Investigation into the Role played by Healthcare Managers in Implementing the National Core Standards at a TB Hospital

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Abstract: *This study focused on evaluating the roles played by healthcare management in meeting the National Core Standards (NCS), case study of a TB hospital. The study found that healthcare management functions in meeting the NCS are multifaceted and linked. The roles are found to comprise of drugs stocks control and procurement, financial planning and management, risk management, infection prevention and control, managing outbreaks and disasters with effective response mechanisms, ensuring the appropriate use of equipment and technologies, human resource management and decision making. The study established that healthcare management roles are faced with implementation and operational obstacles. These include a lack of support from senior management. Healthcare management is found to be vulnerable to an over-burning of inappropriate duties outside the scope of their functions. A general lack of confidence and role authority within the TB hospital healthcare management function was found to exist. The study therefore recommended the improvement of support structures to healthcare managers from senior managers to enhance the attainment of improved healthcare performance.*

Keywords: *healthcare management, tuberculosis, National Core Standards*

I.   Introduction

The NCS for health-care benefactors have been established as a declaration of what is expected to deliver decent and safe quality care. The NCS were framed through an all-encompassing and involved consultation process with different healthcare experts and leaders, including non-profit making organisations. A process of piloting and field testing was executed to ensure that the criterions are universal and meet the acceptable standards applicable to private and public healthcare service providers. South Africa is a very rich and well-resourced country as compared to other countries in Africa but there are still health audits that are questioning compliance of healthcare standards. Some health facilities are forming media headlines about system failure to meet basic healthcare needs. According to the NCS (2011:34), an audit report found that only 32 of the 394 hospitals and clinics audited complied with infection control guidelines and only one of 394 hospitals audited by the Department of Health (DoH) met the accepted standards for cleanliness, infection, drug stocks, staff attitude, patient safety and waiting times. Only Witrand Psychiatric Hospital in Potchefstroom - North West, alone ticked all the boxes in the massive audit of all South Africa's hospitals and clinics. According to the World Health Organisation (WHO) Quality of Care (2006:22) one of the leading interventions to improve quality is leadership because of its fundamental clear evidence that quality initiatives fail to realise their desired outcomes if there is no strong and consistent leadership support. It also states that where there is a perceived weakness in leadership in the health system, strategic interventions may be needed to build commitment and leadership capacity, and to strengthen accountability. This study attempts to respond to concerns and find answers to the root causes of the system failure and results used as recommendations for improving performance in other provinces. Audit results conducted in 2012 about this hospital raised a concern for making NHI a reality. The success of any organisation is dependent on the management structure to transform current health status and to yield better results.

1.1 The Research Problem

According to the National Health Audits that were conducted between May 2011 and May 2012, only one out of 394 health facilities in South Africa had accomplished a 100% performance rating in all the six key priority areas of the National Core Standards. The rest attained good ratings on one or more acceptable performance ratings identified on the key priority areas. The TB hospital was rated amongst the worst

performers in meeting NCSs' Key Priority Areas (KPA). The hospital was rated the worst in clinical staff attitude at 8% in comparison with the other 393 audited institutions. The hospital was also ranked one of the lowest on patient waiting times, cleanliness, patient safety, and attained a below standard of infection control guidelines (NCS, 2011:35). The findings were derived from an inspection process that was audited by a consortium of five bodies. Hospital infrastructure, medical equipment conditions, opening hours, work load, staff numbers and evaluation of standards in six priority areas for NCS were undertaken. The responsibility of healthcare managers is to oversee the performance of their healthcare centres in line with the key performance areas (NCS, 2011:37). The purpose of this study is to investigate the role played by healthcare managers in implementing the National Core Standards. The focal point of this study will be on the TB hospital in order to ascertain healthcare managers' challenges in ensuring compliance in meeting the established and tested standards of the six KPA for South Africa's healthcare service providers.

1.2 Aim of the Study

The aim of this study is to investigate the role played by healthcare managers in implementing the NCS at the TB hospital. This study will achieve this aim through analysing pertinent literature sources that are relevant to this topic to evaluate the findings of other researchers on the same topic to come up with a theoretical framework going forward. This study will employ a qualitative methodology to collect empirical evidence to fulfil the research objectives. The findings from this study will be used to draw up recommendations to management to improve the implementation of the NCS at the TB hospital.

1.3 Research Objectives

The research objectives for project will be as follows:
- To investigate the root causes and reasons that caused the TB hospital to be rated amongst the worst performers in meeting National Core Standards Key Priority Areas;
- To explore the role played by healthcare management in implementing the National Core Standards at the TB Hospital;
- To identify challenges faced by the healthcare managers when implementing the Standards; and
- To make recommendations to the management that will enhance the implementation of the National Core Standards and improve performance of the TB hospital.

1.4 Research Questions

The research questions of this project are as follows:
- What were the root causes and reasons that caused the TB hospital to be rated amongst the worst performers in meeting National Core Standards Key Priority Areas?
- What is the role played by healthcare management in implementing the National Core Standards at the TB hospital?
- What are challenges faced by the healthcare managers when implementing the Standards?
- How can healthcare management bridge the gap in supporting Implementation of the National Core Standards for best healthcare practices and improved performance at the TB hospital?

1.5 Significance of the Study

The analysis of the roles of healthcare managers in meeting and affecting the NCS standards will significantly assist healthcare professionals to improve on gaps that are identified in this study. This study will also highlight macro-challenges that have the net effect of being obstacles to meeting quality clinical care and will attempt to add to scholarly knowledge on models or frameworks that can be employed to assist healthcare industry policy formulation with a focus to advance quality clinical care practices. The TB hospital has been selected based on its performance that was not satisfactory during the health audits. From this study, its inevitable purpose is to assist the TB hospital management and other healthcare institutions in the same ratings category on ways to improve on quality and performance. This study is intended to be beneficial to Office of the Health Compliance Standards in identifying additional frameworks that can be employed to benchmark performance and create a platform to further put measures in place to equip healthcare managers with skills and knowledge to close identifiable gaps.

II.   Literature Review

Several research findings reveal that modern healthcare has become highly complex, error prone and a high risk environment. It is not surprising that healthcare errors and consequential adverse cases have become one of the leading causes of death or injury. This is in spite of the existence of well documented preventive strategies used by healthcare providers to significantly mitigate the occurrence of many of these clinical errors (Kizer & Blum, 2010:12). Given the speed with which biomedical knowledge, diagnostic and treatment

technologies and healthcare practice revolutions, patient safety apprehensions are incessantly changing. New innovations to ease and mitigate morbidity and avoidable mortalities from adverse healthcare occasions should be extensively disseminated and fulfilled. The safe practices must always be updated to stay current with the clinical quality care practice (Kizer & Blum, 2010; NCS, 2011:13).

2.1 The National Core Standards
South Africa's National Core Standards (NCS) were established to ensure that managers in healthcare services are proficient in quality clinical care services that advance the level of patient care and satisfaction. The NCS standards reflect on South Africa's policy context, with a direct specificity to the Department of Health and to a large extent based on current legislation, protocols and guidelines (Mocke, 2011:7; NCS, 2011:9).

2.2 Purpose of the National Core Standards
According to NCS (2011:6) and Mocke (2011:1), the NCS provide for the benchmark for quality improvement in public health establishments' standards. This is defined as "an expected level of performance". The main objectives of the NCS are therefore to:
• Develop a collective definition of quality of care which should be found in all healthcare centres of South Africa and act as a guide to the public, health managers and staff members across all levels;
• Establishing a benchmark that will be used to assess public health establishments, identification of gaps and appraised strengths for continuous improvement; and
• Provide for a national certification framework for public health establishments.

2.3 Six KPAs of National Core Standards
The six KPAs identified in the National Core Standards for the improvement of healthcare service provision in South Africa are outlined as follows:
• Values and Attitudes
• Cleanliness
• Waiting times
• Availability of medicine
• Patient safety and security
• Infection prevention and control (Mocke, 2011:4; NCS, 2011:13).

According to Matsoso (2011:4), the National Core Standards have been grounded on current policy environments and tailored to South Africa's healthcare context, while also reflecting international best practices and a strong evidence base. The author asserts that: *"South Africa is faced with a huge challenge in transforming its healthcare delivery system. The transformation is not only to meet citizen's expectations of good quality care, but also to advance on critical healthcare outcomes linked to the Millennium Development Goals" (*Matsoso, 2011:4). Motsoaledi (2011:6) states that the prominence of providing quality health services is non-negotiable. Motsoaledi (2011:7) affirms that, "quality is defined as getting the best possible results within available resources*"*. Therefore, these National Core Standards set out how best to achieve quality health services. Superior quality of care is ultimate in improving South Africa's current poor health outcomes and in re-establishing patient and staff confidence in the public and private healthcare system (Matsoso, 2011:5). The South African National Department of Health (NDoH) by 2011 had identified a number of areas for speedy improvement. These essential areas include cleaner facilities, shorter patient waiting times and better patient safety and care. In spite of some clear successes, more improvements are needed to ensure patients are provided with proper decent healthcare. All managers are expected to ensure that these standards are met (Motsoaledi, 2011:6). Motsoaledi (2011:6) and Matsoso (2011:4) both concur that simply reminding healthcare staff of their basic duty is not enough to achieve widespread and sustainable improvement in South Africa's quality of care. The factors that contributed to the current situation must also be taken care off. These comprise of poor management, a lack of accountability, a culture of mediocrity rather than excellence, demotivated staff, and an erosion of professional ethics. The Office of the Health Compliance Standards (OHCS) was given the mandate to create National Core standards that would improve current public healthcare system and monitor compliance to standards by all health facilities. KPAs that need to be focused on have been highlighted to fast track the quality improvement process (Motsoaledi, 2011:7).

2.4 The Structure of National Core Standards
There are seven domains in the structure of NCS (NCS, 2011:11). A domain in healthcare service delivery is defined as an area where quality or safety might be at risk (WHO, 2008:2). The NCS are structured into seven cross-cutting domains and the layout is deliberate. The first three domains: Patient Rights, Clinical Governance and Care, and Clinical Support Services are linked directly with the core business of the health

system of delivering quality health care. The other four domains: Public Health, Leadership and Corporate Governance, Operational Management, and Facilities and Infrastructure, firmly form the support system that ensures the system delivers its core business (NCS, 2011:10).

2.5 Patient rights

According to Whittaker, Shaw, Spieker and Linegar (2012:62), the domain of patient rights sets out what a healthcare service centre must do to ensure that patients are respected and have their rights upheld. That includes access to needed care, informed and dignified attention in an acceptable and hygienic setting from the perspective of the patient in accordance to the Batho Pele principles and the Patient Rights Charter. The sub domains for patient rights include respect and dignity, availability of information to patients, physical access to healthcare establishments, medical device risk reduction, unrivalled healthcare capabilities to infection control and prevention including that of TB, reduction of delays in care, continuity of care, emergency care and an effective complaints management (NCS, 2011:13; Whittaker *et al.*, 2012:64).

2.6 Patient safety, clinical governance and care

Whittaker *et al.* (2012:62) stress that clinical governance and care is a domain in the NCS structure that strives to ensure quality nursing in clinical care, ethical practice in discharge of duties, reduction of unintended harm to healthcare providers or patients in identified situations of increased clinical risk. (NCS, 2011:13) further stresses that this domain aims at reducing or preventing scenarios of adverse events that include care-associated infections as well as support to any affected patients and staff. Governance in clinical care will be critically involved in delivering on management and planning, financial management, procurement, human resource management, information management, corporate governance, quality improvement programme, risk management, research governance and the effective communication and management of public relations (Whittaker *et al.*, 2012:65).

2.7 Clinical support services

The clinical support services domain covers specific services critical in the provision of clinical care and incorporates the timely availability of medicines, an efficient diagnostics mechanism, therapeutic and necessary technologies in medical services. The domain also covers systems that monitor the efficiency of the care provided to patients (Whittaker *et al.*, 2012:65; NCS, 2011:14). Identified core areas in this domain entail issues of patient rights enshrined in the patients' health charter, the complaints system, help desk and hospital information and patient perceptions of care (NCS, 2011:15). Whittaker *et al.* (2012:62) add that sterilisation services and mortuary services are also addressed in clinical support services domain.

2.8 Public health

This domain explains the working relationships and dynamics of health facilities with NGOs and other relevant healthcare providers together with local communities to advance health, the prevention of illness, reduction of complications and making sure that integrated quality care is provided for communities even during disaster periods (NCS, 2011:15). Whittaker *et al.* (2012:63) resonate in asserting that population based service planning and delivery, health promotion and disease prevention, disaster preparedness and environmental control are key areas of the public health domain.

2.9 Leadership and corporate governance

The leadership and corporate governance domain covers the strategic direction delivered by senior management. This is achieved through proactive leadership, planning, risk management. These initiatives are supported by the hospital boards, clinical committees and applicable supervisory support structures. The initiatives include strategic functions of communication and quality improvement (NCS, 2011:17; Whittaker *et al.*, 2012:63). Whittaker *et al.* (2012:63) add that the key elements in this domain include oversight and accountability, strategic management, risk management, quality management, effective leadership, communications and public relations.

2.10 Operational management

This domain covers the day-to-day key responsibilities that support and ensure a safe and efficient patient care which comprises management of human resources, finances, assets and consumables as well as information and records (NCS, 2011:16). Whittaker *et al.* (2012:63) echo by stating that the key areas in operational management include human resource management and development, employee wellness, financial resource management, supply chain management, transport and fleet management, information management and the maintenance and update of medical records.

2.11 Facilities and infrastructure

The last domain in the NCS is that of facilities and infrastructure. This domain covers the requirements for clean, safe and secure physical infrastructure. Physical infrastructure in this context refers to buildings, plant and machinery and equipment. Functional, well managed hotels services and effective waste disposal are some of the areas covered in this domain (NCS, 2011:17). Whittaker *et al.* (2012:64) affirm with the latter by stressing that buildings and grounds, machinery and utilities, safety and security, hygiene and cleanliness, linen and laundry and food services are critical components of the facilities and infrastructure domain.

2.12 Principles influencing the development of National Core Standards

According to the NCS (2011:9), prior to April 2008, a response was needed to answer to the concerns on the subject of multiplicities of different standards and their guiding principles for managers throughout the health delivery system. Coupled with the phenomena was the consequent strain in quantifying performance against a common benchmark. In light of these myriad of challenges, by April 2008, a set of "Core Standards for Health Establishments" was launched. Research by NCS (2011:10) further finds that the standards and assessment tools underwent pilot tests between June 2008 and March 2010 in a sample mix of private and public healthcare institutions. In coming up with an approach to the development of the NCS standards, a set of principles were employed that reflect the overall policy direction of the DoH. According to NCS (2011:13), these principles are universality, relevance, validity, logic and reliability and are explained below.

Universality: Universality, in the context of health standards and philosophy, are common and generally applicable assessment measures at all healthcare settings and levels from private to public institutions.

Relevance: Critical elements of care to providing quality care at all South African healthcare centres are holistically taken on board in the established standards and assessment measures.

Validity and Reliability: These are references to what can objectively and practically be measured during audits of healthcare centres.

Logic: Logic refers to tacit philosophy employed in the classification and arrangement of measures, norms and principles into the policies, systems, processes and procedures as well as the outputs (NCS, 2011:11).

2.13 Auditing of National Health Facilities

According to Mocke (2011:3), "….the process of conducting healthcare service delivery audits creates an important opportunity to build an awareness and critical momentum in prioritising the improvement in quality of care at an operational level where it matters most …" A baseline survey conducted by the Health Systems Trust (2011) cited by Mocke (2011:4) states that the positives drawn out from the first audit conducted revealed that audits are driven by top management at national level and there is visible support from management for the process. The audits confirm the transversal nature of healthcare and provide baseline information on the standards of care provided by healthcare facilities. The audits are also aimed at motivating staff to address identified areas where they have shortcomings. Motsoaledi (2011:8) and Mocke (2011:4) agree that the auditing of national health facilities contribute to the improvement of quality of clinical care. The audits emphasise the importance of best practices such as daily checks (fringe temperatures), daily inspections of cleanliness, and the importance of attending IPC training.

2.14 The assessment tool and the measures

In assessing the performance of healthcare service providers, the measures in the assessment tool are the means or evidence for determining that established criteria are met. The criteria are the public and private healthcare service centres. The tools examine direct observations, that is, aspects that can be seen, heard or felt by the assessors. Indirect observations include aspects such as an analysis of the healthcare centre policies, patient record reviews and the minutes of committees. As such, the measures form the basis of the assessment tool used for both self-assessment and the compliance audit (Mocke, 2011:6; NCS, 2011:13).

2.15 Rating of the measures

According to NCS (2011:14), the component measures for each of the standards were classified according to a risk rating approach and employed an adapted matrix used by the Australian Capital Territory Government in 2009. The component assesses the severity of the impact as well as the probability of a risk occurring in each case. In the context of the risk ratings, the respective measures are presented in three risk levels as highlighted below.

Vital: Vital measures are classified as those that ensure that the safety of staff and patients is safeguarded. This aims at ensuring that there are significant, if not a zero tolerance attitude, to unnecessary harm or avoidable deaths (Whittaker *et al.*, 2012:67; NCS, 2011:114).

Essential: Essential measures are considered as those critically fundamental to safe, decent, quality care and designed to provide in-depth views of what is expected within available resources. Examples include clinical risk management, quality improvement processes and guidelines for maternity care (NCS, 2011:15).

Developmental: Measures to development are identified as elements of quality care that health management are expected to aspire to which is purposed to achieve optimal care. Developmental standards improve the healthcare centre's capacity to deliver on optimal care and reflections on continuous advancements (NCS, 2011:15; Mocke, 2011:9).

2.16 Quality standards in healthcare establishments

Standards are critical in benchmarking service provision. According to NCS (2011:10), a standard is a proclamation of an expected level of quality delivery and it reflects a quality based model of performance of a health establishment in providing care. NCS (2011:9) further explains that quality in healthcare centres is defined by six dimensions according to the WHO standards. Quality therefore refers to efficiency, effectiveness, accessibility, patient centeredness, equitability and safety (NCS, 2011:20). Whittaker *et al.* (2012:60) refer to quality in healthcare as, *"the extent to which an organisation meets its clients' needs and expectations. It is a therefore a complex and multifaceted concept that can be assessed and measured against predetermined standards."*

2.17 Conceptualising Performance Standards in Nursing/Clinical Care

Performance in healthcare establishments can be evaluated by employing tools that capture objective and subjective information about a healthcare individual's knowledge base and the actual performance (Aone, 2007:3). Aone (2007:3) explains that the full complement of competency clusters are organised in three distinct domains, leading yourself, leading others and leading the organisation. Aone (2007:4) adds that the three domains comprehend specific competencies for career advancement for the nurse and healthcare professionals.

Leading yourself component: The leading yourself component addresses healthcare issues on the part of staff on adaptability where the staff member is expected to be open to team work, collective influence in clinical practice and flexibility to work in dynamic environments. The staff member is expected to be able to build professional relationships with peers and must be self-motivated. The staff member must be self-aware and execute ability deliver on gained or acquired knowledge (Aone, 2007:4).

Leading others component: Leading others entails effective communication, the ability to resolve conflict within the working environment, including confronting problem employees, leveraging differences, developing and empowering employees to improve on their capacities towards quality clinical care practice as well as advancing collaborative relationships (Aone, 2007:4).

Leading the organisation: The third domain (leading the organisation) entails showing acquired abilities that seek broad business knowledge and change management in advancing healthcare service provision. When leading, strategic perspectives and decisiveness are critical in decision making. Systems thinking require a leader to act systematically and methodically to ensure effective healthcare project management and results based strategic planning (Aone, 2007:4).

2.18 Healthcare Leadership

NCS (2011:16) states that in implementing and monitoring National Core Standards in hospitals, a strong health-care leadership is a driving force. Clinical leadership is therefore critical to an effective and efficient adherence to quality service standards. Doherty (2014:6) states that in hospitals where clinical leadership is strong and maintained, the following features are prevalent:

- A critical mass of skilled clinical staff;
- Frequent and purposeful meetings;
- Leaders with appropriate personalities and traits;
- A strong focus on patient needs within the context of the broader health system;
- A collaborative leadership style and the existence of a multidisciplinary teamwork.

Jones and Bartlett (2012:20) management is a process that is comprised of social and technical functions and activities that occur in an organisation with the goal of accomplishing predetermined objectives through humans and other resources. Jones and Bartlett (2012:20) further assert that managers work through other people, delegating and carrying out interpersonal and technical activities so as to achieve the desired objectives of the study.

2.19 Hospital management and the well-being of patients

According to Booysens (2009:9), healthcare management is the field relating to leadership and administration of hospitals, networks, and healthcare systems. Jooste (2012:336) argues that the responsibility for providing quality healthcare lies with the leadership of healthcare professionals who are ultimately responsible for the well-being of patients at all times.

2.20 The role of healthcare managers
According to Jones and Bartlett (2012:21), managers have six key management functions in a management process and these are explained below.

Planning: Planning requires the manager to set a direction and control what needs to be accomplished. This entails setting priorities and determining performance targets.

Organising: An organising function refers to the overall design of the organisation or unit in the organisation for which the manager is responsible. In addition, organising entails designating reporting relationships and the internal patterns of interaction. The critical components of this function include the determination of positions, assignment of teamwork, distribution of authority and responsibilities.

Staffing: The staffing function denotes to the recruitment and retention of human resources. This function also determines training and development as well as maintenance of the workforce by employing various stratagems and schemes.

Controlling: The controlling function denotes to the monitoring and evaluation of staff activities, performance and taking the most suitable actions for corrective action to improve on performance and quality deliverables.

Directing: The initiation action in the organisation that is achieved through effective leadership and motivation as well as communication with staff is the focus of the 'directing function'.

Decision Making: Decision making is a function that is applied to all the functions of management. It is critical in making effective decisions that are based on consideration of benefits and drawbacks of alternatives within an organisation's quest for improved performance and satisfactory deliverables.

2.21 Challenges to Good Clinical Leadership
Doherty (2014:4) highlights obstacles inherent in South African healthcare management services. She states that these obstacles to good clinical leadership habitually stymie the best efforts of clinical staff management at the healthcare institutions. These problems are outlined as:

- a disjuncture that exists between the identification of complications affecting clinical care and the actions taken in response by the management teams;
- alienation of district hospitals from the primary care services in the district;
- a lack of leadership and management training for all fields of health professionals, as well as insufficient mentoring;
- a failure at district and provincial office levels to deliver an enabling operational environment; and
- A difficult and indecisive monitoring system.

Doherty (2014:4) adds that these leadership obstacles have contributed to the failure of clinical governance systems in South Africa. Aone (2007:12) resonates with the latter by highlighting methods that develop leadership competencies specifically for nurses who commonly constitute hospital unit management roles in general. However, a closer look from several research findings reveal that front line and middle level managers in healthcare are faced with more personal obstacles in their roles (Osbourne, 2011:1). According to Osbourne (2011:1), managers face challenges around self-identity, negative perceptions of the management and human resources issues. Managers are found to experience lack of involvement in decision making and feel challenged by hierarchical organisational structures which tend to impede their authority over their subordinates. Osbourne (2011:2) further stresses that role ambiguity, work pressure, job insecurity, poor organisational communication, conflicts, and conflicting government directives such as demands for cleaner hospitals while insisting on employing fewer cleaners have all impeded on their capacity to deliver. Four key challenges common with both front line and middle level managers in healthcare are:

Managers' struggle with self-identity: Managers struggle to maintain their professional identity, particularly hybrids who view themselves primarily as clinicians. This is because these managers see their clinical functions being side-lined by their managerial roles. Osbourne (2011:3) argues that intrinsic tensions exist between professional beliefs of clinical and medical staff and the managerial burdens for efficiency, resource allocation and cost control.

Negative perception of management: Osbourne (2011:3) argues that the negative perception of management in healthcare establishments presents a number of obstacles to both frontline and middle level managers. Osbourne (2011:3) states that clinicians who assume managerial roles in hospital or clinical settings risk loss of respect and clinical visibility and they have to work to dismiss suspicions that choosing managerial roles is not because of their lack of ability to advance in their clinical careers.

Human resources: According to Loo and Thorpe (2008:89) as well as Savage and Scott (2008:2), most hospitals have challenges in recruiting appropriately skilled professionals in the healthcare establishments. The challenges are further compounded by high turnover of highly competent managers who are hired by private healthcare firms. Osbourne (2011:3) further argues that managers sometimes claim ambiguity in their roles as

they conflict with higher authorities within the healthcare establishments. Managers, therefore, lack definitive job descriptions.

Unpreparedness for roles: Osbourne (2011:4) asserts that many healthcare managers are given their management functions and roles without adequate prior training and experience. Savage and Scott (2008:2) argue that such lack of experience has negative impacts on management performance as well as their ability to monitor staff performance.

2.22 Competencies for Healthcare Managers

Jones and Bartlett (2012:22) assert that in order for the managerial functions (explained in section 2.7.2) to be effectively carried out, managers must possess several key competencies. According to Jones and Bartlett (2012:22), these key competencies include conceptual, interpersonal and technical skills. Bartlett (2012:23) refers to the term 'competency' as a state in which an individual has the requisite, adequate abilities and qualities to execute certain functions. Ross, Wenzel and Mitlying (2009:12) explained the three competency skills as follows:

Conceptual skills: These skills involve the ability to critically analyse and solve complex phenomena. An applicable example is where a hospital manager determines a strategy to reduce patient complaints with regards to food service (Ross *et al.*, 2009:13).

Technical skills: These skills reflect on expertise and ability to execute a specific work related assignment. An example is when a manager develops and implements new incentives for staff in a compensation program (Ross *et al.*, 2009:13).

Interpersonal skills: These are the skills that qualify a manager to communicate with and work well with other individuals, regardless of whether they are peers, subordinates or supervisors. An example is when a manager advices an employee who performs below expected standard requirements on specific key result areas (Ross *et al.*, 2009:13).

2.23 Competency models for healthcare leaders

This section presents literature on competency models for healthcare leaders. These competencies enable the healthcare leaders to effectively carry out their professional nurse and managerial roles and highlighted below (Ross *et al.*, 2009:13).

2.24 Nurse leader patient safety competency model

In relation to healthcare service provision, the NCS emphasise on patient safety. Aone (2007:4) presents a nurse leader's competencies mainly focused on patient safety and one key priority area of the NCS. According to Aone (2007:4), three competency domains namely patient leadership safety, core patient technology and a culture of safety are recognised as critically essential to the development and application of a practice environment that ensures safety. Aone (2007:5) further stresses that the model is designed to assure that the practice environments support exemplary, safe, high quality care of patients and families through effective nurse leadership. A basic assumption of this model is that a leader in a health-care environment is able to maintain a competent workforce.

The healthcare leadership alliance competency model: Stefl (2008:5) states that communication and relationship management domain; professionalism, knowledge of the healthcare environment, business knowledge and skills are competency domains that make up for good leadership qualities in healthcare establishments.

Communication and relationship management: Stefl (2008:5) states that the communication and relationship management domain entails the ability to communicate clearly and unambiguously with internal and external customers is critical in healthcare leadership. This is essential to establish and maintain relationships and for the facilitation of constructive interactions with groups and individuals.

Professionalism: The model asserts that healthcare leaders must show and practice abilities to align organisational and personal conduct with professional and ethical standards which incorporate responsibility to the patient, community, a 'service orientation' and high commitment to improvement and life-long learning (Stefl, 2008:5).

Knowledge of healthcare environment: Knowledge of healthcare environment domain entails a deep understanding of the healthcare system within which the managers operate in relation to functional deliverables mandated by the hospital authorities (Stefl, 2008:5).

Business skills and knowledge: Business skills and knowledge entails the ability to apply business principles which incorporate systems thinking to the healthcare environment. Ross *et al.* (2009:16) add that business knowledge and skills include basic business principles that consist of financial management, human resource management, strategic planning and marketing, risk management, quality improvement, organisational dynamics, and governance (Stefl, 2008:6).

Leadership: Stefl (2008:6) concludes by stating that leadership entails the ability to inspire individual and organisational excellence to create and collectively drive towards a shared vision and to effectively manage change to attain the organisation's strategic ends and improved performance. Stefl (2008:7) and Ross *et al.* (2009:17) both affirm that in keeping with the current focus on outcomes and evidence based management in healthcare establishments, the five domains in the common competency model aim at effectively managing healthcare service delivery and the maintenance of set out international standards to quality clinical care practice.

Behavioural theory of leadership: According to Cherie and Gebrekidan (2009:81), the behavioural theory, also referred to as the functional theory of leadership, focuses on the leader. This theory explains that a leader's conduct within the business environment influences the level of respect from the subordinates. The key attribute in this model is 'an exemplary professional conduct' which effectively leads by example for the subordinates to follow suit in executing their key result areas.

III.   Research Methodology

Research, according to Leedy and Ormrod (2010:3), is a logical and organised process of collecting, analysing and interpreting information in the form of data with an objective of increasing a deep understanding of a phenomenon about which a researcher is concerned with. Huang (2010:100) ascertains that a research methodology on the other hand is essentially a plan, organisation and approach of an enquiry to find alternative tools to solve stated problems and aims to reduce inconsistencies of data validity. According to Van Wyk (2012), a research design is therefore a nonconcrete structure that informs how the research is to be executed. This entails an affirmed strategy that will be used to gather empirical evidence which is being sought to answer a problem that initiated the research itself. Bryman (2012:46) further defines a research design as the procedures that offer researchers an overall structure that consists of ways for collecting and examining data to meet the research objectives. The exploratory research design was chosen since it was the most suitable design to get comprehensive data to find relationships among the research variables to fulfil the research objectives. This qualitative and exploratory research design was the most appropriate and flexible research design to investigate the role played by healthcare managers in implementing the NCS at the TB hospital.

3.1 Research Philosophy

A research philosophy is a belief about the way in which data about a phenomenon ought to be collected, examined and used. The term epistemology refers to what is known to be true as opposed to doxology which refers to what is believed to be true and encompasses that various philosophies of research method. The phenomenological research philosophy was employed in this study to obtain qualitative data that was based on the human experiences which was dominant and more convincing than that of numerical data. This study used interviews that were very natural and depicted real life experiences of the participants that enabled the researcher to investigate the role played by healthcare managers in implementing the NCS at the TB hospital. The phenomenological research philosophy was the most suitable paradigm as it provided a deeper understanding of this topic and comprehensive information that would be identified through the positivist paradigm.

3.2 Research Strategies

Welman Kruger and Mitchell (2011:52) cite two most common research strategies available to business researchers as the quantitative (positivist) and qualitative (phenomenology) research strategies. However, scholars often combine the two research strategies into a single research strategy called combined research strategy. The research instruments in a qualitative approach are flexible, and allow for in-depth semi-structured interviews to be conducted, further permitting the study to gather in-depth data in the phenomena. In a qualitative approach, participants' responses determine which questions follow so as to encourage the flow of information whereas in a quantitative approach, responses have no influence on which and how questions come next. It is apparent that research literature on the healthcare standards and management on manager roles and functions is relatively scarce, especially in the context of South Africa's scarce literature on lessons from earlier healthcare standards' audit/assessment outcomes. Hence, an in-depth, observative behaviour and descriptive analysis of the findings essentially necessitated a qualitative research approach. Mack, Woodsong, MacQueen, Guest and Namey (2010:12), stresses that the strength of qualitative research is in its aptitude to afford complex textual descriptions of how people experience a given research matter. This study employed the in-depth interviews to gather primary data from participants experiences in the implementation of the NCS at the hospital. The interview method was appropriate for this study as it sought to engage its research participants in a way that draws as much as possible their perceptions on performance and management issues in relation to the NCS in South Africa's healthcare settings.

3.3 Phenomenological research strategies

Phenomenologists assert that it is only through the subjective interpretation and interpolation of the collected data that realism can be profusely unstated. The study of phenomena in their natural settings is significant to the interpretivist philosophy, together with the acknowledgement that scientists cannot circumvent affecting those phenomena they study (Mkansi and Acheampong, 2012:133). Phenomenologists concede that there may be several clarifications of reality, but uphold that these interpretations are in themselves a measure of scientific knowledge under study. Interpretivism does not have a custom that is more outstanding to that of positivism, nor is it shorter. The phenomenological research strategies mostly use interviews, focus groups, case studies, action research, grounded theory and ethnography and data gathering instruments. A phenomenological approach was chosen against a positivist approach because of its flexibility in instrument use and permission to the use of semi-structured methods such as in-depth interviews, focus groups and participant. Two qualitative strategies: in-depth interviews and participant observations were employed for purposes of triangulation within the research method to enhance the quality of data gathering by maximising on the depth and breadth of responses and observations for transcription. The qualitative research strategy allowed for an in-depth analysis of the events as they occurred in the natural phenomena and was deemed to be more suitable than a positivism philosophy.

3.4 Target Population

Hancock (2012:16) defines a target population as an all-inclusive establishment of a set of elements, persons or entities from which the study's data will be gathered from to make inferences. According to Kothari (2010:87), a target population is the larger population within the phenomena in which the sample size and its reflective characteristics will be drawn. Both authors Kothari (2010:87) and Hancock (2012:16) concur that a target population that constitutes the research phenomena's setting is that which determines the sampled participants in a research methodology. For purposes of this study, the population was defined as all the staff complement of the TB hospital that stands at eighty-four (84) personnel in general. The management structure of the TB hospital has a staff establishment of ten managers and supervisors of the units/department. It consists of Nursing Service Manager/CEO, Clinical Manager, Assistant Nursing Manager, two Administration Managers and three operational managers. Operational managers oversee more than two units per person.

3.5 Sampling

A sample is defined as a group of elements derived from a larger pool of elements from the same phenomena. Mack *et al.* (2010:16) assert that a study's research objectives and the features of the study population determine which and how many people to select. From this larger pool of potential research participants, the sampled ten elements were healthcare managers including operational managers. Over half of the healthcare managers at the hospital composed of those who were once clinicians from the same or other healthcare institutions and who were now dedicated to management functions. This group delegated their management functions within the clinical settings in which they are actively involved.

3.6 Kinds of sampling

There are two main types of sampling namely: probability and non-probability sampling. With the probability sampling, the chances of each element to be chosen from the population group are known. A non-probability sampling strategy is that in which the chosen elements in a sample have no known chance of being selected from the larger pool that defines the target population. For this study, a non-probability purposive sampling strategy with key informants was chosen. A two-stage purposive sampling technique was employed. The first stage separated managers from the rest of the workforces within TB hospital. The second stage involved identifying managers who are directly linked with healthcare service provision and against managers whose roles were not directly linked to clinical care and reported for duty at dispersed times. This was critical to ensure that managers who are actively on the ground within the phenomena were assumed to be more conversant with the activities that determine compliance to performance standards as required by the National Core Standards. The identified sample elements were regarded as 'key informants' to the research as they constituted management in healthcare at the TB hospital whose roles and functions entail the monitoring and evaluation of the overall performance of the healthcare institution.

3.7 The Research Instrument

Decrouez and Jones (2012:331) expound research instruments as the devices and materials that are employed by a researcher to systematically and methodically gather relevant data to answer the research questions. The research instrument consisted of two sections. Section A covered the demographics data of the participants that included age range, gender, work experience and their highest qualifications. Section B comprised the interview questions that were designed to obtain responses from the participants to answers the

research questions. Section B was guided by in-depth interview questions that were derived from the research questions.

3.8 Interviews

Interviews were conducted on site. The duration of the interviews ranged from 30 minutes to 45 minutes. An audio recording of the interviews was employed as one of the data collection devices, together with 'note scribbling' of key points that the researcher sought from the respondents to elaborate their answers. The open-ended nature of the interviews assisted the researcher in gathering data in a flexible and interactive manner that gave the research participants confidence to participate freely. During interviews, observations were noted for a deeper understanding as well as probing for responses that would otherwise not have been possible with questionnaires if the quantitative method was employed.

3.9 Pilot Study

Mack *et al.* (2010:59) enlighten that a pilot study is a practice that tests the data collection instrument by deploying it into the field to ascertain its applicability and comprehensiveness in addressing all requirements for data collection. Any defects identified in the pilot study will be used to fine-tune the data collection instrument. For gathered data to be acceptable in a research, the research instrument must be pilot tested to enable fine-tuning of the data collection processes that will be undertaken. The research instrument must also employ triangulation within the methodology to test the convergence of gathered responses and consequently enhance data validity (Battaglia, 2011:563). This study pilot tested two healthcare professionals from the TB hospital who were subjected to an in-depth interview using the data collection instrument to ascertain its flexibility and reliability to effectively gather the required data. The two participants used for pilot test were not part of the final sample elements that were selected for the study's data collection process. From the pilot study, the outcomes reflected a satisfaction with the research instrument's design and there were no changes made to the instrument.

3.10 Interview Process

The research participants were informed through the information office two weeks before the questionnaires were administered to ensure that time was allowed for preparation for the interviews and the filling of demographics information. At the administration date, all research participants were available at the hospital's board room between 10H00 to 14H00. The hospital asked that the researcher uses a numbered card from 1 to 10 that would entail a systematic call-up of research participants within the given period of interviews. This was necessitated due to the fact that managers would at least have time for their daily duties and only be available when their interview schedules were due. The first phase of the interview entailed filling in of the demographics information, followed by the interview session. Each session lasted between 30 minutes to 45 minutes of the participants' valuable time.

3.11 Data Analysis

The qualitative data analysis method was used for this study (Saunders, Lewis and Thornhill 2012:194). Hancock (2012:19) suggests that the researcher's gathered data will first be transcribed, summarised and presented in a way that communicates the key points that inform the research. The analysis of data was executed by way of grouping participants' responses into thematic groupings that arose from new inferences as well as the research's objectives. The basic process commenced with labelling and coding every item of information so that differences and similarities between all the different items would be revealed and employed thematic networks and verbal transcriptions. This procedure assisted the researcher to outline and reveal the big picture of the phenomenon to investigate the role played by healthcare managers in implementing the NCS at the TB hospital.

3.12 Trustworthiness of Qualitative Study

According to Golafshani (2009:8) the issue of validity in qualitative research entails that the researcher must ensure 'rigor' in exploring the subjectivity, reflexivity and the social interaction of the interviewing process to enhance quality data gathering. Golafshani, (2009:6) argues that in relation to reliability, credibility and dependability on data outputs in a qualitative study, the researcher 'is the instrument of research'. Since this study was qualitative in nature, it employed the credibility and dependability principles of research. The qualitative method entailed the use of observations in addition to the demographics questionnaire data requirements of the research instrument and in-depth interviews. The congruency between the observations and the interviews enhanced the credibility and dependability of the research process which was equivalent to the validity and reliability of the research. Trustworthiness was guaranteed by way of constant contrasting of the data from the participants. The instrument was simplified in such a method that the outcomes would be dependable even if inquiries were to be conducted at altered periods by another researcher.

3.13 Limitations of the Study

Limitations in research processes are difficulties and events that arise in a study that are out of the researcher's control and limit the extent to which the study delivers applicable outputs and at times affect the end result of the study (Gay, 2009:101). According to Mack, *et al.* (2010:54) a case study based research can be suggestive of what may be found in related organisations, nonetheless additional research would be required to corroborate whether findings from one study would generalise the same study elsewhere. As such, the behaviour of one unit of enquiry may or may not mirror the behaviour of comparable entities or elements. The use of a single research methodology presented a limitation in triangulation of the research. Triangulation between methods could have improved on the validity and reliability of the data as one weakness of one method could have been addressed by the strength of the other. While it was desirable to use a qualitative study in terms of resources, time factor was a constraint as grouping of all healthcare managers was a challenge and affected the timelines of the research progression. However, the study circumvented that challenge by constant sending reminders to the healthcare managers to honour the scheduled interview dates and times.

3.14 Elimination of Bias

Bias in a research study is a distortion in the collected data so that it does not represent reality in the phenomena. As such, bias is a form of organised inaccuracy or error that affects scientific investigations and distorts the measurement process (Babbie, 2009:279). This study made every effort to eliminate bias through the use of open-ended, semi structured questions that were not leading to the answers and used an independent research agent to distribute the questionnaires. High professionalism was observed during the data collection phase through the use of gender neutral words and dressing formally. The study also made efforts in ensuring that the notion of anonymity and confidentiality was maintained to mitigate bias and limitations from giving honest opinions on NCS and management questions from the healthcare managers. Bias was also eliminated through avoiding the identification of the participants by race and also used age ranges instead of actual participants' ages - a practice that would offend them.

3.15 Ethical Considerations

Gay (2009:106) and Mack *et al.* (2010:36) state that the history and development of international research ethics guidance is strongly reflective of abuses and mistakes made in the course of biomedical research in particular. These extremes have resulted in a balanced approach that is universally acceptable in research in which ethical considerations are established as key principles in research norms. As such, the following ethical considerations informed this study.

Ensuring participants have given informed consent: All information and procedures to be followed during the study was disclosed to the hospital authorities and participants to ensure informed consent. Welman *et al.* (2011:181) emphasise the essential role that the principle of voluntary participation plays in encouraging research ethics by hinting that the researcher has a duty to provide the participants with a full clarification of the processes and risks intricate in the study before participants give their consent to participate. Permission was sought from participants for their voluntary participation into this research.

Ensuring no harm comes to participants: All participants of this study were protected from physical and psychological harm. All sensitive questions that would harm the participants were avoided at all times. All the evidence given by the contributors was protected and the researcher organised an expedient and secure venue at the hospital's board room to administer the questionnaires so as to protect the participants from any harm of whatever nature.

Ensuring confidentiality and anonymity: Saunders, Lewis and Thornhill (2009:195) stress that the researcher ought to ensure that the identity of all the research participants is secure and confidential. Therefore, the data collected, information furnished and views expressed were treated with confidentiality.

Ensuring that permission is obtained: According to Saunders *et al.* (2009:194), it is imperative that official channels are exhausted and cleared by formally requesting permission to carry out a study. Obtaining access to research participants and secondary data is an important aspect of this study. A permission letter was obtained from the hospital authorities from Mpumalanga Department of Health Research Unit to grant permission to conduct the study.

IV. Results

The TB hospital management distribution of age ranges shows that half the represented managers in healthcare that has representative of 60% are between 40 and 49 years. About 20% of the managers are found to be between 50-59 years. A representative minority of 20% are between 30-39 years of age. This data reveals that the TB hospital is managed largely by personnel who are above the age of 40 years. Empirical data shows that there are 10% male managers and 90% female managers and there are more female healthcare managers

than their male counterparts with an approximate 10% margin at the public hospital. Two of the representative participants have less than five years of experience in healthcare management. One of the participants have five years to nine years in management, four have 10 to 14 years of managerial experience at the TB hospital, and three has been in management for more than fifteen years. A representative 90 percent of the research participants have no post graduate qualifications but only hold basic diplomas which is not quite healthy for service delivery. Only 20 percent have basic degrees as their highest educational qualifications. The gathered data from the data collection instrument shows that the TB hospital had the worst rating on staff attitudes (8 percent) across the 394 audited hospitals and clinics by the NCS performance auditing committee in 2012. Some 80 percent of the research participants affirm 'staff attitude' as their lowest ever ranking from the last audit performed. However, from the six assessment areas used to benchmark the NCS performance metrics, the TB hospital had other low ratings for instance on staff attitudes across all audited healthcare centres between May 2011 and May 2012. However, data outcomes further reveal that the hospital had two other low performance ratings on patient waiting times (18 percent) and patient safety and security (48 percent). The TB hospital attained just over 53 percent on cleanliness and a little over 60 percent on infection prevention and control. The outcomes, however, show a significant 91 percent achievement on the availability of medicines. On average, empirical data shows that the TB hospital had a 46.7 percent overall performance rating on NCS based performance measurement assessment outcomes. These performance outcomes point to a below average compliance to the NCS at the hospital.

4.1 Perceptions on the staff attitude lowest ranking outcome
On deeper probing of the research participants' opinions on the ratings attained by the hospital, about 40% state that the outcomes on staff attitudes may have been an unfair assessment of the true values and attitudes of staff at the hospital. The acknowledgement for improvements on audit outcomes resonates with 60 percent of the participants. A participant (8) stresses that at management and staff levels, there is need to develop a culture of values and attitudes that improve on communication within the practice and with patients.

4.2 Roles played by healthcare management in implementing the NCS at the TB hospital
Ensuring of patient safety has been noted as a critical role by all research participants in study. Infection prevention and control, human resource management, ensuring disaster and outbreak preparedness and response, risk management, risk reductions, appropriate use of technology, financial management and planning, and information management were key roles identified from the research participants in the study.

4.3 Drug stocks and procurement role
A majority 60 percent of the research participants cite drugs stocks or availability of medicines as one key role mandated to healthcare managers at the TB hospital. A significant 40 percent of the same respondents link availability of medicines with the procurement role.

4.4 Financial management and planning role
Forty percent of the respondents stress that financial management and planning are other key roles of healthcare managers. Participant (10) explained this role by stating that financial management and planning is critical for the operational plan of the hospital to be a success. The operational plan is a comprehensive set of annual activities for the hospital which includes the practice, trainings, procurements, policy making and other strategic activities. Almost every element identified in the hospital operational plan has costs identified by the participant as "transaction costs" and "coordination costs".

4.5 Disaster and outbreaks preparedness and response role
A representative 30 percent of the respondents identified disaster and outbreak preparedness and response as one of the roles played by healthcare managers in meeting the NCS standards. Patient safety is stressed to be top priority and healthcare staff is expected to ensure that patients are moved to safer zones in time during disasters. Participant (5) adds that for outbreaks, effective screening mechanisms for all patients and staffs are quickly conducted, and protective gear is availed to control the spread of an infection.

4.6 Risk management role
Risk management role was identified by 40 percent of the research participants. Risk management is stated by participant (6) as a process of preventing the spread of infections within the hospital units and mitigating chances of infection between patients and clinicians themselves. Participants (1, 8 and 10) state that risk management extends to administrative duties such a medicine storage in controlled temperatures, avoiding scenarios where drugs stock levels are depleted without restocking, ensuring accuracy in capturing patient data to avoid clinical errors and ensuring that patient safety is adequately controlled and monitored by nurses on

duty. Participant (9) adds another dynamic to risk management as the need to ensure that the next of kin of any patient must sign consent forms for an operation on a patient to avoid litigations from law suits.

4.7 Infection prevention and control role
Almost all respondents mention infection prevention and control as one key result area for every healthcare manager. Participants (4 and 6) state that all clinicians must wear appropriate protective clothes, N95 masks when dealing with TB patients especially now that the hospital is even admitting MDR-TB patients, giving visitors and family members surgical masks and when administering injections and doing other duties that may expose healthcare professional to infections to wear gloves to avoid the spread of an infection to and from patients.

4.8 Appropriate use of hospital equipment and technologies role
"*Healthcare managers are expected to understand the different types of hospital equipment functions in order to monitor equipment performance and assign the right people to address technical failures in a hospital unit*" – Participant (4). The latter's assertion resonates with 30 percent of respondents who state that equipment such as monitors' functionality are a responsibility of the hospital unit manager who must ensure they are properly maintained and operated with all alarm systems at full function.

4.9 Identifying challenges faced by healthcare managers when implementing NCS Standards
Primary data shows that healthcare managers faced some internal and external challenges to meet the NCS. Data shows that external challenges for healthcare managers are caused by decisions that are outside their scope of influence, and internal challenges were localized as those obstacles found within the micro management environment of the TB hospital. Infrastructure is the key external challenge that delays decisions for quality improvement at the hospital resulting in delays in decision-making and approval of operational plans from the provincial DoH. This situation further causes the disjuncture between senior clinicians and managers which is not very healthy for the hospital's performance and implementation of the NCS as elaborated below.

4.10 Internal Challenges
Lack of adequate leadership training and mentoring: Though a minority of respondents affirms to this perception, a representative 30 percent of research participants allude to lack of leadership training and capacity building on management
Inadequate monitoring systems: A representative 30 percent of the research participants highlight challenges with the monitoring and evaluation processes of clinical practice performance standards at the TB hospital. Participants (3 and 6) stated that there is need for flexibility and coordination in planning the implementation of internal performance assessments across all the hospital units and the administration components.
Lack of understanding of certain healthcare management roles: A representative 10 percent of the research participants highlighted ambiguity on particular roles that relate to healthcare management. The management assertions of the participant (4) are highlighted as follows:
"One of the major problems that are hardly raised in management meetings is that of duplication of roles and ambiguous responsibility that are faced with an unclear reporting workflow to senior management. This has often led to conflicts between managers who have been clinicians before and those with mainly business administration knowhow."
Difficulties in balancing work priorities: Thirty percent of the research participants highlight challenges with balancing work pressure in relation to their management roles.
Disjuncture between senior clinicians and healthcare managers: A 10 percent of the participants highlights that conflicts are a challenge that affects decision making sometimes threatening the smooth delivery of quality clinical care practice. A participant (7) affirms that management decisions are at times frequently subjected to criticism particularly from senior clinicians who are at times more professionally skilled than the larger pool of the management team.
Lack of influence and authority: A 20 percent of the respondents state that influence and authority in delegating duties to subordinates are at times undermined. Again, the major source of this challenge is aimed at other clinicians who are deemed more academically accomplished within clinical practice.

4.11 External Challenges
As a reality check, the primary findings revealed that the outside hospital environment is dusty and not well taken care of. Waste disposal on the hospital entrance it's a disaster and not appealing. It is quite shocking to see such a state of the hospital especially for TB patient, the reality is, it was like walking between the squatter camps in a public hospital while DoH is striving to match the standard of private facilities. The current

structure of the TB hospital and environment does not cater for NHI. Many such external challenges are discussed below.

Lack of adequate support from Hospital Board / Provincial DoH: Eighty percent of the research participants raise concern with lack of adequate support from the hospital board. Participants stated that feedback on critical decisions that affect our practice from either the hospital board or the Mpumalanga DoH is at times perennially delayed such that healthcare managers are forced to work within their minimal resources, at the same time explicitly expected to meet and exceed on the six KPAs of the NCS.

4.12 Participants' recommendations to management on enhancing the implementation of the NCS and performance improvements

Avoidance of duplication of roles of healthcare managers: Twenty percent of the respondents highlight the need for clarity of healthcare managers' roles to avoid duplication of management functions

Improvements on Staffing: Almost all of the research participants affirm that staffing is critical at the TB hospital. Participants (1, 3, 6, 9 and 10) converge on the notion that the staff attitudes crisis identified in the last NCS audit exercise may be attributed to work pressure on the nursing staff as there are unfilled vacancies and difficulty to retain staff due to unfavourable working conditions. The nurse-patient ratio is stated to be high at 5.3:1 where the hospital engages with 15 new patients on average daily with the patients staying for up to 32 days in hospital and the hospital covers the entire district.

Improvements in planning: A minority 30 percent of the respondents highlight the need to improve on planning. Participants (2 and10) assert that the process of planning by the hospital board is not prioritised until the year has well commenced. The hospital plans inform the annual operational plan for the whole year. Individual managers are required to forward their plans for integration into the hospital operational plan, however the meetings to approve or disapprove contents of the plans are perennially delayed, and when eventually conducted, there is little consultation but rubber stamping the hospital board's draft.

Management training and capacity building: Participants (4, 8 and 9) add that management trainings assists in understanding better the approaches to organising, planning, staffing, and decision making with confidence and not fear. The respondents assert that sometimes they lack confidence particularly when they are looked down at by other qualified healthcare professionals within the same institution of healthcare service provision.

4.13 Analysis of data findings

Participants largely had two perceptions to the ratings received by the hospital from the last NCS compliance audit conducted in 2012. The first one was a surprise on the low ratings, particularly on staff attitudes because management was not even aware of outcomes prior to release to the press. The second perception inclined to a faulty audit mechanism that may not have been holistic and well structured, resulting in shocking ratings for the hospital in general and a lot has changed currently since the audit was in 2012 while the results were published in 2014. The results were not the actual reflection of the current status and might be confusing to the public. It is further stated that quality is defined as attaining best possible results with available resources while there is limitation of resources and sometimes not even available and the staff had to improvise at all times to meet objectives. The main objectives of the national core standards are to develop a collective definition of quality of care which should be found in all healthcare centres of South Africa and act as a guide to the public, health managers and staff members across all levels. Another objective is to establishing a benchmark that will be used to assess public health establishments, identification of gaps and appraised strengths for continuous improvement. The other key objective is to provide for a national certification framework for public health establishments. It is imperative for this study to identify the six KPAs that informed the audit processes across the hospitals and clinics in 2012. The NCS priority areas for the improvement of healthcare service provision in South Africa are outlined as:

- Values and Attitudes
- Cleanliness
- Waiting times
- Availability of medicine
- Patient safety and security
- Infection prevention and control (Mocke, 2011:4 & NCS, 2011:13).

However, findings from Mocke (2011:4) also acknowledge that there were concerns with the audit structure and process. From a "lessons learnt from the NCS baseline audit", Mocke (2011:4) highlights the following concerns:

4.14 Analysis of the audit tool

Some of the information on the tool was not in line to the actual services delivered at the hospitals and clinics in general. Examples included emergency trolleys - glucometer, pulse Oximeter and 9.5 ET tube. There

was no clear criterion of auditing the auditors, an issue of subjectivity. Examples include the HAI benchmarks. The terminology used in the audit processes was sometimes not in resonance with the NCS. Examples included the 'universal precautions' terminology and FEDs (Mocke, 2011:4). These audit tool inconsistencies may tempt to vindicate the assertions of the respondents, however, there were more positives than negatives on the tool used. These include a strong emphasis on the importance of best practices such as daily checks, daily inspections, and the importance of attending IPC trainings. The audit exercise was driven by top management at national level and had visible support from hospital managements. The audit tool managed to confirm the transversal nature of healthcare that it cannot operate in isolation. The tool provided baseline information on the standards of care provided by healthcare providers. In many other audited institutions, the audit exercise managed to motivate staff to work on improving on their shortcomings (annual improvement plan) (Mocke, 2011:6). Participants echoed that something must be done after the audit management at the TB hospital have put measures in place to improve on quality. Management must carry out quarterly quality review through self-assessments, in- service training about KPAs and recognition awards must be done to motivate the staff to strive for quality improvement by providing certificates of achievements and badges.

Decoding management perceptions on audit outcomes: Research participants acknowledged the need for improvements. However, to a small measure they had their reservations to the actuality of the ratings as highlighted earlier.

Analysis of healthcare management roles at the hospital: Empirical data shows that management roles for healthcare managers cover drug stocks and procurement, financial management and planning, disaster and outbreaks preparedness and response, risk management, infection prevention and control and the appropriate use of hospital equipment and technologies.

Organising: Research participants did not explicitly highlight an organising role in their input to healthcare management roles.

Staffing: Research participants raise concerns with difficulty in staff retention due to work conditions and the environment that is not conducive to provide care due to limited resources and a nurse-patient ratio at the TB hospital.

Controlling: Participants highlight their roles as healthcare managers entail them to monitor performance of their staff under their domain of reporting structure.

Directing: The role of directing is not explicitly stressed by the respondents.

Decision Making: Participants again could not explicitly define a 'decision making role' in their areas of influence, save for indirectly highlighting decision making challenges due to criticism by senior clinicians. Despite the negative perceptions associated with making final decisions in hospital units or departments by staff

4.15 Challenges and obstacles to effective healthcare management

The objective of this question sought to evaluate the challenges and obstacles faced by healthcare managers in effectively executing their roles in order to meet the NCS six KPAs.

Leadership, training, mentoring and the three competency skills: Thirty percent of research participants allude to lack of leadership training and capacity building on management.

Healthcare leadership alliance model addressing challenges: The research participants (100%) state that there are difficulties in balancing work priorities, a lack of influence and authority in executing duties to subordinates and an often emotional disjuncture between management and senior clinicians in decision-making processes.

4.16 Communication and Relationship Management

Participants highlight that there are challenges with relationships that sometimes occur at the expense of quality clinical care in the healthcare leadership alliance model.

Professionalism: The model asserts that healthcare leaders must show and practice abilities to align organisational and personal conduct with professional and ethical standards which incorporate responsibility to the patient, community, a 'service orientation' and high commitment to improvement and life-long learning (Stefl, 2008:5).

Knowledge of Healthcare Environment: Knowledge of healthcare environment domain entails a deep understanding of the healthcare system within which the managers operate in relation to functional deliverables mandated by the hospital authorities (Stefl, 2008:5).

Business Skills and Knowledge: Business skills and knowledge entails the ability to apply business principles which incorporate systems thinking to the healthcare environment. Ross *et al.* (2009:16) add that business knowledge and skills include basic business principles that consist of financial management, human resource management, strategic planning and marketing, risk management, quality improvement, organisational dynamics, and governance (Stefl, 2008:6).

Leadership: Stefl (2008:6) and Ross *et al.* (2009:16) state that leadership entails the ability to inspire individual and organisational excellence to create and collectively drive towards a shared vision and to effectively manage change to attain the organisation's strategic ends and improved performance. Stefl (2008:7) and Ross *et al.* (2009:17) both affirm that in keeping with the current focus on outcomes and evidence based management in

healthcare establishments, the five domains in the common competency model aim at effectively managing healthcare service delivery and the maintenance of set out international standards to quality clinical care practice.

4.17 Participants' recommendations on management roles that advance on perceptions on improved implementation, adoption and performance on NCS
Addressing role ambiguity: Twenty percent of the respondents highlight the need for clarity of healthcare managers' roles to avoid duplication of management functions. Osbourne (2011:1) resonates with this assertion when he states that healthcare managers' challenges include role ambiguity.
Effective management of human resources: Almost all of the research participants affirm that staffing is critical at the TB hospital. The nurse patient ratio (5.3:1) is considered high for a focused and dedicated patient care process in clinical practice.
Effective planning and organising: Respondents highlight the need to improve on planning. The participants argue that the process of planning by the hospital board is not prioritised until the year has well commenced. Participants further add that hospital plans inform the annual operational plan for the whole year and individual managers forward their plans for integration into the hospital operational plan. Yet, there is little consultation but rubber stamping the hospital board's draft of an annual operational plan without verifying if all managers' contributions are factored in.
Training and capacity building for healthcare managers: Osbourne (2011:4) highlights that managers sometimes lack confidence particularly when challenged by more clinically accomplished healthcare professionals outside of the management domain.
Addressing senior clinicians and management relations to avoid high prevalence of conflicts: "Conflicts in healthcare have a direct bearing on the effective delivery of quality clinical care to patients. Conflicts are determinant to failure on meeting our national core standards in our public and private healthcare centres." (Motsoaledi, 2011:14). Research participants highlight that conflicts always arise in making decisions that have a bearing on the outputs of clinicians in their respective work roles and functions. Sometimes decisions do not go well with other staff and a disjuncture occurs that affects efficiency of the clinical practice.

V.   Conclusions And Recommendations
Reasons why the TB hospital attained low performance ratings on NCS six key priorities: An overstretched staff compliment that reflects demotivation and a measured lack of support from the hospital's senior management may have contributed to poor hospital ratings particularly on staff attitudes and values. There was a minority section of respondents who raised reservations with the adequacy of the assessment tool used in performance ratings of the healthcare centres in the larger pool of audited sites. Management conflicts with senior staff, as revealed in the study, may be contributing to poor monitoring of clinical practice standards as structured in the NCS. This is because conflicts draw management functions away from keeping a monitoring eye on the day-today activities and check-ups of staff functions as managers and senior clinicians focus on outdoing each other.
Healthcare management roles at the TB hospital: The study found that managers at the TB hospital have a collective understanding of their role functions. Most participants could identify and explain at least five management roles in general. Patient safety was revealed as a critical role by all research participants in study. Infection prevention and control, human resource management, ensuring disaster and outbreak preparedness and response, risk reductions, appropriate use of technology, financial management and planning, and information management were key roles identified from the research participants in the study.
Challenges faced by healthcare managers in meeting six KPAs in NCS: There is a disjuncture in the identification of clinical care complications and the implementation of the right responses by management. There is a relative poor human resource management strategy that does not adequately encourage improvements in performance but rather tends to focus on non-clinical inputs and outcomes that do not directly impact on improvements on NCS standards. Conflicts with senior clinicians and healthcare management exist. Conflicts are found to affect decision making in hospital units and the outcomes of collective teamwork that is envisioned in delivering quality standards in healthcare practice. Conflicts, role ambiguity and lack of support from the hospital boards are found to culminate into a lack of confidence and authority in healthcare management.

5.1 Recommendations
In order for the TB hospital to improve on the DoH objectives and policy direction on attaining quality clinical practice standards in all healthcare services in South Africa, the following recommendations are suggested in this study.
Improving on the support structures to healthcare management functions: The hospital Board and the DoH must ensure that there are no delays in processing operational plans. The operational plans must adequately

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address evaluated and proved commendations from the body of the healthcare management function because it is this function that works directly with the professional staff in clinical practice. Reports from the healthcare management function must be studied, evaluated and gaps revealed in advancing the attainment of positive standards in the NCS domains must be addressed. Resources for the smooth functioning of the healthcare management function must be availed with much emphasis on primary healthcare outcomes. The hospital's senior management must be seen to be advocating for the resource concerns of its healthcare management function at the Provincial DoH.

Routine/periodic management training and capacity building: The negative perceptions associated with healthcare management and the assertions that healthcare managers basically opt for management roles away from clinical roles is found to negatively question their abilities to comprehend the actual activities of clinical practice. The decision making authority in senior management must therefore ensure that its healthcare management function must be routinely capacitated on management functions that improve on their performance to monitor, evaluate, delegate, organize, plan and make decisions that advance the attainment of quality clinical practice standards and values. Training and capacity building significantly arrests the lack of confidence that filters through the management function in healthcare services. It further assists healthcare management function to critically analyse and find congruency in understanding its various roles and eliminate role ambiguity.

Managing conflicts and improving communication between clinicians and healthcare managers: Clinicians are directly involved in clinical practice. Their views are critical in decision making for quality clinical practice standards. However, the negative relations that relatively exist between clinicians and healthcare managers impede the smooth operations of health care. This study recommends that clinicians and healthcare managers must have a policy framework that advances communication efforts, routine meetings, and information exchange and sharing in order to eliminate or mitigate on conflicts that arise from delayed decisions, unclear decisions or conflicting approaches to addressing clinical practice challenges. Effective communication between clinicians and managers encourages a teamwork effort that ultimately results in reduced errors in clinical practice; thus ensuring that patient safety, infection controls and prevention strategies, cleanliness and other KPAs in healthcare service delivery are realistically met.

Improving on internal monitoring and evaluation mechanisms to clinical practice standards: The healthcare management function must put in place a practical policy framework, with activity indicators and benchmarks for healthcare managers. A policy for the accountability and necessary disciplinary processes must be put in place. The framework must be employed as a tool for assessing and auditing healthcare managers' individual performance and that of staff in their unit(s) in relation to the seven domains of the NCS. Monitoring and evaluation mechanisms of clinical practice founded in the NCS domains effectively covers the six KPAs critical in advancing quality clinical care. This study recommends that daily checks, broken down into specific hour(s) grounded timed frames significantly reduce the advent of clinical errors which affect the ratings of the healthcare service hospital. The suggested training and capacity building budget line item envisaged in an annual hospital operational plan's expenditures must therefore support the formulation, design and implementation of an internal monitoring and evaluation mechanism that minimizes clinical errors and conflicts in performance appraisals.

Reducing the burden of inappropriate demands on healthcare managers: This recommendation links with the call for improved support to the healthcare management function. The hospital board's functions must not overburden those of healthcare managers who have a direct link with their staff in clinical practice. Adding to the body of administrative responsibilities to healthcare managers that are outside their scope of mandated functions and roles alienates them from monitoring their staff's daily performances and the process of making emergent decisions associated with patient care and safety. Healthcare managers' roles demand that they work closely in their units or hospital departments to ensure that all the functions that advance quality administration of clinical standards are available exploited and implemented professionally in line with NCS standards of healthcare practice. The provision of the enabling environment by improving infrastructure should be in line with the expected standards.

Instilling routine capacity building trainings to staff on meeting the six KPA of NCS: It is imperative that the healthcare management function conducts trainings and capacity building workshops to clinical and administration staff on the compliance to the seven domains of healthcare service delivery as outlined in the NCS. This initiative must be followed with reports that act as a measure to the efforts made, the effectiveness of the approaches used and an analysis of the findings thereof. It is not sorely a healthcare management responsibility to ensure clinical standards are met. The clinical and administration staff must be found to be participating in decision making on the best stratagems that the TB hospital may require to adopt in meeting the six KPAs of the NCS.

5.2 Areas for Further Study

This study finds that healthcare managers' roles are intricately linked with those of the hospital's decision making boards. There are indications from this study that at times these functions give birth to challenges in separating the actual role activities between the two entities, which leads to an over-burdened healthcare management function, which in turn is expected to ensure direct control and coordination of clinical practice.

As such, this study recommends a further study on the functional roles of the hospital Board in relation to advancing the six KPAs on the national core standards of South Africa. It is expected that the outcomes of this study will add to the body of knowledge of how the hospital boards manage and coordinate the NCS attainment with their healthcare management function and the level of the support-relationship with the Provincial DoH.

5.3 Conclusion

This study managed to identify the seven domains in the Department of Health's National Core Standards. The seven domains are namely: Patient rights, Patient safety, Clinical governance and care, Clinical support services, Public health, Leadership and corporate governance, operational management, and facilities and infrastructure. It is from these domains that the six KPAs envisaged in the NCS are founded. The study therefore identified the six KPAs as values and attitudes, cleanliness, waiting times, availability of medicines, patient safety and security, and infection prevention and control. The findings from the study found that the healthcare management function's roles in meeting the six KPAs are multifaceted and linked. These include drugs stocks control and procurement, financial planning and management, risk management, infection prevention and control, managing outbreaks and disasters with effective response mechanisms, ensuring the appropriate use of equipment and technologies, human resource management and decision making. However, the roles are faced with implementation and operational obstacles as reflected in the study. Primary on these obstacles is the lack of support from senior management. To make the situation more cumbersome, healthcare management is found to be vulnerable to an over-burning of inappropriate duties that can otherwise be executed within the hospital board function. The study points to a general lack of confidence and role authority within the TB hospital healthcare management function. This is reflected in the existence of conflicts with senior clinicians which tend to demoralize the collective effort of team work and decision making processes at clinical services level. The healthcare management function is faced with role ambiguity which compounds more on the prevalence of conflicts with other hospital functions such as the clinicians. Human resource management at the TB hospital points to an overburden staff. The nurse patient ratio (5.3:1) is high by clinical practice standards. This could be a determinant to the culmination of poor staff values and attitudes that were rated as the worst in the six KPAs during the previous NCS audit outcomes in 2012. The study therefore recommended that improving support structures to healthcare managers from senior managers improves on the attainment of improved healthcare performance. Managing conflicts, improving internal monitoring and evaluation mechanisms to clinical performance were found to be critical to meeting the NCS standards. Reducing the burden of inappropriate demands or functions on the healthcare management function were recommended to ensure managers focus on their staff relations and activities that directly advance on quality clinical practice standards reflected in the six KPAs of the NCS.

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