

**EXPLORING LESSONS LEARNED FROM MEDICLINIC WINDHOEK
ACCREDITATION FOR EXTRAPOLATION TO PUBLIC HEALTH
FACILITIES**

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NDESHITEELELA KALEINASHO CONTEH

200335502

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Main Supervisor: Prof. L. Haoses-Gorases

Co-supervisor(s): Mrs. H. Niikondo

DECLARATION

I, **Ndeshiteelela Kaleinasho Conteh**, hereby declare that “Exploring lessons learned from the Mediclinic Windhoek accreditation for extrapolation to public health facilities”, is a true reflection of my own study and has not been submitted for any degree at any other university.

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Ndeshiteelela Kaleinasho Conteh

.....
Date

DEDICATION

I would like to dedicate this thesis work to my parents who worked so hard to support me, encouraged me and emphasized that education is the greatest investment that I can give to myself. It is the selflessness and love they had for me that kept me motivated and focused. I would like to remember my late father, **Hiyavelwa Usco Nambinga** who passed on before my studies were completed. He believed in me, and I will forever be grateful for the sacrifices he made for me to make it through my studies. May his soul rest in eternal peace.

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ABSTRACT

Quality Improvement (QI) is a diverse health care issue with multiple dimensions, which include structural, leadership and organizational attitudes. Generally, private hospitals are perceived to have better quality of care according to international standards; this perspective is true in Namibia, whereby only one private hospital is accredited according to international standards. The purpose of the study was to explore and describe the experiences of staff regarding the COHSASA accreditation process, as well as to explore and describe critical success factors leading to the accreditation of Mediclinic Windhoek. The methodology used in this study was a qualitative study method. A descriptive case study was used to capture the experiences and opinions of staff as well as analyze and interpret their lessons learned from the experience. Data was collected using focus group discussion of homogenous groups of staff, although one heterogeneous group was also interviewed to compare data patterns. Data was captured on a tape recorder after obtaining verbal consent from the participants. Data was analyzed, and themes as well as sub-themes were then derived from the study for interpretation. The findings indicated that the participants had a uniform understanding of what quality and quality improvement of health care entails within their context. They linked quality of care to patient safety and pleasant patient experience during hospital stay or visit. The findings further indicated that the participants perceived maintaining of health care standards as an integral and unending duty and responsibility of staff working together with management. Adhering to the institution's values, policies and culture enhances their ability to render quality care. The participants highlighted that they learned that having clear structures, roles and responsibilities, teamwork, and good communication, as well as continuous training and support, contributes to the delivery of quality

care. Therefore, it was recommended that organizations need to have those structures in place as a vessel for improved quality of care.

LIST OF ABBREVIATIONS

CoHSASA	Council of Health Accreditation for Southern Africa
MAP	Mediclinic Accreditation program
MoHSS	Ministry of Health and Social Services
PDSA	Plan, Do, Study, Act
QA	Quality Assessment
QI	Quality Improvement
QIL	Quality Improvement and Leadership
UNAM	University of Namibia
UNICEF	United Nations International Children's Emergency Fund
MQUAT	Mediclinic Quality Assurance Team
WHO	World Health Organization

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CHAPTER 1

INTRODUCTION AND BACKGROUND

1.1 Introduction and Background

The Government of the Republic of Namibia and the Ministry of Health and Social Services (MoHSS) are committed towards attaining a level of health and social welfare for all Namibians, as health and welfare are fundamental human rights in Namibia. In the MoHSS strategic plan of 2009 – 2013, the mandate of the Ministry is clearly stipulated: the custodian of health and social services, the Ministry of Health and Social Services, has the mandate to oversee, provide and regulate the public, private and non-governmental sectors in the provision of quality health and social welfare services, ensuring equity, accessibility, affordability and sustainability (MoHSS Strategic Plan 2009-2013).

Quality is defined differently by different authors and contexts. Some authors defined quality broadly in two concepts of effectiveness and efficiency. These elements are discussed in terms of the structure of the health care system, processes of care, and outcomes resulting from care. It is clear that, from the above-mentioned definition, quality assurance needs to address multiple dimensions within the health care system before quality delivery is attained. These dimensions involve technical competence of staff, access to services, effectiveness, interpersonal relations, efficiency, and safety, among others. Marchal, Dedzo & Kegels (2010) conducted a study in a high performing hospital in Ghana whose findings suggested that the success of QI efforts in the hospitals largely depend on human resource management. The study found that a human

resource management approach, which included new staff induction, personal development, training, good communication, information sharing and decentralized decision-making, contributed to the high performance of the hospital. The study also identified teamwork and trust as key elements that enhance organizational work climate.

However, Ross (2013) defines quality in two totally different angles from Marchal *et al* (2010). Ross (2013) defines quality as “a measure or degree to which good or service meets established standards or satisfies a customer”. This definition clearly depicts that quality has more than one dimension of measurement and that quality has a lot to do with customer satisfaction as well. This definition also implies that quality is based on the producer’s criteria as much as it is on the consumer’s criteria. In health care, the producer is the health care provider or institution, while the consumer is the patient. Additionally, a product in this case will be the health care/intervention rendered to the patient. Ross (2013) emphasized that customer satisfaction also depends on their understanding and definition of quality of a product.

Ross (2013) has highlighted six (6) factors that affects satisfaction in a producer and consumer relations:

The first aspect or typically primary concern of a consumer is whether the product meets generally accepted standards. For example, a patient will judge a meal served in the hospital based on the food temperature, if it is served on clean utensils, is appropriate for the patient’s condition and so on. Another generally expected and accepted standard by patients is for the hospital room and bedding to be clean.

The second key factor that affects satisfaction is whether the service was acceptable. This key factor entails or focuses on whether the server is competent and served the consumer with an appropriate amount of respect. Ross (2013) has however indicated that there is no “one size fits all” solution to balancing satisfaction of consumers regarding this key factor; producers should customize their products to the individual tastes and preferences of their customers. In a health care setting, this phenomenon is true in rendering an individual based approach, although still within the quality standards of the institution.

The third key factor that plays a role in consumer satisfaction is timeliness. This is the waiting period from the moment the consumer requested or expects to receive the product, to when the product was actually rendered to the consumer. Timeliness is a factor that is assessed in the accreditation of hospitals. Hospitals are assessed for the time that patients wait before they are attended to by a health care giver. Additionally, patients’ satisfaction is hugely influenced by the period of time they spent waiting at a pharmacy, for a meal to be served to them in hospitals, to be attended to by a physician, and so on. Delays at any point are known to diminish the satisfaction of a good service (Ross, 2013).

The fourth key factor is environment. The environment is the social and physical factors surrounding a person (Ross, 2013). In a health care setting, it may be at times challenging to adapt the environment to fit personal preference. However, it is important for health care givers to be sensitive to the desires of their consumers (patients). For example, some patients prefer a bright room, while other prefer dim lights or a darker room in order to sleep well.

The fifth key factor that affects satisfaction is selection. Ross (2013) defines selection as the set of options which a consumer can choose from. Health care is moving toward getting the most out of importance of choice by increasingly involving the patient in decision making regarding their health care (Ross 2013).

The final factor is price. Price is the amount of money to be given to obtain a service (Ross, 2013). There is a relationship between price and value; therefore, when a customer receives a product of the same value for a lower price, their satisfaction goes up (Ross, 2013). This key factor is probably relevant and important in private health facilities and not so relevant in public health facilities. Private health facilities are generally profit based and their revenue is generated from the payments made through patients who visited the health facility. Therefore, pricing and consumer driven satisfaction is crucial to private health facilities. This however, doesn't imply that it's meaningless in public health facilities.

Health care quality is defined by Ross (2013) as the optimum care from service provider in the most appropriate setting in the most appropriate manner for the patient's unique circumstances. Ross (2013) further discussed aspects or dimensions to this definition.

The first dimension is optimal care. Ross (2013) states that optimal care refers to meeting generally accepted standards of medical care practices. This definition entails that optimal care should be delivered by the appropriate health care giver. This additionally also means that optimal care excludes untrained and over qualified health care givers (Ross, 2013). According to

Ross (2013), health care systems fail when undereducated and undertrained personnel provide care. Equally, health care systems also fail when basic tasks are performed by highly skilled personnel. These two scenarios are detrimental to the health care system because the first scenario entails that healthcare providers can perform basic routine care, but in cases where an emergency occurs they would not be able to deliver care beyond their skills. The second scenario depicts that the patient will receive exceptional care from overqualified health care providers, but then the services might be overpriced. Additionally, it is a poor use of the health care provider's skills.

Frush & Krug, 2015 state that poor outcomes or poor quality is not often a result of bad people, but rather the design of the system. They have further stated that every system achieves exactly the results it achieves because of the way it is designed. Furthermore, they have emphasized that it is critically important to introduce change to a process or system in order to bring improvement.

There are many quality improvement methods around the world. However, fundamentally the approaches or methodologies work towards asking teams to identify a problem, measure the problem, develop interventions to fix the problem and finally test the created interventions for success (Frush & Krug, 2015). Frush and Krug 2015 reproduced a model for improvement of which they state that it provides a framework for developing, testing, implementing, and spreading changes that can lead to operational efficiencies, revenue enhancement, and improvement in patient care (Frush & Krug, 2015). The model starts with three essential

questions and then employs “plan, do, study, act” cycles to incorporate changes. The three questions suggested by Frush & Krug, 2015 are:

1. *What are we trying to accomplish?* This process involves identifying what it is that the organization is working towards achieving. Additionally, what then would the aim statement be? Aim statements help anchor efforts to a common purpose (Frush & Krug, 2015).
2. *How will we know that a change is an improvement?* This question enables the organization to create measures that clearly allow teams to determine the impact of their efforts on testing and implementing change. The purpose of measuring is to learn and not to judge or draw comparisons (Frush & Krug, 2015).
3. *What changes can we make that will result in improvement?* Change concepts in quality improvement represent general notions or ideas for change that are believed to result in improvement (Frush & Krug, 2015). These ideas or concepts range from appraisal to evidence based practices that can be replicated.

Figure 1.1 Model for Improvement (Frush & Krug, 2015)



The Plan, Do, Study, Act (PDSA) cycle is a trial and learning methodology in quality improvement efforts. An iterative process of repeating the PDSA cycle allows for knowledge to be built and changes implemented to result in improvement (Frush & Krug, 2015).

Plan: The planning stage is the stage whereby the team states the objectives for the cycle and develops questions to be answered.

Do: This is the stage where implementation is done towards achieving the objectives. This is also the stage where data is collected to inform progress towards the set objectives.

Study: During the study phase, data is analyzed and the results are compared to the predictions made in the plan stage.

Act: During the act stage, the teams review the results from the previous plan, do, and study stages, and consider modifications.

According to Donabedian (2002), quality assurance or improvement has two crucial interrelated components: 1) System design and resource; and 2) System monitoring and readjustment. Donabedian (2002) argues that without sufficient resources and good quality, one can't offer the best care that they are capable of offering. He further urges that a system of care should be designed in a way that facilitates the delivery of good care rather than creating obstacles to good care.

Donabedian (2002) states that system design includes recruitment, training, education, and certification. Additionally, he articulates that it includes the number, distribution, equipment, organization and licensure of hospitals and other health care facilities. Furthermore, he says that system design includes drug testing and marketing, health financing, access to health services, legal protection of the consumer, as well as provider interest (Donabedian, 2002).

Performance monitoring is the process whereby information is collected in order to discover the level of quality produced by the health care system (Donabedian, 2002). Based on the

information collected, interpretations are made and actions taken to maintain and/or improve quality. Again, these two components are interrelated, as it is also at the system design component that the level of performance is set. This is also known as setting standards. Standards require monitoring in order to detect and verify that the expected quality of care is rendered.

Quality monitoring is an activity which by we keep the quality of care under observation (Donabedian, 2002). Donabedian (2002) has outlined a quality monitoring cycle with 5 main steps:

1. Obtaining data on performance
2. Pattern analysis, an activity that is essentially epidemiological in nature
3. Interpretation, which means advancing the hypotheses that might explain the patterns observed
4. Taking preventive, corrective, or promotive action based on the causal hypothesis that has been advanced
5. Obtaining data on subsequent performance to determine the consequence of the actions taken (Donabedian, 2002)

Donabedian (2002) argues that quality assurance is difficult or actually impossible to be introduced and flourish in a health institution whereby the health care institution and system stubbornly oppose it. For quality assurance to work in a health institution, some degree of readiness to accept monitoring must exist or has to be developed. Donabedian (2002) states

that there is one single requisite for success: commitment to quality. Donabedian (2002) further states that commitment to quality is the indisputable desire and determination to dedicate oneself to the best one is capable of, regardless of every challenge or obstacle.

Donabedian (2002) has outlined foundations of quality assurance through monitoring:

A. COMMITMENT TO QUALITY

1. Genuine commitment
2. Internally motivated commitment, not simply a response from external pressures
3. A commitment by everyone in the organization

B. INSTITUTIONALIZATION OF THE COMMITMENT

1. Specification of the organization's goals
2. Establishment of an organizational structure of performance monitoring
 - a. Specification of responsibility for monitoring
 - b. Allocation of resources, money, etc.
3. Design and implementation of a set of formal monitoring activities
 - a. Routine and occasional activities
 - b. Centralized and decentralized activities
4. Establishment of mechanisms for communicating information and implementing action
5. Creation of a culture

C. Agreement on the meaning of quality

(Donabedian, 2002)

The MoHSS has a mission of providing determined leadership in ensuring that health and social welfare services are effective and efficient to create conditions for organized communities, households and individuals to take care of their health (MoHSS, 2010). Consequently, the MoHSS established a quality assurance unit.

Just like many governments in Africa, the Government of the Republic of Namibia and the Ministry of Health and Social Services are committed towards attaining a level of health and social welfare for its citizens because health and welfare are fundamental human rights. In the MoHSS strategic plan of 2009 – 2013, the mandate of the Ministry is clearly stipulated as the custodian of health and social services. The Ministry of Health and Social Services has the mandate to oversee, provide and regulate the public, private and non-governmental sectors in the provision of quality health and social welfare services, ensuring equity, accessibility, affordability and sustainability (MoHSS Strategic Plan 2009-2013). The Government of the Republic of Namibia and the Ministry of Health and Social Services (MoHSS) is committed to ensuring quality health care for all Namibians (MoHSS Strategic Plan 2009-2013). In order to implement, coordinate, plan and monitor the MoHSS quality improvement efforts, a Quality Assurance (QA) unit was established.

The vision of the Quality Assurance unit is “to achieve acceptable levels of quality in public health facilities through developing a continuous mechanism for monitoring quality improvement by setting standards, measuring performance as well as improving quality” (MoHSS, 2013). The government of the Republic of Namibia through the MoHSS had undertaken an assessment on the national quality monitoring system in public hospitals. The findings of the study were aimed to support and establish a clear depiction of the current state of quality improvement efforts in public health facilities in Namibia. The study was not only necessary in order to get a better understanding of the quality improvement system, but it was also noted that the rate of communicable and preventable diseases remains stubbornly high irrespective of the health spending (MoHSS, 2012).

Several studies have shown that numerous health facilities in Namibia are facing great challenges related to governance, financing, resources, coordination and communication, which has led to poor perception of service delivery (MoHSS, 2012). These challenges are further complicated by institutional capacity gaps throughout the health service, duplication of systems and structures, systems, functions as well as inadequate organizational development.

The MoHSS has indicated that it is most concerned about the effectiveness and efficiency of quality management mechanisms across health facilities, and the effect that this might have on the provision of high quality services. The perceived poor quality of services in public hospitals has been and is still the topic that is mostly spoken and reported about in the Namibian social media (MoHSS, 2012). This has provoked a presidential commission of enquiry to investigate the situation at hand. In January 2013, a presidential enquiry report was finalized and the

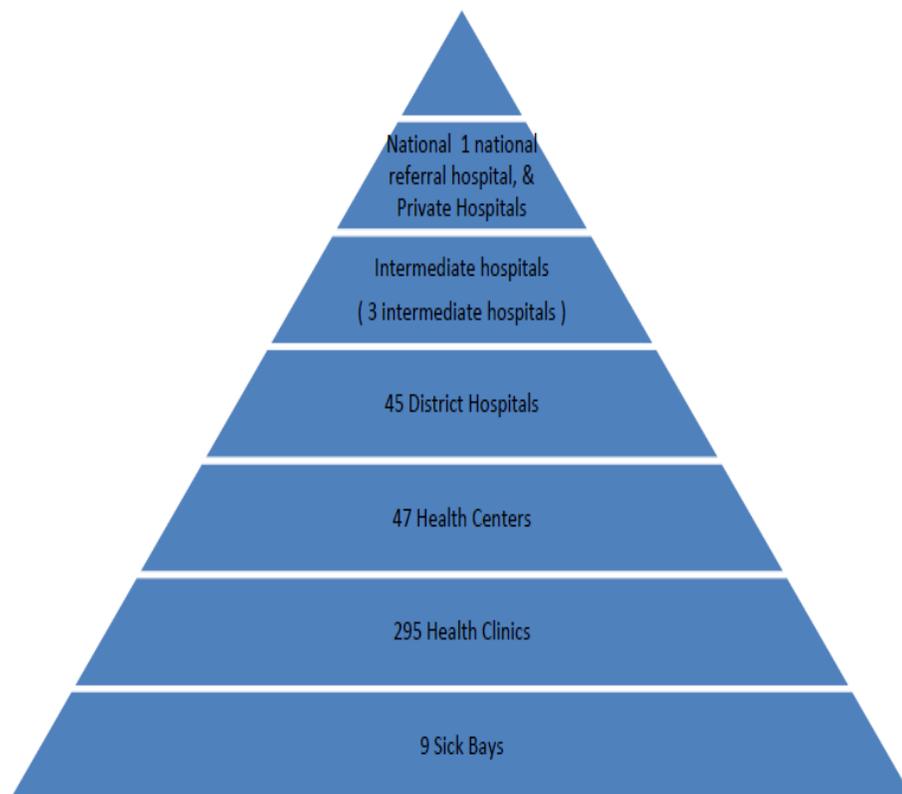
findings indicated a poor health care system and services. Other than the problems identified by the commission, there are also numerous challenges that the MoHSS is facing that negatively affect the delivery of quality care. These include a shortage of health care workers, poorly perceived quality of care of patients, inadequate quality of training curricular, infrastructure, material and internship of nurses and doctors, poor quality of public health facilities, poor status of available equipment and infrastructure, limited availability of medicines in public health facilities, poor referral system for patients, and dilapidating accommodation for health care workers, as well as bureaucracy and delays in implementing program and projects (MoHSS, 2012).

In an attempt to improve the quality of health care in public facilities, the MoHSS, with support from the United States Agency for International Development (USAID), initiated the Quality Improvement and Leadership program (QIL). The program is currently being piloted in the two national referral hospitals: Katutura Hospital and Central Hospital. The program will later be rolled out to other public health facilities once successfully implemented at the two hospitals.

The QIL aims to support the two hospitals in improving the quality of service delivery as well as getting the two hospitals accredited by the Council of Health Service Accreditation of Southern Africa (COHSASA), the body that accredited the Mediclinic Windhoek Namibia. There are various studies that have suggested that there is a role that accreditation plays in quality improvement. According to Lie & Bjornstad (2015), 56% of participants self-reported that quality has improved in their organization as a result of accreditation.

The majority of the Namibian population (85%), especially the lower and middle class, access health care services through public health facilities (MoHSS, 2013). Currently, Namibia has a well-developed infrastructure of networks, consisting of 295 clinics, 47 health centers, 45 district hospitals, 3 intermediate hospitals, 1 national referral hospital, 9 sick bays and various welfare service points (MOHSS, 2012). The public health sector in Namibia is divided into national, regional and district levels as illustrated in figure 1.2 below:

Figure 1.2 National Health Sector Pyramid (MoHSS, 2012)



Generally, private hospitals are perceived to have better quality of care according to international standards. This is no different in Namibia, as the MoHSS is concerned about the effectiveness and efficiency of quality management mechanisms across public hospitals as well as the impact this will have on the quality of care delivered in public health facilities (MoHSS, 2012). The MoHSS has noted that there are some cases reported whereby a patient is admitted with one condition and gets discharged with two more health problems because of the poor quality of care at the health facility (MoHSS, 2012). The situation of poor quality of care in public health facilities further apparent, as it is often reflected in patient complaints as well as through social media (MoHSS, 2012).

However, the phenomenon of public health facilities providing sub-standard health care is changing in some African countries, as there are some public health facilities accredited by the Council of Health Service Accreditation of Southern Africa in countries like South Africa, Botswana, Nigeria, Rwanda and Lesotho (COHSASA, 2015).

COHSASA uses a systems-based approach that focuses on technical, managerial, administrative, and infrastructural and support systems. The approach ensures that all systems improve simultaneously. Health care teams are trained to measure themselves against the set standards, allowing them to monitor their progress (COHSASA, 2015).

COHSASA is the only internationally accredited quality improvement and accreditation body in Africa. COHSASA uses standards that focus on management of the organization including: leadership, roles and responsibilities of staff, management of information, creation and

maintenance of a safe environment for patients, infection prevention and control, quality management and human resource management. The program sets common standards for all service areas that are based on essential functions:

- staff should be trained so that they can meet standards,
- policies and procedures should guide staff to achieve the objectives of the facility,
- there should be a formally structured reaction system (Quality Improvement) to allow the facility to move from where it is to its full potential.

In addition to these common and essential standards, there are service-specific standards that define the specific requirements of individual services, such as infection control in laundries, radiation protection in radiology departments, etc.

There are more than 3,800 measurable criteria in a comprehensive set of COHSASA hospital standards. Criteria that are partially compliant or non-compliant are known as deficiencies. The level of improvement can be indicated by the number of deficiencies at the baseline survey which have achieved compliance at the time of the external survey.

1.2 Problem statement

There is an increased demand for the delivery of quality care and safe health care in facilities all over the world. There are numerous health care facilities implementing accreditation programs in different countries to ensure maximum delivery of quality health care services and achieve accreditation according to international quality standards. In Namibia, Mediclinic Windhoek Hospital is the first and only health facility in Namibia that underwent the quality improvement program and accreditation and still maintains its accreditation. Mediclinic Windhoek was accredited last in 2014. Accreditation programs in low and middle income countries like Namibia provide important innovations in governance and leadership which can be adopted in other countries (Smits, H., Supachutikul, A., & Mate, K. S. 2014). These important lessons can also be extrapolated to other public and private health facilities in Namibia in order to improve the quality of care rendered.

With this private hospital being the only hospital accredited in Namibia, the researcher wants to know what the critical success factors that contributed to the accreditation of Mediclinic Windhoek are. Furthermore, the study aimed to explore and describe the success factors and lessons learned in delivering of care by the Mediclinic staff who underwent the accreditation process in quality of care rendered in the private sector.

1.3 Purpose of study

The purpose of the study was to explore and document the lessons learned by staff that participated in the quality improvement activities at Mediclinic Windhoek Hospital which resulted in the accreditation of Mediclinic Windhoek Hospital, so that the lessons learned can be extrapolated to other hospitals participating and aspiring to improve quality and get accredited.

1.4 Objectives of the study

- To explore and describe the experiences of staff regarding the COHSASA accreditation process.
- To explore and describe critical success factors leading to the accreditation of Mediclinic Windhoek Hospital.

1.5 Significance of the study

The findings of this study can be used by the MoHSS in general and in health facilities in particular in order to inform, enhance and support their quality improvement efforts. Additionally, the findings of the study can be utilized as a guiding document and be a reference document which the Ministry of Health can use to prepare them for the rigorous process, draw lessons learned and replicate good quality improvement practices in the rest of the public health facilities. This will give the MoHSS an idea on how to plan, implement, and monitor and evaluate the process better, as well as strengthen partnerships between the two hospitals.

1.6 Definition of key concepts

The concepts to be defined are resulting from the study “Exploring lessons learned from the Mediclinic Windhoek accreditation for extrapolation to public health facilities”.

The concepts are defined as follows:

1.6.1 Accreditation

Accreditation is the process by which a non-governmental or private body evaluates the quality of an institution as a whole or for a specific program in order to formally recognize it as having met the set minimum standards of quality. The result of this process is usually the award of a status or recognition and at times a license to operate (UNESCO 2007).

Ng, K.B., Leung, K.K., Johnston, M.J., Cowling, J.B. (2013) define accreditation “as a public recognition by a national healthcare accreditation body of the achievement of accreditation standards by a healthcare organization, demonstrated through an independent external peer assessment of that organization’s level of performance in relation to the standards” (Ng et al, 2013). Accreditation is a certification process that is strategic and important in improving care and delivery of care in a hospital. Additionally, accreditation offers an opportunity for organizational development and learning. The accreditation process is performed by external assessors who are usually a multidisciplinary team. These assessments often include self-appraisal, on-site surveys, peer review interviews, documentation review, equipment checks and the appraisal of key clinical and organizational data (Ng et al, 2013).

In this study, accreditation will refer to the evaluation of Mediclinic Windhoek by COHSASA towards accreditation of the facility against quality standards.

1.6.2 Quality Improvement

Quality improvement in public health is defined as the combined and unceasing efforts of everyone, including health care professionals, patients and their families, researchers, educators,

to make changes that will lead to better patient outcomes (health), better system performance (care) and better professional development (learning) (Batalden P & Davidoff F. 2015).

1.6.3 Quality Standards

Quality Standard is a level or degree of quality that is considered proper or acceptable (Longman dictionary, 2015).

1.6.4 Quality Assessment

Assessment is an act of assessing. To assess means to calculate or decide the value or amount of something. It also to judge or evaluate (Longman dictionary, 2015). Therefore, quality assessment is the process of evaluating or judging for quality.

1.6.5 Extrapolation

Extrapolation is the process taken from the verb extrapolate. Extrapolate is to extend an application of a method or conclusion to an unknown situation assuming that existing trends will continue or similar methods will be applicable (Longman Dictionary, 2015).

1.6.6 Focus group

De Vos et al, 2005 defines focus group as a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive and non-threatening environment (De Vos et al, 2005).

1.6.7 Quality Assurance

A system for evaluating performance, as in the delivery of services or the quality of products.

Provided to consumers, customers, or patients (Online Medical dictionary, 2015)

1.6.8 Public Health

Public health refers to all organized measures (whether public or private) to prevent disease, promote health, and prolong life among the population as a whole. Its activities aim to provide conditions in which people can be healthy and focus on entire populations, not just on individual patients or diseases. Thus, public health is concerned with the total system and not only the eradication of a particular disease (WHO, 2015)

1.7 Limitations of study

The researcher experienced limited time in conducting the study as the researcher was migrating out of Namibia a few weeks before the commencement of the study. The available time affected the sample size as the researcher could only interview a limited number of participants. Additionally, the patient influx patterns greatly affected the participation of study participants. The interviews were scheduled during a certain day of the week because of the hospital schedule, whereby some days are very busy, and nurses and other staff are unable to participate in the study.

Even with limited time, focus group discussion appointments were at times postponed or rescheduled due to shortage of staff at the hospital. There were times when the patient flow was high and staff could not be availed for the interviews.

Mediclinic Windhoek is one of the busiest private hospitals in Windhoek. Because of the staff work load, focus group discussions were at times not started on time as participants first had to attend to their patients. Additionally, some participants didn't want to engage in deep discussions during the focus group discussions, as they were thinking about attending to their patients. This might have affected or limited the participants' ability to pay attention and fully participate in the study.

Limited financial resources disabled the researcher from hiring a research assistant and a transcriber. This study was self-financed and the researcher had to conduct the interviews as well as make field notes. This at times proved time-consuming, as sometimes the researcher paused the participants to note down important things to be followed up.

Summary

This chapter described the angle and focus of this study. The chapter also presented the statement of the problem, the aim and objectives of the study, as well as the limitations of the study.

CHAPTER 2

RESEARCH METHODOLOGY

2.1 Introduction

This chapter will describe the research methodology that was applied or implemented during this study. This chapter will describe the qualitative study approach using focus group discussions, sampling population, sampling size, research instruments, data collection method, and data analysis, as well as ethical considerations that were applied in this study.

This research aimed to explore and document the experiences and lessons learned by staff that participated in the accreditation of the Mediclinic Windhoek hospital, so that the lessons learned can be extrapolated to other hospitals participating and aspiring to improve quality and get accredited. The objective of the study was to explore and describe the experience of staff who participated in the COHSASA accreditation process.

2.2 Research design

The study undertaken is a qualitative, explorative descriptive study. Qualitative research can be defined as a research design that collects data through textual techniques and not numerically (Holloway, 2005).

2.2.1 Qualitative Study Design

A qualitative study design was chosen because it has the ability to capture and represent the views of the participants of the study. This is, its own way, is the sole purpose of conducting a qualitative study. According to Yin (2009), qualitative research is able to represent the views and

perceptions of the people or the study subjects. This, he additionally highlighted, can be the main or major purpose of the study (Yin, 2009). Yin (2009) also stated that qualitative studies cover contextual conditions within where the study subjects are; as he strongly acknowledges that context influences human events (Yin, 2009). His sentiments are in line with the researcher's in selecting the appropriate research design for the study of lessons learned at the Mediclinic Windhoek hospital. The qualitative study findings and emerging ideas can represent the views, ideas and meaning given to real-life events by the people who live them, not the values, preconceptions or meaning of the researcher (Yin, 2009). One of the advantages of a qualitative study is that the research design is able to contextualize the conditions of the event that took place. The study covers the social, institutional and environmental conditions which strongly influence people's lives and the way they perceive things.

2.2.2 Exploratory Design

The study was explorative because the study hoped to capture and retain a holistic and meaningful characteristic of the accreditation experience of the Mediclinic hospital staff; where by the study's main aim is to gather information about the experiences of the Mediclinic Windhoek staff who underwent accreditation.

2.2.3 Descriptive Design

A descriptive case study approach was used to capture the experiences and lessons learned.

According to De Vos et al, the descriptive case study is also called an intrinsic case study because it strives to describe, analyze and interpret a particular phenomenon (De Vos et al, 2011). De Vos further emphasizes that casing has become increasingly become an acceptable

scientific tool that captures a deep understanding of mechanisms of change. These sentiments are supported by Guest and Namey (2015), whereby they stated that case studies focus on a single phenomenon, and methods to select cases can vary, as some cases are selected because they are thought to be critical, a model case, revelatory case or modal case.

Data was collected in July 2014, whereby staff of Mediclinic Windhoek were interviewed regarding their experience and lessons learned during the Mediclinic Windhoek accreditation process. Therefore, the findings of this study were explained through themes that emerged from the data collection.

2.3 Research setting

The study was conducted at Mediclinic Windhoek hospital which is situated in Windhoek, the capital city of Namibia. The Mediclinic Windhoek hospital is part of Mediclinic southern Africa, with its headquarters in South Africa. Mediclinic Windhoek is a private health facility mostly serving the middle income population of Namibia as well as international patients. The vision of Mediclinic Windhoek is to be locally preferred for:

- Delivering excellent patient care
- Ensuring aligned relationships with doctor communities
- Being an employer of choice, appointing and retaining competent staff
- Building constructive relationships with stakeholders
- Being a valued member of the community

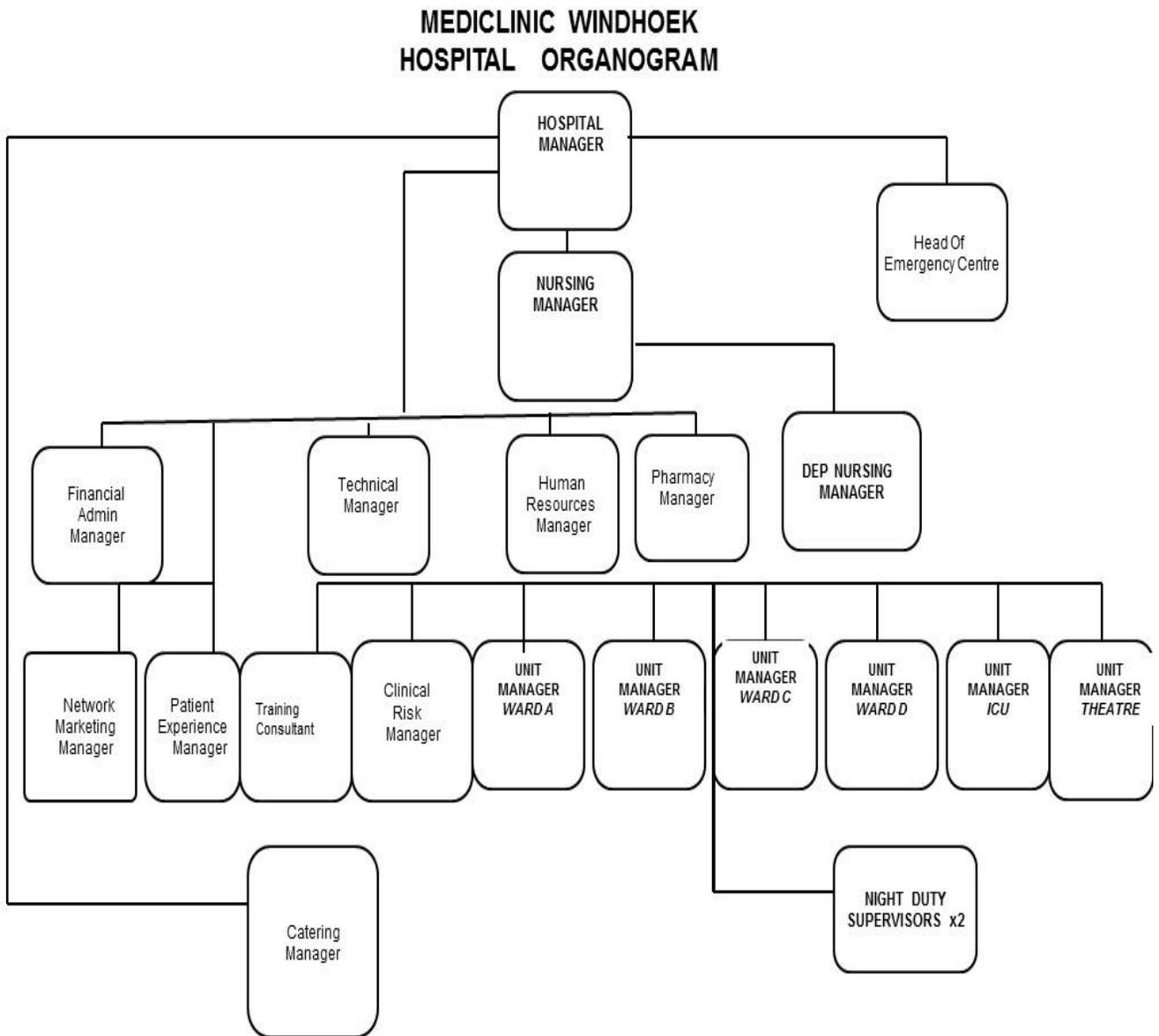
Mediclinic has well defined core values that the institution strives to live by. The core values of the hospital are patient safety, client focus, mutual trust and respect, team work and performance driven (Mediclinic, 2015).

The hospital is managed by the hospital Manager who directly supervises the nursing Manager, financial admin Manager, technical Manager, human resource Manager, the pharmacy Manager and the head of emergency unit. The nursing Manager is deputized the deputy nursing Manager who directly supervises the heads of the wards including theatre as well as the training consultant and clinical risk Manager.

The Mediclinic Windhoek hospital has a staff capacity of two hundred and seventy (270). The bed size is one hundred and ten (110) and the hospital sees about 75 patients every day. The hospital has some departments or services that are outsourced and these staff are not part of the Mediclinic Windhoek staff establishment. Departments that are outsourced are the security department, whereby there are three (3) guards during the day and 2 guards covering the night shift. The cleaning department is also fully outsourced, with 38 staff. Just like other private hospitals, general practitioners or doctors as well as other specialists have private practices and are only using the theatre facilities and admitting patients in the hospital wards. The Mediclinic Hospital then charges the patient for occupancy. The Radiology department and Pathology departments are leasing rooms at the hospital and are independent service providers.

The hospital has a clearly defined hierarchy of responsibilities as outlined in the hospital organogram below:

Figure 2.1 Hospital organogram, Windhoek Mediclinic



(Compiled: June 2010) Revised March 2015

2.4 Population and study population

A population is the total set of people who are of interest to the researcher (Sipa, 2015, and Polgar and Thomas, 2013). The population of a study consists of all objects and elements that meet the criteria for inclusion (Sipa, 2015). A study population is a subset of the population with the characteristics of interest defined by the eligibility criteria. For this study, the study population was the staff employed by Mediclinic Windhoek between June 2010 and December 2014 who participated in any of the accreditation processes. It is from this population that the sample to be studied was drawn. The study population consisted of different cadres of staff from different departments within the Mediclinic Windhoek team as per the hospital's staff establishment. These cadres consists of registered nurses, enrolled nurses, administration staff, as well as management staff.

2.5 Sampling and sampling method

It is not always feasible to study the whole research study population and therefore sampling becomes vital. Sampling enables the researcher to access a subset of the population to make the research more feasible. Sampling is a process that involves the taking of any portion of a population or universe as representative of that population or universe (De Vos et al, 2005). Sampling is a cost saving way to create sets of cases in research studies.

A non-probability sampling method was used in this study. In non-probability sampling, the odds of selecting a particular individual are not known because the researcher doesn't know the population size or the members of the population (De Vos et al, 2005)

Therefore, a purposive sampling method was applied to this study. Purposive sampling is used when a particular case has or illustrates some features or processes of interest to the study (De Vos et al, 2011). Purposive sampling is entirely based on the researcher's judgement, in that a sample is composed of elements that contain the most characteristic, representative or typical attributes of the population (De Vos et al, 2005). Although purposive sampling is seen by some as judgmental sampling (De Vos et al, 2011), the researcher was interested in interviewing Mediclinic staff that were employed and participated in the accreditation processes of Mediclinic. This inclusion criteria is perceived by the researcher responsive to the study objectives. These sentiments are further supported by Creswell, (2014) when he cited: "The idea behind qualitative research is to purposefully select participants or sites (or documents or visual material) that will best help the researcher understand the problem and the research question" (Creswell 2014).

The researcher is aware that this type of sampling has some level of bias attached, as not everyone has an equal chance of being selected for the study. Additionally, the staff will be interviewed during business hours, so the participants interviewed will also depend on their availability at a specific time. However, the sampling method was appropriate for the specific phenomenon of interest to the researcher.

Likewise, the researcher is aware of the fact that the findings of this study cannot be generalized as this study is descriptive case study (also called an intrinsic case study) because it strives to describe, analyze and interpret a particular phenomenon (De Vos et al, 2011).

The participants in the study were sampled from the larger population of staff employed by Mediclinic Windhoek, which comprises of registered and enrolled nurses, kitchen staff, laundry staff, and managers of Mediclinic Windhoek who worked, participated and contributed to quality improvement/assurance activities.

- **Inclusion criteria**

Inclusion criteria is an imperative prerequisite for consideration when choosing a sample (Sipa, 2015). The criteria assists the researcher with deciding which participants to include in the study.

In this study, the inclusion criteria for the objectives were:

- Staff must be on the Mediclinic staff establishment
- Staff eligible for the study must have been employed at the Mediclinic Windhoek hospital between June 2010 and June 2014, which is the period of the two accreditations of Mediclinic Windhoek
- Staff who agree to voluntarily participate in the study
- Staff must be able to communicate in English

- **Exclusion criteria**

The exclusion criteria consists of basic features that enable the researcher to exclude participants who do not have the characteristics of interest to the researcher (Sipa, 2015). Additionally, Sipa (2015) highlights that the exclusion criteria aids the researcher to exclude participants who by their inclusion would not meet the purpose of the study (Sipa, 2015).

The following was the exclusion criteria for the study:

- All staff that are not on the Mediclinic staff establishment or are working in outsourced departments, such as radiology, medical doctors, the cleaners, laboratory services, dental services, physiotherapists, drivers, and porters
- Staff that were employed at Mediclinic Windhoek after June 2014
- Staff who were on night duty, working night shift or who had a day off

The sample size was not predetermined by the researcher but was rather determined by the saturation levels of the data during the interview. Additionally, the sample size was largely determined by staff availability and patient flow during the research period. Polgar and Thomas (2013) state that there is no magic number that can be regarded as the optimal sample size in qualitative research, but rather that the optimum sample size would depend on the characteristics of the research study as well as the context from which the data is being collected (Polgar and Thomas, 2013). In addition, Guest and Namey further highlighted that the sampling method used in a study determines the sample size, as well as the efforts required.

The researcher conducted 6 focused group discussions and 3 key informant interviews, as well as an interview with 2 staff members from a certain department with which a focus group discussion could not be established due to work flow and other duties. The researcher chose to have the majority of groups to be homogenous as homogeneity is important in focus group discussions: participants perceive each other as fundamentally similar and they will spend less time explaining each other, giving more time to discuss the issues at hand (Yin, 2009). In order to

assess and pick potential new emerging themes, the researcher decided to conduct a focus group discussion with one heterogeneous group.

The researcher grouped the participants for focus group discussion according to their ranks in order to form homogenous groups as follows:

- 2 groups of registered nurses, consisting of 6 participants per group (homogenous)
- 2 groups of enrolled nurses, consisting of 6 participants per group (homogenous)
- 1 group of unit secretaries consisting of 6 participants
- 1 heterogeneous group consisting of a registered nurse, enrolled nurse, unit secretary, technical staff, laundry staff and pharmacy staff
- 3 key informant interviews
- 2 individual staff interviews

The total number of staff reached was 41, out of a total number of 270 staff who worked for Mediclinic at the time of the interview. The total number of staff who underwent or experienced the accreditation was unknown and therefore an accurate fraction of the sample or participants reached could not be determined.

2.6 Data Collection

Data collection is the process of acquiring information from the source of information, in this case the research participants. Yin (2009) defines data collection as “the collection of organized information usually as a result of experience, observation or experiment” (Yin, 2009). The

researcher collected the data through focus group discussions. Focus group discussions are a form of interviews and are also known as group interviews (De Vos et al, 2005). The purpose of data collection for this study was to find out the lessons learned by the Mediclinic Windhoek staff who participated in the accreditation process of the hospital. The findings of the study can help public health facilities to extrapolate the process.

2.7 Piloting of the study

A pilot study is a system whereby the researcher uses similar subject, location, data collection method and data analysis method to collect data from a small intended test population (Sipa, 2015). Pilot testing is a fundamental rule of research, but according to De Vos et al, 2005, it presents special problems with focus groups. They claim that the questions used in focus group discussions are hard to separate from the environment of the focus group discussions. They have additionally cited that a true pilot actually happens with the first focus group with the participants (De Vos et al, 2005).

In this study, a pilot was conducted at Mediclinic Windhoek with staff from the kitchen department about two weeks before the actual commencement of the study. The kitchen department was randomly selected with no special reason. The staff from the kitchen department were then excluded from the study. The pilot test was aimed to inform the researcher regarding the clarity of the questions on the data collection tool as well as indicate whether adjustments and refinements were needed on the data collection tool.

Piloting the data collection tool also enabled the researcher to have an idea of how long the focus group discussion may take. This information served as a guide to setting up the interview times and spacing between the focus groups.

No major glitches were identified during the piloting of the tool, except there is a need for the researcher to keep probing, engaging and encourage in-depth discussions of some concepts on the research guide like “role during accreditation”. The researcher also learned that she needs to regulate and manage the group by encouraging the “quitter” participants to share their opinions and thoughts and by managing the dominant participants to give a chance to other participants to also participate in the study.

2.8 Data collection method

Qualitative studies typically employ un-structured or semi-structured interviews as a method of data collection (De Vos et al, 2005). Interviewing is the predominant mode of data or information collection in qualitative research (De Vos, 2011). The researcher collected information through direct interchange with a group of Mediclinic Windhoek staff and individuals using focus group discussions. As stated earlier, the data collection was done using focused group discussions, with mostly homogeneous groups.

The use of focus group discussions in the study was used to support the researcher in acquiring powerful interpretive insights. Denzin & Lincoln (2008) have asserted the relevance of this kind of methodology because of their synergic potentials: “focus group discussions often produce data that are seldom produced through individual interviewing or observation and that results in

powerful interpretative insights” (Denzin & Lincoln, 2008). The purpose of using the focus group discussion in the study is to promote self-disclosure among participants (De Vos et al, 2005). The researcher needed multiple view points and responses regarding the experiences of Mediclinic staff during the accreditation period.

The researcher applied interviewing techniques and tips that are outlined in the research book written by De Vos et al, 2011. De Vos et al (2011) have also outlined communication techniques for a successful interview, which the researcher applied, including attempting to avoid common pitfalls in interviewing. Additionally, the researcher simultaneously took notes of important points that emerged as well as those that needed further probing.

The researcher applied a research guide to facilitate the focus group discussions during the interviews. The same research guide was applied to the key informants as well as the individual interviews that were done in the situation where a focus group discussion was not feasible. Data was also captured with a tape recorder (verbal consent for recording was granted). The researcher explained to the participants that the tape recorder is used in order to effectively and correctly capture the data for transcription purposes.

The research guide was made up of open ended opinion questions. The open ended opinion questions on the research guide required the research participants to reflect on their own individual and subjective experience of the accreditation process. Open ended questions are known to elicit more detailed responses from the research participant (Polgar & Thomas, 2013).

A research guide with carefully generated and sequenced questions that are aligned to the study objective were developed for the data collection through the following steps:

1. Developing questions for the data collection tool in consideration of the objective and purpose of the study.
2. Peer reviewing of the data collection tool by sharing it with the supervisor as well as classmates to ensure clarity of the questions as well as increase trustworthiness of the data collection tool.
3. Piloting the research guide.

The data collection tool consisted of the following open ended questions that were administered by the researcher using a research guide:

1. What is your understanding of quality? And what is quality improvement?
2. What was your role in the accreditation process? What was your responsibility?
3. What would you say are critical things that contribute to the successful accreditation of Mediclinic-Windhoek?

What are the factors that contribute to quality improvement activities at Mediclinic Windhoek?
4. Where there any challenges during the accreditation process?

How did you overcome them?

5. Is there anything that could have been done better? What are the specific recommendations?
6. What would you say are the lessons learnt from this process? In your view is there any lessons that can apply to other health facilities?
7. Do you think care has improved in Mediclinic after or as a result of accreditation? Please elaborate explain with specific examples in the areas where quality has improved.

- **Overview of the fieldwork activities**

The data collection was conducted by the researcher during the period of 25th July –7th August 2014. Data was collected using a research guide that was applied by the researcher alone by interviewing the research participants in focus group discussions. The research guide was carefully generated and sequenced questions that are aligned to the study objective were developed for the data collection.

2.9 Description of participants

Participants were identified and classified into groups according to their ranks in order to form homogenous groups. The selection of participants was done according to the inclusion and exclusion criteria. No demographic information or department of the participants were collected as it is of no value-add to the objectives of the study. The research participants consisted of registered nurses, enrolled nurses, unit secretaries, technical staff, pharmacy staff and management staff.

2.9.1 Focus group discussions

Data collection was done using focused group discussions, whereby homogeneous groups were formed. The use of focus group discussions in the study was aimed for the researcher to acquire powerful interpretive insights. Denzin & Lincoln (2008) asserted the relevance of this kind of methodology because of their synergic potentials: “focus group discussions often produce data that are seldom produced through individual interviewing or observation and that results in powerful interpretative insights” (Denzin & Lincoln, 2008).

De Vos (2005) has identified three basic uses for focus groups: the first two supported the researcher in selecting this method of data collection:

- They are used as a self-contained method in studies in which they serve as the principal source of data.
- They are used as supplementary source of data in studies that rely on some other primary source of data like a survey.
- They are used in multi-method studies that combine two or more means of gathering data in which no one primary method determines the use of the others (De Vos et al, 2005).

The focus group discussions consisted of 6 participants in each group. De Vos et al, (2005) recommends that the focus groups consist of six to ten participants. Groups of this size enable participants to participate in the discussion while eliciting a wide range of responses. The researcher decided to have 6 participants in order for the participants not to feel overcrowded and

left out with the discussion. Additionally, having 6 participants enabled the researcher to manage the group since there was no research assistant recruited for this study. The researcher used a research guide with open ended questions to guide the discussions, of which each participant expressed their thoughts, ideas and experiences in response to the questions.

2.9.2 Individual interviews

Individual interview is a method of data collection that involves collecting data from an individual during a face to face encounter (Sipa, 2015). Face to face interviews offer the researcher much more flexibility, as they enable the researcher and the participant an opportunity to follow up on interesting and emerging themes that emerge in the interview (De Vos et al, 2005). The researcher chose to have key informant interviews in order to elicit facts from the participants. Also, key informants are generally known to be experts or have more knowledge regarding the phenomena under study.

Face to face interviews were done with key informants who are in the senior management of Mediclinic Windhoek. The process was advantageous as the key informants were open to describing their experiences and thoughts without fearing that someone has heard their opinion. Additionally, interviewing key informants individually and separately from the junior staff improved the perceived limited freedom of participation and expression of junior staff in the study.

2.9.3 Preparation of the research field

For this study, data was collected after approval from the University of Namibia. A submission and presentation was made to the Mediclinic Windhoek management and staff explaining the purpose of the study and the entire methodology of the study. The researcher presented the research proposal to not only get buy-in into the study but also for staff and management to seek clarification, ask questions regarding the study, as well as be informed why Mediclinic was selected for the study.

Upon receiving verbal consent from the management of Mediclinic Windhoek, tentative dates and time for interviews were agreed upon by the researcher and the deputy nursing Manager. The deputy nursing Manager of Mediclinic Windhoek is responsible for managing the staff and therefore was in a good position to guide the schedule for the studies depending on availability of staff and hospital work load.

2.9.4 Field notes

Field notes are the written conversations taken during the qualitative research period (Sipa, 2015). Field notes can be written or taken by hand or recorder. In a case where the field notes are taken by hand, they should be written up punctually and as full as possible (Krueger & Casey, 2000).

Field notes assist the researcher to remember what happened in the interviews and correlate and incorporate the information with the voice recorded data in order to ensure

trustworthiness (Sipa, 2015). Sipa, 2015, further highlighted that field notes serve as a supplement for data that cannot be portrayed by audio-taped interviews; for example, non-verbal communication such as body language (Sipa, 2015).

In this study, the researcher captured or wrote down what she has heard and observed from the participants through non-verbal communication. The researcher also noted down things that need further probing and new emerging themes from the discussion.

The researcher obtained verbal consent from the participants to participate in the study. Verbal consent (as opposed to written consent) was obtained in order to maintain anonymity of the participants. This was maintained by not requiring written consent from participants or use of their names during the interviews.

2.9.4 Voice recording

A voice recorder was used to capture the verbal interaction during all interview sessions. Using a voice recorder enabled the researcher to effectively capture the conversations as they take place, which otherwise would have been difficult if the researcher tried to write down the interactions.

The researcher prepared the voice recorder daily by checking the battery status and charging the recorder daily after each use. Additionally, the researcher named the files on the recorder as per the group aggregation; for example, Registered nurse 1 would mean that it is the first group of comprised of registered nurses. A back up copy of the interview clips were made and kept on the researcher's laptop and on a flash disk in case any data loss occurred. To maintain confidentiality

and data safety, the voice recorder and flash disk were stored separately in separate lockable cabinets.

The laptop used to transfer the recording of the voice clips also stored the interview files for back up. The laptop is password locked and only the researcher can access the information on the laptop.

2.10 Communication techniques applied during data collection

According to De Vos et al, 2005, active interviewing is not confined to asking questions and recording answers, and therefore communication techniques need to be employed by the interviewer in order to facilitate responsiveness of the participants. The following communication techniques were employed as advised by De Vos et al, 2005:

- **Minimal verbal responses**

A verbal response that correlates with occasional nodding, e.g. “*mm-mm, yes I see*” will show the participant that the researcher is listening (De Vos et al, 2005).

- **Paraphrasing**

This involves a verbal response in which the researcher will enhance meaning by stating the participant’s words in another form with the same meaning (De Vos et al, 2005).

- **Clarification**

This embraces a technique that will be used to get clarity on unclear statements e.g. “*Could you tell me more about...? You seem to be saying....*” (De Vos et al, 2005).

- **Reflection**

Reflect back on something important that someone said in order to have them expand on that idea. “*So you believe...?*” (De Vos et al, 2005).

- **Listening**

Interviewers are required to have terrific listening skills (De Vos et al, 2005).

- **Probing**

The purpose of probing is to deepen a response to a question so that the data is enriched, and this gives indications to the participant about the level of response that is desired. Probing is a technique to persuade the participant to give more important information regarding the issue being discussed (De Vos et al, 2005).

There are different methods of probing, but the researcher mostly used the following methods:

- *Linking*: Linking up the participants comments with the information which the researcher wants to know (De Vos et al, 2005).
- *Encouraging*: Giving compliments to participants to encourage participants to carry on (De Vos et al, 2005).

- *Showing understanding and allowing time for elaboration*: letting the participant know that his comments are understood and treasured and allowing him time for further comments (De Vos et al, 2005).

2.11 Measure to ensure trustworthiness

There are various criteria that are important in guiding the researcher to maintain consistency and neutrality of the entire research process (Sipa, 2015). The following criteria were employed as follows:

2.11.1 Transferability

The study findings are transferable as they can be used or applied to other health facilities. The researcher will disseminate the findings of the study with the staff and management of Mediclinic Windhoek for their consumption as need be.

2.11.2 Validity

In qualitative research, the term validity is sometimes used in a much more comprehensive sense. Schreier (2013) states that validity in this comprehensive sense refers to your entire study and the soundness of your findings and conclusions (Schreier, 2013).

There are two types of validity that were tested on the data collection tool: content and face validity. Content validity was ensured by the researcher through having the data collection tool

reviewed by the supervisor as well as by peers. Content validity aims to measure whether the data collection tool is responding to the objectives of the study. These sentiments are supported by Schreier (2013): “validity is used in a narrow sense, referring to the extent to which your instruments help you set out to capture what you set up to capture”.

Face validity was ensured during the piloting of the data collection tool. After piloting, the data collection tool was refined to ensure that the necessary elements are captured in the tool in order to collect data that informs the study objectives.

2.11.3 Reliability

Reliability refers to the degree of consistency with which instances are assigned to the same category by different observers or by the same observer on different occasions (Silverman, 2007).

Silverman, (2007) suggests two ways to satisfy the reliability criteria in qualitative research:

- By making the research process transparent by describing the research strategy and data analysis methods in a sufficiently detailed manner in the research report
- By paying attention to “theoretical transparency” through making explicit the theoretical position from which the interpretation takes place.

In this study, reliability was ensured as the researcher herself collected the data as well as transcribed the data using a transcription device called Olympus DSS player to effectively and accurately transcribe the data. Also, the researcher pre-tested (piloted) the interview schedule to ensure reliability in the context of qualitative research.

2.11.4 Principles of trustworthiness

Table 1.1

Principle	Application in the study
<p>Credibility: The criteria of credibility encompasses establishing that the results of a study are credible or believable from the perspective of the participant in the research study (Trochim, 2006).</p>	<p>The study aimed to understand and describe the experiences of Mediclinic Windhoek during the accreditation process. Credibility in this qualitative study was only legitimized by the research participants as they described their experiences through their eyes and their realities.</p>
<p>Transferability: Transferability refers to the ability of study results to be generalized or transferred to other contexts or settings (Trochim, 2006)</p>	<p>The study finding's ability to be transferred largely depends on the person that is considering the transferability, as they have a better understanding of the context for which the findings can be utilized or generalized. However, the researcher in this study facilitated the possibility of transferability by thoroughly describing the experiences of the research participants.</p>
<p>Confirmability: The principle of confirmability refers to the extent to which results can be confirmed or corroborated by</p>	<p>In this study, the researcher used a systematic process to collect and analyze the data for this study. Additionally, during the data collection</p>

<p>others (Trochim, 2006). According to Trochim, (2006), there are a number of ways to enhance confirmability. One way is to conduct a data audit to examine data collection and analysis in order to make judgements about potential distortion or even bias.</p>	<p>process, the researcher took field notes which were used during the data analysis phase in order to confirm the findings.</p>
<p>Dependability: The principle of dependability encompasses of the ability to get the same results if the same observation or study was done twice (Trochim, 2006).</p>	<p>In this study, the researcher was unable to guarantee dependability of the results as the ever changing context of the research and research participants can compromise the principle of dependability. Additionally, according to Trochim (2006), measuring the same twice means that two different things are being measured.</p>
<p>Justice: The principle of justice refers to equal share and fairness (Orb et al, 2001). The principle of justice also involves avoiding exploitation of the research participants as well as abuse of the research participants.</p>	<p>In this study, the researcher didn't perceive any potential factor that could cause abuse or exploitation of the research participants. However, the researcher contributed to the principal of justice by intentionally probing and asking the contributions of research participants that seemed a little quieter than others in the focus group discussions. This</p>

	<p>was done in order to also involve and give an equal share of contributions to the “quiet” research participants.</p>
<p>Respect: The principle of respect has two chambers which involve allowing the research participant to exercise their autonomy (respect for autonomy) as well as the ability to treat people with reasonable consideration (respect for persons) (Sim & Wright, 2002)</p>	<p>In this study, the researcher maintained the principle of respect for both autonomy and respect by:</p> <ul style="list-style-type: none"> • Acquiring informed consent from the participants • Ensuring confidentiality and privacy by not using the participants and explaining how data would be managed. • Ensuring that the research procedures do not tamper with the human dignity of the research participants. This involved not asking dehumanizing or embarrassing questions to the research participants. • Being honest about what the findings of the study will/could be used for.

2.12 Data transcription

The voice recordings of the interviews and focus group discussions were transcribed using the Olympus DSS Player Standard software immediately after the interview. Using transcription software improves data accuracy, as transcription is clearer and faster. The researcher created transcription files in a word document that are stored on the laptop. The files were labelled according to the groupings of the focus group discussions. Although qualitative research analysis can be made easier by using computer-assisted software like NVIVO or Atlas.ti, the researcher analyzed the data manually as the data was small. After the data was transcribed, the researcher analyzed the data through content analysis. The researcher printed out the transcribed data so that analysis and coding was done on hard copy.

After the data was transcribed, the researcher analyzed the data through content analysis. Yin, (2009) has described five analytic techniques that a researcher can consider using in analyzing qualitative research data namely: Pattern Matching, Explanation Building, Time-series Analysis, Logic Models and Cross-case Synthesis.

The researcher used pattern matching and explanation building techniques to analyze the data, and interpret and describe the experiences and sentiments emerging from this study. The researcher also applied the 8 steps of data analysis as proposed by Tesch as written by De Vos, (2002):

1. The researcher carefully read through all the transcriptions, making notes of ideas that came to mind.

2. The researcher selected one interview and read it to try to get meaning in the information, writing down thoughts coming to mind.
3. After going through the transcripts, the researcher arranged similar topics in groups by forming columns labelled major topics, unique topics, and leftovers.
4. The researcher then abbreviated the topics as codes and wrote the codes next to the appropriate segment of the text. The researcher then observed the organization of data to check if new categories or codes emerged.
5. The researcher found the most descriptive wording for the topics and converted them into categories. The aim was to reduce the total list of categories by grouping topics together that relate to each other. Lines drawn between the categories indicated interrelationship of categories.
6. A final decision was then made on the abbreviation of each category and the codes were arranged alphabetically.
7. The data material belonging to each category was put together in one place and preliminary analysis performed.
8. Recoding of the data was done if necessary.

(De Vos, 2002)

2.13 Coding

Coding is probably the most widely known and popular method of qualitative data analysis (Schreier, 2013). Some authors define coding generally, like Gibbs (2007) who describes coding as the activity of finding out what your data is all about. He further highlighted that coding is a

conceptual process, as by generating a code, you identify a part of your data as an illustration of a given concept (Schreier, 2013).

The following steps were employed during the coding of the data:

Attribute coding: is the notation, usually at the beginning of a data set rather than embedded within it, descriptive information such as work setting, participant's characteristics or demographics, or time frame (Saldana, 2009). At this stage, the researcher sorted the transcribed data according to their cadres and focus group discussions. The data was coded as follows:

- Registered nurses
 - Enrolled nurses
 - Technical staff
 - Key Informant 1
 - Key informant 2
 - Key informant 3
 - Unit secretaries
 - Heterogeneous group
-
- **Simultaneous coding:** Saldana, 2009, describes this type of coding as the application of two or more codes to a single qualitative datum, or the overlapped occurrence of two or more codes applied to sequential units of qualitative data. He further highlighted that simultaneous coding is suitable when the data's content suggests multiple connotations (Saldana, 2009). The researcher identified the following categories of themes using the simultaneous coding method:

- Quality and Quality improvement
- Roles in accreditation process
- Key success factors
- Challenges during accreditation
- Gaps and recommendations
- Lessons learned

The researcher read and studied the transcripts and used highlighters to identify and mark common themes and sub-themes across the transcripts that were transcribed per focus group discussion or interview. Additionally, the researcher also searched the transcripts for less common or contradicting themes. Data was coded according to topics and ideas whereby coding categories were compared across the groups interviewed.

2.14 Qualitative Data Analysis

De Vos et al, 2008 defines qualitative analysis as a non-numerical examination and interpretation of observations for the purpose of discovering underlying meanings and patterns of relationships. Qualitative data analysis was done on the data collected from the study, whereby the researcher conducted a non-numerical examination and interpretation of observations for the purpose of discovering underlying meanings and configurations of connection that will enable the researcher to make inferences from the findings. This is supported by what De Vos et al. have noted: that qualitative data analysis is first and foremost a form of inductive reasoning, thinking and theorizing which is certainly far removed from structured, mechanical and technical procedures to make inferences from empirical data (De Vos et al. 2011).

In this study, data analysis was employed as a two-fold approach. Data was first analyzed at the site during data collection, and the second aspect of data collection was done away from the site. De Vos et al, 2005, stated that data collection and analysis typically go hand in hand in order to build a coherent interpretation of the data (De Vos et al, 2005).

There are various ways of analyzing qualitative data: one of the many ways is qualitative content analysis (QCA) (Schreier, 2013). QCA is a method for describing the meaning of qualitative material in a systematic way. This description is done by assigning successive parts of the data to categories of your coding frame (Schreier, 2013).

The researcher applied QCA to this study as recommended by Schreier, 2013. Schreier, 2013, states that QCA can be used when dealing with verbal data in qualitative research. The researcher took the following steps in data analysis as suggested by Sipa, 2015:

- **Reading:** at this stage, the researcher was absorbed in the reading and re-reading as well as reviewing of the field notes in order to extract categories and subcategories (Sipa, 2015).
- **Coding:** at this stage, the researcher began to attach codes to pieces of texts by listening to emerging categories and subcategories (Sipa, 2015).

- **Displaying:** after the coding of the data, the researcher explored categories as well as display subcategories (Sipa, 2015).
- **Reducing:** at this stage the researcher reduced the data to vital points (Sipa, 2015).
- **Interpretation:** lastly, the researcher then made the overall interpretation of the study findings and finding the relation of the categories (Sipa, 2015).

2.15 Ethical consideration

Hammersley & Traianou (2012) describe ethics as a set of principles that exemplify what is good or right. As researchers, we are morally bound to carry out our research in a way that it doesn't cause harm to the study participants. This means that we are at all times required to be mindful when designing our research in such a way that it does not cause any type of harm to the participants (Bloomberg & Volpe, 2012). In any research, the researcher, the research institution, the research ethics committee and regulatory bodies apply ethical considerations in research (Sipa, 2015).

In this study, the research ethics were considered in terms of the purpose, design, methods of data collection and data analysis, as well as the interpretation of the data. Furthermore, ethical considerations were considered regarding the presentation, publication and dissemination of the study findings. The researcher worked closely with the research study supervisors in order to guide and monitor the adherence to ethical standards as approved by the University of Namibia (UNAM) research committee.

This study involved human subjects and therefore the researcher understood the potential invasion of privacy and confidentiality when a voice recorder was used during data collection. To assure the participants, the researcher asked for permission to use a voice recorder; citing that the purpose of using the voice recorder was to ensure that all discussions are accurately captured and the process of transcription is made easier and more accurate.

2.15.1 Permission to conduct the research

To sustain ethical standards, the researcher submitted and presented the research proposal for approval to the Post-graduate studies Committee of the University of Namibia. Permission was granted to the researcher by the University of Namibia Post-graduate studies Committee and clearance given by the UNAM research and publication committee.

Additionally, a presentation was made to the Mediclinic Windhoek management and staff explaining the purpose of the study and the entire methodology of the study. The researcher conducted a presentation of the research proposal to enable staff and management to seek clarification and ask questions regarding the study, be informed why Mediclinic Windhoek was selected for the study, become familiar with the study methodology, as well as share the researcher's contact details for any enquiry or concerns that may arise. The presentation also enabled the researcher to gauge the expectations of the research participants and to clarify any issues that may arise.

The researcher explained to the staff the benefit of the study to the institution and how the findings can support the MoHSS with the rolling out of their quality improvement program. Written approval for the study was given to the researcher by the Hospital Manager who approved the study proposal on behalf of the Mediclinic head office.

2.15.2 Confidentiality and anonymity

Confidentiality in research is the process whereby the management of data is done in such a way that the participant's responses are not linked to their names (Sipa, 2015). Confidentiality also refers to the non-disclosure of the research information that the researcher discussed with the research participants (Sipa, 2015).

The participants were informed by the researcher on how confidentiality will be maintained throughout the study. Confidentiality was maintained by keeping the records of the interview (audio and written) in a lockable cabinet with only the researcher having access to it. The transcribed records were stored on a password locked computer, which only the researcher had access to.

Anonymity refers to the inability of the researcher to link research responses to the identity of the research participants (Sipa, 2015). The principle of anonymity was maintained by the researcher by not using and documenting the research participant's real names through the interview process, and by not obtaining any data that could link the individual participants to the information collected during the study.

2.15.3 Informed Consent

Informed consent means that the research participants have adequate information regarding the study as well as a good understanding of the research information in order to make a decision or make a choice to participate in the study or not (Sipa, 2015).

The researcher obtained verbal consent from the participants as opposed to written consent as the researcher was maintaining the principle of anonymity. The researcher felt that if participants had to give written consent to the study, it would then mean that the participants write down their name or sign, which can easily be linked to the identity of the participant. During the process of obtaining verbal consent, the researcher informed the participants that participation in the study is voluntary and the recruitment of participants is not coerced.

Furthermore, the researcher also explained to the research participants that they are free to withdraw at any time from the study for whatever reason, without any repercussions from the researcher or the Mediclinic Windhoek management.

2.15.4 Privacy

Privacy was ensured by conducting the focus group discussions and interviewing in a room or space where participants chose. The participants chose to have the interviews in a boardroom in the basement of the hospital, a place where the participants felt that no external person was hearing the discussions.

2.15.5 Balancing benefits and risks

The researcher didn't foresee or ascertain any harm, whether physical, emotional, social, economic or legal, to the participants as a result of the study. However, the research participants were told of their right to withdraw their participation in the research study. The researcher further explained to the research participants that if they foresee or actually experience any risk or discomfort, they can openly and freely withdraw from the study without any repercussions.

The researcher also informed the study participants that if participants ever feel like they are unable to answer certain questions as a result of shame, guilt or the question violates their privacy, then they can choose not to answer that question if they still want to participate in the study. The participants were informed about the writing of field notes as a way of data collection as recommended by Sipa (2015).

Summary

This chapter introduced the reader to the methodological approach to this research study. This chapter briefly stated the research design and method chosen to conduct this research study. Additionally, the researcher detailed the method of sampling, data collection, transcribing, coding and analysis of data. The researcher also discussed the steps taken to maintain ethical considerations in research. The next chapter will deal with presentation and discussion of data.

CHAPTER 3

DATA ANALYSIS AND RESULTS

3.1 Introduction

This chapter presents the results and discussions of the findings. The study aimed to explore and describe the experiences and lessons learned by Mediclinic Windhoek staff that participated in the accreditation program. Data was collected from Mediclinic Windhoek staff who were grouped into 6 participants per group for focus group discussions. Most of the groups were homogenous and one group was heterogeneous. Key informants were also interviewed to gain deeper insight. Data was analyzed manually by deducing themes and sub-themes from the data collected. Findings are discussed based on the themes and questions asked during the research. The findings of the study are discussed with literature control in this chapter.

3.2 Qualitative data analysis

The qualitative data collected from the participants was analysed using a systematic process in order to deduce themes and sub-themes. The process of data analysis is comprehensively described in the previous chapter.

3.3 Discussions of themes and sub-themes

Six (6) main themes and twenty one (21) sub-themes are discussed in this section. The discussions include quotations of responses from the participants that are supported by literature control. The themes and sub-themes are presented in table 3.1:

Table 2: Main Themes and Sub-themes

Objective 1: To explore and describe the experiences of staff regarding COHSASA accreditation process

Main theme 1:	Sub-theme
3.1.1 Perception of participants on the concept of quality and quality improvement	3.1.1.1 Rendering services according to standards. 3.1.1.2 Patient satisfaction
Main theme 2:	
3.1.2 Experiences of participants regarding roles during accreditation	3.1.2.1 On-the-job roles and responsibilities
Main theme 3:	
3.1.3 Experiences of participants regarding challenges during accreditation	3.1.3.1 Hospital renovation 3.1.3.2 Shortage of staff and high staff turnover 3.1.3.3 Increased administration and paper work
Main theme 4:	

3.1.4 Suggestions made by the participants	3.1.4.1 Proper and timely planning 3.1.4.2 Buy in from medical doctors
Main theme 5:	
3.1.5 Lessons learned as experienced by the participants	3.1.5.1 Quality improvement efforts 3.1.5.2 Accreditation as a process of continuous learning 3.1.5.3 Maintaining good record keeping 3.1.5.4 Communication

Objective 2: To explore and describe critical success factors leading to the accreditation of Mediclinic Windhoek

Main theme 6:	
3.1.6 Participants' perceptions regarding success factors that lead to accreditation	3.1.6.1 Internal Monitoring systems and processes 3.1.6.2 Patient-centered approach 3.1.6.3 Availability and implementation of policies 3.1.6.4 Performance appraisal 3.1.6.5 Organizational values, culture and attitudes 3.1.6.6 In-service training and orientation

	<p>program</p> <p>3.1.6.7 Support staff in wards</p> <p>3.1.6.8 Availability of equipment</p> <p>3.1.6.9 Leadership and management</p>
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3.1.1 Theme 1: Perception of participants on the concept quality and quality improvement

Quality is the standard of something as measured against other things of similar kind; the degree of excellence of something (Online Oxford dictionary, 2015).

Quality improvement in public health is defined as the combined and unceasing efforts of everyone - health care professionals, patients and their families, researchers, and educators - to make changes that will lead to better patient outcomes (health), better system performance (care) and better professional development (learning) (Batalden P & Davidoff F, 2015).

The following sub-themes or categories were developed in this regard:

3.1.1.1 Sub-theme: Participants’ understanding or perceptions regarding rendering of services according to the standards.

The research participants were asked to define or explain their understanding of what quality and quality improvement was. The researcher was interested in determining the understanding of research participants regarding quality and quality improvement across the different groups of research participants.

Most of the staff define quality as a way of rendering services to a patient according to the set standards. However, some staff have defined quality as when you have provided care according to the standards set for the institution. This was emphasized by one key informant, when she/he noted that:

“Quality cannot be achieved if there are no predetermined standards”.
(Participant 1)

One of the enrolled nurse participant in the focus group discussions responded in a similar and supporting idea, that:

“Quality has to do with the way I render the best care to my patient according to the hospital policies. I render my best care so that patients will always refer to my hospital to receive care”.
(Participant 2)

One of the participants from the heterogeneous group provided a very passionate representation of quality. She defined quality *“as an act that begins in the heart”*. She defined quality as something you do from the inside of your heart to offer the best possible care to patients. Although some participants directly link quality care to patient care and others to implementation of policies, a few participants defined quality in the context of having up-to-date, serviced equipment. These participants felt that when the planned maintenance schedules are successfully implemented, then they have given quality care.

A very few staff who are not involved in direct patient care defined quality according to the achievement of a planned schedule as well as their ability to respond to “call outs”, such as technical staff who are responsible to service and maintain hospital equipment. Additionally, the participants have added that quality also involves identifying the need to have new equipment to improve delivery of care.

When the participants were asked about their understanding of quality improvement, most staff defined quality improvement as a process whereby challenges in rendering quality care are identified and steps are taken to rectify the identified challenge or weaknesses. Most staff across the groups interviewed expressed that quality improvement enables hospitals or institutions to move from a not-so-good situation to a much better if not best situation. Likewise, the participants reported that quality improvement is not a once-off activity, but rather an ongoing and never-ending process. In order to clearly define quality improvement, some staff defined it according to departmental contexts.

“Quality improvement is what we need to improve on. For me quality improvement means you need to deliver better service, like getting new equipment to improve the delivery of care”.

(Participant 3)

3.1.1.2 Sub-theme: Experiences of participants on patient satisfaction

The Oxford dictionary defines the satisfaction as fulfilment of one's wishes, expectations or needs, or the pleasure derived from this (Online Oxford dictionary 2015).

Therefore, in this study, patient satisfaction refers to the extent to which the expectation or needs of the patient regarding the care they have received at Mediclinic Windhoek was met.

Although patient needs may vary from patient to patient as well as their diagnosis, Maslow's (1943) hierarchy of needs outlines basic need of a person regardless of the health status at a point and time. McLeod (2014) has updated Maslow's hierarchy of needs pyramid as depicted in Figure 3 below:

Figure 3.1: Maslow's hierarchy of needs pyramid (McLeod, 2014)



These hierarchy of needs can help a care provider in addressing the basic needs of a patient in order to satisfy their patient, as in the case of the Mediclinic Windhoek.

The majority of staff associated rendering of quality services directly to patient satisfaction. Most staff expressed that they tend to feel that they have provided quality care if the patient was pleased with the hospital stay. The majority of participants expressed that, at times when a patient has a complaint about the services, they tend to feel that they have not provided quality care. There are exit surveys done for every patient upon discharge at Mediclinic Windhoek. In these exit surveys, the patients can express their satisfaction with the services.

These sentiments were expressed by one of the participants who was an enrolled nurse, citing:

“When a patient is not satisfied with the service then you have to improve so you can have be good and then excellent”.

(Participant 4)

Furthermore, one of the participants expressed that a satisfied patient is a happy patient and that making the patient happy is a component of quality care. Some participants expressed that patients tend to be more satisfied with the quality of care given to them if they are informed, and nurses and health care workers take time to give health education to the patients.

Quality is the service you give to the patient. This also involves the health education you give to the patient, because an informed patient is a happy patient.

(Participant 5)

However, a few staff expressed that there are occasionally some patients that don't express satisfaction even though services were rendered according to standards. In their own words they said:

“In private hospital, sometimes you find those difficult patients. No matter how good you are with them, they will always complain. It's part of our life”.

(Participant 6)

3.1.2 Theme 2: Experiences of participants regarding roles during accreditation

Accreditation is the process by which a non-governmental or private body evaluates the quality of an institution as a whole or for a specific program in order to formally recognize it as having met the set minimum standards of quality. The result of this process is usually the award of a status or recognition and at times a license to operate (UNESCO, 2007).

The participants were asked of the role that they played during the accreditation process. The purpose of identifying the roles of the participants was that the researcher was interested in knowing if accreditation roles and job descriptions are different during the process of accreditation.

3.1.2.1 Sub-theme: Experiences of participants regarding roles during accreditation

Some staff reported that the workload during the accreditation was not significantly increased, although a few staff reported that their workload increased during the accreditation period. The increase in workload was reported by staff in managerial and supervisory positions, as they had to prepare staff for the accreditation as well as verify that systems are functional and there is evidence of their functionality.

Even though some staff stated that the workload had not significantly increased, they agreed that there is more pressure during the accreditation, as everything is scrutinized. Staff however reported that they appreciated the scrutiny from an external assessor, and findings always give a fresh perspective regarding the functionality of the hospital.

Some staff reported that record keeping expectations are higher during accreditation, as missing records affect the grading of the criteria. However, maintaining the record keeping standards becomes a challenge when you are over worked and understaffed. Nurses expressed that they at times struggle with maintaining proper record keeping, especially when the wards are full, as their primary role is to provide care and administration and record keeping becomes secondary.

Most of the participants reported that they didn't receive any additional or different role to play during the accreditation. Additionally, the participants highlighted that their roles during accreditation was identical and aligned with their job description. For example, a registered nurse

was expected to fulfil his/her job description by integrating quality standards in that job description. The following statements are evidence of this:

“Our role during the accreditation was tied to our job description. We were just expected to know our environment”.

(Participant 7)

“My role was strategic as usual. I had a supportive role to ensure that everyone was on board regarding accreditation. I supported with the drafting of the preparatory program, ensure that policies are drafted and completed as well, as support unit Managers to ensure that they know the policies. I also supported the unit Managers to ensure that policies and protocols are implemented and staff are compliant”.

(Participant 8)

Although most staff stated that their role during accreditation was not different from their job description, one of the participants stated that they had an extra and unique role as a result of the accreditation:

“It was my duty to retrieve all patient files that are needed for auditing when COHSASA came. Also, it was my role to review existing policies as well as draft policies that are not in place. This role was unique to the accreditation process. Unlike the other staff, their role was just to carry out their job descriptions. I had to help departments prepare for the accreditation”.

(Participant 9)

3.1.3 Theme 3: Challenges during accreditation

In this research study, challenges are regarded as tasks or a situation that challenges someone's ability (Oxford online dictionary, 2015)

Participants were asked to recall and express their experiences regarding any task or situation that challenged them during the accreditation process and period. Although the process of accreditation was successful, participants have reported some challenges during the accreditation process

3.1.3.1 Sub-theme: Experiences of participants regarding hospital renovation

One of the key informant has reported that the physical environment of the hospital was not conducive for an assessment as there was construction going on. The hospital was noisy and dusty. It was a challenge to keep the hospital free from dust.

Another challenge reported was that, because of the construction the hospital had to change the entrance of the hospital which was not correct according to the accreditation criteria. The hospital used the same door for patients and visitors to enter the hospital, delivery pick- ups and drop off. The staff have also reported that it was challenging to participate in the accreditation process on days when the hospital has staff shortage and high patient influx. This was reported mostly by staff working in the theatre department.

“When COHSASA came to do the inspection there was construction going on at the hospital. So it was noisy and dusty. I felt that it was not fair to undergo an accreditation the same time that there is construction going on. Like you can’t maintain certain things. Example we had to change the entrance to the hospital. We had to use the same entrance for visitors, patients, deliveries, taking refuse out and that is not ideal. But when they interviewed the staff they picked up that staff knew the correct way to do things, it’s just because of the situation”

(Participant 10)

3.1.3.2 Sub-theme: Experiences of participants on shortage of staff and high staff turnover

A high staff turnover may have a negative implication on the overall performance of an organization as it affects the continuum of care. In this research study, staff turnover refers to the number or proportion of employees that leave the organization and are replaced by new employees.

Staff have stated that accreditation requires a lot of time and it can be challenging to balance patient care and fulfill assessment requirements. Additionally, a few staff have reported that the accreditation process was new to them and were not sure of what to expect so they experienced anxiety. There has been staff resignation which at times disproportioned the staff and patient ratio. Some participants also highlighted that when new staff are recruited, it takes a bit of time for them to learn the Mediclinic Windhoek culture and values. Some staff have however highlighted that most of the challenges they have experienced during the accreditation process

are not unique to the accreditation process but to the general working environment at Mediclinic Windhoek.

The following statements are evidence of this:

“High staff turn-over posed a challenge. It takes time for new staff to know and understand their job description or job profiles. They first have to understand their job profiles before we can even expect them to deliver on the standards.

(Participant 11)

“Shortage of manpower has been a challenge. Some staff have left because some can’t cope with the Mediclinic standards especially if you come from state hospital. That’s my opinion. The rules are tight, the attitude towards patient and colleagues is different here.

(Participant 12)

“And also that the work over load is due to staff shortage. And sometimes we have new staff that you have to train. And then you can’t really maintain the standard of like going back to evaluate what you have done”

(Participant 13)

3.1.3.3 Sub-theme: Experiences of participants on increased administration and paperwork

Medical records aid various functions but their primary purpose is to support patient care (Mann & William, 2003). Mann & William, (2003) have highlighted primary and secondary purposes of medical records:

Primary: Support patient care by aiding memoir and communication (Mann & William, 2003).

Secondary: Serve as a medico-legal document and can be a source of information for audits, resource allocation, epidemiology, service planning and performance monitoring (Mann & William, 2003).

With that said, it is vital to document every intervention and observation of a patient. In a busy hospital like Mediclinic Windhoek one can comprehend the extent and amount of record keeping maintenance that health care providers undergo.

Most staff have reported that in general, Mediclinic Windhoek requires a lot of paper work which consumes a lot of time from the staff especially when there is staff shortage. With the reported challenges, staff were quick to report that the management of the hospital are supporting to staff in resolving challenges that arise up on a daily basis.

One key informant has reported that the latest accreditation required a lot of time and work to prepare the staff. Additionally, the key informant felt that there was not enough time for

Mediclinic Windhoek to prepare as they just completed a rigorous process of renewing their policies and rebranding the image of Mediclinic Windhoek. Some management staff were required to work over weekends to go through the policies. Team work enabled the management to update our policies and files to make them ready for accreditation.

Majority of participants have reported that, the accreditation assessment is evidence based. This evidence should be written documenting the occurrence of an intervention. During the preparation for the accreditation, a lot of preparation had to be done. A lot of preparation was put in administration as well as ensuring that the processes of delivery of care are recorded.

“The biggest challenge that I experienced last year was the fact that all policies were due for renewal. We changed to a new brand. And all our policies needed to be changed to a new format. The old format is out, so we needed to change all the policies and procedure to the new brand and logo. This was hard work. It was a lot of administration work.

(Participant 14)

“Too much paper work especially during accreditation. We are care givers and naturally we don’t prioritize paper work. My priority is to give care. There is too much paper work here”

(Participant 15)

3.1.4 Theme 4: Suggestions made by participants

With the above said, staff have expressed that there are some things that could have done better in order for the participants to plan and reduce the anxiety and work overload that comes with preparing for accreditation.

3.1.4.1 Sub-theme: Experiences of participants on timely and proper planning for accreditation

One of such is planning and preparing ahead of time for the accreditation. One of the key informant stated that, the last accreditation for Mediclinic Windhoek came at an unfortunate time as Mediclinic was going through the rebranding process. This process increased the work load and minimized the time for preparing for the accreditation. The participant is of the opinion that proper planning could have aided the situation as dates we agreed on without really comprehending the extent of the ground work.

One of the key informant said that:

“For me, the time of rebranding and accreditation was too close. It was hard work”.

(Participant 16)

In addition, one of the study participants highlighted that there were so many preparations for different accreditations that were concurrently taking place with the COHSASA accreditation.

Another key informant echoed the same sentiments:

“It could have been better if we were sent earlier the new format for the re-branding. We could have worked on that earlier before the preparation of the accreditation. For me the time of rebranding and accreditation was too close”

(Participant 17)

“With the last accreditation we had so many things going on. We had the International Standard of Organization (ISO) that was looking at how we treat our environment, dispose waste and so on. Soon after ISO, we had to face COHSASA. At the same time, our policies were expiring and needed revision. It was tough. We also had to work hard because the hospital was going through rebranding. But if we plan properly on the accreditation timing then things could have be better”

(Participant 18)

Most staff have stated that some areas such as remuneration, long term capacity development for staff, develop a staff retention plan for long term staff retention need to be improved for general performance and satisfaction of staff. In relation to the accreditation process, most staff have expressed that there is too much paper work and forms be compressed to allow nurses to spent less time on filling out form and registers and spend more time on clinical care.

3.1.4.2 Sub-theme: Experiences of participants regarding buy in from medical doctors

Most nurses have reported that most physicians do not adhere to the requirements of record keeping and that most incomplete records are due to the omission of the physicians. Most nurses have expressed that they would like to see physicians taking an active role in not only the accreditation process but also in the internal quality assurance programs.

Poor involvement and buy-in of medical doctors in the quality improvement process was stated as a challenge. Some participants have stated that doctors are not on board with the quality improvement processes (both internal and external) and that affects the scoring of the institution. The participants feel that, medical doctors are important key players in the improvement of quality and accreditation process but yet seem to have less interest in the process.

Some staff have further highlighted that, there are no consequences to the physicians that do not adequately document or update patient records as physicians are bringing “business” to the hospital.

“The omissions by medical doctors affected us negatively during the accreditation process. For example regarding the documentation or signing of telephoning orders, Dr’s notes and their signatures on patient documents. It would be good to bring doctors on board and have their mind set changed”

3.1.5 Theme 5: Lessons learned as experienced by participants

Oxford online dictionary defines lesson as something that is learned or is to be learned by a student (Oxford online dictionary, 2015).

The accreditation process of Mediclinic Windhoek has been described by some of the participants as a learning experience where by some participants have stated that they have increased their knowledge and skills during the accreditation process. Others have stated that they had a change of attitude and have identified factors that can enhance accreditation success as well as negatively impact the accreditation.

3.1.5.1 Sub-theme: Lessons learned by participants regarding quality improvement efforts

Quality improvement in public health is defined as the combined and unceasing efforts of everyone; health care professionals, patients and their families, researchers, educators to make changes that will lead to better patient outcomes (health), better system performance (care) and better professional development (learning) (Batalden P & Davidoff F, 2015)

Staff have reported that there are some lessons they have learned during the accreditation process. Staff have expressed that they have come to realize that accreditation can be acquired and maintained if the hospital already has core quality assurance systems and processes in place that are regularly and continuously monitored and evaluated. Vast majority of participants have further stated that, if strict supervision is employed, even prior accreditation then things will be

done accordingly. Participants have emphasized on the vital role that supervision plays in staff performance. One of the key participants indicated:

“On-going supervision is very important, not just during accreditation but even before. It should be part of quality assurance”

(Participant 20)

One of the participants mentioned that the greatest lesson they have learned while working at Mediclinic Windhoek for a couple years is that quality improvement and accreditation takes off once the basics of service delivery are improved. The enrolled nurse stated that:

“If you want to be successfully accredited, start by improving the basics. The basics are like improving nursing care. When you start with the basic then the foundation is stable”

(Participant 21)

3.1.5.2 Sub-theme: Expressions by participants on accreditation as a process of continuous learning

Most of the participants have stressed that the accreditation was a learning experience and a hospital becomes a learning institution as they continuously strive to improve the delivery of quality care. Participants felt that the quality improvement and accreditation process aided them

in understanding that a hospital is a learning environment and learning doesn't not end with formal education. This was echoed in the following sentiments:

“Throughout my work experience, I can say that Mediclinic is one of the places I worked that is a teaching environment. Here there is the right way to do things. There are guidelines and policies in place”

(Participant 22)

“You must continue learning the procedures. A hospital should have a process of reviewing procedures so that staff can do it correctly in the wards”

(Participant 23)

3.1.5.3 Sub-theme: Experiences made by participants regarding maintaining of good record keeping

Record keeping is the act or occupation of keeping records or accounts (Oxford online dictionary, 2015). Record keeping in health care is central as medical records are legal documents and are a source of information. Additionally, record keeping supports patient care as well as facilitate continuation of care. Record keeping enables different care givers to communicate, collaborate and coordinate patient care and intended outcomes.

Participants have reported and emphasized the importance of record keeping as one of the lessons they have learned during and after the accreditation process.

Some staff have reported that having good or proper record keeping positively affects the implementation of quality improvement programs especially accreditation. This, according to the participants; supports the rule of “*what is not recorded is not done*” of which accreditation entirely revolves around presenting proof or evidence that there are processes and systems. Documenting also provides evidence that a certain health care was given to the patient correctly.

The following statements were evidence of this:

“During accreditation, it helps a lot when you have your files up to date. It is good when you have your record keeping in order”.

(Participant 24)

“Maintain good record keeping. If it is not written then it is not done. Even when you have done something wrong, write it down. It helps you improve when patient file audits are done”

(Participant 25)

3.1.5.4 Sub-theme: Expressions made by the participants regarding communication

Communication as key has been experienced and expressed by the participants. According to Webster (2012), communication is perceived as an act or process of transmitting information in the context of ideas, behavior, attitudes and emotions. Communication takes place between more than two people when one passes information to another.

It is evident that there should be a sender and a receiver. There are two types of communication; verbal for example, face to face conversations, communications via the phone, television or mass media, whereas non-verbal communication includes body language, gestures, dress code and so on. It is imperative to have sound or good communication skills for your message to be received well.

One of the lessons learned by the participants is the importance of open and closed communication that leads to success (Chipare, 2014).

Study participants have emphasized that they have learned that communication plays a huge role in successful implementation of quality improvement and accreditation. Participants stated that communication between staff and management is imperative; as much as communication between staff and departments. Staff were quick to point out that, open communication enhances team work and also facilitates continuous learning in a work environment.

Additionally, participants stated that communication between the hospital and the patient is also important. This type of communication builds the trust that the patient has in the staff and that enhances the satisfaction of the patient who is like a client for private owned health facilities.

“Having a positive attitude towards the colleague and the patient plays a big role in the overall delivery of care. The core values for Mediclinic helps shape our culture and attitude. It also helps how we communicate”
(Participant 26)

“Regular meetings and feedback with staff and the quality assurance committee is important for the continuous improvement of quality activities”
(Participant 27)

“The client satisfaction survey helps us improve our delivery of care so that the patient is satisfied with the service we give”
(Participant 28)

Objective 2: To explore and describe critical success factors leading to the accreditation of Mediclinic Windhoek

3.1.6 Theme 6: Participants perceptions or experiences regarding success factors that leads to accreditation

Success is the accomplishment of a purpose or an aim (Online Oxford dictionary, 2015).

For the purpose of this research study, success elements are factors that contributed to the fruitful accreditation of Mediclinic Windhoek as experienced or known by the research study participants. These success factors are self-reported by the participants who experienced and underwent the process of accreditation.

According to COHSASA (2015) full accreditation is attained when all service elements score at least 80/100 and there are no non-compliant service elements or criteria that could result in injury of patients and staff (COHSASA, 2015).

3.1.6.1 Sub-theme: Participants experiences regarding internal quality monitoring systems and processes

In order for organizations to measure or determine that the standards are adhered to in the process of rendering care; the institution has to have processes and means in place to measure improvement as a result of an intervention. When organizations are striving for accreditation, it is imperative to have process measures in the organizations in order to inform the organization of the progress as well as create a balanced set for monitoring the progress of improvement.

Frush & Krug, (2015) stated that process measures help determine whether an activity has been accomplished and this helps track the progress of the project. Internal quality monitoring systems requires the organization to have tools and resources in place to implement, record, monitor and evaluate the administration of care against the set standards. Additionally, these monitoring systems need to have an approach of addressing and correcting deviations from the set standard of care delivery.

Common in most participants report is the continuous internal quality monitoring in the hospital. Participants have reported that the hospital has an internal quality monitoring program known as MQUAT that enables the hospital to monitor adherence to standards even outside accreditation.

The process involves Managers and head of departments assessing and documenting staff adherence to different policies and standards of the hospital. It was additionally reported that as part of the quality assurances policies, staff are required to conduct monthly patient audits whereby departments review patient care including documentation. This process enables staff to pick out gaps in service delivery and they come up with a plan of action to address any gaps when identified. This process, according to participants is a very important process that enables continuous learning for staff.

Additionally, it makes it a learning process because both management and staff are committed towards improve service delivery so that patients are satisfied with the quality of care rendered. Some staff have reported that patients admitted to Mediclinic are given an opportunity to rate

their stay at Mediclinic Windhoek. The hospital has mobilized the staff to be reporting adverse events. According to the staff, they don't see the reporting of adverse events as an opportunity to be blamed, but they see it as an opportunity to improve the system and monitor the systems so that it remains intact in delivering quality care.

The following statements are evidence of this:

“Each department has quality Improvement Programs which enable departments to continuously better themselves”

(Participant 29)

“There is a client service manager who comes in and asks the patient questions regarding their hospital stay, and she will come back to us or the management if there is a complaint or the patient is unhappy. Every day the client service manager comes in”

(Participant 30)

3.1.6.2 Sub-theme: Participants experiences regarding patient centered approach

Epstein and Street, (2011) define patient centered approach as an approach to where by health care providers are rendering care to patients in a more collaborative manner with the patient. This means that care rendered to a patient while the patient is partaking in this care. Additionally, patient centered care involves helping the patient be involved, informed, respected and listened to.

This approach was stated as one of the important approaches in delivering quality of care to patients.

Most of the participants were proud to state that in their job, they are centered towards customer care and satisfaction and so they look forward to being evaluated by the patients so that they can improve on things that need improvement. They have further stated that one of the hospital's values is to apply a patient centered approach in rendering patient care and they strive to uphold the values of Mediclinic Windhoek. Some staff have stated that apart from the continuous internal quality programs, they also rely on the feedback given by the patients to improve the care they render. Although the feedback given by the patients at times don't impact the elements of accreditation, it helps them improve the image and reputation of Mediclinic Windhoek. One of the enrolled nurses noted:

*“Here at Mediclinic Windhoek we emphasize more on client satisfaction. We are more centered towards client satisfaction, the patient journey at the hospital and how we can satisfy the patient”
enrolled nurse participant.*

(Participant 31)

The participant further elaborated that, it is hospital policy to administer a questionnaire to the patient on a daily basis, to assess the satisfaction of the patient with the care rendered to him or her. The hospital has care ambassadors that go from door to door within the hospital to assess this. The final report is given to the unit Manager especially in cases where the patient is dissatisfied with the care he/she is receiving. One of the participant supported this and said:

“All these things help us improve. If there is a complaint, the unit Manager will look in to it. For example if the TV is not working, then we will liaise with the technical team to come and fix the TV”.

(Participant 32)

Most participants have stated that, these patient questionnaires allows for timely response and management of problems so that errors and shortcomings in the system do not accumulate and go unaddressed. One of the unit secretary participants made the following statement:

“This questionnaires help the Managers identify weak points and immediately take action. Here we don’t wait or ignore a problem, we act immediately”.

(Participant 33)

Although the Mediclinic hospital is patient satisfaction and the staff strive to maintain and fulfill the value for the hospital, one of the participant mentioned that the love for their job motivates them to deliver on their job description as well as contribute to the commitment of rendering patient centered care which positively influence the quality of care delivered. In her own words the responded said:

“The love for my job makes me give quality care to my patients. When I come to work, I see it as a calling because I know that I am happy when the client is happy”.

(Participant 34)

3.1.6.3 Sub-theme: Experiences of participants regarding availability and implementation of policies

For the purposes of this research study, availability and implementation of policies refers to the ability of hospital policies to be used, obtained or be at some one’s disposal especially the staff (Online Oxford dictionary, 2015).

In order for services to be rendered according to the set standards and accuracy, it is vital for an organization to have guiding documents such as polices and guidelines to direct the implementation of activities and the conduct there of.

Health care workers need to be trained in this guiding documents to ensure that they comprehend the guidelines and they are able to access, review and implement the guidelines as stipulated by the organization. Policies enable an organization to have a standardized manner of executing tasks which in turn protects the patient and the health care provider.

Vast majority of staff have reported that Mediclinic Windhoek was successfully accredited because there are clear accessible policies, guidelines and the evaluations for adherence to policies are regularly, consistently and strictly checked. This process is done by conducting compulsory training procedures for specific wards as well as offering staff free courses to enroll in. Once staff have enrolled on a short course and completes the course, they are awarded with MAP (Mediclinic Accreditation Program) points of which certain cadres of staff are expected to have. Staff have expressed that they are motivated to do short courses because they grow personally and they are able to deliver on their outputs as per their job descriptions.

One of the research participants in the registered nurse group cited:

“We have 6 months and 3 months courses on things like pain management. We do these courses and it keeps you updated. It boosts your confidence. The courses are free. Mediclinic pays for it”

(Participant 35)

“We are motivated to do these course because you gain knowledge and you get MAP points and get a certificate. Mediclinic has a policy where a registered nurse has to get 30 points in a year. It keeps you updated and helps you maintain the standards”

(Participant 36)

Astonishingly, one of the participants in the registered nurse group felt that her department “rehearsed” to prepare for accreditation. The participant stated that there was a lot of “spoon feeding” prior the accreditation and there is actually a lot of room for improvement in their department. The participant said:

“If COHSASA walks in today we will fail because they prepared us for COHSASA. The files are nice and neat. We clean the drawers when they look for neatness, we check registers for completion to see if the specialist’s initials are there. I don’t know about other wards but our ward doesn’t get feedback. I don’t know what mistakes were found”.

(Participant 37)

One of the key informants has stated that having up to date policies that are known and monitored for adherence has contributed to the successful accreditation. The availability of up to date policies enables the staff to know what is expected and allowed in the hospital setting. The

participant have further emphasized that, having standards or policies is the cornerstone to improving quality of care. Policies are there to guide staff. Some nurses have highlighted that, if a hospital is striving for accreditation, their staff need to be regularly and continuously trained in the specific policies.

Some staff have also reported that in-service training and orientation of hospital policies and culture is essential in successful accreditation. The following statement from the study participants echoed to support this success factor:

“We revise standards every three months to make sure that we don’t go off the rail. We have an internal “mini COHSASA” that checks the standards. We also have the MQUAT that is involved in the evaluation of departments. These evaluations are more or less the same as the ones COHSASA looks at”
(Participant 38)

3.1.6.4 Sub-theme: Experiences of participants regarding performance appraisal

Performance appraisals are a vital part of supervisory responsibilities. Appraisals are not only beneficial for the employee but are equally beneficial for the organization or the employer (Shi & Johnson, 2014). Although performance appraisals inform organizational decisions to determine promotions, salaries demotions, lay-offs and terminations; they also equally provide a mechanism and opportunity for employees to receive useful coaching as well as suggested changes in behavior, attitudes, knowledge and skills (Shi & Johnson, 2014).

The majority of participants have stated that there is a systematic process to assess staff performance as well as provide feedback regarding their performance. All the staff including the Managers are regularly assessed on the deliverables on job performance. Managers and head of departments are committed to regularly assess and support performance of staff working under their authority. The findings of the performance assessment of staff are then used to either appraise a staff member. The assessment indicates whether there were or were no gaps in performance. In cases where gaps are identified, capacity building plans are designed with non performing staff in areas needing attention; for staff to improve and deliver care that is up to the predetermined standards of Mediclinic Windhoek. The following statements are evidence of this:

“We constantly have trainings and we have evaluations to check our performance. If there are challenges with your performance then you develop a capacity building plan with your supervisor”

(Participant 39)

“The involvement of management is a success factor. Here the management is always involved in everything. I know that there is always someone who will ask questions on how I treat the patient. The management is always there to assess how you are doing”

(Participant 40)

One of the participants highlighted the role team work plays to enhance on job performance. The participant quoted that:

“We work as a team. If there is something difficult that you are struggling with then you highlight it so that it can be given attention”

(Participant 41)

“Mediclinic management makes sure that you know what your role is, what your job description is and ensure that you concentrate on it”

(Participant 42)

Another participant supported that team work

between all staff and management contributes to successful accreditation by saying:

“There is high team spirit. There is team work. We do team building activities. As a matter of fact we just came from a team building activity”

(Participant 43)

One of the participants felt that, caring for other work colleagues beyond the workplace enhance team work. That; the participant feels it strengthens the relationship between staff and it positively impacts team work.

Staff have stated that the system of having corrective counselling applied to staff who have been identified to require further support to enable them deliver and carry out their job descriptions has contributed greatly to the improvement of the delivery of services at Mediclinic. Some staff

have attributed the successful accreditation of the hospital to the staff appraisal system that encourages staff to strive to deliver quality care as well as on job performance.

3.1.6.5 Sub-theme: Experiences of participants regarding organizational values, culture and attitudes

Oxford dictionary defines values as a person's principals or standard of behavior or ones judgement of what is important in life (Oxford Online dictionary, 2015).

Just like people, organizations can define their standard of behavior of which all employees simulate and adhere to in order to create a value system for the organization.

Culture is refers to the customs, arts, social institutions and achievements of a particular nation or people (Oxford online dictionary, 2015). For the purposes of this study, the Mediclinic Windhoek culture refers to the customs and way of doing things and achieving results at the Mediclinic Windhoek hospital. Attitude is a settled way of thinking of feeling about something or someone, typically one that is reflected in someone's behavior (Oxford online dictionary, 2015).

The spirit and culture of team work was one of the success factors that staff attribute the successful accreditation of Mediclinic Windhoek. Staff have reported that there is a culture of team work within departments as well as interdepartmental. They have additionally reported that, one is motivated to do your work because everyone else is doing their part. According to the

participants, staff as well as management are committed and put in a lot of effort in upholding the standards and satisfying the patient.

One of the study participants emphasized that, their clarity and understanding of the role that each department plays to the overall health service delivery motivates them to bring their part. The participant has further stated that, it is in each department and individual's contribution that will satisfy the patient as well as achieve quality care. The following statements are evidence of

this:

“Our attitude and sense of responsibility helps us succeed. I know I am responsible for the patient so I know how to behave. You have to try to be professional all the time”

(Participant 44)

“Discipline played a big role. Punctuality and dealing with things on time like giving the medicine of the patients on time. Also when I do my procedures, I can't take a short cut, I need to do it as I was taught”

(Participant 45)

Most participants stated that, there is a positive attitude towards the reporting of adverse events. Mediclinic Windhoek introduced an adverse event reporting program as way of working towards quality improvement at the hospital. The participants stated that, the staff have a positive attitude towards adverse reporting as the program findings are not used to punish the staff but rather to

identify weakness so that they are changed into strengths in order to support quality improvement efforts of the hospital. The following statements are evidence of this:

“We introduced the adverse event reporting program. Back in the days the program was misunderstood because when people were asked to write an adverse event report they thought that it was for punitive purposes. I had to really give training to the people to change the misconception about the program. I now think that people are comfortable with the reporting of adverse events as they now know that it’s not about an individual. Now there is a culture of reporting adverse events”

(Participant 46)

“If you know your policies then you will do what you are supposed to do. Here you must be accountable for your actions. People work as a team and people encourage each other to do the correct thing and help those that don’t know”

(Participant 47)

3.1.6.6 Sub-theme: Experiences of participants regarding in-service training and orientation program

In-service training refers to the capacity building efforts that Medclinic implements in order to improve and increase the knowledge of staff regarding the implementation of tasks and execution of job descriptions. In service training and orientation is not only beneficial to the employee but it benefits the organization too.

Shi & Johnson (2014) refer to such efforts as professional development. Professional development includes mentoring programs, training, and employee involvement in organizational improvement as well as decision making. They have further cited that professional development pays off in two key ways. Firstly, professional development leads to greater job satisfaction by the employees, improved morale, reduced staff turnover as well as improved performance (Shi & Johnson, 2014). Secondly, an organization benefits from staff with a wide range of skills, knowledge and attitudes.

Some staff have stated that the orientation program for new staff initiates them to perform and adhere to the quality standards that the institution has in place. New staff undergo about a month's long orientation period where they are familiarized with their work environment, the culture and policies. During the probation and orientation period, the new staff is attached to a mentor who supports the staff to learn and settle in to the new work environment. A mentor is trained and certified to work as a mentor.

Some staff have highlighted passion and love for the job as one of the factors that contributed to accreditation. They have stated that having love for their job keeps the staff motivated to render quality care to patients. Having a mentor and a support system keeps them motivated and willing to learn.

The training that the staff undergo is not just oral training, but it also involves practical demonstration of different medical procedures. Some staff have additionally stated that, on a

regular basis, staff are assessed on selected procedures to monitor for compliance and compliance gaps.

The following sentences are evidence of this:

“In-service training of staff is vital. Mediclinic invests so much in-service training. All the staff members in all departments are expected to do certain procedure that are specific to that department. Example surgical ward will be evaluated on the hand washing procedure or wound dressing. At the end of the day, even unit Managers are evaluated on how they manage their units as well as on how the units are performing. That way unit Managers make sure that the people under them perform”

(Participant 48)

“Every department has 5 basic procedures that you have to do. After orientation, you do those procedures. I think after a year or so, you do the procedures again. It is compulsory so that the standards are kept”.

(Participant 49)

The participants have reported that, although the evaluations keep them on their toes as far as rendering quality care according to set standards; they also appreciate the assessments as it ensures that a certain procedure will be done by different nurses in the same manner which depicts quality and professionalism towards the patient. Some staff have supported that and have additionally mentioned that, every department has 5 compulsory basic procedures that they continuously assess among the staff of that department. Once staff are assessed regarding

compliance to the standards, feedback is given, gaps identified and a plan of action is developed to address the gaps.

When asked about the role that staff have played during the accreditation process, most of the staff have reported that their role during accreditation has not changed much and they were expected to just perform and deliver according to their job descriptions. Most participants have reported that accreditation doesn't change their roles, rather it is a continuation of their normal routines. A participant reported that, she feels that if you are already carrying out your job description in line with the set standards and policies then there is no need to get a different role during accreditation or making quality improvement as an intervention that is extra work to your employment duties. One of the participants with a technical background said:

“Our normal day to day role didn't change during the accreditation. Basically, everyone has a job description and if we keep in line with that we will meet the role we have to play during accreditation”

(Participant 50)

3.1.6.7 Sub-theme: Experiences of participants on support staff in wards

Some staff have described their success factors by comparing what Mediclinic Windhoek has in place compared to public hospitals and some private facilities. The Mediclinic hospital has support staff who assist with non-medical care of patients. Some participants stated that

Mediclinic Windhoek has support staff who makes the workload easier for the nurses as the nurses now don't have to be doing routine activities like bed making, full washes, feeding patients as well as preparing for admissions and discharges of patients. There are two types of support staff: Those responsible for pampering patients' i.e. doing their hair and nails; as well as the unit secretaries that assist with the administration involved in discharging patients.

Nurses have also supported these sentiments by stating that work like bed making, full washes, feeding patients that are unable to eat by themselves, administration takes up a lot of their time to do clinical work.

Nurses have also further highlighted that the fact that the hospital has technicians available 24 hours makes their work easier as equipment are serviced and repaired on time. They have expressed the frustration of nurses working in other hospitals that don't even have the necessary equipment or utilities to render quality care.

The following statements are evidence of this:

“At Mediclinic, you don't have an excuse not to do your work. Everything is provided for you. All the equipment and materials to do your work is available”

(Participant 51)

3.1.6.8 Sub-theme: Experiences on availability of equipment

For the purposes of this research study, medical equipment refers to any needed item in the hospital to fulfil the purpose of care according to set standards.

Participants have reported that, availability of state of the art medical equipment enables them to deliver quality care to patients and it actually goes beyond just availability for accreditation. Staff have expressed their pride for the fact that the hospital ensures that all needed equipment and utilizes are available. The hospital also has mechanisms to service and check equipment on a regular ongoing basis.

According to most staff, have technicians at hand 24 hours in a hospital greatly supports and make it tranquil for the staff to render quality health care. The staff responsible for servicing and taking care of the equipment have job cards and schedules to ensure that equipment are checked and validated. Additionally, there is a Manager allocated to supervise and ensure that job cards are completed and equipment are serviced, repaired and replaced when need be.

One of the technical staff supported that by saying:

“We have Managers that ensure that we take our job seriously and that we perform. We receive a job card and you fill in what you have done. The Manager checks the schedules daily as well as looks at the job cards on a weekly basis. Job cards are signed off by the Manager when the job is done”

(Participant 52)

3.1.6.9 Sub-theme: Experiences of participants regarding leadership and management

Leadership is defined as the act of leading a group of people or an organization (Online Oxford dictionary, 2015).

Leadership and management are interdependent and complementary roles that can enhance organizational success (Shi & Johnson, 2014). Although these terms at times are used interchangeably, Shi & Johnson, (2014) have distinctively described the difference. According to them, Leadership has a lot to do with the future of an organization. “Leadership assures that the organization has an appropriate vision of the future which is informed by boundary across and external connections, and it tests its vision’s viability through calculated risk” (Shi & Johnson, 2014).

Meanwhile, Shi & Johnson (2014), state that “management focuses on the current or present, assuring that operations that support the vision and mission run effectively and efficiently” (Shi & Johnson, 2014).

Shi & Johnson, (2014) gave an example of the difference between leadership and management which can be equated to the Mediclinic Windhoek context. Their example is that, in a health care setting, leadership would set a goal for the organization of achieving the highest possible quality improvement recognition by going through an accreditation program. Management would then operationalize and oversee the implementation of activities that will help reach the attainment of

the goal. Management would also be involved in managing the people and the resources needed for the attainment of the goal (Shi & Johnson, 2014).

The role that the management and leadership of Mediclinic Windhoek played in the accreditation was perceived and appreciated by the participants.

Some staff have reported that Mediclinic Windhoek has been successfully accredited because of the seriousness and commitment of the management in carrying out their management and supportive roles. Most staff have expressed that the management of Mediclinic Windhoek as well as the head office staff are hands on regarding to timely response of crisis. There is effective enforcement or monitoring of compliance to standards even when it's not accreditation time.

Some of the participants stated that, the Mediclinic management has a system of dealing with non-adherence to policies. The participant has specifically mention that there are repercussions for not abiding to the rules of the organization. The seriousness and consistency of the management in checking for adherence and having policies in place is transparent. According to the participants, transparency does impact positively the culture at work which then positively impacts service delivery.

The participant said that:

“There is transparency, a lot of transparency. Even when it comes to the uniform or dressing code and punctuality at work. Here at Mediclinic you know the rules and you know that you must abide to the rules. There are consequences for not abiding to the rules”

(Participant 52)

Another participants believed what the other participants said. This was expressed by the following

“We have strong discipline. We are disciplined. We know our policies. We are not allowed to have nail polish for those that are working with patients and hair must be tied at the back. The Managers come and check these things. But even when you come here, you feel the need to be properly dressed”

(Participant 53)

ng
quote:

Very few staff however have expressed that at times, management is not always transparent in handling staff and patient conflict. Although this is not directly associated to the accreditation success, it negatively impacts their motivation of which according to them is an essential ingredient to delivering of quality care.

“There are values that guide us. Mediclinic has values that we strive to achieve and keep. We have five values: patient safety, client orientation, mutual trust and respect, performance driven. So we strive to build on these values. As managers when we strive to live it out so it will have an impact on the staff. We need to be role models”

(Participant 53)

“Proper and good supervision contributed to the successful accreditation. They do audits here. Any patient file can be taken and be checked and if there is anything wrong then you will be called to be accountable and to learn from your mistake. The audits are done by the staff also.

(Participant 43)

CHAPTER 4

CONCLUSIONS, RECOMMENDATIONS, LIMITATIONS AND SUMMARY

4.1 Introduction

This chapter deliberates on the discussions from the study findings and the conclusion derived from the findings of the study in contrast to other literature. The study aimed to capture the experiences and lessons learned during the accreditation of Mediclinic Windhoek. The study also explored self-reported success factors that contributed to the successful accreditation of Mediclinic Windhoek. This chapter correspondingly outlines the recommendations as well as the limitations of the study.

4.1.1 Conclusion

This qualitative study aimed to capture the experiences and lessons learned from the Mediclinic Windhoek staff who were involved in the accreditation process. The study aimed to provide an insight of what the staff have learned regarding successful accreditation. The findings of the study are aimed to be extrapolated to public health facilities.

Although the findings of the study cannot be generalized, the findings can give an indication or an idea of what systems, processes, practices and culture that staff feel have contributed to the successful accreditation.

Objective 1: To explore and describe the experiences of staff regarding the COHSASA accreditation process

The vast majority of the participants, both key informants and focus group participants noted that the quality improvement program has enabled them to be comfortable with reporting adverse events so that corrections can be implemented immediately to improve the quality of care. It is clear from the Mediclinic Windhoek staff experiences that accreditation plays a critical role in the continuous learning process of an institutions. This role is highlighted in the peer reviewed monthly patient file audits that the Mediclinic staff are expected to review.

Cochrane, (2014) supports the impression by stating that accreditation and compliance to minimum standards enhances peer reviewable achievement of best practices as well as continuous learning and improvement. Staff have continuously mentioned that they are motivated to uphold the Mediclinic Windhoek values because of the work culture and emphasis and support by the Mediclinic management. The hospital further has systems in place to monitor for deviations from the culture, values and practices which are set by the organization to achieve quality health care and accreditation.

It is clear from the responses of the Mediclinic Windhoek staff that delivering quality health care service is far beyond just rendering care according to set standards. Additionally, even when staff of Mediclinic are assessed on procedures regularly, the majority of staff have indicated that patient satisfaction plays a huge role in affirming the provision of quality care.

This findings are consistent and in support of Ross (2013) who stated that, one dimension of quality is also determined by the satisfaction of a customer; in this case a customer is the patient. Although a hospital's definition and standard of quality maybe different to that of a patient or customer; it is important for service providers to be sensitive and aware of what the patient would embrace as acceptable standards of care.

Even though Mediclinic Windhoek is successfully accredited, there has been challenges reported through the process too. This is an indication that, even successful processes and achievements have faced obstacles. However, when an organization and its people are committed to achieving the quality that they have committed to accomplish then they will come up with means to overcome the obstacles and not give up. Commitment to quality improvement is a requisite to success (Donabedian, 2002).

The findings of the study suggest that, feedback from the patient about their hospital experience can greatly inform the hospital on what patients view as quality.

Objective 2: To explore and describe critical success factors leading to the accreditation of Mediclinic Windhoek hospital

The findings of the Mediclinic Windhoek study revealed that successful accreditation will require collaborative performance by both the management and staff. The findings further put emphasis on the importance of having systems and processes that are regularly reviewed for functionality and compliance in order to attain the quality improvement goals and objectives. Various literature has outlined that the benefits and advantages of accreditation are not only to

the consumers and organization, but the benefit and advantage of accreditation is also to the organization's staff. Cochrane has supported that by emphasizing on the role that accreditation plays in creating a culture of excellence and motivation among staff (Cochrane, 2014). It is evident from the findings of the study that staff motivation plays a very big role in attaining accreditation.

The role that management plays in the successful accreditation is undeniable. Successful managers are administrators that understand people because Managers manage and work with people. Organizations are affected by interpersonal and intergroup factors (Fallon (Jr) and Zgodzinski, 2012). Management has a strong and critical role to provide leadership, training, promote accountability as well as ensuring that compliance to set standards. Governance and leadership are key components in having effective and efficient organizations. Fallon (jr) and Zgodzinski (2012) define leadership as “skills needed or necessary to integrate rules, regulations and policies to enable the organization to not only exist but also to thrive”. Additionally, they have stated that a successful Manager must be familiar with different styles and theories of leadership and methods of shaping behaviors of individuals and groups (Fallon (Jr) and Zgodzinski, 2012). Although there has been various theories developed to analyze and explain individual behavior, these theories can also apply to groups of people (Fallon (Jr and Zgodzinski, 2012):

- **Causality:** Human behavior is a result of forces acting on people. These forces can be external or internal to an individual and these influences can be genetics, experience and environment. In contrasting the findings at Mediclinic Windhoek, the findings are

supportive of what Fallon and Zgodzinski are stating. The successful accreditation of Mediclinic can also be attributed to continuous quality improvement practices at Mediclinic which have created an environment and an ongoing experience for health workers. One of the participants in the study has lamented that, even when there is no accreditation going on, Managers always do assessments of adherence to quality standards.

Additionally, the vision of Mediclinic Windhoek is to deliver measurable quality clinical outcomes; and therefore they have strived to create an environment that supports that vision by setting standards for quality care, monitoring adherence to standards, applying corrective measures for deviations from standards as well as providing the necessary skills, support and resources to the staff to contribute towards the achievement of the vision.

- **Directedness:** Human behavior is not only caused, it is pointed toward something. This is referred to as being directed to something i.e. people want things. This theory supports the sentiments of the participants when they stated that, the way they conduct themselves at work is because they want to live up to the values of Mediclinic Windhoek. One of such values is patient safety. Participants have stated that, getting feedback from their patients on how their stay in the hospital was enables them to improve service delivery so that patients are happy and satisfied with the delivery of health care. This, the participants added; makes potential clients to choose to be hospitalized at Mediclinic rather than at any hospital whether it's a public or private hospital.

The fact that they want to be the preferred hospital in Namibia obligates the workers in Mediclinic Windhoek to shape their behavior and the organizational behavior to ensure that goals and aspirations of Mediclinic Windhoek are reached.

Motivation: A result of analyzing underlying behavior, a push, want, need, drive or motive can be found to explain most rational actions taken by individuals. Additionally, there seem to be a direct relationship between accreditation and staff motivation. Cochrane, (2014) stated that accreditation has a positive impact on staff motivation as it alleviates the fear and blame for reporting adverse events. The same sentiments have been expressed by participants when they stated that on-job motivation enables them to improve performance.

The findings of the study suggests that, successful accreditation programs principally depend on the management style as well as organizational systems of the organization to improve quality. Also, the study revealed that the management of an organization or institutions sets the tempo, culture and hugely shapes the behavior of staff. Therefore, if a Manager has to succeed with managing people, they need to understand how people operate and have a manage style that motivates people and creates a culture of delivering quality care. Furthermore, the study has also suggested that, accreditation can be achieved and maintain when health facilities or organization have continuous quality improvement systems that are already integrated in the system as part of daily health care delivery. Accountability and responsibility of management and staff has attributed to the success of Mediclinic Windhoek as this has enhanced team work, motivation and shared vision of Mediclinic Windhoek.

The findings are in support of Bjornstad and Lie (2015) who reported that the majority of staff who had accreditation programs at their institution self-reported improvement in the quality of service delivery as a result of accreditation. Additionally, the same study also states that the majority of participants reported that accreditation has improved the overall quality of services at country level. This is a phenomenon that requires further research in Namibia.

Parand et al, 2014 conducted a study titled: *The role of hospital Managers in quality and patient safety: a systematic review* and the study findings suggests that there is an association between Managerial involvement and quality and safety (Parand et al, 2014). This findings imply that QI programs succeed better when Managers are involved are supporting the planning, implementation and review of the QI programs. Furthermore, the findings highlight that senior management support and engagement was identified as one of the primary factors associated with good quality hospital outcomes and quality improvement (QI) programs.

Additionally, Parand et al, 2014 suggest that the following a key elements deemed necessary for management engagement to support QI efforts: 1) Senior management leadership and commitment 2) Provision of resources and opportunities for QI education and information dissemination 3) accountability of senior and middle management 4) Involvement of middle management is QI planning 5) Middle management own and operate the QI program.

These findings are similar to the experiences expressed by the participants in this study. The findings of this study reveal that Managers of the Mediclinic hospital are involved in the

planning, monitoring, reviewing and evaluation of progress regarding the QI program. It is also evident that there is engagement, communication and a good relationship between clinical staff as well as with the Managers. Additionally, the findings of Mediclinic suggest that the institution is intentional with the promotion of organizational culture on QI. According to Parand et al, quality improvement should be supported by organizational structures, ensuring that there is procurement of resources for QI efforts and provision of resources for staffing and staff education (Parand et al, 2014).

4.2 Recommendations

The following are the recommendations that were derived from the participant's experiences according to the objectives of the study:

4.2.1 Mobilize Medical Officers to buy into quality improvement programs

The research findings revealed that there was minimal involvement of medical doctors in quality improvement programs. Medical doctors are one of the key personnel in patient care, and therefore their involvement and contribution to quality improvement efforts is crucial. It is imperative for Mediclinic Windhoek to have a clear understanding of what the barrier is that seem to cause low involvement of medical doctors in quality improvement efforts. Involvement of all staff at all levels of an organization is crucial for success in efforts of quality improvement.

4.2.2 Lessons to the public health facilities

The research findings revealed that one of the key contributing factor to quality care in Mediclinic Windhoek is having effective management and leadership systems. Effective

management and leadership systems play an important role in ensuring that quality of care is rendered; sound organizational values, culture and principles are enforced through performance appraisal and internal monitoring and evaluation systems. Given these documented lessons from Mediclinic Windhoek, public health facilities can consider replicating these practises to their setting in order to improve the quality of care rendered in their facilities.

4.3 Further Research

Further research is needed to:

- Determine whether the successful accreditation of Mediclinic Windhoek has impacted patient outcomes, and to what extent.
- To assess whether Mediclinic Windhoek has a formally structured monitoring system to measure the extent to which the organization meets its overall objectives.
- To assess the feasibility of rolling accreditation programs to public hospitals considering the current resources and systems in place in the public sector.
- Determine if the experiences of staff and success factors change over time as Mediclinic Windhoek maintains accreditation.

4.4 Limitations

There were various limitations to the actual implementation of this study. The period of data collection was not enough to interview more study participants as the researcher was migrating out of Namibia at the time close to the data collection. The researcher and the Mediclinic

Windhoek management worked closely after the data collection process in order to cater for follow up questions or clarifications incase gaps were identified during data transcription and analysis. The researcher and the management of Mediclinic corresponded via email in cases where clarifications and additional information was needed by the researcher.

Lack of financial resources made it impossible to recruit a research assistant to assist with data collection and therefore the researcher worked around the clock to interview as many participants as available as well as utilize a tape recorder to capture the information accurately. Lack of financial resources also made it impossible for the researcher to hire a data transcriber, therefore the researcher transcribed the data herself. Although that contributed to the transcription of the data taking long before analysis, it has increased the reliability of data collected as the researcher transcribed and analyzed the data herself. At time, Mediclinic Windhoek had a high influx of patients and so focus group discussion meetings or appointment had to be rescheduled as staff were not available to participate in the study.

Summary

The purpose of this study was to explore and describe the experiences of staff regrading COHSASA accreditation. Additionally, the study also aimed to explore and describe critical success factors leading to the accreditation of Mediclinic Windhoek. The findings of this study will inform the MoHSS as they roll out quality improvement activities.

A research guide was used to facilitate the focus group discussion. Focused group discussions were used as a method of data collection from participants that experienced accreditation. A

semi-structured research guide was used to facilitate the interviews. The researcher was able to hear from the participants what their experiences were during accreditation. The participants shared their experiences, thoughts and feelings that they experienced during the accreditation process.

Themes and sub-themes were extracted from the information that the participants shared. The participants reported success factors which they think and feel have contributed to the successful accreditation of Mediclinic Windhoek.

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Annexures

Annexure A: Ethical clearance for research



Annexure B: Permission to conduct research: Mediclinic Windhoek

The screenshot shows an email interface with the following details:

- Sender:** Conteh, Ndeshiteelela <nconteh@msh.org>
- Recipient:** elmariev, gordonc, gordonchristin., basenero, jacqui
- Date:** 1/30/14
- Subject:** Dear Ms Vink
- Body:**

My name is Ndeshi and I work for Management Sciences for Health (MSH). MSH through funding from USAID is supporting the Ministry of Health and Social Services to implement the Quality Improvement and Leadership (QIL) Programme through the CoHSASA accreditation programme. I am also doing a Master of Public Health and I am interested in documenting the experiences of Medi-clinic during the accreditation process, of which medi-clinic remains the only CoHSASA accredited health facility in Namibia. The plan is that the findings and the research report will be utilized by the MoHSS to roll out their QIL as well as contribute to lessons learned in country and perhaps globally .

My research proposal is still with the University of Namibia, pending post graduate approval but I am willing to share with you the draft proposal. I am also available to conduct a presentation to the relevant Med-clinic management if need be.

The screenshot shows a reply email with the following details:

- Sender:** Vink, Elmarie <elmariev@mediclinic.co.za>
- Recipient:** Ndeshiteelela
- Date:** 2/4/14
- Subject:** Dear Ndeshi, Your request has been approved. Regards,
- Body:**

Dear Ndeshi,
Your request has been approved.
Regards,

Elmarie Vink
Hospital Manager
[MEDICLINIC WINDHOEK](http://www.mediclinic.co.za)

Helidoor Street
Eros, Windhoek
PO Box 9819
Windhoek
T +264 61 433 1000
F +264 61 220 027
M +264 81 230 5847
www.mediclinic.co.za

Annexure C: Research Guide

Date:

Group:

EXPLORING THE LESSONS LEARNED FROM MEDICLINIC WINDHOEK ACCREDITATION PROCESS FOR EXTRAPOLATION TO PUBLIC HEALTH FACILITIES

- 1. Greet and introduce yourself to the participants**
- 2. Explain the purpose and objective of the research**
- 3. Obtain verbal consent to interview participants**
- 4. Assure the participants of anonymity, confidentiality and voluntary participation**
- 5. Assure participants on feedback after the findings**

8. What is your understanding of quality? What is quality improvement?
9. What was your role in the accreditation process?
10. What would you say are critical things that contributed to successful accreditation of Mediclinic Windhoek and overall quality improvement?
11. Were there any challenges during the accreditation process? How did you overcome them?
12. Is there anything that could have been done better? What are the specific recommendations?

13. What would you say are the lessons learnt from this process? In your view are there any lessons that can be applied to other health facilities?
14. Do you think care has improved at Mediclinic Windhoek after accreditation? Please elaborate or explain with specific examples in the areas where quality has improved