE

Zambia is one of the developing countries in the world and it is apparently having a critical shortage of nurses in most health facilities.

Improving quality of care is one of the goals in the Zambia Health Reforms Programme (Government of Zambia 1992). Decision makers, patients and health providers have expressed dissatisfaction with the quality care in the public sector (MOH, 1993).

In order to ensure provision of quality services, health providers must adhere to monitoring of and evaluating of the care given according to professional standards. The first step in improving quality of care is an articulation of minimum standards that are acceptable and affordable so as to meet clients' needs, in a timely manner.

Care needs to be improved in Zambia. Health workers need to improve their communicative skills and to integrate acceptable cultural norms in their practice to better understand and meet the needs and expectations of the patients they serve (Ndulo 1999).

Quality of care seems to be one of the important factors that influence the individual's choice of treatment. It has also been observed that efficiency of the prescribed treatment means much to people. The people in the community are critical to and dissatisfied with the quality of care provided by the health care providers (Ndulo, 1999).

Good quality care includes effective communication between the provider and the patient. Communication between health care providers and patients as a way of sharing views that gained greater acceptance over the past years (Sitzia and Wood 1997).

This indicates that nurses do not provide quality care not because they lack equipment but even when equipment are available, the quality of care is still being compromised. Communication is a major component of the patient-nurse interaction. Effective communication is particularly important in order *for* the

nurse to understand the patient's problems and be able to outline interventions particularly to that patient to provide quality care. The information between patients and nurses is an important variant of quality of care and could determine whether a patient has received the care to his satisfaction.

The Central Board of Health (1997) stressed on the client's right to information and privacy, among other elements of quality care.

In a study, shortage of drugs at the health institution and patient's inability to buy drugs for themselves were identified as major problems by the patients and also by the nurses (Faxelid Etal 1997). Despite making a correct diagnosis if drugs prescribed are not available and affordable then quality of care will be compromised.

A study was conducted by Mutwale from Lusaka who indicated that there was generally a shortage of manpower in many institutions. This scenario made her conclude that shortage of manpower and health workload has led to the emphasis of getting work done without reference to quality care.

It was concluded that the consumers of health services are not satisfied with the care provided because the health provider is overwhelmed by the workload due to shortage of staff. Hence the quality of care that is provided has been comprised. The health provider aims at attending to all the clients but not to satisfy every client's needs.

A quality assurance workshop was conducted in Monze 1994 to sensitise the health workers on the importance of providing quality care to their clients. This means provisions of better management for the individual and family. Improving accessibility of services and holding patients in high esteem through consultation and involvement in health care plans.

Another study was conducted in Kafue 2000 District on the waiting time of patients from the time they register at the hospital up to the time of receiving treatment. This was done as a way to improve the quality of care by minimising the waiting time of patients. It was concluded that patients take a long time to be

seen and receive treatment and hence the quality of care has been ineffective as patients spend their time waiting.

CONCLUSION

Zambia being one of the developing countries have faced a lot of challenges due to economic recession, poverty and a critical shortage of Nurses in most health institutions. The challenge to improve the quality of care has been a great blow to the nation as clients, families and communities demand for quality services.

Zambia's health reforms states that they should be equal access to cosy-effective quality care as close to the family as possible. This vision has not yet been realised due to constraining factors like loss of manpower due to the HIV/AIDS pandemic, shortage of staff as a result of poor conditions of services making the health personnel (Nurses) to go out in search of greener pastures, and inadequate monitoring and evaluation of Nursing care. Effective communication is also cardinal to the nursing profession if quality of care can be improved.

CHAPTER THREE

3.0 RESEARCH METHODOLOGY

3.1 INTRODUCTION

Research methodology refers to the way the researcher collects data, whether by observation, questioning or measuring. The researcher uses methods of observation and measurement to collect data in the experimental design, questioning and measurement in the survey and all three methods in the historical design (seaman and verhonick 1982).

3.2 RESEARCH DESIGN

Research design is the overall plan for a research study (Dempsey and Dempsey 2000).

A research design is a programme to guide a researcher in collecting, analysing and interpreting observed facts. The purpose of this study was to determine to what extent the nursing care given to patients meet the set standards or guidelines of Nursing Care Management. A non-interventional descriptive study was used and involved exploration of variables. A non-interventional descriptive design was used as the investigator aimed at observing, describe, explore and assemble new knowledge (seaman & Verhonick 1982).

A descriptive cross sectional is more effective in finding out the nature of the problem more accurately and the possible influencing factors. The information was collected by means of a questionnaire. A questionnaire schedule was used because the researcher was dealing with a literate group therefore; self-reports given reflected the view of the subjects on the quality of nursing care. This method gives respondents freedom to express themselves.

The research design was both qualitative and quantitative. A qualitative research are models of systematic inquiry concerned with understanding human beings and nature of their transactions with themselves and with their own surroundings (Polit and Hungler 1997). A qualitative study was used in order to identify and

explore non-numerical factors influencing the quality of care.

A quantitative research design involves systematic collection of numeric information, usually, under conditions of considerable control and procedures (Polit and Hungler 1997). The study was quantitative because data collected was quantified in numerical values and percentages in order to make statistical influence.

The study aims at quantifying certain variables that are influencing the quality of nursing care at one point in time.

3.3 RESEARCH SETTING

Research setting is the time and place where the study takes place (Active study dictionary 1999). The study was conducted at Kafue District in Lusaka Province. Four wards were selected for the study and these were Female, Male, Maternity and Admission Wards. All the wards provide nursing care to the patients from admission to discharge.

Kafue District Hospital is located in Kafue within Kafue District. It serves a population of 178,343. (According to 2000 census). The Hospital offers promotive, preventive, curative and rehabilitative services and the bed capacity is 60. The Hospital admits about 12 patients per day

STUDY POPULATION

Study population is the total group of individuals, people or things meeting the designated criteria of interest to the investigator (Dempsey and Dempsey 2000).

The study population comprise of Nursing Staff at Kafue District Hospital who were eligible for interview regardless of whether or not they had received any training in quality assurance.

The accessible population is the population of subjects who were available to the researcher. Therefore, the accessible population were nurses providing nursing

care to patients at the time when the investigator was collecting data at the Hospital.

It was necessary to interview the nurses in order to get first hand information on the quality of nursing care provided.

3.4 SAMPLE SELECTION

Sample selection is the process of selecting a portion of the population to represent the entire population (Polit and Hungler 1997). The total population from which the sample was drawn for the study included the Ward Managers, Registered Nurses, and Zambia Enrolled Nurses who were working in the wards.

The selection of subjects was done by random sampling. Simple random sampling is a probability sampling procedure in which the required number of sampling units is selected at random *from* the population in such a manner that each population element has an equal chance (probability) of being selected *for* the sample (Dempsey and Dempsey 2000).

The advantages of sampling is that it is quicker to study a sample than to study all elements in the population and the findings can be generalised because the sample has a representation of the characteristics in the population. The identified persons of concern were the nurses since the study seeks to find out the quality of nursing care being provided.

3.5 SAMPLE SIZE

A sample size is a smaller part of the population selected in such a way that individuals in the sample represent (as nearly as possible) the characteristics of the population. (Dempsey and Dempsey 2000). A sample size of 50 nurses was drawn from four {4} different wards within Kafue District Hospital. The sample size was selected purposively mainly because of the limited time given to conduct and complete the study and submit the report. A financial constraint is also another reason *for* selecting a smaller sample size because a larger study would require more finances.

3.6 DATA COLLECTION TOOL

Data collection tool is an instrument to collect information in a format useful to the investigator (treece and treece 1986). A self-administered questionnaire was used as a means of collecting data. The method was appropriate because of the nature of the information required. This method allows the investigator to get self-reports on the factors affecting the quality of nursing care.

A questionnaire is a method of gathering self-report information from respondents through self-administration of questions in a paper and pencil format (Polit and Hungler 1997). The questionnaire method was used because of the following advantages:

- It is a relatively simple method of obtaining data.
- It is a rapid and efficient method of gathering information
- The questionnaires can be flexible concerning the type of item, the order of items and the topics covered by the investigator.
- It is one of the tools easier to test for reliability and validity.
- It is a simple procedure for exploring a new topic.
- Data from close-tended items are relatively easy to tabulate.
- Respondents can remain anonymous.

However, there are a number of disadvantages with this method of data collection:

- The instrument is unable to probe a topic in depth
- The respondents may omit or disregard any items, he/she chooses without giving an explanation.
- Some items may force the subjects to select responses that are not of their actual choice.
- The amount of information that can be gathered is limited by subject's available time and interest span

3.6.1 VALIDITY

In quantitative research, validity is the ability of the data gathering instrument to measure what it intends to measure and in qualitative research, it is the extent to which research finding, represent reality (Dempsey and Dempsey 2000).

Validity constitutes external and internal validity. External validity is the extent to which the findings of the research can be generalised to a larger population or to a different social, economical, political setting. The implication is to have a representative sample.

A random sampling method was used in order to give each one a chance to participate. This was an attempt to determine if the studied variables are actually the influencing factors to quality Nursing care.

Internal validity refers to interpretation of findings within the study or data collected. It is the degree to which the researcher is able to accomplish the study. Validity was upheld by the tool used, which reflected the factors under study. During administration of the questionnaire, observations were made to respondents engaged to see if they exhibit the measured variables.

The validity of the instrument was measured by justifying each question in relation to the objectives of the study. When conducting the study there was uniformity and conformity in the way the question were asked. The question were written in simple and clear language

3.6.2 RELIABILITY

In quantitative research, reliability is the stability of a measuring instrument over time and in qualitative research, it is the measure of the extent to which random variation may have influenced stability and consistency of results (Dempsey and Dempsey 2000).

Two basic sources of inaccuracy are present and these are:

- Deficient in Instrument
- Inconsistence in taking readings from the instruments

These problems were overcome by a good understanding of the instruments and how it was to be used. The respondents were literate enough to understand the

instrument presented to them and were allowed to answer the instrument when they are free and relaxed to avoid inaccuracies in data collection.

Reliability of the instrument was measured to establish consistency and dependability of the instrument. To ensure validity and reliability, the supervisor and colleagues reviewed the instrument. A pilot study was also conducted to test the validity and reliability of the tools.

3.7 DATA COLLECTION TECHNIQUE

Data collection technique is the process of getting information needed to address a research problem (Polit and Hungler 1997).

It allows for systematic collection of information about our objectives of the study. Data collection consists of primary and secondary data collection techniques. The primary method was used in the study. This technique is used when the researcher is involved in collecting data on his/her own. She/he may use:

- Observation
- Interviews
- Administering written questionnaire
- Focus group discussion (FGD).

A written questionnaire was used. Questions were read carefully to avoid cross-examining respondents. Questions not understood were merely repeated to indicate the direction to the answer. Probing was done to those questions not fully answered by respondents.

3.8 PILOT STUDY

A pilot study is a small-scale version or mal run of the major study (Samodi, et al 1995). To evaluate the research methodology, a pilot study was conducted in order to recognise problems early and information was obtained for improving the project or assessing the feasibility of the study.

It was also done for the purpose of determining reactions of respondents to the research procedure. Validity and Reliability of the data collection tool and procedure for data processing and analysis.

The pilot study was conducted in Kafue at Zambia Helpers Association Hospital because the hospital has similar characteristics to the study site.

A sample size of 10% of the study was used. Nurses providing the care to clients at the time of data collection were interviewed. Amendments to the questions were made to enable all respondents to understand the questions and avoid ambiguity.

3.9 ETHICAL AND CULTURAL CONSIDERATIONS

Ethics are a system of moral values that is concerned with the degree to which procedures adhere to professional, legal and social obligations to the research subjects (Polit and Hungler 1997).

Before conducting the research, written consent to carry out the study in Kafue District was obtained from the Provincial Health Director, Lusaka Province and the Director of Kafue District Health Management Board. Consent was also obtained from the respondents after explaining to them the purpose of the study and that their responses would assist in planning the type of care to give to their clients. Privacy and anonymity was maintained by using serial numbers.

CHAPTER FOUR

4.0. DATA ANALYSIS AND PRESENTATION OF FINDINGS

4.1. INTRODUCTION

The purpose of the study was to determine the factors that influence the quality of nursing care at Kafue District Hospital.

4.2. DATA ANALYSIS

Data Analysis is the systematic organisation and synthesis of research data, and the testing of research hypothesis using these data.(polit and Hungler, 1997).

The main purpose of data analysis is to derive meaning and interpretations from research findings, which comes through the researcher's knowledge and expertise in the area of study.

Data was collected using a structured self-administered questionnaire. All data was analysed manually with the aid of a calculator. Data was checked for completeness; it was coded and categorised and entered on the data master sheet. The responses from open ended questions were also categorised and suitable terms were formulated to bring all such related data together.

4.3. PRESENTATION OF DATA

The data are presented in table form since it is more appropriate means of presenting the findings, as they were easy to interpret. It is also useful in drawing meaningful inferences. Cross tabulations were used to combine information on two or more variables in order to arrive at a positive explanation of the problems.

SECTION A: DEMOGRAPHIC DATA

TABLE 1: DISTRIBUTION OF RESPONDENTS BY AGE

AGE RANGE	FREQUENCY	RELATIVE FREQUENCY (PERCENTAGE)
20 - 29	11	22
30- 39	18	36
40 - 49	12	24
50 - 59	9	18
TOTAL	50	100

Majority of the respondents were aged 30 –39 years (36%) and only 18% were aged 50 – 59 years.

TABLE 2: DISTRIBUTION OF RESPONDENTS BY SEX

SEX	FREQUENCY	RELATIVE FREQUENCY PERCENTAGE
MALE	14	28
FEMALE	36	72
TOTAL	50	100

Majority of the respondents were females (72%) and 28 % were males.

TABLE 3: DISTRIBUTION BY RANK AND TRAINING SCHOOL

RANK	TRAINING SCHOOL		FREQUENCY	PERCENTAGE
	REGISTERED NURSING SCHOOL	ENROLLED NURSING SCHOOL		
WARD MANAGER	4		4	8
REGISTERED MIDWIFE	5		5	10
REGISTERED NURSE	8		8	16
REGISTERED MIDWIFE 2 YEAR PROG		15	15	30
REGISTERED 2 YEAR PROG		18	18	36
TOTAL	17	33	50	100

This table shows that majority of the respondents 36% were from Registered 2 year program.

SECTION B. QUALITY OF CARE

TABLE 4: RESPONDENTS LENGTH OF SERVICE

LENGTH OF SERVICE	FREQUENCY	PERCENTAGE
0 – 2 YEARS	7	14
3 – 5 YEARS	7	14
6 – 10 YEARS	11	22
10 AND ABOVE	25	50
TOTAL	50	100

The majority of the respondents 50% have worked for 10 years and above.

TABLE 5: NURSING CARE DELIVERY SYSTEM PRACTICED DURING TRAINING

NURSING CARE DELIVERY SYSTEM	FREQUENCY	PERCENTAGE
PATIENT ALLOCATION	14	28
TASK ALLOCATION	14	28
TEAM NURSING	22	44
TOTAL	50	150

Majority of the respondents 44% used team nursing and 28% used Task allocation and patient allocation.

TABLE 6: NURSING CARE DELIVERY SYSTEM PREFERRED AND REASONS GIVEN.

REASONS GIVEN	NURSING CARE MODEL			FREQUENCY	PERCENTAGE
	PATIENT ALLOCATION	TASK ALLOCATION	TEAM NURSING		
There is continuity of care	11	4	17	32	64
Less staff for increased patients	18	6	3	27	54
Promotes individualised care and report	27	1	0	28	56

The table shows that 27 respondents preferred patient allocation for a Nursing Care Model because there will be continuity of care if used.

TABLE 7: RESPONDENTS WHO PRACTICED NURSING CARE MODEL

PRACTICED	FREQUENCY	PERCENTAGE
YES	18	36
NO	32	64
TOTAL	50	100

Majority of the respondents 64% did practice the model of nursing taught At school while 36% failed to practice the Nursing Model taught at school.

TABLE 8: REASONS FOR NOT PRACTICING THE NURSING MODEL TAUGHT AT SCHOOL

REASONS	FREQUENCY	PERCENTAGE
Too much documentation	10	20
Inadequate medical surgical supplies and staff.	16	32
No motivation	14	28

Majority of the respondents 32% did not practice nursing model because of inadequate medical and surgical supplies and staffing

TABLE 9: RESPONDENTS WHO INTRODUCED PATIENT ALLOCATION INTO THEIR PRACTICE

PRACTICED	FREQUENCY	PERCENTAGE
YES	20	40
NO	30	60
TOTAL	50	100

Majority of the respondents 60% did not use patient allocation in the ward.

TABLE 10: RESPONDENT’S REASONS FOR NOT USING PATIENT ALLOCATION

REASONS	FREQUENCY	PERCENTAGE
Inadequate staffing	21	42
Inadequate equipment	15	30
High patient – nurse ratio	10	20
Used only on very ill patients	20	40

Majority of the respondents (42%) did not use patient allocation because of inadequate staffing.

TABLE 11: NURSING CARE DELIVERY SYSTEM USED IN THE WARD

NURSING CARE DELIVERY SYSTEM	FREQUENCY	PERCENTAGE
Patient Allocation	10	20
Task Allocation	25	50
Team Nursing	15	30
TOTAL	50	100

The table shows that majority of the respondents (50%) use task allocation in the ward while 30% use team nursing and only 20% use patient allocation.

TABLE 12: RESPONDENTS' OPINION ON THE QUALITY OF NURSING CARE

NURSING CARE	FREQUENCY	PERCENTAGE
High Quality	6	12
Average Quality	29	58
Low Quality	15	30
TOTAL	50	100

The table shows that majority of the respondents (58%) were of the opinion that the delivery of nursing care was of average quality.

TABLE 13: REASONS WHY NURSING CARE PLANS WERE NOT WRITTEN

LIMITATION	FREQUENCY	PERCENTAGE
Inadequate Resources	37	74
Time Consuming	29	58
High Patient – nurse Ratio	10	20

Majority of the respondents 74% portrayed that Nurses did not write the

Nursing Care Plans due to inadequate resources (Material, Human, Finance) and 58% indicated that it is time consuming while 20% indicated it becomes outdated by the time it is read.

SECTION C: STAFFING LEVELS

TABLE 14: RESPONDENTS' OPINION ON THE STAFFING PATTERN ON THEIR WARDS

STAFFING PATTERN	FREQUENCY	PERCENTAGE
ADEQUATE	6	12
FAIRLY ADEQUATE	14	28
INADEQUATE	18	36
VERY INADEQUATE	12	24
TOTAL	50	100

Majority of the respondents 36% were of the opinion that the staffing pattern was inadequate.

TABLE 15: RESPONDENTS' OPINION ON THE EFFECT OF STAFFING ON QUALITY OF NURSING CARE

EFFECT	FREQUENCY	
PATIENTS ARE NEGLECTED	39	78
INCREASED WORKLOAD ON NURSES AND FAIL TO MEET PATIENT'S NEEDS	20	40
NO NURSE- PATIENT INTERACTION	32	64

The majority of the respondents 78% are of the opinion that patients are neglected.

TABLE 16: RATE OF ADMISSION PATTERN IN THE WARD

ADMISSION PATTERN	FREQUENCY	PERCENTAGE
HIGH	19	38
MODERATE	26	52
LOW	5	10
TOTAL	50	100

Majority of the respondent 52% were of the opinion that the rate of admission is moderate.

TABLE 17: STAFFING LEVELS ON THE WARD

STAFFING LEVELS	FREQUENCY	PERCENTAGE
ADEQUATE	4	8
MODERATE	21	42
POOR	25	50
TOTAL	50	100

Majority of the respondents 50 % were of the opinion that the staffing levels are poor.

SECTION D

KNOWLEDGE

TABLE 18: RESPONDENTS WHO KNEW WHAT NURSING PROCESS INVOLVES

RESPONSE	FREQUENCY	PERCENTAGE
KNOWLEDGEABLE	31	62
NOT KNOWLEDGEABLE	19	38
TOTAL	50	100

Majority of the respondents (62%) knew what the nursing process involves and 38% were not knowledgeable.

TABLE 19: RESPONSES ON THE ADVANTAGES OF USING NURSING CARE PLANS

ADVANTAGES	FREQUENCY	PERCENTAGE
Helps to plan care	33	66
Nurses become accountable	21	42
Easy to identify weaknesses	22	44
For care to be evaluated	26	52
There is continuity of care	20	40

The table shows that majority of the respondents 66% indicated Nursing Care plans provides a basis for planning care.

TABLE 20: RESPONDENTS' COMMENTS ON WAYS OF IMPROVING QUALITY OF NURSING CARE

COMMENT	FREQUENCY	PERCENTAGE
Adequate Resources Provided	28	50
Training in quality care	28	56
Employ patient allocation	22	44
Intensify outreach activities to sensitise on good health habits	21	42
Staff motivation	24	48

Majority of the responses 56% were on improving the resources and training in quality care.

TABLE 21: KNOWLEDGE ON THE QUALITY OF CARE

QUALITY OF CARE	FREQUENCY	PERCENTAGE
Assess, report, implement	38	76
Assess, report and intervention	11	22
Allocation of tasks	1	2
TOTAL	50	100

Majority of the respondents 76% were knowledgeable about what quality care is about.

TABLE 22: AVAILABILITY OF MEDICAL / SURGICAL SUPPLIES AND TRANSPORT AT THE HOSPITAL

SUPPLIES	FREQUENCY	PERCENTAGE
Yes	29	58
No	21	42
TOTAL	50	100

Majority of the respondents agree that supplies and transport are available.

SECTION E**TABLE 23: AGE IN RELATION TO CARE**

AGE IN YEARS	LEVEL OF CARE			TOTAL
	VERY GOOD	SATISFACTORY	POOR	
20 – 29	0 (0 %)	8 (30%)	3 (13%)	11 (22%)
30 – 39	0 (0 %)	9 (33%)	10 (43%)	19 (38%)
40 – 49	0 (0 %)	7 (26%)	5 (22%)	12 (24%)
50 - 59	0 (0 %)	3 (11%)	5 (22%)	8 (16%)
TOTAL	0 (0 %)	27 (54%)	23 (46%)	50 (100%)

Majority of the respondents 43% who reported that there was poor quality of Nursing Care were aged between 30 – 39

TABLE 24: AGE IN RELATION TO STAFFING LEVELS

AGE IN YEARS	STAFFING LEVELS			TOTAL
	ADEQUATE	MODERATE	POOR	
20 – 29	0 (0%)	7 (32%)	4 (17%)	11 (22%)
30 – 39	1 (25%)	8 (36%)	9 (38%)	18(36)
40 – 49	1 (25%)	4 (18%)	7 (29%)	12 (24%)
50 – 59	2 (50%)	3 (14%)	4 (17%)	9 (18%)
TOTAL	4 (8%)	22 (44%)	24(48%)	50 (100%)

Majority of the respondents 37% who reported that there was poor staffing were aged between 30 – 39.

TABLE 25: AGE IN RELATION TO KNOWLEDGE

AGE IN YEARS	LEVEL OF KNOWLEDGE			TOTAL
	HIGH	MODERATE	LOW	
20 – 29	10 (29%)	2 (15%)	0 (0%)	12 (24%)
30 – 39	10 (29%)	5 (38%)	1 (33%)	16 (32%)
40 – 49	9 (26%)	2 (15%)	1 (33%)	12 (24%)
50 – 59	5 (15%)	4 (30%)	1 (33%)	10 (20%)
TOTAL	34 (68%)	13 (26%)	3 (6%)	50%

Majority of the respondents 29% who had high knowledge were aged between 30-39 and 20 – 29.

TABLE 26: SEX IN RELATION TO QUALITY OF CARE

SEX	LEVEL OF CARE			TOTAL
	V. GOOD	STATISFACTORY	POOR	
FEMALE	0 (0%)	16 (95%)	17 (71%)	33 (66%)
MALE	0 (0%)	10 (38%)	7 (29%)	17 (34%)
TOTAL	0 (0%)	26 (52%)	24 (48%)	50 (100%)

Majority of the respondents (71%) who reported that there was poor quality of care were females.

TABLE 27: SEX IN RELATION TO STAFFING LEVELS

SEX	STAFFING LEVELS			TOTAL
	ADEQUATE	MODERATE	POOR	
FEMALE	3 (75%)	13 (62%)	20 (80%)	36 (72%)
MALE	1 (25%)	8 (38%)	5 (20%)	14 (28%)
TOTAL	4 (8%)	21 (42%)	15 (50%)	50 (100%)

Majority of the respondents who reported that there was poor staffing (80%) were females.

TABLE: 28: SEX IN RELATION TO KNOWLEDGE

SEX	LEVELS OF KNOWLEDGE			TOTAL
	HIGH	MODERATE	LOW	
FEMALE	26 (76%)	7 (54%)	3 (100%)	36 (72%)
MALE	8 (24%)	6 (46%)	0 (0%)	14 (28%)
TOTAL	34 (68%)	13 (26%)	3 (6%)	50 (100%)

Majority of the respondents 76% who had high levels of knowledge were females.

TABLE 29: RANK IN RELATION TO CARE

RANK	LEVEL OF CARE			TOTAL
	VERY GOOD	SATISFACTORY	POOR	
WARD MANAGER	0	3 (11%)	1 (4%)	4 (8%)
REGISTERED MIDWIFE	0	5 (19%)	0 (0%)	5 (10%)
REGISTERED NURSE	0	7 (26%)	1 (4%)	8 (16%)
ENROLLED MIDWIFE	0	6 (22%)	9 (39%)	15 (30%)
ENROLLED NURSE	0	6 (22%)	12 (52%)	18 (36%)
TOTAL	0 (0%)	27 (54%)	23 (46%)	50 (100%)

Majority of the respondents 52% who reported that the care was poor were enrolled nurses and none reported that the care was very good.

TABLE 30: RANK IN RELATION TO STAFFING LEVELS

RANK	STAFFING LEVELS			TOTAL
	ADEQUATE	MODERATE	POOR	
WARD MANAGER	1 (20%)	1 (5%)	2 (8%)	4 (8%)
REGISTERED MIDWIFE	0 (0%)	2 (10%)	3 (12%)	5 (10%)
REGISTERED NURSE	0 (0%)	5 (25%)	3 (12%)	8 (16%)
ENROLLED MIDWIFE	4 (80%)	5 (25%)	6 (24%)	15 (30%)
ENROLLED NURSE	0 (0%)	7 (35%)	11 (44%)	18 (36%)
TOTAL	5 (10%)	20 (40%)	25 (48%)	50 (100%)

Majority of the respondents 48% who reported that there was poor staffing levels were enrolled nurses.

TABLE 31: RANK IN RELATION TO KNOWLEDGE

RANK	LEVEL OF KNOWLEDGE			TOTAL
	HIGH	MODERATE	LOW	
WARD MANAGER	3 (9%)	1 (8%)	0 (0%)	4 (8%)
REGISTERED MIDWIFE	4 (12%)	1 (8%)	0 (0%)	5 (10%)
REGISTERED NURSE	8 (24%)	0 (0%)	0 (%)	8 (16%)
ENROLLED MIDWIFE	9 (26%)	5 (42%)	1 (25%)	15 (30 %)
ENROLLED NURSE	10 (29 %)	5 (42%)	3 (75%)	18 (36 %)
TOTAL	34 (68%)	12 (24%)	4 (8%)	50 (100 %)

Majority of the respondents 29 % who had high knowledge were enrolled nurses.

TABLE 32: LENGTH OF SERVICE IN RELATION TO CARE

LENGTH OF SERVICE	LEVEL OF CARE			TOTAL
	VERY GOOD	SATISFACTORY	POOR	
YEARS 0 - 2	0 (0 %)	4 (16%)	2 (6%)	6 (12%)
YEARS 3 - 6	0 (0 %)	3 (12%)	4 (12%)	7 (14%)
YEARS 6 - 9	0 (0%)	6 (24%)	7 (26%)	13 (20%)
10 AND ABOVE	0 (0%)	10 (40%)	14 (52%)	24 (48%)
TOTAL	0 (0 %)	23 (46%)	27 (54%)	50 (100%)

Majority of the respondents (52%) who reported poor quality of care had worked for 10 and above years.

TABLE 33: LENGTH OF SERVICE IN RELATIONT TO STAFFING

LENGTH OF SERVICE	STAFFING LEVELS			TOTAL
	ADEQUATE	MODERATE	POOR	
YEARS 0 - 2	0 (0 %)	3 (12%)	8 (24%)	11 (22%)
YEARS 3 - 6	0 (0 %)	6 (24%)	4 (12%)	10 (20%)
YEARS 6 - 9	0 (0%)	5 (20%)	10 (38%)	15 (30%)
10 AND ABOVE	0 (0%)	9 (39%)	5 (19%)	14 (28%)
TOTAL	0 (0 %)	23 (46%)	27 (54%)	50 (100%)

Majority of the respondents 38 % who reported that there poor staffing worked for 6 – 10 years.

TABLE 34: LENGTH OF SERVICE IN RELATION TO LEVEL OF KNOWLEDGE

LENGTH OF SERVICE	LEVEL OF KNOWLEDGE			TOTAL
	HIGH	MODERATE	LOW	
0 – 2 YEARS	(18%) 5	1 (10%)	3 (25%)	9 (18%)
3 – 5 YEARS	8 (32%)	3 (30%)	1 (8%)	12 (24%)
6 – 9 YEARS	12 (42%)	4 (40%)	2 (16%)	18 (36%)
10 AND ABOVE	3 (14%)	2 (20%)	6 (48%)	11 (22%)
TOTAL	28 (56%)	10 (20%)	12 (24%)	50 (100%)

Majority of the respondents 42% who had high levels of knowledge worked for 6 – 10 years.

CHAPTER FIVE

5.0 DISCUSSION OF FINDINGS AND IMPLICATIONS FOR THE HEALTH CARE SYSTEM

5.1 CHARACTERISTICS OF THE SAMPLE

The purpose of the study was to determine the factors that influence the quality of nursing care. This chapter discusses the results of the study. The sample size was 50 and out of the fifty respondents questioned (72%, 36) were females and (28%, 14) were males. The population sample constituted of registered midwives 5(10%), registered nurses 8(16%), enrolled nurses 18(36%) and enrolled midwives 15(30%). (50%, 25) of the respondents had been practicing nursing between 10 and above years.

5.2 NURSING CARE

Several approaches of nursing care being are used in delivering of nursing care to patients. The study shows that the most popular approach is task allocation used by (50%, 25) of the respondents followed by team nursing (30% 15) and patient allocation which is used by (20%, 10) of the respondents Table 11. Even though the respondents practice all the approaches (44%, 22) prefer patient allocation as a better model of nursing care delivery (Table 6). This could be attributed to the fact that patient allocation promotes nurse patient relationship and rapport, it provides a basis for continuity of care as handover is systematic and it promotes individualised patient care. The study revealed that the nursing care rendered in the wards is of poor quality (43%, 10) and was reported by respondents between the ages of 30 – 39 years. This is because the nursing process which promotes the use of patient allocation was introduced in the wards in the late 1980's and hence the ages between 40 – 49 were not taught the nursing process. The study also revealed that (32%, 16) of the respondents reported that shortage of medical/surgical supplies and staff contributed to the inadequate nursing care rendered to the patients (Table 9) This concurs with hypothesis number one, which says that there is a relationship between staffing levels and the quality of care.

Findings in table 12 shows that the majority of the respondents (50%, 25) used task allocation as a model of nursing care delivery which explains why quality of care is inadequate. This answers the hypothesis number 2 which says “the use of task allocation has lowered the quality if nursing care”.

The study also revealed that the age groups of nurses rendering care to the patients have also influenced the quality of care. The majority of respondents who rendered poor nursing care (43%, 10) were aged between 30 – 39 years of age (Table 28). This could be attributed to the fact that this age group could have served for more than 10 years as such they are no longer motivated to do more. This is also due to the fact that the more the nurses get experience, they are prone to make shortcuts in their nursing care practices and can even influence the new nurses who work with them. This also could be attributed to inadequate equipment and poor conditions of services that has led to demotivation among nurses.

The study revealed that female (71%, 17) respondents reported that there was poor quality of care than the male respondents (29%, 7). This could be due to the fact that nursing as a profession used to enrol females only and it was only recently that male counterparts were enrolled. This is also in line with Sorensen and Luckmann, (1986) which states that “Nursing has traditionally been a woman’s occupation”, that is why many females have joined nursing as compared to men.

The study revealed that (52%, 12) of the respondents who reported poor quality of care were enrolled nurses. This can be alluded to the fact that there are more enrolled nursing schools than registered nursing schools. The enrolled nurses are also the bedside care givers who spend more time with the patients while registered nurses do most of the administrative duties of supervising. No respondents (0%, 0) has reported that quality care was very good, this is because the standards of nursing care has fallen down compared to the latter years.

5.3 STAFFING PATTERN

The number of staff and infrastructure needed at an acceptable level of quality help to define the level of need that can be met with the available resources. Staffing in an institution is of the most priority as these are the care givers of clients, in an institution, in order to meet the acceptable levels of performance. The study revealed that (58%, 29) of the respondents were of the opinion that the staffing pattern on the wards are inadequate (Table 16). This could be attributed to the brain drain in which nurses go for greener pastures. The other factor may be due to poor remuneration offered to the nurses and hence prefer to do part time jobs else where to make ends meet. The availability of resources coupled with the adequate nursing staff can render nursing care to be of quality. The study shows that the staffing pattern has an influence on the quality of nursing care rendered to clients.

Inadequate staffing entails that nurses are over worked to the extent that the care they provide is compromised. The nurse who is over worked will take measures eg. Shortcuts in order to manage to take care of all the patients in her care or use task allocation as an alternative to meet all the needs of her patients. It also shows that poor staffing can make nurses not to document the care they rendered to their patients.

The findings also reveal that (48%, 11) of the respondents who reported poor staffing were enrolled nurses. This can be attributed to the fact that there are more enrolled nurses who practice bedside nursing than registered nurses due to the nature of their job description. The enrolled nurses are also responsible for the daily care of the patients and hence they are more affected by the shortage than registered nurses. Most of the registered nurses are leaving for greener pastures, leaving the enrolled nurses to look after patients.

5.4 KNOWLEDGE

Apart from staffing pattern, knowledge is also an important component in the delivery of quality nursing care. Health providers (nurses) quality of care implies that the nurse has the skills and knowledge to improve care, as care will be evidence-based. In accordance with Zambian Health and Demographic Survey

conducted between 2001 and 2002, it was established that knowledge is a precondition of proper or higher utilisation of any given service. (CSO and MOH, 2003)

The study revealed that respondents (62%, 31) know what the nursing process involves and alluded that the use of nursing care plans, helps to plan care (66%, 33) and that is easy to evaluate care. Though nursing care plans are supposed to be written, there are many constraints that hinder the writing of nursing care plans. Among the many constraints are that nurses are over worked and find writing care plans a strain and also lack of inadequate stationery to put it on paper is one of the constraints. Some respondents alluded to lack of knowledge and skills on how to write nursing care plans as it was not introduced in the wards and no training was conducted.

The study revealed that respondents aged between 30 – 39 and 20 – 29 had high levels of knowledge on care (29%, 10). This could be attributed to the fact that these age groups were taught the nursing process at the schools of nursing, compared to the other two older groups.

The study also revealed that age of the nurses had an effect on the actual knowledge that the respondents had. The study shows that (62%, 31) of the respondents had high levels of knowledge which can be attributed to the fact that as one grows old they tend to forget easily and fails to do the right thing. It is therefore important to recruit nurses on quality of care through the use of nursing care plans, so as be abreast with the latest trends in practice.

The study revealed that (74%, 37) of the respondents were knowledgeable about the normal nurse-patient ratio. This can be attributed to the fact that most of the nurses have been practicing for a long time and hence are aware of the normal patient ratio.

The study revealed that (29%, 10) of the respondents who had high levels of knowledge were enrolled nurses even though the rank of individual nurses did not influence the level of knowledge the respondent had on nursing care. The study shows that (45%, 15) who were registered had high levels of knowledge while

(55%, 19) of the enrolled nurses had high levels of knowledge. This could be attributed to the fact that all these respondents trained in basic nursing when the curriculum did have adequate coverage on the quality of care and what it entails. The other reason is that enrolled nurses have been found to be better skilled in procedures than their counterparts.

The study reveals that (50%, 25) of the respondents with low levels of knowledge had served between 10 and above years. This indicates that the nurses who had been long in service fail to keep abreast with the information pertaining to better practice in the provision of quality care. The nurses need to have in-service training so that they are enlightened on quality services to render to their clients. It therefore shows that there is a relationship between knowledge and the ability to provide quality services.

SUMMARY OF FINDINGS

The findings of the study reveal that the quality of nursing care has been compromised due to many factors. Some of the constraining factors identified were shortage of staff, inadequate equipment and lack of knowledge in the use of nursing care plans and patient allocation. Due to shortage of staff, the nursing care has been compromised as the nurses prefer to use task allocation in order to meet the demands of the many patients in the ward. Task allocation entails that one nurse completes all tasks allocated to her/him for all the patients.

These constraints have adversely affected the quality of nursing care in that it is of poor quality rendering the care not to be equitable to our clients and does not maximise the health benefits to the masses they serve. In order to achieve good quality nursing care, there is need to change the staffing pattern, to have in-service training in order to have knowledgeable and competent nurses so as to provide quality nursing care. There is need also for the nurses to be cost conscious by proper allocation of resources to areas of need. There must also be consistent application of knowledge and skills by the nurses.

NURSING IMPLICATIONS

The study has shown that though nurses were in the position to provide quality care, there are factors that hinder them from providing the care that they so wish to give. It has shown that shortage of staff (36%) is one of the contributing factors to poor quality of care due to critical shortages of staff in the wards, the standards and quality of nursing is affected. This implies that the senior staff must use their discretion so that they can allocate staff on the basis of the number and type of patients being nursed and the type of nursing tasks that need to be carried out.

In addition to this, the senior staff or managers should be knowledgeable about the nursing model such as patient allocation can be better used to deliver quality care. Nurses need to be appraised for good jobs they are doing when need arises so that it lifts and boosts their morale. The nurses should also advocate for better conditions of service so that more nurses are attracted and retained. Adequate supervision is also needed from managers so that the nurses are regularly evaluated on their performance to see if there are within the nursing standards.

Managers should ensure that available resources are utilised in the most effective manner by allocating them where they are needed and accounting for them. This will motivate the staff if the resources are readily available.

In addition, another implication is that nurse managers should be in a position to train their staff nurses on the use of patient allocation as it has been found out from the study that majority (50%) of the nurses use task allocation as a model of nursing. In order for quality nursing care to meet acceptable standards, nurses must be acquainted with knowledge on the use of patient allocation and writing of nursing care plans which should be supervised by managers.

It is also important to improve the levels of staffing in order to ensure that nurses offer individualised patient care without over working themselves therefore carrying out an efficient and effective quality of care. Information is also important to nurses which managers should ensure that it flows to the right people at the right time to be efficient in our care, for care to be continued and of high quality.

Finally, this study revealed that nurses have a positive attitude of improving nursing care to affordable and set standards if constraints in physical environment and organisation support were removed such as low staffing levels, an erratic and adequate supply of equipment and low morale (lack of motivation).

CONCLUSION

The purpose of the study was to determine the factors that influence the quality of nursing care at Kafue District Hospital.

Quality of nursing care must be delivered by all professionals if we want our clients to be satisfied. It is therefore necessary to know the factors that influence the quality of nursing care in order to improve the nursing care being given to clients and families.

The study findings revealed that majority of the respondents 58% were of the notion that poor quality care was due to shortage of staff and the use of task allocation as a model of care. Inadequate staffing levels was reported by 36% of the respondents which proves the hypothesis which says that there is a relationship between staffing levels and quality of nursing care provided. And 50% of the respondent used task allocation to deliver nursing care to clients, which led to poor quality of care. This also supports the hypothesis number 2, which says, "The use of task allocation has lowered the quality of nursing care".

6.2 RECOMMENDATION

The nurse managers should orient their staff nurses on quality care so that they are made aware of providing quality care to their clients

It should be made known to the staff that they should be able to use the minimum available resources effectively so as to minimize over use and misuse and should be accountable in their delivery of care.

Quality assurance should be regarded as an integral part of health care and should become rooted in hospital management.

Government should consider improving the conditions of service for nurses so that they are motivated to provide quality care. This will also lessen the number of nurses going out of the country for greener pastures.

There should be constant supervision by nurse managers in order to maintain the standard of nursing care and hence enhance the quality of nursing care.

Government should ensure that medical and surgical supplies are made available for the nurses to use in order to improve the quality of care given to their clients.

Concrete quality goals, which are measurable and based on professional judgement, safety guidelines, patient wishes, economic conditions should be established for each department and should be continuously monitored.

Staffing is also an integral part in improving quality therefore government should look for means of improving staffing levels either by providing a retention fund to nurses to minimize the brain drain

Existing systems for quality assurance should be co-ordinated with new methods such as quality circles, Nursing audit. Information system, which supports continuous monitoring of quality at the departmental level, should be developed.

Ministry of health should consider training nurses on quality and how to be effective so as to make them accountable and effective.

Education addressing quality should be included in all health profession curriculums, from the basic education level through continuing education.

6.3 LIMITATIONS OF THE STUDY

- A sample size of 50 (fifty), which is small was selected for the study due to inadequate time and resources. As a result findings are not going to be generalised to a larger population
- Due to shortage of staff, the time of data collection was prolonged as the research had to wait for those on leave and nights off and sometimes it was difficult to get hold of these nurses.
- Lack of published literature nationally was one of the problems encountered by the researcher and no study was conducted on quality within the nation.
- Another limiting, factor was the reluctance of nurses to participate in the way as subjects of study.

DATA ANALYSIS

Data analysis is the systematic organisation and synthesis of research data, and the testing of research hypotheses using those data (Polit and Hungler 1997).

Data analysis is a process by which data is summarized and described and if possible make references from the study sample, to the population from which sample is drawn. Data can be useful when arranged in a meaningful manner in order to be able to derive patterns of relationships.

Following collection of data from the Hospital, each questionnaire was checked for completeness. Data from open-ended questions were organised and then coded. This

made it easy to draw frequency and cross tabulation from conclusions on the variables and objectives of the study. Frequency count of each variable was made and calculated into percentages. This makes it easier to compare groups than when absolute numbers are given since percentages standardise the data. Description of the data was done together with tables.

2.6 DISSEMINATION OF FINDINGS

The dissemination of findings was done by holding meetings with relevant authority such as the ward manager and staff. The executive summary of the findings was sent to Kafue District Hospital Authorities, for implementation of recommendations to all staff in different departments of the hospital. Findings of the study will also be disseminated to all interested parties such as General Nursing council of Zambia and the ministry of Health. The study findings and reports will be made available and accessible to the policy makers and non-governmental organisation that have programmes to improve the quality of nursing care.

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7.0. LIST OF APPENDICES

UNIVERSITY OF ZAMBIA

SCHOOL OF MEDICINE

DEPARTMENT OF POST BASIC NURSING

7.1 SELF-ADMINISTERED QUESTIONNAIRE TO HEALTH CARE PROVIDERS

TOPIC: FACTORS INFLUENCING THE QUALITY OF NURSING CARE AT KAFUE DISTRICT HOSPITAL.

QUESTIONNAIRE NUMBER.....

INSTRUCTION TO RESPONDENTS

1. Do not write your name on the questionnaire
2. Tick in the box next to your answer
3. Write in the space provided for open-ended questions
4. Answer all questions correctly

SECTION A
DEMOGRAPHIC DATA

1. How old were you on the last Birthday?
- a. 20 - 29
- b. 30 - 39
- c. 40 - 49
- d. 50 - 59
2. What is your sex?
- a. Female
- b. Male
3. What is your Rank?
- a. Ward Manager
- b. Registered Midwife
- c. Registered Nurse
- d. Enrolled Midwife
- e. Enrolled Nurse
4. Where were you trained as Nurse?
-
5. When did you qualify from the school of Nursing?

SECTION B

PRACTICE

6. For how long have you been working as a Nurse?

a. 6 months – 1 year

b. 5 years

c. 6 – 10 years

d. 10 and above

7. Have you worked in the same hospital since you qualified?

a. Yes

b. No

8. What type of Nursing Care delivery system was used in the hospital where you trained?

a. Task Allocation

b. Patient Allocation

c. Team Nursing

9. Which Nursing care delivery system in question 8 would you favour if you were given the option to choose?

10. Please state reasons for your answer in question 9

11. Did you find it difficult to apply and implement the delivery system of Nursing care taught at school into practice?

a. Yes

b. No

If yes give reasons for your answer.

12. Was patient allocation introduced in your present ward?

a. Yes

b. No.

If your answer to question 12 is No, please explain.

13. Which approaches do you mostly use in the wards?

a. Patient allocation

b. Task allocation

c. Team Nursing

14. Are you still employing the Nursing process through any of the approaches you mentioned?

- a. Yes
- b. No

15. How would you describe the present delivery of Nursing care in your department ward? Is it of;

- a. High quality
- b. Average quality
- c. Low quality

16. If patient allocation is being used, are Nursing care plans written and followed in your department / ward?

- a. Yes
- b. No.

If your answer to question 16 is No, give reasons for your answer.

17. List the limitations you have come across in the use of Nursing care Plans?

18. Name the constraint you find in implementing patient allocation in your ward?

SECTION C.

STAFFING

19. How would you rate the staffing pattern on your ward?

- a. Adequate
- b. Fairly adequate
- c. Inadequate
- d. Very adequate

20. How does the staffing pattern on the ward affect the quality of Nursing Care?

- a. Excellent
- b. Good
- c. Poor

21. How many patients do you admit in your ward everyday?

- a. 5 - 10
- b. 11 - 15
- c. 15 - 20
- d. 21 - 25

22. How would you rate the admission pattern on your ward with the staffing pattern?

- a. High
- b. Moderate
- c. Low

SECTION D
KNOWLEDGE

24. Was the Nursing process taught in the school of Nursing?
- a. Yes
- b. No

If Yes, did you use the Nursing process in the ward?

- a. Yes
- b. No

25. State in your own words what the Nursing process involves?
- _____
- _____
- _____

26. What are some of the advantages of using Nursing Care Plans in Nursing?
- _____
- _____
- _____

27. What are some ways you can employ to improve the quality of Nursing care?
- _____
- _____
- _____

28. What is the normal nurse-patient ratio?
- a. 0 – 6 patients per Nurse
- b. 7 – 12 Patients per Nurse
- c. More than 12 patients per nurse

29. What is quality of care?
- a. Patients allocation where nurses assess, report the interventions, findings and evaluate the care
 - b. Assess patient's problems, report findings and interventions.
 - c. Allocation of tasks rather than patient.
 - d. Other, specify

Thank you for your cooperation

God Bless You!

APPENDIX

Figure 1

CRITICAL PATHWAY

Total Knee Replacement

(Elective)

Average Length Of Stay 15

DAY	1	2	3
DATE		<u>Operation Day</u>	
CONSULTS	- Admission assessment -Form completed -Anaesthetic assessment -Orthopaedic consult/admission		-Medical review
TESTS	-As per admission -Assessment form Ward pre-op check list	-Post op- X- ray -X- ray checked -Limb exercise & Chest Physio	-Xray checked Post-op bloods →
ACTIVITY/ MOBILITY	-Deep breathing & -Coughing & pre-op -Limb exercises Novaderm shower/ wash	→ Bed rest	IV OUT Cease IV antibiotics Commence oral antibiotics Redivac, out if applicable Leave wound intact →
DISCHARGE PLANNING	-Consult/ act on admission -Assessment form -Discuss Discharge of options	→	
TEACHING	-Lifting techniques whilst In bed -Pre-op education		
SIGNATURE			
VARIANCES			

Figure 2

CRITICAL PATHWAY
Total Knee Replacement
(Elective)

<u>DAY</u>	6		7		8
DATE					
CONSULTS					
<u>TESTS</u>					
ACTIVITY/ MOBILITY	-Commence mobility -Full Arm Support Frame -Non-cemented -Partial Weight bearing -Cemented -Full Weight bearing -Knee flexion& extension -Black slab/ dressing down -Creep bandage		→ → -Daily Airstrip& crepe bandage		→ → →
DISCHARGE PLANNING			-Tentative Discharge Plan		→
<u>TEACHING</u>					
<u>SIGNATURE</u>					
<u>VARIANCES</u>					

Figure 3

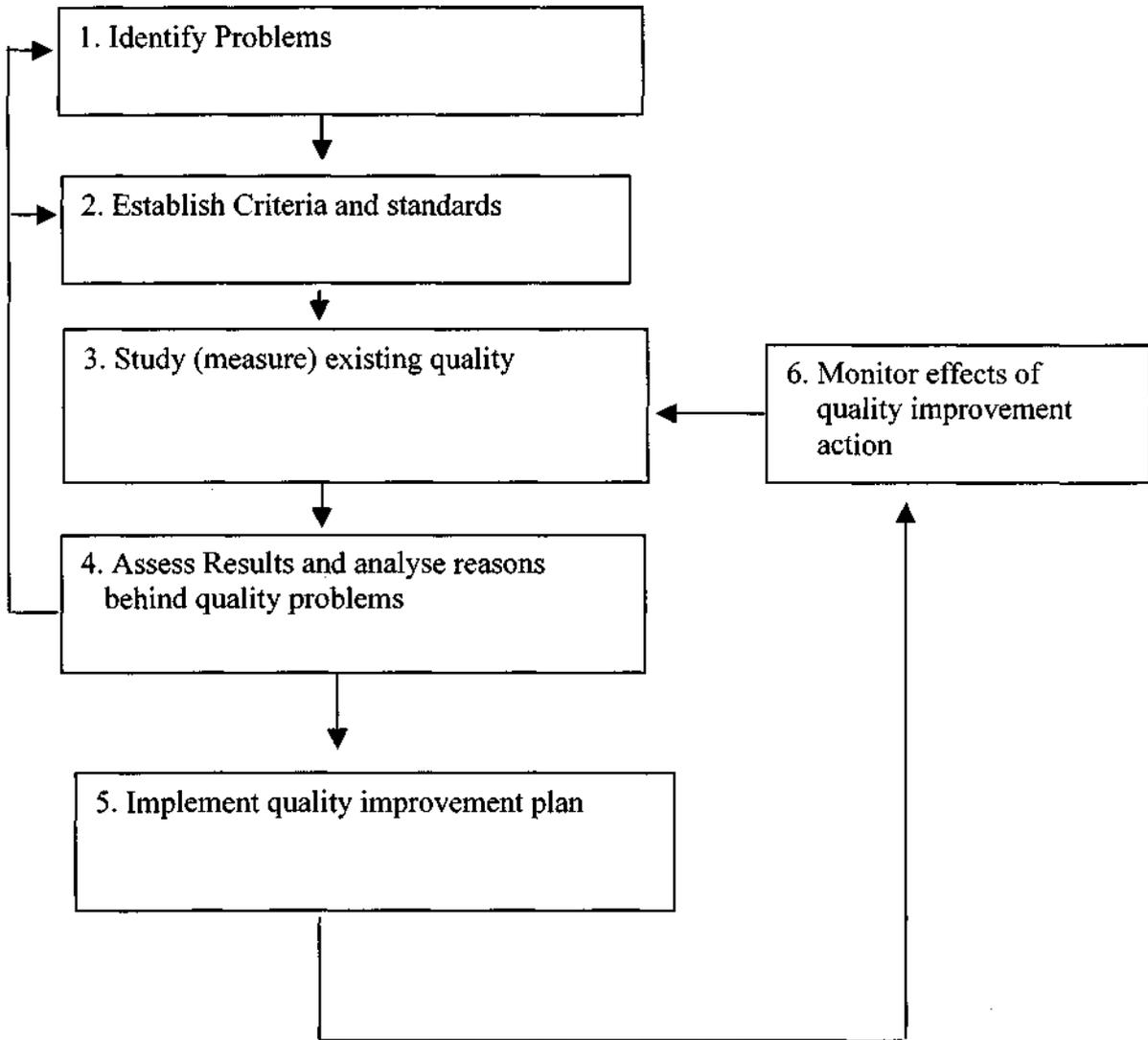
CRITICAL PATHWAY

Total Knee Replacement

(Elective)

<u>DAY</u>	11		12		13
<u>DATE</u>			Operation Day		
<u>CONSULTS</u>					
<u>TESTS</u>					
<u>ACTIVITY/ MOBILITY</u>	-Crutch walking -On stairs		→ Removal of alternate sutures and steristrip wound		→ Remove remaining sutures
<u>DISCHARGE PLANNING</u>			-Check transport arrangements -Medical certificate if required		Organise: -Walking aids -Outpatients -Physiotherapy appoint ment -Home visited by OT -Home care -Discharge summa ry -Notify Local Doctors
<u>TEACHING</u>					
<u>SIGNATURE</u>					
<u>VARIANCES</u>					

The Assurance process can be illustrated as follows:



Source: Health Care Quality Assurance in Sweden

RESEARCH WORK SCHEDULE

TASK TO BE PERFORMED	DATES	RESPONSIBLE PERSON	PERSONNEL DAILY REQUIREMENT
Finalised research proposal	1 st June to 20 August	Investigator	11 weeks
Clearance from School and funding Authority	2 nd August to 31 st December	<ul style="list-style-type: none"> • Investigator • Director KDHMB 	19 weeks
Data collection tool	23 rd – 31 st August	Investigator	10 days
Data analysis	11 th – 29 th October	Investigator	18 days
Report writing	1 st November - 3 rd December	Investigator	22 days
Draft report to PBN	6 th December - 31 st December	Investigator	25 days
Finalising report	3 rd January - 31 st January	Investigator	28 days
Monitoring and evaluation	Continues	<ul style="list-style-type: none"> • PBN researcher Supervisor • Investigator 	Continuous

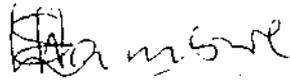
4
10
objection
Ay. N.S.


The University of Zambia
School of Medicine
Department of PBN
P O Box 50110
LUSAKA

23rd August, 2004

Provincial Health Director
Kafue Health Office
P O Box 30205
LUSAKA

The Head of Department
School of Medicine
Department of PBN
LUSAKA



Chief of PBN
School of Medicine
LUSAKA
Ay. N.S.


Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY

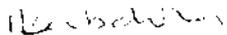
I am a 4th year student currently pursuing a Bachelor of Science (B.Sc) Degree in Nursing at the above mentioned institution.

In partial fulfilment for B.Sc Degree, I am required to carry out a research. The topic of my study is to determine the factors that influence the quality of nursing care at Kafue District Hospital.

I therefore request for permission to carry out the research study from 30th August, 2004 to 10th September, 2004. The target population are nurses who will be attending to the patients at the time of my study.

I thank you in advance for your favourable consideration.

Yours faithfully



Abbudula Nosiah Hichilema

District Director of Health
Kafue District Health Management Board

BUDGET FOR RESEARCH

ITEM DESCRIPTION	UNIT COST	QUALITY	TOTAL
Roll of tying paper	27,000	4 rims	108,000
Text books	2,500	4	10,000
Staplers	500	10	5,000
Pencil	500	10	5,000
Marker	500	2	1,000
Calculator	8,000	2	16,000
Stapler	3,000	4	12,000
Scientific calculator	80,000	1	80,000
Roller	20,000	1	20,000
Stapler	10,000	1	10,000
Stapling clips	5,000	5	25,000
Staplers	5,000	2	10,000
Charts	20,000	2	40,000
Research bag	45,000	1	45,000
Staples	3,000	4	12,000
Staples	5,000	2 boxes	10,000
3 TOTAL			414,000
PERSONAL COSTS			
Transport (fuel) x 2	20,000	10 days	200,000
Per diem allowance	50,000 x 2	10 days	1,000,000
TRAINING SERVICES			
Typing interviews schedule & checklist	3,500	10	35,000
Photocopying interview schedule	400	600 pages	240,000
Research proposal typing	3,500	50 pages	175,000
Typing the report	3,500	80 pages	280,000
Photocopying the report	400	320 pages	128,000
Binding the report	150,000	4	750,000
3 TOTAL			1,608,000
TOTAL CONTINGENCY (10%)			160,800
GRAND TOTAL			3,222,000

BUDGET JUSTIFICATION

- **STATIONARY**

Stationery which includes typing, paper, pens, pencils, marker and tipex will be needed for the investigator to be able to write down the information to be obtained during the data collection analysis and report writing, files, staples and a perforator will be used to keep the work in order.

- **PERSONNEL**

The investigator will be entitled to lunch allowance for the days they will be collecting data. Lockable bags are needed for keeping and carrying the questionnaires safely and to ensure confidentiality. Fuel will be needed to enable the investigator and the assistance to travel to and from the hospital or study site.

- **TYPING SERVICES**

The secretarial services which include typing, photocopying, recording and building the final reports will need binding for them to be a success.

MARK SHEET

VARIABLE	QUESTION NUMBER	WRONG	CORRECT	TOTAL MARKS
CARE	8	9	b, c	2
	9	9	b, c	2
	10	-	a, b, c	3
	11	-	a, b, c	3
	12	-	a, b, c	2

75% - 100% Adequate Nursing Care

50% - 74% Moderate Nursing Care

0% - 49% Poor Nursing Care

VARIABLE	Question Number		Number of Nurses per shift
Staffing Level	19-23	Adequate	5-6
		Moderate	3-4
		Poor	1-2

VARIABLE	QUESTION NUMBER	WRONG	CORRECT	TOTAL MARKS
Knowledge	24	NO	YES	2
	25	-	-	4
	26	-	-	4
	27	-	-	1
	28	B, c	a	1
	29	B, c, d	a	1

75% - 100% High

50% - 74% Moderate

0% - 49% Poor