HEALTH CARE USERS' EXPERIENCES AND PERCEPTIONS OF WAITING TIME AT A DIABETES CLINIC IN AN ACADEMIC HOSPITAL

Monica Maphefo Mokgoko

HEALTH CARE USERS' EXPERIENCES AND PERCEPTIONS OF WAITING TIME AT A DIABETES CLINIC IN AN ACADEMIC HOSPITAL

Monica Maphefo Mokgoko

A full dissertation submitted to the Faculty of Health Sciences, University of the Witwatersrand in fulfilment of the requirements of the degree
of
Master of Science in Nursing

Johannesburg, 2013

DECLARATION

I, Maphefo Monica Mokgoko declare that this full dissertation is my own work. It is being submitted for the degree of Master of Science in Nursing at University of the Witwatersrand, Johannesburg. It has not been submitted before for any other degree or examination at this or any other University.

MAPHEFO MONICA MOKGOKO

This _____day of_____2012

The Human Research Ethics Committee (Medical)

Clearance certificate: M090908

I DEDICATE THIS RESEARCH TO:

1. Mr. M. J. Letuke, (my father) I will always remember your words of encouragement. (Robala ka Kagiso, Kgabo)

2. Mrs. A. N. Letuke, (my mother) I thank you for your prayers and blessings for all the best in my life.

3. Mr. M. J. Mokgoko, (my husband) your ability to protect, support and provide for your family remain the unforgettable memories. (Robala ka Kagiso, Kgabo).

4. Dr. Didintle Mokgoko, (my daughter-first born) I will always be grateful for your support during literature search and critique for language proficiency.

5. Ditiro Mokgoko, (my daughter -second born) for your unconditional love, support and understanding for my circumstances. Your assistance with graphs, printing and general computer skills was unbelievable.

6. My sisters and brothers, thank you for your continued support.

"KE LEBOGILE BAKGATLA"

ACKNOWLEDGEMENTS

I would like to express my sincere gratitude to the following:

1. The Almighty God for carrying me through all the days of my life.

1. Participants in this study for their willingness, patience, and cooperation.

2. My sincere thanks to the staff at the diabetes clinic for their support.

3. Dr. L. M. Modiba, I would like to thank you so much for your great support, patience and words of encouragement after listening to both my study and personal challenges.

4. Mrs. M. A. Ntswane-Lebang for your guidance at the time when my spirit was down. You reached out and held my hand to comfort me during your supervision and restored my confidence. (Posthumously, I thank you)

5. Prof. J. C. Bruce, my greatest gratitude goes out for your unreserved guidance, encouragement, and positive criticism regarding ideas, language or the choice of words. You are open, accommodating, non judgemental and willing to educate. I will forever be grateful.

6. Prof. J. E. Maree, you came in when my progress was compromised and you reminded me that there is light at the end of the tunnel. I regained strength when you shared your personal experiences regarding your studies with me. (Daarvoor sal Ek altyd baie dankbaar wees).

7. Ms. S. Schmollgruber, your comments and suggestions took this study to completion. Your support and believing in me will be appreciated always.

ABSTRACT

Despite the technological developments in medical care, patients still experience unacceptable levels of waiting time (Barlow 2002). Health care users perceive waiting time as a problem and this is articulated by media reports on how citizens complain about long waiting before receiving any medical attention especially for a prearranged appointment. They express dissatisfaction about long waiting time at various departments such as admissions, casualty, polyclinic, and pharmacy. Waiting time is perceived as a problem equal to lack of access to health care services in South Africa and internationally. These complaints prompt negative media reporting about health care services at public hospitals and clinics. Such damaging reports about health facilities may prevent nursing and other health professions from attracting neophytes. The result will be more staff shortage that impacts negatively on waiting time. On the other hand the working class citizens expect to receive health care services in public health facilities timely and go to work.

Unfortunately patients and their relatives wait longer than they anticipated and the waiting causes anger, anxiety, fear, frustration, and sadness. These emotions are caused by lack of information about the doctors' whereabouts and often cause conflicts between users and health workers. Some public hospitals and clinics do not have mechanisms on information giving regarding the doctors' activities that may affect the waiting time. This information may assist patients to make informed decisions whether to wait or reschedule an appointment. In an attempt to reduce waiting time the Gauteng Department of Health introduced several measures. The problem statement for this research study is that health care users express dissatisfaction about waiting time at public health facilities and they lodge complaints which make approximately 20-30% of the Patients Complaints Hotline in the Gauteng Province.

It was in view of this problem statement that the purpose of this research study was formulated to explore health care users' experiences of waiting time at a diabetes clinic in an academic hospital and describe perceptions to which they give rise; in order to utilise the findings to facilitate formulation of policy guidelines for management of waiting time aimed at promotion of comfort in the outpatient departments..

To achieve the purpose of this research study, one research question needed to be posed as follows:

1. What are your experiences of waiting time at this diabetic clinic?

To address this research question, four objectives were formulated as follows:

1. To explore and describe health care users' experiences of waiting time at a diabetes clinic in an academic hospital.
2. To describe perceptions that health care users' experiences of waiting time at a diabetes clinic, give rise to.
3. To produce recommendations that will facilitate formulation of proposed policy guidelines.
4. To develop a proposed policy and guidelines on Promotion of Comfort in the Out Patient Departments to enhance client satisfaction of waiting time.

To achieve these objectives, qualitative research that is explorative, descriptive, contextual, and theory generative was used. Purposive sampling was used and patients and their escorts excluding children were interviewed. Sources of data collection were interviews, observations, waiting time records and photographs. Individual interviews were conducted with the participants and recorded on the audio tape. Observation of the setting succeeded the individual interviews to verify or nullify what the participants mentioned.

The waiting time documents were analysed together with the photographs of significance to this research study. Tesch's steps of qualitative data analysis were followed. Necessary permission was requested and obtained from Gauteng Department of Health, management of the academic hospital and the participants. Ethical and protocol approval were obtained from Human Research Ethics Committee and Postgraduate Committee at University of the Witwatersrand. The findings of this research study concurred with the problem statement that health care users express dissatisfaction with waiting time at public health facilities. Five themes and nineteen subthemes emerged and the results indicate that approximately 100% of participants experienced emotional distress while 60% of participants reported physical distress. Approximately 30% of participants developed coping mechanisms due to the discomfort. There was a feeling of helplessness that was mentioned by approximately 50% of participants. Lastly perceptions were created in approximately 50% of participants. Recommendations of this research study were produced according to the objectives that were to facilitate formulation and development of a proposed policy and guidelines.

TABLE OF CONTENTS

DECLARATION	I
DEDICATION	II
ACKNOWLEDGEMENTS	III
ABSTRACT	IV
TABLE OF CONTENTS	V
LIST OF GRAPHS	VI
LIST OF TABLES	VII
LIST OF PHOTOGRAPHS	VIII
LIST OF MODELS	IX
LIST OF ANNEXURES	X

CHAPTER ONE: ORIENTATION OF THE STUDY

1.1	INTRODUCTION	1--2
1.2	BACKGROUND	3--8
1.3	RATIONAL OF THE STUDY	9--10
1.4	PROBLEM STATEMENT	10--11
1.5	PURPOSE OF THE STUDY	11—12
1.6.	RESEARCH QUESTION	12

1.7	RESEARCH OBJECTIVES	13
1.8	CENTRAL THEORETICAL STATEMENT	13—14
1.9	RESEARCHER' ASSUMPTIONS	14
1.10	PARADIGMATIC PERSPECTIVE	14
	1.10.1 Meta-theoretical assumptions	15--19
	1.10.2 Theoretical assumptions	19
	1.10.3 Operational definitions	19--20
	1.10.4 Methodological assumptions	20—24
1.11	RESEARCH METHODOLOGY	23
	1.11.1. Research Design	23--24
1.12	ETHICAL CONSIDERATION	25-26
1.13	OUTLINE OF THE DISSERTATION	26—27
1.14	SUMMARY	27

CHAPTER TWO: RESEARCH METHODOLOGY

2.1	INTRODUCTION	28
2.2	RESEARCH OBJECTIVES	28
2.3	RESEARCH DESIGN	29

	2.3.1 Qualitative Inquiry	29—31
	2.3.2 Exploratory Research	31—32
	2.3.3 Contextual	32—33
	2.3.4 Descriptive Research	33—34
	2.3.5 Setting	34—37
2.4	RESEARCH METHODOLOGY	38
	2.4.1 Population and Sampling	38
	2.4.1.1 Population	38
	2.4.1.2 Sampling Method	38
	2.4.1.3 Sample Criteria	39
	2.4.1.4 Sample Characteristics	39—43
	2.4.1.5 General Characteristics	40—43
	2.4.1.6 Sample Size	43
2.5.	Data Collection	44
2.5.1	The Process of Data Collection	44—49
2.6	DATA ANALYSIS	49-50
	2.6.1 Coding Procedures	51
2.7	MEASURES TO ENSURE TRUSTWORTHINESS	51

2.7.1 Credibility 51

2.7.2 Dependability 51

2.7.3 Transferability 52

2.7.4 Confirmability 52

2.8 SUMMARY 55

CHAPTER THREE: DISCUSSION OF RESULTS AND LITERATURE REVIEW

3.1 INTRODUCTION 56—59

3.2 THE INTERVIEW SETTING 59--60

3.3 OVERVIEW OF DATA ANALYSIS 60

3.4 THEMES AND SUB-THEMES THAT EMEGERGED 60--62

3.4.1 Theme One: Physical Distress 62

3.4.1.1 Sub-Theme: Poor access to health care services and service points 63--66

3.4.1.2 Sub-Theme: Long waiting for doctors and medicines 67--79

3.4.1.3 Inadequate and Uncomfortable seats 70--71

3.4.1.4 Sub-Theme: Getting hungry, thirsty and tired 72-73

3.4.1.5 Sub-Theme: Inability to use the toilet 74—77

3.4.2 Theme two: emotional distress 77

	3.4.2.1. Sub-Theme: Anger	77--80
	3.4.2.2 Sub-Theme: Anxiety	80--83
	3.4.2.3 Sub-Theme: Fear	83--85
	3.4.2.4 Sub-Theme: Frustration	85--91
	3.4.2.5 Sub-Theme: Sadness	91--98
	3.4.3 THEME THREE: COPING MECHANISIMS	98
	3.4.3.1 Sub-Theme: I use the toilet in the morning only or never	98--99
	3.4.3.2 Sub-Theme: Bring food from home	99-100
	3.4.4 THEME FOUR: A SENSE OF HELPLESSNESS	100
	3.4.4.1 Sub-Theme: Unable to answer back when shouted at by clinic staff	100--102
	3.4.4.2 Sub-Theme: No money, nothing to eat	102
	3.4.4.3 Sub-Theme: Unable to hear when names are called	102-104
	3.4.5 THEME FIVE: PERCEPTIONS CREATED	104-108
3.5	DISCUSSION OF THE RESULTS	108-110
3.6	THE WORLDWIDE DOCTOR-PATIENT RATIO	111-112
3.7	THE ASSUMPTIONS OF THIS STUDY WERE AS FOLLOWS	112-114
3.8	OBSERVATIONS	114-119
3.9	WAITING TIME DOCUMENTS	119-120
3.10	PHOTOGRAPHS	121-127

3.11	THE FINDINGS OF THIS STUDY IN RELATION TO:	128
	3.11.1 The Scope of Practice: Registered Nurses	128-129
	3.11.2 Maslow's Hierarchy of Needs	130-131
	3.11.3 The Significance of the health workers ' attitudes towards users	132
3.12	SUMMARY	132

CHAPTER FOUR: THEORETICAL FRAMEWORK

4.1	INTRODUCTION.	133
4.2	THE DEFINITION	133
4.3	THE VISION	134
4.4	THE MISSION	134
4.5	THE HISTORY	134-135
4.6	THE BATHO PELE PRINCIPLES	135-138
4.7	BATHO PELE PRINCIPLES IN RELATION TO THE FINDINGS	138
	4.7.1 Consultation	138-140
	4.7.2 Service Delivery Standards	140-143
	4.7.3 Access	143-145
	4.7.4 Courtesy	146-147

4.7.5 Information Giving 147-148

4.7.6 Openness and Transparency 148-149

4.7.7 Redress 149-150

4.7.8 Best Value for Money 150-151

4.7.9 Innovation and Reward 151

4.7.10 Service Delivery Impact 152

4.7.11 Leadership 152

4.8 SUMMARY 153

CHAPTER FIVE: EVAUATION OF THE STUDY, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION 154

5.2 EVALUATION OF THE STUDY 154-156

5.3 LIMITATION 156-157

5.4 RECOMMENDATION 157-159

5.5 CONCLUSION 159-161

5.6 SUMMARY 161

CHAPTER SIX: RECOMMENDATION OF A PROPOSED POLICY, GUIDELINES AND OUTPATIENT GUIDE

6.1	INTRODUCTION	162
6.2	THE PURPOSE OF THE GUIDELINES	162
6.3	THE OBJECTIVES	162-163
6.4	THE SCOPE	163
6.5	THE OVERVIEW OF POLICY GUIDELINES	163
6.5.1.	Consultation	163-164
6.5.2	Service Delivery Standards	164
6.5.3	Access.	165-166
6.5.4	Courtesy.	166
6.5.5	Information Giving	167
6.5.6.	Openness and Transparency.	168
6.5.7	Redress	169
6.5.8.	Best Value for Money	169
6.5.9	Innovation and Reward	170
6.5.10	Service Delivery Impact	170
6.5.11	Leadership	170
6.6	ENFORCEMENT	170

6.7 PROPOSED POLICY ON PROMOTION OF COMFORT IN THE OUT PATIENT DEPARTMENTS 171-178

Out Patient Information Guide 179

6.8 SUMMARY 180

BIBLIGRAPHY 181-198

TRANSCRIPTS OF INDIVIDUAL INTERVIEWS 207-219

LIST OF GRAPHS

Graph 1:1 Gauteng Complaints Call Centre 5

Graph 1.2 Gauteng Population versus Nursing Manpower 7

Graph 2.1 Total number of patients at the diabetes clinic under study 36

LIST OF TABLES

Table 1:1 Categories of complaints 6

Table 1.2 Gauteng Population versus Nursing Manpower 7

Table 1.3 Overview of the Research Methodology 25

Table 2.1 Total of patients at the diabetes clinic under study 35

Table 2.2	Sample Characteristics	39
Table 2.2	Measures of Trustworthiness in application	53-54
Table 3.1	Themes and Sub-themes	61
Table 3.2	Discussion and Results	110
Table 3.3	World Doctor- Patient Ratio	111
Table 3.4	The 2007- 2011 Staff- Patient Ratio	111
Table 3.5	Maslow' s Hierarchy of Needs	131

LIST OF PHOTOGRAPHS

Photograph no. 1	The Waiting room	122
Photograph no. 2	The Consulting room	123
Photograph no. 3	The Female bathrooms	124
Photograph no. 4	The Female toilet	125
Photograph no. 5	The first male toilet	126
Photograph no. 6	The second male toilet	127

LIST OF MODELS

Model 4.1	Model of Framework- *Batho Pele Principles*	136

A LIST OF ANNEXURES

ANNEXURE A	Interview Guide	199
ANNEXURE B	Letter to HOD of Health	200
ANNEXURE C	Letter to the Chief Executive Officer	201
ANNEXURE D	Information Sheet.	202
ANNEXURE E	Voluntary consent to participate	203
ANNEXURE F	Voluntary consent to record the interview	204
ANNEXURE G	Letter of Approval of Title	205
ANNEXURE H	Clearance Certificate	206

CHAPTER ONE

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Health care users express dissatisfaction with waiting time for health care services at public hospitals and clinics in South Africa and internationally. Barlow (2002) reported that despite the technological and organisational developments in medical care, and many changes driven by both management and government within today's National Health Service (NHS) hospitals, patients still experience unacceptable levels of waiting. Whether these are the initial wait to see a doctor, followed by the wait to be treated or simply the waits in the queue or in the accident and emergency department, waiting remains long. However, of all these waits, the one that is perhaps the hardest to condone, is the wait in the hospitals' outpatient clinic for a pre-arranged appointment. To address this problem the Gauteng Department of Health has introduced the waiting time project in 2005. But while measures are put in place to monitor and reduce waiting time health care users' experiences and perceptions to which they give rise remain unknown.

Although there may be various causes of long waiting times that involve clerks, doctors, and pharmacists a fair share of dissatisfaction is directed at nurses. However in spite of the unfair share of complaints levelled at them, nurses still have the desire and passion to research for new knowledge that will improve clinical and non-clinical practices. This is in line with the Batho Pele policy established in 1997 that seeks to improve users' experiences of poor and unfriendly service in order to rectify perceptions about health care services. McSherry, Simmons & Abbott (2002) stated that nursing research is the new knowledge generated by finding valid answers to questions that have been raised with respect to the care of patients generally or of a particular group of clients. The expectation is that research findings will be generalisable beyond the immediate context. Stoop, Vrangbaek & Berg (2005) indicate that waiting times limit or restrict access to health care and are therefore an important concern for those interested in quality improvement.

Wijewickrama & Takakuwa (2006) found that one consistent feature of patient dissatisfaction has been expressed with the length of waiting time in the outpatient departments throughout the world. Oxford Dictionary (2011) describes experiences as an event which leaves an impression on one and practical contact with and observation of facts or events. Nearly a decade later after Barlow reported on the dissatisfaction especially with pre-arranged outpatient appointments, Cao, Wan & Tu *et al*. (2011) investigated the efficacy of the web-based appointment system in the registration service for outpatients. They found that compared to the usual queuing method, the web-based appointment system could significantly increase patient's satisfaction with registration and reduce total waiting time effectively. Although it is a known and researched subject that users express dissatisfaction about waiting time for health care services at public health facilities, their experiences and perceptions are not known in this facility. It is against this background that this study sought to explore their experiences of waiting time at a diabetes clinic in an academic hospital and describe perceptions they give rise to.

Furthermore the activities and actions that do or do not take place at the selected setting were observed and the description thereof is provided in the next chapter. The waiting time documents were analysed to get a sense of how long patients wait and why. Lastly the photographs that have the significance to this study were captured to verify or nullify claims made by participants during individual interviews. Bauer & Gaskell (2006) contend that when photographs are attested, witnessed, and logged for time, place and circumstances, they can have powerful evidential or persuasive value. Therefore through analysis of various data mentioned above this study sought to produce findings that facilitated development of policy and guidelines for promotion of comfort in the Out Patient Departments, aimed to enhance client satisfaction. Booyens (2008) points out that a policy creates the context within which heath care should be practiced to prevent temporary problems from becoming permanent.

1.2 BACKGROUND

Health care services are believed to be negatively affected by long waiting time in South Africa and internationally. The study conducted by Propper, Croxson & Shearer (2002) revealed that waiting times for National Health Service hospital services have been a major political issue in the United Kingdom for several decades. Waiting times were a focus of government policy in the 1980s, yet remained long for routine hospital procedures. Reducing waiting times was one of the objectives of the major United Kingdom government health policy reform of the early 1990s. The increasing numbers of patients with non-communicable diseases is among the causes of long waiting time, it may be as Berne, Levy & Koeppen *et al*. (2004) reported that an estimated 15million people in the United States have type 2 non-insulin dependent diabetes mellitus, and the incidence is increasing worldwide. Berne, *et al.* (2004) further found that in the United States the prevalence of type II diabetes is expected to double by the year 2025 and the epidemic is also growing in children as much as it is in adults.

The increase is also noted in African countries as Tsiko (2006) revealed that the number of patients seeking medical assistance for diabetes is rising at a time when health experts say the continent's overburdened health care systems are ill-equipped to diagnose the disease and the majority of the poor cannot afford the cost of treatment. In 2003 Zimbabwe recorded more than 90 thousand cases of diabetes, an increase of 3 thousand from the 1997 figure. Tsiko (2006) also found that in Senegal, the National Centre against Diabetes reported an average of 200 new cases each year in the 1980s. However this figure has increased more than 10 times with 2 411 new cases reported in 2005. The prevalence of diabetes in particular the type 2 form is increasing throughout the world and in developing countries, this increase is expected to be at the rate of 90%, largely as a result of increasing sedentary lifestyles and obesity in an aging population. South Africa is faced with competition of resources for treatment of HIV/AIDS, tuberculosis and malaria which often receive priority. Estimates by the International Diabetes Federation who held a congress in Cape Town (South Africa) in 2006 are that diabetes affects approximately 246 million people worldwide. According to the South African Medical Research Council diabetes is estimated to have caused 22,412 deaths in 2000 making it the seventh leading cause of death in South Africa.

Experts estimate that approximately 3.5 million South Africans have diabetes with the type II form being the most common (95%). The above statement is consistent with the Gauteng Department of Health's report (South Africa) that stated that 21 914 newly diagnosed diabetic patients were put on treatment in all three regions in 2005. The three regions are: Region A: Johannesburg Metro and West Rand; Region B: Ekurhuleni and Sedibeng; Region C: Tshwane and Metsweding. The figure has tripled in 2010 reaching 74 704 (Gauteng Department of Health 2010). Waiting time is an important component of access to health care services and the South Africa's ***Batho Pele Policy*** (1997) defines access as "*receiving health care services easily, comfortably and promptly*". Anderson & Karlberg (2000) subsequently confirmed that according to international definitions, it is possible to define access as "the *ability to seek and receive care from the provider of choice at the time the patient chooses"*. Sadly the large numbers of people with diabetes continue to increase queues for booked patients resulting in more dissatisfaction. Hence research by Gulliford, Figueroa & Munoz *et al.* (2002) recommends that services available must be relevant and effective if the population is to 'gain access to satisfactory health outcomes'. While (Muntlin, Gunningberg & Carlsson 2005) appealed that more attention should be paid to the specific needs and expectations of the non- urgent patients who are in majority at emergency departments.

Saidi (2007) then assert that it is imperative to determine the health care users' actual needs as opposed to perceived needs before any health facility is built. Jawahar (2007) confirmed that in order to improve the satisfaction level of patients, infrastructure modification as per their suggestions were taken up at a hospital in India. This was later supported by Morton & Bevan (2008) when they recommended that policy makers should find ways to exploit the different insights from management science and economic views respectively to design coherent and effective systems for performance improvement. Booyens (2008) concurs that a policy also serves as standard of performance to determine how well members are living up to the professed intentions. Although Thompson, Yarnold & Adams (2005) previously revealed that there are two distinct dimensions of waiting time: the actual (measured) and perceived (subjective) waiting time, it is alleged that patients wait longer than they anticipated. Sithole, M'kumbuzi & Stewart *et al.* (2008) conducted the operational study at one regional hospital's pharmacy also in Gauteng Province and confirmed that the actual waiting time was six hours while according to patients, the acceptable (expected) waiting time was approximately two hours.

Consistent with that is the 2010-2011 waiting time's monthly statistics for out patients' clinics from one academic hospital in Gauteng Province as it shows that the actual waiting time was approximately six hours. Due to the high prevalence of diabetes the numbers of booked patients at this clinic under study grow while resources remain the same and thus, have a negative impact on health care users' experiences and perceptions of waiting. In the Gauteng Province such experiences have caused dissatisfaction that result in approximately 20% - 30% of complaints emanating from waiting time being lodged at Gauteng Patients Complaints Call Centre annually presented in **Graph: 1.1 and Table: 1.1** below.

Graph1.1: Gauteng Patients Complaints Call Centre

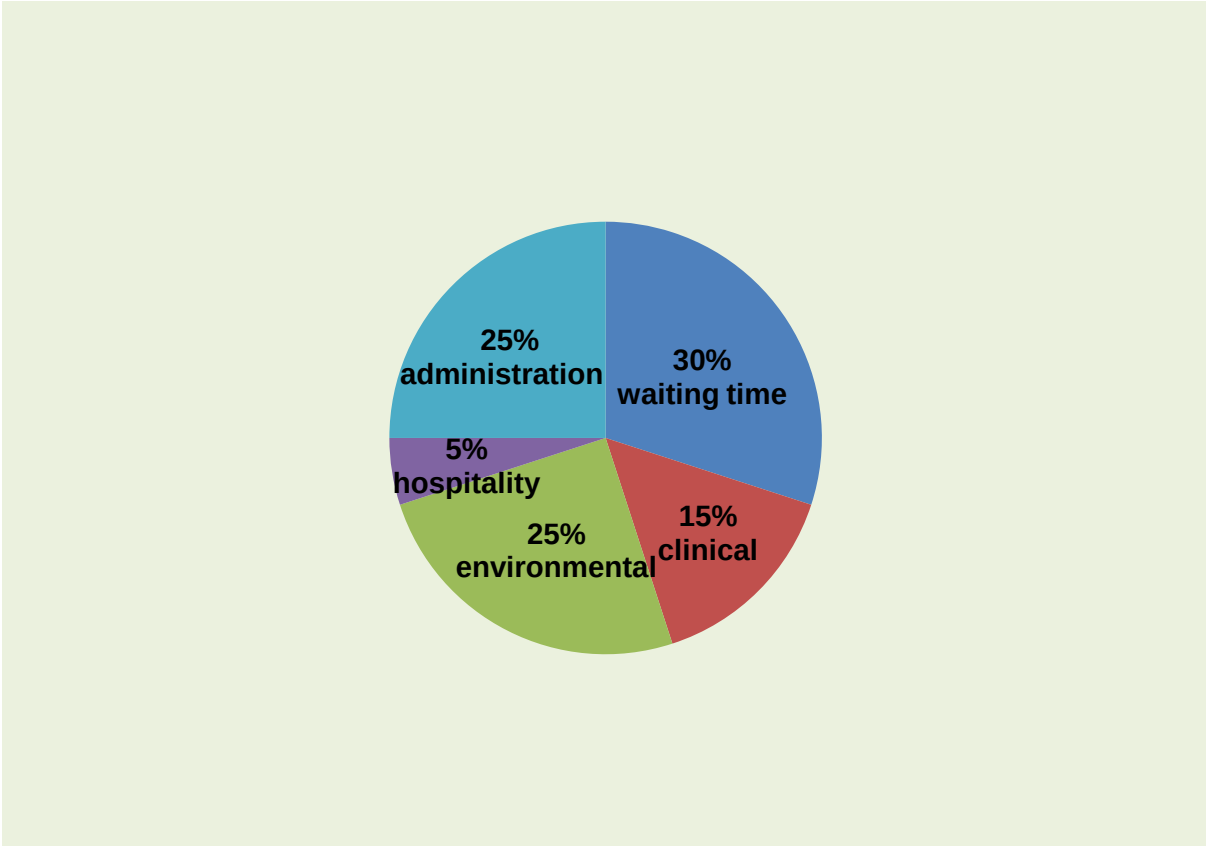


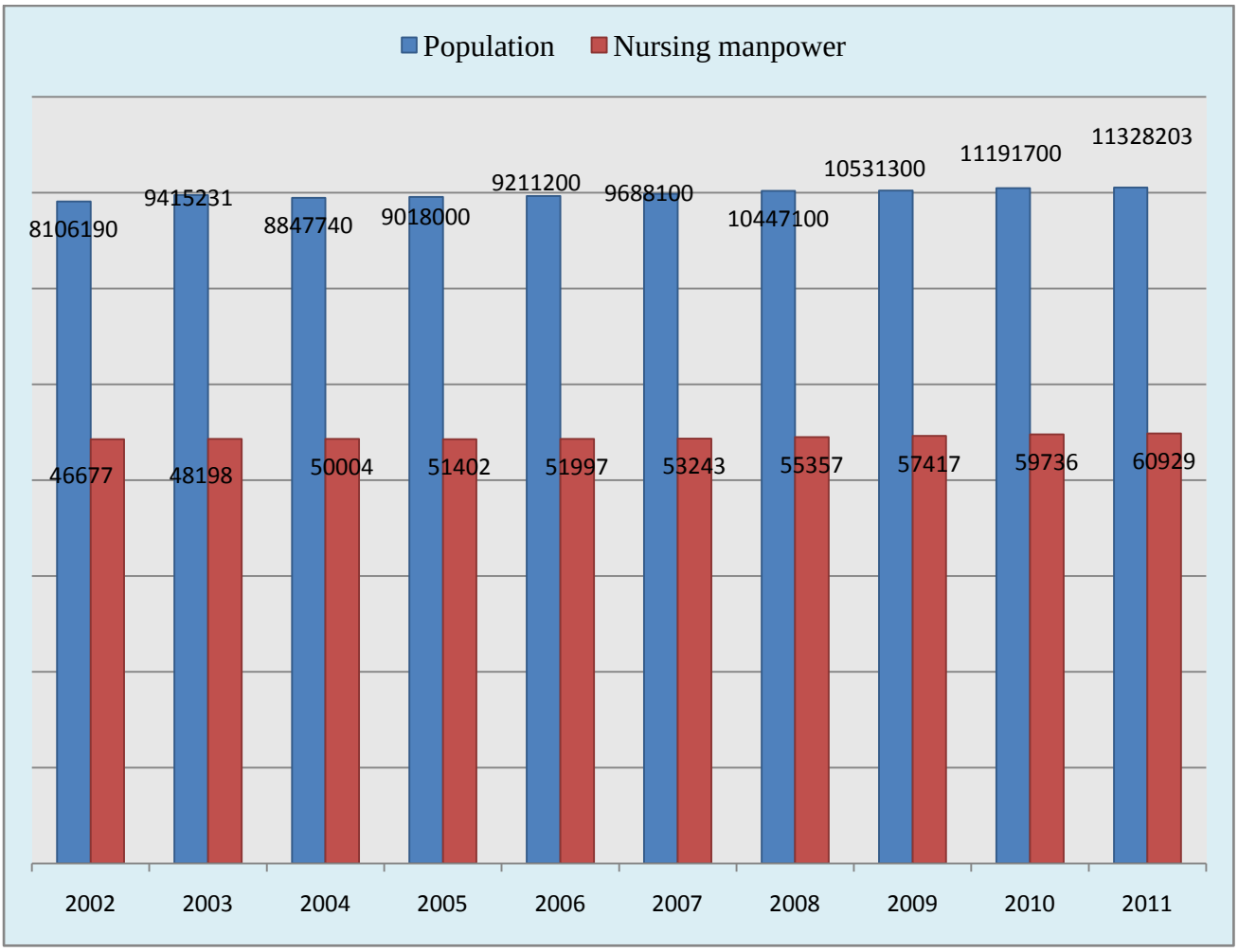
Table 1.1: Categories of complaints

Administration, Waiting time 30%	**Clinical 15%**	**Environmental/ Infrastructure 25%**	**Hospitality 5%**	**Communication Information 25%**
- Delayed and missing files - To see a doctor - Medicines - Unfair billing	- Death of patient - Still birth -Maternal death -Medical negligence -Poor professional care	- Not user or disabled friendly -Security and safety: -missing patients -patient falls -patient burns	- Food - Linen - Housekeeping - Ablution facilities	-Signage -Identification of staff -staff attitude -no information giving

Users complain that they wait long to receive their files at admissions, to see the doctor at polyclinic and to receive their medicines at pharmacy. Saidi (2007) found that patients from certain hospitals in South Africa are often sent back to Community Health Centres resulting in frustration. This is confirmed by Masae & Suwandechochai (2011) that the increase of numbers of patients leads to the long waiting time at the out patients department in Thailand. Waiting time results in patients' dissatisfaction and some leave before receiving services. These complaints attract negative media publicity regarding the health profession in general. Such damaging reports may prevent nursing and other health professions from attracting neophytes. The result will be more staff shortage that impacts negatively on waiting time. The South African Nursing Council's 2002-2011 report regarding Gauteng population versus nursing person power confirms nurse shortage within the provincial government. The report tables a clear population-nurse ratio disproportion in **Table: 1.2 and Graph: 1.2** below.

Table 1.2: The Gauteng population versus nursing person power ratio

Year	Gauteng population	Nursing person power	Nurse-population ratio
2002	8106190	46677	173: 1
2003	9415231	48198	195: 1
2004	8847740	50004	176: 1
2005	9018000	51402	175: 1
2006	9688100	51997	186: 1
2007	9688100	53243	181: 1
2008	10447100	55357	188: 1
2009	10531300	57417	183: 1
2010	11191700	59736	187: 1
2011	11328203	60929	185: 1



Graph: 1.2 Gauteng Population versus nursing person power

Although both the Gauteng population and nursing person power figures are growing yearly, nursing person power cannot compare with the population and therefore battles to cope with the workload. On the other hand users especially the working class citizens expect to receive health care services at public hospitals and clinics timely and return to work. Unfortunately they wait longer than they anticipated and this causes anger, anxiety, fear, frustration, and sadness to them. Health care users feel vulnerable and uncared for and therefore, all these negative experiences create wrong perceptions about the causes of waiting time. A study by Wiman & Wikblad (2007) showed encounters in which nurses presented poor attitude towards patients as well as a lack of communication. The environment in the waiting areas is also a cause for concern as reported by Saidi (2007) that users are generally concerned about cleanliness and ablution facilities. Especially regarding blood on the floors and dirty linen that they fear may lead to the spread of germs and infections. Saidi (2007) also found that one third of complaints were related to experiences such as poor attitudes, lack of communication, discourtesy and rudeness towards patients, and that if these were avoided then patient satisfaction would be achieved.

Later Jawaid, Ahmed & Alam, *et al*. (2009) confirmed that for most patients, a visit to a hospital is often a new and frightening experience. Though interactions with patients seems routine to the hospital staff, the experience of receiving health care services is not routine to patients. Unfortunately the structure of health system does not give users and patients an option to use alternative hospitals that may be perceived better. While measures to reduce waiting time are implemented in Gauteng Province, users' experiences and perceptions of waiting time remain unknown. Users visit hospitals often being emotionally unstable due to the circumstances surrounding their visits and expect caring, empathy, sympathy, and at the very least some compassion or understanding for their situation. It was therefore critical to uncover users concerns that are often taken for granted or go unnoticed. The aim of this study was to explore their experiences of waiting time at a diabetic clinic in an academic hospital and describe perceptions to which they give rise. Recently (Entwistle, Firnigl & Ryan *et al.* 2011) surveyed which experiences of service delivery matter to users and why? They concluded that the existing health care quality frameworks do not cover a rich array of users' experiences.

1.3 RATIONALE FOR THE STUDY

The National Department of Health has introduced the National Quality Program to fast track service improvement through core standards in South Africa. Waiting time is one of these standards contained in the Abridged Version of 2011. These standards concede with Batho Pele principle on access, to ensure that all health care users receive health care services easily, comfortably, and promptly (Batho Pele Handbook 1997; Patients' Right Charter 1999). The focus is that waiting areas such as outpatient clinics, admissions, pharmacies and accident and emergency departments should attain their benchmarks. Because while users have the right to complain about health care services according to South Africa's Patients' Right Charter (1999) it was however critical to know their dissatisfaction regarding waiting time. The interviews offered users the opportunity to raise issues for concern from the customers' perspective that are often taken for granted. The findings were then used to provide recommendations for formulation of policy and guidelines aimed at promotion of comfort at outpatient departments to enhance client satisfaction of waiting time. Gauteng Department of Health (2009-2014) confirms that the strategic objectives and expected outcomes for improved client satisfaction rate are stipulated to increase from 67% to 70%. This research study will also serve as a basis for future research on management of waiting time at public hospitals and clinics. Patients have expressed dissatisfaction and continue to do so often through media resulting in negative publicity about health care services. This negative publicity is responsible for health care users' wrong perceptions about waiting time at public health facilities. Sithole et al. 2008 proved that patients wait longer than they expected. She also found that the expected estimated waiting time according to the patients was approximately 2 hours while the actual waiting time was 6 hours. However the health professionals who are concerned about quality improvement do not want to see patients and their relatives being negatively affected by waiting time. So the rationale for this study can be stated as follows:

- To listen to health care users' concerns of waiting time.
- To highlight their views and opinions of waiting time.

- To uncover day to day activities that are taken for granted but have negative impact on their perceptions about health care services.
- To seek better ways of doing things differently to improve clinical practices.
- To present this study as a basis for future research on promotion of comfort in the outpatient departments at public hospitals and clinics.

Based on the theoretical framework of this study it is anticipated that it will be possible to generalise its findings to other public hospitals and clinics' waiting areas through the developed policy and guidelines to improve clinical and non-clinical practices. Entwistle *et al*. (2011) suggested that policy makers, service providers and researchers should attend to the range of experiences that matter and to take seriously the need for responsiveness to individuals.

1.4 PROBLEM STATEMENT

Health care users perceive waiting time at various departments such as admissions, casualty, polyclinic and pharmacy as a problem equal to lack of access to health care services in the Gauteng Province. They express dissatisfaction that is articulated by media reports on how patients and their relatives complain about long waiting before receiving medical attention especially in the outpatient departments for booked appointments. Wijewickrama *et al.* (2006) found that one consistent feature of patient dissatisfaction has been expressed with the length of waiting time in the outpatient departments throughout the world. This dissatisfaction resulted in 20% to 30% annual complaints received at Gauteng Patients' complaints call centre **(Graph: 1.1 and Table: 1.1 pp 5-6**). Saidi (2007) found that users are often not emotionally stable and conditions in the waiting areas make them feel bad. They are generally concerned about cleanliness and ablution facilities. Especially so regarding blood on the floors and dirty linen that they fear may lead to the spread of germs and infections. A service described as "very poor" is characterized by long waiting time; poorly managed waiting rooms; poor housekeeping; and lack of respect and care for patients in South Africa.

Muhondwa, Leshabari & Mwangu *et al.* (2008) confirmed that these conditions together with negative attitudes from some nurses cause anger, anxiety, fear, frustration and sadness in patients. Health care users feel vulnerable and uncared for, unfortunately the structure of health care system does not give users an option to use alternative hospitals that may be perceived as being better. The emotional and physical stress that diabetic patients endure may have a negative impact on their condition, leading to poor control. The effects by Gauteng Department of Health to reduce waiting time are minimal as resources remain constrained due to the increasing numbers of diabetic patients. This situation result in some health institutions failing to attain their own waiting time benchmarks. The public health facilities are supposed to conduct the client satisfaction survey annually through a questionnaire to find out how patients feel about certain areas of service delivery. Unfortunately the survey does not adequately cover patients' experiences and perceptions of waiting time. Although it is a known and researched subject that users complain about long waiting for health care services at public hospitals and clinics, little is known about their experiences and perceptions to which they give rise. Jawaid *et al.* (2009) confirm that there are a few studies in Pakistan and Iran about measuring patient satisfaction in different domains like in-patient, day case surgery but data about experiences and satisfaction from Out Patients Department (OPD) is limited.

It was in view of the above problem statement that the purpose of this study was formulated.

1.5 PURPOSE OF THE STUDY

Mouton (2006) points out that the exploratory studies that include pilot studies and other qualitative research aim to establish the facts from which new data is gathered. Brink (2008) stated that the research purpose is generated from the problem; it identifies the specific aim, goal and gives the reason for the study. Henning (2009) confirms that it is the purpose of the research that will have the most influence on the use of certain methods of data collection and especially analysis. The purpose of this non experimental research design of exploratory, descriptive, contextual and theory generative in the qualitative paradigm was to explore health care users' experiences of waiting time at a diabetes clinic in an academic hospital and describe perceptions to which they give rise.

Therefore through exploration, description, observation, analysing of waiting time documents and capturing of photographs, this study sought and produce findings that facilitated the development of a proposed policy, guidelines and outpatient guide on promotion of comfort in the outpatient departments, aimed to enhance client satisfaction of waiting time.

To achieve the purpose of this research study, one research question needed to be posed.

1.6 RESEARCH QUESTION

Holliday (2006) states that a research question in a qualitative paradigm is sufficiently open-ended to allow full exploration and the emergence of factors and issues during the process of the subsequent investigation which the researcher may have not thought about previously. Therefore qualitative research does not conjure the same precision required for questions which must be narrow to allow maximum control in quantitative research. Badenhorst (2007) affirms that a question unpacks the research problem and purpose to give the reader some idea of the scope of the project, while it indicates the size of the project and the area it will cover. Henning (2009) emphasizes that if a researcher wants to look into social reality using a prepared questionnaire with specific items to which people must respond by choosing a predetermined set of scaled responses, the study will be known as a quantitative inquiry. Holliday (2006) further elaborates that basically questions are about things that fascinate, puzzle, anger, and shock us about social life. According to the convictions above that the interview guide that composed of one open-ended question aimed at exploring and describing health care users' experiences and perceptions of waiting time was formulated for this study. The interview guide also included prompts to further explore particular topics. Clarifications and follow-up questions were used to further understand themes emerging from different participants' experiences and perceptions.

The following one open-ended question was posed to participants at a diabetes clinic in an academic hospital:

What are your experiences of waiting time at this diabetes clinic?

To address this research question four objectives were formulated.

1.7 RESEARCH OBJECTIVES

Brink (2008) states that objectives are defined as clear, concise, declarative statements that are written in the present tense. Therefore the objectives of this study were:

- To explore and describe health care users' experiences of waiting time at a diabetes clinic in an academic hospital.
- To describe perceptions that health care users' experiences of waiting time at a diabetes clinic, give rise to.
- To produce recommendations that will facilitate formulation of policy and guidelines
- To develop policy and guidelines on promotion of comfort in the outpatient departments to enhance client satisfaction of waiting time.

1.8 CENTRAL THEORETICAL STATEMENT

Holliday (2006) points out that a framework is a pivotal part of qualitative health science research. It thus states whether the researcher's position results from her agreement or disagreement with current discussions or issues. Furthermore it states how the researcher's ideology based on this position intends to impact on the research setting and the people involved. Creswell (2009) affirms that this approach is popular in qualitative research in which investigators begin with a theoretical model such as adoption of health practices or a quality life theoretical orientation to call for action or change. Holliday (2006) further alerts that it is difficult to find good examples of the conceptual framework because many researchers find it difficult to see their own ideological positioning easily. This research study however based its theoretical framework on ***Batho Pele Policy*** which seeks to improve health care users' lives through making health services accessible. Accordingly it sought to identify the shortfalls within the clinical and non-clinical practice in relation to the Batho Pele principles.

The researcher was confident that through training and emphasis of these principles users' physical and emotional comfort can be promoted during waiting time to enhance client satisfaction. Therefore it was imperative to listen to their views and concerns in order to develop policy and guidelines aimed at promotion of comfort at out-patient departments. The theoretical framework for this study is presented in chapter four.

1.9 RESEARCHER'S ASSUMPTIONS

Burns & Grove (2003) state that assumptions refer to statements that are taken for granted or considered true, even though they have not been scientifically tested. Assumptions influence the development and implementation of the research process. In research studies assumptions are embedded in the philosophical base of the framework, study design and interpretation of the findings

The assumptions were as follows:

1. Health care users who are disgruntled have had bad experiences.
2. Some causes of waiting time are human made and can be eliminated through training and development of policy and guidelines aimed at promotion of comfort in the outpatient departments.
3. Qualitative research methodology would determine health care users' experiences and perceptions that have not been uncovered.
4. This study would reveal patients' concerns that are often taken for granted.
5. Waiting times is subjective and will be perceived differently and every situation will be viewed by its own circumstances and outcome.
6. Patients believe **t**hat they wait long because health workers do not care.

1.10 PARADIGMATIC PERSPECTIVE

The paradigmatic perspective of this research study is based on meta- theoretical, theoretical and methodological assumptions.

1.10.1 Meta-theoretical assumptions

Mouton (2006) points out the meta-theoretical assumptions are not testable and deal with the researcher's views of humans and society. While these assumptions provide no epistemic findings, they serve as a framework within which theoretical statements are made. This theory is based on ***Batho Pele*** policy. ***Batho Pele*** is a concept of "Putting People First" which was introduced by the South African Government in 1997. This policy remains the government's single most campaign to achieve the necessary transformation of the hearts and minds of public servants and to put health care users at the centre of planning and operations.

To achieve this transformation, health workers should observe all principles of Batho Pele which are discussed below as follows:

- **Consultation**

Oxford Dictionary (2011) states that consultation is seeking permission to do something. In this context consultation means that health care users should be consulted about the health care services they will and would wish to receive and wherever possible should be given a choice about those that are offered (Batho Pele Handbook 1997).

- **Service Delivery Standards**

Service Delivery Standards implies that health care users should be informed about quality of public services they will receive so that they are aware of what to expect. The Batho Pele Handbook (1997) points out that while financial constraints can limit service delivery health workers do not have the reason not to strive for service excellence within available resources.

- **Access**

Oxford Dictionary (2011) defines access as the opportunity to approach or enter a place. For this study access means that all health care users should receive services that they are entitled to easily, timely and comfortably (Batho Pele Handbook). The study by Barlow (2002) revealed that customers frequently have to wait during the process of acquiring a service. These waiting experiences are typically negative and have been shown to affect the customers' overall satisfaction and their evaluation of service they encounter. SAHRC (2009) surveyed access to health care services especially for the poor and found that it is severely constrained by expensive, inadequate or non-existent transport, by serious shortages with regard to emergency transport, and by long waiting times at clinics and other health care facilities. Knowing the users' needs and expectations and being able to provide services quicker and better will improve their experiences and perceptions of waiting time.

- **Courtesy**

Oxford Dictionary (2011) points out that courtesy means a polite speech or action. In this context courtesy means that clinic staff should treat patients and their relatives with respect and consideration. Clinic staff ought to show respect and consideration towards users by displaying a positive attitude. It may be as Nairn, Whotton & Marshall (2004) found that the manner in which nurses spoke to the elderly at times shovels a patronizing and ageist attitude. Such bad staff attitudes contravene the Batho Pele principles, Code of Conduct, Nurses' Scope of Practice and bring health care services into disrepute.

- **Information Giving**

Information Giving means that users should be given full accurate information about clinic services they are entitled to receive. They should be told about specific and relevant information concerning their care to prevent unnecessary waits and to assist them to make informed decisions.

The study by Nairn *et al*. (2004) showed that the overall length of stay in the department is perceived as better for those patients provided with information every 15 minutes, than those not provided with information.

- **Openness and Transparency**

Clinic staff should be open and transparent about available and unavailable services and provide full accurate information hereto. Being open and transparent about services offered will build health care users' confidence and prevent wrong perceptions. The availability of other diabetes health care services such as podiatrist, dietician, eye clinic and others should all be made open and transparent.

- **Redress**

If the promised standard of service is not delivered, users should be offered an apology, a full explanation and a speedy and effective remedy. It was mentioned in the problem statement that health care users often express dissatisfaction with waiting time. It is important to note that not only do they have the right, but are expected to complain. It is critical that health workers should see complaints as an opportunity to learn and improve services and therefore respond positively, promptly, sympathetically, efficiently, and effectively. A satisfactory response would include an apology, resolution to the problem and promise to ensure that a similar incident does not recur.

- **Best Value for money**

Health care services should be provided timely, economically and efficiently in order to give users the best possible value for money. This means that procedures should be done right the first time to prevent long hospital stays and potential litigation.

- **Innovation and Reward**

Health care authorities need to show that staffs' commitment, energy and skills are being harnessed to tackle inefficient, outdated and bureaucratic practices. The clinic staff should be encouraged to find better and easier ways of promoting comfort in the outpatient departments and be recognized for every effort. Such compliments should be communicated to clinic staff in order to encourage best practice.

- **Service Delivery Impact**

Through service delivery impact the evidence should demonstrate both realization of intended objectives and outcomes. Compliance with all Batho Pele principles will have a positive service delivery impact and therefore enhance client satisfaction.

- **Leadership**

Management should provide strategic direction and support, be visible and accessible to the team. The unit managers' names should be displayed so that users should know whom to speak to when necessary and undertake necessary corrective measures to enhance client satisfaction. All clinic delivery services should be in accordance with Batho Pele Principles presented in chapter four as **Model: 4.1** on page 131.

1.10.2 Theoretical assumptions

Mouton (2006) points out that, theoretical statements are testable and provide epistemic findings about the research domain. They give form to the hypotheses or central theoretical statements of the research, and form the framework for the epistemic statements in the research.

Oxford Dictionary (2011) defines perceptions as the ability to see, hear or become aware of something through the senses. Perceptions in this context will be how diabetic patients and their relatives interpret activities that do or do not take place during waiting at a diabetic clinic in an academic hospital under study. What they make out of all activities to be.

1.10.3 Operational definitions

Health care users: People who seek and receive health care services at public hospitals and clinics (National Health Act no: 61 of 2003). However for the researcher's purpose in the context of this research study, health care users will refer to patients and their relatives at the diabetes clinic in an academic hospital under study.

Experiences: Oxford Dictionary (2011) defines experiences as practical contact with and observation of facts or events. Experiences are the events which leave an impression on one's mind. In this research study the experiences will refer to the impact of activities that do or do not take place during waiting time and affect diabetic patients and their relatives either physically or emotionally. Most importantly how such activities make them feel about the health care services at this clinic.

Perceptions: Oxford Dictionary (2011) states that perceptions are the ability to see, hear or become aware of something through the senses. Perceptions in this context will be how diabetic patients and their relatives interpret activities that do or do not take place during waiting at this diabetes clinic. What they make out all such activities to be.

Waiting time: Waiting time according to (Oxford Dictionary 2011) is delay action until a particular time or event. Therefore in the context of this research study waiting time will refer to; from the moment the diabetic patients register at this clinic to get their files, to be seen by the doctor and until they receive their medicines at pharmacy.

Public Hospitals: Oxford Dictionary (2011) defines public hospitals as institutions that provide medical treatment and nursing care for sick or injured people in general funded by the state. In this context a public hospital will refer to an academic hospital under study.

Academic hospital: It is a public hospital whereby training for health professionals and health workers take places. An academic hospital in this research study refers to the one under study.

Comfort: Comfort is a state of physical ease (Oxford Dictionary 2011). However for the purpose of this research study, comfort refers to both physical and emotional ease.

1.10.4. Methodological assumptions

Health care users' experiences and perceptions of waiting time were explored during individual interviews. Data analysis was done from which themes and sub-themes emerged. Because this study was functional it would be possible to operationalise it to improve clinical and non-clinical practices. The findings of this research study were used to develop policy and guidelines aimed at promoting comfort during waiting time to enhance client satisfaction in the outpatient departments at public health facilities.

1.10.4.1 The following dimensions of research were the typology used in this study

- Epistemological dimension:

Mouton (2006) asserts that epistemological dimension means that the scientific inquiry is driven by the search for 'true' or at least truthful knowledge. The predominant purpose of all research is to arrive at results that are as close to the truth as possible, i.e. the most valid findings possible. The aim is not merely to understand phenomena, but rather to provide valid and reliable understanding of reality.

This research study sought to provide knowledge that is substantiated as opposed to opinion and hence provide accurate representation of reality through listening to health care users themselves in order to understand the reality behind their alleged expressions of dissatisfaction with waiting time at public health facilities. This was done by capturing their voices and thereby putting voices and faces together including observation of the setting, analysing of waiting time documents and photographs, by so doing getting firsthand knowledge not the unconfirmed media reports as it was mentioned in the problem statement. The truth that needed validation was, what makes health care users dissatisfied, what was happening or not happening during waiting time, what are their experiences, expectations and perceptions of waiting time. The phenomena may be observable or unobservable, verbal or non-verbal and individuals or collectives. This research study sought to explore health care users' experiences and perceptions of waiting time at a diabetes clinic in an academic hospital. The one most important aim of this research study was to utilise the findings to develop policy and guidelines aimed at promoting comfort during waiting time to enhance patient satisfaction.

- Methodological dimension:

Mouton (2006) indicates that methodological dimension refers to the 'knowledge of how' or 'know how' to do things or the total set of 'means' that scientists employ in researching their goal of valid knowledge This research study used three levels of methodological dimensions that are as follows: research techniques, research methods and methodological paradigm.

- **Research techniques.**

Research techniques are the specific and concrete means that the researcher uses to execute specific tasks (Mouton 2006). The population for this research study was the patients and their relatives who are older than 18 years of age from all races. Both males and females were included only children were excluded from the study. Methods of data collection were individual interviews, observations, analysing of waiting time documents and photographs. In-depth unstructured interviews were conducted with participants using an interview guide that consisted of one open-ended question.

The Tesch method of analysing qualitative data was used (Tesch 1990; Creswell 2009).

- **Research methods**

This research study used a Non-probability; purposive sampling according to Creswell (2009). In-depth unstructured individual interviews were conducted with participants using an interview guide that consisted of one open-ended question. The setting together with participants were observed, described and presented in chapter two.

- **Methodological paradigms**

Mouton (2006) asserts that research may be regarded as objective by virtue of its being critical, balanced, unbiased, systematic and controllable. It is about the nature of the research process and the most appropriate methods to be used about the relative worth of quantitative and qualitative methods, about interpretation versus explanation, and about the ideal universal statements versus specific and local generalisation. Based on the purpose of this research study a non experimental research design of a descriptive, exploratory and contextual nature in the qualitative paradigm as opposed to a quantitative inquiry was used to explore and describe health care users' experiences and perceptions of waiting time.

- The ontological dimensions:

Mouton (2006) defines "The term ontology" as the study of being or reality. Research is always directed at an aspect or aspects of social reality. In the final instance, all research is aimed at improved understanding by describing, explaining and evaluating phenomena in the social world. This reality includes human activities, characteristics, institutions, products, society, and nature of history, behaviour and status of mental entities.

Phenomena may be distinguished in terms of observable non-observable, verbal and non-verbal or individual and collective dimensions. In trying to distinguish the phenomena of this study which were health care users' experiences and perceptions of waiting time, it was possible to conduct individual interviews and to do observations of a collective. These collectives that included patients' activities and the clinic environment were observed and all these were discussed in chapters two and three in detail. Nevertheless the researcher acknowledged the fact that certain aspects of human behaviour such as moral, emotional and spiritual are extremely difficult to observe or measure systematically.

- The teleological dimension:

This research study was intentional and goal- directed, its main aim being the understanding of health care users' experiences and perceptions of waiting time. The understanding in this research was made possible through data analysis of individual interviews and observations of the setting. This research study had both the theoretical and practical aims as its goal. The theoretical aim was to give a detailed description of patients' behaviour, opinions and concerns about waiting time. While the practical aim was to develop policy guidelines on promotion of comfort during waiting time, the researcher was confident that through knowledge reality can and must be changed as asserted by Mouton (2006).

The research process for this research study is presented below in detail.

1.11 RESEARCH METHODOLOGY

1.11.1 RESEARCH DESIGN

A research design is a blueprint for conducting a study that maximises control over factors that could interfere with the validity of the findings. The control provided by the design increases the probability that the study results will be accurate reflections of reality (Uys & Basson 2000; Burns *et al.* 2007; Macnee 2004; Polit & Beck 2004; Nieswiadomy 2008). So, based on the purpose of this research study a non experimental research design of a descriptive, exploratory and contextual nature in the qualitative paradigm was used.

Through exploration, description, observation of the setting and activities thereof, analysing of waiting time documents and capturing of photographs of significance, this research study produced findings that facilitated formulation of policy and guidelines on promotion of comfort during waiting time aimed at enhancing client satisfaction.

1.11.2 RESEARCH METHOD

The purpose of this non experimental research design, of exploratory, descriptive, contextual, theory generative in the qualitative paradigm was to explore and describe health care users' experiences of waiting time at the diabetes clinic in an academic hospital and describe perceptions to which they give rise. Methodological perspectives of this research study were with regards to the purpose and objectives of the study, data collection, population and sampling, measures of trustworthiness, data analysis and description of results. A methodological overview of the study is presented below in **Table: 1.3** however a detailed description thereof is presented in chapter two.

Table: 1.3: Overview of the Research Methodology

Research objectives	**Data collection**	**Sample and sampling**	**Trustworthiness**	**Data analysis**
To explore and describe health care users' experiences of waiting time at a diabetic clinic in an academic hospital.	Individual interviews, observations, analysing of waiting time documents and photographs	Pilot study: 2 participants Main study: 10 participants Sampling: purposive	Guba's model Lincoln & Guba, (1985)	Tesch's guidelines (Tesch, 1990; Tesch in Creswell, 2009)
To describe perceptions that, health care users' experiences give rise to.	Deductive and Inductive logic	Pilot study: 2 participants Main study: 10 participants Sampling: purposive	Guba's model Lincoln & Guba (1985)	Tesch's guidelines (Tesch 1990; Tesch in Creswell 2009)
To formulate policy and guidelines on promotion of comfort in the outpatient departments.	Deductive and Inductive logic	Sample: Sampling method: purposive sampling		

1.13 ETHICAL CONSIDERATIONS

This research study used mainly human participants regarding their views and concerns based on experiences and perceptions of waiting time, it was therefore critical that their rights be respected throughout the stages of research from data collection to report writing as prescribed by Human Research Ethics Committee of University of the Witwatersrand. Brink (2008) stated that ethical considerations mean the protection of the rights of the participants.

Ethical considerations were observed as follows**:**

1.13.1 Approvals for Research

- Ethical clearance was sought from the Human Research Ethics Committee of University of the Witwatersrand to conduct the study. (**Clearance certificate M090908: 2009/10/02) (Annexure H).**
- The research protocol was submitted to the Postgraduate Committee of the Faculty of Health Sciences at University of the Witwatersrand for approval. Approval was granted: (**Annexure G).**
- Other written permission to conduct this research was requested and obtained from the following appropriate authorities:
- Head of Gauteng Department of Health (**Annexure B)**
- Chief Executive Officer of the academic hospital concerned. (**Annexure C)**

1.13.2 Principle of respect for persons

- It is important for participants to understand their participation in the study. So in order for them to understand this whole process the researcher gave them an informed written consent that explained the topic, purpose, procedures to be followed. This informed written consent also informed them that the interview would be recorded and allowed them to or not to consent (**Annexure: E & F).**

- Participants were also informed that they have the right to stop the interview at any time without giving the reason.
- The verbal consent was negotiated and renegotiated throughout the interview to verify if the participants were still willing to participate.

1.13.3 Confidentiality

- Participants were reassured that they would not be intimidated or discriminated against.
- They were ensured confidentiality that was maintained during the analysis and reporting of data collected.
- An information letter accompanied the data collection tool to inform the participants about the purpose of the study and their role as participants. **(Annexure: D)**
- Participants were reassured that their names will not be reflected on raw data or results of the study.

1.13.4 Principle of justice

- Participants were reassured that they have been selected based on the fact that they have experiences to share not due to any form of discrimination.
- Participants were also informed that new patients were excluded due to insufficient experience to illuminate the research topic.

1.13.5 Principle of beneficence

- The topic for this research was not exposing participants to any new potential risk of physical and emotional discomfort than what they continually experience.
- However they were advised to inform the researcher of any discomfort.

1.14 OUTLINE OF THE DISSERTATION

The dissertation comprises of the following six chapters:

- Chapter One –Orientation to the research study

- Chapter Two –Research Methodology
- Chapter Three –Discussion of Results and Literature Control
- Chapter Four – Theoretical Framework
- Chapter Five – Evaluation of the Study, Limitations and Recommendations
- Chapter Six – Recommendations of a Policy and Guidelines for Operationalisation

1.15 SUMMARY

The high volume of patients seeking medical treatment for communicable and non-communicable diseases at public health facilities has increased the waiting time for health care services. This negative impact has forced patients to express dissatisfaction that is presented as complaints about health workers, hospitals, clinics and or the Gauteng Department of Health. Most complaints emanate from waiting time and have attracted negative media reporting and general criticism from communities about the reputation of some health care facilities. This chapter presented an overview of the research study in order to navigate the reader through to the remaining parts of the dissertation. The chapter described the background on which the research idea was formed. The rationale of the research study and the practicality thereof, based on the problem statement, the purpose and objectives, the researcher's assumptions in accordance with the theoretical framework and the research design. Due to the nature of this research topic that involved mainly humans as participants and not objects, compliance with ethical standards was imperative. Detailed discussion hereof is presented through Annexure H. So the demand for client satisfaction and the need to build their confidence in the public health system prefaced this research study as we continually identify gaps within clinical and non-clinical practices. This research study found that health care users' dissatisfaction about health care services is caused by physical and emotional distress during waiting time. Hence, the policy and guidelines on "Promotion of Comfort in the Out-Patient Departments" together with the Out Patient Information Guide were developed for operationalisation at public hospitals and clinics and submitted to the Gauteng Department of Health for approval.

The following chapter detailed the research methodology used for this research study.

CHAPTER TWO

RESEARCH METHODOLOGY

2.1 INTRODUCTION

Silverman (2008) points out that methodology is a general approach to studying research topics. Henning (2009) agrees that methodology means that we come to know by inquiring in certain ways. It is concerned with the specific ways that we can use to try and understand our world better and the practice of coming to know how we study this practice. Oxford Dictionary (2011) defines methodology as a system of methods used in a particular field. So, this chapter provides an account of the research methodology that was used to achieve the research purpose and objectives. It presents in detail the research design that is explorative descriptive, contextual and theory generative in a qualitative paradigm. This design puts emphasis on the setting which distinguishes health care users' experiences from perceptions as revealed by the details of the researcher's observations. The research methods are described with reference to the setting, population and sampling, sampling method, criteria and characteristics, sample size, data collection and analysis methods and ensuring trustworthiness of the research study.

2.2. RESEARCH OBJECTIVES

According to the Oxford Dictionary (2011) objectives are goals or aims. Brink (2006) affirms that objectives are concrete, measurable end towards which effort or ambition is directed. Objectives are clear, concise, declarative statements that are written in the present tense.

The following four objectives were formulated for this research study.

- To explore and describe health care users' experiences of waiting time at a diabetes clinic in an academic hospital.
- To describe perceptions that health care users' experiences of waiting time at a diabetes clinic, give rise to.
- To produce recommendations that will facilitate formulation of policy guidelines.
- To develop a proposed policy on promotion of comfort in the outpatient departments to enhance client satisfaction

2.3. RESEARCH DESIGN

Babbie & Mouton (2003) point out that a research design is a plan or blue print of how you intend conducting the research. A year later Macnee (2004) shares the same opinion that a research design is the overall plan for systemic collection of new information and confirming the existing knowledge in a manner that assures that the answers found will be as meaningful and accurate as possible. Later Nieswiadomy (2008) confirmed the definition and simplified it by stating that it is the pattern, recipe or plan for a research study. Based on the purpose of this study a non experimental research design of exploratory, descriptive, contextual, theory generative in the qualitative paradigm as opposed to a quantitative inquiry was used to meet the objectives of this study.

2.3.1 Qualitative inquiry

Mouton (2003) emphasises that qualitative researchers always attempt to study human action from the insider's perspective "emic". The goal of research is defined as describing and understanding (Verstehen) rather than the explanation and prediction of human behaviour. It is the qualitative researcher's desire to be as nonintrusive as possible, in contrast to the experimental and survey researcher who intervenes in the research process through various mechanisms such as setting up laboratory conditions. The qualitative researcher wishes to observe events and actions as they happen without any intervention or interference, which is the exact opposite of quantitative research.

Burns *et al.* (2003) argue that personal experience is often characterised as being anecdotal, ungeneralisable; and a poor bases for making scientific decisions. However, it is often a more powerful persuader than scientific publication in changing clinical practice. According to the researcher's own understanding and interpretation of the difference between quantitative and qualitative paradigms, experiences and perceptions could only be accurately explored, described and interpreted when using a qualitative paradigm in this study. Macnee (2004) states that qualitative research intentionally seeks to avoid external control over setting and factors. It gains knowledge that informs our practice broadly and holistically understanding that knowledge is evolving and contextual. Brink (2006) indicates that quality methods focus on the quality aspects through understanding the meaning of human experience from the participants' view points in the context where in actions take place. A decade later Nairn *et al.* (2004) quoting (Britten & Shaw 1994) assert that prolonged waits can cause considerable distress and elicit narratives from patients that would not be captured in quantitative data. Hence the use of in-depth unstructured interviews in this study made it possible to uncover health care users' experiences and perceptions of waiting times.

Something that would not be possible using a quantitative approach, as argued by Nairn *et al.* (2004) that patient questionnaires do not access independent phenomena but, in a sense, actively construct them by forcing users to express themselves in alien terms consequently, inferences made from their results may misrepresent the true beliefs of service users. Brink (2006) is of the opinion that a non-experimental approach concentrates on qualitative aspects such as meaning, experience and understanding. Burns *et al.* (2007) confirm this by arguing that qualitative research is conducted to promote understanding of human experiences and situations and to develop theories that describe these experiences and situation. Because human emotions are difficult to quantify, qualitative research seems to be a more effective method of investigating emotional responses than quantitative research. While Nieswiadomy (2008) is inconsistent when she states that qualitative research focuses on gaining insight and understanding about an individual's perception of events. This design became useful in this study because the aim was to understand the phenomena which are health care users' experiences and perceptions of waiting time at a diabetic clinic. As Henning (2009) states that a qualitative enquiry will offer participants a more open-ended way for giving their views in the form of interviews, observe their setting, interactions and listen to their conversations.

Henning (2009) further indicates that in a quantitative paradigm, respondents or research subjects are usually not free to express data that cannot be captured by the predetermined instruments because the researcher plans and executes this control in the way the study and its instruments are designed. On the other hand in a qualitative study the "variables" are usually not controlled because it is exactly this freedom and natural development of action and representation that we wish to capture. We want to understand, and also explain in argument, by using evidence from the data and from the literature, what the phenomenon or phenomena that we are studying are about (Henning 2009). The researcher was physically involved throughout the research process as the main instrument of data collection. Through individual interviews, observations, analysing of waiting time documents and interpreting photographs. Although qualitative research is often criticised for subjectivity, sample size and trustworthiness, the researcher was confident that a qualitative inquiry was appropriate in achieving the purpose of this research because it sought to capture health care users' views about waiting time not the researcher' s perspectives. The intent was to see what measures of improvement can be put in place according to the framework of this research study which is Batho Pele Principles. And so as mentioned in the purpose of this research study, through exploration and description of patients' experiences of waiting time in the diabetes clinic, knowledge gained assisted the researcher to understand what health or caring means to patients. This was made possible by the researcher's ability and knowledge to put aside any preconceived ideas and opinions that she had about waiting time, in order to consider the perspectives that were forthcoming.

2.3.2 Exploratory Studies

Babbie *et al.* (2003) point out that, exploratory studies are essential for breaking new ground and can yield new insights and comprehension into a research topic. Nieswiadomy (2008) stated that an exploratory research is appropriate when little is known about the phenomena and therefore little written on the topic. This research study sought to explore health care users' experiences of waiting time and describe perceptions to which they give rise, as mentioned in the problem statement that little is known on this phenomena. Additionally various previous researches regarding waiting time did not cover experiences and perceptions of health care users.

Jawaid (2009) confirms that there are few studies from Pakistan and Iran about measuring the patient satisfaction in different domains like in-patient, day case surgery satisfaction but data about patient experiences from Out Patient Department (OPD) is limited.

The following were the suitable reasons behind this exploratory study as proposed by Babbie *et al.* (2003)

- To explicate the central concepts and constructs of a study.
- To develop a new hypothesis about an existing phenomenon

This research study was conducted through a survey of health care users who had practical experiences of waiting time at this diabetes clinic. The survey used unstructured interviews, observations, analysis of waiting time documents and photographs.

2.3.3 Contextual

Morse & Field (2002) point out that qualitative inquiry provides theory; firstly theory may be applied clinically, either to the setting from which it was developed or to another setting. Secondly the findings provide rich description that enables the readers to understand and make sense of clinical reality. Babbie *et al.* (2003) indicate that while the quantitative researcher aims at analysing variables and the relationships between them in isolation from context or setting to increase generalisability, the qualitative researcher aims to describe and understand events within the concrete, natural context in which they occur. Babbie *et al.* (2003) further argue that it is only if one understands events against the background of the whole context and how such a context confers meaning to the events concerned, that one can truly claim they understand the events. Although Burns *et al.* (2003) argue that personal experience is often characterised as being anecdotal, ungeneralisable; and a poor basis for making scientific decisions, the researcher was confident that description and understanding of health care users' views regarding waiting time at a diabetes clinic was important to health workers' perspectives in shaping clinical settings.

The context of this research study was determined and driven by Gauteng Health Department's aspiration to meet the needs and expectations of health care users as outlined/contained in the Constitution of South Africa chapter two, the Bill of Rights (The Constitution 1996). Where it says every citizen has the right to health care services. This means that all barriers to access of health care services must be rectified and this study identified waiting time as one such barrier that ought to be addressed. The waiting time at the diabetes clinic in an academic hospital was the context for this research study. The researcher stayed at this clinic long enough to observe actions, events and processes that have an effect on health care users' experiences and perceptions of waiting time. These observations provided the knowledge that the researcher understood, interpreted and analysed the manner in which health care users draw meaning about waiting time. Babbie *et al.* (2003) emphasize that qualitative research is especially appropriate to the study of those attitudes and behaviours best understood within their natural setting as opposed to the somewhat artificial settings of experiments and surveys. Observations and unstructured interviews were then conducted at this diabetes clinic which was the natural setting where health care users' experiences and perceptions of waiting time are born. The researcher used knowledge gained from these, to make recommendations to Gauteng Health Department to develop policy and policy guidelines that will enhance client satisfaction of waiting time at public health facilities as it was mentioned in the objectives of this research study.

2.3.4 Descriptive Research

Uys *et al.* (2000) assert that the most important methodological consideration in respect of descriptive studies is the collecting of accurate data on the domain phenomenon to be studied and then describing it accurately and carefully. Burns *et al*. (2003) explain that the descriptive study is designed to gain more information about characteristics within a particular field of study. Its purpose is to provide a picture of a situation as it naturally happens. Babbie *et al.* (2003) emphasize that when a researcher carefully and deliberately observes situations and events and provides descriptions that are typically more accurate and precise, the approach is descriptive research.

Lastly, Macnee (2004) confirms that the descriptive research gives account of how many participants were interviewed, their age and gender. In this research study it involved collection of qualitative data through individual interviews which were transcribed verbatim. Description of themes and sub-themes that emerged from interview transcripts was used to give an account of participants' characteristics, concerns and opinions about waiting time. The description also includes the physical environment that is detailed further under the next sub-heading "setting".

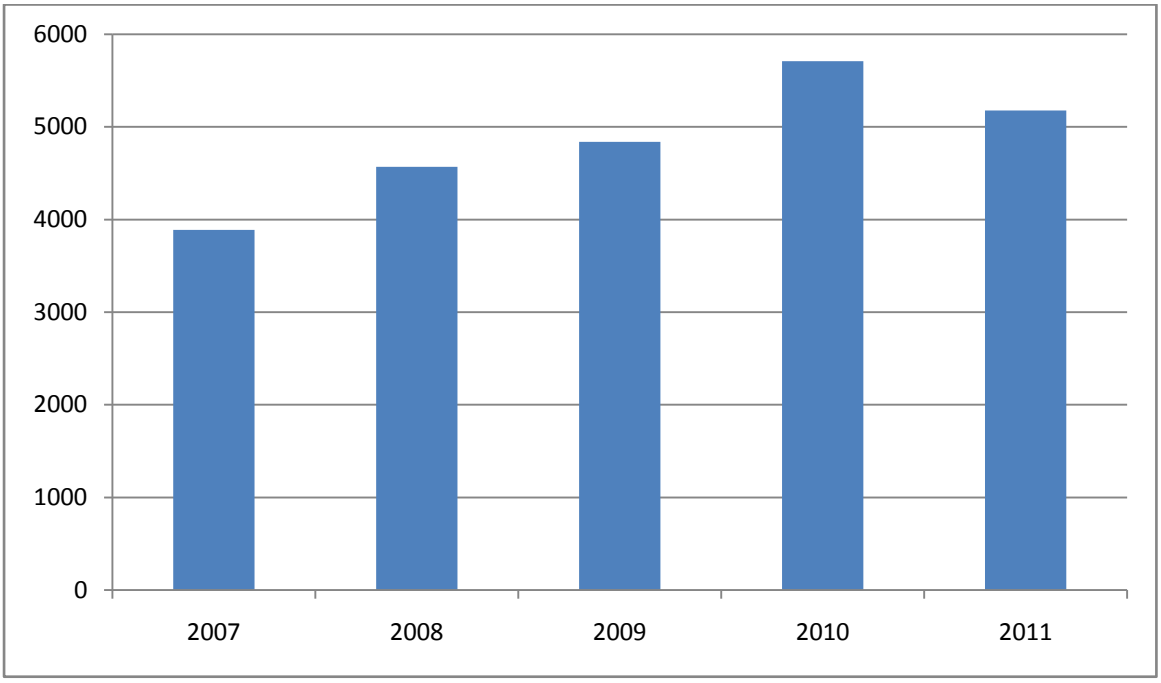
2.3.4.1 Setting

Polit *et al.* (2004) stated that setting refers to the physical location and conditions in which data collection takes place in a study. Polit *et al.* (2004) further explain that in-depth qualitative studies are especially likely to be done in natural settings because qualitative researchers are interested in studying the context where in participants' experiences take place. Holliday (2006) explains that interviews and observations need to be located within a bounded setting and become valid because they interconnect via an environment which contains other actions, events, icons and so on, which gives them meaning, in opposition to the notion of survey in quantitative research. Bailey (2007) confirms that rather than controlling events the researcher attempts to become part of the setting, with the goal of providing in-depth descriptions and analytic understanding of the meanings participants in a setting attached to their interactions and routines. The diabetes clinic in an academic hospital was the appropriate setting for data collection through individual interviews, observation, analysing of waiting time documents and photographs. This was possible because participants were familiar with the environment and were confident to mention and refer to recent events, actions and icons as explained by Holliday (2006). Current events such as what was happening there and then on the day of the interview were mentioned and related to what happened in the past which are now referred to as experiences. Words such as "**even now"** were articulated by most participants. These words were an emphasis of *"if you don't believe what I am telling you, you can see for yourself.* Such emphases of claims were later verified as facts through observations.

The researcher made several visits to this diabetes clinic to be directly involved with users and personally gained experience regarding waiting time. During these visits the researcher was successful in data collection from all sources. Other services that are also rendered within this setting include asthma, respiratory, renal, metabolic, bone, and endocrine. Staff allocation for this diabetes clinic includes 9 doctors, 7 nurses, 4 clerks and 1 cleaner. The medical team comprised of 2 professors, 3 consultants, 2 registers, 1 medical officer, and 1 medical intern. The availability of these doctors was affected by conferences, leave, rotation, shortages in other departments, and ward rounds. There were 10 consulting rooms. One room had a desk and a chair for the doctor, 2 chairs for a patient and escort, an examination bed, 2 waste plastics for general and medical wastes respectively. Present in the consulting room are 1 diagnostic set mounted on the wall, 1 electronic blood pressure monitor. As part of diabetic care, patients are referred to the eye clinic in area 457 for screening. This is a fully functional ophthalmic clinic. It is operated daily by eye specialists such an ophthalmologist and nurses. In the absence of abnormalities patients are followed up annually. Other services are that of a dedicated dietician available on Monday and Thursday. For the care of their feet patients are referred to the podiatrist who is available on Monday and Friday. One cleaner is allocated weekly to this clinic on rotational basis. The clinic has seen an increase in the numbers of patients annually resulting in a vast staff – patient ratio disproportion. In 2007 the clinic saw 3887 patients. In 2008, 4569 patients were seen. The number of patients continued to grow and 4839 were seen in 2009. Later in 2010, 5710 patients were seen prompting hospital management put control measures in place to intensify admission criteria and that explains the minimal drop to a total of 5178 in 2011. The table below presents the increased number of patients from 2007-2010 and a minimal drop in 2011.

Table 2.1 Total numbers of patients at the diabetes clinic under study.

Year	2007	2008	2009	2010	2011
Number of patients	3887	4569	4839	5710	5178
Increase by percentage		17.5%	24.5%	46.9%	33.2%



Graph 2.1 Total numbers of patients at the diabetes clinic under study.

The clinic runs twice a week on Mondays and Thursdays only and bookings are done according to availability of staff and to control overcrowding, however some patients do not adhere strictly to their appointment dates which results in patients' numbers being more or less than what was allocated. On the day when many patients turn up without appointments, the workload becomes more. This situation brings about an imbalanced spread of workload. The clinic space seemed adequate for the number of booked people with diabetes per visit. Unfortunately the numbers cannot be fully controlled because patients have their own circumstances that the clinic should accommodate in accordance with the Patients' Rights Charter that stipulates that no patient shall be turned back from any health care facility without proper medical assessment, recommendations for alternatives or referral. So such circumstances make the clinic space appear inadequate. The official working hours for the diabetic clinic are from 07H00 – 12H00. The plan is for the diabetic patients to be finished by 12h00 in order to give space for patients coming to other clinics such as, renal which start at 12h00. Although registration at the administration office starts at 07H00 patients arrive an hour or two earlier. They have various reasons for arriving too early at the clinic. Some patients come early because they have to catch the busses that carry people to work; these are the only transport for them.

Others get lifts from someone they know who goes to work. No matter how different the reasons are, ultimately all patients have one wish and that is to receive medical attention timely and return home early. Although the space and seats seemed adequate for the number of booked patients, some participants reported that often some patients have to stand due to shortage of seats or broken ones. Patients have to share seats with escorts. Unfortunately one patient may have more than one escort and they all need to sit down while waiting for health care service. Again due to patients' medical or physical condition that require family members to be with them. For example most patients with physical disabilities use wheelchairs. So they need someone to push them around. Patients are encouraged to utilize other allied services of the dietician and podiatrist that are available. So they are either referred by doctors or they go as self referrals. People with diabetes are prone to leg ulcers due to poor circulation, especially those with poor compliance to treatment. So these together with any other skin conditions that require dressings are attended to in Surgical Out-Patients Department (SOPD). The information on posters varies to include foot care, leg ulcers, insulin, skin care, HIV/AIDS, patients' rights and responsibilities, complaints procedure, hand washing and others. This provision of information is aimed at promoting self care that plays an important part in management of diabetes.

According to the National Standards Compliance guidelines, doctors should manage patients comprehensively, including diabetic patients. So when patients need to be x-rayed they go to the x-ray department and bring their plates to be checked by the doctor using the viewer in the treatment room. The patient does not need to be referred to polyclinic which is something that can be seen as time consuming and inconvenience for patients as mentioned during individual interviews. One participant mentioned during the interview that "*it was time consuming for the doctors to refer them to polyclinic when they report minor ailments such as flues and colds".* Managing people with diabetes comprehensively is one of the best practices of health care services expected of health care practitioners. There is a telephone in this room to facilitate communication both within and outside the clinic. The emergency room is situated far from all clinic activities and its location rendered it suitable for interviews to be conducted quietly away from any disruptions. This diabetes clinic does not dispense medicines, something that patients would love to have so from here they have to go and join the queue at the main pharmacy.

2.4 RESEARCH METHODOLOGY

2.4.1 Population and Sampling

2.4.1.1 Population

A population is a complete set of persons or objects that posses some common characteristic of interest to the researcher Burns *et al.* (2003). Similar definition is outlined by (Brink 2006; Nieswiadomy 2008), while Macnee (2004) defines population as a large group of patients about whom researchers are interested in gaining knowledge. In this research study patients and their relatives who attended this diabetes clinic under study were identified.

2.4.1.2 Sampling Method

Burns *et al.* (2003) stated that a sample is a group of people, events, behaviours, or other elements with which to conduct a study. Macnee (2004) argue that one of the first things that differentiate a qualitative sample from a quantitative sample is the language used to describe the people in the study. In qualitative research, the individuals that comprise a sample are often called participants and in quantitative research they are called subjects. Polit *et al.* (2004) confirm that in a qualitative study sampling means identifying participants who will bring to the study detail and complexity. Brink (2006) is in consistent that when a researcher selects a sample from a population in order to obtain information regarding a phenomenon in a way that is representative, the process is called sampling. In view of the above the purposive sampling was used to select participants who had characteristics that were related to the purpose of the research and the research question, according to Holliday (2006). Once patients and their escorts were identified, they were then approached and requested for their permission and willingness to participate in this research study. Some participants were willing to participate but did not like the idea of identifying themselves. They said that they feared intimidation.

2.4.1.3 Sampling criteria

Sampling criteria is the list of characteristics essential for inclusion or exclusion in the target group (Burns *et al.* 2003). Participants included in this research study were health care users of all race groups who were older than 18 years of age and children were excluded. Patients who are admitted in this clinic speak some of the eleven South African languages and others, so to avoid language barrier, participants had to be those who speak the languages that the researcher can speak, understand, interpret and analyze. The clinic admits both newly diagnosed people with diabetes and old ones. So it was important that the researcher leaves out the newly diagnosed patients as they do not have as much experiences as their older counterparts. It was due to such conditions that purposive sampling became useful and meaningful.

2.4.1.4 Sample characteristics

A total of ten participants were interviewed. Only relevant characteristics of participants to this study are presented below in **Table: 2.2**

Table 2.2: Sample Characteristics

Participant	Gender	Race	Home Language	Level of Education	Employment Status
1	Female	Black	Zulu	High School Education	Employed
2	Female	Black	Setswana	Primary School Education	Employed
3	Female	Black	Zulu	Primary School Education	Unemployed
4	Female	Asian	Chinese	High School Education	Employed
5	Male	Black	Setswana	Primary School Education	Pensioner
6	Female	White	Greek	High School Education	Pensioner
7	Female	Black	Sotho	Primary School Education	Employed
8	Female	White	Afrikaans	Primary School Education	Unemployed
9	Female	Black	Zulu	Primary School Education	Pensioner
10	Female	Black	Sotho	High School Education	Employed

2.4.1.5 General characteristics:

Participants were one male and nine female adults. All participants reside within the Johannesburg Metropolitan Municipal area. Some are either pensioners or unemployed whilst others are employed. They have been coming to this clinic for longer than a year and have opinions regarding waiting time.

Participant no: One

This was a black middle aged Zulu woman who spoke well and with confidence. Although she was Zulu she spoke mostly in Sesotho but uttered or expressed some words such as *filthy, menstruation and stools* in English. Her voice was loud, calling a spade a spade. She had high school education and was employed but laughed when asked where and refused to say where. She was tall, big, and with a dark complexion, no wrinkles and she covered her head. She was approximately 1.7m tall and weighing 95kg. She wore spectacles and said that she got them sometime back not certain. She has been diabetic for approximately 5years and is on oral medicines. Her family medical history includes diabetes, hypertension and arthritis.

Participant no: Two

She is a black middle aged woman who spoke very well in Setswana and seemed comfortable with the discussion. She was approximately 1.5m tall and weighing 70kg which. She was a pretty woman with a beautiful smile and a beautiful set of teeth. She had a fair skin colour with a low pitched voice. Her face has few wrinkles and she was wearing a hat that covered her head. She was a domestic servant who only obtained primary education because she grew up without both parents. She was diagnosed diabetic ten years ago. She does not wear spectacles but her eyes appeared mildly affected by diabetes and she mentioned in her own admission that she wants to go for an eye test. Because she grew up as an orphan she did not know her family medical history.

Participant no: Three

This was a middle aged Zulu woman who only had primary education and was looking for a job. She was obese and tall approximately 1.7m tall and 100kg body mass. She did not wear spectacles and said that she had no problems with her eyes. Her face did not have any wrinkles and she covered her head. From her face she appeared troubled, shy with minimal eye contact. She had primary level education. Although she was uncomfortable at the start of the interview she appeared relaxed as the discussion continued. She also in her own admission mentioned that she feared intimidation from clinic staff. However she managed to voice her opinions. She said that there was no history of diabetes in the family but did not seem confident with her answer. She was diagnosed for nearly a year ago.

Participant no: Four

A young Asian woman in her thirties diagnosed juvenile diabetes twenty years ago and has been on diabetes treatment since. She has Insulin Dependent Diabetes Mellitus (IDDM) and was coping well with the disease. She was slightly overweight and tall. She was approximately 1.6m tall and 70kg body mass. She does not were spectacles and said that she has no trouble with her eyes. Her face looked lively with no signs of ageing. She works in the family business. She was friendly and seemed comfortable with the interview and had high school education. There was family medical history of diabetes but no hypertension. She was speaking loud and a bit faster than everyone, open and upfront with information. She was clearly troubled by some changes that were put in place as it can be expected of a patient who has been attending the clinic for the past 20years. She said that some of the previous systems were just perfect for her. Despite her frustration she managed to share some jokes about how patients try to cope with waiting time.

Participant no: Five

An elderly black male who spoke Setswana and only had primary education, he is a pensioner of medium height and small built, approximately 1.5m tall weighing 55kg. He seemed frail due to his medical conditions including diabetes. Apart from the diabetes clinic he also attended the urology clinic for his prostate. Although he did not wear spectacles, his eyes were clearly diseased and he admitted that he could not see as well as he use to.

He could not recall when he was diagnosed but said it has been years. However he was concerned that he does not have money for spectacles even though he has no idea how much they were. His hair was mixed in grey and black. He has a family medical history of diabetes, hypertension and epilepsy. He did not know anything about cancer in the family because he grew up in the deep rural areas where people in the olden days never used western medication and diagnosis. He also said that even if someone had a urological problem it was probably kept a secret.

Participant no: Six

An elderly white woman of Greek origin communicating fairly well in English and was outspoken. She was a pensioner with wrinkles on the face and her head was covered with grey hairs. She communicated her concerns and appreciations very well. She was approximately 1.5m tall and 60 kg body mass. She did not wear spectacles and said that she only uses them for reading otherwise she can see. She said that her parents did not have diabetes but one sister is also diabetic. She has been diabetic for more than ten years and has seen all good and bad changes in the clinic.

Participant no: Seven

This was young black Zulu woman who spoke in Sesotho and had primary school education only. She was employed and was accompanying her two relatives who came to different clinics. She was approximately 1.6m tall weighing 75kg. Her face was young looking with no grey hairs. She was clearly frustrated because of the two clinics taking place simultaneously forcing her to run around and sometimes losing her place in the queue. She was very much concerned about the attitude of health workers especially administration officers.

Participant no: Eight

This was an elderly white Afrikaans woman who communicated well in English. She was a pensioner and accompanies her husband every time to the clinic. Her hair was grey but not completely. She had wrinkles. She was a short person of approximately 1.4m tall but overweight with approximately 100kg body mass.

She was a pensioner but never had to work. Husband worked alone until retirement and injured his back which made him a wheelchair occupant. She left school early and only got primary education because she got married and started having children. She said that her mother in law was also a diabetic patient and some family members suffered from heart conditions. She was concerned about lack of respect for wheelchair occupants in terms of parking and no consideration to be seen first.

Participant no: Nine

This was an elderly black Zulu woman who was clearly upset because some of her clinic records were missing and this was not the first time. She was a pensioner of 70-75years of age who had only primary school education. Her face had wrinkles and she wore a hat to cover her head. She did not know any family medical history and seemed uninterested in history. She was diagnosed five years ago after she had a stroke and was admitted in the ward.

Participant no: Ten

She was a black middle aged woman who spoke Sesotho and had high school education. She works at a clothing store. She was approximately 1.6.m tall and 120kg body mass, dark complexion with a rough and loud voice. She was confident and giving information outright. She did not wear spectacles and said that her eyes were not bad. She said that her mother had hypertension but no diabetes but her father was diabetic. She said that she was a relative to one of the nurses but was not expecting special treatment and was proud to queue like all patients

2.4.1.6 Sample size

There are no criteria or rules for sample size in qualitative research. A guiding principle is data saturation; that is, to the point at which no new information is obtained and redundancy is achieved (Polit *et al.* 2004; Nieswiadomy 2008; Macnee 2004).

Holliday (2006) adds that in Naturalism, the researcher continues in the field until representativeness and exhaustiveness are confirmed i.e. when the same features begin to emerge again and again. Data thus needs to be collected until it tells nothing new, as evidence that there is maximum coverage and that nothing has been overlooked. In contrast to the goal of quantitative research that seeks to acquire a sample that is as representative as possible of the population of interest so that the findings from the study can be generalized Macnee (2004) explains. Despite the criticism for the small sample in a qualitative research, saturation in this study was reached after ten participants were interviewed. The possibility of reaching data saturation from a small sample of approximately 10 participants is supported by (Sandelowski 1995) in (Burns *et al.* 2003) when they assert that in qualitative research, the focus is on the quality of information obtained from the person, situation or event sampled rather than the size of the sample. The depth of information that was obtained assisted in gaining insight into health care users' experiences and perceptions of waiting time. Participants were carefully selected and only those that the researcher believed would provide rich data to discover new meaning of waiting time at the diabetic clinic were interviewed.

2.5 Data Collection

According to Burns *et al.* (2003) data collection is the precise, systematic gathering of information relevant to the research purpose or the specific objectives, questions, or hypothesis of a study. Polit *et al.* (2004) point out that data collection is the gathering of information to address a research problem.

2.5.1 The process of data collection

2.5.1.1 Gaining Access

It is important to gain permission to enter the field that has been decided on. This is of prime importance in order to get the study started according to de Vos, Strydom and Delpoort *et al.* (2005). Creswell (2003) refers to gaining access as an element of the researcher's role.

He further emphasise that it is important to gain access to research or archival sites by seeking the approval of gatekeepers. Burns *et al.* (2003) also note that in order to collect data; the researcher must obtain permission from the setting or agency where the study is to be conducted. Written permission to conduct this study was obtained from the Ethics Committee for Human Research and Post Graduate Committee at University of the Witwatersrand before the researcher could visit the diabetes clinic. The researcher also obtained written permission from the management of the hospital concerned. The researcher further obtained verbal permission from the unit manager of the diabetes clinic after proper introduction and negotiation were done. Participants were also requested for their permission to be part of the research study, through the informed consent that the researcher provided. Permission was subsequently granted through signatures on the informed consent forms. However this was not to be the end of the request for permission as it was followed by verbal consent that I negotiated and renegotiate during the interviews to verify permission.

2.5.1.2 Method of Data Collection

2.5.1.2.1 Pilot Study

McSherry *et al.* (2002) point out that pilot study is used to develop a research plan to try out data analysis techniques to refine tolls of research. This gives an opportunity to determine whether or not the proposed study is feasible and identify any problems with the design.

The following were the reasons why the researcher conducted a pilot study before *this* actual research study. To:

- Determine whether the proposed study was feasible.
- Identify problems with the design
- Refine data collection and analyse plan
- Examine sample size

A pilot study was conducted as recommended by Nieswiadomy (2008) that it is advisable to conduct a pilot study before the study subjects are approached. The actual research study was carried out on two participants who met the selection criteria at one academic hospital. This pilot study did not yield any problems with the design or the research questions.

I used four methods of data collection for this research study.

- **Unstructured interview**

It is an interview that is initiated with a broad question; participants are usually encouraged to elaborate further on particular dimensions of a topic and often control the content of the interview (Burns *et al*. 2003). In-depth unstructured interviews were conducted with health care users using an interview guide that consisted of only one open-ended question to allow information to flow freely as opposed to an interview guide with several structured questions in a quantitative study where the researcher uses strategies to control the content of the interview. Follow up questions varied according to what participants mentioned, in order to probe for clarification of their meaning. Probing for clarification of meaning assisted in revealing issues that are often taken for granted. Issues that can be referred to gaps between what is happening in clinical practice and what ought to happen as outlined by Batho Pele Principles. In this study participants were encouraged to speak in the language of their choice. Four languages used were Setswana, Sotho, Zulu and English. The main question in the interview guide was the following:

"What are your experiences of waiting time at this diabetes clinic? (Annexure A)

The emergency room is situated far from all clinic activities and its location rendered it suitable for interviews to be conducted quietly away from any disruptions. I was allocated this room to conduct individual interviews. There was a desk where I put all the interview material. Three chairs are kept in this room allowing the interviewer, interviewee and the escort to sit comfortably.

The door was kept closed during the interviews preventing noise coming from outside and allowing the discussions to take place uninterrupted. I greeted the participants and introduced myself first. In order to build rapport I created a less formal environment by conducting small talks with each participant after greetings. Approximately five to ten minutes was spent on explaining the purpose of the meeting and encouraging them to speak in their preferred language. This time spent ensured a relaxed and less formal environment as envisaged by me. Permission to participate and to record the discussion was negotiated and renegotiated and obtained before and during the discussion. Some participants chose to remain anonymous and could not sign the written consent form. Participants mentioned fear of intimidation by the clinic staff. This concern still remained after the researcher explained that their names would not be mentioned. The voice recorder was switched on at the beginning of the interviews and off immediately at the end. The same exercise continued with all participants in a similar pattern. This diabetes clinic does not dispense medicines, something that patients would love to have so from here they have to go and join the queue at the main pharmacy. My intent of unstructured interviews was as described by Burns *et al.* (2003) to encourage participants to continue talking by using techniques such as nodding the head and making sounds that indicate interest. I also used communication methods such as listening, probing, clarifying and observing (among others) to gather data as suggested by Uys & Middleton (2004). Non-verbal communication of the participants were observed and reported in the field notes as well. All interviews were recorded on audiotape, with the written permission from each participant, and then transcribed verbatim, for analysis purposes. The participants were assured that their names will not appear on the tapes or notes and that the audio tapes and transcriptions will be kept under lock and key to ensure confidentiality. The tapes and transcripts will be destroyed by burning after two years if the study is published and if unpublished they will be destroyed after six years.

- **Advantages of interviews**

The following advantages of interviews were suitable for this study as outlined by Polit *et al*. (2004); Nieswiadomy (2008)

- ✓ Most of data obtained were usable
- ✓ In-depth responses were obtained
- ✓ Non-verbal behaviour and verbal mannerisms were observed

- **Disadvantages of interviews**

Interviews too have their own shortcomings which have been outlined by (Nieswiadomy 2008). The following disadvantages were identified in this research study:

- ✓ Interviews were time consuming and expensive
- ✓ Arrangements for interviews were slightly difficult to make because participants were anxious to see the doctor.
- ✓ Participants were anxious because answers are being recorded

Health care users who were already seating on the queue that was going to the doctors' rooms were reluctant to participate in the study as they feared losing their positions. Although participants willingly gave consent for the interview to be recorded, some had doubts due to fear of intimidation.

- **Observations**

Field notes

Field notes are a written account of things that the researcher hears, sees experiences and thinks about in the course of interviewing according to de Vos *et al*. (2005). Creswell (2003) adds that the researcher takes field notes on the behaviour and activities of individuals at the research site. In this research study all relevant field notes were written and will be kept as part of the raw data. The report on observations is presented in detail in the next chapter.

- **Analyzing documents**

In qualitative studies text is considered a rich source of data Burns *et al*. (2003) and Brink (2008) add that hospital records, admission charts, incident reports, care plan statements, students' test and examination results and sick leave records all constitute rich data sources.

Brink (2008) further explains that although records are an economical source of information; permit an examination of trends over time and eliminate the need for the researcher to seek cooperation from participants; however they are subject to the following shortcomings:

- They may be exposed to many sources of error.
- They may contain institutional biases
- Facts may be distorted some omitted
- Record keeping may be erratic
- The collection of data may have been stopped for political or financial reasons
- Some data are not available owing to their confidential nature.

Various authors; in De Vos *et al.* (2005) classified documents as personal and official. The researcher found the latter to be relevant to this research study. The report on waiting time documents is presented in chapter 3.

- **Photographs**

Bauer & Gaskell (2006) contend that when photographs are attested and witnessed, and logged for time, place and circumstances, they can have powerful evidential or persuasive value Participants have stated that the conditions of the toilets at this clinic are not satisfactory. They alleged that toilets are clean in the morning and become dirty as the day goes by. So the photographs were taken in June 2012 between 07H00 – 13H00 so as to verify or nullify these allegations. The report on photographs together with their images is presented in chapter three.

2.6 DATA ANALYSIS

Responses were collected until data reached saturation and with no new themes emerging. The Tesch method of analysing qualitative data (Tesch 1990 in Creswell 2009) was used to analyse data. The steps followed are presented as follows:

- Step 1- researcher read and re-read all the transcriptions carefully in order to get a sense of the whole.
- Step 2- Thereafter used one document to get the meaning of it and wrote thoughts in the margin.
- Step 3 - A list of topics was made and similar topics clustered.
- Step 4 - Topics were given codes in the form of abbreviations and were written next to appropriate segments of the text.
- Step 5 -Topics were given names and turned into categories and grouped to reduce categories.
- Step 6 - Codes were given alphabets.
- Step 7- All data material were then assembled into one place to perform a preliminary analysis.
- Step 8 - It was not necessary to recode as the researcher was pleased with the themes that emerged.

I read and re-read carefully through each transcript in order to get a sense of what was said by participants after listening repeatedly to recordings on the tape. The next step was to read through one interview transcript of interest and asked this question: what is this really saying? From this, topics were identified and written in the margin of the document. The procedure was repeated with all transcripts one after the other paying attention to underlying meaning rather than the content. This was followed by making a list of topics and then clustering of similar ones. At this stage codes were abbreviated and written next to the segments of the text. This step also led to the discovery of new topics that were not previously identified. It was at this stage where I was ready for refinement of organized data and turning topics into categories. This was the time to give codes the alphabets and some segments in the content were placed in more than one category because they fitted. At the completion of coding all materials belonging to each category were checked and assembled in one place. Then descriptive words were used to translate coded topics into five themes. As the content for each category was identified and summarized, commonalities, uniqueness, confusions, contradictions including missing information were identified. I then confidently discarded irrelevant data. The final step of recoding as stipulated by Tesch's guidelines was not required because categories were homogenous from which five themes and 19 sub-themes emerged and are presented next.

2.6.1 Coding Procedure

The coding procedure was done in accordance with Tesch's guidelines and the researcher read through each transcript carefully to get a full picture of what was being said.

2.7 MEASURES TO ENSURE TRUSTWORTHINESS

Trustworthiness means the degree of confidence that qualitative researchers have in their data, assessed using the four criteria of credibility, dependability, transferability and conformability outlined by Lincoln & Guba (1985).

2.7.1 Credibility

Credibility refers to confidence in the truth of the data and interpretation thereof. Babbie *et al.* (2003) explained that there should be compatibility between the constructed realities that exist in the minds of the respondents and those that are attributed to them.

2.7.2 Dependability

Dependability refers to the stability of the data over time and over conditions. Babbie *et al.* (2003) point out that an inquiry should provide evidence that if repeated with the same or similar respondents in the same context, its findings would be similar. The audit trail used in this study will include raw data, description of how data was collected, categorization and how analysis was achieved. All these will be kept for review when requested at any time.

2.7.3 Transferability

Transferability refers to the extent to which findings can be transferred to other groups or settings (Babbie *et al*. 2003). The framework of this research study was based on Batho Pele Principles. Government officials, academics, managers on all levels and especially health care users in public health facilities hope see health services being rendered in line with Batho Pele framework. I have provided sufficient descriptive data in the research report and am confident that these findings will be transferable to other Gauteng's public hospitals. It may be as Bailey (2007) points out that locating one's research within an explicit conceptual or theoretical frame increases the likelihood of analytic generalization.

2.7.4 Confirmability

Babbie *et al*. (2003) point out that confirmability refers to the objectivity or neutrality of the data that has the potential for congruence between two or more independent people about the data's accuracy, relevance or meaning. Application of trustworthiness is presented in Table: 2.2 on pp 53-54.

Table: 2.2. Measures of Trustworthiness in Application

CRITERIA	STRATEGY	APLLICATION
Credibility	• Triangulation	Two research experts, who have extensive knowledge and experience in qualitative research studies, supervised this study from beginning until completion.
		The researcher' s qualifications together with the experience from current employment at Central Office (Gauteng Provincial Health Department) enabled her to conduct individual interviews and analysis of all sources of data successfully.
		Different sources of data were collected and analyzed. These include individual interviews, observation of the setting, waiting time records and photographs.
	• Prolonged engagement	Although I was not known to the clinic staff, they welcomed me and granted me permission to come in anytime. This permission enabled me to make several visits to the setting until data saturation was reached.
	• Persistent observation	I dedicated some visits to make observations of the setting, activities and interactions. Photographs of significance to the study were captured as well.
	• Referential adequacy	Fields notes for this study will be kept safe and be made available when requested. The audio tape that was used to capture the participants' voices is in safe keeping. The copies of photographs that have the significance to this study are presented in chapter three. Furthermore the original images will be burned onto a CD and kept safe. The waiting time records were analyzed and will remain in safe keeping.

	• Peer debriefing	My colleague who was simultaneously registered as researcher at another university not the University of the Witwatersrand was available to co-check my work as required.
	• Member checks	I managed to verify data with the participants and this enabled me to modify my approach with the next one and the next. My style became better and easier until completion.
Dependability	• Inquiry audit	A senior researcher was consulted as a field supervisor throughout the study and made invaluable contributions by cross-checking the codes.
Transferability	• Thick description	I made observations of the setting, warm bodies and their activities. The report is presented in chapters two and three.
	• Purposive sampling	The purposive sampling was used to select participants who had characteristics that were related to the purpose of the research and the research question, according to Holliday, (2006: 21).
Confirmability	• Raw data • Instrument developed information	Field notes, voice recorder, all written material used in the process of this study will be kept in safe keeping. The report of the pilot study with two participants who met the selection criteria is available and is kept in safe keeping.

2.8 SUMMARY

This chapter described the research methodology used; the objectives, design, population and sample, data collection and analysis, lastly measures to ensure trustworthiness. Based on the purpose of this study a non experimental research design of exploratory, descriptive, contextual, theory generative in the qualitative paradigm as opposed to a quantitative inquiry was used to meet the objectives of this research study. The following chapter presents the analysis of the individual interviews, observations, waiting time documents and photographs and literature control.

CHAPTER THREE

DISCUSSION OF RESULTS AND LITERATURE CONTROL

3.1 INTRODUCTION

Burns *et al*. (2003) point out that the purpose and timing of the literature review in a qualitative research vary based on the type of study to be conducted. De Vos *et al.* (2005) add that a review of literature is aimed at contributing towards a clearer understanding of the nature and meaning of the problem that has been identified. In this research study the problem was identified as health care users' experiences and perceptions of waiting time at the diabetes clinic in an academic hospital. Therefore this research study used the phenomenologist approach according Burns *et al.* (2003) that believes that literature should be reviewed after data collection and analysis so that the researcher is not influenced by the information thereof. Moreover, that there is limited research on this topic. Mouton (2006) concurs that literature review is used as a map that provides guidelines through existing body of knowledge as this study hitherto enjoyed limited attention locally and internationally. Nieswiadomy (2008) affirms that qualitative researchers review literature at the conclusion of the study to inform readers how their findings fit into the existing body of knowledge on the topic of interest. I compared the information from the literature with the findings of this research study and determined similarities and differences. Furthermore the comparison also revealed the knowledge gap that is not covered by the previous researches to complete theory generation. Sources of literature review and the search strategy are presented below.

Primary sources:

Books: Nursing research; Social Science research; Education research.

Secondary sources:

- Journals: Nursing; Medical and Human Sciences.
- Research Engines: Pubmed & Medline
- Professional bodies: South African Nursing Council.
- Legislative prescripts: Government Gazettes; Policies and guidelines

Search strategy:

- Wits Health Science Library electronic databases
- Search terms: health care users; experiences; perceptions; waiting time.
- Inclusion criteria: Out Patient Departments.
- Exclusion criteria: In patient; Emergency Departments; Surgical procedures

The findings of this research study were combined with the information from literature and then used to reflect the current knowledge that is needed to promote comfort in the Out Patient Departments in relation to the theoretical framework used. The functions of literature review are outlined by Brink (2006) in application to this research study as follows:

- To determine what is already known about the topic.
- To place the study in the context of the general body of knowledge.
- To compare the findings of the existing studies with those of the study at hand.
- To inform or support a qualitative study, especially in conjunction with data collection and analysis.

In this chapter empirical data from individual interviews, observations, waiting time documents and photographs were analysed to identify specific themes and related sub-themes. Ten individual interviews were conducted for data collection in relation to the first and second study objectives that were: firstly to explore health care users' experiences of waiting time and secondly to describe the perceptions to which they give rise at a diabetes clinic in an academic hospital. Health care services in South Africa and internationally are believed to be negatively affected by long waiting times. The increasing number of patients with non- communicable diseases is among the causes of long waiting time. Dunhill and Pounder (2004) point out that the length of time patients have to wait in the clinic before being seen is a common source of frustration. Berne *et al*. (2004) alerted that an estimated 15 million people in the United States have type II non-insulin dependent diabetes mellitus, and this incidence is increasing worldwide. In the United States the prevalence of type II diabetes is expected to double by the year 2025.

Tsiko (2006) confirms that the epidemic is also noted in Africa, at a time when health experts say the continent's overburdened health care systems are ill-equipped to diagnose the disease and the majority of the poor cannot afford the cost of treatment. Jawahar (2007) surveyed the satisfaction level of patients and also to get feedback about the services provided in the outpatient departments. Tsiko (2006) concluded that outpatient departments in any hospital are considered to be shop window of the hospital. Furthermore patients are faced with various problems such as overcrowding, delay in consultation, lack of proper guidance and others that lead to their dissatisfaction at a super specialty hospital in India. Gauteng Department of Health (2010) indicate that in 2005, 21 914 newly diagnosed people with diabetes were put on treatment in all three regions. The figure has tripled in 2010 reaching 74 704. The number of patients seen yearly at this diabetes clinic is also evidence to the prevalence of diabetes. Hence the booking system that is used to control the patients' flow but walk-ins are always present. Wijewickrama *et al*. (2006) confirmed that patients who did not make appointments (walk-ins) are unavoidable and their service time invariably impacts on the waiting time for scheduled appointments. Consistent with the system used at this diabetes clinic, Patrick (2011) developed a model to determine optimal outpatient scheduling that recommend the "do today's demand today". This model seeks to increase access to health care services and reduce dissatisfaction and complaints from patients who were allegedly turned back due to wrong date often by a clerk who refused to open a file.

In an attempt to reduce waiting time the Gauteng Department of Health introduced the following measures:

- The project manager for waiting time was appointed at central office in 2005 to identify causes of long waiting time and put measures in place aimed at reducing waiting time.
- Measures that were introduced included the supply of electronic monitoring devices to hospitals. The use of these devices was to record the time of arrival and departure in order to calculate the overall waiting time for health care services on different days.
- Quality managers were subsequently appointed in hospitals and clinics to monitor and evaluate waiting time.
- Queue marshals were appointed in hospitals and clinics to ensure that patients wait in the appropriate queues and prevent them from wondering around in the corridors. They also attend to queries from users and give information where possible.

- The smart card was also introduced in order to fast track admission of patients especially in an emergency situation, because it contains patients' brief medical records.

Unfortunately due to the problems encountered these measures do not have much impact to date. For example, queue marshals are not appointed on permanent posts and in some facilities they are not available. The smart card was only used as a pilot before it was withdrawn due to financial constraints. Some electronic devices were allegedly vandalised while others were stolen. Then they were recalled and the project withdrawn indefinitely. It is unclear whether the culprits were health workers or users. Quality managers keep changing due to the need for both personal and professional growth. Unconfirmed isolated cases of patients who died in the queue together with complaints about critical and terminally ill patients who were allegedly left unattended have been reported to Gauteng Health Department and some end up in litigation. Therefore in the absence of a dedicated manager the project suffers a setback. Such complaints have attracted negative media publicity regarding health care services. The main aim of this research study was to explore health care users' experiences of waiting time at a diabetes clinic in an academic hospital and describe their perceptions thereof. It was anticipated that due to the prevalence of the disease that impact negatively on waiting time diabetic patients may therefore have stories to share. The study cited (Tsiko 2006) reported that diabetes is responsible for so much suffering and loss of life, yet so little is being done to tackle it. So, in this research study the sufferings of people with diabetes were uncovered when five themes and 19 sub-themes emerged.

3.2 THE INTERVIEW SETTING

Polit *et al*. (2004) point out that setting is the physical location and conditions in which data collection takes place in a study. In-depth qualitative studies are especially likely to be done in natural settings because qualitative researchers are interested in studying the context of participants' experiences. Bailey (2007) states that rather than controlling events the researcher attempts to become part of the setting, with the goal of providing in-depth descriptions and analytic understanding of the meanings that participants in a setting attached to their interactions and routines.

Holliday (2006) asserts that interviews and observations need to be located within a bounded setting and become valid because they interconnect via an environment which contains other actions, events, icons and so on, which give them meaning in opposition to the notion of a survey in quantitative research. The diabetes clinic in an academic hospital was the suitable setting for data collection in this study. All sources of data collection including individual interviews, observations, analysis of waiting time documents and photographs were conducted in this setting. The emergency room was used for interviews and its door was kept closed to prevent the noise and allowing the discussions to take place uninterrupted. Staff never came into this room because no patient needed emergency care during the interviews. I greeted the participants and introduced myself to them. Some of the participants spoke Afrikaans, Greek and Chinese, I therefore verified if they were comfortable to speak in English, to do that we engaged in informal conversation. This time spent ensured a less formal and relaxed environment as it was envisaged during which the purpose of the meeting was explained while advising participants that they have the right to stop the interview anytime. I went on to negotiate, renegotiate and obtained permission to participate and record the discussion. Despite the explanation that their names would not be mentioned, some participants chose to remain anonymous and could not sign the written consent form stating fear of intimidation by the clinic staff as their reason. Nevertheless the voice recorder was switched on at the beginning and off immediately at the end of the interviews, throughout to complete ten interviews successfully.

3.3 OVERVIEW OF DATA ANALYSIS

Responses were collected until data reached saturation and with no new themes emerging. The Tesch method of analyzing qualitative data was used (Tesch 1990 in Creswell 2009). The steps that were followed are presented in chapter 2 pp 49-50.

3.4 THEMES THAT EMERGED FROM INDIVIDUAL INTERVIEWS

Oxford Dictionary (2011) describes a theme as frequent recurring group of notes in a composition or an idea that is often repeated in literature.

Data from ten individual interviews were carefully analyzed as described in afore mentioned paragraph. Five themes and nineteen sub-themes emerged from individual interviews on completion of coding process. These are tabled and presented below in **Table: 3.1**

Table: 3. 1 Themes and sub-themes from individual interviews

THEMES	SUB-THEMES
Physical distress	• Poor access to health care services and service points • Long waiting for doctors and medicines • Inadequate and uncomfortable seats. • Getting hungry and thirsty. • Inability to use toilets.
Emotional distress	• **Anger**: shouted at by staff ; long waiting • **Anxiety**: missing and mix up of files; inability to hear when names are called; no information on doctors' whereabouts. • **Fear:** toilet hygiene; how to get home; different doctors every clinic visit. • **Frustration:** Poor filing system; no choice of doctors; different doctors every clinic visit; bad staff attitude; inability to hear when names are called; no information on doctors' whereabouts • **Sadness:** no physical assessment; shouted by staffs; long waiting for doctors and medicines; embarrassment in toilets; No toilet paper supply; no apology.
Development of coping mechanism	• Use of toilet before it gets dirty. • Bring food from home.
A sense of helplessness	• Unable to answer back when falsely accused or shouted at by staff. • No money; nothing to eat. • Unable to hear due to levels of noise
Perceptions created	• Only patients who are seen by the professor or consultant receive optimal treatment. • Clinic staffs treat patients with disrespect because they are uneducated. • Patients are treated like guinea pigs for training purposes • Doctors come late because they do not feel sorry for patients

SAHRC (2007) indicates that the right to health care is generally referred to as fundamental to the physical and mental well being of all individuals and as a necessary condition for the exercise of the human rights including the pursuit of an adequate standard of living. The findings of this research study were congruent with this statement when the themes below emerged.

3.4.1 THEME ONE: PHYSICAL DISTRESS

According to the World Health Organization (2004) health is defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The physical distress refers to things, situations or circumstances that affect participants physically causing some suffering. This statement justifies the reason behind the expression of dissatisfaction by users regarding the physical environment at the diabetes clinic under study. The Nursing Science Literature advocates physical and emotional comfort as the first step towards basic nursing care in which interaction between the health workers and health care users takes place. Physical and emotional comfort should be promoted before any procedure can be performed on patients to ensure cooperation. Bruce & Stellenberg (2007) attested that patients' privacy and comfort are the general principles for all procedures. This implies that users should receive comfort from admissions throughout their stay until they have received all health care services. A study by Sithole *et al.* (2008) found that dissatisfaction which may result from any combination of anxiety, frustration, depression, discomfort, prolonged pain and suffering that patients have to endure in long queues may contribute to defaulting and non-compliance which in turn can negate the gains, outcomes and impact of health interventions and the quality of life of patients. Although Tsiko (2006) found that in Kenya, almost all patients (96%) waited for services longer than 90 minutes, which was acceptable waiting time, the study also found that this was likely to discourage potential clients from utilizing services, resulting in low uptake because this initial experience negatively influences subsequent attendance.

3.4.1.1 Sub-theme: Poor access to health care services and service points

The Health Act no: 61 of 2003 stipulates that if a public health establishment is not capable of providing the necessary treatment or care, the health establishment in question must transfer the user concerned to an appropriate public health establishment which is capable of providing the necessary treatment or care. According to the National Department of Health (2008) satellite clinics are not authorised to keep certain medicines. Therefore patients are referred for tertiary health care services to this diabetes clinic. Some patients stayed far from the hospital and therefore complained about transport problems to and from this diabetes clinic. Due to long waiting time, they were forced to come early in the morning. The problem was that they did not finish as early as they had hoped. The impact of these referrals was that because it was not the patients' choice to attend this diabetes clinic, they had to make means of transport to and from the diabetes clinic. Some patients used their own cars while others relied on public transport. Although participants were pleased with the medicines that they received every time they came for check up, they were however concerned about transport especially in the afternoon. Due to long waiting time some patients reported that they finished late previously and could not find public transport to take them back home. One participant said that she finished so late that she only arrived home at 9 pm. As a result of this experience she feared for her safety.

Gulliford *et al.* (2002) conducted a study regarding what does access to health care mean?, they found that the extent to which a population 'gains access' also depends on financial, organizational and social or cultural barriers that limit utilisation of services. Thus access measured in terms of utilisation is dependent on the affordability, physical accessibility and acceptability of services and not merely adequacy of supply. Nkosi, Goudge & Kahn (2007) looked at cost as a barrier to primary health care for rural poor in South Africa and reported that in general poverty increases people' s vulnerability to ill health. This was due to high travel cost and the fact that facilities were too far. Sithole *et al.* (2008) found that transport cost was of concern to patients as often it has to be doubled when they need an escort. The problem becomes worse when they do not receive medicines on the same day and are forced to return the next day. Recently Harris *et al.* (2011) studied inequities in access to health care in South Africa and confirmed that vast distances and travel costs were among access barriers especially in rural areas. In addition, the other participant mentioned that sometimes they finish late when public transport is no longer available.

Then, users have to make calls here and there asking for a lift back home. Department of Public Service and Administration (2012) confirm that people in South Africa often face great inconvenience due to long distance travels to obtain services and information they need from government institutions. Wheelchair occupants and their escorts experience difficulty to access service points, as one participant mentioned that it was not easy to push her husband to and from service points. She also said that the parking bays for the disabled were unlawfully occupied by able persons. Lastly when they finally arrive at this clinic, they are made to wait in the queue because there is no recognition for VIP status. This status offers first preference to people with special needs to access health care services like all citizens as stipulated by Batho Pele policy. Unfortunately not all measures for the VIP status were implemented. The toilets were also not disabled friendly, no rails and door handles were higher and difficult to reach another cause for concern. People with visual impairments did not have any reading material in Braille. Various reading materials such as pamphlets, brochures and posters were inaccessible to them and they relied on their escorts to read for them.

Persons with hearing impairments also experienced problems as they often could not hear when their names were called out due to the levels of noise. There were no special measures to ensure that they can hear. They also missed on group health education given in the waiting room or any announcements. In the absence of the VIP status the number card system as mentioned by the participants would assist this group to check their own numbers against others in the queue. Participants made mention of other units that used card system which appeared to be working better as it is easier to follow the sequence in numbers than when any other method. Bruijns, Wallis & Burch (2008) evaluated the impact of introducing nurse triage and concluded that it was possible to reduce waiting time of patients attending a busy public hospital emergency department in South Africa. Although the study was conducted for emergency departments, the results indicate that it is possible to utilize the strategy in Out Patient Departments. Meanwhile, the Gauteng Health Department's 2009-2014's strategic objective is to undertake specific interventions to reduce waiting times at all out-patient departments and pharmacies. The recommended strategies to reduce waiting time include the following:

- Strengthening of help desks.
- Introduction of fast queues for people with special needs.
- Implementation of effective triage system

- Introduction of clear visible signage to guide patients
- Training of queue marshals
- Kgatelopele project for distribution of medication for chronic patients.

While the National Health Insurance is underway with the few 10 pilot sites selected to roll out the system, other measures to promote access to health care services should be improved.

Participants had this to say about poor access to services and service points:

Participant no: 1

"I would like to ... something that can be improved, you find that you came early to hospital – you came early now the sisters there on the table they mix files. I ask the sisters to write like-like at the chemist. When we go to the chemist, we get numbers. You know when you are this number, you are this number – you go with your number. When our files come from reception, they go to, they go to the sister – sisters do not keep them accordingly, you hear me. You see someone who came after you going in first – you go to ask why it is happening like this and they say we have mixed the cards up. Something like this does not work. They should have cards like at pharmacy. At pharmacy they give us number- they give us numbers to say who you are after, just like that. That is something we ask otherwise the system is poor".

Participant no: 2

"I am not working I do not know what to do but I like to come and I pay R40.00 for every check up. We sit long at chemist and get tired and hungry. We wake up early and leave at 5am. I sit and sit the whole day and get hungry. You see we have to eat then if I have money I buy something and eat but the shop here is expensive. Right now since I came I have not seen the doctor I don't have money to buy food. Here food is expensive".

Participant no: 3

"The other thing is that we get out late. Sometimes you find that is 6pm and you are at the chemist. The other time when there were floods in Soweto, there were no taxis, I arrived home at 9 pm. I saw an improvement at dispensary; they give us a three months supply of repeats".

Participant no: 4

"Sometimes no transport, no transport because it is six o clock and everything has left. We have to phone here and there to find a lift. So I think more people to the chemist. More experienced people. People kill themselves inside there, experienced people because one asks the other. Every hour they call only ten people. So we have to spend the whole day".

Participant no: 5

"*I think if they have a number system, if you are number 20, 30, 40 or 80 and you know you are that number. Because some people come late but all of a sudden they are seen first. Whereas I got to be up and dressed at half past five. I got to leave to be here at six o clock. I am still like last to go, a lot of times. He is in a lot of pain that is the only thing I can suggest. We have been coming here long and we don't complain about that. They used to see wheelchairs first but they have stopped that and there is one big- big problem, downs stairs in the parking, in the orange block there is no parking for disabled people for wheelchairs. And in the green block where is parking for disabled people, you find staff and young ones park there. I can't get him in and out of wheelchair in a normal parking. So I got to stop in the middle of the road, get him out of a wheelchair. Leave him in the middle of the road. So it is difficult with a wheelchair in a normal parking. There is only wheelchair parking in the green block not in the orange block. I don't want to push him all the way to the green block".*

Participant no: 6

"You see sometimes you find that your name is called but people are making noise and you cannot hear your name when it is called. You find that you have a hearing problem. I am like that I have that problem, now you find people talking loud. Patients and staffs especially at the admission desk. When staff is coming to work in the morning they speak loud, they greet each other and are shouting. You wonder why are not speaking softly. No I do not like it, noise and the long waiting for doctors. Maybe there must be someone to make people speak softly because when names are called, patients should hear their names. But white people do not speak loud, is only us, this is our thing. Somebody will say hi! How are you? And the person is just next to her. It is just like when we speak on the phone".

3.4.1.2 Sub-theme: Long waiting for doctors and medicines.

The Gauteng Department of Health's strategic plan (2009 -2014) has stipulated that patients are to be processed within 2 hours of arrival. Furthermore the waiting time for pharmacy should be reduced to 1 hour. However the actual waiting time for this clinic under study was approximately 4 hours. Patients still had to wait for approximately 5 hours at pharmacy for their medicines, bringing the total waiting time at this diabetic clinic to approximately 8 hours per visit. Some participants mentioned that sometimes they only finish as late as 17H00 or 18H00 at pharmacy to receive their medicines. They said that by the time they finished, public transport was no longer available. Stoop *et al.* (2005) revealed that waiting times limit access to health care and are therefore an important concern for those who are interested in quality improvement. Participants have expressed their dissatisfaction around the fact that patients and their relatives sit and wait for long periods of time at this diabetes clinic despite being sick and often not feeling well. Firstly they waited long for the administration staff to pull out, register and issue their files. Secondly they waited for the doctors to perform a medical examination. The last wait was at the pharmacy to collect their medicines. While patients expressed dissatisfaction with the day to day clinic activities, the clinic staff seemed content, something that patients interpret as non caring attitude.

Klitzman (2007) examined the views and experiences of conflicts concerning time in health care, from the perspective of physicians who have become patients. He found that doctors recognized how patients' experience of increased discomfort, anxiety, pain, uncertainty and reduced social status affects their perceptions of waiting time. Therefore they need to be more sensitive to how their definitions, perceptions, and experiences concerning time can differ from those of patients. Therefore, while everything may have appeared normal and acceptable to clinic staff, it is not the case with health care users. Especially because they visit hospitals often not emotionally stable due to the circumstances surrounding their visits and they expect caring, empathy, sympathy, and at the very least some compassion or understanding for their situation. But regardless of patients not being physically fit to sit and stand long due to their illnesses, they had no choice.

Saidi (2007) attest patients especially are not in a condition to wait too long for service and high congestion makes it difficult to access health care services at certain hospitals, which makes waiting time long. Sithole *et al.* (2008) found that some patients do not to receive medicines from pharmacy on the same day. They have to return the next day and this makes them default and greatly affect compliance and health outcomes. This study also found that the expected estimated waiting time from the patients' point of view was approximately 2 hours while the actual waiting time was 6 hours. Later Jawaid *et al*. (2009) proved that doctors, nurses, management, medical associations and accreditation organizations have some stake in defining the standards of medical care but patients are the single largest category and because patients are the largest category, their opinions therefore cannot be ignored. The National Quality Core Standards (2011) reiterates the importance of availability of basic medicines and supplies as an area of quality improvement.

About long waiting for doctors and medicines participants had this to say:

Participant no: 1

"You know when you come to hospital, there are those who handle people well and others do not treat people well. Like at the clinic, you seat for a long time. Since you came what time? You will only leave at 5 or 6 o'clock waiting for tablets you see. They very slow that side, even here they are a little bit slow but better than that side".

Participant no: 2

"Like sitting and waiting, sitting and waiting is a bit long. We tend to get hungry waiting long. Ha...Ha...Ha... Now that we seeing new doctors it is taking longer, it has taken longer".

Participant no: 3

"The noise and the fact that doctors come late even though I don't know why they are late. I end here. Yes it does not go well with me. I just want to mention what does not go well with me, what does not go well with me. We do not know if doctors start somewhere or not. I do not know but we are punctual, we arrive here at 06h00 but even now we are still waiting for the doctors. They come at 11h00. Some patients arrive at 05h00. It is the same as in another clinic. You see I have 2 illnesses; I come for diabetes and prostate. I come on different days

but even in the other clinic we wait for doctors. We wait for a lo...ng time. When they come we are already hungry".

Participant no: 4

"I am a little bit confused because I spent a lot of time here from seven o clock. I came they took my blood and they test the urine. And I wait and I see only 2 doctors, they come. For how many patients, too many. They say one doctor is on leave so only two doctors for so many people. After the doctor we going to the chemist with the script we spent five –six hours to get our medicines. Sometimes no transport, no transport because it is six o clock and everything has left. We have to phone here and there to find a lift. So I think more people to the chemist. More experienced people. People kill themselves inside there, experienced people because one asks the other. Every hour they call only ten people. So we have to spend the whole day".

Participant no: 5

"Time we spent here, normally it depends if the doctors are here. It can be 2-3 hours. The last time we came here we only saw the doctor at 12 o' clock. So that was a very long time. I feel terrible because we were waiting for the Dr. Brown so all of a sudden we were told she wasn't coming. I mean they could have told us to see another doctor that was terrible. Nurses are very good, clerks are polite and doctors are ok. Dr. Naidoo is under a lot of pressure with all the people but she was happy to see us she didn't complain".

Participant no: 6

"*Here at the clinic – the most painful thing is that we come early- having arrived early doctors come late. They come at about 09H00 or 10H00 we sit and wait...We get hungry, we have to go and buy food so that we can eat. Sometimes even the medicine you find that some of us did not take treatment in the morning because we want to rush to the clinic and come back home to take our treatment. So things like that make us feel bad". (She frowned and looked straight in eyes) but the treatment I don't want to lie well I do not know but for my side the treatment is best. Even the medicines that they give me are enough. (She looks cheerful) The main problem is at the chemist. At the chemist we sit until we say "Ja- Baas", seated there at the chemist. Either than that, I do not see anything bad. Maybe I do not know, maybe I cannot think of anything now but otherwise treatment is good. The problem is that doctors come late. No it really makes me angry – it makes me angry, it takes away the love*

that love is no longer there. You see right now, when did we come? They are not yet hear. We have been here long. You see now we are going for urine testing. When we finish we are still going to sit and wait. They are not yet here. These are the things that make me feel bad. But the treatment shoo, I like it because they give me enough medicines".

3.4.1.3 Sub-theme: Inadequate and uncomfortable seats

Seats were not adequate for patients and their relatives to sit down and some were broken and uncomfortable. Some users were forced to stand during while waiting for services. This means that users experienced physical discomfort as they sat on uncomfortable seats or stood up. This situation brings about physical and emotional discomfort during waiting time. One participant reported that he felt bad watching sick and weak patients standing because they could not find seats. Eilers (2004) found that when the reception is comfortable and patients are distracted, they think they have waited a shorter time. She then recommends that arranging chairs into clusters, using soothing colors, natural lighting and table lamps create a relaxing environment. Eilers (2004) further recommends activities such as puzzles, coloring materials, aquariums, current magazines and news papers to be supplied so as to decrease the perceived waiting time.

Unfortunately some of these entertainment supplies cannot be realized yet in South Africa's public hospitals and clinics because of a backlog on the priority list. Eilers (2004) reported on improving patients' satisfaction with waiting time and not on how patients themselves experienced the environment. Saidi (2007) found that there is inadequate space for patients to sit while waiting and some seats were broken and that patients sat on them because they had no choice. Sithole *et al.* (2008) confirms revealed that dissatisfaction which may result from any combination of anxiety, frustration, depression, discomfort/prolonged pain and suffering that patients have to endure in long queues may contribute to defaulting and non-compliance which in turn can negate the gains, outcomes and impact of health interventions and the patients' quality of life.

In relation to uncomfortable and inadequate seats, participants said the following:

Participant no: 1

"The chairs are not enough in this clinic but also at the chemist patients are many and chairs are not enough. Some patients do not get chairs they have to stand. I do not like it because I get tired. But when I found a seat then I do not have a problem. But I can see that those who are standing have a problem. You can see that this patient is not well but he has to stand and he is weak and he has to stand for a long time. I would like to see these things being corrected maybe even the doctors feel sorry for us, feel sorry that we spent the whole day here. Even though I do not know what is keeping them but maybe they can make a plan and say that let us feel sorry for these people. People spent the whole day in hospital."

Participant no: 2

"People sometimes get angry for standing so long and they make noise. People who are waiting they lose patience and they start screaming".

Participant no: 3

"One thing I would like to mention is that most of the time you will find that most people do not know the clinic time you find that they come early and stand. You find that one patient is tired and sick but has to stand like that.

If maybe there could be built in chairs so that patients can move in order, so that while they are seated, they should know who they are behind because some do not come to one clinic, they go from one department to the other, on the same day they have two clinics according to the illnesses. The next thing if she is called in another clinic while she is not there, there must be a way of keeping her place. At the moment when the name is called and the person cannot hear her name, there is always confusion. This makes the patient to go late to the chemist to a point whereby sometimes she has to come back the next day".

3.4.1.4 Sub-theme: Getting hungry, thirsty and tired

Participants mentioned hunger and thirst as some of their discomforts that are exacerbated by their medical condition - diabetes mellitus. The problem is that sometimes they do not bring food from home and they have no money to buy something to eat from the hospital cafeteria. They said that food from the cafeteria was expensive and due to their low socio-economic status they could not afford it. Some of the patients were pensioners while others were unemployed and therefore did not have enough money to buy food. They had to pay R40.00 per visit and could not afford to pay money for consultation and food. This problem was again caused by the fact that they did not choose to come to this diabetic clinic as they were referred for further management. In their local clinics they were not asked to pay R40 for a visit. Patients were also afraid to go to the canteen to get something to eat because if they did not hear when their names were called out then their files would be put away. This clinic had a water cooler to supply drinking water to patients in the waiting area. The supply of drinking water reinforces the promotion of healthy life style that health workers speak and write about.

One participant mentioned that patients who were on oral diabetic treatment were told not to eat in the morning before coming to the clinic. She claimed that only those who use injections were allowed to eat. However, the researcher could not verify these claims with clinic staff. Such misconception about what to eat and what not to eat for diabetic patients can be corrected when proper consultation is done by health practitioners. Group or individual health education remains vital as part of management of diabetes. Sadly this misunderstanding came from a participant who has been diabetic for approximately 10 years and coming to the same clinic. This was an indication of missed opportunities for information giving creating the gaps within the clinical practice. Patients should be encouraged to eat before coming to clinic and to bring something to eat to promote comfort during waiting time. Those who are not supposed to eat due to blood tests e. g. fasting blood sugar should be given the reason and be attended timely to prevent starvation that cause both physical and emotional discomfort.

The following is what participants said regarding getting hungry, thirsty and tired.

Participant no: 1

"You know that, sometimes we get very hungry because we did not eat and they shout at you and say you know that you are taking tablets, you are not supposed to eat before coming to clinic. Only those who use injections are allowed to eat. You cannot help it because you are so hungry. You find that since you ate last night, now in the morning you want to have something to eat. You want to eat some bread. Now when you get here, they ask you why you ate."

Participant no: 2

"We sit long at chemist and get hungry. We wake up early and leave at 5am. I sit and sit the whole day and get hungry. You see we have to eat then if I have money I buy something and eat but the shop here is expensive. Right now since I came I have not seen the doctor I don't have money to buy food. Here food is expensive. I am not working I do not know what to do but I like to come and I pay R40.00 for every check up".

Participant no: 3

"We tend to get hungry waiting long. Ha...Ha...Ha... Now that we seeing new doctors it is taking longer, it has taken longer. I get hungry and as diabetics we must have food, we have to have something like sweets or food. So we bring food, we bring something like a picnic basket. When we come to hospital is like we come to a picnic actually. Ha...Ha...Ha...So we tend to bring our own food because you can't really go to a canteen. You have to be tested; you have to listen when you are called so you can't go to the canteen. I think a lot of people bring their own food, like a picnic basket".

Participant no: 4

"Doctors also come late we wait long and get hungry, some of us do not have money. We get hungry, we shiver, so I am a pensioner I don't have money to buy food. These are the things that do not go well with me".

3.4.1.5 Sub-theme: Inability to use the toilet

Accordingly public health facilities are supposed and expected to have higher hygiene standards than non health organizations. Therefore it is of concern when institutions such as hotels and restaurants are perceived to perform better in this regard. One participant mentioned in disgust that the toilets at the restaurants were much cleaner compared to those at this diabetes clinic and others within the hospital. She and other participants claimed that the toilets were mostly clean in the morning and got dirty as the day progressed. She claimed that one could tell from a bad smell about 5 meters away that toilets were nearby. As a result she never goes to the toilet and only goes if necessary. The other reason was that there was no toilet paper but she ensures that she brings her own. This claim was confirmed by the male participant who compared that smell to the one coming from the pit privies in the rural areas where he grew up. He further said that people were used to such a bad smell from a pit privy not from a toilet in an urban area especially in the hospital. In addition he mentioned that some male patients urinated on the floors and left the toilet without flushing. People with diabetes need to use the toilet more frequently than those without therefore for their sake toilets should be up to standard at all times.

According to the Patients' Right Charter, users too have a responsibility to prevent and report fraud, corruption, vandalism or theft of state property. Berkow, Beers and Bogin *et al*. (1997) indicate that because kidneys produce excessive urine in people with diabetes therefore, they pass large volumes frequently. National Department of Health (1998) confirms that frequent urination is among clinical features of diabetes. However patients themselves should be responsible enough and look after clinic resources. South African Human Rights Commission surveyed access to health in all provinces and its 2007 synthesis report confirmed that cleanliness of facilities generally varies from one facility to the next. In Gauteng, the state of hygiene in hospitals left much to be desired. Although cleaning staff were visible at all facilities the level of cleanliness and standard of hygiene was below what is expected of a hospital. One participant stated that the toilets were filthy and that users were responsible for that. She also felt that it was unfair for the cleaners to have to clean the mess that can be avoided if users were more careful and considerate. The other participant reported that the second ladies toilet has been out of order for months.

Some participants also said that they only go to the toilet in the morning when they are still clean because they feared to get illnesses from them. Saidi (2007) found that users are generally concerned about the state of hospitals in terms of cleanliness and management of housekeeping issues like the bedding and ablution facilities. Poor hygiene is viewed as lack of respect towards health care users. Accordingly toilets are supposed to be cleaned every day and when necessary. National Department of Health (2011) conducted a survey regarding patients' concerns based on raised complaints and media reports and revealed that public hospitals and clinics are often found to be dirty, untidy and unhygienic. These conditions showed that the staff did not care for or respect their patients or their own colleagues. Cleaning materials and equipments were often not adequate or available. Lack of maintenance reinforces the impression of patient neglect. This is one of the commonest problems raised in media reports, complaints and by visitors. Hence, the introduction of six most critical areas to fast track quality service in public hospitals and clinics by honorable Dr. A. Motsoaledi, Minister of Health. National Quality Core Standards (2011) stipulates that cleanliness under Infection Prevention and Control program is among the list of six priorities of quality improvement. Public health facilities should have enough stocks of cleaning materials and equipments. Taps are supposed to be in working order to allow people to wash their hands after the use of toilet. Taps were in good working order not licking. There should be a supply of toilet paper at all times. Unfortunately at this clinic some of these factors are only ideal and not realistic according to what participants confidently reported.

The participants said the following about inability to use the toilet.

Participant no: 1

"The toilets here- have you seen them? 'Shoo' they are filthy. What make toilets to be filthy are us patients, you hear me- women- a woman will go in there and leave stools in there especially at the entrance that side of social workers. "*When you go inside, there is a smell of stools right through. Women! We, women, we are filthy. I mean when you are menstruating, you know you are menstruating. When you make a mess, you should ask for a toilet paper and clean up, clean up don't leave the mess like that. The next person coming in, that is germs –we pick them, so how shall we get better, we will not get better. I mean you can see that you messed up. Maybe you were in a hurry, you had a stomach problem. You should stop, ask for a mop from the cleaners and clean up your mess.*

If you leave it like that....who is supposed to clean it? Even the cleaners I think they get tired – they become impatient about our filthiness as women patients, joo hai me this is what does not sit well with me".

Participant no: 2

"So about the toilets since I came here you see the ladies toilets since, the other one is not working is out of order. I started here in November I am not sure about the exact date it has always been out of order. This thing makes us feel bad because I am old and we have to queue and sometimes by the time I go in I have already wet myself. One day I found pads on the floor. Because we are all women the pad is not written the name on it. So if someone walks in she will think it is my pad. I felt bad about that. A person will think it is mine. So I felt bad but today they are much better".

Participant no: 3

"Toilets are not clean ok there is no toilet paper still and there is only two toilet pap... er... two toilets and we have to share and the smell is terrible. Sometimes I do not even want to go in there. I do not go in there, the other thing they have to test our urine and I tell the doctor that I do not have urine, sorry. When I am desperate I take a chance".

Participant no: 4

"Sometimes one toilet is dirty the other one is clean. The other one is full of tissues. You wonder where all these tissues come from. Why is the toilet not flushed? And there is a bad smell. Some patients urinate on the floors and we have to stamp on the urine. You can see that this is urine. I don't like that; I don't like stamping on someone's urine. It is not nice".

Participant no: 5

"The toilets I can't tell you about the toilets because I never go. Only if necessary, like I went now. No toilet paper, the floors are disgusting for a hospital. I mean you go to the hotel first class; you go to restaurant first class. You come to hospital, health department big question, when are they going to fix that? If you go to the toilets five meters away, you know you are going to the toilet. The supervisor to come and check the toilets, say alright they are clean. Also us we also not careful, no toilet paper never-never.

Me, I make sure that when I come I bring my own toilet paper just in case. Toilets they do not smell hygienic, they should put handy andy. If a foreigner or tourist comes to hospital, he will go to the toilet. Even if they visit somebody they will need a toilet".

Participant no: 6

"The toilets are not clean, so when I come in the morning I make sure that I use the toilet because I don't want to find it in a mess. It gets very messy, it gets very messy. You cannot even get inside, you can hardly go inside. Sometimes I use the one on the other side next to the social workers' office, you see that one. You see if it is early then they are still clean. But we, patients are to blame for the mess. We don't love ourselves; we don't love ourselves. Being a woman, you know that you are menstruating, you want to leave a mess behind who is supposed to clean that mess, who is supposed to clean that mess. When you stand up from the toilet seat, you are supposed to look at the seat, you must say let me look you must look if you see something wrong clean it, use your hands when you finished you can wash your hands. Dirt will not stick on your hands it comes off, so what is a problem? We patients, we should blame ourselves; we should put the blame on our side. People who are cleaning, are they supposed to clean our mess? They get tired we should not say they should clean; it is their job, they getting paid".

3.4.2 THEME TWO: EMOTIONAL DISTRESS

Emotional distress refers to things, activities, situations or circumstances that cause disturbances on health care users' mind. Such distresses are discussed below.

3.4.2.1 Sub-theme: Anger

Some participants reported that some health workers often display bad attitudes towards patients and their relatives resulting in feelings of anger. They felt that the manner in which some clinic staff members spoke to them did not show respect and consideration for the age difference. This made them feel like they were spoken to like children.

A decade later Nairn *et al.* (2004) reports in consistent with Britten & Shaw (1994) that the manner in which nurses spoke to the elderly showed a patronizing and ageist attitude. This non caring attitude can produce negative experiences. Saidi (2007) agrees that respect and dignity are important in the way that users are treated by staff. It is important that staff should not shout at users but rather treat them in a respectful and dignified manner. Similar findings were found by Sithole *et al*. (2008) confirmed that some staff at pharmacy displayed unprofessional conduct. Some pharmacists told patients that if they can wait the whole day for their pension money, then they can also wait the whole day for their medicines. Muhondwa *et al.* (2008) studied patient satisfaction and found that staff used humiliating words while attending to them. This was experienced from nurses in particular that they were rude, uncaring and fond of using humiliating language. In South Africa the Batho Pele policy stipulates that users should be treated with respect and consideration. Health care users expect the clinic staff to take the age difference into account when speaking to them. Participants mentioned that it was unacceptable for young clinic staff e.g. nurses, administration staff including doctors to speak to them as if they were children. For example addressing older persons by their first names as a young person is considered disrespectful in both Black and Afrikaans cultures.

Blacks and Afrikaners teach their children to address older persons as “Tannie” and “Oom” “Mme and Malome” or at least by surnames as “Mr., Ms. or Mrs.” “Meneer, Mejuffrou or Mevrou” and “Ntate and Mme”, while their English counterparts and or other race groups may not be offended when addressed by their first names. One participant explained how she got angry because a young nurse did not speak well with her. She said that the nurse was young enough to be her child, thus cannot speak to her like that. National Department of Health (2011) found that health workers are often far too rude and uncaring to their patients. One participant believed that the reason for this lack of respect towards patients is because of their educational status. She further stated however that being educated does not give the nurse any right to be disrespectful and treat elders like children. The same participant experienced similar disrespect from the clerk during registration to get her file. She unfortunately did not know that she was supposed to bring small change for payment. She had a R100 note, and the clerk refused to take it ordering her to go and find small change. Asking for small change may be legitimate however how the clerk spoke was unacceptable. The clinic staff had a tendency to mix and misplace files.

When the files are found, those responsible do not apologise. This made one patient angry as she expected the clerk to admit that she was at fault, what is called ordinary manners. The staff's attitude not to apologise is a violation of the Batho Pele principle on redress. In addition the Code of Conduct for public service requires employees to be polite, helpful, and treat users as customers who are entitled to receive high standards of service. The other aspect that angered participants was the long waiting in general. One participant claimed that waiting takes away her love to come to this clinic. Sadly most patients at this clinic were from low socio economic group and therefore do not have a choice to go to other facilities that may be perceived better. Valenzuela, Wirtz and Tellez *et al.* (2010) studied users' experiences of waiting time and factors associated with the perceptions of low quality of care in Mexico. Valenzuela, Wirtz and Tellez *et al.* (2010) reported that patients here and in other Latin American countries opt to use fee for service despite the financial implications. While Umar *et al.* (2011) confirm that patients perceive long waiting as a barrier to actually obtaining health care services. Umar *et al.* (2011) further warn that patients may be reluctant to return to the facility that they believe does not understand their needs and demands. In Mexico and elsewhere the use of other service providers is an option but based on knowledge gained from this research study and anecdotal knowledge on unemployment, for most patients who use public health facilities in South Africa it is not. So they have no choice but to hope that staff attitudes and other causes of discomfort at outpatients department will improve. And that is what this research study sought to highlight.

Participants had this to say:

Participant no: 1

*"It is just that on my last appointment there is a young nurse who nearly disturbed my emotions. Because I went to fetch..., I went to fetch the urine bottle when I returned I found that she has moved my chair she put it away, she has put even my things away. She said because you did not tell anyone that you going away. So me I did not want to say anything. I did what she said I must do, but knowing that I was disturbed. But I told the people I was sitting next to. I told them I even left my pink card. Ok then when I came back she kept shouting at me about urine and she attended to me after everyone. A young nurse this one, so I felt that I was not handled properly. Sisters handle us well. Doctors handle us well. I have never had anything that went bad with me it was only this one. I did not like the manner in which she spoke to me b*ecause *I am old and I have children. Because she is educated and I*

am not, that did not feel right. The other thing is that I did not know that I should bring small change. So you have to go and get change and this makes me feel bad. Is it at the admission desk? Yes like today the clerk said go and get small change (voice changes), she speaks in a commanding voice. We don't have that. I said in hospital we are treated like children and he said go and get change. I had a R100 note. Go and get change. I met a security guard. The security guard said that he will use my R100 to buy airtime and he will give me his small change. Then it went on well".

Participant no: 2

"What I do not like about missing files is that the clerk did not apologize even after she saw that it was her mistake. She wanted to put blame on me".

Participant no: 3

"The problem is that doctors come late. No it really makes me angry – it makes me angry, it takes away the love that love is no longer there. You see right now, when did we come? They are not yet hear. We have been here long".

3.4.2.2 Sub-theme: Anxiety

Some participants mentioned that files were often misplaced, mixed up or went missing for a while. The problem was that during the time when the files went missing patients became anxious knowing that without them; they may not see the doctors. When the files were finally found, the staff members failed to apologise to the patients. One elderly lady said that this happened to her not once but on several occasions such that every time she comes to the clinic she panics and feels anxious about her missing file. Because of this problem users lose their sequence in the queue and some get confused. As a result they begin to suspect that those who came late were seen first. Sadly this was reported by the participant whose husband was a wheelchair occupant and apparently gets irritated by the commotion.

This is the patient who should not be made to wait in the first place but should be granted the VIP status given his circumstances. This is an area that challenges health workers to consider the things that people with special needs go through daily. The other participant who had a hearing impairment said that there was too much noise that prevented him to hear when his name was called. He became anxious because when he missed to hear his name, his file was put aside that means he would be seen much later than it was supposed to be. The other participant blamed the clerks as she pointed at her file to show the card that was missing. She demonstrated in disgust and emphasised that it was a pink card that every patient is supposed to get but hers could not be found. That implied that she had to return to the administration office to check if it was found. One after the other participants suggested that clinic staff should use the number card system that they believe could prevent files from being mixed up or misplaced. They said that the card system was working well in other units such as the pharmacy. Some participants thought that nurses were responsible for the problem after receiving files from administration desk while others blamed clerks. The problem of missing and mix up of files can be corrected by implementing service deliver standards stipulated in the Batho Pele policy. Every unit or clinic should be encouraged to set up service delivery standards according to the type of services to be rendered. These standards will provide guidance on how files should be handled to avoid the inconvenience that was experienced by both patients and the staffs themselves resulting in anxiety. Participants complained that they often sit without being told when the doctors will be coming. Lack of information was also responsible for anxiety. Nairn *et al*. (2004) also showed that the overall length of stay in the department is perceived as better for those patients provided with information every 15 minutes than those patients not provided with information.

Participants had this to say about their anxiety:

Participant no: 1

"I would like to ... something that can be improved, you find that you came early to hospital – you came early now the sisters there on the table they mix files. I ask the sisters to write like-like at the chemist. When we go to the chemist, we get numbers. You know when you are this number, you are this number – you go with your number. When our files come from reception, they go to, they go to the sister – sisters do not keep them accordingly, you see.

You see someone who came after you going in first – you go to ask why it is happening like this and they say we have mixed the cards up. Something like this does not work. They should have cards like at pharmacy. At the chemist they give us number- they give us numbers to say who you are after. That is something we ask otherwise the system is poor".

Participant no: 2

"You see sometimes you find that your name is called but people are making noise and you cannot hear your name when it is called. You find that you have a hearing problem. I am like that I have that problem, now you find people talking loud. Patients and staffs especially at the admission desk. When staff is coming to work in the morning they speak loud, they greet each other and are shouting. You wonder why they are not speaking softly. No, I do not like it, noise and the long waiting for doctors".

Participant no: 3

"Waiting time, I understand you have to wait because that is part of coming to hospital but I feel they should maybe use the number system. Because my husband is on a wheelchair and he gets very irritated because he sees people coming after us going to the doctor before us and is just that they mix files up. I think if they have a number system, if you are number 20, 30, 40 or 80 and you know you are that number. Because some people come late but all of a sudden they are seen first".

Participant no: 4

"I came early like I came early. That means my file was misplaced when they took it out I do not know what happening. I sat and sat until all doctors were about to go away without me being seen. When I asked from the one who takes files out, she said, no I did not put my file in there when I arrived early. I said I came early in the morning. I arrived when that sister I do not know her name when she was there they were having a prayer, they used to have a prayer but now they do not have it anymore. I arrived and you took our cards and now my file is missing and cannot be found and even the doctors are now going away. Hai she started looking, when she …after she shouted at me telling me that I had just arrived. That did not go well with me. Hai when she was …she found it and she found that she is the one who put it at the wrong place it was her mistake. Hai then everything came to an end.

Then it happened again, the problem is always with the files. Then it happened again another day. File… file… file could not be found. Hai then she asked me are you sure that you left the card here or you left it somewhere? Then I said how I can leave it somewhere because I have to go to the dispensary. So I waited because we could not find the file until the doctor left then I was seen by another doctor, because of the file it happened three times. So my problem is that when I come to clinic I always think about the problem with the file".

Participant no: 5

"At the admission desk, clerks have their own things. They have their own things. They delay; sometimes you find that they mix files. I am talking to you now I did not get my small card. I have to go back to find it. I got the big file but they did not give me the small card".

3.4.2.3 Sub-theme: Fear

The condition of the toilets as previously discussed under the sub-theme: inability to use the toilet makes patients fear that they could pick up germs that could cause diseases to them. One participant wondered how their health could improve under such unhygienic conditions within the hospital. Participants also mentioned that their other fear was caused by not knowing how to get home after finishing late at pharmacy because there was no transport. An elderly participant said that she only got home at nine in the evening and that was very scary. The main wish from all participants and is to finish early so that they could get transport back home for those who relied on public transport and lifts. Those who used their own transport also had the same wish to finish early and return home. Jawahar (2006) points out that nowadays patients are looking for hassle free and quick services in the fast growing world. Accessibility to health facilities was reported by Saidi (2007) that some users do not have money for public transport even if the facility is on the main public transport route in South Africa. He indicated that this creates a need for an integrated transport system between the referral health facilities. Most importantly he recommends that users should feel secure both in transit to and fro, but also within the hospital premises. Fortunately the integrated transport system is currently available from some satellite clinics to tertiary hospitals in Gauteng Province. However priority is given to those considered frail and the new referrals going to various departments such as cardiology, urology, gynecology and many others.

South African Human Rights Commission (2009) found that access to health care services especially for the poor is severely constrained by inadequate or non-existent transport and by long waiting times at clinics and other health care service providers. Recently Harris *et al.* (2011) examined inequities in access to health care in South Africa and confirmed that travel costs, medical fees, long queues and disempowerment are access barriers despite constitutional rights. The Patients' Right Charter recommends a healthy and safe environment that will ensure physical and mental wellbeing. These include water supply, sanitation, infection and all environmental dangers.

The following is what participants mentioned about their fear:

Participant no: 1

"When you make a mess, you should ask for a toilet paper and clean up, clean up don't leave the mess like that. The next person coming in, that is germs –we pick them, so how shall we get better, we will not get better. I mean you can see that you messed up"

Participant no: 2

"Toilets are not clean ok there is no toilet paper still and there is only two toilet pap... er... two toilets and we have to share and the smell is terrible. Sometimes I do not even want to go in there. I do not go in there, the other thing they have to test our urine and I tell the doctor that I do not have urine, sorry.

Participant no: 3

"The toilets I can't tell you about the toilets because I never go. Only if necessary, like I went now. No toilet paper, the floors are disgusting for a hospital. I mean you go to the hotel first class; you go to restaurant first class. You come to hospital, health department big question, when are they going to fix that? If you go to the toilets five meters away, you know you are going to the toilet. The supervisor to come and check the toilets, say alright they are clean. Also us we also not careful, no toilet paper never-never. Me, I make sure that when I come I bring my own toilet paper just in case. Toilets they do not smell hygienic, they should put handy andy. If a foreigner or tourist comes to hospital, he will go to the toilet. Even if they visit somebody they will need a toilet".

Participant no: 4

"After seeing the doctors we go to the chemist with the script we spent five –six hours to get our medicines. Sometimes no transport, no transport because it is six o clock and everything has left. We have to phone here and there to get a lift"

Participant no: 5

"The other thing is that we get out late. Sometimes you find that is 6pm and you are at the chemist. The other time when there were floods in Soweto, there were no taxis, I arrived home at 9pm".

Participant no: 6

"The toilets are not clean, so when I come in the morning I make sure that I use the toilet because I don't want to find it in a mess. It gets very messy, it gets very messy. You cannot even get inside, you can hardly go inside. Sometimes I use the one on the other side next to the social workers' office, you see that one. You see if it is early then they are still clean. But we, patients are to blame for the mess. We don't love ourselves; we don't love ourselves. Being a woman, you know that you are menstruating, you want to leave a mess behind who is supposed yoo clean that mess, who is supposed to clean that mess. When you stand up from the toilet seat, you are supposed to look at the seat, you must say let me look you must look if you see something wrong clean it, use your hands when you finished you can wash your hands. Dirt will not stick on your hands it comes off, so what is a problem? We patients, we should blame ourselves; we should put the blame on our side. People who are cleaning, are they supposed to clean our mess? They get tired we should not say they should clean; it is their job, they getting paid".

3.4.2.4 Sub-theme: Frustration

Oxford Dictionary (2011) defines frustration as cause to feel dissatisfied. This diabetes clinic under study is one of the units where training of medical students, interns and registrars take place. They were allocated and rotated at intervals according to their learning objectives.

One of their requirements is to examine and prescribe medicines for diabetic patients in order to complete their prescribed learning hours. The average stay for them at this clinic was approximately 6 weeks. Furthermore even the permanent doctors, often had to attend other duties such as lectures in the morning or ward rounds. This implies that patients who were booked for review in a months' time would most likely not find that team of doctors. Meanwhile users were concerned about lack of update on the doctors' whereabouts but also the fact that they are seen by different doctors every time they come to the clinic. Hence the frustration regarding constant change of doctors with every clinic visit which, gave rise to a perception that they were not properly cared for medically. The Patients Rights Charter says that patients have the right to be treated by the practitioner of their choice. If the choice of doctors is not possible this should be communicated to patients. One participant reported that they were made to wait for a certain doctor only to be told much later that the doctor was not coming. She said that if they were told earlier they would have asked to be seen by another doctor. It is therefore important to provide the above information so as to enable users to make an informed decision whether to be seen by another doctor or reschedule an appointment. Unfortunately such vital information was not given in this clinic leaving users wondering and feeling frustrated as a result.

Naumann & Miles (2001) demonstrated that telling customers how long their expected waiting time will be can improve their perceptions with those procedures. Patients' perceptions may also be enhanced by keeping them occupied during waiting time. Ajayi (2002) found that patients preferred to be given health education on specific diseases during waiting time. Patients thought that health education was an acceptable and useful way to utilise waiting time in the out patients clinic. Meanwhile Dunnill *et al* (2004) found that the length of waiting time at a clinic before patients can be seen is a common cause of frustration. Therefore the information that is provided to them before and during waiting time is very important. Of most importance Dunnill *et al.* (2004) reported that users, desire for written and verbal information. Giving health education to keep patients occupied may prevent unoccupied time during which they become anxious, feel neglected and uncared for. This study however found that due to staff shortage, especially nurses, health education was not given adequately. The study by (Nairn *et al.* 2004) found that patient satisfaction improved when perceived waiting times were shorter than expected and levels of satisfaction were longer when perceived waiting times were longer than expected.

Nairn *et al.* (2004) further emphasize how unoccupied time feels longer than occupied time, and how anxiety and uncertainty makes wait feel longer. This illustrates the importance of information giving and communication skills which may influence the experience of waiting time. Nairn *et al.* (2004) also showed that the overall length of stay in the department is perceived as better for those patients provided with information every 15 minutes than those patients not provided with information. Health care users visit hospitals and clinic often not emotionally stable due to the circumstances surrounding their visits and they expect caring, empathy, sympathy, and at the very least some compassion or understanding for their situation. Unfortunately when such expectations are not met negative perceptions are created and they think that long waiting time is due to uncaring. Although interactions with patients seems routine to the hospital staff, to them the experience of receiving health care comes with uncertainties. Users are concerned that new doctors tend to ask for tests which they believe were done previously. One participant felt that it was time consuming and hectic, she also believed that patients were treated like guinea pigs because new doctors did not know what they were doing. Patients tend to get patients get used to the attending doctors and wish to see them every time they come to clinic. Feddock, Hoellein & Griffith *et al*. (2005) confirm that patients who have established continuity with their outpatient clinic are in general more satisfied.

Consistent with the findings of this research study Feddock, Hoellein & Griffith *et al.* (2005) reported that patients were more satisfied with the care provided by a long term regular physician. Patients believed that such a physician was able to meet their expectations and provide higher quality. This diabetes clinic did not give information regarding the doctors' whereabouts e.g. doctors attending a meeting, doctors in theatre, how many doctors on duty and their names. Mohamad (2005) revealed the reasons behind the absence of doctors from their consulting rooms is that some doctors double up as lecturers, on call and doing further studies. The study by Muhondwa *et al*. (2008) asserts that the majority of patients (62%) reported that they were unable to see a doctor of their choice. However since Muhimbili is a teaching hospital for the Muhimbili University of Health and Allied Sciences, postgraduate students and interns attend to patients along with consultants as part of their training, and therefore it may not always be possible for a patient to be seen by a particular consultant in Dar Es Salaam, Tanzania. The constant change of doctors is often a cause for concern to patients who fear that they may not be receiving the best care possible.

The other cause of frustration was the feeling of hunger because patients were told not to eat before coming to the clinic. One participant mentioned that nurses shouted at them for eating in the morning, she was unhappy with the way in which that message was communicated to patients. Adding on to what else was causing frustration was the abuse of disabled parking to get patients on and off the wheelchairs. SAHRC (2009) showed that the medical and health personnel often have a poor or discriminatory attitude towards vulnerable individuals or groups, which leads to poor access to health care services for vulnerable people It is possible to prevent some frustration by information giving through word of mouth or written. Information can be put on posters or notice boards especially about doctors' whereabouts and their names. Other institutions such as Dischem pharmacies in South Africa put the names of pharmacists on the notice board with a message. Dunnill *et al*. (2004) advised that users may be reassured by advance notification about which doctors are available.

Participants have voiced their frustrations like this:

Participant no: 1

"For instance there was one doctor when I was here the last visit for my repeat, he was fighting about my wait, for sugar diabetes – he checked me and explained to me and motivated me. I saw his commitment. Doctors are not the same. Others do not check you. They do not even check your blood sugar they just write. Doctors are not the same. They are like nurses. If you get the right one, then you got the right one – I do not know how they work, where they are working, if they could, I am asking. If you have a doctor you should see him all the time, so that you can know your doctor. So, when I ask which doctor I am seeing? They say "hey, doctors are the same; they are all doctors for sugar, sit where we told you to should sit"

Participant no: 2

"It is frustrating to explain your condition all over again to another doctor".

Participant no: 3

"You know that, sometimes we get very hungry because we did not eat and they shout at you and say you know that you are taking tablets, you are not supposed to eat before coming to clinic. Only those who use injections are allowed to eat. You cannot help it because you are so hungry. You find that since you ate last night, now in the morning you want to have something to eat. You want to eat some bread. Now when you get here, they ask you why you ate. So I don't know we are living like that it is on and off. Some days you go home happy, other days you feel sad because someone didn't speak well with you. So what can we say? Where can we ask help from? If we do not come here to be shouted at, and for all sorts of miracles to be done to us, what can we say?"

Participant no: 4

"I find that the hospital is fine, I am not complaining so much about it. The only time that I do feel it, is now that they have changed doctors. I had one doctor all the time that I have been here for the past 20 years. I find that because I had one doctor, I was very happy. Now they have changed doctors and at the moment I find that I do not know who I am seeing and I also do not know where I am going. There is a bit of confusion there.

Participant no: 5

"Now that we have new doctors, a new doctor does not know what you are all about because each diabetic patient is different and each patient needs to be treated differently. So you need to go through the tests all over again, it is a bit hectic, is a bit of time consuming and it is a bit agitating. So seeing different doctors is like you are a guinea pig. Not so happy because you can't say to the doctor this is what I have or this is what I had. You might be having other illnesses like hypertension or arthritis and the new doctor maybe is only worried about diabetes. Seeing one doctor is faster".

Participant no: 6

"When our files come from reception, they go to, they go to the sisters – sisters do not keep them accordingly, you see. You see someone who came after you going in first – you go to ask why it is happening like this and they say we have mixed the cards up. Something like this does not work"

Participant no: 7

"I am a little bit confused because I spent a lot of time here from seven o clock. I came they took my blood and they test the urine. And I wait and I see only 2 doctors, they come. For how many patients, too many. They say one doctor is on leave so only two doctors for so many people. After the doctor we going to the chemist with the script we spent five –six hours to get our medicines. Sometimes no transport, no transport because it is six o clock and everything has left. We have to phone here and there to find a lift. So I think more people to the chemist. More experienced people. People kill themselves inside there, experienced people because one asks the other. Every hour they call only ten people. So we have to spend the whole day"

Participant no: 8

"Another thing when we are in hospital, we are afraid to ask. When we do not understand, the clerks are not approachable, they have a problem of saying I am the one who works here, but when they talk to white people, they talk nicely and this is not a nice thing. Sometimes when you ask something they become impatient. They treat you like you have come to ask for trouble. People should talk properly; they should know that they are employed. They must know how to handle patients, they must not shout. Some people are not educated, they are not educated. We are not all educated. Sometimes patients come with referral notes and instead of explaining properly what the note says or where you should go, they should explain well because they have information".

Participant no: 9

"They used to see wheelchairs first but they have stopped that and there is one big- big problem, downs stairs in the parking, in the orange block there is no parking for disabled people for wheelchairs. And in the green block where is parking for disabled people, you find staff and young ones park there. I can't get him in and out of wheelchair in a normal parking. So I got to stop in the middle of the road, get him out of a wheelchair. Leave him in the middle of the road. So it is difficult with a wheelchair in a normal parking. There is only wheelchair parking in the green block not in the orange block. I don't want to push him all the way to the green block"

Participant no: 10

"We do not know if doctors start somewhere or not. I do not know but we are punctual, we arrive here at 06h00 but even now we are still waiting for the doctors. They come at 11h00. Some patients arrive at 05h00. It is the same as in another clinic. You see I have 2 illnesses; I come for diabetes and prostate. I come on different days but even in the other clinic we wait for doctors. We wait for a lo-ng time. When they come we are already hungry. I would like to see these things being corrected maybe even the doctors feel sorry for us, feel sorry that we spent the whole day here. Even though I do not know what is keeping them but maybe they can make a plan and say, that let us feel sorry for these people. People spent the whole day in hospital. The last time we came here we only saw the doctor at 12 o clock. So, that was a very long time. I feel terrible because we were waiting for Dr. Brown so all of a sudden we were told she was not coming. I mean they could have told us to see another doctor that was terrible. Dr. Naidoo is under a lot of pressure with all the people but she was happy to see us she didn't complain. We kept asking and they said she was coming, she was coming. I wish they had told us that the she was not coming you must see this one. And that is again where the numbers come in".

3.4.2.5 Sub-theme: Sadness

Most patients came to this diabetes clinic after they were seen at satellite clinics. Some have also been to traditional and spiritual healers. de V van Niekerk (2012) highlights that traditional healers are the first to be called for help when illness strikes the majority of South Africans. Then as a last resort patients go to hospitals and clinics. From the satellite clinics they are referred by nurse practitioners for further management by the doctors at tertiary level. Some are referred by the General Practitioners. Patients have confidence that finally the medical assessment here would be more comprehensive than what nurse practitioners in the satellite clinics could do. However participants reported that doctors do not perform a full physical assessment on patients. This was of concern as patients thought that doctors did not care for them. Therefore they felt sad because they feared that their ailments would worsen or complicate. Especially after having waited so long and only to spent few minutes with the doctor. Unfortunately the doctor-patient ratio is disproportional and disenables them to perform a proper physical assessment on some patients.

According to National Core Standards doctors are supposed to manage patients comprehensively. It is only when an ailment requires a specialist care such as urology; gynecology, cardiac, orthopedic to mention but a few, that a patient should be referred accordingly. Otherwise diabetic patients should not be referred to polyclinic for minor ailments such as flu. Therefore when doctors do not perform a full physical assessment to exclude such ailments according to patients' expectations, they felt disappointed and sad. It is for that reason they stated that it was time consuming and inconvenient to be sent from a diabetes clinic to polyclinic for other minor ailments. Although patients were disappointed that doctors did not do a full physical assessment they mentioned that doctors should at least listen to them. That implies that reassurance and kindness from the doctors and clinic staff in general could prevent the ill feelings. Management of diabetes includes several types of routine blood tests. Some of these tests can be done randomly while others require that patients should fast. Compliance in this regard was often poor at this clinic and unfortunately patients were labeled uncooperative. Hence the alleged shouting which patients thought was unwarranted. Clearly from what participants said, they were uncertain as to or not to eat.

The fact is that patients with diabetes are mostly encouraged to eat breakfast for fear of hypoglycemia. The emphasis is that they should not miss their meals and that they know. However, for the purpose of certain blood tests they are supposed to fast. The challenge is how to communicate this information as part of self care. Based on what participants have said, patients did not have such information and that is the reason why they felt sad because they did not eat to be spiteful. Robbins, Bertakis & Helms *et al.* (1993) studied the influence of physician practice behavior on patient satisfaction and reported that patients were most satisfied with medical visits in which they were examined, given health education and their treatment plan was discussed. Almost a decade later Pollock (2002) reported that shortage of time in general practice consultation is widely acknowledged to constrain the quality of care of patients. It is also considered a major obstacle to the realization of a more patient centered medical practice that actively involves patient in their treatment plan. Oermann (2003) studied the effects of educational intervention in waiting room on patient satisfaction and reported that health education assists patients to acquire the knowledge and skills they need to understand and manage their conditions. Oermann (2003) indicate that patient education during waiting time will meet their learning needs and may influence satisfaction with a clinic visit.

Dunnill *et al.* (2004) also indicated that it is not only the time spent on consultation that is important but the content as well. Furthermore they emphasised that patients expected to receive advice, reassurance and treatment that is not available where they came from. Mohamad (2005) studied patients' waiting time at a teaching hospital in Malaysia and found that it affected their satisfaction towards the services offered. He identified the main factors leading to long waiting time as registration time, number of doctors and clerks. He concluded that insufficient number of doctors would increase patients' waiting time. Disproportionate doctor-patient numbers would cause a bottleneck in a queue of service. Therefore a well planned schedule should be implemented so that patient care is not adversely affected. Similar findings by Wijewickrama *et al*. (2006) showed that patients wait long time for consultations that only last for few minutes at a University hospital in Japan. Over the years this disproportionately long waiting time in the consultation room has been the focus of research among academicians and practitioners. The observations of this research study indicate that this diabetes clinic did not have adequate staff to cover all procedures as a result health education was not given satisfactorily.

Jawahar (2007) confirms that twenty nine percent of patients said that they do not know much about services in the clinic and the details of individual treatment. This he said reveals that patients' participation in their care has a special place with regard to their satisfaction. Participants in this study also mentioned that doctors should at least listen to what they have to say. Anderson, Camacho & Balkrishnan (2007) found that patients are satisfied when the doctor is willing to listen to them. Even after they have already waited long in the waiting room, patients expect to spend reasonable time with the doctor. This implies that patients will not be satisfied with reduced doctor-patient time. The findings by Muhondwa *et al*. (2008) are consistent that a common complaint made by patients at Muhimbili hospital in Dar Es Salaam, Tanzania, concerns the length of time they spent waiting to be attended. The other complaint regards the inadequate time spent with the service providers, who are perceived as perfunctory. Recently waiting time was highlighted when Umar *et al.* (2011) measured the level of patient's satisfaction with waiting time in a tertiary health institution in Northern Nigeria and confirmed that patients will have to wait longer on the queues before seeing their providers, as long as the imbalance in the doctor-patient ratio is not addressed. A disproportionate number of doctors and patients would increase patient waiting time in Nigeria.

The challenge for nurses in this case was information giving through individual or group health education. It is not possible to apply a one size fits all approach in the management of diabetes because there will always be indications to run tests over and above routine ones. Therefore it is imperative that users are informed in a manner that will display respect and consideration to prevent ill feelings. Umar *et al*. (2011) highlighted that over the years population has increased several folds without a commensurate increase in the number of health care providers. This research study therefore recommends that because health education is not given accordingly, clinic staff especially nurses should anticipate and accommodate that some patients may not understand their treatment plan adequately. Seedat & Rayner (2011) emphasise that hypertensive patients have the right to be informed about the status and progress of their condition. The main objective of patient education is to empower them to participate actively and ensure the quality of their treatment plan. This requires effective, honest and open two way communication between them and care providers. It is essential that health professionals acquire communication and counseling skills and use such in the patients' preferred language of choice.

These are critical in the management of life-long conditions. Although, Seedat & Rayner's (2011) focus is South African Hypertension Guideline, diabetes is among the life-long conditions mentioned. The researcher is pleased that this emphasis also applies to the patients in this study and elsewhere. Participants complained about inadequate physical assessment by doctors but were however pleased with their attitudes. Unfortunately users cannot say the same about some clinic staff especially nurses and clerks. According to the Batho Pele's Courtesy principle, users should be treated with respect and dignity. Health care users should be addressed properly by their surnames and be spoken to politely. Recently Entwistle *et al.* (2012) examined which experiences of health care delivery matter to service users and why? They confirm that when health care users feel respected, that contributes to their care. The clinic has two female toilets and one was out of order and remained so for some time. Patients were forced to wait long for their turn before getting a chance to use a toilet said one participant. She mentioned that sometime in the past out of desperation she accidentally wet her pants while waiting in the queue before she could get her chance to relieve herself. Such happenings are insults on an individual's self worth and results in feelings of sadness as a consequence.

This means that during this time when only one female toilet was working no intervention was made by clinic staff to assist patients. Intervention such as identifying other toilets in the neighborhood and inform patients to use them for the sake of patient advocacy. It is possible that due to lack of knowledge diabetic patients assumed that they were not allowed to use the toilets in other departments. Patient advocacy ensures that users receive equal access to available resources. In addition clerks expected patients to pay with small change for their registration; unfortunately this information was not communicated to them well in advance. When patients were already at the admission desk, the clerks shouted at them for paying with large amounts of money that need change. Unfortunately some patients did not know or think that this would be a problem. So, the manner in which clerks communicated this information was seen to be disrespectful and inconsiderate. Participants mentioned that the clerks spoke to them as if they were children. The other issue that was of concern to users was that often they have inquiries to make to administrative staff as they are in the front line. However, they were seen to be unapproachable and users were scared to enquire from them. Because the manner in which they spoke to patients was unacceptable.

Mokoka, Ehlers & Oosthuizen (2011) studied the factors influencing the retention of registered nurses in the Gauteng Province and found that some nurses indicated that if patients and their relatives could show respect to them, they would remain at their current employ. It may be true that some patients are often rude to health workers; doctors often meet difficult patients as well. However health workers in general ought to rise above users' bad behavior. A future study that aims to look at users' behavior towards health workers may highlight the extent of this phenomenon. Some participants believe that they receive ill treatment from clinic staff because of their low socio economic status. This makes them feel sad and helpless. The other reason for participants to feel sad was that sometimes they finish late at pharmacy and go home without medicines, forcing them to return the next day. Users miss transport to get home as most of them relied on public transport or lifts. One participant said we have to phone here and there to ask for a lift back home. For clinic staff after serving the last patients or when it was time to close and go home, this may be the end of a long day at work but to some patients after receiving medicines the problem is how to get home. National Department of Health (2011) warns that patients who are unable to receive the treatment that they need on the day they came to collect it, suffer not only the inconvenience and costs but possibly the worsening of their condition.

The clinic staff experienced the mix up and missing of files affecting users negatively, because patients cannot be seen without files. This implies that those who came late may be seen before their counter parts that came before them. Often those whose files went missing accusation were leveled at them for being responsible for the mishap. When the files were finally found the staff concerned failed to apologize even if they realized that they were at fault. The principle of redress requires health workers to apologize when users receive poor or unintended service. An apology includes a promise to correct the situation and prevent similar incident from recurring. Sadly this was not the case here and that hurt the patients' feelings. Failure to apologize is interpreted as arrogance and disrespect towards patients. The importance of redress cannot be over emphasised in cases such as this as it is ordinary manners. The findings of this research study consistently agree with (Robbins *et al*. 1993; Pollock 2002; Mohammad 2005; Wijewickrama *et al*. 2006; Muhondwa *et al*. 2008; Umar *et al.* 2011) that patients express dissatisfaction with waiting time. However these previous studies did not explore how such dissatisfaction affects users both physically and emotionally which is a knowledge gap that this study sought to make contribution to. It was for this reason that I mentioned in the problem statement that although it is a known and researched subject that users express dissatisfaction with long waiting for health care services at public health facilities, little is known about their experiences and perceptions that they give rise to internationally and in South Africa.

Participants had this to say about feeling sad:

Participant no: 1

"Doctors are not the same, others do not check you. They do not even check your blood sugar they just write. Doctors are not the same. They are like nurses, if you get the right one, then you got the right one".

Participant no: 2

"You know that, sometimes we get very hungry because we did not eat and they shout at you and say you know that you are taking tablets, you are not supposed to eat before coming to clinic. Only those who use injections are allowed to eat. You cannot help it because you are so hungry. You find that since you ate last night, now in the morning you want to have

something to eat. You want to eat some bread. Now when you get here, they ask you why you ate. So, I do not know we are living like that it is on and off. Some days you go home happy, other days you feel sad because someone did not speak well with you. So what can we say? Where can we ask help from? If we don't come here to be shouted at and for all sorts of miracles to be done to us, what can we say?"

Participant no: 3

"So about the toilets since I came here you see the ladies toilets since, the other one is not working is out of order. I started here in November I am not sure about the exact date it has always been out of order. This thing makes us feel bad because I am old and we have to queue and sometimes by the time I go in I have already wet myself. One day I found pads on the floor. Because we are all women the pad is not written the name on it. So if someone walks in she will think it is my pad. I felt bad about that. A person will think it is mine. So I felt bad but today they are much better. The other thing is that I did not know that I should bring small change. So you have to go and get change and this makes me feel bad. Like today the clerk said go and get small change, we do not have it. I said in hospital we are treated like children"

Participant no: 4

"Another thing when we are in hospital, we are afraid to ask. When we do not understand, the clerks are not approachable, they have a problem of saying I am the one who works here, but when they talk to white people, they talk nicely and this is not a nice thing. Sometimes when you ask something they become impatient. They treat you like you have come to ask for trouble. People should talk properly; they should know that they are employed. They must know how to handle patients, they must not shout. Some people are not educated, they are not educated. We are not all educated".

Participant no: 5

"What I do not like about missing files is that the clerk did not apologize even after she saw that it was her mistake. She wanted to put blame on me".

Participant no: 6

"I am a little bit confused because I spent a lot of time here from seven o clock. I came they took my blood and they test the urine. And I wait and I see only 2 doctors, they come, for how many patients, too many? They say one doctor is on leave so only two doctors for so many people. After the doctor we going to the chemist with the script we spent five –six hours to get our medicines. Sometimes no transport, no transport because it is six o clock and everything has left".

3.4.3 THEME THREE: COPING MECHANISMS

3.4.3.1 Sub-theme: I use the toilet in the morning only or never

Urinalysis is one of the diagnostic investigations that form the vital part of management of diabetes form which several ailments may be excluded. However due to unhygienic conditions of the toilets users were forced to develop some mechanism to cope without using them. These mechanisms included unhealthy ones such as not to drink fluids to prevent the production of urine. One participant said that she tells nurses and doctors that she does not have urine when in fact she is lying. So, this attempt to avoid using the toilets has negative effects on the management and monitoring of their conditions because without urinalysis necessary warning signs may be missed. Toilets were reported to be clean in the morning but become dirty as the day went by. Some participants mentioned that they go to the toilets only in the morning while they are still clean. They blame health care users for being responsible for the messes in the toilets. They said that other users do not clean up their messes before leaving the toilets. It may be true however the question is, how can users clean whatever mess they have caused when the toilet paper is not supplied? It is unclear whether patients leave their mess deliberately or it is because the cleaning material or equipments such toilet paper and brush are not supplied. Meanwhile the National Department of Health (2011) survey has revealed that public hospitals and clinics are often found to be dirty, untidy and unhygienic. Furthermore the National Department of Health' strategic plan 2009–2014 seeks to ensure that cleanliness is improved in all hospitals and clinics.

One participant said that sometimes she goes to the toilet next to the social workers' office while the other one said that she only goes when necessary otherwise no. She claimed that one could smell the toilets 5 meters away.

Patients had this to say about I use the toilet in the morning only or never:

Participant no: 1

"I do not go in there, the other thing they have to test our urine and I tell the doctor that I do not have urine, sorry".

Participant no: 2

"The toilets are not clean, so when I come in the morning I make sure that I use the toilet because I do not want to find them in a mess, they get very messy, they get very messy. You cannot even get inside, you can hardly go inside. Sometimes I use the one on the other side next to the social workers' office, you see that one. You see if it is early then they are still clean.

Participant no: 3

"The toilets, I cannot tell you about the toilets because I never go, only when necessary".

3.4.3.2 Sub-theme: Bring food from home

People with diabetes cannot stay hungry for too long but because they came early and waited long they got hungry, thirsty and tired. This clinic did not use the number card system so users were afraid to lose their positions if they left the queue. Moreover because there was also no information about when the doctors will be coming, so they could not go anywhere because they did not know when they might be called. They were forced to stick around in order to keep their place. It is possible for patients to spend almost the whole day at the hospital on certain clinic days. These long day spent at the hospital have been reported by some participants as either affecting their relationship with their employers, compliance to treatment or both.

To prevent losing their place or going hungry they decided to bring food from home. Some patients did not bring food from home and had no money to buy from the canteen as they mentioned that food was expensive. Some participants reported that sometimes they have to return to clinic, hospital or pharmacy the next day. Recent study by Sithole *et al.* (2008) found that the double cost of transport incurred when patients fail to access their medication on one day lead them to default pharmacological treatment regimes.. It is in view of such circumstances that health workers ought to be mindful and eliminate causes of long waiting time that are person made. So that patients are seen and finish timely. So in order for patients to cope with this long waiting time they view a clinic visit like going to a picnic and therefore they bring picnic baskets.

Participants said the following about bringing food from home:

Participant no: 1

"I get hungry and as diabetics we must have food, we have to have something like sweets or food. So we bring food, we bring something like a picnic basket. When we come to hospital is like we come to a picnic actually. Ha...Ha...Ha...So we tend to bring our own food because you can't really go to a canteen. You have to be tested; you have to listen when you are called so you can't go to the canteen. I think a lot of people bring their own food, like a picnic basket".

3.4.4 THEME FOUR: A SENSE OF HELPLESSNESS

3.4.4.1 Sub-theme: Unable to answer back when falsely accused or shouted at by clinic staff:

Most of the clinic staff was younger than users, some young enough to be their children or grand children. Now due to cultural beliefs, users expect to be spoken to in a respectful manner.

Unfortunately in this clinic patients felt that some clinic staff spoke to them as if they were small children. Participants mentioned that it was unacceptable for health workers to speak in that way to them. However users concealed their true feelings for the sake of peace or fear of intimidation. One participant said that nurses shout at them when they had eaten before coming to the clinic. She said that there was nothing that they can do because they have no choice but to come here to be shouted at and for all sorts of miracles to happen to them. The other one mentioned that when the young nurse did not speak well with her; she kept quiet, knowing that she was emotionally disturbed. This implied that patients could do something but they however did not have a choice but to keep quiet because it was neither the time nor place. The other participant felt helpless when she could not understand why they were told to weigh with their shoes on. While at her local clinic patients have to take their shoes off before getting on to the bathroom scale. She did not ask why because she did not want to exchange words with nurses. Patients anticipate that the reply or response that they might get could be unacceptable leading to unworthy arguments. As a result they chose to keep quiet because they feel helpless to defend themselves. These and other daily activities that happen to patients in the care of health workers, go unnoticed. However their impact bit by bit creates negative experiences as it was mentioned earlier that they are taken for granted.

Another participant reported that clerks were reluctant to provide information that patients so desperately needed. She went on to say that they should not act as if they were doing them a favour. Furthermore she mentioned that some users are not educated therefore clerks as their responsibility should take that into account while at work. Nairn *et al.* (2004) found that patients work hard at being undemanding and compliant, with the aim of being good patients. By being 'good' they hide personal disappointment at the quality of care and maintain good relationship with nursing staff. Mohamad (2005) after investigating the possible operational problems at one of the teaching hospitals in Malaysia recommends that there should be at least one clerk delegated to provide information to users while others do registration. Assigning a dedicated employee to handle enquires will assist him or her to relax and speak well to health care users. This will allow him or her to relax and be enabled to speak politely, provide necessary information as expected by users. However given the current status quo of staff shortage this study recommends that every staff member should display respect during their encounter with users no matter who they are.

After all users have a constitutional right to access health care services promptly, easily, comfortably and feel secure both physically and emotionally, something that this study sought to highlight. Muhondwa *et al.* (2008) reported that users have made a plea to health workers to refrain from using bad language when responding to their enquiries. They then advise health workers that users should be treated with respect and consideration regardless of their socio-economic or educational status. Furthermore Muhondwa *et al.* (2008) caution that patients should not be expected to be grateful for whatever is done to or for them. Their needs should be taken into account regardless of their indigent status to promote comfort.

3.4.4.2 Sub-theme: No money; nothing to eat.

Some participants mentioned their plight of getting tired and hungry while waiting for the doctors or medicines. They said that they had no money to buy food from the canteen because it was expensive. Unfortunately they did not say why they cannot bring food from home. This plight was mentioned by those who were unemployed and the pensioners. They did not ask for food or money to buy something but to be attended timely so that they can return home earlier.

3.4.4.3 Sub-theme: Unable to hear when names are called

The other plight that was mentioned was the inability to hear when names where called out. The level of noise in the waiting area indicates that the hearing impairments are often taken for granted. Health workers together with users forget that among them there are people who are hard of hearing. Some hearing defects are due to old age while others are inborn.

Participants communicated their sense of helplessness in this way:

Participant no: 1

"You know that, sometimes we get very hungry because we did not eat and they shout at you and say you know that you are taking tablets, you are not supposed to eat before coming to clinic. Only those who use injections are allowed to eat. You cannot help it because you are so hungry. You find that since you ate last night, now in the morning you want to have something to eat. You want to eat some bread, now when you get here; they ask you why you ate. So I do not know we are living like that it is on and off. Some days you go home happy, other days you feel sad because someone did not speak well with you. So what can we say? Where can we ask help from? If we do not come here to be shouted at and for all sorts of miracles to be done to us, what can we say?"

Participant no: 2

"I went to fetch the urine bottle when I return I found that she moved my chair and my bags away and she said that it was because I did not tell anyone. I did not want to say anything; I did what she said I must do knowing that I was disturbed because I told the people that I was sitting next to. I even left my clinic documents. I am used to being weighed without shoes, so hear they weigh us with shoes on but I do not want to exchange words with them. I am not working I do not know what to do but I like to come and I pay R40.00 for every check up. We sit long at chemist and get hungry. We wake up early and leave at 5am. I sit and sit the whole day and get hungry. You see we have to eat then if I have money I buy something and eat but the shop here is expensive. Right now since I came I have not seen the doctor I do not have money to buy food. Here food is expensive".

Participant no: 3

"Patients and staffs especially at the admission desk. When staff is coming to work in the morning they speak loud, they greet each other and are shouting. You wonder why are not speaking softly. No I do not like it, noise and the long waiting for doctors. The other thing is that toilets are sometimes dirty. We are used to it, people are not the same some are like this others are like that. You have no choice because you are pressed".

Participant no: 4

"You find that she must go to work and she spends the whole day in hospital, when she is supposed to ask for another day from work is a problem. It affects us because sometimes we

are afraid to ask from work to come to hospital. You keep quiet only to find that the illness is serious at the end of the day. That is why they say for us black people it is so hard to find out what is eating us up because we are afraid to go to the doctor to say please check me because I am not sure but I do not feel well. By the time we stand up you find that it is too late".

Participant no: 5

"What I do not like about missing files is that the clerk did not apologize even after she saw that it was her mistake. She wanted to put blame on me".

3.4.5 THEME FIVE: PERCEPTIONS CREATED

Oxford Dictionary (2011) defines perceptions as the ability to see, hear or become aware of something through the senses. Perceptions in this context meant how users interpret activities that do or do not take place during waiting at this diabetic clinic under study in an academic hospital. Naumann *et al*. (2001) surveyed patients' perceptions of waiting and revealed that these may be negatively associated with the time they spend waiting for treatment. Jawahar (2007) emphasised that patient satisfaction surveys are useful in gaining an understanding of users' needs and their perception of the service received. Research by Saidi (2007) confirms that behavior and actions of people are motivated by perceptions and not rational reasoning. Thus the way people feel about a facility is influenced by their feeling about it. Saidi (2007) then showed that perceptions are formed through:

- feelings, beliefs, mental pictures, gut feeling;
- the sum total of reception of information accumulated over time including experiences;
- the reality that obtains although it may not be 'true' and
- change with changing circumstances-information

Health care users came early to this clinic hoping to be attended to timely so that they could go back home early while public transport was still available.

Users expected doctors to also start seeing patients from as early as 08h00; unfortunately doctors arrived late. Their expectation was not met leaving them with various emotions such as anger, frustration and sadness. Lack of information on doctors' whereabouts exacerbated the situation. This experience gave rise to wrong perceptions about the doctors. Naumann *et al.* (2001) state that telling patients how long they will wait was positively related to satisfaction perception. Some participants had perceptions that tests were repeated because either the doctors did not know what they were doing or it was for training purposes. In which case, patients were treated as guinea pigs. Again lack of information about when and why tests should be done played its part. In addition one participant stated that doctors came late because they were not empathetic with their circumstances. He made a request that doctors should feel sorry that patients arrived early in the morning to the clinic, spent the whole day, got hungry and left late in the afternoon. Pollock & Grime (2002) recommended that doctors need to have a greater awareness of patients' anxieties about time. Thus doctors should reassure patients to allay such anxieties. Although this study was for depression, patients may become depressed now and then especially diabetics.

Therefore any reassurance to allay anxieties also applies here as well. One participant mentioned that a nurse did not speak well with her because she was illiterate. She also said that at her local clinic they were told to take their shoes off before weighing but that was not the case here as she was told to weigh with her shoes on. According to her this did not make sense and nurses did not bother to explain. Nonetheless, she did not want to ask questions as she believes that nurses would not give an explanation because she was illiterate. The other participant mentioned that she experienced bad staff attitude from the administration clerks. She said that clerks did not attend to queries from users kindly and politely. Clerks were rude, impatient and did not take into consideration the fact that some patients were illiterate and could not understand when they spoke fast. Some patients at this clinic were seen by the professor while others were seen by medical interns and registrars. Those who were not seen by the professor thought that their treatment was sub-optimal. National Health Act no. 61 2004 stipulates that it is possible for health workers to prevent perceptions by giving information in a language that patients understand taking into account their level of literacy. In spite of that patients do not receive necessary information to prevent perceptions. Later Saidi (2007) demonstrated that information can assist how patients feel about health care services.

Thus the way a person feels about a hospital is not based on whether it is able to address their health needs and wants, but it is influenced by their feelings about it. Informing patients about different doctors for certain patients will therefore allay anxieties that lead to perceptions. Evidence by Muhondwa *et al.* (2008) found that patients are made to pay an additional fee to be taken through the service delivery station quicker than usual and those who cannot afford will wait longer. They further confirm that there is a tendency for health care providers to treat patients of low socio-economic status poorly. The study was conducted in Tanzania but the findings are inconsistent with how the participants in this study believe that things do or do not happen on account of the educational and economical status. Ayers (2008) cautions that perceptions of waiting time are important because they influence patients' attitudes towards every other elements of experience including the quality of medical care delivered. Recently Tateke, Woldie & Ololo (2012) attest that there is a growing consensus that assessment of the quality of hospital services should be based in part on patients' perceptions of overall care and patient satisfaction. Although Thompson *et al.* (1996) found that there were two types of waiting time the actual and perceived waiting time. This research study however found that some patients waited for approximately 4 hours at the diabetes clinic and approximately 6 hours at the pharmacy. The findings are that the actual waiting time outweighed the perceived waiting time.

The following issues of concern created perceptions:

Participant no: 1

"We get different doctors; every doctor comes with his own story. We do not get one straight doctor; like that side there is a professor so I do not know who those who go to the professor are and they stay there. If you see the same doctor, he is able to look at your schedule and make follow ups but if you keep changing doctors, this month you see this one he tells you this, the following month you see another one he tells you this, now you do not know what is happening"

Participant no: 2

"I did not like the manner in which she spoke to me. Because I am old and I have children. Because she is educated and I am not, that did not feel right. The other thing is that at the clinic we are used to, before weighing we take off our shoes. So I do not understand how these things work. Here they weigh us with shoes on. Now I do not understand and because they say this sugar diabetes that I have is the one about weight. Doctors say that I am overweight, and my weight is not coming down so I told the doctor last time that I was weighed with my shoes on. Doctor said it doesn't matter. I do not know maybe after weighing they do something that separates. I am not educated, (she laughs.) I do not understand these things. I do not like to exchange words with the nurses, I do not, and I like to keep quit".

Participant no: 3

"Now that we have new doctors, a new doctor doesn't know what you all about because each diabetic patient is different and each patient needs to be treated differently. So you need to go through the tests all over again, it is a bit hectic, is a bit of time consuming and it is a bit agitating. So seeing different doctors is like you are a guinea pig. Ha... Ha... Ha. Not so happy because you can't say to the doctor this is what I have or this is what I had. You might be having other illnesses like hypertension or arthritis and the new doctor maybe is only worried about diabetes. Seeing one doctor is faster".

Participant no: 4

"I would like to see these things being corrected maybe even the doctors feel sorry for us, feel sorry that we spent the whole day here. Even though I do not know what is keeping them but maybe they can make a plan and say that let us feel sorry for these people. People spent the whole day in hospital".

Participant no: 5

"Another thing when we are in hospital, we are afraid to ask. When we do not understand, the clerks are not approachable, they have a problem of saying I am the one who works here, but when they talk to white people, they talk nicely and this is not a nice thing. Sometimes when you ask something they become impatient. They treat you like you have come to ask for

trouble. People should talk properly; they should know that they are employed. They must know how to handle patients, they must not shout. Some people are not educated, they are not educated. We are not all educated. Sometimes patients come with referral notes and instead of explaining properly what the note says or where you should go, they should explain well because they have information".

3.5 DISCUSSION OF THE RESULTS

This section discusses the five themes that emerged from the individual interviews, summarized and percentages allocated accordingly.

3.5.1 Physical Distress:

The first theme to emerge is physical distress from which five sub-themes emerged. Regarding physical distress, approximately 60% of participants reported poor access to services and service points as the cause of their discomfort. Long waiting for doctors and medicines was the second stressor and seats were reported as inadequate and uncomfortable. While the fact that users wait long and get tired, hungry and thirsty was also of concern. Lastly the inability to use the toilets due to unhygienic conditions added to the list of physical distress.

3.5.2 Emotional Distress:

Emotional distress emerged second and generated five sub-themes. All participants mentioned how they experienced various emotions as a result of activities or actions that do or do not take place during waiting time. So, emotional distress was reported by approximately 100% of participants and was categorized as anger, anxiety, fear, frustration and sadness. Some emotions fitted in more than one categories and this emphasizes the gravity of the users' concerns that are often taken for granted, as it was mentioned earlier.

3.5.3 Developed Coping Mechanism:

Users had to adapt to conditions in the Out Patient Departments and in order for that to happen they needed to do something. Participants that made up approximately 30% have spontaneously stated how they have managed to develop coping mechanisms to minimize discomfort. However those coping mechanisms were only for the physical discomfort while emotional distress remained.

3.5.4 A Sense of helplessness:

Approximately 50% of participants have related how they felt helpless at some point due to bad staff attitude that displayed disrespect towards them.

3.5.5 Perceptions created:

This research study sought to describe perceptions to which users' experiences give rise to and approximately 50% of the participants stated spontaneously what they think are the reasons behind some unpleasant activities and actions of the clinic processes and staffs. Unfortunately lack of information led to creation of such perceptions. The discussion and results are presented below in **Table: 3.2.**

Table 3.3: Discussion and results

THEME	SUB-THEME	PERCENTAGE
Physical distress	Poor access to health care services and service points Long waiting for doctors and medicines Inadequate seats and uncomfortable. Getting hungry and thirsty. Inability to use toilets.	60%
Emotional distress	**Anger:** shouted at by staff; long waiting time **Anxiety**: missing and mix up of files; inability to hear when names were called; doctors' whereabouts. **Fear:** toilets hygiene; how to get home; not receiving best treatment because of new doctors every time **Frustration:** Poor filing system; no choice of doctors; different doctors every clinic visit; discourtesy; inability to hear when names are called; no information about doctors' whereabouts **Sadness:** no physical assessment; shouted by staffs; long waiting for doctors and medicines; embarrassment in toilets; No toilet paper supply; no apology	100%
Coping mechanisms	Use of toilet in the morning only or never. Bringing food from home	30%
A sense of helplessness	Unable to answer back; No money, nothing to eat. Unable to hear due to levels of noise	50%
Perceptions	Patients who are seen by the professor receive optimal treatment. Clinic staffs are disrespectful because patients are uneducated. Patients are treated like guinea pigs for training purposes Doctors come late because they do not feel sorry for patients	50%

3.6. Topic: The Worldwide Doctor-Patient Ratio

WHO (2011) reported that the worldwide doctor-patient ratio is not constant across the globe. It varies from very high in the underdeveloped countries to a bit lower in the economically developing countries, to very low in the developed countries (the United Kingdom, Germany, United States, etc). Cuba has the best doctor- to- patient ratio in the world and about 10% of its annual spending is on health. The worldwide doctor-patient ratio is presented below in **Table: 3.3.**

Table: 3.3: Worldwide Doctor –Patient Ratio for five countries

South Africa	United Kingdom	Germany	United States	Cuba
1: 300	1: 440	1: 300	1: 390	1: 170

According to the above estimates, the numbers of patients at the diabetes clinic under study are more than that of doctors making the ratio disproportional. This explains why it is not always possible for doctors to perform physical assessment to all patients. The 2007-2011 staff-patient ratios for the diabetes clinic under study are presented below in **Table: 3.4.**

Table: 3.4. The 2007-2011 Staff-Patient Ratios at the diabetes clinic under study

Year	**Doctor-Patient ratio**	**Nurse-Patient ratio**	**Clerk-Patient ratio**
2007	1: 431	1: 555	1: 971
2008	1: 507	1: 652	1: 1142
2009	1: 537	1: 691	1: 1209
2010	1: 634	1: 815	1: 1427
2011	1: 575	1: 739	1: 1294

Although this clinic is managed by 9 medical doctors, this team is often depleted by other duties and responsibilities both professional and personal. Doctors attend meetings, training; do ward rounds before coming to this clinic and manage outreach services.

Participants mentioned that they are not told in advance that the doctors are not available, only to be told after having waited long. The researcher envisaged that the observations in this study will verify or nullify what participants have mentioned during individual interviews, this information about doctors' whereabouts is consistent. The reasons for unavailability of doctors are legitimate however lack of information giving to assist users to make informed decisions causes frustration. This diabetes clinic has seen an increase in the numbers of patients annually resulting in a vast staff–patient ratio disproportion. In 2007 the clinic saw 3887 patients. In 2008, 4569 patients were seen. The number of patients continued to grow to 4839 in 2009. Then 5710 patients were seen in 2010 prompting hospital management put control measures in place to intensify admission criteria and that explains the minimal drop to a total of 5178 in 2011. National Department of Health (2011) points out that the rationale for introducing the National Health Insurance is to eliminate the current tiered system where those with the greatest need have the least access and poor outcomes. Its objective thereof is to strengthen the under-resourced and strained public sector so as to improve health system performance. Approximately 10 districts were selected for piloting in 2012 and while other facilities are being identified for inclusion in the program, quality improvement plans should be reinforced.

3.7 THE ASSUMPTIONS OF THIS STUDY WERE AS FOLLOWS:

3.7.1 Health care users who are disgruntled have had bad experiences.

Ten participants one by one mentioned some bad experiences that occurred during waiting time. These experiences caused either physical or emotional distress.

3.7.2Some causes of waiting time are human made and can be eliminated through training and policy guidelines aimed to promote comfort during waiting time.

The findings of this research study indicate that all ten participants suffered various emotional distresses. Some participants felt angry because of the way clinic staff spoke to them. Surely the nurses and clerks can avoid shouting at patients and treat them with respect and consideration. Furthermore patients wait long for their files because they get mixed up or misfiled. These two shortcomings are manmade.

3.7.3 Qualitative research methodology would determine health care users' experiences and perceptions that have not been uncovered.

In-depth unstructured interviews were conducted with health care users using an interview guide that consisted of one open-ended question to allow information to flow freely. Follow up questions were asked according to what participants mentioned to probe for clarification of their meaning. Although it is a known and researched subject that health care users complain about long waiting for health care services at public hospitals and clinics, little is known about their experiences and perceptions to which they give rise. Therefore it was critical for the researcher to use the qualitative research methodology. The findings of this research study are testimony to that.

3.7.4. This research study would reveal patients' concerns that are often taken for granted.

Some of the statements that were categorised and later became subthemes are about issues that health workers do not regard as concerns for health care users. One participant mentioned the inability to hear when his name is called out due to noise. If clinic staff thought that some of their patients could be having hearing impairments, they would not make noise.

3.7.5 Waiting times is subjective and will be perceived differently and every situation will be viewed by its own circumstances and outcome.

Although some participants mentioned waiting time as a concern others did not say anything about it. They were more concerned about issues such as staff attitude.

3.7.6 Patients believe that they wait long because health workers do not care.

Approximately 50% of participants mentioned perceptions that can be related to non caring attitudes. Users thought that only patients who are seen by the professor receive optimal treatment.

3.8 OBSERVATIONS IN THIS RESEACH STUDY

Creswell (2009) points out that the qualitative observations are those in which the researcher takes field notes on the behaviour of the people and the activities at the research site. Observation is a technique for collecting descriptive data on behaviour, events and situations; it is extremely useful in health care sciences studies because it allows the researcher to observe behaviour as it occurs, (Creswell 2003; Burns *et al*. 2003; Brink 2008). De Vos *et al.* (2005) argue that observation is a fundamental method of gathering data for qualitative studies. The aim is to gather firsthand information in a naturally occurring situation. Brink (2008) adds that observations may be structured or unstructured. Unstructured observation involves the collection of descriptive information that is analysed qualitatively rather than quantitatively. Again Brink (2008) validate that observation may have an advantage of getting reliable information as what people say that they do is often not what they actually do. However, the researcher was mindful about the possibility of the following suitable disadvantages of observation in this study:

- Participants may react or behave differently when they know that they are being observed
- Emotions, prejudices and values can all influence the way that behaviours and events are observed.

3.8.1 The purpose of observations for this study:

- To describe the setting, the activities that took place and the people hereof.
- To gain firsthand experience of the setting and the activities thereof.
- To have an opportunity to observe things that may escape the participants' awareness and may be regarded insignificant.
- To learn about things that participants may not be willing to talk about during interviews because they regard them to be sensitive.
- To distinguish between facts and perceptions from participants about the setting during interviews.
- To have a better understanding and therefore interpret what participants said to enhance data analysis

There is no queue for people with special needs so patients are encouraged to bring their escorts to assist them. The help desk was not available however the nursing station was easily accessible for this and other purposes. The nurses at this station were very busy with management of various clinics to ensure the smooth running concurrently in this area daily. The escorts also assisted with collection of medicines at pharmacy. However during data collection at the beginning of March 2012, I learnt that there was an interruption of supply for diabetic medicines and others. Some patients were deferred back to their local clinics for the supply of insulin injections and its accessories. The colour of the clinic walls was cream white and all the doors were orange, this contrast brightens up the surroundings. Educational posters regarding health issues were clearly displayed on the walls of the waiting room area giving patients something to read and take home. Users need to be given pamphlets or brochures to take home as well. Some posters were from the Department of Health while others were from private companies that manufacture and sell diabetic treatment, monitors and accessories. These posters were informative, legible; colourful and user friendly except that they were written mostly in English. At the entrance there was a notice board where the hours of all clinic services were displayed.

Lighting was sufficient despite the fact that two lights were non-functional but no flickering or dullness was noted. The administration office is the first room next to the entrance where all enquiries that should not go to the nursing station are handled. This office has got windows all round increasing visibility of administration staff present in the office; however these windows do not open and therefore this created a barrier between the users and administration staff. This barrier not only did it create a non customer friendly environment but it also minimised the sound of a conversation between users and administration staff making communication difficult. There is a water cooler with disposable paper glasses, hot water is not supplied. All chairs in the waiting room were orange and attached to each other in groups of four to restrict their movement. Others were not attached to one another to allow easy utilisation where and when a need arose both inside and outside the clinic. Chairs were facing towards the administration office so that patients can listen to their names. While patients waited to get their files nurses gave group health education to them and their relatives. Behind these chairs was the nurses' station with two large desks and chairs facing towards the patients from behind. Once their files were acquired, patients waited in the queue to be weighed and their blood pressures monitored before going to the monitoring room wherein two nurses performed urinalysis and hemoglucotest.

There were seven chairs in the monitoring room, five for patients and two for nurses. Group and individual health education were also given in there. Two small rooms for equipments and treatment were found inside the monitoring room. Waste bags that were kept in the treatment room were labelled according to their various uses. Two sharp containers were seen on the desk. One was too full and could not be properly closed posing a safety risk, while the other one was half full. There is a fridge in the equipment room wherein emergency medicines are kept. Hence the two wheelchairs that were kept in the monitoring room to ensure that patients receive emergency medical treatment timely to promote access to health care services in accordance with Batho Pele policy (1997) and the Bill of Rights (1996) that stipulate that all patients have the right to emergency health care. There were steel dustbins without lids wherein patients could throw their unwanted staff to prevent litter on the floors.

The emergency room was situated far from all clinic activities. Its location rendered it suitable for interviews to be conducted quietly away from any disruptions. The fact that patients waited long in queues enabled participants to feel relaxed during interviews without fear of being delayed. There were two queues, the first one was going to the monitoring room where urinalysis was done and the second one going to doctors rooms. Patients in the first queue looked unfriendly, anxious and unwilling to speak to anyone let alone a stranger. The researcher realised that these patients were holding urine bottles and did not want anyone to see them. They were also anxious to know their vital signs which are very important to them as they often cause arguments. The nurses are always concerned about urine results unfortunately the way they do it, is often interpreted as shouting. That is the reason why patients were anxious while waiting for urinalysis. The researcher approached participants in the queue and invited them to participate in this study because, after urinalysis and now without urine bottles and knowing their observations they go to the doctors' queue and interestingly, the same patients now looked friendlier, relaxed and willing to speak.

The researcher quickly learnt that it was best to approach patients who are sitting in the doctors' queue than those in the first queue. The arrangement of the seats allows movement in between chairs without causing an unnecessary stare that could raise anxiety that could prevent participants from being natural. Patients were seated most of the time; however few patients were noticed wandering around. When asked why that was happening nurses said that there was a problem with their files from administration staff. This kind of a problem also came up during the interviews from more than one participant. Patients put their appointment cards at the admin office for their registration and to get their files. This process had some flaws because files are not pulled out according to the principle of first come first served. That means some patients' files cannot be readily found and that makes them to wait while their counter parts that came late get files first. Sometimes when files are found some medical records or appointment cards are missing, because of this practice patients became agitated and started shouting at nurses and administration staff. The shouting got out of control and became disruptive making patients to appear aggressive while nurses seemed unaffected, uncaring and helpless.

When asked why they were not doing anything to solve the problem the answer was that because it was not their fault, but the administration officers. Reluctantly one nurse went to the administration desk and enquired on behalf of the patients and resolved the problem. From the researcher's analysis this situation seemed like an ongoing type of inconvenience not only affecting patients but affecting nursing staff as well. And even if they chose to ignore it, they end up feeling sorry for patients and they remedy the situation but only temporarily. Such occurrences are consistent with what participants mentioned during the interviews which causes frustration. The researcher was lucky to witness this frustration from the patients' faces at the time when it happened. One elderly lady who also participated in the study said that on the day of the interview the administration officer did not give her all her records and that the same thing happened to her on previous clinic visits. She referred to this incident as one of her nightmares whenever she has to come to the clinic. Otherwise patients were well oriented with where to go for what. However they did not understand other clinic processes and procedures that involved their treatment plan for example. Floors were hygienically clean; this was the researcher's own observations supported by participants' comments, as one of them even said, "*Floors are clean, I wish my floors were this clean"* While waiting patients interact with each other through small conversations.

Common topics of conversations include: when did you start coming here? What medicines do you take? What time did you arrive today? From these discussions users are able to tell who came before or after. They advocated for one another and came in defence and affirmed that the one who was complaining was right because he came early but those who came after him got their files first. Fortunately there was no conflict among patients due to mix up of the files, they blamed nurses and clerks. These small talks among patients generate some levels of noise can be expected from people waiting and ultimately finding ways of buying time or relieving their frustrations. Because of this noise the clinic was not a quiet place and again that interfered with communication especially for those patients with hearing impairments. Among patients there were husbands, wives, sisters, neighbours, grand children, all accompanying their relatives. There was also a man on a wheelchair who was accompanied by his wife. Some patients appeared partially blind while others were weak and needed escorts.

This explains why some users cannot find seats sometimes. The environment in the clinic in general including all consulting room is hygienically clean free from smells. However the same cannot be said about the toilets. There are two female toilets that were not kept clean all day and there was no supply of toilet paper. It is unclear why toilet paper is not supplied regularly. The male toilets seemed more neglected. The interviews were conducted at the diabetic clinic that was selected as the suitable setting for the study. The clinic has four doctors consulting rooms, one observation room, a nurses' station; two duty rooms for nursing staff and an emergency room. The emergency room is situated away from the two queues, one going for observation and other one for doctors and remains unused most of the time.

3.9 WAITING TIME DOCUMENTS

In qualitative studies text is considered a rich source of data (Burns *et al.* 2003). Brink (2008) added that hospital records, admission charts, incident reports, care plan statements, students' test and examination results and sick leave records all constitute rich data sources. Brink further explains that although records are an economical source of information; permit an examination of trends over time and eliminate the need for the researcher to seek cooperation from participants; however they are subject to the following shortcomings:

- They may be exposed to many sources of error.
- They may contain institutional biases
- Facts may be distorted some omitted
- Record keeping may be erratic
- The collection of data may have been stopped for political or financial reasons
- Some data are not available owing to their confidential nature.

The process of waiting time unfolds as follows: administration office start to register patients at 07H00. At this time patients have already arrived and there are unconfirmed claims that some arrive from 06h00 or earlier.

Doctors do the ward rounds in the morning and start at the clinic at approximately 09H00. The daily waiting time monitoring is not done due to absence of queue marshals. The clinic finishes at 12H00 making the waiting time to be approximately 4 hours. Then patients go to pharmacy to get their medicines where they wait for approximately 6 hours.

- Strengthening of help desks.

This diabetes clinic has not yet established a dedicated help desk. Health care users rely on any of the clinic staff to attend to their enquiries. They usually approach clerks moreover that they are in the frontline. However one participant mentioned that clerks here were not handling their inquiries kindly. She said that they are impatient and that it was as if they do you a favor when they attend to you. The next location is the nurse's station that deals with a fair amount of enquiries and problems, such as those that are not within their competency. The last area is the doctors' rooms that are spared for clarity regarding medical conditions especially. The first help desk is available at the hospital's main entrance and it is run by two officers. The second one is at pharmacy and one officer is in charge.

- Introduction of fast queues for people with special needs

This clinic has not introduced a fast queue. A fast queue refers to the VIP status which means recognition of people with special needs. Patients were seen on a principle of first come first served basis which is a disadvantage for people with special needs; however those that need emergency care were seen first.

- Implementation of effective triage system

Oxford Dictionary (2011) defines triage as the assessment of the seriousness of the wounds or illnesses to decide the order in which a large number of patients should be treated. Triage system area 264 is available opposite casualty 165 and two nurses and one doctor take charge of it.

- Introduction of clear visible signage to guide patients

Signage is present but not user friendly due markings that are fading away.

3.10 PHOTOGRAPHS

Bauer & Gaskell (2006) contend that when photographs are attested and witnessed, and logged for time, place and circumstances, they can have powerful evidential or persuasive value. The photographs of the following areas were taken: waiting room; consulting room; two female toilets; two male toilets.

Photograph no. 1: Waiting room

This photograph shows clean floors as it was mentioned during individual interviews when one participant said that *"the floors are clean, I wish mine were like this".* Seats are joined together in fours to prevent them from being moved. This is one strategy to prevent theft and vandalism of state property. Behind the chairs there is a desk that is used as a nursing station. Next to the desk we can see a notice board with various posters. One cleaner is responsible for the general hygiene of the clinic and the toilets.

Photograph no. 2: Consulting room

This is a photograph of one of the consulting rooms and all of them look the same. They are all equipped with examination beds which are used for physical assessments. A hand washing basin, soap and functional taps that were not leaking are there for doctors to wash their hands when necessary. A screen that separates the examination bed from the consulting area can be seen hanging and neatly tied to provide privacy when necessary. In addition two chairs one for the doctor and one for the patient can be seen. Usually there are two chairs for the patient and the escort. It was unclear where the other one was and why.

Photograph no. 3: Female Bathrooms

This is the entrance of the toilet which was hygienically clean. There was supply of hand paper towel and the waste bag. However the soap container was empty.

Photograph no. 4: Female toilet

Firstly the concern is the physical structure in terms of the broken floor tiles and the absence of the cover for the cistern. Secondly, some used pieces tissues have been thrown on the floor. This verifies the claims made by one participant when she mentioned that often users throw tissues on the floor. She mentioned that sometime in the past she found a soiled sanitary towel on the floor and was embarrassed as she feared that if someone walked in, she would think that it was hers. Nevertheless this toilet was found to be reasonably clean which verifies that users are responsible for the messes. There was no bad smell.

Photograph no. 5: First male toilet

Photograph no. 6: Second male toilet

Both toilets appeared reasonably clean except for the tissues that were lying on the floor but there was no bad smell. There was no toilet paper.

3.11 THE FINDINGS OF THIS RESEARCH STUDY IN RELATION TO:

3.11.1 THE SCOPE OF PRACTICE: REGISTERED NURSES.

Nursing Act No. 33 of 2005 has stipulated regulations under which nurses are expected to perform their duties. Any transgression is punishable by law. This study has revealed that some nurses at the diabetes clinic under study were in violation of the following:

- ***"The treatment and care of and the administration of medicine to a patient, including the monitoring of the patients' vital signs and of his reaction to disease conditions, trauma, stress, anxiety, medication and treatment".***

Participants stated that they were negatively affected by the manner in which some nurses spoke to them. Such attitudes did not reflect respect and consideration for patients which resulted in feelings of sadness and helplessness. Furthermore the mix up and missing of files also caused some anxiety to some patients.

- ***"The prescribed, promotion or maintenance of hygiene, physical comfort and re-assurance of the patient"***

Participants voiced some concerns regarding the conditions of the toilets that they feared could spread germs. Some felt embarrassed while others avoided using them out of fear of picking up germs. Disabled people experienced problems with access to service points. In addition they had to wait long on wheelchairs as they were not afforded the VIP status. Some patients did not get seats and had to stand while waiting for doctors. While those who found seats did not enjoy any comfort as some of them were broken or uncomfortable. Due to long waiting time patients experienced hunger that compromised their comfort.

- ***"The facilitation of communication by and with a patient in the execution of the nursing regimen";***

Participants have voiced their dissatisfaction with the fact that they were not told about the doctors' whereabouts to allow them to make informed decisions.

- ***"The establishment and maintenance, in the execution of nursing regimen, of an environment in which the physical and mental health of a patient is promoted;***

In relation to physical and mental health the participants mentioned that they feel sad when they do not get seats because they get tired from standing. Users also feel angry when clinic staff shouts at them.

- ***"The provision of effective patient advocacy to enable the patient to obtain the health care he needs".***

Nurses at diabetes clinic under study failed to intervene when patients' files went missing or got mixed up by clerks. Patients were left to sort out the problem by themselves. The researcher was lucky to witness this kind of frustration that was mentioned during individual interviews first hand.

3.11.2 MASLOW' S HIERARCHY OF NEEDS

Health care users like everybody else have needs that are required to keep alive, healthy and happy. This section will present the users' findings according to Maslow's Hierarchy of needs. These needs ought to be always respected even when someone becomes ill and acquire the patient status. However this research study revealed evidence of the users' needs that were not met almost violated.

- **Biological and Physiological needs**

Participants mentioned that while they waiting for doctors, they get hungry, thirsty. Often they get tired from standing due to inadequate or uncomfortable seats.

- **Safety needs**

Patients finish late at pharmacy and become stranded because they have no transport to return home. They fear for their safety as they try to find transport back home. The other concern around safety is caused by the poor toilet hygiene. Patients fear that they could pick up illnesses from the dirty toilets.

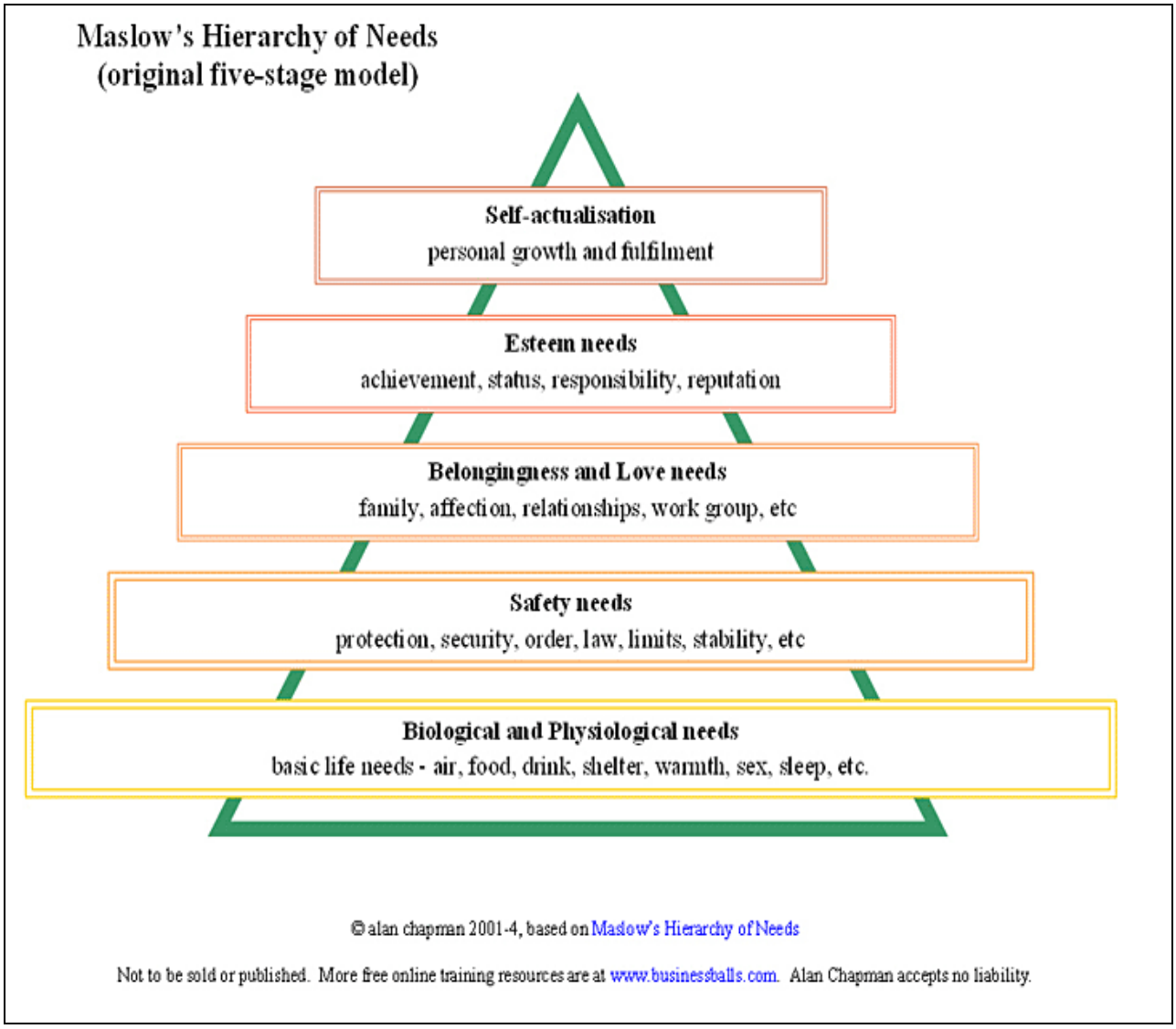
- **Belongingness and Love needs**

The long waiting time makes patients feel that doctors do not care for them. They suspect a non caring attitude coming from clinic staffs and therefore preventing the feeling of belonging. The lack of information why some patients are seen by the professor give rise to a perception that those patients are better cared for than their counterparts.

- **Esteem needs**

Participants stated that clinic staff spoke to them in a demeaning manner, they also mentioned their perception that staff treats them with disrespect because they are poor and illiterate.

Table: 3.5 **M**aslow's Hierarchy of Needs



3.11.3. THE SIGNIFICANCE OF HEALTH WORKERS' ATTITUDES TOWARDS HEALTH CARE USERS

The World Health Organization Report (2012) reports on the impact of health research. Over the last few years, there has been a sustained effort at the international level to encourage research initiatives and knowledge to action practices in public health. The World Health Report (2012) further highlights the significance of conducting and translating health research to help promote healthy behaviors (WHO 2012). Health workers are expected to conduct themselves in certain ways towards patients and their relatives as their customers. Internationally there is guidance in the field of psychology that is cross cutting to mankind in general. While in South Africa we have policies, regulations, laws that were extracted from the Constitution of South Africa 1996 as amended. All these have intent to improve interpersonal relations between service providers and users officially and unofficially. Attempts were made previously and recommendations are ongoing regarding the subject of behavior. The emphasis of Batho Pele policy through its principles is how and not what health care services should be rendered to the users.

3.12 SUMMARY

The findings of this research study indicate that most dissatisfaction do not require financial resources to be rectified. This means that while financial constraints can limit service delivery, health workers do not have the reason not to strive for service excellence within available resources. Most areas of dissatisfaction expressed by health care users are about negative attitudes, poor communication and lack of information. Evidence by Nairn *et al.* 2004 showed that patients are generally satisfied with the care they receive, but the area of communication and information giving remain areas of concern to many. This implies that if users are treated with respect and consideration in the Out Patient Departments they will have positive experiences and perceptions about health care services.

CHAPTER FOUR

THEORETICAL FRAMEWORK

4.1 INTRODUCTION

Henning (2009) asserts that when a researcher sets out to investigate an issue, the researcher does so from a position of knowledge and this can frame her or his inquiry. Henning (2009) further states that theories help us sort out our world make and sense of it, guide us on how to behave in it and predict what might happen next. They are derived from information that people collect by seeing, hearing, touching, sensing, smelling and feeling. It is against this background that the framework for this research was based on ***Batho Pele policy*** that seeks to improve the attitudes of health workers to enhance client satisfaction.

4.2 THE DEFINITION

Batho Pele, a Sotho translation for "People First", is an initiative to get public servants, to be service oriented, to strive for excellence in service delivery and to commit to continuous service delivery improvement. It is a way of delivering services by putting citizens at the centre of public service planning and operation. It is a major departure from a dispensation, which excluded the majority of South Africans from government machinery to the one that seeks to include all citizens for the achievement of a better life for all through services, products, and programmes of a democratic dispensation (Batho Pele 1997).

4.3 THE VISION

The vision of Batho Pele is to continually improve the lives of the people of South Africa by a transformed public service, which is representative, coherent, transparent, efficient, effective, accountable and responsive to the needs of all. The findings of this research study have showed coherence between what Batho Pele policy seeks to address and some of the causes of health care users' dissatisfaction that result into negative experiences giving rise to perceptions. The vision of this study is to highlight the gap between the services that are delivered and how we ought to deliver them to meet health care users' needs and expectations.

4.4 THE MISSION

Batho Pele policy (1997) The creation of the people-centred and a people - driven public service that is characterised by equity, quality, timeliness and a strong code of ethics. The findings of this research study revealed that health care users' dissatisfaction emanate from experiences of waiting time that give rise to perceptions about public health care services. Such experiences are responsible for the physical and emotional distress that is at the centre of Gauteng Health's Complaints. The mission of this study therefore is to promote comfort in the Out Patient Departments during waiting time to enhance client satisfaction.

4.5 THE HISTORY

Batho Pele policy was introduced in 1997 and has its roots in a series of policies and legislative frameworks. These policies and legislative frameworks have been categorised into three themes namely: those that are overarching or transversal, those that deal with access to information and those that deal with transformation of service delivery. The researcher therefore views ***Batho***

Pele principles as the basic theoretical framework for improvement of health care users' experiences and perceptions of waiting time at public hospitals and clinics. The need to conduct this research study was supported by the users' claims that there are discrepancies between the services that public hospitals and clinics pledge to offer and the actual service they receive. The broad objective here is to promote comfort during waiting time so as to deliver according to the needs and expectations of health care users, in order to create positive perceptions regarding the public health care services.

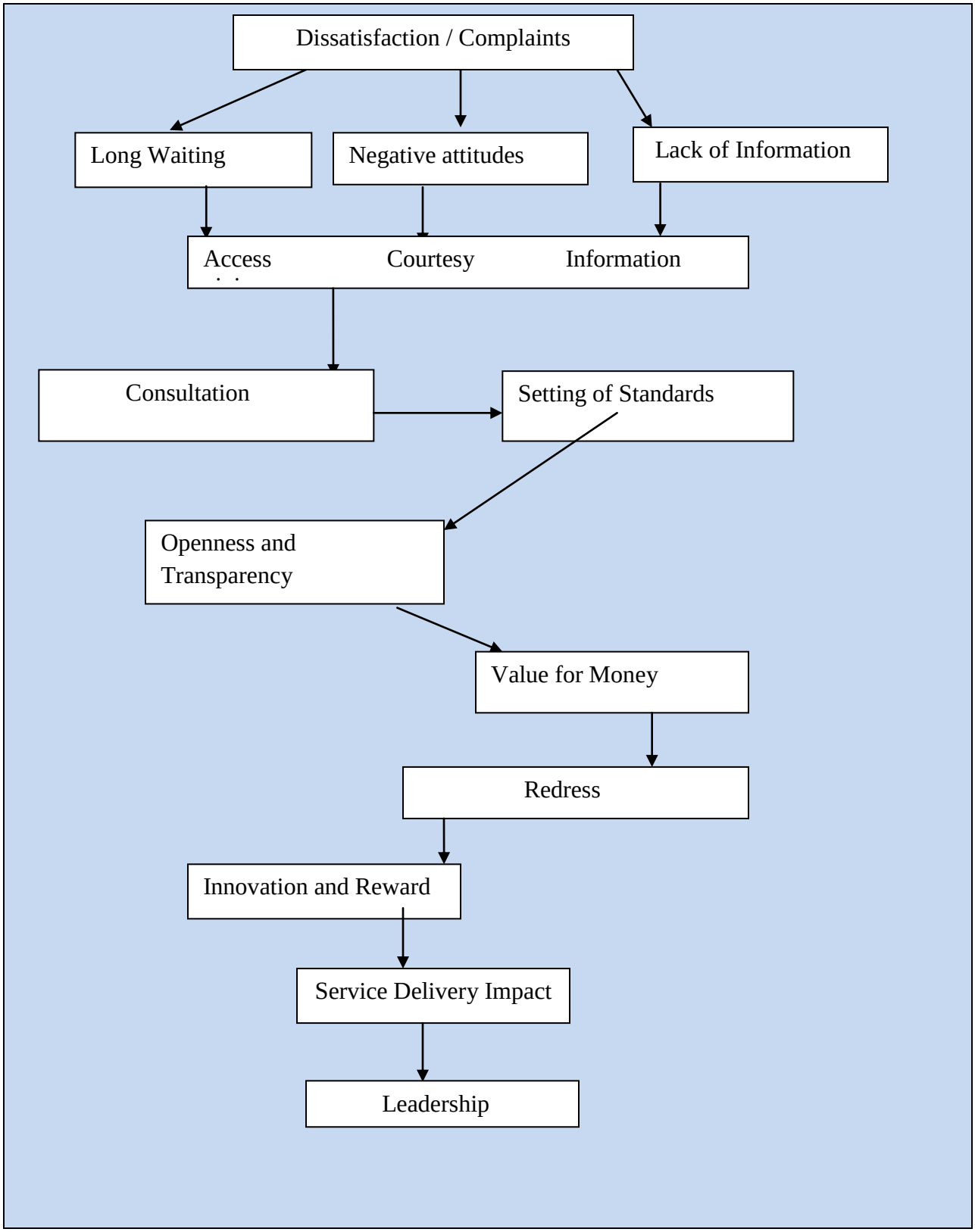
4.6. BATHO PELE PRINCIPLES

The Batho Pele principles are based on the following legislatures:

- The Constitution of South Africa of 1996 (as amended).
- The White Paper on Transformation of the Public Service of 1995
- The Promotion of Access to Information Act 2 of 2000
- The Bill of rights – Chapter 2
- National Health Act, 61 of 2003
- Code of Conduct
- Patients Rights Charter
- Public Service Regulation of 1999 and 2001

Eight principles were introduced which are Consultation, Service Delivery Standards, Access, Courtesy, Information, Openness and Transparency, Redress and Best Value for money. The Gauteng Department of the Premier has subsequently added three more principles bringing them to a total of eleven. They are Innovation and Reward, Service Delivery Impact and Leadership. The researcher finds all eleven principles relevant to the objectives of this study. The findings of this research indicate that it is imperative for health workers to learn, understand but most importantly accept them principles as the basis for improving health care users' experiences and perceptions of waiting time. So the theoretical framework of this research was based on Batho Pele policy which is its premise. The eleven Batho Pele principles are presented as **Model: 4.1** below

Model 4.1 Model of Framework: "Batho Pele Principle"



- **Description of the model of framework**

This research study is based on the framework of Batho Pele Principles and its relationship with the findings is presented in detail as follows:

Health care users express dissatisfaction regarding the health care services they receive at public hospitals and clinics as evidenced by the Gauteng Patients complaints call centre report (2011). Such dissatisfactions are lodged formally as complaints through verbal and written communication which are directed to Gauteng Complaints Call Centre as it was mentioned in the problem statement. These complaints are either minor or serious in nature. The Serious Adverse Events include loss of life, permanent damage and potential litigation. The model starts with the dissatisfaction that occur during waiting time. Accordingly these emanate from three common areas of disgruntlement that are long waiting time, negative staff attitudes and lack of information. These three imply poor access to services, no courtesy and information giving. Access has been defined as the ability for patients to receive health care services easily, promptly and comfortably (Batho Pele policy 1997). Furthermore health care users complain about the negative attitudes that are displayed by some health workers when they speak to them. This means that some of the clinic staff do not show respect and consideration to patients, by so doing violate the courtesy principle.

In addition health care users should be given relevant information regarding clinic processes that they are entitled to receive, so lack not giving them such information is not consistent with this principle. So to improve the three principles, health care users should be consulted in order to identify their expectations, needs and opinions. Once these are known then it will be possible to set up service delivery standards. With the service delivery standards in place health workers will perform duties within their prescripts with the desire to promote comfort during waiting time. After checking that service delivery standards are achievable, then they should be made open and transparent. In this case the service delivery standards will cover filing, medical services and others. Such standards should be communicated to health care users so that they can observe if they are met.

When they are not in some areas then not only it is their right but they are expected to complain. A complaint should be immediately attended to by offering an apology together with a sympathetic and a positive response. Simultaneously a complaint should be viewed as an opportunity for improvement therefore a positive response will include an explanation and a promise to ensure that similar incidents do not recur, by putting systems in place pursued through innovation and reward to correct shortfalls. Public hospitals and clinics will benefit a lot when they create conducive environment wherein health workers feel free to be innovative. Then shortfalls can be corrected by doing things differently when health workers are encouraged to find better ways of improving even those things which seem perfect, to provide an even better value service and they should be recognized for excellence. When new ideas are included and the obsolete ones withdrawn then services will ensure that health care users realise best value for money. This will enable the public service to enjoy a positive service delivery impact that reflect good leadership through strategic direction and support to health workers from management. Leadership should also ensure that disciplinary actions are taken against those who are violating some efforts that are aimed at improving the quality of service through the Batho Pele policy. The researcher is confident that through compliance with the Batho Pele policy, health care users' comfort at outpatient departments can be promoted to enhance client satisfaction. Ultimately improve users' experiences and perceptions of waiting time.

4.7. THE DISCUSSION OF BATHO PELE PRINCIPLES IN RELATION TO THE FINDINGS

4.7.1 CONSULTATION

Consultation: Health care users should be consulted about the level and quality of health care services they will and would wish to receive and wherever possible should be given a choice about services that are offered.

Their views, expectations and perceptions should be listened to and be involved in their own treatment plan.

Consultation in relation to this study means that nurse clinicians and doctors should speak to diabetic patients about their conditions and involve them in their treatment plan. However this study found that consultation was inadequate. As a result participants stated that doctors did not perform physical assessments and this created perceptions that they did not care for patients. The study previously cited Nairn *et al.* (2004) asserts that patients should be listened to and their opinions be respected. The attitude that professionals know best was now open to significant challenges. Nurses explained procedures beforehand, and did not commence with them until patients had given some kind of permission; this exemplifies a patient-centred approach. Physicians, however, often provided information about the procedure while beginning the procedure and this is viewed by patients as poor or lack of consultation. Approximately fifteen years later some patients still experience lack of involvement in their treatment plan. Health workers should perceive health care users as customers, like any other customer in the business industry.

Jawahar (2006) confirm that twenty nine percent of patients said that they do not know much about services in the clinic and the details of individual treatment. This he said reveals that patients' participation in their care has a special place with regard to their satisfaction. That means patients need to be consulted in order to inform and legitimise decisions regarding the treatment they should receive. Consultation in this regard will clarify their expectations and understanding behind the reasons for doctors not to be able to perform full physical assessments at all times. The study by Jawaid *et al.* (2009) found that although interaction with patients seems routine to the hospital staffs, the experience of receiving health care is not routine to patients.
Hence the attention, attitude, and the information the hospital staff provide are very important to the patients. Patients, doctors, nurses, management, medical associations or accreditation organizations all have some stake in defining the standards of medical care but patients are the single largest category. This means then that no matter how insignificant the information about their conditions may be to doctors and nurses, to patients and their relatives that is vital. In South Africa, the National Department of Health (2007) recommends that public hospitals and clinics should conduct the client satisfaction surveys twice annually, to ensure that services remain relevant and realistic standards are maintained.

And if health care users' concerns are taken into consideration then measures will be put in place to ensure that services are responsive to their needs and expectations and client satisfaction will be enhanced as it was mentioned in the objectives of this study. Participants in this study were concerned about other ailments that they feared may be missed if physical assessment was not done to them. They were also dissatisfied that doctors do not take time to explain what was wrong with them, and that often it was difficult for patients to explain their ailments because they see different doctors every time they come for a check up. Patients feel that they are not involved in their treatment plan because there is poor communication between them and doctors. Being seen by different doctors every time they come to the clinic makes patients doubt that they may be getting sub-optimal care. They suspect that tests are repeated for training purposes not in their best interest but they are used as guinea pigs. These kinds of dissatisfaction force patients to have negative perceptions about health care services considering how they are often treated. Because of that they may lose confidence unfortunately the system does not offer them a choice to use other facilities that may be perceived to be better. Patients may be consulted collectively or as individuals depending on the subject or topic to allay anxiety and prevent perceptions.

4.7.1.1 To achieve consultation the following should be undertaken:

- The diabetes clinic should conduct its own client satisfaction surveys.
- All patients should be done a comprehensive assessment and be informed about their illnesses and if it is not necessary, they should be given an explanation.
- Their views, needs and expectations regarding the treatment plan should be taken into consideration where possible e. g. the wish to be seen by the same doctor.
- Where it is not possible an explanation should be provided.

4.7.2. SERVICE DELIVERY STANDARDS

Oxford Dictionary (2011) defines a standard as something used as a measure in order to make comparisons. The service delivery standards refer to the agreed level of quality that health care users at the diabetic clinic should be told about.

In the context of this study standards will cover clinic processes and procedures about registration documents such as identity books, proof of residence, appointment cards and small change. The filing system and the available medical services will also be included in the service delivery standards. This research study revealed that the filing system was not satisfactory and therefore had a negative impact on waiting time. If clerks followed a proper filing system, patients' files will be issued timely and bring about immediate positive impact on waiting time to meet health care users' expectations and thereby improve their experiences and perceptions. The information regarding what to bring to clinic will prevent unnecessary conflicts between clerks and patients. Conflicts that involve small change as it emerged during individual interviews will be prevented. While financial constraints can limit service delivery, health workers do not have the reason not to strive for service excellence within available resources because various researches, found that most areas of dissatisfaction expressed by users were about negative attitudes, poor communication and lack of information. Evidence by Nairn *et al*. (2004) showed that patients are satisfied with the care they receive, but communication and information giving remain areas of concern to many.

Muhondwa *et al*. (2008) assert that patients should not be expected to be grateful for whatever is done to or for them. Their needs should be taken into account regardless of their indigent status and promote comfort. And fortunately all these concerns do not need money to rectify but compliance with Batho Pele policy. Participants have mentioned that each time they come for follow up visits, they see different doctors and they believe that, they are not well cared for medically due to this phenomenon. Participants stated that it was frustrating to explain your condition to another doctor all over again, because every doctor uses his own discretion so when patients see a different doctor he may do his own investigations. Participants said that this practice makes them feel like guinea pigs, and that it was hectic, time consuming and agitating. Health care users' experiences of several investigations performed on them without any explanation give rise to perceptions that such are not in their best interest. Such perceptions can be prevented by service deliver standards that will inform patients as to when and why the investigations might be done or and repeated. The researcher has learned that some of the participants who have been diabetic for several years did not know the frequency for routine blood tests as part of diabetic care. This led to conflicts between the nursing staff and them.

Some participants mentioned that sometimes they are shouted at for having eaten and often it is the opposite leaving them with feelings of frustration, helplessness and sadness. In addition they also stated that doctors do not do a full physical assessment of patients, so they think that it is because doctors do not care for them and this makes them feel sad because they fear that their conditions will complicate. Their expectation is to have a full physical assessment after being to satellite clinics or traditional healers. They were referred to this academic hospital for higher level management. Unfortunately, it was not possible for doctors to perform a comprehensive assessment to all patients because of work overload that was encountered. As part of their training, medical interns together with consultants see patients at this clinic. Medical interns spent approximately 6 weeks at this clinic and then move to another department to meet their study requirements. This rotation of doctors makes it impossible for patients to be seen by doctors of their choice or the same one in the next visit. The study by Muhondwa *et al*. (2008) asserts that postgraduate students and interns attend to patients along with consultants as part of their training, and therefore it may not be possible for a patient to be seen by a particular consultant. This is often a cause for concern as patients fear that they may not be receiving the best care possible. It is therefore imperative for the clinic to communicate this information through service delivery standards.

Health care users should be made to understand that for them to receive the quality of the services described in the service delivery standards, they should accept their responsibility and provide necessary requirements for registration, display respect and avoid abusive behavior and language towards health workers. Participants also mentioned the need for the clinic to use the card system which they believe will make it possible for the first come first served principle with the exception of persons with special needs. In addition the level of noise was of concern as it prevented some patients to hear when their names were called, especially those with hearing impairments. The level of quality of health care services should be of highest quality standards to promote clinical practices. While setting of standards and reviewing them are underway consideration should be taken to ensure that they are achievable, realistic and time bound. The Patients Rights Charter says that patients have the right to be treated by the practitioner of their choice. If the choice of doctors is not possible this should be communicated to patients.

It is therefore important to provide the above information so as to enable them to make an informed decision whether to be seen by another doctor or reschedule an appointment

4.7.2.1 To achieve service delivery standards the following should be undertaken

- Inform patients about challenges regarding the choice of doctors, a comprehensive assessment and doctors' whereabouts.
- Provide information about the VIP status to strengthen the triage system.
- Display information about registration documents.
- Develop the effective and efficient filing system.
- Introduce a card system.
- Display noise free signs and posters.
- Strengthen hygienic conditions in the toilet.

4.7.3 ACCESS

Anderson & Karlberg (2000) state that access is the ability to seek and receive care from the provider of choice at the time the patient chooses. According to South Africa's Batho Pele policy access is defined as receiving health care services easily, comfortably and promptly (Batho Pele Handbook 1997). In this research study access means that patients with diabetes should receive treatment timely and without difficulty. Unfortunately that was not the case during individual interviews as one by one participants mentioned factors that affect them negatively while seeking health care services. All three elements of access that are easy, comfort and prompt are not met. Patients could not reach home easily due to transport problems when they finished late at pharmacy. In addition there was no recognition for VIP status to persons with special needs such as wheelchair occupants and those with hearing or visual impairments. These and other factors affected patients both physically and emotionally preventing comfort during waiting time.

The study by Barlow (2002) showed that customers frequently have to wait during the process of acquiring a service. These waiting experiences are typically negative and have been shown to affect the customers' overall satisfaction and their evaluation of service they encounter. SAHRC (2009) found that access to health care services, especially for the poor, is severely constrained by expensive, inadequate or non-existent transport, by serious shortages with regard to emergency transport, and by long waiting times at clinics and other health care service providers. The element of comfort was compromised by uncomfortable and inadequate seats of which some were broken both in this clinic and also at the chemist as mentioned by some participants. Some users do not get seats and are forced to stand; they do not like it because they get tired. Those who are weak and frail are affected by the standing and discomfort from the seats. Saidi (2007) found that some seats were broken and that patients sit on them because they have no choice. The other cause of discomfort for patients was getting hungry, thirsty and tired while waiting for doctors and medicines. Unfortunately some did not have money to buy food from the hospital canteen because they said it was expensive. The feelings of thirst and hunger caused physical and emotional distress to users which make services inaccessible.

The study by Eilers (2004) revealed that if waiting time cannot be reduced then patients' perceptions of time wait, can improve when the reception area is comfortable and patients are distracted because they think they waited for a shorter time. Public health authorities are required to make hospitals and clinics services accessible to people with disabilities by providing ramps and designated parking bays for wheelchair occupants. Unfortunately during the individual interviews one participant mentioned that the designated parking was occupied by able persons and she battles to get her husband on and off the wheelchair from an ordinary parking bay. Lack of access to information was evidenced by displayed posters on the walls inside the clinic that were written in English only. This means that people who could not read in English including those with visual impairments did not access the information from the posters. The other area that was found to have poor access was ablution facilities as toilets were not disabled friendly. In addition the hygiene of the toilets was often not up to standard. These conditions compromised comfort during waiting as patients feared to catch germs and become ill.

Some patients asked the question how they can get well using such toilets. While others said that they prefer to use other toilets away from the clinic that are believed to be cleaner. Due to conditions of the toilets users developed various coping mechanisms. Some went to the toilet only in the morning while they were still clean; others lied to nurses and doctors that they did not have urine. All these complaints compromised comfort in the out-patient department. Knowing health care users needs and expectations and being able to provide services quicker and better will improve their experiences and perceptions of waiting time. Treating patients with respect and consideration will improve access to services. Provision of clean toilets for patients and their relatives is but a right to basic services and respect for human dignity. SAHRC (2009) confirm that the right of access to health care services is one of the indivisible and interdependent rights entrenched in the Constitution of the Republic of South Africa Act, 108 0f 1996, especially the Bill of Rights contained in Chapter 2 thereof. According to the three elements contained in the definition of access, the diabetes clinic under study was found to be non-compliant.

4.7.3.1 To achieve access the following should be undertaken:

- All public hospitals and clinics should introduce the triage system so that patients with special needs should not be left to wait in the queue.
- All patients should be attended to timely so that they can return home early.
- Toilets should be cleaned daily and when necessary so that patients are able to use them whenever they need to.
- The filing system should be improved to be effective and efficient.
- The clinic should introduce a number card system to ensure that patients are seen on a first come first served principle in exception of emergencies.
- Seats should be adequate and comfortable so patients and their escorts could be seated during waiting time.
- Disabled parking bays should be reserved for that purpose only.
- Information should be communicated in other local languages.

4.7.4 COURTESY

Health care users should be treated with courtesy and consideration. However some participants have voiced dissatisfaction regarding the manner in which the clinic staff spoke to them. Some thought that health workers gave them poor treatment because they were not educated. While others said that it was because of their low socio-economic status. Participants expect health workers to consider age difference and treat them with respect regardless of their circumstances. Health workers should observe different ways of addressing patients according to their cultural background. For instance black people may feel offended to be addressed by their first names especially by young clinic staff. Nairn *et al.* (2004) found that the complaints around discourtesy differed according to race. Complaints were coming more from black African American than their white counterparts. Participants stated few incidents that they interpreted as lack of respect displayed by clerks or nurses. During registration clerks were allegedly not approachable and reluctant to give information. Apparently clinic staff did not apologised to patients after wrongfully accusing them of missing files. Muhondwa *et al.* (2008) studied patient satisfaction and found that staffs used humiliating words while attending to them. This was experienced from nurses in particular that they were rude, uncaring and fond of using humiliating language.

Furthermore as courtesy health workers should wear their name tags so that health care users can identify them as it is their right to know the identity of staffs that are treating them. SAHRC (2009) indicates that the right to health care is generally referred to as fundamental to the physical and mental well being of all individuals and as a necessary condition for the exercise of the human rights including the pursuit of an adequate standard of living. Those who are required to wear uniform and distinguishing devices should do so with pride. Medical records should be treated with respect by using legible handwritings, signatures and designations. This will enable patients to identify the practitioners who treated them. Treating them with consideration and respect displayed through positive attitudes from health workers will reduce their anger, anxiety, fear, frustration and sadness.

4.7.4.1 To achieve courtesy the following should be undertaken:

- Health workers should speak politely to patients in a manner that displays respect.
- When a mistake has occurred health workers should apologise immediately and promise that it would not happen again.
- When talking to patients caution should be taken not to instruct but to request them, for example when they are told to bring small change.
- Health workers should wear their identity cards so that patients could know who they are speaking to.
- All entries in the medical records should be legible, dated, signed with designations.

4.7.5 INFORMATION GIVING

Health care users should be given full, accurate information about services they are entitled to receive. However the clinic staff here did not give information regarding the doctors' whereabouts e.g. doctors attending a meeting, doctors in theatre, how many doctors on duty and their names. Participants felt that such information would assist them to make informed decisions. Lack of information giving may cause anxiety and frustration. Evidence by Nairn *et al.* 2004 found that patients are satisfied with the care they receive, but the area of communication and information giving remains an area of concern to many. Participants have mentioned that some patients are treated by the professor and that they are anxious and wonder who are entitled to that. Such anxieties and wonders may result into frustration and sadness as patients try to guise for answers. Patients should not be made to look for answers when the reason is legitimate and there is nothing to hide. The reason for some patients to be treated by the professor is that their medical conditions are more serious than their counterparts. Once patients understand such facts they will begin to appreciate that their health status is better than those. Due to the clinic workload it is difficult almost impossible for health workers to have time to answer some queries or questions from health workers. It is therefore imperative to compile necessary information and provide it in the form of posters or pamphlets. A notice board is suitable to provide information that changes day to day especially the doctors' whereabouts.

Then users may be encouraged to read it. Nairn *et al.* (2004) showed that the overall length of stay in the department is perceived as better for those patients provided with information every 15 minutes than those patients not provided with information. The other information that is not given to patients in advance is regarding registration requirements such as small change, appointment cards, identity documents, proof of residence and others. This information can be communicated through posters so that patients can read them while waiting; it may be as Nairn *et al*. 2004 found that unoccupied time feels longer than occupied time, and how anxiety and uncertainty makes waits feel longer. This illustrates the importance of information giving and communication skills, which may influence the experience of waiting time. Provision of relevant information about clinic processes and services will prevent unnecessary waits. The study by Wiman *et al*. (2004) showed that communication skills are a prerequisite for a good relationship between nurses and patients. Hospitals should communicate their strengths, own up to their shortfalls and make a promise to improve. This will boost health care users' confidence and prevent bad experiences that give rise to negative perceptions about health care services.

4.7.5.1 To achieve Information giving the following should be undertaken:

- Provide information regarding registration requirements e.g. small change, appointment cards, identity documents, proof of residence and others.
- Provide information regarding choice of doctors, physical assessment, and others doctors' duties such as ward rounds, theater and emergencies.
- Communicate the purpose of triage so that patients do not suspect favoritism when they see someone being attended to first.
- Communicate the criteria for patients who are treated by the consultant or professor.
- Give all relevant information.

4.7.6 OPENNESS AND TRANSPARENCY

Health care users should be given full, accurate information about services they are entitled to receive. Clinic staff should be open about constraints and how they plan to rectify them.

Involve them in the solution to curb the stealing of toilet papers. Talking about it openly may scare the culprits.

4.7.6.1 To achieve Openness and Transparency the following should be undertaken:

- Give health education in the waiting area and engage with health care users.
- Note their concerns, opinions, expectations and needs.
- Do not take anything for granted.

4.7.7 REDRESS

If the promised standard of service is not delivered, health care users should be offered an apology, a full explanation, speedy and effective remedy. Clinic staffs should take note that health care users not only do they have the right but are expected to complain, and complaints should be responded to, efficiently, effectively, positively, promptly and sympathetically, and be seen as opportunities to learn and improve services. Evidence by (Wiman *et al.* 2004; Saidi 2007) proved that one third of emergency department patients' complaints were related to experiences such as poor attitudes towards patients, lack of communication, discourtesy and rudeness, and that if these were avoided then patient satisfaction would be achieved. Unfortunately the structure of health system does not give users and patients an option to use alternative hospitals that may be perceived better. Health care users visit hospitals often not in their right frame of mind due to the circumstances surrounding their visits, so they expect empathy, sympathy, caring and at the very least some compassion or understanding for their situation. Unfortunately when such expectations are not met wrong perceptions are created and they think that long waiting time is due to lack of care. Often patients' files get mixed up or miss. While the file is missing patients become anxious thinking that without their files the doctor may not see them. Unfortunately they are falsely accused of the mix up and missing of files.

When the files are finally found and the clinic staff is at fault, they do not apologise to the patients. One participant said that it happened to her on several occasions and the staff failed to apologise to her. So every time she comes to clinic she panics and becomes anxious about the file that often goes missing.

4.7.7.1 To achieve redress the following should be undertaken:

- The complaints management system should be displayed in all waiting areas with the name of the unit manager.
- The complaints, compliments or suggestion boxes should be visible and accessible to patients and be read regularly in order to improve clinical practices.
- Patients should be positively encouraged to express their dissatisfaction about anything and do it verbally or in writing without victimization.
- Provide a satisfactory response.
- All health workers should be trained to manage complaints in a satisfactory manner.
- Put measures in place to prevent recurrence.

4.7.8 BEST VALUE FOR MONEY

Public health services should be provided economically and efficiently in order to give health care users the best possible value for money. Treating patients with consideration means that procedures will be done right the first time to prevent medical negligence that result into complications and potential litigation. Diabetic patients should be treated early and go to the pharmacy for the medicines on the same day. This will enable patients to catch their transport back home and prevent the return to clinic for medicines the next day. South African Human Rights Commission (2009) found that access to health care services especially for the poor is severely constrained by inadequate or non-existent transport and by long waiting times at clinics and other health care service providers. Recently Harries *et al.* (2011) examined inequities in access to health care in South Africa and confirmed that travel costs, medical fees, long queues and disempowerment are access barriers despite constitutional rights. The patients' right charter recommends a healthy and safe environment that will ensure physical and mental wellbeing

4.7.8.1 To achieve Best Value for money the following should be undertaken:

- Procedures will be done right the first time to prevent diabetic complications and potential litigation.
- Patients should receive their medicines on the same day, not told to return tomorrow.
- Clinic staff and health care users should be encouraged to report theft of toilet papers.
- Broken seats that compromise physical comfort should be condemned immediately.
- Patients should be classified properly and fees charged correctly.

4.7.9 INNOVATION AND REWARD

Health care authorities need to show that staff' commitment, energy and skills are being harnessed to tackle inefficient, outdated and bureaucratic practices. Health workers should be encouraged to find better and easier ways of improving even those things that seem perfect, to provide improved health care service and they should be recognized for excellence. The clinic staffs in this study should address the causes of long waiting time that are manmade such as mix up and missing of files. Such causes do not need money or any resources to rectify. It is also possible to display respect and consideration when health care users' concerns that are often taken for granted are known. One participant complimented 1 clerk and 1 nurse for the manner in which they speak to all patients. Such compliments need to be given to the persons concerned as they deserve appraisal.

To achieve Innovation and Reward the following should be undertaken:

- Health workers should be encouraged to employ practices that will prevent problems from occurring in the first place.

4.7.10 SERVICE DELIVERY IMPACT

The service delivery impact is all about how much does the organization achieves the objectives of Batho Pele policy after all initiatives. The evidence should demonstrate both realization of intended objectives, outcomes and impact. Compliance to all Batho Pele principles will promote comfort during waiting time to enhance client satisfaction.

4.7.10.1 To achieve Service Delivery Impact the following should be undertaken:

- Physical and emotional comfort should be promoted in all public hospitals and clinics' waiting areas.

4.7.11 LEADERSHIP

Health workers should receive strategic direction and support from management in order to achieve their objectives. Leaders should be visible and display commitment to the teams' objectives by giving constructive feedback that would result into corrective measures being taken to ensure success.

4.7.11.1 To achieve leadership the following should be undertaken:

- Health workers should enjoy guidance and support on how to from senior managers.
- The presence of managers should be viewed and felt as valuable towards service delivery rather than policing.

4.8. SUMMARY

This chapter presented the framework for this research study and its relationship with the findings. The benefits of compliance and how it can be achieved were also outlined.

CHAPTER FIVE

EVALUATION OF THE STUDY, LIMITATIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

The formal complaints regarding waiting time at public health facilities that are lodged at Gauteng Health Department or through negative media publicity are a premise for this research study. The intent was to understand the causes of those dissatisfactions and provide evidence of their existence and possible mechanisms to address them. The completion of this study saw the presentation of a dissertation including a proposed policy and guidelines on promotion of comfort in the outpatient departments at public health facilities.

5.2 EVALUATION OF THE STUDY

The purpose of this research study was to explore and describe health care users' experiences of waiting time at a diabetes clinic in an academic hospital and describe the perceptions to which they give rise. To achieve this purpose four objectives were formulated. To meet these objectives data were collected through in-depth individual interviews that were purposively selected at a diabetes clinic in an academic hospital. The purposive selection was preceded by a pilot study that was conducted with two participants. The preparation for individual interviews was adequately informed in terms of the reasons behind inclusion and exclusion for participation in the study. Other data collection methods were through observations, analysing of waiting time documents and photographs. All data was analysed according to Tesch's method of analysing qualitative data in Creswell (2009).

Themes and sub-themes that emerged together with findings from observations and photographs verified that patients visit a health care facility often not emotionally stable due to circumstances surrounding that visit. Users expect compassion, empathy, sympathy and at the very least some understanding for their situation. When these expectations are not met they feel that health workers do not care for them at least not according to their expectations. Patients assume that health workers are trained to be healers through listening, comforting and attend to both their physical and emotional needs. Unfortunately health workers often unintentionally fail to attend to those aspects and this is viewed as a non-caring attitude. Lack of proper consultation and inclusion in the treatment plan which is often taken for granted due to the assumption that after all this is a strange jargon that patients do not understand does not meet their expectation. The expectation is that they wish to know more about their illnesses. Such inconsideration go unnoticed by health workers and yet they form part of users' experiences which sadly give rise to negative perceptions about health care services. Services are rendered according to the different levels of the health care facilities. And if these were made known to the community then patients would understand how the systems work. It would assist them to accept why they should go to certain health care facilities and not where they would rather go.

This lack of information giving about available or unavailable health care services and how they are rendered makes patients feel left out without a sense of belonging or partnership in the health care system. Patients come early for their medical checkups and expect to be attended to timely so that they could return home. Most of them due to their low socio economic status relied on public transport which is not available late in the afternoon. People with special needs such as wheelchair occupants experience poor access to health care services and service points. All these challenges prevent access to health care services to be received easily, comfortably and promptly. The manner in which users are sometimes spoken to by some health workers is unacceptable to most of them. Participants feel that they are treated with disrespect as if they were children especially by young clinic staff. Furthermore failure to wear name tags by some health workers created a non patient friendly environment. Ultimately failure by some clinic staffs to apologise to patients when files are misplaced or go missing is interpreted as arrogant.

Then ten interview transcripts were analysed according to Tesch's steps in Creswell (2009) that saw the emergent of five themes and nineteen sub-themes. These themes and sub-themes brought the deductive reasoning process to conclusive statements that were used to formulate the recommendations for formulation of policy and guidelines on promotion of comfort in the outpatient departments. The findings of this research study confirmed that health care users' experiences and perceptions of waiting time could only be explored and described using a qualitative paradigm as opposed to a quantitative one. This current research study also confirmed that users' expressions of dissatisfaction about waiting time are caused by concerns and activities that occur during waiting time at outpatient departments. However the framework of this research study offers confidence that if health workers are compliant to it client satisfaction of waiting time can be enhanced. The researcher's assumptions were validated by individual interviews, observations, analysis of waiting time documents and photographs.

5.3 LIMITATIONS

Participants were purposefully selected from one clinic and only those who spoke the languages that the researcher could speak, understand and interpret were interviewed. Participants spoke only the four languages that are Setswana, Sotho, English and Zulu. The researcher therefore believes that some potential respondents may have been left out. Therefore on account of language barrier, their concerns and opinions regarding the topic of this research study have not been explored. The other group that was purposely left out was the newly diagnosed patients because the researcher believes that they have insufficient experiences compared to their counterparts. Due to the unstructured individual interviews and the subjectivity of the opinions expressed by participants, the data extrapolated could only be validated through the methods that were described in chapter two. Although public hospitals and clinics have similar weaknesses and strengths, each one of them is unique. The research study was conducted at one diabetes clinic in one academic hospital therefore what came out as a challenge; the situation might be different in another public health facility. Moreover that some challenges were human made while others were systemic.

The human made challenges may be caused and corrected by different managerial and leadership skills. Therefore, it is possible to find one health facility that has adequate, comfortable and unbroken seats for example but suffer from poor staff attitude and vice versa. In which case, users will be dissatisfied in one way or another. Nevertheless, the Gauteng Department of Health through the Infra-structure Directorate has a system in place to provide the necessary equipments and furniture as recommended. The challenge is for the health authorities to take the users' needs and expectations into consideration.

5.4 RECOMMENDATIONS

Firstly the findings of this research study informed the formulation of a proposed policy and guidelines on promotion of comfort in the outpatient departments and along with that, this study recommends that public health facilities should comply with the Batho Pele policy. This will ultimately improve users' experiences and perceptions of waiting time. To realise this health workers from all occupational categories that are nursing, medical, pharmacists, allied, support, administration, cleaners, porters, messengers, security and others should all undergo training on Batho Pele policy. This research study found that if health workers become mindful of patients' concerns, opinions, needs and expectations their dissatisfaction would be reduced and so would complaints. According to service delivery standards it was mentioned that while financial constraints can limit service delivery, health workers do not have the reason not to strive for service excellence within available resources because various research found that most areas of dissatisfaction expressed by users were about negative attitudes, poor conditions in the waiting areas and lack of information. In view of the above the special recommendation would therefore be to encourage health workers to treat patients with courtesy regardless of their low socio-economic and or educational status. Improving the seating areas and ablution facilities will have a positive impact on comfort during waiting time. It was mentioned in the background that users visit hospitals often not in their right frame of mind due to the circumstances surrounding their visits and they expect caring, empathy, sympathy and at the very least some compassion or understanding for their situation.

If users observe these then their experiences and perceptions about health care services would be positive and enhance client satisfaction. Barlow (2002) points out that satisfaction equals perception minus expectation. This implies that if a patient receives a better service than they expected they will leave happy. The general users' perception is that health workers are often rude and uncaring. So the challenge is to display respect and empathy then it will be possible for them to accept other logistics that are beyond the health workers' control at the unit level.

The following measures can be applied to show respect to users:

- Display positive attitudes and politeness.
- Provide information on doctors' whereabouts and how long users will wait.
- Arrange seats to allow users to have conversations.
- Utilise the health promoters to give health education during waiting time.
- Train queue marshals to be health promoters as well.
- Oermann (2003) suggested provision of informational videotapes on health topics in the waiting areas.
- Patrick (2011) recommends the "do today's demand today" method. This is the one that the clinic under study uses and is working.
- Masae *et al.* (2011) proposed shifting doctors' schedule

Secondly this research study recommends that public hospitals and clinics conduct the patient satisfaction surveys regularly as prescribed by the National Department of Health but most importantly utilise the results to review clinical practices aimed at improving quality health care. Although the researcher believes that some potential respondents may have been left out, the findings of this research study based on its framework suggest that it is possible to transfer the recommendations to other public hospitals and clinics. As a researcher like other health professionals we admit that reduction of waiting time is complex and that its success is reliant on various logistics.

Therefore the researcher argues that while various measures are put in place to reduce waiting time, it is possible to promote comfort in the outpatient departments and improve users' experiences and perceptions of waiting time. The Gauteng Department of Health's objective is to undertake specific interventions to reduce waiting time in all waiting areas and pharmacies. The interventions that Gauteng Department of Health recommends include the following:

- Strengthening of help desks.
- Introduction of fast queues for people with special needs.
- Implementation of effective triage system
- Introduction of clear visible signage to guide patients
- Training of queue marshals

Thirdly it is recommended that all measures to manage waiting time be taken into consideration daily to improve users' experiences. Lastly this research study should be used in future researches on how to promote comfort in the waiting areas aimed at enhancing health care users' experiences and perceptions of waiting time.

5.5 CONCLUSION

The findings of this research study clearly supported the problem statement that health care users perceive waiting time at various departments such as admissions, casualty, polyclinic and pharmacy as a problem equal to lack of access to health care services at Gauteng Province' s public hospitals and clinics. Users' express dissatisfaction regarding the activities that happen or do not happen to them while waiting in the outpatient departments. The qualitative research that was explorative descriptive contextual and theory generative was used successfully to achieve the purpose and objectives of this research study. Exploration was used to gain insight into health care users' experiences and perceptions of waiting time.

The themes and sub-themes that emerged from individual interviews were described to give account of their views and opinions of waiting time. Furthermore observations were used to describe activities that take place during waiting time that are often taken for granted as users are expected to be grateful for whatever is done for or to them. Two and then subsequently ten individual interviews were conducted. The dissatisfaction that they mentioned confirmed the gap between what happens in the clinical practice and what ought to happen as outlined by Batho Pele principles. Observations verified the claims that were mentioned during individual interviews, while waiting time documents showed the ineffectiveness of the program as intended. Lastly photographs verified concerns around ablution facilities that Saidi (2007) reported that their conditions leave much to be desired. The literature control conducted in this study validated the themes and sub-themes that finally emerged at the end of data analysis. The results of this research study indicate that most dissatisfaction does not rely on money to be rectified. Most dissatisfaction is manmade as it was stated among the assumptions. Therefore, while financial constraints can limit service delivery, health workers do not have the reason not to strive for service excellence within available resources because various researches, found that most areas of dissatisfaction expressed by users were about negative attitudes, poor communication and lack of information.

Evidence by Nairn *et al.* (2004) showed that patients are satisfied with the care they receive, but communication and information giving remain of concern for many. In light of the large number of complaints received by Gauteng Complaints Call Centre and the findings of this study, it is evident that the Batho Pele policy as the government' most important campaign since its inception in 1997 has not succeeded in transforming the hearts and minds of health workers to adopt a patient centred approach. This research study sought to highlight the gap between what Batho Pele policy (2007) stipulates and what happens in reality to assist health authorities to find measures that can remedy the dire situation in order to improve users' experiences and perceptions of waiting time. The ultimate aim was to enhance client satisfaction through the development of a policy and guidelines. Based on the information that was extrapolated in this research study the emphasis should be on how to deliver services more than what services are to be delivered.

Because the findings filled the gap that although it is a known and researched subject that health care users complain about long waiting for health care services at public hospitals and clinics, little is known about their experiences and perceptions to which they give rise. I am confident that through compliance with the concept of ***People First,*** client satisfaction of waiting time is not farfetched**.**

5.6 SUMMARY

This chapter outlined the evaluation, limitations and recommendations for this research study. These limitations need to be considered in future researches on this phenomenon. The recommendations as informed by the findings were also presented. The next chapter presents such recommendations in detail.

CHAPTER SIX

RECOMMENDATIONS FOR FORMULATION OF A POLICY AND GUIDELINES

6.1 INTRODUCTION

This chapter will present three copies of a proposed policy, guidelines and outpatient guide. These proposals contribute to the improvement of quality health care services regarding the promotion of comfort in the outpatient departments at public health facilities. These three copies below have been submitted to Gauteng Department of Health for consultation and approval.

6.2 THE PURPOSE OF THE GUIDELINES

The purpose of these guidelines is to ensure that all health workers at public health facilities know and understand the mission and vision of the Batho Pele policy. Knowing it will emphasise its application in the day to day interaction with health care users. The aim is to promote comfort in the Out Patient Departments and improve health care users' experiences and perceptions of health care services to enhance client satisfaction of waiting time. These policy guidelines were formulated in order to improve clinical and non-clinical activities to adopt a patient- cantered approach. Their concepts are generic and covered within the framework of Batho Pele policy, enabling them to be generalized to all outpatient departments at public health facilities.

6.3 THE OBJECTIVES OF THE GUIDELINES

The objectives of these policy guidelines are as follows:

- To assist health workers to improve on service delivery.
- To highlight the activities that, promote comfort at outpatient departments.
- To enhance client satisfaction of waiting time.

6.4. THE SCOPE

These policy guidelines apply to health workers from all occupational categories who are employed at public health facilities. The focus should be all front line and back office staff, those who are in direct contact with users and those who are not.

6.5 THE OVERVIEW OF POLICY GUIDELINES

6.5.1 CONSULTATION

Consultation is a process of listening to patients' views, needs, expectations, perceptions and involving them in their treatment plan.

- Doctors and nurse clinicians are encouraged to take a detailed patient history, perform a comprehensive assessment and where necessary conduct essential tests or procedures to ensure quality health care.
- Involve patients in their treatment plan to promote compliance and self care through health education.
- Request and obtain informed consent before doing any procedure to prevent anxiety or misunderstanding.

6.5.1.1 Impact of consultation

- Patients would be compliant to their treatment plan.
- Understanding and acceptance would prevent negative perceptions.
- Ultimately patients would receive Best Value for Money.

6.5.2 SERVICE DELIVERY STANDARDS

- Patients should be informed about clinic procedures and processes, be classified and charged correctly.
- Information about which patients are seen by the professor or consultants should be well communicated.
- The outpatient clinics should use the number card system to prevent the files from getting misplaced.
- Noise free posters or signs should be displayed to reduce the level of noise so that patients especially those with hearing impairments can hear when their names are called.
- The clinic staff should ensure that toilets are cleaned and kept clean the whole day to enable users to use them without fear of picking up germs that cause diseases.
- Users should be informed about the purpose of triage and why some patients may be seen first.

6.5.2.1. Impact of Service Delivery Standards

- Patient would be more compliant to treatment and confident in the health care services.
- Patients with special needs would receive medical attention timely to prevent complications.
- Conflict between health care users and health workers would be prevented.
- Waiting time may be reduced.
- Anxiety would be allayed especially of patients with hearing impairments.
- There would be less dissatisfaction and the image of the clinic would be promoted.

6.5.3 ACCESS

All people with diabetes should have equal access to the services to which they are entitled, and to receive them easily, comfortably and promptly. Comfort can be promoted during waiting time to promote access.

- All public health facilities should introduce the triage system so that patients with special needs could be attended to timely.
- Introduce a card system to ensure that the principle of first come first served is used except for emergencies.
- Administration staff should introduce efficient and effective filing system in order to facilitate registration so that patients can be seen timely, get medicines at pharmacy early and get transport back home.
- Seats should be adequate, comfortable and not broken so that all patients and their escorts can sit down during waiting time.
- Parking space for the disabled should be reserved for that purpose to offer wheelchair occupants adequate space on and off. The Gauteng Health Service Pledge regarding people with special needs says “We commit ourselves to improving our ability to meet your needs”.
- Posters including signage should be written in the languages that are commonly spoken in the specific area.
- Information about doctors’ whereabouts should be given so that patients can make informed decisions like to return the next day.
- Toilets should be cleaned daily and when necessary so that they remain clean all day, this would make patients comfortable during waiting without fear of picking up germs that cause diseases.

6.5.3.1. Impact of Access on the Service

- Complications that occur during waiting time would be prevented.

- Client satisfaction would be enhanced following reduced waiting time.
- Health care users would have positive experiences and perceptions of waiting time.
- Patients would be comfortable, relaxed and therefore waiting would be bearable.
- Health care services would be accessible.
- Patients would access information about health care services in their own languages and have a better understanding to promote compliance.

6.5.4. COURTESY

Health care users should be treated with courtesy and consideration.

- People with diabetes together with their relatives should be treated with courtesy and consideration in order to preserve and promote the feeling of self-worth.
- Health workers should greet and speak politely with users in the language that they understand and they should not be shouted at.
- Health workers should wear identity cards or name tags so that patients can know who they are speaking to.

6.5.4.1. Impact of Courtesy

- When health care users are treated with courtesy and consideration they gain a sense of self worth that normally gets tarnished by illness and a strange environment.
- Talking to them politely will promote healthy staff-patient relations and prevent conflicts.
- Healthy staff-patient relations will enhance client satisfaction.
- Complaints and potential litigation would be prevented.

6.5.5. INFORMATION GIVING

- Patients should be given information on posters or pamphlets about what to bring to clinic to facilitate registration. For example small change, identity book, appointment card, proof of residence and others.
- Display information about the doctors' duties outside the clinic on notice boards or posters. For example doctors are in theater, doing ward rounds or attending to an emergency.
- Provide information about the dates when doctors would be occasionally unavailable due to training, seminars or conferences to prevent patients from getting anxious and frustrated.
- Provide information about special doctors for certain patients and give the reasons. For example why some patients are treated by the professor. This will prevent wrong perceptions from being created.
- Communicate information about triage and give the reasons why some patients may be attended to first.

6.5.5.1 Impact of Information Giving

- Information about what to bring from home to facilitate registration will prevent unnecessary conflict between clinic staff and patients.
- Information about the doctors' whereabouts will assist patients to make informed decisions without blaming clinic staff.
- Information about why some patients are treated by the professor will assist them to be grateful that their conditions are not worse.
- The information about the triage system will ensure that emergency patients receive treatment timely and prevent unnecessary perceptions.
- All uncertainties would be clarified thereby preventing dissatisfaction that lead to complaints.
- Anxiety would be allayed.

6.5.6 OPENNESS AND TRANSPARENCY

- Openness and transparency will prevent criticism and negative media publicity about health care services.
- Service delivery standards should be made known to health care users. This will prevent perceptions.

6.5.6.1 Impact of Openness and Transparency

- Diabetic patients will understand and appreciate why certain things do happen the way they do and not according to their expectations.
- There will be better compliance.
- Gradually there would be mutual understanding and empathy between the parties concerned.

6.5.7 REDRESS

- The name of the unit manager should be communicated to health care users to contact in case of complaints.
- The complaints, compliments or suggestion box should be visible and accessible.
- Patients should be positively encouraged to express their dissatisfaction if they are not pleased with the service they receive and they can do it verbally or in writing without victimization.
- Complaints should be managed timely at functional level where they occurred and be resolved as quickly as possible, however if they are of serious nature and cannot be resolved here and then they should be escalated to the next level.
- The suggestion box should be opened and suggestions read regularly and utilise them to improve the services and prevent recurrence of similar incidents.

6.5.7.1 Impact of Redress

- Encouraging patients to complain will offer opportunities to improve clinical practice.
- If complainants receive a positive and honest response they will be satisfied and not seek legal advice for litigation.
- A functional complaints management system will ensure satisfactory responses.

6.5.8 BEST VALUE FOR MONEY

Diabetic patients should receive health care services cost effectively and efficiently.

- People with diabetes should be treated with consideration to prevent complications that can cause hospitalization.
- People with diabetes should be classified properly and fees charged accordingly.
- Patients should receive medicines from the pharmacy on the same day.

6.5.8.1 Impact of Best Value for Money

- Procedures should be done right the first time to prevent complications and potential litigation.
- Comfort during waiting time will be promoted.
- Client satisfaction will be enhanced.
- Government would not spent money on potential litigation.

6.5.9 INNOVATION AND REWARD

Clinic staff should be encouraged to introduce new procedures to improve day to day activities and be rewarded for that.

- Clinic staff should conduct client satisfaction surveys and implement suggestions thereof.

6.5.9.1 Impact of Innovation and Reward

- New ideas would inject more energy towards quality improvement
- Recognition for excellence would motive staffs not to compromise the quality of service.
- Staff moral would be enhanced.

6.5.10. SERVICE DELIVERY IMPACT

- Health care users' experiences of waiting time would positive.
- No negative perceptions about health care services.
- Complaints and litigation would be reduced.

6.5.11. LEADERSHIP

- Hospital management should provide strategic direction and support in order to achieve their objectives.
- The clinic manager should be visible and display commitment to the teams efforts by giving feedback that will result into corrective measures being taken to ensure success.

6.5.11.1. Impact of Leadership

- There would be team spirit and willingness to excel.
- Shortcomings such as mix up and missing of files can be corrected.

6.6. ENFORCEMENT

Any violation of this policy will be regarded as a serious offense by Gauteng Health Department as an employer. The public health authorities will be expected to discipline those found to be in violation of these guidelines.

PROPOSED POLICY ON PROMOTION OF COMFORT IN THE OUT PATIENT DEPARTMENTS

Formulated	2012 August 01
Edition	1st edition
Authors:	District Health Services
Owner	Managers concerned
Approval Date	2012 December 31
Amendment Date	2017 December 15

1.	INTRODUCTION	3
2	LEGAL FRAMEWORK	3
3	SCOPE OF APPLICATION	3
4	DEFINITION OF TERMS	3
5	ACRONYMS.	4
6	RESPONSIBILITIES	4
7	INPUTS AND OUTPUTS FOR POLICY AMENDMENTS	4
8	MONITORING AND CONTROL	4
9	THE OVERVIEW OF THE POLICY STATEMENTS	4
	9.1 Consultation	4
	9.2 Service Delivery Standards	5
	9.3 Access	5
	9.4 Courtesy	5
	9.5 Information Giving	6
	9.6 Openness and Transparency	6
	9.7 Redress	6
	9.8 Value for Money	7
	9.9 Innovation and Reward	7
	9.10 Service Delivery Impact	7
	9.11 Leadership	7
10	POLICY SIGN OFF	8
11	APPROVAL SIGNING OFF	8

1. INTRODUCTION

This document is a Gauteng Health Department's policy guidelines on Promotion of Comfort in the Out Patient Departments.

2. LEGAL FRAMEWORK

- National Health Act no: 61 of 2003
- Nursing Act , 2005 (Act No. 33 of 2005)
- Public Service Act 1994 as Amended
- Batho Pele Policy 1997
- Patients Rights Charter
- Gauteng Service Charter

3. SCOPE OF APPLICATION

These policy guidelines apply to all employees of Gauteng Department of Health employed in terms of Public Service Act.

4. DEFINITIONS OF TERMS

4.1 Health care users

People who seek health care services at public health facilities as patients, friends or relatives

4.2 Waiting time

From the moment health care users register as patients and when they receive health care services at public health facilities.

4.3 Experiences

Events regarded as affecting health care users negatively about waiting time at public health facilities.

4.5 Perceptions

Action by which the health care users' minds refer their sensations to waiting time at public health facilities

4.6 Comfort

Physical and emotional ease

5. ACRONYMS

Acceptable abbreviations of titles or names e.g.:

HOD: Head of Department

6. RESPONSIBILITIES

The HOD of Health will be responsible for the promotion of comfort at outpatient departments' policy.

The Quality Assurance Directorate will ensure that all Gauteng's public health facilities have access and knowledge of this policy.

Public health facilities will ensure that health care users have knowledge of this policy.

7. INPUTS AND OUTPUTS FOR POLICY AMENDMENT

This policy will be reviewed after 5 years accordingly. Any changes will be discussed among all stake holders and referred to the HOD for approval.

8. MONITORING AND CONTROL

All public health facilities will be monitored for compliance regarding promotion of comfort at outpatient departments through clinical and non clinical audits.

9. OVERVIEW OF THE POLICY STATEMENTS

9.1 Consultation

- Doctors and Nurse Clinicians are encouraged to perform a comprehensive assessment on patients when necessary, to prevent perceptions about non-caring attitudes.
- Involve patients in their treatment plan to promote compliance and self care.
- Request and obtain consent before doing any procedures to prevent anxiety.

9.2 Service Delivery Standards

- Provide information about clinic processes and procedures in advance to users, to facilitate registration, e.g. registration requirements: I.D document, proof of residence, pay slip, small change, appointment card and others.
- Clerks should categorise and charge patients correctly to prevent incorrect billing that result in complaints.
- Introduce the triage system and educate patients about its purpose so that those who need emergency medical care will be seen first.
- Introduce the card system to promote the first come first served principle. This will prevent the anger as a result of the suspicion about favouritism.
- The filing system must be effective and efficient to prevent unnecessary waits.
- Control noise in all waiting areas by putting up noise free posters. People with hearing impairments are unable to hear when their names are called out due to the level of noise.

9.3 Access

- Public health facilities should provide resources for the disabled to offer them easy access to health care services.
- Disabled parking should be reserved for that purpose to offer wheelchair occupants adequate space on and off.
- Improve the filing system to fast track registration for all patients.
- Patients should be seen timely and receive medicines at pharmacy on the same day.
- Educational material should be provided in all local languages.

- Seats should be adequate, comfortable and not broken so that all patients and their escorts can sit down during waiting time.
- Give information about doctors' whereabouts so that patients can make informed decisions such as to see another doctor or to come back next time.
- Toilets should be cleaned daily and when necessary so that they remain clean all day, this would promote comfort during waiting and offer peace of mind without fear of picking up germs that cause diseases.

9.4 Courtesy

- Greet and speak politely with users in the language that they understand and do not shout at them.
- Wear your identity cards or name tags so that patients can know who they are speaking to, to promote easy inter-relations.
- Display empathy, compassion, and understanding for their circumstances.
- Be polite, kind and display a caring attitude.

9.5 Information Giving

- Provide information about the triage system and or VIP status to prevent suspicions of favouritism that give rise to negative perceptions about health care services.
- Provide information on doctors' whereabouts to assist patients to make informed decisions
- Educate patients why the consultant or professor sees some patients. To prevent perceptions that those patients receive the best treatment while others receive sub-optimal treatment.
- Give information through posters and pamphlets about registration requirements.
- Display information about doctors' duties that they do before coming to the clinic on notice boards. For example when doctors are in theater, doing ward rounds or attending to an emergency.
- Provide information about the dates when doctors would be occasionally unavailable due to training, seminars or conferences to prevent patients from getting anxious and frustrated.

9.6 Openness and Transparency

- Educate health care users about health services that are available or unavailable.
- Openness and transparency will prevent criticism and negative media publicity about health care services.
- Upon setting up service delivery standards, educate users about them.

9.7 Redress

- Display the name of the Unit Manager so that patients know who they should speak to about complaints.
- Encourage users to complain as soon as they are not satisfied so that a solution can reached where the problem occurred.
- Manage complaints timely and provide satisfactory responses.
- Apologise to the complainant for that mishap or misunderstanding.
- The complaints, compliments or suggestion box should be visible, accessible and be opened and read regularly.

9.8 Value for Money

- Patients should be attended to timely and receive their medicines on the same day if possible. To avoid double transport costs.
- Out patients should be treated with consideration to prevent complications that can cause hospitalization.
- Patients should be classified and charged correctly.
- Patients should be seen timely and manage to get transport to return home safely.

9.9 Innovation and Reward

- Health workers should be encouraged to identify new ways to promote comfort in the Out Patient Departments.
- Complaints should be used to as a mirror to improve service delivery

- Oral and written suggestions should be taken into consideration.
- Conduct client satisfaction surveys and implement appropriate suggestions thereof.

9.10. Service Delivery Impact

- Health care users' experiences of waiting time will be positive.
- Negative perceptions about health care services will be prevented.
- Complaints that emanate from waiting time and its activities that result in litigation would be reduced.

9.11.Leadership

- Health authorities should support all efforts that are put in to promote comfort in the Out Patient Departments.
- Managers should be visible and display commitment to ensure that client satisfaction of waiting time is enhanced.

- **POLICY SIGN OFF**

The managers who are responsible for formulation of this policy or its review will attach their signatures and submit it for approval.

- **POLICY APPROVAL SIGN OFF**

The HOD of Health takes overall accountability of this policy. Check cover page as approved document with signatures.

BATHO PELE PRINCIPLES

CONSULTATION

Talk to the doctor or nurse about your conditions, treatment and what you want to know and expect.

The doctor or nurse clinician will perform a full physical assessment when necessary.

We encourage you to participate in the client satisfaction survey.

SERVICE DELIVERY STANDARDS

Bring registration requirements **i.e. ID DOCUMENT;** pay slip, pension card; proof of residence, appointment card; small change and others.

Hand in your appointment card first and wait in the appropriate queue.

Avoid noise so that you can hear when your names are called.

Patients with special needs will be seen first, inform the clinic staff.

Doctors may attend to other duties before coming to the clinic.

You will be seen by different doctors because of other duties that they do.

The professor and or consultant will see patients according to their conditions.

OUT- PATIENTS GUIDE

ACCESS

.You will be seen on a first come first serve basis except in an emergency
. Patients with special needs will be seen first.
. You will be attended to timely.
. Ask to be given information in the local language of your choice if necessary and where possible an interpreter will be used.

COURTESY

Clinic staffs will speak to you politely with respect, be kind to them.
Tell us how you want us to address you.

We will request other information from you, help us to help you.

You have the right to address us by the names on our name tags.

You have the right to know about your condition but the file remains the clinic property.

GIVING OF INFORMATION

Tell us everything about your condition. Be honest

Ask us about anything that you need to know.

REDRESS

Talk to any staff or unit manager about your dissatisfaction so that the issue can be resolved timely.

We have provided boxes for the complaints, compliments or suggestions feel free to drop in all written ones.

You will be given a satisfactory response and or apology where appropriate.

VALUE FOR MONEY

Make sure you provide registration requirements so that you are classified correctly.

Be honest so that procedures can be done correctly the first time to prevent complications.

Report vandalism or theft of government property e.g. toilet paper
Report fraud and corruption

LEADERSHIP

Senior managers are there to listen to your concerns

Feel free to speak to senior managers at your clinic before you seek help outside

SUMMARY

This chapter presented the proposed copies of a policy, guidelines and outpatient guide that were informed by the findings of this research study. These proposed policy and guidelines on the promotion of comfort in the Out Patient Departments at public health facilities were submitted for consultation and approval.

BIBLIOGRAPHY:

African National Congress, 1994 A National Health Plan for South Africa: Johannesburg South Africa 45 p.

Aljunid, S. M. 1996, Challenges facing Primary Health care doctors: http://www.pcdom.org.my/phc/cmcrole. pp. 60-75.

Ajayi, I. O. 2002. Patients' waiting time at outpatient clinic in Nigeria – can it be put to better use? Volume 47, issue 2. pp. 121-126

Ajayi, I. O., Olumide, E. A. & Oyediran, O, 2005. Patients' satisfaction with the services provided at a general outpatients' clinic. Volume, 34, issue 2, pp. 133- 140.

Anderson, G. & Karlberg, I. 2000, Lack of integration, and seasonal variations in demand explained performance problems and waiting times for patients at emergency departments: Health Policy 55. pp. 187-207

Anderson, R. T., Camacho, F. T. & Balkrishnan, R., 2007. Willing to wait? The influence of patient' waits time on satisfaction with primary care BMC Health Services Research, volume 7 no. 31.

Avi, M., Ond, M. B. & Arthur, A. 2008 Exploring patient satisfaction with out-patient services, volume 3 issue 2, pp. 59-65

Ayers, A. A. 2008 Managing wait times for greater custom satisfaction. The Journal of Urgent care Medicine, pp. 61-63

Babbie, E. R. & Mouton, J. 2003. The Basics of Social Research, Cape Town: Oxford University press, pp. 53-272.

Badenhorst, C. 2007. Research writing, breaking the barriers, 1st ed. van Schaik Publishers, pp. 25-26.

Bailey, C. A. 2007. A Guide to Qualitative Field Research, 2nd Sage publications, Inc, pp. 3-182

Bamgboye, E. A. & Jarallah, J. S. 1994 Long waiting outpatients: target audience for health education, volume 23. Issue 1, pp. 49-54.

Batho Pele Handbook, 1997, A service delivery improvement Guide, pp. 1-205

Barlow, G. 2002**.** Auditing hospital queuing. *Managerial Auditing Journal vol*. 17, pp. 397-403.

Bauer, M. W. & Gaskell, G., 2006. Qualitative Researching with Text, Image and Sound: A Practical Handbook, 96 p.

Berkow, R., Beers, M. H. & Bogin, R. M., 1997, The Merck Manual of Medical Information, 718 p

Berne, R. M, Levy, M. N. & Koeppen, B. M., 2004. Physiology 5th ed. Mosby, 779 p

Booyens, S. W. 2001. Introduction to Health Services Management, 2nd ed. Cape Town, South Africa: Kenwyn: Juta pp. 15-60.

Booyens, S. W. 2008. Introduction to Health Services Management, 3rd ed. Cape Town, South Africa: Juta Academic, pp. 41-72

Bos, N., Sizmur, S., Graham, C. & van Stel, H. F., 2012, The accident and emergency department questionnaire: a measure for patients' experiences in the accident and emergency department. pp 90-96.

Brink, H., 2008, Fundamentals of research methodology for health care professional 2nd ed. Cape Town: South Africa. pp. 10-155

Bruce, J. C. M., 2003, A Model for Restructuring Specialist Nurse education in a University context. Unpublished doctoral Dissertation University of the Witwatersrand Johannesburg pp. 35-75

Bruce, J. C. & Stellenberg, E. Z., 2007, Nursing Practice - Medical and Surgical nursing for hospitals and communities, Elsevier limited, African edition, pp.50-76

Bruijns, S. R., Wallis, L. A., & Burch, V. C., 2008 Effect of introduction of nurse triage on waiting time in a South African emergency department 2008. Emergency medical journal, volume 25, pp. 395-402

Burns, N. & Grove, S. K,. 2001. The practice of nursing research: critique & utilization. 4th ed. Philadelphia: Saunders Company. pp. 32-56.

Burns, N. & Grove, S. K**.,** 2003, Understanding Nursing Research, 3rd ed. W.B. Philadelphia, Saunders Company**.** pp. 18-549.

Burns, N. & Grove, S. K., 2007, Understanding Nursing Research. 3rd ed. W.B. Philadelphia*:* Saunders Company**.** pp. 18-549.

Campbell, P. C., Olufunlayo, T. F. & Onyenwenyi, A. O. 2010, An assessment of client satisfaction with services at a model primary health care centre in Ogun State, Nigeria (1): 13-8.

Cao, W., Wan, Y. & Tu, H., 2011, A web based appointment system to reduce waiting time for outpatients: a retrospective study, pp. 11-318

Cheek, J. 2000, Postmodern and post structural approaches to nursing research Thousand Oaks, Calif: Sage Publications. pp 40-67.

Cherry, K., 2001, Maslow's Hierarchy of needs: Abraham Maslow's Hierarchy of Needs motivational model, pp 4-9.

Chung, K. C., Hamill, J. B., Kim, H. M., et al. 1999. Predictors of Patient Satisfaction in an Outpatient Plastic Surgery Clinic volume 45, pp. 56-60

Cole, F. L., Mackey, T. A. & Lindenberg, J. 2001. Wait Time and Satisfaction with Care and Service at Nurse Practitioner Managed Clinic volume 13, issue 10.

Conner-Spady, B. L., Sanmartin, C. & Johnston, G. H., 2011, The importance of patient expectations as a determinant of satisfaction with waiting times for hip and knee replacement surgery Volume 101, issue 3 pp. 245-252

Coomber, B. & Barriball, K. L. 2012, Impact of job satisfaction components on intent to leave and turnover for hospital-based nurses: A review of the research literature. Volume 44, issue 2, pp. 297-314.

Corney, R. 1999**.** Changes in patient satisfaction and experience in primary and secondary care: The effect of general practice fund holding. *British Journal of General Practice 49 pp. 27-30*

Creswell, J. N. 2003. Research design qualitative and quantitative approaches 2nd ed. London: Sage, pp. 185-188.

Creswell, J. W. 2005. Research design qualitative and quantitative approaches, Mixed methods): 3rd ed. London: Sage Publications. pp. 15- 123

Creswell, J. W. & Plano, V. L., 2007, Designing and Conducting Mixed Methods Research. Thousand Oaks, Calif. Sage Publications, pp. 20-127.

Creswell, J. W. 2009. Research Resign Qualitative and Quantitative Approaches: 3rd ed. London: Thousand Oaks, Calif. Sage Publications. pp. 61-190.

de Groot, I. B., Otten, W. & Dijs- Elsinga, J., et al., Smeets, 2012. Choosing between hospitals: The influence of the experience of other patients pp. 45-78.

den Hartigh, W. 2012. South Africa, Cuba to train more doctors, Metro Media South Africa. pp. 41-50

de V van Niekerk, J. P. 2012. Traditional healers formalised? South African Medical Journal, volume. 102, no. 3 pp. 25-60.

De Vos, A. S., 2002, Research at grass roots for the social sciences and human service professions 2nd Edition. Pretoria: Van Schaik.

De Vos, A. S., Strydom, & Delpoort, 2005, Research at Grassroots Level: A Premier for the Caring Professions 3rd ed. *Pretoria: Van Schaik, pp. 123-315.*

Denzin, N. K. & Lincoln, Y. 2000**.** Handbook for Qualitative Research 2nd ed Sage Publication, pp. 143-150.

Denzin, N. K. & Lincoln, Y. S. 2011 Handbook for Qualitative Research 4th ed. Sage Publication, Inc. pp. 203-220

Department of Health, 2004, Province announces plan to manage hospital wait times. Nova Scotia, Canada. pp. 65-102.

Department of Public Service and Administration 2009, Extensive provision of primary health care facilities in ISRD nodes pp. 23- 230.

Department of Public Service and Administration 2012: Framework on Signage, pp. 32-80.

Dexter, F. 1999. Design of appointment systems for pre-anaesthesia evaluation clinics to minimize patient waiting times: A review of computer simulation and patient survey studies. Volume, 89 no 4 pp. 1-27

Dijkstra, K., Pieterse, M. E. & Pruyn, A, 2008, Stress – reducing effects of indoor plants in the built healthcare environment: The mediating role of perceived attractiveness volume 47, issue 3 pp. 279-283

Dunnill, M. G. S. & Pounder, R. E. 2004, Medical outpatients: changes that can benefit patients. Volume 4, no 1 pp. 45-49

Eilers, G. 2004. Improving patient satisfaction with waiting; The journal of American College, *Health volume 53, no. 1 July/ August, pp. 41-43*

Endacott, R. 2006. Clinical research 4: Qualitative data collection and analysis. Elsevier Ltd. 16, pp. 48-52.

Entwistle, V., Firnigl, D. & Ryan, M., et al. 2011, Which experiences of health care delivery services matter to service users and why? A Critical Interpretive Synthesis and Conceptual Map Volume 17, No. 2 pp. 70-78

Eygelaar, J. E. & Stellenberg, E. L. 2012, Barriers to quality patient care in rural district hospitals. Curationis; volume 35, no. 1 pp. 123-127

Feddock, C. A., Hoellein, A. R. & Griffith, C. H., et al. 2005, Can physicians improve Patient Satisfaction with Long Waiting Times? Sage Publications, volume 28, no. 1 pp. 40-52

Gauteng Department of Health and Social Development, Annual Report 2009/2010 pp. 23-155

Gauteng Department of Health and Social Development, 2009 Strategic plan 2009-2014, pp. 35- 179.

Gauteng Department of Health, 2011, A Framework for Quality Assurance for Health Care Institutions, pp.15-65

Gauteng Department of Health, 2012, Gauteng Health Turnaround Strategy: Towards Effective Service Delivery and a clean Audit in 2014, pp. 20- 156

Government Notice, 1990, South African Nursing Council: Rules Setting Out the Acts or Omissions in Respect of Which the Council May Take Disciplinary Steps, pp. 54-180.

Government Gazette, 1997, Pharmacy Amendment Act, pp. 34 - 190

Government Gazette, National Health Act no. 61 of 2003 vol. 469,

Government Gazette: Nursing Act no. 33 of 2005.

Government Gazette, 2011, National Health Amendment Bill, volume 547

Gerrish, K. & Lacey, A., 2006, The Research Process in Nursing 5th ed. Blackwell Publishing

Gulliford, M., Figueroa, M. J. & Morgan, M., 2002, What does access to health care mean? Volume 3, pp. Kings College London, UK, pp. 186-188.

Gulf Medical University, Worldwide Doctor- Patient Ration

Harris, B., Goudge, J. & Ataguba, J. E., 2011, Inequities in access to health care in South Africa. Volume, 32 pp. 102-123

Harper, P. R. & Gamlin, H. M., 2003, Reduced outpatient waiting times with improved appointment scheduling: a simulation modelling approach. Volume 5, pp. 207-222.

Health Systems Trust, 2007, Guide to Measuring Client Satisfaction. Strategy and Tactics, pp. 1-10.

Helbig, M., Helbig, S. & Kahla- Witzsch, A. H., 2009, Quality management: reduction of waiting time and efficiency enhancement in an ENT- university outpatients' department

Henning, E., 2009, Finding your way in qualitative research. Van Schaik Publishers pp. 1-15.

Hill, C. J. & Joonas, K. 2005. The Impact of Unacceptable Wait Time on Health Care Patients' Attitudes and Actions volume 23(2) The Haworth Press

Holliday, A. 2006, Stepping stones to achieve your doctorate. London; Thousand Oaks, Calif. SAGE Publishers, pp. 31-53.

Holloway, I. M., Smith, P., Warren, J. 1998 Patients experienced a lack of control over their time in hospital. Oxford: Blackwell Publishing, pp. 1-16.

Hoffstetter, P., Hammer, S. & Rohrl, S., 2012, As time goes by – is it worth intensifying patient care during the waiting period for Radiological Examinations?

Huisman, E. R. C. M., Morales, E. & van Hoof, J., et al. 2012. Healing environment: A review of the impact of physical environmental factors on users. Volume 58, pp. 70-80.

Jooste, K. 2003, Leadership in health services management. pp. 10-34

Jawaid, M., Ahmed, N. & Alam, S. N., et al. 2009. Patients Experiences and Satisfaction from Surgical Out Patient Department of a Tertiary care teaching hospital. vol. 25 no. 3 439-442

Jawahar, S. K. 2007, A study on Outpatient Satisfaction at a Super Special Hospital in India vol. 2, no2 pp. 81-93.

Joonas, K. & Wang, W. H. 2012, A Research of Service Outcomes in Taiwan: The Role Patients' Quality Perceptions and Wait Time. Hospital topics, 90: 1, 1-10 Routledge.

Kats, J. G. 1991. Managing Quality: A guide to monitoring and evaluating nursing services, pp. 19-36

Klitzman, R. 2007. "Patient- time", "doctor time", and "Institution time": Perceptions and definitions of time among doctors who become patients. volume, 66, issue 2 pp. 147-155.

LaGanga, L. R. & Lawrence, S. R. 2008, Clinic No- Shows and Overbooking: Reflections and New Directions in Appointment Yield Management

Lietz, C. A., Langer, C. L. & Furman, R. 2006. Establishing Trustworthiness in Qualitative Research in Social Work: Implication form the study regarding spirituality volume 5 (4) pp. 441-458.

Langley, G. 2003. A Model for the facilitation of mental health of the client diagnosed with borderline personality disorder in the psychiatric community services. Johannesburg. pp. 20-69.

Lincoln, Y. S. & Guba, E. G., 1985, Naturalistic Inquiry, London: Sage. pp. 301-331.

Lofvendal, S., Eckerlund, I. & Hansagi, H., et al. 2005, Waiting for orthopaedic surgery: factors associated with waiting time and patients' opinion volume 17 no, 2 pp. 133-140. Oxford University Press

McCarthy, K., McGee, H. M. & O'Boyle, C. A. 2010, Outpatient clinic waiting times and non-attendance as indicators of quality. Volume 5, issue 3 pp. 287-293

Macnee, C., 2004. Understanding Nursing Research: reading and Using Research in Practice: Lippincott William & Wilkins. pp. 105-189.

Mackey, T. A. & Cole, F. L., 1997, Patient waiting times in a nurse managed clinic. volume 1 no. 1. Internet Scientific Publications, pp. 14- 55

Mahmood, A., Chaudhury, H. & Valente, M. 2009, Nurse' perceptions of how physical environment affects medication errors in acute care settings. Volume 24, issue 4, pp. 229-237.

Mahomed, H, & Bachman, M. O., 1998 Block appointment in an overloaded South African health centre: qualitative and quantitative evaluation. Volume 11 no 4 pp. 123-126

Mallidou, A. A., Cummings, G. G. & Estabrooks, C. A., 2010, Nurse speciality subcultures and patient outcomes in acute care hospitals: A multiple –group structural equation modelling. Volume 48, issue 1. pp. 81-93.

Masae, M. & Suwandechochai, R., 2011, Improvement the waiting time of patient in the ophthalmology outpatient Department pp. 20- 116

Marshal, C. & Rossman, G. B. 1995, Designing Qualitative Research, 2nd edition, pp. 5-80

Mayan, M. J. 2001. *An introduction to qualitative methods: A training module for students and professionals.* Alberta: The International Institute for Qualitative Methodology, pp.12-56.

McSherry, R., Simmons, M. & Abbott, P. 2002. Evidence - Informed Nursing. A Guide for Clinical nurses. Routledge, pp. 15-175.

McCabe, C. 2004. Nurse – patient communication: an exploration of patients' experiences. Volume, 13 issue 1, pp. 1-2.

Metherell, M. 2004, Rebate fails to cut public hospital wait times. www.smh.com.au

Miles, M. B. & Huberman, A. M. 1994, Qualitative data analysis: A source new book of new methods: 2nd edition. pp. 20-238.

Mohamad, H. A. 2005. Study on outpatients' waiting time in Hospital University Kebangsaan Malaysia (HUKM) through the sigma approach.

Mokoka, K. E., Ehlers, V. J. & Oosthuizen, M. J. 2011. Curationis Factors influencing the retention of registered nurses in the Gauteng Province of South Africa

Morse, J. M. 1991. Qualitative Nursing Research: A Contemporary Dialogue. Revised edition, pp. 3-15

Morse, J. M. 2000. The Nature of Qualitative Evidence, Sage publications, pp. 5-10

Morse, J. M. & Field, P. A. 2002, Nursing Research: *The Application of Quality Approaches 2nd ed* Chapman & Hall, 15 p

Mouton, J., 1996, Understanding Social Research Pretoria: Van Schaik, pp 96-157

Mouton, J. 2003, The practice of social research, Cape Town: Oxford university press, pp 46-120.

Mouton, J., 2003, How to succeed in your Master's & Doctoral Studies, A South African Guide and resource book, Pretoria: Van Schaik, pp 15-150

Mouton, J. 2006, Understanding Social Research Pretoria: Van Schaik, pp. 119-120.

Morton, A. & Bevan, G., 2008, What's in a wait? Contrasting Management Science and Economic Perspectives on Waiting for Emergency care. pp. 207-217

Munhall, P. L. 2001, Nursing Research: a qualitative perspective. 3rd ed. Boston: Jones and Bartlett Publications, pp. 30-119.

Muntlin, A., Gunningberg, L. & Carlsson, M. 2005, Patients' perceptions of quality of care at an emergency department and identification of areas for quality improvement, Blackwell publishing limited Volume 15 1045 – 1056

Muhondwa, E. P. I., Leshabari, M. T. & Mwangu, M., et al. 2008, Patient Satisfaction at the Muhimbili National Hospital in Daar Es Salaam, Tanzania Volume 5, no. 2

Nairn, S., Whotton, E. & Marshal, C., et al. 2004, The patient experience in emergency department: A review of the literature.

Naumann, S. & Miles, J. A. 2001, Managing waiting patients' perceptions: The role of process control. Journal of Management in Medicine, volume 15 no. 5 pp. 376-586

National Department of Health, 1998, National program for control and management of Diabetes Type II at primary level. Government Printers, pp. 1-80.

National Department of Health 2000, Reducing Waiting Times for Public Hospitals Elective Services. Government Strategy, pp. 12-105

National Department of Health 2003, Standard Treatment Guidelines and Essential Drug List, pp. 14-59.

National Department of Health 2004, Ethics in Health Research Principles, Structures and Processes, pp. 60- 84

National Department of Health 2005, A Policy on Quality in Health Care for South Africa, pp. 2-30.

National Department of Health, 2007, A Policy on Quality in Health care for South Africa Government Printers, pp. 7-63

National Department of Health, 2008, Standard treatment guidelines and Essential Medicine List Essential Drug Program Primary Health care level 4th ed. Pretoria, South Africa, pp.10-51.

National Department of Health, 2011, National Core Standards for Health Establishment in South Africa, Abridged version, Published Tshwane, South Africa, pp. 1-109

National Department of Health, 2011, National Health Insurance in South Africa, Policy Paper, pp. 18- 97

Nettina, S. M., 2006, The Lippincott Manual of Nursing Practice, Publisher Ambler, PA: Lippincott Williams & Wilkins.

New Sunday Times, 2005, Unhappy over time spent waiting. *New Straits Times*

Nieswiadomy, R. M. 2002. Foundations of Nursing Research 4th ed. New Jersey: Prentice Hall, pp. 1-120.

Nieswiadomy, R. M. 2008. Foundations of Nursing Research 5th ed. Upper Saddle river, N. J. Pearson/Prentice Hall, pp. 59-245.

Nkosi, M., Goudge, J. & Kahn, K., 2007, Cost still a barrier to primary health care for rural poor in South Africa. Health Economist Unit Rockefeller Foundation

Oxford South African Pocket Dictionary, 2011, 3rd ed. Oxford University Press

Oermann, M. H. 2003. Effects of Educational Intervention in Waiting Room on Patient Satisfaction volume, 26 no. 2 pp. 150-158

Omer, K., Cockcroft, A. & Andersson, N., 2011, Impact of a hospital improvement initiative in Bagladesh on patient experiences two cross-sectional studies.

Patrick, J. 2011, A Markov decision model for determining optimal outpatient scheduling. 15: 91-102 Springer Science + Business Media

Pollard, R., 2005, Public waiting longer despite private health boost Health www.smh.com.au

Polit, D. F. & Beck, C. T., 2001, Nursing Research, Principles and Methods 5th ed. Philadelphia: Lippincott.

Polit, D. F. & Beck, C. T. 2001, Essentials of nursing research: methods, appraisal and utilization. 5th ed. Philadelphia Lippincott

Polit, D. F. & Beck, C. T., 2004, Nursing Research, Principles and Methods 7th ed. Philadelphia: Lippincott. pp. 28-732

Pollock, K. 2002. Patients' perceptions of entitlement to time in general practice consultations for depression: qualitative study.

Pollock, K. & Grime, J. 2002 Patients' perceptions of entitlement to time in general practice consultation for depression: qualitative study. Department of Medicine Management, Keele University

Priest, H. 2002, An approach to the phenomenological analysis of data: EBSCO Publishers pp. 50-63

Propper, C., Croxson, B. & Shearer, A. 2002, waiting times for hospital admissions: the impact of GP funding. Journal of Health Economics, 21 pp. 227-252

Rapport, F. 2004, New qualitative methodologies in health and social care research London: New York, Routledge.

Reidenbach, R. E. & Sandifer-Smallwood, B. 1990 Exploring Perceptions of Hospital Operations by a Modified SERVQUAL Approach Vol. 10, no. 4, pp. 47-55

Robbins, J. A., Bertakis, K. D. & Helms, L. J. et al. 1993 volume 25, no. 1, pp. 17-20

Rubin, J. H. & Rubin, I. S. 2005, Qualitative Interviewing: The Art of Hearing Data. 2nd ed Sage Publications Thousand Oaks London, New Delhi

Saidi, M. 2007. Developing a User- Perception Assessment Tool for Health Facilities in South Africa, Architectural Science Intern report, pp. 8-11

Seedat, Y. K. & Rayner, B. L. 2011, South African Hypertension Guideline, South African Medical Journal, volume 102, no. 1.

Sello, D. A., Serfontein, J. H. P. & Lubbe, M. S., 2012, Factors influence access to pharmaceutical services in underserviced areas of West Rand District, Gauteng Province, South Africa. Health S. A. volume 17 no 1.

Sickinger, S. & Kolisch, R. 2009, The performance of a generalized Bailey- Welch rule for outpatient appointment scheduling under inpatient and emergency demand

Silverman, D. 2006. Qualitative Research: Theory, Method and Practice 2nd ed. Sage Publications

Silverman, D. 2008. Doing Qualitative Research: A practical handbook, Sage Publication

Sithole, N., M'kumbuzi, V. R. P. & Stewart, A. V., 2008, Patient waiting time at Helen Joseph hospital pharmacy in South Africa: A qualitative management tool, pp. 3-9.

Sing, H., Haqq, E. D. & Mustapha, N. 1999. Patients' perception and satisfaction with health care professionals at primary care facilities in Trinidad and Tobago. Vol. 77(4)

Sofaer, S. & Firminger, K., 2005, Patient' perceptions of the quality of health services, Vol. 26: 513-559

SooHoo, N. F., Lieberman, J. R. & Farng, E., 2010, Development of quality of care indicators for patients undergoing total hip replacement or total knee replacement, Volume 21, issue 1 pp. 14-18.

South African Human Rights Commission, 2007, The Right to have Access to Health Care Services: Synthesis Report.

South African Human Rights Commission, 2009, The Right to have Access to Health Care Services: Synthesis Report.

Somerset, M., Faulkner, A. & Shaw, A., et al. 1999. Obstacles on the path to a primary-care led National Health Services: complexities of outpatient care volume 48, Issue 2 pp. 213-225.

Stoop, A. P., Vrangbaek, K. & Berg, M., 2005, Theory and practice of waiting time data as a performance indicator in health care The Netherlands health policy, pp. 41-51

Tarl, M. 2002. The essential researcher's handbook for nurses and health care professionals 2nd ed. Edinburg; New York: Bailliere Tindall.

Tarling, M., Crofts, L. & Kitson, A. 2005, The Essential Researcher' Handbook for Nurses and Health care Professional 2nd ed. Bailliere Tindall.

Tateke, T., Woldie, M. & Ololo, S. 2012. Determinants of patient satisfaction with outpatient health services at public and private hospitals in Addis Ababa: Ethiopia. Volume 4, no, 1 pp. 11

Terre Blanche, M., Durrheim, K. & Painter, D., 2007**,** Research in practice - Applied methods for the Social Sciences, Cape Town: UCT

Tesch, R. 1990**.** Qualitative Research: Analysis Types and Software Tools. New York: Falmer Press. pp. 12; 142-145.

The Constitution of the Republic of South Africa Act No. 108 of 1996, Access to Quality service

The South African Human Rights Commission 2007, Rights to have access to health care services Synthesis report

The South African Nursing Council: Nursing Act No. 33 of 2005 Rules Setting Out the Acts or Omissions in Respect of which the Council May Take Disciplinary Steps.

The White Paper on the Transformation of the Public Service of 1995, www.dpsa.gov.za

The World Health Organisation 2004, Practical Guidelines for Infection Control in Health Care Facilities. SEARO Regional Publication no. 41 WPRO Regional Publications

The World Health Organisation, 2010, Health Systems Financing The path to Universal Coverage

The World Health Organisation, 2012, The World Health Report

Thompson, D. A., Yarnold, P. R. & Adams, S. I., et al. 1996. How accurate are waiting time perceptions of patients in the Emergency Department? Annals of Emergency Medicine: vol. 28. pp. 652-656.

Trafford, V. & Lesham, S., 2008, Stepping stones to achieving your doctorate Maidenhead: Open University, Press, New York: McGraw- Hill.

Tsiko, S. 2006. Diabetes in Africa: http//gibbsmagazine.com/diabetes. pp. 1-2.

Tshabalala, A. M. 2005**.** Mobile clinic users' opinions on health care services provision in the Muldersdrift area, Gauteng Province

Umar, I., Oche, M. O. & Umar, A. S., 2011, Patient waiting time in a tertiary health institution in Northern Nigeria Volume 3, 2 pp. 78-82.

Uys, H. H. M. & Basson, A. A., 2000, Research Methodology in Nursing 3rd ed Kagiso Pretoria. pp. 37-38

Uys, L. R. & Middleton, L., 2004**,** Mental Health Nursing 2nd Ed. USA: Addison- Wesley Nursing.

U. S. Department of Health and Human Services 2012. A Federal Government Web site: Healthy People 2020. 200 Independence Avenue. S. W., Washington, D. C.

Valenzuela, M. L. S., Wirtz, V. J. & Tellez, Y. S. A., et al. 2010. Ambulatory health service users' experiences of waiting time and expenditure and factors associated with the perception of low quality of care in Mexico BMC Health Service Research volume 15 pp. 355-360

Ward, P. R. 2009. Quality in Health Care, Volume 17 no. 1, pp. 49-54. Radcliffe Publishing Ltd.

Wijewickrama, A. K. A. & Takakuwa, S. 2006. Simulation analysis of an outpatient Department of internal medicine in a University Hospital

Wiman, E., & Wikblad, K**.** 2007. Trauma patients' encounters with the team in the emergency department- A qualitative study. International Journal of Nursing Studies vol. 44. pp. 714-722.

ANNEXURE A

THE INTERVIEW GUIDE

The main question for this research study will be:

1. Tell me about your experiences of waiting time at this diabetes clinic?

The researcher may for the sake of a clear understanding, put the question to participants as follows: "***What can you tell me about your experiences of waiting time at this diabetic clinic?"*** Subsequent questions and prompts will be guided by the discussion in order to clarify vague statements and to understand participants' meanings. Such questions will be based upon topics generated through literature.

The following topics will be explored:

1. Waiting time
2. Staff attitude
3. Noise
4. Language
5. Environment.

Prompts will be as follows:

1. Do you want to talk more about that?
2. You were saying...?
3. What did you mean when you said...?.
4. You mentioned that..."
5. You said things like that, what things?

ANNEXURE B

P.O. Box 846
Mondeor
2110

The Head of Department
Gauteng Health Department and Social Development
37 Sauer Street
JOHANNESBURG
2107

Dear /Madam

REFERENCE: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY AT A DIABETES CLINIC IN AN ACADEMIC HOSPITAL.

I am a postgraduate student at University of the Witwatersrand, pursuing the degree of Master of Science in Nursing. I hereby request permission to conduct research on ***"Health care users' experiences of waiting time at a diabetes clinic."*** Participants will be interviewed in order to explore and describe their experiences and perceptions of waiting time at this hospital. Through exploration, this study intends to produce findings that will facilitate formulation of policy guidelines for management of waiting time, aimed at improving client satisfaction of waiting time at public hospitals. Waiting time records will be checked to see how long have patients waited. Photographs of the physical structure will be taken.

The names of the hospital and of participants will not be disclosed in the report and information given will be treated with confidentiality. A copy of the report will be provided to you on completion of the study and also after proposal.

Thanking you in advance

Yours sincerely,

_____

Monica Maphefo Mokgoko
082 369 7576

ANNEXURE C

P.O. Box 846
Mondeor
2110

The Chief Executive Officer
Charlotte Maxeke Johannesburg Academic Hospital
Private bag X 39
JOHANNESBURG
2000

Dear Sir/Madam

REFERENCE: REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY AT YOUR HOSPITAL.

I am a postgraduate student at University of the Witwatersrand, pursuing the degree of Master of Science in Nursing. I hereby request permission to conduct research on ***"Health care users' experiences of waiting time at a diabetes clinic."*** Participants will be interviewed in order to explore and describe their experiences of waiting time at this hospital. Through exploration, this study intends to produce findings that will facilitate formulation of policy guidelines for management of waiting time, aimed at improving client satisfaction of waiting time at public hospitals. Waiting time records will be checked to see how long have patients waited. Photographs of the physical structure will be taken.

The hospital name and those of participants will not be disclosed in the report and information given will be treated with confidentiality. A copy of the report will be provided to you on completion of the study and also after proposal.

Thanking you in advance

Yours sincerely,

_____

Monica Maphefo Mokgoko
082 369 7576

ANNEXURE D

INFORMATION SHEET

Dear Sir / Madam

My name is Monica Mokgoko. I am a student at Wits University and kindly invite you to participate in this study that intends to get information regarding waiting time at this hospital. You have been chosen because you are likely to provide me with the valuable information that I need for this study. Your participation is completely voluntary with no obligation of some kind. You have the right not to begin or stop at any time without giving the reason, or face any penalty.

If you would like to participate, you will be asked to share your experiences and perceptions regarding waiting time at this clinic. This will be done through an interview that will be recorded on tape and will last for about 30-60minutes, your names will not be written on the tapes and/or notes. The tapes and notes will be kept under lock and key and destroyed after two years of publication of this research and if the research is not published they will be destroyed after six years.

This research study has received approval from Human Research Ethics Committee and Postgraduate Committee of University of the Witwatersrand.

Your participation is highly appreciated.

Yours faithfully,

_____

Monica Maphefo Mokgoko
Cell: 082 369 7576

ANNEXURE E

Title of Research: Health care users' experiences of waiting time at a diabetes clinic in an academic hospital.

Hospital: Charlotte Maxeke Johannesburg Academic Hospital

Researcher: Mrs. Monica Maphefo Mokgoko.

Contacts: Cell no: 082 369 7576.

E-mail: MonicaMokgoko@gauteng.gov.za

VOLUNTARY INFORMED CONSENT TO PARTICIPATE IN THIS RESEARCH STUDY

I ----------, give consent and willingly agree to participate in the above-mentioned study.

I have read the research title and received explanation about it. I therefore understand the study procedure and fully participate voluntarily and will be free to withdraw anytime without penalty or prejudice. I understand that the interview will last for about 30-60 minutes and will be recorded on tape and later transcribed. The researcher has given me assurance of anonymity and confidentiality in the study. I will be given access to the research findings, should I wish to do so.

I hereby consent to participate in the study.

Participant's signature_____

Date: _____ Time_____

Interviewer's signature _____

Date _____ Time _____

ANNEXURE F

Title of Research: Health care users' experiences of waiting time at a diabetes clinic in an academic hospital.

Hospital: Charlotte Maxeke Johannesburg Academic Hospital

Researcher: Mrs. Monica Maphefo Mokgoko.

Contacts: Cell no: 082 369 7576.

E-mail: Monica.Mokgoko@gauteng.gov.za

VOLUNTARY INFORMED CONSENT FOR THE INTERVIEW TO BE RECORDED ON TAPE

I ----------, give consent and willingly agree that the interview be recorded on tape.

I have read the research title and received explanation about it. I therefore understand the study procedure and fully participate voluntarily and will be free to withdraw anytime without penalty or prejudice. I understand that the interview will last for about 30-60 minutes. The researcher has given me assurance of anonymity and confidentiality in the study. I will be given access to the research findings, should I wish to do so.

I hereby consent for the interview to be recorded on tape.

Participant's signature_____

Date: _____ Time_____

Interviewer's signature _____

Date _____ Time _____

ANNEXURE G

Faculty of Health Sciences
Medical School, 7 York Road, Parktown, 2193
Fax: (011) 717-2119
Tel: (011) 717-2076

Reference: Ms Salamina Segole
E-mail: salamina.segole@wits.ac.za
20 March 2012
Person No: 0606625H
PAG

Mrs MM Mokgoko
P O Box 846
Mondeor
Johannesburg
2110
South Africa

Dear Mrs Mokgoko

Master of Science in Nursing: Approval of Title

We have pleasure in advising that your proposal entitled "*Health care users' experiences and perceptions of waiting time at a diabetic clinic in an academic hospital*" has been approved. Please note that any amendments to this title have to be endorsed by the Faculty's higher degrees committee and formally approved.

Yours sincerely

Mrs Sandra Benn
Faculty Registrar
Faculty of Health Sciences

ANNEXURE H

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG
Division of the Deputy Registrar (Research)

HUMAN RESEARCH ETHICS COMMITTEE (MEDICAL)
R14/49 Mrs Monica Maphefo Mokgoko

CLEARANCE CERTIFICATE	**M090908**
PROJECT	Health Care Users' Experiences and Perceptions of Waiting Time at a Diabetic Clinic in an Academic Hospital (revised title)
INVESTIGATORS	Mrs Monica Maphefo Mokgoko.
DEPARTMENT	Department of Nursing Education
DATE CONSIDERED	2009/10/02
DECISION OF THE COMMITTEE*	Approved unconditionally

Unless otherwise specified this ethical clearance is valid for 5 years and may be renewed upon application.

DATE 07/12/2012 **CHAIRPERSON** .....
(Professor PE Cleaton-Jones)

*Guidelines for written 'informed consent' attached where applicable
cc: Supervisor :

DECLARATION OF INVESTIGATOR(S)

To be completed in duplicate and **ONE COPY** returned to the Secretary at Room 10004, 10th Floor, Senate House, University.
I/We fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I/we undertake to resubmit the protocol to the Committee. **I agree to a completion of a yearly progress report.**

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES...

TRANSCRIPTS FOR INDIVIDUAL INTERVIEWS

Participant no: One

Q: Tell me about your experiences of waiting time at this diabetes clinic?

R: I would like to - - - something that can be improved, you find that you came early to hospital - - you came early now the sisters there on the table they mix files. I ask the sisters to write like- like at the chemist. When we go to the chemist, - - we get numbers. You know when you are this number - you are this number – you go with your number. When our files come from - - from reception, they go to, they go to - - to the sisters – and the sisters do not keep them accordingly, you hear me. You see someone who came after you going in first – you go to ask why it is happening like this and they say we have mixed the cards up. Something like this does not work. They should have cards like at pharmacy. At pharmacy they give us number- they give us numbers to say who you are after, just like that. That is something that we …that we … ask otherwise the system is poor. Even the toilets are very, very dirty. The toilets here- (*have you seen them?)* (*Shoo*) they are filthy. And what makes toilets to be filthy is us people, people do you hear me?- women- a woman will go in there and leave stools in there ---especially at the entrance that side of social workers.

When you want to go inside, there is a smell of stools right through. Women! We! Women, we are very filthy. I mean when you are menstruating you know you are menstruating. When you make a mess you should ask for a toilet paper and clean up- clean up do not leave the mess like that. The next person coming in, that is germs –we pick them, so how shall we get better, we will not get better. I mean you can see that you have passed a stool up. Maybe you were … were in a hurry, you … had a stomach problem. You should stop, ask for a mop from the cleaners and clean up your mess. If you leave it like that....who is supposed to clean it? Even the cleaners I think they get tired – they become impatient about…about our filthiness as women, patients, (*joo hai*) me this thing does ….not does not sit well with me.

Otherwise the hospital has improved even at the chemist, things go right…things have…have…improved and even the doctors give us the correct medication. So far this is the complaint that I had. I do not know others will come and say their stories as well. *"So how do you interact with them?"* we interact well with nurses we interact well with doctors. We get different doctors; every doctor comes with his own story. When you go to another doctor, we do not get one straight doctor; like that side there is a professor so I do not know who those who go to the professor are and they stay there. If you see the same doctor, he is able to look at your schedule accordingly and make follow ups but if you keep changing doctors, this month you see this one he tells you this, the following month you see another one he tells you this, (ah)- now you do not know what is happening. Otherwise doctors here doctors for sugar, are very good, it is just that every doctor comes with his own ideas. The other one does not know what happened to you.

For instance there was one doctor when I was here the last visit for my repeat, he was fighting about my wait, for sugar diabetes – he checked me, showed me and explained to me and motivated me. I saw his commitment. Doctors are not the same. Others don't check you. They do not even check your blood sugar they just write. Doctors are not the same. They are like nurses. If you get the right one, then you got the right one – I do not know how they work, how they are working if they could do like that, I am asking. If you have a doctor you should see him all the time, so that you can know your doctor. So, when I ask which doctor I am seeing? They say "*hey, doctors are the same; they are all doctors for sugar, sit where we told you to sit".* (Ha... ha... ha...) (She bursts into laughter).

Participant no: Two

Q: Tell me about your experiences of waiting time at this diabetes clinic?

R: You know when you come to hospital; there are those who handle people well you see and there are…others who…do …not treat people well. And now---like at the clinic, you will seat for a long time. Since you came what time? You will only leave at 5 or 6 o'clock there waiting for tablets you see. They very slow that side, you see even here they are a little bit slow but they are better-- they are not like that side, you see.

And you know that sometimes we get very hungry because we did not eat and they shout at you and say you know that you are taking tablets, you are not supposed to eat before coming to clinic. Only those who use injections are allowed to eat. You cannot help it because you are so hungry. You find that since you ate last night, now in the morning you want to have something to eat. You want to eat some bread. Now when you get here, they ask you why you ate. (mm) So I do not know we are living like that it is on and off. Some days you go home happy, other days you come back with broken spirit because someone did not speak well with you. Now what can we say? Where can we go to ask for help? If we do not come here to be shouted at and for them to do all sorts of miracles to us, what can we say? The doctors are alright I do not want to lie. They are not impatient with us. The doctor is even able to ask how you feel, is there no pain somewhere somehow besides diabetes, you see. He is able to ask you few things. And you are able to explain that I feel like this or like that. No they are very good. The only trouble is these…these nurses and at the chemist they are impatient. And we sit with them anyway you see when I leave here I am going there, I am only going to sit there I am only going to leave at six o' clock. It is like park station, you si….t there. They take long to call people, they take long, after a long time they call about ten people. And this time they are worse, in the afternoon at around three it is then that they seem to wake up wake up and the queue seems to be moving. That is that.

Participant no: Three

Q: Tell me about your experiences of waiting time at this diabetes clinic?

R: Since I started, I ---I have been well handled. I never saw anything wrong. It is just that on –on--my last appointment there is a young nurse who nearly disturbed my emotions. Because I went to...I went to fetch the urine bottle when I returned I found that she had ---she had moved my chair she put it away, she has put even my things away. She said because you did not tell anyone that you going away. So me I did not want to say anything. I did what she said I must do, but knowing that I was disturbed. But I told the people I was sitting next to. I told them I even left my pink card. Ok then when I came back she kept shouting at me about urine and she attended to me after everyone. A young nurse this one, so I felt that I was not handled properly.

Sisters handle us well. Doctors handle us well. I have never had anything that went bad with me it was only this one. I did not like the manner in which she spoke to me. Because I am old and I have children. Because she is educated and I am not, that did not feel right. The other thing is that I did not know that I should bring small change, you should have small change. So you have to go and get change and this makes me feel bad. Is it at the admission desk? Yes like today the clerk said *go and get small change* (voice changes), she speaks in a commanding voice. We don't have that. I said in hospital we are treated like children and he said *go and get change* I had a R100 note go and get change. I met a security guard. The security guard said that he will use my R100 to buy airtime and he will give me his small change. Then it went on well. But on my return I found my card among other cards then I was called to do what I had to do. ….The other thing is that at the clinic we are used to, before weighing we take off our shoes. So I do not understand how these things work. Here they weigh us with shoes on. Now I do not understand and because they say this sugar diabetes that I have is the one about weight. So I do not know Doctors say that I am overweight, and my weight is not coming down so I told the doctor last time that I was weighed with my shoes on.

Doctor said it doesn't matter. I do not know maybe after weighing they do something that separates. I am not educated, (she laughs.) I want to understand these things. I do not like to exchange words with the nurses, I do not, and I like to keep quite. I am not working I do not know what to do but I like to come and I pay R40.00 for every check up. We sit long at chemist and get hungry. We wake up early and leave at 5am. I sit and sit the whole day and get hungry. You see we have to eat then if I have money I buy something and eat but the shop here is expensive. *So how long do you wait for the doctor?* Right now since I came I have not seen the doctor I don't have money to buy food. Here food is expensive. So about the toilets since I came here you see the ladies toilets since, the other one is not working is out of order. I started here in November I am not sure about the exact date it has always been out of order. This thing makes us feel bad because I am old and we have to queue and sometimes by the time I go in I have already wet myself. One day I found pads on the floor. Because we are all women the pad is not written the name on it. So if someone walks in she will think it is my pad. I felt bad about that. A person will think it is mine. So I felt bad but today they are much better.

Participant no: Four

Q: Tell me about your experiences of waiting time at this diabetes clinic?

R: I find that the hospital is fine, I am not complaining so much about it. The only time that I do feel it, is now that they have changed doctors. I had one doctor all the time that I have been here for the past 20 years. I find that because I had one doctor, I was very happy. Now they have changed doctors and at the moment I find that I do not know who I am seeing and I also do not know where I am going. There is a bit of confusion there but the time spent in here is acceptable err...err... I do not mind because I know they have to do the test, we have to do the test. The nurses' attitudes are also fine. I am not upset about that they do try and help me when I come eh here. Eh there is not really much eh err... I am not very very upset about anything here. Like sitting and waiting, sitting and waiting is a bit long. We tend to get hungry waiting long. Ha...Ha...Ha... Now that we seeing new doctors it is taking longer, it has taken longer. Toilets are not clean ok there is no toilet paper still and there is only two toilet pap... err... two toilets and we have to share and the smell is terrible. Sometimes I don't even want to go in there. *So how do you feel about the toilets?* I do not go in there, the other thing they have to test our urine and I tell the doctor that I do not have urine, sorry. *So you do not go to the toilet while you here?*

No when I am desperate I take a chance. Ha...Ha...Ha... Otherwise everything is fine. I do not come here every often but that is what I have seen so far. *You mentioned something about getting hungry?* I get hungry and as diabetics we must have food, we have to have something like sweets or food. So we bring food, we bring something like a picnic basket. When we come to hospital is like we come to a picnic actually. Ha...Ha...Ha...So we tend to bring our own food because you can't really go to a canteen. You have to be tested; you have to listen when you are called so you can't go to the canteen. I think a lot of people bring their own food, like a picnic basket. Now that we have new doctors, a new doctor doesn't know what you all about because each diabetic patient is different and each patient needs to be treated differently. So you need to go through the tests all over again, it is a bit hectic, is a bit of time consuming and it is a bit agitating. So seeing different doctors is like you are a guinea pig.

Ha... Ha... Ha... *So how do you feel about being a guinea pig?* Not so happy because you can't say to the doctor this is what I have or this is what I had. You might be having other illnesses like hypertension or arthritis and the new doctor maybe is only worried about diabetes. Seeing one doctor is faster.

Participant no: Five

Q: Tell me about your experiences of waiting time at this diabetes clinic?

R: That is eh err... me, the way I feel about how I am handled here at this clinic is that there is noise and doctors also come late we wait long and get hungry, some of us do not have money. We get hungry, we shiver, so I am a pensioner I don't have money to buy food. These are the things that do not go well with me. The noise and the fact that doctors come late even though I don't know why they are late. I end here. *So you say you do not like that*. Yes it does not go well with me. I just want to mention what does not go well with me. What does not go well with me. We do not know if doctors start somewhere or not. I do not know but we are punctual, we arrive here at 06h00 but even now we are still waiting for the doctors. They come at 11h00. Some patients arrive at 05h00. It is the same as in another clinic. You see I have 2 illnesses; I come for diabetes and prostate. I come on different days but even in the other clinic we wait for doctors. We wait for a lo…ng time. When they come we are already hungry. Even now I am hungry and I do not have money to buy food. The other thing is nurses eh err... I have notice anything bad. I have noticed. They speak well with me. I do not know about others but me I do not have a problem. Nurses are also human because patients also have their own things. Ha... ha... ha... (he bursts into a laughter). *You mentioned something about the noise?* You see sometimes you find that your name is called but people are making noise and you cannot hear your name when it is called. You find that you have a hearing problem. I am like that I have that problem, now you find people talking loud. *Who is making noise?*

Patients and staffs especially at the admission desk. When staff is coming to work in the morning they speak loud, they greet each other and are shouting. You wonder why are not speaking softly. *How does this make you feel?* No I do not like it, noise and the long waiting for doctors. The other thing is that toilets are sometimes dirty. We are use to it, people are not the same some are like this other are like that. You have no choice because you are pressed. (Sounds helpless) *How do you feel about that?* Aahh... we are used to it. Sometimes one toilet is dirty the other one is clean. The other one is full of tissues. You wonder where all these tissues come from. Why is the toilet not flushed? And there is a bad smell. Me I just want to talk about what does go well with me. I come from rural area we use a pit privy; we are used to bad smells but not in the hospital. Some patients urinate on the floors and we have to stamp on the urine. You can see that this is urine. I don't like that; I don't like stamping on someone's urine. It is not nice.

The chairs are not enough in this clinic but also at the chemist patients are many and chairs are not enough. Some patients do not get chairs they have to stand. *How do you feel about standing?* I do not like it because I get tired. But when I found a seat then I do not have a problem. But I can see that those who are standing have a problem. You can see that this patient is not well but he has to stand and he is weak and he has to stand for a long time. What do you think can be done? I would like to see these things being corrected maybe even the doctors feel sorry for us, feel sorry that we spent the whole day here. Even though I do not know what is keeping them but maybe they can make a plan and say that let us feel sorry for these people. People spent the whole day in hospital. Maybe there must be someone to make people speak softly because when names are called, patients should hear their names. But white people do not speak loud, is only us, this is our thing. Somebody will say hi! How are you? And the person is just next to her. It is just like when we speak on the phone. (He laughs softly)

Participant no: Six

Q: Tell me about your experiences of waiting time at this diabetes clinic?

R: I am a little bit confused because I spent a lot of time here from seven o clock. I came they took my blood and they test the urine. And I wait and I see only 2 doctors, they come. For how many patients, too many? They say one doctor is on leave so only two doctors for so many people. After the doctor we going to the chemist with the script we spent five –six hours to get our medicines. Sometimes no transport, no transport because it is six o clock and everything has left. We have to phone here and there to find a lift. So I think more people to the chemist. More experienced people. People kill themselves inside there, experienced people because one asks the other. Every hour they call only ten people. So we have to spend the whole day. The staffs here are very nice. The toilets I cannot tell you about the toilets because I never go. Only if necessary, like I went now. *How is it?* No toilet paper, the floors are disgusting for a hospital. I mean you go to the hotel first class; you go to restaurant first class. You come to hospital, health department big question, when are they going to fix that? People sometimes get angry for standing so long and they make noise.

People who are waiting they lose patience and they start screaming. If you go to the toilets five meters away, you know you are going to the toilet. The floors are clean and when they clean they clean properly. I want to thank the government for giving us a chance to speak and to support us. It is just small things. People go to the chemist, you don't eat or drink, they eat and they drink. There is nobody saying my dear can you read? If you cannot read ask your neighbor. Do not put litter on the floor; they put litter on the floor. There must be someone to supervise. They must write in their language. If they cannot read then someone, someone like you must come and say here and there- here and there somebody must come to check. The supervisor must come and check. The supervisor to come and check the toilets, say alright they are clean. Also us we also not careful, no toilet paper never-never. Me, I make sure that when I come I bring my own toilet paper just in case. Toilets they don't smell hygienic, they should put handy andy. If a foreigner or tourist comes to hospital, he will go to the toilet. Even if they visit somebody they will need a toilet.

Participant no: Seven

Q: Tell me about your experiences of waiting time at this diabetes clinic?

R: One thing I would like to mention is that most of the time you will find that most people do not know the clinic time you find that they come early and stand. You find that one patient is tired and sick but has to stand like that. If maybe there could be built in chairs so that patients can move in order, so that while they are seated, they should know who they are behind because some do not come to one clinic, they go from one department to the other, on the same day they have two clinics. According to the illnesses, the next thing if she is called in another clinic while she is not there, there must be a way of keeping her place. At the moment when the name is called and the person cannot hear her name, there is always confusion. This makes the patient to go late to the chemist to a point whereby sometimes she has to come back the next day. This causes a problem because you find that her medicines are finished and she can go for a day or two without. You find that she must go to work and she spends the whole day in hospital, when she is supposed to ask for another day from work is a problem. *How does this affect you?* It affects us because sometimes we are afraid to ask from work to come to hospital.

You keep quiet only to find that the illness is serious at the end of the day. That is why they say for us black people it is so hard to find out what is eating us up because we are afraid to go to the doctor to say please check me because I am not sure but I do not feel well. By the time we stand up you find that it is too late. Another thing when we are in hospital, we are afraid to ask. When we do not understand, the clerks are not approachable, they have a problem of saying I am the one who works here, but when they talk to white people, they talk nicely and this is not a nice thing. Sometimes when you ask something they become impatient. They treat you like you have come to ask for trouble. People should talk properly; they should know that they are employed. They must know how to handle patients, they must not shout. Some people are not educated, they are not educated. We are not all educated. Sometimes patients come with referral notes and instead of explaining properly what the note says or where you should go, they should explain well because they have information.

Participant no: Eight

Q: Tell me about your experiences of waiting time at this diabetes clinic?

Waiting time, I understand you have to wait because that is part of coming to hospital but I feel they should maybe use the number system. Because my husband is on a wheelchair and he gets very irritated because he sees people coming after us going to the doctor before us and is just that they mix files up. I think if they have a number system, if you are number 20, 30, 40 or 80 and you know you are that number. Because some people come late but all of a sudden they are seen first. Whereas I got to be up and dressed at half past five. I got to leave to be here at six o clock. I still am like last to go a lot of times. He is in a lot of pain that is the only thing I can suggest. We have been coming here long and we don't complain about that. They used to see wheelchairs first but they have stopped that and there is one big- big problem, downs stairs in the parking, in the orange block there is no parking for disabled people for wheelchairs. And in the green block where is parking for disabled people, you find staff and young ones park there. I can't get him in and out of wheelchair in a normal parking. So I got to stop in the middle of the road, get him out of a wheelchair. Leave him in the middle of the road.

So it is difficult with a wheelchair in a normal parking. There is only wheelchair parking in the green block not in the orange block. I don't want to push him all the way to the green block. Otherwise the clinic is efficient. Nurses they know us by names. Time we spent here, normally it depends if the doctors are here. It can be 2-3 hours. The last time we came here we only saw the doctor at 12 o clock. So that was a very long time. *So how does that make you feel?* Terrible because we waiting for the Dr. Brown so all of a sudden we were told she wasn't coming. I mean they could have told us to see another doctor that was terrible. Nurses are very good, clerks are polite and doctors are ok. Dr. Naidoo is under a lot of pressure with all the people but she was happy to see us she didn't complain. Chairs are fine at least they are enough today and the toilets are normally clean. We bring our own food. Floors are clean and they shine, I wish my floors were like that. *So you said you waited long the last time?*

We kept asking and they said she was coming, she was coming. I wish they had told us that the she wasn't coming you must see this one. And that is again where the numbers come in. If you know what number you are and you see number 40 and you know you are number 10 and you still sitting here then you can do something. They can use the numbers like at the arthritis clinic. The files get mixed up at the clerks even the cards. One day one black said this lady was before me. My husband gets irritable when these things happen. He has been diabetic since 1994. The nurses know us so well.

Participant no: Nine

Q: Tell me about your experiences of waiting time at this diabetes clinic?

R: I started in 1996 in May. I was admitted because I had a mild stroke… That is when they found out that I have diabetes. They admitted me so in the ward I was treated well it was nice everything. They were alright. So I was discharged and I came to attend the clinic even here at this clinic I found that all was well, they treat people well, but it happened, I came early like I came early. That means my file was misplaced when they took it out I do not know what happening. I sat and sat until all doctors were about to go away without me being seen. When I asked from the one who takes files out, she said, no I did not put my file in there when I arrived early. I said I came early in the morning. I arrived when that sister I do not know her name when she was there they were having a prayer, they used to have a prayer but now they do not have it anymore. I arrived and you took our cards and now my file is missing and cannot be found and even the doctors are now going away. Hai she started looking, when she …after she shouted at me telling me that I had just arrived. *How did you feel about that?* That did not go well with me. Hai when she was …she found it and she found that she is the one who put it at the wrong place it was her mistake. Hai then everything came to an end. Then it happened again, the problem is always with the files. Then it happened again another day. File… file… file could not be found. Hai then she asked me are you sure that you left the card here or you left it somewhere? Then I said how can I leave it somewhere because I have to go to the dispensary. So I waited because we could not find the file until the doctor left then I was seen by another doctor, because of the file it happened three times.

So my problem is that when I come to clinic I always think about the problem with the file. Otherwise the treatment is alright even the sisters speak well to us. The other thing is that we get out late. Sometimes you find that is 6pm and you are at the chemist. The other time when there were floods in Soweto, there were no taxis, I arrived home at 9pm. I saw an improvement at dispensary; they give us a three months supply of repeats. *So you like that?* Yes I think it is an improvement. What I do not like about missing files is that the clerk did not apologize even after she saw that it was her mistake. She wanted to put blame on me.

Participant no: Ten

Q: Tell me about your experiences of waiting time at this diabetes clinic?

R: Here at the clinic – the most painful thing is that we come early- having arrived early doctors come late. They come at about 09H00 or 10H00 we sit and wait...We get hungry, we have to go and buy food so that we can eat. Sometimes even the medicine you find that some of us did not take treatment in the morning because we want to rush to the clinic and come back home to take our treatment. So things like that make us feel bad, *(she frowns and looks straight in the researcher's eyes)* but the treatment I don't want to lie well I do not know but for my side the treatment is best. Even the medicines that they give me are enough. (*She looks cheerful)* The main problem is at the chemist. At the chemist we sit until we say "Ja-Baas", seated there at the chemist. Either than that, I do not see anything bad. Maybe I do not know, maybe I cannot think of anything now but otherwise treatment is good. The problem is that doctors come late. *So how do you feel?* No it really makes me angry – it makes me angry, it takes away the love that love is no longer there. You see right now, when did we come? They are not yet hear. We have been here long. You see now we are going for urine testing. When we finish we are still going to sit and wait. They are not yet here. These are the things that make me feel bad. But the treatment ohoo I like it because they give me enough medicines. At the admission desk, clerks have their own things. They have their own things. *What things?* They delay; sometimes you find that they mix files. I am talking to you now I did not get my small card. I have to go back to find it. I got the big file but they didn't give the small card.

What is it that you wish to see happen? They should change, people, but it is not all of them, they are not the same; they are not the same. Some speak well; they speak so well. Like the one at the corner, the. er...er the one who makes appointments and give us appointment cards, shoo she is a very nice lady, a very nice lady. *So how are the others?* The others do not speak well, is like they shout. Just like other sisters. You see one of the sisters is my relative but I do not go to her for special favors. I sit and move with queue. Sometimes she sees me in the queue and greets me. She is very kind. I do not speak like that because she is family is just that she is kind. You see people are not the same. You mention going to the toilets for urine, *how are they?* The toilets are not clean, so when I come in the morning I make sure that I use the toilet because I do not want to find it in a mess. They get very messy, they get very messy.

You cannot even get inside, you can hardly go inside. Sometimes I use the one on the other side next to the social workers' office, you see that one. "*Heads nod"*. You see if it is early then they are still clean. But we, patients are to blame for the mess. We do not love ourselves; we do not love ourselves. Being a woman, you know that you are menstruating, you want to leave a mess behind who is supposed to clean that mess, who is supposed to clean that mess. When you stand up from the toilet seat, you are supposed to look at the seat, you must say let me look you must look if you see something wrong clean it, use your hands when you finished you can wash your hands. Dirt will not stick on your hands it comes off, so what is a problem? We patients, we should blame ourselves; we should put the blame on our side. People who are cleaning, are they supposed to clean our mess? "*She shakes her head"* they get tired we should not say they should clean; it is their job, they getting paid. There is nothing more important than respect in this world. When a younger person shows respect to the older person and the older one also respecting the younger one then the things will be fine. "*She concludes with a smile".*