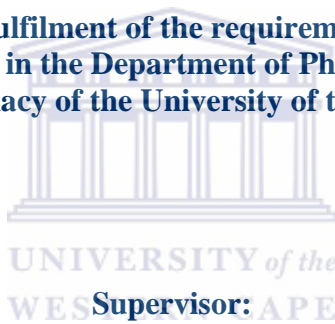Investigation of factors influencing pharmaceutical services
and their relation to quality pharmaceutical service delivery
in hospitals of a private health care provider group

MOEKETSI SEBASTIAN THOBELI
(DipNur., B.Pharm)

**A thesis submitted in partial fulfilment of the requirements for the degree of Magister
Pharmaceuticae in the Department of Pharmacy Practice,
School of Pharmacy of the University of the Western Cape**

Supervisor:

Prof. Nadine Carol Butler, Ph.D., FPS

School of Pharmacy

UNIVERSITY *of the*
WESTERN CAPE

March 2007

To my wife, Khopotso and daughter, Mpho:

M.S. Thobeli

(March 2007)

DECLARATION

I declare that <u>Investigation into factors influencing pharmaceutical services and their relation to delivery of quality pharmaceutical services in hospitals of a private health care provider group</u> is my own work, that it has not been submitted before for any degree or examination in any other university and that all he sources I have used or quoted have been indicated and acknowledged as complete references.

Moeketsi Sebastian Thobeli   March 2007

Signed: **………………………..**

ACKNOWLEDGEMENTS

My sincere thankfulness and admiration go out to the following people without whom my research project would not have been successful:

- Prof. N.C. Butler – my research supervisor and teacher for her patience, guidance and allowing me to learn the research process.

- Afrox Pharmacy Management Services (APMS) - for sponsoring my research and their personnel for giving me the necessary support to conduct and complete my research project.

- Khopotso Thobeli (neé Lesaoana) – my wife and colleague for proofreading sections of my thesis and for her unconditional support, true love, encouragement and faith in me.

- Thabo Thobeli, D.T. Smith, M.D. Moilwa (may her soul rest in peace)   T.E. Moopu and their families – my brother, sisters and role models for their unreserved love and wishing me well in my studies

- UWC Financial Aid Office personnel, particularly R.L. Bell, for their steadfast support since my undergraduate studies.

- UWC Postgraduate Enrolment and Throughput (PET) Project for the encouragement and academic support.

- UWC School of Pharmacy staff, especially H. Samsodien (neé Kagee), Professors J.A. Syce and H.M.J. Leng for setting me off on the path of postgraduate studies.

- My postgraduate colleagues, in particular L.N. Manthata, D.N. Tshambuluka,   J.K. Kgomo and K. Obikeze for being there through good and challenging times.

- Professors C. Linder and D. Marshall of the UWC Physics Department for their encouragement and technical support.

- All my friends at UWC and in the Cape Peninsula for being my family and making my stay here pleasant and memorable

Investigation of factors influencing pharmaceutical services and their relation to quality pharmaceutical service delivery in hospitals of a private health care provider group

TABLE OF CONTENTS

UNIVERSITY *of the*

WESTERN CAPE

KEYWORDS

- Consumer behaviour

- Medicines legislation

- Pharmaceutical care

- Pharmaceutical service delivery

- Private health care

- Private hospitals

- Qualitative research

- Quality

- South Africa

- Transformation

ABSTRACT

Efforts to improve the quality of service delivery are an ongoing feature in different organisations. In the private health care sector, particularly pharmaceutical services in private hospitals, such efforts are important because of the sector's commercial nature. This stems from the fact that customers pay a lot of money for services and expect services that are worth the money they pay. A private health care delivery group encourages such efforts in pharmacies of its hospitals through scientific research.

Service providers and consumers were engaged to gain an appreciation of quality service delivery. The qualitative research method was used for the reason that it is scientific research that seeks to provide understanding and insight into social experiences as appreciated by the people involved and that it is a process of disciplined investigation that is methodical and verifiable.

The research project was conducted to identify factors that influence pharmaceutical service delivery, to establish the understanding of quality pharmaceutical service delivery and establish the expectations of customers regarding pharmaceutical service rendered in a private hospital group.
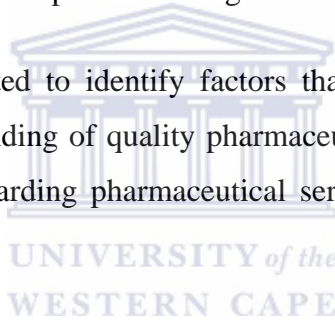
Glossary

AIDS	Acquired immuno-deficiency syndrome
ANC	African National Congress
Ethicals	Medicinal products
HIV	Human immuno-virus
JSE	Johannesburg Securities Exchange
Surgicals	Surgical products
TB	Tuberculosis
TTO	To take out (discharge medicine)
Vacolitres	Intravenous infusions

LIST OF FIGURES

LIST OF TABLES

UNIVERSITY of the

WESTERN CAPE

LIST OF APPENDICES

Chapter 1

Introduction

Chapter one provides the premise for this research by explaining how legislative changes in post-1994 South Africa had an impact on health care delivery. It then explores the extent of private health care provider groups and the influence of those legislative changes in the health care industry, particularly relating to hospitals of the private health care provider group in which the research was done. Furthermore, it states the motivation of this research, highlighting quality service provision as a fundamental reputation in the success of hospitals. This Chapter also states the purpose and limitations of this research.

1.1 BACKGROUND FOR THE RESEARCH

1.1.1 Political transition: An opportunity for change

Commentators, both domestic and abroad, have hailed South Africa's relatively peaceful political transition as phenomenal. The process of change might have been worse for the reason that discriminatory laws that made life for the majority of citizens intolerable beset the previous political *status quo*. As the country works towards strengthening its democracy and eliminating discrimination and poverty, inherited from its apartheid past, it has to grapple with serious challenges. Government continues though to demonstrate political will in facing up to those challenges. In September 2001, President Thabo Mbeki said, "Since the dawn of democracy in 1994, government has made steady progress in implementing its mandate to create a better life for all South Africans" (South African yearbook, 2001/2002).

Amongst the challenges facing South Africa is delivery of quality health care services to its citizenry and maintenance of good health. As far back as the early 1990s, during deliberations on the disposition of post-apartheid health care, some members of the progressive health movement were of the view that the private health care sector should be forbidden with the demise of apartheid, disputing its significance in the envisaged South Africa. Others were of the opinion that the new government should expend its efforts to improve public health services as best as possible given its fiscal constraints and ignore the private sector (Doherty *et al* 2002). As recently as 2001, President Thabo Mbeki acceded in the ruling political party's weekly on-line newsletter that, "In the seven years since our liberation, perhaps the most contentious issues to which our country has been exposed have related to health" (Mbeki, 2001). Dr Ayanda Ntsaluba, Director

2

General in the National Department of Health, echoed this sentiment when he commented that, "the HIV and Aids epidemics remain a major public health challenge, both in their own right and in fuelling the Tuberculosis epidemic" (Department of Health annual report, 2002/2003).

1.1.2 Private hospital sector in South Africa

By and large, the tendency in the 1990s and prior, was to regard the public and private health care sectors as separate and independent of one another. Such a tendency may, amongst other reasons, persist amongst those who might fail to appreciate the relevance of this research. In spite of that, it is true that the private health care and private hospital sectors exist, are considerable and have shown steady growth over time in South Africa. Figure 1.1 below aptly corroborates this pronouncement. Interestingly, this growth transpired notwithstanding a moratorium that government placed in 1991 on development of new private hospital beds pending development of policy on "certificate of need" (Cornell *et al* 2001). This shows that it would be naïve and myopic to ignore the private health care sector and private hospitals sector.

Figure 1.1: Total number of private hospital beds and annual growth rate

(Source: Cornell *et al*, 2001)

3
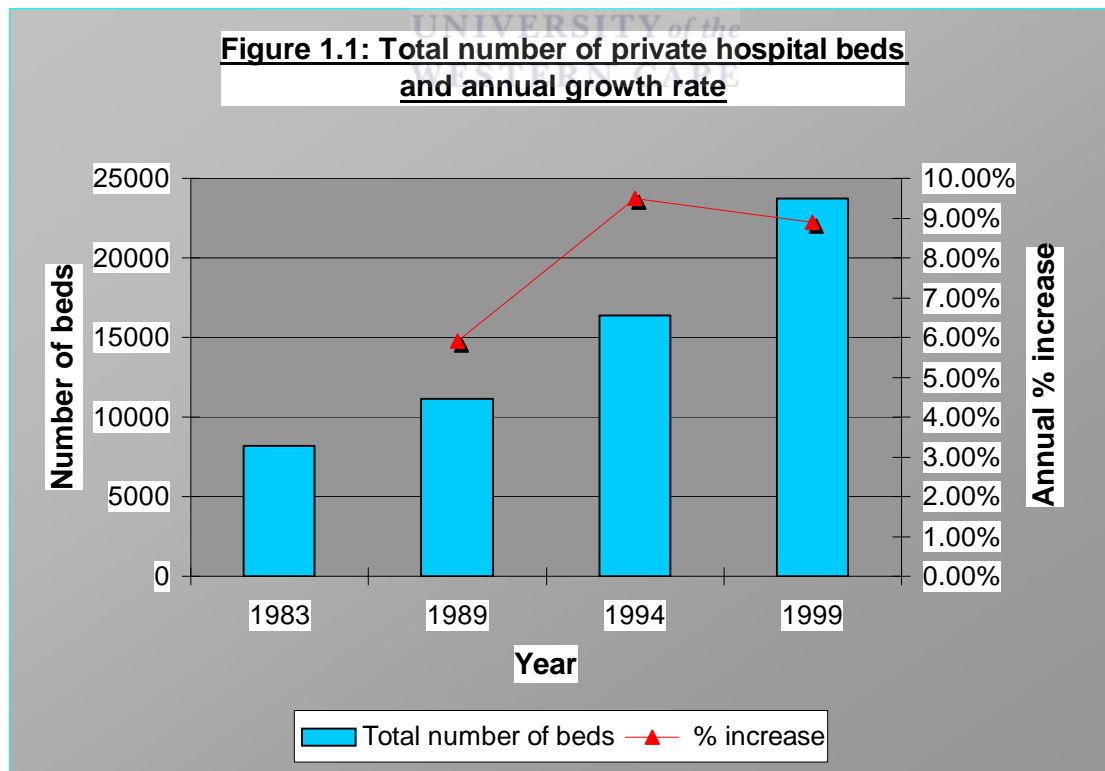
Figure 1.1 also illustrates the progressive escalation in private hospital beds over a 16 year period from 8 220 in 1983 to 23 706 in 1999. Between 1983 and 1989, the growth rate was 5.9% and post-1994 it was comparable to the 1989 to 1994 period - 9.5% and 8.9% respectively.

Table 1.1 represents South Africa's provincial spread by 1999, of private hospitals and day clinics. A remarkable point illustrated here is that there were approximately 3.4 private beds for every 1 000 medical scheme members as compared to 3 public beds for every 1 000 population of non-medical scheme members. Generally, the number of private hospital beds relative to the private sector population was equivalent to that in the public sector at national level.

Table 1.1: Distribution of private hospitals and day clinics by province, 1999

Province	Nō. of Hospitals & Day Clinics	Nō. of Beds	% of Total Beds	Distribution of Medical Scheme Population	Beds per 1 000 Medical Scheme Population
Eastern Cape	18	1 224	5.2%	13.5%	1.3
Free State	11	937	4.0%	5.4%	2.5
Gauteng	85	10 605	44.7%	32.2%	4.7
Kwazulu-Natal	28	4 974	21.0%	15.2%	4.7
Limpopo	2	273	3.4%	8.2%	1.4
Mpumalanga	8	804	1.2%	5.9%	0.7
Northern Cape	3	297	1.3%	2.0%	2.1
North West	9	795	3.4%	5.8%	1.9
Western Cape	36	3 797	16.0%	11.7%	4.7
TOTAL PRIVATE	**200**	**23 706**	**100%**	**100%**	**3.4**
TOTAL PUBLIC		**105 441**			**3.04**

(Source: Cornell *et al*, 2001)

Even though the national averages for beds in both the private and public sectors relative to the population were similar, there were considerable variations amongst the provinces in the spread of private beds. Gauteng, Kwazulu-Natal and Western Cape provinces had the highest averages of private beds, whereas Mpumalanga province had the least.

4

The rest of the provinces averaged between 1.3 and 2.5 private beds per 1 000 medical scheme population.

1.2   MOTIVATION FOR THE RESEARCH

1.2.1   Lessons learned from the past

This research is not meant to either condone the private health care sector in general or justify the existence of private hospitals in particular. On the contrary, its premise is an appreciation of the interdependence of public and private health care sectors as well as the recognition that health care is universally recognised as a basic human right (People's Health Movement, 1978), protected by the constitution of the Republic of South Africa (Bill of Rights, 1996). Besides, experience demonstrated that options that were considered in the 1990s, as alluded to earlier, attested to being politically incorrect and economically expensive. An expectation by those opposed to the private health care sector of government to ignore the private sector might have entailed that government would not have to dedicate its time and effort to interrelate with the private sector but instead would use such time and effort to enhance the public health care sector. However, knowledge accrued during the course of the 1990s established that, left to its own devices, the private sector affected the public sector adversely. Members of private "institutional" financing intermediaries that include medical schemes, health insurance products and workplace services provided by private firms, who could no longer carry on contributing financially for their medical costs to be covered, found themselves excluded by these private "institutional" financing intermediaries. They thus relied on the already over-burdened public sector for continued medical treatment (Cornell *et al* 2001).

One approach that government employed in order to influence private health care sector behaviour was to amend the law and promulgate regulations of the Medical Schemes Amendment Act 62 of 2002 and the Medicines and Related Substances Amendment Act 90 of 1997. Implications that these legislation and their regulations, in particular the latter, will have on the future practice of pharmacy, particularly in the private health care sector, are especially the focus of this study.

5

1.2.2 Role of pharmacists in the private hospital health care team

In view of the fact that amendments to the law in terms of the Medicines and Related Substances Amendment Act 90 of 1997 and regulations that come with it, pharmacists' practice models as well as operating practices in private hospitals and their profitability will continue to be challenged. More than ever before in South Africa, the pharmacy profession is faced with the question of whether or not its role, seen as a "distributive function" adds any value to the health care team. This question has also been asked a number of times over the years in the United States of America as well as in many other western nations where pharmacy continues to be regarded as the most trusted profession, even though such status has not translated into considerable compensation for the pharmacists' professional services. According to Tony De Nicola, a New York registered pharmacist and president of a global consulting firm which advises retailers, wholesalers and suppliers around the world on issues of sales and marketing within the pharmacy industry, stakeholders whose say influences pharmacists' reimbursement, continually have reservations about the value of pharmacists' "distribution function". Apparently, "They say that this 'count and pour, lick and stick' function has little value in the overall scheme of quality health care and can, in many cases, be performed more accurately and at much lower cost by automated dispensing machines" (De Nicola, 2000).

To further compound the challenges facing pharmacists and the pharmacy profession, especially in private hospitals, which are run along commercial lines, regulations of the new legislation expound pricing regulations, which forbid profiteering from the transaction of medicines. "These regulations articulate the processes and mechanisms to be followed to give effect to the provisions of Section 22G (Pricing committee) (of the Medicines and Related Substances Amendment Act 90 of 1997)" (Tshabalala-Msimang, 2004). Indeed the challenge for pharmacists is to develop and expand their practice models to go beyond the so-called "count and pour, lick and stick" function so that they may earn their compensation in exchange for advice, products and professional services that are not necessarily attached to the supply of medicines *per se*. As such, emphasis in the paradigm of pharmacy practice has to shift so as to boost the worth of the medicines and / or other treatment that patients receive.

6

Unquestionably, pharmaceutical products play a pivotal role in health care provision. They continue to be effective means of treatment when used properly, the world over, for the mere fact that many lives have been and continue to be saved, along with their quality improved because of the transformation brought about by pharmaceutical products in treatment and prevention of many diseases (National drug policy for South Africa, 1996). As such, pharmacists and well functioning pharmaceutical services in hospitals fulfil this pivotal role.

Prior to the pronouncement of amendments to the law and its regulations, pharmaceuticals were seemingly the most important assets, second to human resources, in the private hospital sector. This was the case primarily for the reason that they were the main source of business returns as suggestive in the company financial statements (Afrox Healthcare Limited 2001, 2002) and perhaps not so much for their therapeutic nature. Pharmacists were the ones responsible for this valuable asset and as such, their role on the business side was well defined. This role was arguably accentuated above that of a professional health care team member with unique skills and knowledge, given the commercial nature of private hospitals. The change in emphasis of pharmaceuticals as profit commodities, brought about by amendments in the law, therefore also necessitates a consideration of the viability of pharmacists' role in the private hospital sector, especially pertaining to the so-called "distributive role".

Something else that the new legislative challenges necessitates is constant revisiting by pharmacists, especially in the private hospital sector, of their collaboration first amongst their peers and with their colleagues in other health care professions, mainly medical practitioners and nurses. More so because, as pharmacists adapt their practice models from the so-called "distributive function" that their peers and probably other health care professionals may have espoused to depict their fundamental role, to those that encompass more facets of pharmaceutical care, they might encounter resistance from others who might deem that pharmacists infringe on their professional territory. Pharmacists will have to understand their own scope of practice and work in a professional collaborative environment with other professionals.

1.2.3   The need to assess the quality of service provision

Legislative amendments have undoubtedly had an important influence on the pharmacy profession on the whole and in particular private health care providers in South Africa, as mentioned earlier. These changes, in addition to heightened competition in the private health care industry, are posing a challenge to providers to render quality service (Chen *et al* 2003). Private health care providers in industrialised countries are also affected by the increased competition and strive to distinguish themselves from each other by assessing the quality of services they provide (McAlexander *et al* 1994, and Kaldenberg *et al* 1997). Accordingly, the success of a private hospital more often than not depends on its recognition to provide quality service (Hurst *et al* 1994). SERVQUAL (Parasuraman *et al* 1988) is one popular instrument that came into being to measure quality of service. Providers in different settings, in which service provision is the core business, including health care, can apply this instrument to help them find ways to narrow service quality disparities and to prioritise on which disparities to concentrate.

1.3   PURPOSE OF THE RESEARCH

The purpose of this research was to investigate factors influencing pharmaceutical services and their relation to delivery of quality pharmaceutical services in hospitals of a private health care provider group. This was achieved by engaging pharmacists and their customers in the private hospital sector, affording them an opportunity to define a practice model that will permit them to deliver quality pharmaceutical services, given

i.   The impact of the current amendments in the legislation in terms of the Medicines and Related Substances Amendment Act 90 of 1997; and

ii.   The ongoing overall quality improvement efforts in the hospitals of the private health care provider group.

1.4   RESEARCH OBJECTIVES

i.   To identify key factors that influence pharmaceutical service delivery in a private sector hospital group.

ii.   To establish the understanding of quality pharmaceutical service delivery in a private sector hospital group.

8

iii.   To establish the expectations of customers regarding pharmaceutical services rendered in a private sector hospital group.

1.5   ASSUMPTIONS ON WHICH THE RESEARCH PROJECT RESTED

The research was conducted in the Western Cape. Pharmacy managers, pharmacists, nurses, doctors and clients / patients from four hospitals of the private health care provider group were included. Whilst information gathered was not projected to the entire group, it served as an indicator of services rendered by the group.

1.6   RESEARCH AREA

The research was conducted in hospital pharmacies of a private health care provider group in the Western Cape. There are only four hospital pharmacies in this group in the Western Cape and all four were included.

1.7   RESEARCH POPULATION

The research population included both internal and external customers of the company. A customer is a person who buys products or services offered by the company (The Concise Oxford Dictionary, 1990). However, in this research, customers referred to all people who are impacted upon by the services and products of the company. Thus, internal customers are those who are part of the company and include pharmacists, medical practitioners and nurses whereas external customers are not part of the company and consist of patients. The thrust of this research was to appreciate, from the perception of both internal and external customers, their understanding of quality pharmaceutical service. As such, the views of pharmacy managers, pharmacists, nurses and doctors, regarded as internal customers and those of patients, regarded as external customers, were sought from the respective facilities within the group of private hospitals.

Chapter 2

Health care provision

in South Africa:

Literature review

Chapter two discusses the health care industry and health care provision in South Africa by looking at the industry's characteristics pre-1994 and the transformation that took place post-1994. It also gives a brief profile of a private health care provider group in southern Africa and highlights factors that influence customers' perceptions of service delivery from literature reviews. Furthermore, it looks at SERVQUAL, the popular tool for measuring service quality relative to this research.

2.1 HEALTH CARE INDUSTRY IN SOUTH AFRICA

2.1.1 Characteristics of the South African health care industry

A distinct separation between public and private sectors exemplifies the health care industry in South Africa in terms of facilities, personnel and financial support. The larger public sector is under-resourced and over-used while the smaller but fast growing private sector, run largely along commercial lines, caters to middle- and high-income earners who tend to be either members of medical schemes or who can meet the expense of such private health care. Provision of health care varies from primary health care, offered free of charge by the state, to specialised health care services available in the private sector for those who can afford it. Despite the fact that the state pays for about 40% of all expenditure on health care, provincial health departments and local authorities have to provide public health care services to 80% of the population whilst the private sector provides for the remaining 20% (Whittaker *et al* 2000). This minority utilise private health care since they contribute towards and private "institutional" financing intermediaries that cover their health care expenses. Furthermore, about 30% of those who are not covered utilise the private health care services based on out-of-pocket payment (Cornell *et al* 2001).

2.1.2 South Africa's health care expenditure

Prior to the 1994 democratic elections, health care in South Africa was characterised by inequity in the provision and financing of services across the country. There were 14 different health departments, and allocation of hospitals was along different racial groups (MRC News, August 2000). Such a situation led to unnecessary fragmentation and duplication of services and resources.

11

Noteworthy is that against international standards of health care expenditure, South Africa had been spending a relatively higher proportion of its gross domestic product (GDP). During the 1998 / 1999 fiscal year, it allocated 8.8% (R70.2 billion) to health care whereas Venezuela, which was the closest in terms of GDP, for the same period, devoted 7.5%. The equivalent average for middle-income countries was 5.7% (Doherty *et al* 2002). The Minister of Health Dr. Mantombazana Tshabalala-Msimang mentioned in her address to delegates at the launch of the South African Institute of Healthcare Managers (SAIHM) in 2003 that based on the indicators of health systems as per the World Health Organisation's (WHO) Millennium Goals, South Africa should be doing well compared to other countries because it spent about 8.5% of its GDP on health in 2000. However, the country's health outcomes were not reflective of the amount of resources ploughed into this sector. Approximately 60% of health resources were spent on the private sector, which is used by about 20% of the population (Tshabalala-Msimang, 2003). That translated into R5 714 per capita per annum in the private sector as opposed to public spending, which was approximately R695 per capita per annum. As a result of this skew in spending patterns, the country was ranked 175th out of 197 countries in terms of the WHO measure of health system performance in the 2000 survey. Differences in expenditure on medicines per person also vary widely between the sectors. In that same year, approximately R8.25-billion was spent on medicines, with the state spending 24% of this, thus R59.36 was spent on medicines per person in the public sector as opposed to R800.29 per person in the private sector (Doherty *et al* 2002).

Fundamental shortcomings of the health care industry were already recognised by the time the country went to its first democratic elections in 1994. There was an enormous disproportionate distribution of resources mainly based on racial, geographic and socio-economic status of the population. The public sector was not coping with service delivery to the majority of the population because the fragmentation of the public health care sector led to wastage of scanty resources and inefficiency, whereas the private sector, whilst providing for a fraction of the population, used a larger share of the health care resources. It was obvious that remodelling of the system in its entirety was crucial and urgent.

12

2.2 TRANSFORMATION IN THE SOUTH AFRICAN HEALTH CARE SECTOR

2.2.1 Organising a fragmented health sector

After South Africa's first democratic elections in 1994, the dismantling of the country's race-based health system began. For the first two years after the 1994 democratic elections, the government was almost entirely preoccupied with reorganising a very fragmented and chaotic health system, which implied that 14 different health bureaucracies had to be organised into one national and nine provincial departments of health. According to the Medical Research Council (MRC), the challenge that followed was to ensure that the system delivers on its promises (MRC News, August 2000). Even though restructuring of the health care sector is government priority, transformation between 1994 and 1999 focused primarily on the public sector and to a lesser extent regulations that are now influencing the private sector, were developed.

2.2.2 Improving health care provision

Considerable progress has been made in redressing inefficiencies inherited from South Africa's apartheid past, especially in the public health care sector. More needs to be done still, but as alluded to earlier, government continues to show commitment to the goal of health care provision to its citizenry. At national level, the South African government, through the Ministry of Health, is dedicated to address health problems by ensuring equity in healthcare delivery. Government's commitment is evident in the fact that in February 1996 a National Drug Policy (NDP), which is a comprehensive strategy for the transformation of pharmaceutical services, was adopted. In 1998, the completed Standard Treatment Guidelines (STG) and Essential Drugs List (EDL) were introduced as important milestones in pursuance of the objectives of the NDP and Essential Drugs Programme (EDP) (National Drug Policy of South Africa, 1996). It would be ideal for government to provide for the whole population, however since the private sector exists, is an important stakeholder in the health care industry, and that consumers seem pay for services that they receive in the private sector, lessons learned in this sector can contribute equally well to achievement of the ideal of health care for all.

2.3   PRIVATE   HEALTH   CARE   PROVIDER   GROUPS   IN SOUTH AFRICA

The National Health Accounts, private sector report (March 2001) concluded that, "it is evident that the private sector is substantial and is growing in terms of the number of providers working in this sector and the level of expenditure by private funding sources and financing intermediaries" (Cornell *et al* 2001). In spite of this fact, seemingly there is still limited research done in this sector about services. Perhaps it might be because of the competitive nature of the sector and of the information, that different stakeholders do not readily make such information available. A different situation exists in the public health care sector, in which information on the nature of services offered is readily available. Both sectors offer different services, in the form of preventive, diagnostic, therapeutic, curative and rehabilitative services. A common feature in these services is the use of pharmaceutical products. Hence, the impetus for this research is the need to establish what factors influence delivery of pharmaceutical services in hospitals of a private health care provider group.

Table 2.1 below gives an overview of the major private health care provider group hospitals in South Africa and provincial dispersion of private beds as at 1999. The major providers in the private hospitals sector in 1999 were the Afrox Healthcare, Medi-Clinic and Netcare groups. Others were classified as independent private health care provider groups. Afrox Healthcare was strongly concentrated in Gauteng where it had about half the number of its total beds. In other provinces, the number of beds was noticeably smaller. It had the most number of hospitals compared to the other groups, even though it had none in the Northern Cape and Limpopo provinces. Medi-Clinic was the only group to have hospitals in all nine provinces, the most number being in the Western Cape, Gauteng, Free State and Mpumalanga provinces, respectively. It was also the only amongst the three major groups to have hospitals in Limpopo and the Northern Cape. In terms of number of beds, Netcare was the biggest, mainly based in Gauteng and had a strong presence in Kwazulu-Natal with none in Limpopo, Mpumalanga and Northern Cape. Most of the independent hospitals (65%) were in Gauteng and Kwazulu-Natal with

14

the remaining 35%, accounting for 18.6%, distributed across the seven provinces (Cornell *et al* 2001).

Table 2.1: Distribution of private beds by hospital group and province, 1999

Province	Nō of beds	Nō of hosp. & Day clinics	Afrox Healthcare		Medi-Clinic		Netcare		Independent	
			Beds	Hosp	Beds	Hosp	Beds	Hosp	Beds	Hosp
Eastern Cape	1 224	18	528	6	30	1	392	3	274	8
Free State	937	11	228	2	502	4	34	1	173	4
Gauteng	10605	85	2 448	21	809	3	4 134	23	3 214	38
Kwazulu-Natal	4 974	28	546	2	176	2	1 172	6	3 080	18
Limpopo	273	2	-	-	186	1	-	-	87	1
Mpumalanga	804	8	323	3	451	4	-	-	30	1
Northern Cape	297	3	-	-	273	2	-	-	24	1
North West	795	9	349	3	176	2	144	1	126	3
Western Cape	3 797	36	534	5	1 970	15	567	4	726	12
TOTAL	23 706	200	4 956	42	4 573	34	6 443	38	7 736	86

(Source: Cornell *et al*, 2001)

2.4   A BRIEF PROFILE OF A PRIVATE HEALTH CARE PROVIDER GROUP IN SOUTHERN AFRICA

The private health care provider group, which is the subject of this research, is one of the larger private health care provider groups in southern Africa with approximately 34% share of the private health care market. It competes with two other large private hospital groups and a number of health care services companies. It was listed on the JSE Securities Exchange in 1999 through a reverse listing of health care interests of a company involved in supply of industrial gases and a health care company. Approximately for the past 14 years, the group has doubled in size every four years and presently operates 63 acute care hospitals with a comprehensive geographic spread in seven South African provinces and Botswana. Also, it operates same day surgical centres and related health care service related businesses that complement the services offered in the hospitals. With a business strategy that inculcates a vision to deliver quality health

15

care for all, a mission dedicated to the well being of their patients by providing superior, professional service, promising quality patient care, clinical excellence, quality facilities and dedication to their mission, their strategic intent is to be "best in class" (Afrox Healthcare Limited, 2002).

In a competitive and fast changing market, the services are continuously being upgraded to ensure the group remains in the forefront of private health care provision. Pharmaceutical services rendered by the hospital pharmacies are one of the many services offered by the group. Factors that influence these services and their relation to delivery of quality services will be investigated in this research project so as to ensure that only quality pharmaceutical services are delivered by the group's hospital pharmacies.

A former chairperson of the board of directors of the private health care provider group commented that, "The group and the private health care industry as a whole have developed considerable expertise in managing health care business. We can be an important player in helping to improve the services of public hospitals and thus contribute to the establishment of good, quality health care for all our citizens" (Afrox Healthcare Limited, 2001).

2.5 FACTORS AFFECTING DELIVERY OF PHARMACEUTICAL SERVICES

2.5.1 Service delivery influences perceptions

Consumers rely on various informational prompts that they correlate with products or services to appraise the excellence of such products or services. It is these prompts, which may be inherent or extrinsic, that bestow the basis for consumers' perceptions. More often than not, it is relatively straightforward for consumers to appraise the excellence of products as compared to those of services. By using inherent prompts like physical characteristics of the products such as colour, odour, size, texture, and extrinsic prompts for instance advertising, brand image, packaging, pricing, consumers tend to justify their decisions for choosing one product over the other. In the case of a health care consumer, the prompts used to choose a product are different and in some instances, the consumer leaves a knowledgeable party *e.g.* a medical practitioner as in the case of prescription

16

medicines to make the choice. The prompts used to choose health care products include amongst others medical indication, therapeutic index, efficacy, formulation and price. On the other hand, appraisal of services is not as straightforward. This difficulty is because of "certain distinctive characteristics of services: they are intangible, they are variable, they are perishable, and they are simultaneously produced and consumed" (Schiffman and Kanuk, 2000). Providers convince consumers to utilise services, pay for them then receive and consume them later. An example is the counselling that a patient may receive from the pharmacist. Consumers overcome the inability to compare services alongside, as is the case with products, by exploiting proxy cues to appraise such services (Schiffman and Kanuk, 2000).

The following factors are mentioned in literature as influencing consumers' perceptions of service delivery.

- Tangibles – Physical facilities, equipment and appearance of personnel.
- Reliability – Ability to perform the promised service dependably and accurately.
- Responsiveness – Willingness to help customers and provide prompt service.
- Assurance – (including competence, courtesy, credibility and security) Knowledge and courtesy of employees and their ability to inspire trust and confidence.
- Empathy – (including access, communication, understanding the customer) Caring and individualised attention that the firm provides to its customers

(Van Iwaarden *et al* 2003 and Schiffman and Kanuk, 2000).

These factors have been adapted for use in the health care sector as follows

- Tangibles – the infrastructure and availability of pharmaceuticals
- Reliability – the ability to perform the services offered
- Responsiveness – willingness to assist clients / customers
- Assurance – ability of the service provider to be knowledgeable and to inspire confidence and trust
- Empathy – ability to care and display compassion towards clients

(Smith and Engelbrecht, 2001).

2.5.2   Quality of pharmaceutical services delivery

The private health care provider group as a company has always held quality service provision as top priority striving to encourage quality awareness throughout. However, these heightened awareness drives, based on persuasion, do not always result in behavioural modification by personnel. Such drives do not yield the needed results because they do not identify the deeds to be done, establish no clear responsibility for doing the needed deeds and provide no structure process for 'how to go from here to there' (Mills, 1989). The private heath care provider group demonstrated its commitment to quality service provision by granting approval of this study. Given that the context of this research is health care, specifically delivery of pharmaceutical services in hospitals of a private health care provider group, the consideration of quality will be confined to this area.

Efforts of research in the past 30 years in the quality field at attempting to define quality care are regarded as research's fundamental input (Brook *et al* 2000). The Institute of Medicine (IOM) defines quality of health care services as, "The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (Institute of Medicine, 1990). Seemingly, definitions of quality care have two parts that people regard as essential. One part is giving care of high technical quality, which in this case means that services offered are performed in a technically excellent manner to ensure that the needed health outcomes surpass the risks by a sufficiently wide margin. Another part is that all health care consumers wish to be treated in a humane, culturally and consensually informed manner (Brook *et al* 1983). Results of a study by Cheng *et al* (2003) highlighted the equally important, if not more so, significance of interpersonal skills as is clinical competence, to patient satisfaction.

Furthermore, research has revealed that quality differs considerably (Lohr *et al* 1986) depending on where it is sought and that whilst improving it can be a challenge (Brook *et al* 1973), it is possible to achieve even though this achievement has not been realised on the whole.

18

In a challenging environment for pharmacists like the one of private health care hospitals, even more so with the new legislation, the two components of quality remain relevant more than ever before. As mentioned earlier, pharmacists have to do far more than what they have been doing in order to emerge and proceed as professionals who can contribute in a meaningful way within the multidisciplinary health care team. Whereas other health care team members participate as medical care practitioners, others as nursing care practitioners, and so on, pharmacists will have to participate as pharmaceutical care practitioners. Pharmaceutical care is an important concept that justifies mentioning when quality of pharmaceutical services is discussed because it essentially epitomises services provided by pharmacists. It is a concept that changed the perspective of services and care provided by pharmacists, and symbolises a crucial shift in the pharmacy profession from drug products' distribution as the primary focus to patient outcomes of care. Pharmaceutical care was defined by Hepler and Strand as: "The responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient's quality of life." These outcomes are: (a) cure of a disease; (b) elimination or reduction of a patient's symptomatology; (c) arresting or slowing of a disease process; or (d) preventing a disease or symptomatology (Hepler and Strand, 1989). Provision of quality pharmaceutical services by pharmacists then will have to involve provision of pharmaceutical care, bearing in mind the two components of quality of care.

2.5.3 Measuring the quality of pharmaceutical services

Ideas as to how delivery of quality pharmaceutical services can be enhanced have to be considered in conjunction with how such quality services can be measured. Fortunately, the question has changed from whether quality can be measured to how best to measure it, as has been demonstrated by research in the last 30 years (Wagner *et al* 1999 and Brook *et al* 2000).

Assessment of service quality may be based on structural measures (intrinsic characteristics of service providers), process measures (performance of service providers) or outcome measures (what happens to service consumers). Such measures could be acquired reasonably with ease, provided that there was adequate information to allow for the relationship amongst structural, process and outcome measures to be conceived of

19

with confidence. Inconveniently, the use of structural and outcome measures together, as opposed to process measures, to assess quality is encumbered with problems. Lau *et al* (1982) investigated whether structural measures of quality prognosticate what was in fact performed on patients. They considered, for example, whether a board certified physician in the USA generated improved processes or outcomes versus one who is not board certified. In the end they found that, by and large, relationships involving structural and process variables are feeble, contradictory and incongruent (Lau *et al* 1982). Another case in point is the fact that hospital accreditation is paid for in the USA; nevertheless numerous surveys have exposed vast disparities in hospital care. There is also no proof to sustain propositions that the disparities in hospital care would be any greater in the lack of accreditation (Chassin *et al* 1987). Thus, the sole use of structural measures to assess service quality is ill advised.

According to Brook *et al* (2000), when it comes to selecting a service provider or a hospital, people seek information on health outcomes associated with such service provider or hospital. Then again, other factors like consumers' drug allergy history often have an effect on health outcomes, which insinuate that health services produce outcomes only to some extent (Brook *et al* 2000). An example is a patient whose prescription is filled without receiving appropriate counselling which would establish whether the patient has a history of allergies. If nothing untoward happens to the patient whilst on therapy, it may appear that they received excellent service because the outcome was without any problems. However, any undesirable effects that may occur would cast doubt on the quality of the service, but the damage would be done. As such the sole use of outcome measures are also inadequate to assess quality. Something else to be considered when outcome measures are to be used to assess quality is the time factor between the actual outcome and when the service was provided. It may so happen that the time difference is big and thus render the outcome worthless as a measure of quality.

Following the contention against the exclusive use of structural and outcome measures to appraise quality, it makes sense that process assessments should also be scrutinised for their quality appraisal suitability. Process measures express criteria of care that should be observed for quality to be evident. However, quality is not appraised according to

compliance with all suggested criteria of care, instead it is appraised according to compliance with a least set number of indicators. A comparative study by Dubois *et al* (1987) of five different quality assessment methods illustrates this point pertinently. In the study of 300 patients receiving care, only four percent received care that complied with all precise criteria of care, which implies that 96% of the patients did not receive quality care, if quality care means adherence to all criteria of care. It is precisely because of this that Brook *et al* (2000) affirm that: "Process assessments produce the harshest judgement of the quality of care". It is worth mentioning that it was a result of monitoring the process of production instead of the product itself that Deming initiated the concept of continuous quality improvement (Deming, 1986). He underlined quality achievement as an incessant process involving every member of an organisation as did Juran (1989), who highlighted the idea of "teamwork and introduced the steps of planning, control and improvement of quality." In this research, the views of service providers and perceptions of service consumers were educed by different data collection methods in order to meet the research objectives.

2.6   SERVQUAL - THE POPULAR TOOL FOR MEASURING SERVICE QUALITY

Service providers can use the SERVQUAL (Parasuraman et *al* 1988) tool to measure the quality of their service. This method evolved from a need to appreciate the perception of service needs of target customers by service providers. Its authors developed it pragmatically and it allows providers to prioritise and utilise resources for improving their services. The authors carried out a qualitative study in which they collected data by means of a sample of customers who answered questions based on a number of fundamental service dimensions. The SERVQUAL instrument comprises of five dimensions of tangibles, reliability, responsiveness, assurance and empathy. Twenty-two statements measure the performance across the five dimensions using a seven point likert scale measuring both customer expectations and perceptions (*see* Appendix 11) (Gabbie and O'Neill, 1996). A score of seven indicates strong agreement, one indicates strong disagreement and the middle numbers indicate feelings that are not strong. Critics have

suggested that the broad-spectrum nature of the tool may be inappropriate for any service and that some of the items may need adaptation (Finn and Lamb 1991). Others have queried the theoretical basis and psychometric properties of the SERVQUAL instrument (Carman, 1990, Babakus and Boller, 1992, Teas, 1994, and Lam and Woo, 1997) and its application in the health care setting (Headley and Miller, 1993, McAlexander *et al* 1994 and Lam and Woo, 1997). Still, some critics have argued that the items signify just a single factor instead of five following their failure to reproduce the five factors of SERVQUAL (Carman, 1990, Babakus and Mangold, 1992, and Orwig *et al* 1997). Despite the contention over the application of SERVQUAL to evaluate quality of service, it was found to be reliable in estimating quality of service in the five dimensions (Parasuraman *et al* 1988, and Parasuraman *et al* 1991) and latest research undertakings have supported the findings of Parasuraman *et al* (1988, 1991) (Jiang *et al* 2000 and Jiang *et al* 2002).

2.6.1   A critique of the SERVQUAL instrument

The earlier uses of the SERVQUAL instrument in the health care setting have produced varied outcomes. Babakus and Mangold (1992) have verified the reliability and validity of the SERVQUAL instrument in the hospital environment. In a study undertaken in an Australian hospital by Chen *et al* (2003) staff members, as internal customers, were requested to appraise the service quality of the hospital. The results indicated the SERVQUAL instrument to be acceptably valid and reliable, a verdict which is congruent with other investigations in the health care industry. A distinct benefit of the SERVQUAL tool is that it is a tried and tested instrument which can be used comparatively for benchmarking purposes and benefits from being statistically valid as a result of extensive field testing and refinement (Brysland and Curry, 2001).

Lam and Woo (1997) have argued that the broad-spectrum character of the SERVQUAL tool to be inappropriate for hospital settings. SERVQUAL is also unable to give a complete picture of needs, expectations and perceptions in a service organisation context because, "service provision is complex, is not simply a matter of meeting expressed

needs but of finding out unexpressed needs, setting priorities, allocating resources and publicly justifying and accounting for what has been done" (Gaster, 1995).

Although the SERVQUAL tool has been criticised extensively on both theoretical and operational grounds, Asubonteng *et al* (1996) concluded that, "Until a better but equally simple model emerges, SERVQUAL will predominate as a quality measure".

In conclusion, disparities in the South African health care industry and health care provision were highlighted. Those disparities influenced legislative amendments which necessitated a change in the role of the pharmacist, especially in the private health care sector. The need for improvement of pharmaceutical services led to the review of factors that influence pharmaceutical service delivery and hence the requirement for this study.

UNIVERSITY of the
WESTERN CAPE

Chapter 3

Research Design and Methods

Chapter three describes and justifies how this research was planned and executed by explaining its design and methods. It also looks at the different data collection strategies used and explains how the tool to measure the quality of pharmaceutical service delivery in hospitals of a private health care provider group will be created.

3.1   RESEARCH DESIGN

The intention of this research was to investigate perceptions of customers concerning pharmaceutical services offered in hospitals of a private health care provider group. Furthermore, it was to characterise the quality pharmaceutical services concept, to recognise pertinent elements of quality service and to identify factors that influence delivery of quality pharmaceutical service from those perceptions.

Since the purpose of a research project determines its design, the approach of this project was essentially that of qualitative research. This approach was used because it is scientific research that seeks to provide understanding and insight into social experiences as appreciated by the people involved and that it is a process of disciplined investigation that is methodical and verifiable.

Worth mentioning, is that qualitative research differs from that carried out in the biological and physical sciences, also called positivist or quantitative research, in which setting of hypotheses, experimental control and then projection to a population is underscored. Emphasis is placed on measurement and analysis of causal relationships between variables (Denzin and Lincoln, 2001), on finding predictability or discovering consistent, understandable and predictable laws of nature (Kruger, 1998). In contrast though, researchers in the post-positivist or qualitative paradigm "stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry, seeking answers to questions that stress how social experience is created and given meaning" (Denzin and Lincoln, 2001). It is with this understanding that perceptions of customers about their experiences of pharmaceutical services offered by pharmacists in hospitals of a private health care provider group was investigated, hence qualitative research methods was used.

25

3.2   ETHICAL ISSUES

3.2.1   Ethical considerations

The private health care provider group sanctioned and supported the research project, as such they have granted permission to carry out the research in their hospitals. Management primed staff at the facilities included in the study that the study was sanctioned and that their co-operation and participation was appreciated. For research information to be trustworthy, it is imperative that respondents participate in an honest manner. Such expectations place ethical obligations on the interviewer to "cause no harm on those being studied" (Rubin and Rubin, 1995), as a result of their participation. Amongst these obligations is to inform prospective participants about the nature of the research, its intended use and to seek their approval prior to participating. This was accomplished in this research by sending out letters and consent forms to pharmacy managers (*see* Appendices 1 and 2) for them to participate in the interviews. Together with the pharmacists who participated in the focus group discussions, the pharmacy managers were informed that the interviews and FGD sessions would approximately be 60 minutes in duration and tape-recorded to facilitate easy capture of the on-going discussion and the audio-recording would subsequently be transcribed for analysis purposes. During focus group discussions, participants were requested to maintain group confidentiality. They were also requested to grant their permission to quote them during reporting without identifying them by name but would be identified by the category of work, *e.g.* nurse or pharmacist. Invitation letters (*see* Appendix 11) were sent to patients, nurses and doctors to participate in the research by responding to questionnaires (*see* Appendix 9). The ethics committee of the university granted permission for the research.

3.2.2   Research data management

The research data collected was in the form of audio-tape recordings transcribed onto computer and hand written notes. During the course of the research, the researcher stored this data under lock and key and on computer in his university campus office. The researcher and the research supervisor only had access to the data. On completion of the

26

study, erasure of all audio-tape recordings, deletion of computer records and eradication of all hand written notes by the researcher ensured the disposal of the collected data.

3.3   QUALITATIVE RESEARCH METHOD

"Qualitative research is an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyses words, reports detailed views of informants, and conducts the study in a natural setting" (Creswell, 1998). Implicit in qualitative research is the importance on processes and meanings that seek to make sense of the culture and social behaviour of people. There is no emphasis in terms of amount, intensity, frequency and quantity when such processes and meanings are measured or examined.

3.3.1   Multimethod research approach

Qualitative research is inherently multimethod in focus. The use of multiple methods, or triangulation, reflects an attempt to secure an in-depth understanding of the phenomenon in question. Qualitative researchers are of the view that "reality can never be fully apprehended, only approximated" and as such they depend on various methods to ensure that as much of reality as possible is captured (Denzin and Lincoln, 2001).

Methodological methods that adequately capture how people expect to be treated can be a challenge to choose, more so when dealing with perceptions that may not be similar, as in the case of service provision. A multimethod approach can help alleviate this difficulty. Advantageously, qualitative research as a set of interpretive practices, privileges no single methodology over any other (Denzin and Lincoln, 2001) hence observational studies, interviews, focus group discussions and questionnaire surveys were used in this research. Figure 3.1 below, shows this research approach and the sequence of the methods. This approach was utilised to explore this area as it does so essentially from the experiences, opinions, feelings and knowledge of those being studied. As such, it was driven by "customer voices". In her research paper, Sofaer (2002) points out the rise in the use of rigorous qualitative research methods in the health services and policy

research. She particularly mentions focus groups and interviews as accepted components of the advancement of suitable and dependable appraisal instruments. "They are particularly useful in developing surveys to gather data on the experiences and responses of patients and consumers to plan services and providers" (Sofaer, 2002)

The combination of multiple methods, empirical materials, perspectives and observers in a single study is best understood then, as a strategy that adds rigor, breadth and depth to any investigation (Denzin and Lincoln, 2001).
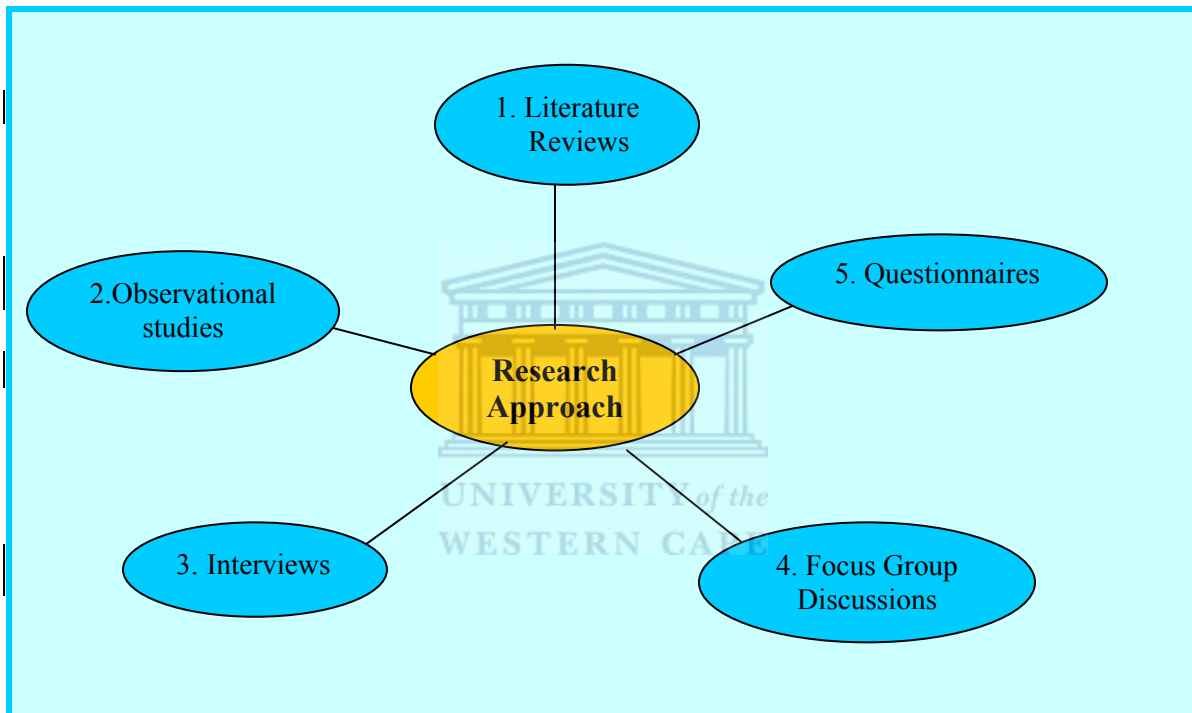
Fig. 3.1: Schematic representation of the multimethod research approach

3.3.2   Data collection strategies

Research data collection is required to be meticulous so as to ensure that appropriate data needed to provide answers to the stated research objectives are collected. In order to accomplish this, the following data collection strategies were selected as part of the research design. They were considered suitable to facilitate data collection and discussion in the research.

3.3.2.1 Observations

Qualitative research is conducted in the natural setting of those being studied, so anyone who is not part of such a setting may be perceived as an intruder of some sort. Within such a setting are people with a culture that is unique to them by virtue of belonging. That culture establishes precincts amid those who should or should not be inculcated with its customs. However, in order to appreciate that culture, the researcher does not have to belong to the culture, but may do so by overcoming its established boundaries and be received as an insider (Rubin and Rubin, 1995).

In 2004, the researcher spent three months of internship in a pharmacy of one of the hospitals included in the research. To help surmount the established precincts the researcher also acted as a participant observer in order to gain familiarity with their culture. Participant observation is a specific form of field research in which the researcher participates as an actor in the events under study. This strategy helped the researcher to be accepted amongst those studied and gained their trust as one of them. In so doing the research respondents are more likely to open up and share their feelings, thoughts and experiences about their lives and world. Also the researcher learned some of the culture by observing and by carrying out some tasks as taught by others, as well as keeping hand written notes of daily happenings. Observations were also carried out to assess whether the list of factors mentioned in literature as influencing consumers' perceptions of service delivery (*see* Section 2.5.1) was complete for this research project.

Seeing that the researcher did this on an ongoing basis, this strategy simultaneously served as a verification and trustworthiness procedure of prolonged engagement and persistent observation.

Information gained from literature and the participant observation period assisted in the development of interview questions for the pharmacy managers.

3.3.2.2 Qualitative research interviews

3.3.2.2.1 Definition and purpose

The qualitative research interview is a research tool that takes advantage of people's normal conversational skills. It transcends the conventional impromptu exchange of

29

views as a conversation to become a careful question and listening process, the purpose of which is to obtain new knowledge (Kvale, 1996). Furthermore, the research interview is a purposeful technique of learning about other people's experiences, feelings and thoughts pertaining to their worlds. A fundamental assumption of knowledge created by qualitative research interview is that it is contextual, seeing that it takes cognisance of the dynamism of people's lives and their worlds. Therefore, aspirations of the interviewer are to appreciate and elucidate meaning of specific circumstances instead of seeking rules that are constant regardless of time and prevailing conditions. In fact the interviewer and respondent are regarded as co-authors of the knowledge because of the inadvertent reciprocal influence that exists between them during the interview. This undoubtedly places the interviewer as an important methodological tool in data creation and hence demands curiosity for new knowledge, empathy, sensitivity, and good research skills from the researcher if he is to realise this role (Kvale, 1996). Of the different types of qualitative research interviews available, the semi-structured format was used to interview pharmacy managers. This approach was used because the researcher specifically wanted to gain the pharmacy managers' insight into factors that influence the quality of pharmaceutical services and their relation to quality pharmaceutical service delivery in hospitals of a private health care provider group. Each interview was conducted separately with the managers as the custodians of services provided. The managers were included because there were only four of them in that category. They were the ones to provide insight into the business of their respective pharmacies. The interview questions, developed from the factors mentioned in literature as influencing pharmaceutical service provision, were not piloted because of the nature of the interview which allowed for open unrestrictive discussion and also permitted the researcher to understand the nature of the work environment as experienced during the period spent as a participant observer. Having introduced the topic for discussion, the interviewer interviewed the four pharmacy managers from the respective pharmacies (*see* Appendix 3) in their offices during scheduled times so that the interviews were not disturbed and the service was not interrupted. Table 3.1 indicates the sample size for the qualitative research interview.

Table 3.1: Sample size for qualitative research interview

Data research strategy	Sample size
Qualitative research interview	4 pharmacy managers

3.3.2.3   Documentation

Participants were informed that a tape recorder and hand written notes would be used to document the discussions. The tape recorder enhances data collection accuracy, aids in data analysis and affords the researcher the opportunity to pay more attention to the topic and dynamics of the interview (Rubin and Rubin, 1995). Hand written notes are equally valuable as they are used to prepare subsequent questions as the interview proceeds. Importantly participants were urged to speak clearly to assure audibility of the recording. The researcher guaranteed that the interviews remained confidential (*see* Appendices 1 and 2) because these are important and serious ethical considerations. The data was analysed as explained above (Section 3.2.2).

3.3.3   Focus group discussions

Focus group discussion (FGD) is a technique that is often employed in qualitative research to collect data. Even though it uses properties of group dynamics to explore various issues, its well-defined purpose, size, composition and procedure differentiates it from informal group discussions. The purpose of a FGD is information collection from and listening to specially selected participants who have particular shared characteristics that relate to the discussion subject (Kruger, 1998). Carefully predetermined questions are discussed in a non-threatening environment that permits participants to share insights on the discussion topic. This interaction or group dynamic is what makes FGDs valuable in providing information to answer questions of a qualitative nature.

A group size of six to eight participants is recommended, but increasingly groups of four to six participants are becoming popular. These mini focus groups are generally drawn on when the objective is to gain depth in discussion. Information obtained is not meant to generalise to a population because it is not statistically projectable, but then again that is not the aim of qualitative research. Rather it is to gain thorough understanding of specific circumstances (Kruger, 1998).

31

3.3.3.1   The purpose of focus group discussions in this research

The purpose of this research project is to explore pharmacists' perceptions of pharmaceutical service provision in hospitals of a private health care provider group. The reason for this is that it is these pharmacists who are at the forefront of this service provision every working day. The FGD strategy of data collection served this purpose well because it provided considerable understanding of pharmacists' actions, feelings and thoughts whilst being inexpensive in terms of time and monetary resources. Furthermore, the envisaged number of pharmacists allowed for them to participate as a homogenous group, which made FGD an appropriate strategy to employ. More importantly is that FGD has high face validity (Kruger, 1998). Validity is the degree to which a method actually measures that which it purports to measure and is based on the relationship between the researcher and respondent. According to Mariampolski (1984), it is the researcher's competency to explore, challenge and search for truthful responses that permit qualitative approaches to produce discerning findings. Face validity refers to the extent to which results appear valid and the high face validity of FGDs is an outcome of the believability of the comments from participants. It is one of the major ways of measuring validity in qualitative research.

3.3.3.2   Sampling, group size and discussion procedure

One pharmacist, selected by the researcher from each of the four hospitals included in the research, was invited to participate in the discussions. Such purposive sampling aimed to maximise the scope and range of information (Katzenellenbogen *et al* 1997), and not to necessarily be statistically representative of all hospitals of the provider group. The intention though was to provide sufficient knowledge of how this research was conducted to allow others to decide on how much the information gathered, conclusions reached and recommendations suggested can be applied to their situations. Prospective participants were also informed of the procedure of the discussion, which involved using predetermined questions (*see* Appendix 7) to facilitate discussions that lasted for approximately 45 to 90 minutes. The questions were developed from information gathered from the managers' interviews. Such information highlighted the key factors that influence pharmaceutical service delivery and helped establish the understanding of

quality pharmaceutical service delivery from the providers' viewpoint, in a private sector hospital group. Table 3.2 specify the sample size for focus group discussion.

Table 3.2: Sample size for focus group discussion

Data research strategy	Sample size
Focus group discussion	4 pharmacists

3.3.3.3   Documentation

As for the interview a tape recorder and hand written notes were used to document the discussions. The tape recorder enhanced data collection accuracy, aided in easy capture of the ongoing discussion and afforded the researcher to concentrate on the discussion (Patton, 1989). Hand written notes were equally valuable as they were used to prepare subsequent questions as the discussion proceeded. Importantly, participants were urged to speak clearly, one at a time, so as to assure audibility of the recording. Here as well the researcher guaranteed that the discussions remained anonymous and participants were encouraged to ensure group anonymity because these are important and serious ethical considerations.
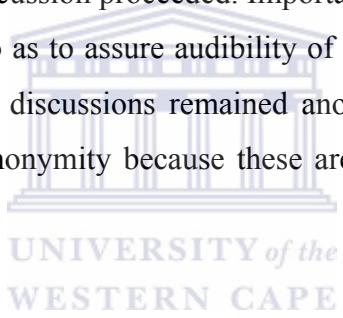
3.3.4   Questionnaires

3.3.4.1   Motivation for using questionnaires

Whilst the other data collection strategies (interviews and focus group discussions) were used to educe information from service providers, questionnaires were used to elicit the perceptions of service consumers and as such establish their expectations regarding pharmaceutical services rendered in a private sector hospital. This strategy was used seeing that the number of consumers is larger than that of providers. Thus this strategy offered the added advantage of convenience in administering it to a large audience and financial affordability. Furthermore, its purposes was to assess the level of congruency between what the service providers deemed as important elements of quality service and what consumers perceived as such. Agreement between these points of view would reinforce in the service providers that the consumers are satisfied with their efforts and to

keep up providing such quality service. Alternatively, any inconsistency would highlight areas that need improvement in service provision.

3.3.4.2   Construction of the questionnaire

Construction of the questionnaire was informed by the factors that influence service as mentioned in literature and by themes that emerged from the other data collection strategies. Essentially the questionnaire sought qualitative data because, as informed by the quality care definition of Brook *et al* that: "all patients wish to be treated in a humane and culturally appropriate manner and be invited to participate fully in deciding about their therapy" (Brook *et al* 2000), this data collection strategy was suitable to inform the researchers of what the consumers expected. All the respective consumers of pharmaceutical services were asked the same questions in the same order, because the emphasis was on service provision to consumers. Furthermore, the closed ended question format of the questionnaire was used since it offered, amongst others, advantages of being easy and quick to answer, ease of comparing respondents' answers, analysis convenience, response choices making questions clearer and ease of replicating the study (Heslop, 2003) (*see* Appendix 9).

The questionnaire comprised of 15 questions, which are related to the factors influencing consumers' perceptions of service delivery, as indicated in Table 3.3 below. The questionnaire was piloted amongst post-graduate students who found that some statements where long thus needed to be more concise. The modified statements are included in the final questionnaire.

Table 3.3: Factors affecting pharmaceutical services delivery and related question-numbers in questionnaire

Factors	Question(s) number
Tangibles	1
Reliability	6, 8, 9, 10, 14
Responsiveness	5, 11
Assurance	2, 3, 4, 12, 15
Empathy	7, 13

Table 3.4 illustrates the different sample sizes for the respective participants of the questionnaire data collection strategy. The participants were purposively selected from the hospitals based on the different fields of speciality for the doctors, different units and shifts for the nurses and the different indication for medical and surgical interventions for the patients.

Table 3.4: Sample size for questionnaire

Data research strategy	Sample size
Questionnaire	40 Patients
	15 Nurses
	10 Doctors

The pharmacists' abilities to perform the services they offer (reliability), to be knowledgeable and to inspire confidence and trust (assurance) emerged as the factors against which their professional aver were adjudicated. As such more questions were assigned to these factors in the questionnaire. The factors dealing with the structural elements (security and access, and storage space) were omitted from the questionnaire because their importance was established in the previous section

3.4   RESEARCH DATA ANALYSIS

This part of the research is as important as any other, if not more so. It is by transforming collected data into units or themes that make sense that the purpose of the research will be appreciated. During this research project, the work environment life of some participants was studied as they provided services on one hand and that of others as they consumed such services. Clearly analysing social life can be a complex activity, but then there are several approaches and procedures in the qualitative research method that may be used for data analysis. As Punch (1998) puts it: "This variety and diversity in approaches underlines the point that there is no single right way to do qualitative data analysis; no single logical framework" (Punch, 1998).

Analysis of qualitative data is systematic, sequential, verifiable, and continuous as can be seen in Creswell's (1998) approach. He speaks of: "the researcher engaging in the

process of moving in analytic circles rather that using fixed linear approach" (Creswell, 1998). Various data collection strategies were employed as the research developed, as indicated in Figure 3.1 above. At each step data was collected, processed and resultant information fed into the next step.

The strategy of data analysis that was employed was a thematic analysis based on the questions asked during the interviews with the managers and in the focus group discussions

3.4.1 Verification and trustworthiness procedures

Qualitative research is often criticised for its seeming lack of objectivity, that it is value, time and context bound (Denzin and Lincoln, 2001). Such criticism is derived from the positivistic paradigm's judgement of research quality based on internal and external validity, reliability and objectivity. It would be improper though to examine rigour in one paradigm (qualitative research) by applying criteria meant for assessment in another paradigm (quantitative research) (Lincoln et al 1985), for the reason that those criteria will be prejudiced in favour of the research tradition that created them (Morgan, 1983). Creswell (1998) proposed eight verification procedures for qualitative research and further recommended that researchers engage in at least two to emphasise the objectivity of their research. Prolonged engagement and persistent observation, triangulation, and member checks are three procedures that were used to verify the trustworthiness of this research (Creswell, 1998).

3.4.1.1 Prolonged engagement and persistent observation

This entails working with the subjects of the research in their natural setting, day in and day out, for extended periods of time. The researcher becomes a participant observer, as he learns the culture of and builds a trust relationship with the participants. Given the time spent with the participants in their work environment, misrepresentation of information or distortion of facts was avoided.

For this research, the researcher initially attended work sessions at least once a week in a chosen hospital to gain familiarity with the environment. Thereafter he spent five days a

36

week, as part of the personnel for a period of 3 months. This ensured that he gained the necessary information whilst being part of the team.

3.4.1.2   Triangulation

This refers to the utilisation of multiple methods to substantiate evidence obtained on a theme. In this research project five methods were used, see Figure 3.1 above.

3.4.1.3   Member checks

This procedure involves seeking confirmation from participants as to what the researcher captured to be a true and accurate account of what they said. This procedure was engaged in prior to proceeding to the next data collection stage so as to ensure that the previous data fed into the next stage of data collection.

Chapter 4

Results:

Presentation and Discussions

In this study, the factors influencing pharmaceutical services and their relation to quality pharmaceutical service delivery in a private health sector provider group in the Western Cape were studied. Four private hospital pharmacies were sampled. In addition to a period of participant observation by the researcher, interviews were conducted with pharmacy managers, focus group discussions with pharmacists from each of the pharmacies and the opinions of doctors, nurses and patients were sought using questionnaires.

4.1. OBSERVATIONS

4.1.1 The initial visits

A visit by the researcher to one of the sites included in the research project initiated the observations. The intention of the visit was to introduce the researcher, clarify the purpose of the research to those who were to participate and significantly, have an eyewitness version of the set-up and what was happening at the site. Management would have primed the staff about the research, however, since the researcher was an outsider attempting to learn about the culture of how services are rendered, this visit was necessary to establish a trust relationship from the onset. Observations conducted during that initial visit were unstructured because the idea was to absorb as much as possible without being prescriptive. Visits were also undertaken at the other sites.

The observations were meant to note both structural and process elements that are necessary for providing pharmaceutical services. It was noticeable that the list of factors mentioned in literature, as influencing consumers' perceptions of service delivery was not complete for this project. Accordingly, two more factors were included in order to facilitate discussions, especially related to structural elements, these are access and security, and storage space. As far as structural elements are concerned, the researcher's observations concurred with what the pharmacy managers mentioned when answering questions during the interviews on their facilities' infrastructures. It appeared that even though structural limitations exist, they were not particularly hindering the facilities' efforts to provide services. More than anything else, it appeared that infrastructure was important as a platform for service delivery because the level of consistency amongst the

pharmacy managers' responses, suggests that differences in size and design do not matter.

4.1.2   Participant observations

As follow-on to the initial visits, the researcher spent approximately 400 hours working in one of the facilities as a participant observer. Working 8-hour shifts five days a week just like the rest of the workers at the facility covered the 400 hours. As such, the researcher spent approximately 6 weeks at the facility, immersed in service provision as rendered at the particular facility. It was during this period mainly that the process elements that are necessary for providing pharmaceutical services were noted. Again, the researcher's observations are more or less similar to what the pharmacy managers and pharmacists highlighted during their interviews and focus group discussions, respectively. A significant observation however was that pharmacists were, for the most part, working behind the scenes. They virtually had no contact with service consumers, except in the case of patients, when they collect their discharge medicines on their way out because they could not wait for those medicines to be delivered to the wards. However, a system was being tried out were patients would be required to collect their discharge medicines from the pharmacy. Cooperation with nurses involved clarification of a written drug prescription, informing them of an expired prescription, highlighting a different drug name to the one written on the prescription chart, or when nurses come to either drop or collect an urgently needed drug order. Not much was different to collaboration with prescribing medical practitioners. Such collaboration, largely involved a telephone call to clarify a prescription, to request that a non-formulary drug be substituted with one kept by the pharmacy and occasionally the medical practitioners would ask for prices of drugs from the pharmacy.

These observations were pointed out and formed the basis of focus group discussions with pharmacists. It was clear that whilst the pharmacists and pharmacy managers were aware of the pharmaceutical care concept, they did not apply it as much as they could in their respective facilities.

4.1.2.1   Verification and trustworthiness procedures

4.1.2.1.1   Prolonged engagement and persistent observation

The knowledge that the researcher gained was from exposure to the work environment in one of the research sites. The researcher was in a unique position to observe on an on-going basis the proceedings at the work place.

4.2.   ANALYSIS OF INTERVIEWS WITH PHARMACY MANAGERS

Verbatim transcription of tape-recorded interviews conducted with four pharmacy managers produced 58 pages of 1.5-spaced text (*see* Appendix 4). The strategy of data analysis that was employed was a thematic analysis based on the questions asked during the interviews with the managers and in the focus group discussions.

4.2.1   Description

Description is an account that stays close to data as originally recorded, making it feasible to reduce large interview material into concise text. This then provides the basis for further data analysis. The pharmacy managers' interview text was described under headings of factors that influence how consumers experience pharmacy services, as used in the interviews.

4.2.1.1.   Tangibles – The infrastructure and availability of pharmaceuticals

Of the four pharmacy managers interviewed only two agreed that their pharmacy layouts permit logical flow of work. In one of these two, pharmacy D, apparently all pharmacy personnel contributed in rearranging the pharmacy layout to suit them. Layouts of the other two, pharmacies B and C, do not permit logical flow of work due to structural constraints. Pharmacy C is a bit small, although the alphabetical arrangement of stock on shelves does assist in the logical flow of work. In the case of pharmacy B, which is built on two floors, the reason why flow of work is not logical is that surgicals and ethicals are located on separate floors, the ground and first floors respectively. However, the workflow on the separate floors themselves is logical.

As far as easy access to all items for staff is concerned, frequent-use items are less than an arm's length away from the point of dispensing in pharmacies A, B and D. In pharmacy C they are not since they are placed alphabetically and depending on the name of the item, they may be farther than an arm's length. All items in need are equal to or less than five walking steps away from area of dispensing in pharmacies B and D. In pharmacy A, ease of access to all items holds only for the ethicals but not always for surgicals. This is because of space limitations in the section where surgicals are kept.

There is room for all staff members in the dispensary of all but pharmacy C that has a small area. Pharmacies do not carry too much stock because of space limitation and advantageously this allows room for all the stock in the dispensary.

Pharmacies B and D are easily cleanable whereas pharmacy C is not because it is small and the flooring is old. In pharmacy B cleaning the floors is a problem. They are kept clean by being swept everyday and conditioned twice a year. The surgicals' shelves are cleaned once a month, but ethicals' shelves are done at convenient times.

All the pharmacies have the capacity that allows for effective communication because they have telephones, facsimile (fax) machines, photocopier machines, computers and printing machines. Noise levels are sufficiently low. However a printer machine in pharmacy D makes a noise, which is not loud but irritating.

Stock control is done according to strict company procedures. It is procured from approved suppliers only using an auto-order computer system, even though it not being fully functional yet, otherwise telephonic orders are placed. In pharmacy A the storeman counts the surgicals and vacoliters stock once a week and orders new stock according to its movement. Pharmacists replace ethicals on a daily basis to the suggested stock levels unless the movement in stock increases, in which case more stock will be ordered or vice versa. The pharmacists in pharmacy A conceded that they do not have maximum/minimum stock levels on their ethical stock, but that they just replace based on a "feel" which is an estimate based on stock movement. It was also difficult to have minimum/maximum stock levels in pharmacy C, which operates both as a hospital and retail pharmacy. In case of pharmacy D though, minimum/maximum stock levels ordering system applies. In the event of items being out-of-stock the pharmacists source it

from an alternative supplier, or from other hospitals within the group, failing which the prescribing doctor will be asked to prescribe a substitute item, if applicable. Of paramount importance is that the client will receive a service and especially the end user, the patient will receive treatment. Expired or damaged stock is disposed of in accordance with company protocol and the Medicines and Related Substances Amendment Act 90 of 1997.

There is no system at the pharmacies to monitor performance of suppliers. However, suppliers' performance is analysed on an annual basis by the group's head office and input from individual pharmacies is sought with regards to suppliers' performance. Another explanation for lack of a monitoring is that suppliers do deliver on their part.

4.2.1.2. Access and security

Except for pharmacy C the other three pharmacies have effective security systems in place to ensure that only authorised persons have access to the dispensary. These systems entail lockable doors whose keys are kept by pharmacists only and doors that require access codes, which are known to the pharmacists. This code is changed regularly in the case of pharmacy D. Pharmacy C that has an interface between hospital and retail pharmacy attributes the lack of effective security system to the dispensary layout. A sign that reads "Authorised Persons Only" is the only measure in place. Apparently other hospital staff members, especially nursing staff, walk through the dispensary to collect items from the ordering clerk whose office is situated behind the dispensary.

All the pharmacies comply with the legal requirements for control of access to different schedules of medicines. Schedule 6 medicines and above are kept in locked cupboards and their movements are recorded in registers. Only pharmacists keep the scheduled drugs' cupboard keys.

As far as workplace safety is concerned, there is a health and safety committee in each of the hospitals and pharmacies have representatives on these committees. Registered nurses, who oversee health and safety in general, from structural to environmental matters, head these committees. They inspect the facilities on a regular basis. Employees have also received safety booklets, which outline the company's safety protocols.

43

4.2.1.3   Storage space

There is adequate storage space for stock received in all the pharmacies except for pharmacy C because it is too small to accommodate stock when orders are big. Thermolabile pharmaceuticals are stored in refrigerators, equipped with maximum/minimum thermometers, capable of storing products between 2°C - 8°C and committed to storage of such thermolabile pharmaceuticals only, except in case of pharmacy B, which is in the process of securing a thermometer. The temperature in the refrigerators is checked and recorded everyday. No method is used to ensure that the refrigerator is cleaned, defrosted and checked periodically by a responsible person in pharmacies A and B. In pharmacy A it is done apparently before they get an inspection from the pharmacy council whereas in pharmacy B, it is something that hardly crosses their minds. In pharmacy D, it is done every month when stock is counted.

4.2.1.4   Reliability – the ability to perform the services offered

The pharmacy managers' work experience for the company ranges from 18 months to 3 years. They all enjoy being pharmacists, as well as the varied nature of their work, from administrative tasks, financial management, stock control, human resource management and dispensing, to the professional interaction and friendliness amongst colleagues and hospital staff members and working with people.

Challenges of working in their respective settings also vary. These include, according to pharmacy A manager, ensuring that the other units in the hospital operate at the same level of strict ethical, moral and friendliness standards that the pharmacy demands.
According to pharmacy B manager challenges are to be able to understand and manage all protocols that the company has put in place. That is so because the company is such an organised and well-run machine in terms of controls and protocols that if these are implemented properly it will be a superb system.
Pharmacy C manager considers the rigid system, especially for pharmacy managers, of submitting reports and sticking to deadlines, as challenges whereas doctors' preferences of pharmaceutical products are the challenges facing the pharmacy D manager. The manager has to ensure that the hospital's formulary of pharmaceutical and surgical

products is maintained and thus has to persuade sometimes reluctant doctors not to prescribe particular items.

Descriptions of services that pharmacy managers render as individuals entail management of stock as the prime service according to pharmacy B manager because that will ensure availability of stock for doctors and surgeons to use and that a huge percentage of the revenue and margin required for the existence of the hospital is in the pharmacy. According to pharmacy A manager, consistent and ethical service is uppermost. In the pharmacy they maintain certain standards, which they would like the whole hospital to uphold as well. Pharmacy C manager regards compliance with all the requirements of the pharmacy manager's position and providing to the best of his ability as the pinnacle of providing a service. Pharmacy D manager regards the energy she puts into her work, which will influence others positively along with meeting her joint performance management targets as reflective of the service she provides.

The pharmacy staff and pharmacists follow specific written standard operating procedures concerning their day-to-day duties. They also have joint performance management documents, which are signed agreements between staff and management to inform them of what their job descriptions are as well as what is expected of them so that they know what they are measured on. These documents are reviewed on a regular basis.

Management styles differ amongst the pharmacy managers. Pharmacy A manager describes her style as: "a little authoritative but quite consultative," because she wants things to be done correctly. Pharmacy B manager describes his as follows: "I'll show you how to do it," rather than "I'll tell you how to do it," type. Apparently he is not a dictatorial manager but neither is he good at delegating and tends to want to do lots of things himself. Pharmacy C manager said that he has been told, during exit interviews with pharmacists who terminated their work contracts at the pharmacy he manages, that his management style is "too soft". "I drive from the back" is how pharmacy D manager describes her management style. According to her, it may not necessarily be a good way but her staff members are happy.

The range of activities in a typical day for pharmacy managers is similar across the pharmacies. They include, and not necessarily in order of priority, human resource

management, dispensing of prescriptions, replacing stock on the emergency cupboard, ordering stock, compiling reports, and attending meetings.

With regards to their interpersonal communication skills, the pharmacy managers' comments were varied. The manager of pharmacy A commented that, whilst it is a difficult question, she understands herself and thinks that her skills are pretty good; she speaks to her staff members individually or in a group. She thinks she is 'pretty friendly' but also quite demanding as well – authoritative. Pharmacy B's manager thinks his skills are very good, that he communicates plus gets on well with people and he has lots of patience, which compensates for his lack in delegating. The manager of pharmacy C considers his interpersonal communication skills as one of his weak points for which he has been criticised before. Apparently, he does not communicate well and tends to procrastinate. However, he reckons that given the set-up that he works in, where there are communication problems between pharmacy and nursing staff, and characterised by a high turnover of pharmacists, he is still there because he is coping. He has adapted to the situation by being proactive in his communication and that has led to less conflict between pharmacy and nursing staff. Pharmacy D's manager deems her interpersonal communication skills to be clear, consistent and constant. She ensures that she does not send out different messages in her communication and is professional all the time. It is important for her to understand the person that one is working with and her staff members appreciate that. She utilises the management support in terms of documents, protocols and disciplinary procedures in her communication.

4.2.1.5   Responsiveness – willingness to assist clients/customers

Pharmacy managers explained how they ensured that their clients received service that satisfied them by categorising such clients. The manager of pharmacy B agreed that they do not really have an overlap with inpatients in that they dispense pharmaceuticals to nursing staff who in turn issue to patients. Sometimes they dispense to few discharged patients who pass by the pharmacy to collect their take-home medicines. They are trying to introduce a system whereby all discharged patients would pass by the pharmacy to collect their medicines during pharmacy hours. As for patients who are issued with their discharge (take home) medicines whilst in the wards, a pharmacy service card or call card

is included which states the name of the dispensing pharmacist, the pharmacy telephone number and the patient's hospital admission number. That information can be used by the patient should they have any query relating to their medication dosages, interactions, side effects or to seek advice once they are home. Such a set-up also applies in case of pharmacy A.

As for doctors, who are mostly in theatre, there is a hatch between theatre and pharmacy A through which communication is possible. Thus, they communicate as often as necessary. The pharmacy A manager talks to all nurses in charge of wards every morning during her ward rounds and subsequently during meetings that are held once a month. It is at such meetings that any dissatisfaction with the service provided can be communicated. Other than the communication, pharmacy also ensures that patients' prescriptions medicines and surgical products are delivered to the wards on the hour, as well as to make certain that ward stock is delivered same day during the same part of the day, i.e. morning orders will be delivered on the same day before lunch. They also measure their service levels to wards, which are calculated by capturing the number of line items ordered versus the number of line items issued. Service levels are around 96% - 97% for pharmacy, A which is a good indication of their service levels to the wards.

Drug company representatives are generally allowed to consult with pharmacy staff after 14H00 because of the work pressure that the pharmacy personnel are under.

Pharmacy B's manager emphasised the importance of adhering to protocol and standard operating practices. He reckons that doing that should ensure that a proper service is rendered. He also keeps his ear to the ground for complaints filtering through from ward secretaries, unit managers or billing clerks about the dissatisfaction voiced by any client. He would then follow up such complaint by addressing the pharmacy personnel involved and remedy the situation as it arises. He draws a lot from his experience working in retail pharmacy and is aware of the so-called golden moment, or first impression, whereby the impact created during that moment is sure to last. As such he sets a good example to other pharmacy personnel by dealing with clients in a manner that leaves a good impression.

47

Pharmacy C, having an interface of hospital and retail clients, is unique amongst the pharmacies sampled. One of the paramount elements here is that retail clients should not wait too long for service, lest they get irritated, become impatient and walk out of the pharmacy. To curb such a situation the pharmacy installed an additional computer workstation to cope with the flow of retail patients. Also a service that is offered in the retail side is that if a particular medication is out of stock at a particular time, the pharmacy offers to order and deliver it to the customer. As for inpatients, they also get a speedy service, ensuring that they get correct medication made possible by a system that is in place to double check every dispensed prescription before it is delivered to the wards. With doctors a line of communication is kept open at all times. The pharmacy personnel inform them of any formulary changes and get them to comply with the formulary standards as set by the company. Even though the Medicines and Related Substances Amendment Act 90 of 1997 allows pharmacists to substitute prescribed drugs, pharmacists still inform the prescribing doctor first, out of courteousness.

The manager of pharmacy D relies on asking clients if they are satisfied with the service provided. That will ensure that the end results are positive.

Of the features that impact negatively on clients, pharmacies B and D mentioned lack of contact with patients. Although both managers agreed that it would be of benefit to the pharmacy, they nonetheless believed that resources restrained them from offering the service. Pharmacy A's manager regarded a lack of retail pharmacy service as a problem, although not really of much impact. For the manager of pharmacy C, extended waiting times for either the hospital or retail clients during busy times impacts negatively on the clients.

As far as the turnaround time for ward prescription charts is concerned, pharmacies A, B and D endeavour to deliver on the hour. This time varies though and may be anytime between 61 minutes to 90 minutes in the case of pharmacy A, and in the case of pharmacy B, it may be up to 120 minutes. Pharmacy D has devised a system that helps them stick to the hourly turnaround time. This system entails placing scripts in a box with shelves bearing consecutive hourly periods. It allows for scripts to be placed in shelves that correspond to times that scripts arrived in the pharmacy. In that way scripts are

processed on the hour. Pharmacy C tries to process scripts of inpatients every 30 minutes, and those of the retail patients are processed in lesser time.

There is a system for monitoring performance of different facilities with regards to responsiveness. In pharmacies A, B and C this system is in the form of a delivery/receipt book, which is placed in the wards. The date, patient's name and admission number are written in this book and when the person responsible to fetch or return scripts, referred to as the runner, goes on a ward round the related time is then included. This is a record of when the scripts were collected and returned. It is then used to monitor performance of pharmacies with regards to turnaround time. Pharmacy D however relies on the system of the box with time slots to self-monitor their performance. Mentioned also as a system of self-monitoring, is customer service levels, which measures how many line items are ordered against how many are issued. This is calculated as a percentage at the end of the month. Pharmacy D aims for 95%.

The pharmacy managers employ different methods to address motivation levels of staff members. Pharmacy A's manager thinks there is a certain amount of self-motivation that is called for in adults of which her staff members are. Other than that, every now and then she brings cake to share with them or they go out for lunch. Staff members are congratulated or thank for doing well to reinforce positive behaviour. When negative behaviour is noticed, a cooling off period is allowed before it is addressed. There is also a system of rotating tasks for billing clerks, who other than capturing invoices are allowed to pick ward stock. At pharmacies A, B, and D weekly meetings are held where staff members may raise any grievances that they may have. During these meetings, pharmacy B's staff may also be complemented on anything they need to be complemented on. They are also afforded extra time off during the month following stock-takes when they stayed late in the evenings. They also go out for meals. At pharmacy C, they have an appraisal system were the manager meets staff members on a one-on-one basis to talk about various issues. He believes that this helps since staff members, especially front shop assistants, have been working at the pharmacy for a long time. However, he mentions that the turnover rate of pharmacists has been high and attributes two possible reasons to this. The first reason being that of the communication problem between pharmacy and nursing

49

and apparently he has suggested to the hospital manager to get someone in from outside, perhaps a motivational speaker, to talk to the people involved. This has not happened yet. The second reason for the high turnover rate of pharmacists may be their remuneration packages, which might demotivate them and they leave as soon as they get a better offer from somewhere else. Other than grievances raised during weekly meetings at pharmacy D, outside speakers are also invited to give talks. As such that time is used to learn, to gain experience when it comes to personal skills, life skills training and for their own pharmacy house keeping. Employee of the month award is another innovation that the pharmacy manager has implemented to address the staff members motivation levels. The beneficiary of the award receives a certificate, to be displayed for the month, plus a R50 gift voucher. This is awarded to the staff member voted for by colleagues as having performed extra special that month.

4.2.1.6. Assurance – ability of the service provider to be knowledgeable and to inspire confidence and trust

Two of the four pharmacy managers interviewed (pharmacies A and B) said that they are not involved in any continuing professional development programmes. On the other hand pharmacy D's manager, who stated that he was involved indicated that the courses she attended related to management skills training, like disciplinary and advanced disciplinary process skills, recruitment, and are not necessarily related to pharmaceuticals. The manager of pharmacy C said he occasionally attended a programme organised by the pharmaceutical society or by one of the pharmaceutical companies. He even suggested a system be put in place that will oblige pharmacists to attend such programmes.

On what ways they have of knowing that clients are satisfied with the service that they offer, the manager of pharmacy A indicated that she relies on the service levels to the wards, which measure how well they are supplying stock to the wards. Other than that she listens for complaints, which will be an indication of dissatisfaction on the part of the clients. The manager of pharmacy B talks to patients when they collect their discharge medicines. Any concerns will be addressed then. There is also the pharmacy service card, which bears the name of the dispensing pharmacist, hospital telephone number and the

patient's admission number. The patient can use this card to raise any concern after discharge. At pharmacy C there is no system in place. They also used the pharmacy service card, but that was not sustained. Pharmacy D relies on close verbal communication with the nursing personnel in the wards. The pharmacy manager meets with the nurses regularly to discuss pharmacy and nursing related issues. There is no system of knowing if patients are satisfied with the service offered.

Pharmacy managers at pharmacies A and B do not know how patients are made aware of their rights at their facilities, whereas pharmacy C's manager, at all times informs the patients of the option of generic medicines which they may choose. This option is also communicated to pharmacy D patients through the use of pamphlets.

According to the understanding of pharmacy A's manager, a quality service as envisaged by the company, means that the customer comes first, (and) that the customer gets what the customer wants. For the manager of pharmacy B it means the right medicine at the right time to the right patient at the right price, quickly and they must have recourse should they be unhappy. It also means that correct standard operating practices must be followed. The patient must see a personal interest in them by the staff other than the health care. Pharmacy C's manager understands it to be a service that satisfies the customer and ensures that they get the correct medication on time.

Although the pharmacy manager at pharmacy A admits that the effectiveness of the system is based on their feelings and perceptions because there is no means of measuring it, she also points out that the service providers, especially in pharmacy contribute to its effectiveness. No clear indications of what makes the present system effective was given by both pharmacy B and C's managers. Pharmacy C's manager conceded that at the moment the system was not as effective as they would like it to be ensure that patients receive quality service because of not having ward rounds.

The essential elements of providing a pharmaceutical service according to the manager of pharmacy A entails ensuring that the client receives what they need in excellent quality, in the required quantity, at an affordable price and preferable with a smile. The manager of pharmacy B emphasises the need for highly ethical, trained or willing to be trained staff, which are prepared to go the extra mile. Pharmacy C's manager highlighted the

51

assurance of the patient receiving the pharmaceutical service that satisfies them. The manager of pharmacy D mentioned dispensing of medication – correct, accurate, and with patient oriented counselling. Also important is that the nurses receive their stock on time and continuing education relating to medicines, and ensuring that the doctors receive quality stock. There are also the regular meetings with the pharmaceutical company representatives. As such the pharmaceutical service that pharmacy D provides is 4 fold according to the pharmacy manager.

The written information available for locum pharmacists, in the form of standard operating procedures (SOPs), needs to be updated in pharmacies A, B and C. However, pharmacy A's manager indicated that pharmacy A has a permanent locum who has written up in her own book what she needs to do in order to operate in the facility. Pharmacy B's manager stated that the SOPs are electronically filed and would be a daunting task for a locum to try to read through. He thinks teaching from other staff members was more practical. Pharmacy C only SOPs for the pharmacy are available, other than that the locum is informed by word of mouth. Pharmacy D manager admitted to the availability of SOPs that will allow a locum pharmacist to operate in that facility.

4.2.1.7 Empathy – ability to care and display compassion towards clients

Pharmacists at pharmacy A are very seldom called on to counsel patients because most of their inpatients are on bedrest post-surgery. Those discharged are counselled in an open area. However, the manager's office may be used as a private counselling area. Pharmacy B has a semi-private area outside the dispensary for counselling patients. On the retail side, pharmacy C has a private area for counselling patients. Pharmacy D's manager indicated that they do not have a private area for counselling patients because they never do counselling, not even to patients who are discharged going home. The nurses do patient counselling in the wards.

Pharmacies A and B issue the pharmacy service cards to patients with their discharge medicines and these cards may then be used by the patients to phone in to voice their dissatisfaction with the service provided. They can also use these cards to phone in to have their questions, regarding their prescribed medication once thy have been

discharged, addressed. Pharmacy C relies on the feedback that they receive from quality questionnaires that are completed by inpatients on leaving the hospital. Retail patients may use the telephone number on the medicine label to have their questions answered with regards to their prescribed medicines. Pharmacy D sends out surveys to doctors as their clients twice a year to answer pharmacy-service related questions and for the doctors to voice any dissatisfaction. Other than that doctors may phone the pharmacy manager to report any incident that caused them dissatisfaction. Nursing staff as clients may compile incident reports, called yellow cards, if they are dissatisfied with pharmacy.

4.2.2   Categorisation

Categorisation is a systematic process of identifying key factors and possible relationships between them, making it possible for the sorting of text into convenient categories. According to Kvale: "categories can be developed in advance or they can arise *ad hoc* during analysis" (Kvale, 1996). From the assessment of the managers' interviews, issues that emerged with consistency were discussed under categories that were developed in advance. These issues are regarded by the managers as necessary requirements for quality service delivery. As far as the pharmacy infrastructure and availability of pharmaceuticals are concerned, the managers agreed that there needs to be logical work flow that allows easy access to items, enough room for staff members and stock, stock procurement and control procedures, effective communication infrastructure, supplier performance monitoring and dealing with out of stock situations, and that the pharmacy should be easily cleanable. Regarding access and security to the pharmacy, the managers highlighted the security systems that are in place that ensures access of authorised persons into the pharmacy, control of access to scheduled substances and health and safety procedures. As for the storage space in the pharmacy, the managers agreed that the storage space does accommodate the received stock; the thermolabile pharmaceuticals are kept at temperatures of 2°– 8°C in a committed refrigerator; disposal of damaged / expired stock was

Figure 4.1 affords a different and concise depiction of these expediently referred to "issues that emerged with consistency from pharmacy managers' interviews" - storage

space, access and security, and tangibles, highlighting their level of availability in the respective facilities.

Figure 4.1: Issues that emerged with uniformity from pharmacy managers' interviews
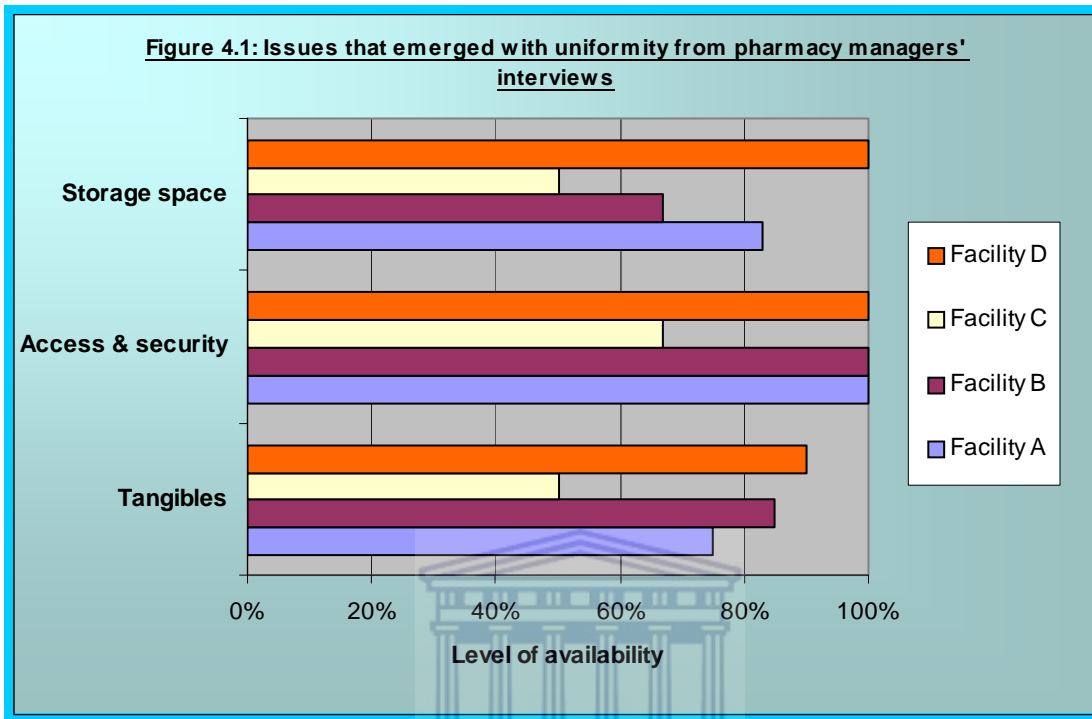
4.2.2.1 Issues that need exploration that emerged from pharmacy managers' interviews

A second category emerged from categorisation of the pharmacy managers' interviews. With these issues, there was no consistency in what the pharmacy managers said and they were also not amenable to categorisation similar to the "consistent" issues. They were thus conveniently referred to as "issues that need exploration". As such, they will be explored further in the next data collection phase. These were reliability, responsiveness, assurance, and empathy. To facilitate exploration of these issues in the next data collection stage, *ad hoc* categories were further developed *viz.* job satisfaction, essential elements of quality services, challenges, client satisfaction, continuing professional development, management style, turnaround time, and interpersonal communication style.

4.2.2.1.1 Job satisfaction

A necessary feature of service provision is that providers be satisfied with what they are offering. This instils a sense of conviction rather than a sense of duty in performing the job at hand. The pharmacy managers expressed, in one way or another that they enjoyed what they were doing. "I love being a pharmacist, I find it always interesting always new and I like being occupied," was what one of them said.

It is imperative to establish what the pharmacists' perceptions are of their jobs, just like it was ascertained with the managers, because they are the ones who are at the frontline of providing the service everyday.

4.2.2.1.2 Essential elements of quality service

Pharmacy managers mentioned different elements as being essential for quality service. "You need highly ethical staff, who know their job or are willing to learn," said one manager. "To ensure that your patients have what they need," said the other manager. Still the other said that, "dispensing of medication, but the correct dispensing, dispensing with counselling," is an essential element of quality service.

The importance of establishing what pharmacists regard as essential elements of delivering quality pharmaceutical services is that these elements are at the core of the service that they provide. Also knowing what these are will differentiate between "any service" and quality service.

4.2.2.1.3 Challenges of working in a private hospital pharmacy

It is evident from what pharmacy managers have said that it was fundamental that infrastructure be in place to allow for service provision. However, there are also challenges that they mentioned that might hinder their efforts towards providing quality services. One pharmacy manager mentioned, "to ensure that the hospital operates at the same level of codes that we (as pharmacy) demand, that I find difficult". The other manager mentioned, referring to the company that, "one finds that they have a very rigid system, a rigid system for reporting, stick to times, that makes it a bit difficult". Still the other mentioned that, "to be able to understand and to manage all the protocols that they

55

have put (in place) which are superb". Challenges may either be a hindrance by causing unnecessary frustrations or an inspiration to performing at optimal level. Of course, it is desirable that they be viewed as an inspiration. A starting point of dealing effectively with challenges is to recognise them as such.

4.2.2.1.4   Client satisfaction

"Client satisfaction reflects the gap between the expected service and the experience of the service from the clients' point of view" (Smith *et al* 2001). In the private healthcare sector, clients' expectations of service provision are especially high because of the relatively high health care costs involved. Thus, it is necessary that a system that assesses their level of satisfaction be in place to avoid a situation of reacting only after complaints have been lodged. Such a system will avoid a situation in which health care providers operate with a false hope that nothing will go wrong. The pharmacy managers seemed to suggest that there was no system in place for clients to voice their dissatisfaction with the service that they provided. This issue was explored with pharmacists to gain more insight of its importance in delivering quality service.

4.2.2.1.5   Continuing professional development

This issue is of particular concern since all the pharmacy managers conceded to not participating in any form of continuing professional development. As Els and du Plessis point out, "in our post-modernistic society improvements in health care have heightened the expectations that individuals have of the services they make use of. These improvements have also brought challenges to the status of professionals, who have increasingly been required to demonstrate their abilities in order to justify their position" (Els and du Plessis 2003).

The significance of continuing professional development (CPD) cannot be over emphasised and needs to be inculcated in all pharmacists who want to provide quality services. It will be discussed with pharmacists to establish ways of ensuring that they appreciate its importance.

4.2.2.1.6   Management styles in respective pharmacies

Any organisation needs leadership in order for that organisation to proceed in the desirable direction. That desirable direction, in the case of pharmacies is that of providing quality services that will satisfy their clients. It is also true that one is only a leader if there are followers in the particular direction chosen by the leader. Pharmacy managers described varying leadership styles and include, "I have a little tendency to be authoritative", "I tend to want to do lots of things myself", "I've been told (*my management style*) is too soft" and "I drive from the back".

It is proper to find out from the people who are led how they perceive the leadership that should steer them in the direction of quality service provision.

4.2.2.1.7   Turnaround time of prescription charts

Turnaround time of prescription charts refers to the period it takes for a prescription chart to leave the ward, go to the pharmacy for the prescription to be filled and eventually return to the ward. Pharmacists and nurses alike agree that this time should be as short as possible. This agreement stems from an understanding of dosage when it comes to patients' prescribed treatment. It is defined as "The regimen governing the size, frequency and number of doses of a therapeutic agent to be administered to a patient". (Mosby's medical, nursing and allied health dictionary, 1990). By keeping turnaround time as short as possible, nurses are able to administer patients' treatment on scheduled times with minimum disruption to their ward routine tasks. Any delays, either by the wards in sending scripts to the pharmacy or by the pharmacy in returning them with the prescribed treatment to the wards, results in consternation on both sides, which affects the quality of their work and service to the doctors and their patients.

Whilst the managers have to ensure that they have systems in place that are supposed to keep turnaround time at a minimum, pharmacists are responsible to implement those systems. So their views will be explored to find out effectiveness of the systems.

57

4.2.2.1.8   Interpersonal communication style

The health care team is multidisciplinary. More importantly is that this team comprises of individuals from respective backgrounds and persuasion brought together apparently by the conviction to perform according to dictates of their professions. Pharmacy managers were asked to comment on their interpersonal communication skills because a pharmacist as a member of this team has an obvious crucial part to fulfil. Communication is the unique tool that offers a link to facilitate cooperation amongst the multidisciplinary team members, with patients as consumers and individual pharmacists. The managers' remarks included: "I think it's important to me because there is no way you can get your job done if you don't get buy-in from the people around you". This remark aptly emphasises the need to explore this area during the FGD with pharmacists because of their daily contact with colleagues from other professions and with patients.

4.2.3   Interpretation

The commitment of the provider group is to offer its customers quality services at all times. Hence, it strives to encourage quality awareness amongst its workers throughout the hospital. Pharmacy managers gave the impression that they are dedicated to that commitment in that their interview responses reflected an understanding of company policy and business strategy. Their individual efforts towards service provision manifest in the ways in which they manage their respective pharmacies. Those ways varied thus referred to as "issues that need further exploration" and further explored with pharmacists.

It would seem that provision of pharmaceutical services does involve both structural and process elements. Whilst the structural elements were undoubtedly agreed upon, there is a need for a common understanding of the process elements. This point further demonstrates that it is not the commitment to provide services that is lacking but rather a common approach to providing the services.

58

4.2.4   Verification and trustworthiness procedures

4.2.4.1   Member checks

After transcribing the tape recorded interviews and comprehend them, the researcher went back to seek confirmation from the managers of the correctness of the information. The managers accepted the account as true.

4.3   ANALYSIS OF PHARMACISTS' FOCUS GROUP DISCUSSIONS

4.3.1   Overall impression

A focus group discussion (FGD) was conducted lasting approximately 60 minutes with three pharmacists. Even though the arrangement was to include four pharmacists in the group discussion, only three participated, seeing that the fourth was unable to attend due to work related changes that happened at his workplace. Nonetheless, those who participated share amongst them three to twelve years' work experience as pharmacists and between two and four-and-half years experience working in pharmacies of the private health care provider group hospitals. During the discussion, initially the participants sounded apprehensive perhaps for the reason that it was the first FGD they were attending. However, as the discussion progressed, they sounded relatively relaxed yet cautious about their input. At the end of the discussion, allowance was also made for participants to add on to what was discussed after the tape recorder was switched off. Notes were taken of what was said. There was a feeling amongst the participants that whilst they are working hard at meeting the goals as set by the company, it seemed that the company moved the "goal posts" every time. They felt that there was more work coming pharmacy's way especially in the form of "paperwork" which implied less time to do pharmacy related work.

The FGD proved to be a platform for them to express themselves as they responded to the pre-arranged questions of the discussion guide. As planned, the facilitator was supposed to give a summary of the discussion at the end to ensure that the participants' ideas were captured clearly, correctly and entirely. In addition, the summation would allow participants to verify it as a true reflection of what was discussed. However, a summary

was not given due to time limitation. The pharmacists had to return to their respective posts prior to the summation of the proceedings. It was proper to adhere to the agreed time limit of 60 minutes so as to ensure that they will attend the next FGD rather than exceed the time limit and risk not having them subsequently. As such the resolution was to offer a summary at the beginning of the next focus group discussion. That would serve as a reminder for the participants of the previous discussion and act as a bridge to the follow-up discussion; it would also serve as verification and trustworthiness procedure. It was also apparent that a more meaningful summary would be possible after an opportunity to review the focus group discussion transcript.

4.3.2   A summary of the first FGD with pharmacists

Providing a pharmaceutical service in the private sector entails ensuring the availability in hospital of those products that are necessary for the improvement of patients' health and doing it as best possible. That is important because the people expecting a good service are paying for it. On the other hand quality pharmaceutical service calls to mind accuracy and efficiency in dispensing, ensuring that correct and competent service is provided at all times.

Interacting with other professionals, with patients, providing some clinical input not just dispensing and being offered an opportunity to attend courses contributes to job satisfaction amongst the pharmacists. A workplace dislike is the seeming communication barrier between nursing and pharmacy staff. This may be attributed to the fact that there is an increase in the number of nursing agency staff employed at the hospitals. "They may not be as committed to the hospital as the permanent staff," and may thus not adhere to the operational processes between pharmacy and the wards. It is this communication barrier and "the fact that private hospitals very much rely on budgets and making a profit" resulting in increased administrative work for the pharmacists, which may affect the quality of the service provided, patients' happiness and the health of the pharmacists. All this tends to shift the pharmacists' focus from "traditional" pharmacy to the business aspect.

4.3.3 Verification and trustworthiness procedures

4.3.3.1 Member checks

Prior to the commencement of the follow up FGD with the pharmacists, the researcher narrated to them information gathered from the previous discussion so as to allow them an opportunity to accept or reject it as a true or false account of what they had said. The pharmacists accepted that account as true. The follow up discussion continued and the researcher verified the information at the end of that session.

4.3.4 Points to be considered in follow up focus group discussion

The purpose of the follow up focus group discussion (FGD) was to elucidate some of the ideas that came up in the previous FGD. To facilitate this clarification process, pharmacists will be asked to elaborate on the following points:

4.3.4.1 Pharmaceutical services:
Other than ensuring availability of pharmaceuticals, what else do they do?

4.3.4.2 Communication with nurses and management:
How can they improve communication between nursing and pharmacy personnel and with pharmacy management?

4.3.4.3 Increasing paperwork:
How does the seemingly increased reporting and administrative work affect the quality of their service?

4.3.4.4 Continuing professional development:
What concrete suggestions do they have of going about continuing professional development (CPD); do they see a link between personal competence and quality service delivery?

4.3.4.5 Pharmacy management:
Do they have any input in how their pharmacies should be managed?

4.3.4.6 Future of pharmacy:
How do they anticipate the future of pharmacy in the private sector?

4.3.5   A summary of the follow up FGD

The pharmacists agreed in principle that there was more to pharmaceutical services provision than merely ensuring availability of pharmaceuticals and dispensing them. Therapeutic drug counselling, empathy, stock control, giving drug related advice and dispensing were mentioned amongst the unique expertise that pharmacists possess allowing them to give a people-centred quality service. They gave the impression that they are clued up about the concept of pharmaceutical care as an important philosophy of services that pharmacists render.

Communication is a tool that facilitates and enhances cooperation but is importantly a two way process. The apparent communication barrier between nurses and pharmacists was recognised as a challenge. Most probably, it stems from the increased employment of agency nursing staff that, in the opinion of one of the participants in the FGD, seem to lack the commitment of service provision that permanent personnel have. In addition, the increased administrative workload leaves little time for interaction between nurses and pharmacists. This is over and above the fact that pharmacists hardly get an opportunity to go on ward rounds. Part of dealing with the communication barrier challenge lies precisely in pharmacists becoming more visible in the wards interacting with nurses and patients, being available to answer medicine related queries. The ideal situation though would be to have more pharmacy personnel to help do this work as well as being in the pharmacy.

The commercial side of private hospitals brings in the business returns and it appears that it is emphasised more than the professional side of pharmacy. This slanted emphasis frustrates pharmacists in not being able to perform pharmaceutical care subsequently disadvantaging patients, nurses and doctors.

Keeping the mind active and stimulated by participating in continuing professional development is very important. However, the manner in which they go about it varies amongst the hospital pharmacies. Some pharmacy managers inform their pharmacists of the available opportunities whilst others neglect to do so. A revised notification process is needed.

Pharmacy managers welcome suggestions on how efficiency in the pharmacies can be improved so pharmacists do give input on how the pharmacy should be managed. Clinical pharmacy seems to be where the future of pharmacy in the private hospital sector lies, especially against a backdrop of recent legislative changes. Pharmacists have to adapt their practice models notwithstanding the possible resistance that they may encounter from other health care workers.

4.3.6 Interpretation

Pharmacists eloquently articulated a notion that suggests that they preferred to contribute more of their skills in providing pharmaceutical services. However, a different picture unfolds on the practice side. Their current practice model does not permit them to do so. Procuring and dispensing pharmaceuticals use up most of their time whilst the rest is used to complete administrative tasks. They did however acknowledge the need to participate in such functions as part of the pharmacists' scope of practice. However, their contention lies in management's seemingly partial degree of emphasis between the commercial and professional duties, with their own preference being on the latter. A need to change the way of practicing is unavoidable though, given the recent legislative amendments to the Medicines and Related Substances Act 101 of 1965.

They will also have to refrain from operating isolated from the rest of the health care team to overcome cooperation barriers, especially communication barriers. This is linked with their need to practice pharmaceutical care holistically and not piecemeal as the case may be currently.

Continuing professional development does happen to some extent. A concerted effort is needed especially from the individual pharmacists to participate more in order to remain in the forefront of developments in the pharmacy profession.

4.4 QUESTIONNAIRES: CUSTOMERS' PERSPECTIVE

4.4.1 Overall customers' viewpoint of pharmaceutical services

Knowledge of customers' perceptions of the services that they receive is an important step in the comprehensive pursuit for improved quality in health care. Coupled to this is

the need to differentiate between the purely clinical quality of health care and the experience of quality health care because it is particularly the experience that determines the quality of health services in general. Clinical quality, referred to as the degree to which the clinical interventions experienced by those individuals who were actually served by the health system succeeded in enhancing the quality of life enjoyed by those individuals, all other things being equal, is vital to the experience (Reinhardt, 1998).

Customers' experiences of the services provided by pharmacists were elicited by asking them to respond to statements related to factors that affect pharmaceutical services. Figure 4.2 depicts the responses as they contribute to the customers' overall perspective towards the respective factors. Overall, there was agreement amongst the customers that these factors are important in the provision of quality pharmaceutical services as shown by the substantial positive contributions of their responses. In particular, there was absolute agreement on the important role of pharmacists in the hospitals of ensuring that medicines are available at all times. With regards to the other factors, there was some uncertainty and difference of opinion amongst customers about the pharmacists' ability to perform the services offered (reliability), willingness to assist customers (responsiveness), ability to be knowledgeable and to inspire confidence and trust (assurance) and their ability to care and display compassion towards clients (empathy). By looking at the respective categories of customers' responses to individual questions on the questionnaire further elucidated the customers' viewpoints.

Fig. 4.2: Customers' viewpoint on factors affecting pharmaceutical services [N=65]
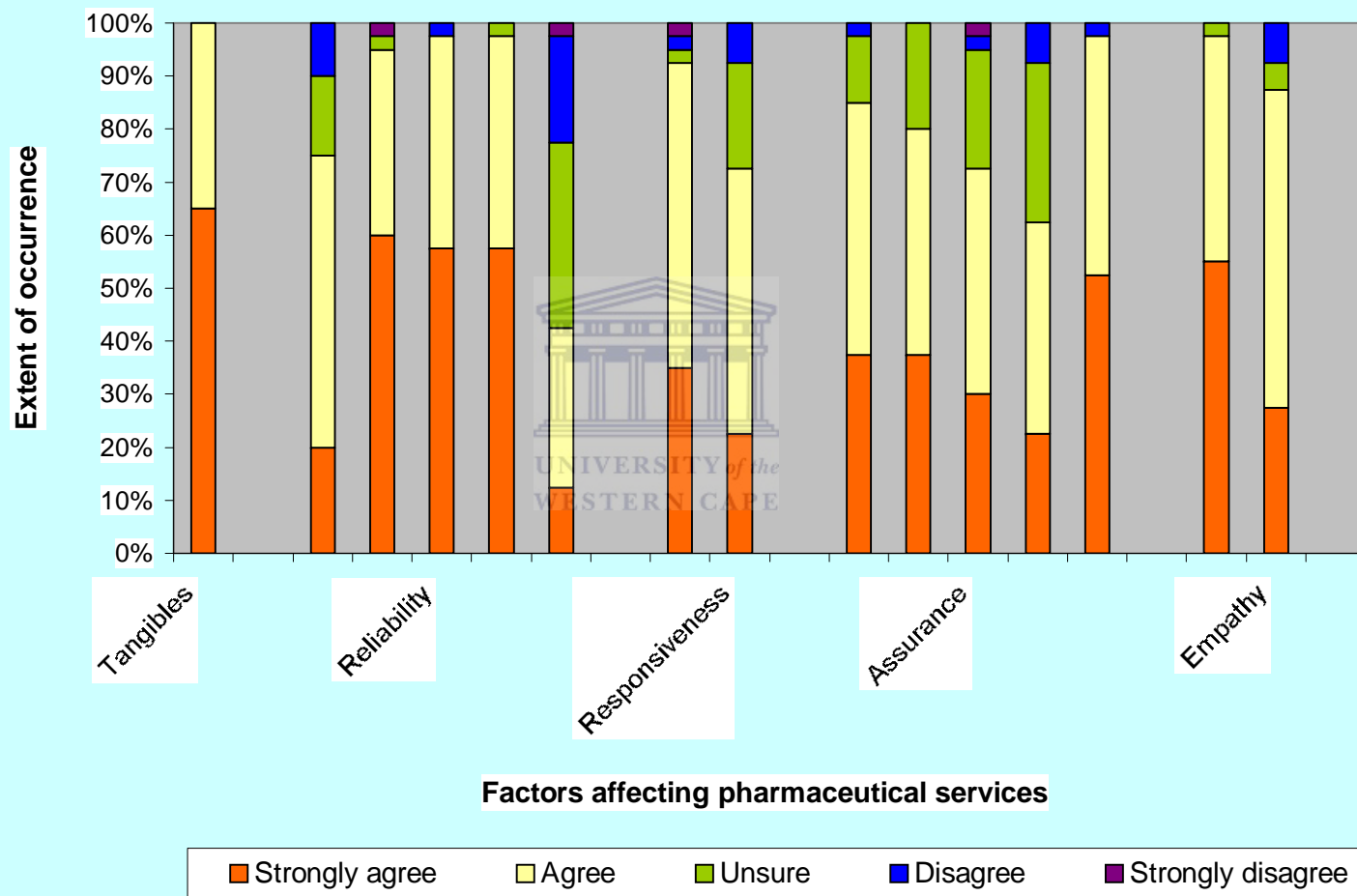
4.4.2 Nurses' notions of pharmaceutical services

Nurses are responsible for administering the treatment prescribed by doctors and dispensed by pharmacists to patients; they thus act as the link between pharmacists, doctors and patients. When the quality of pharmaceutical services is discussed it is accordingly important to obtain the nurses' views.

Figure 4.3 below depicts nurses' ideas *vis-à-vis* pharmaceutical services. It is a representation of responses to statements from the questionnaire (*see* Appendix 9) administered to the consumers of pharmaceutical services in hospitals of a group of private health care provider. Considered in conjunction with Table 3.3, they demonstrate that generally nurses gave positive responses to the statements, at the same time indicating no strong disagreement to any of the statements. The latter point implies that nurses are not the ones who contributed the "strongly disagree" responses on Figure 4.2.

Fig.4.3: Nurses' notions of pharmaceutical services [N=15]
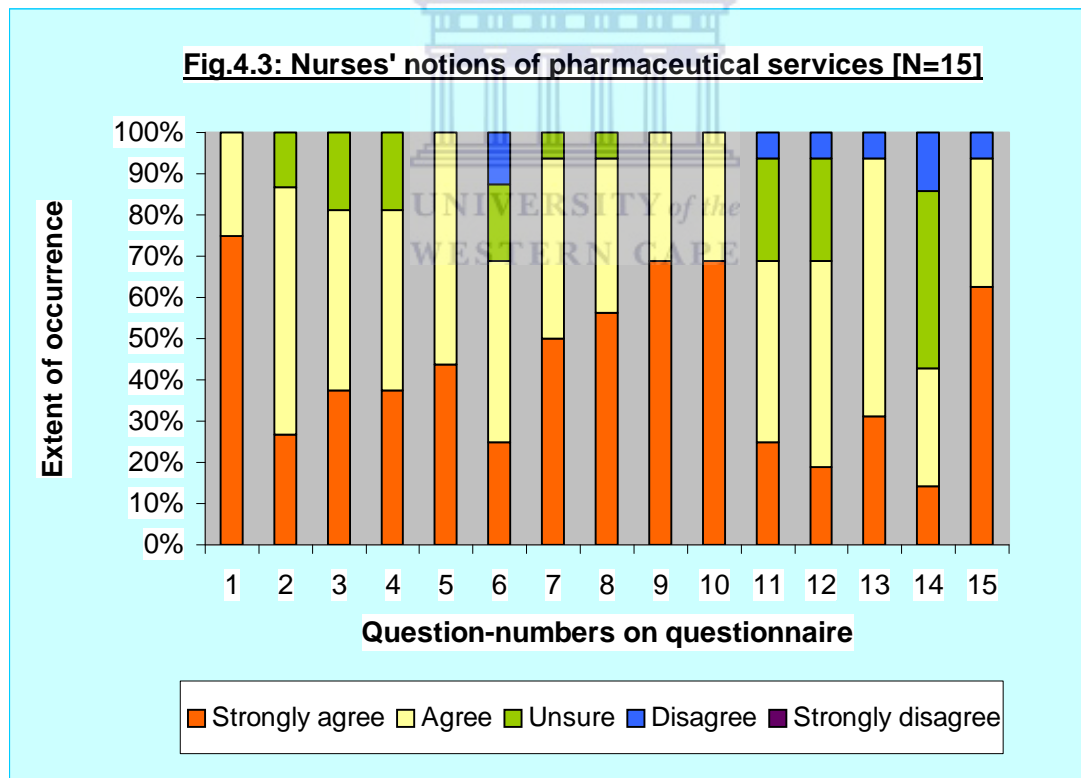
Nurses do not doubt or dispute that provision of quality pharmaceutical service entails availability of medicines (statement 1, related to tangibles) and that it calls for drug

related patient counselling, equally for inpatients (statement 5, related to responsiveness) as for discharged patients (statements 9 and 10, related to reliability).

Even though some nurses mainly gave positive responses, others either had doubts or disagreed with the other statements. By implication, some nurses have reservations with regards to pharmacists not delivering pharmaceutical services according to nurses' expectations and on time (statements 6 and 14, related to reliability), that pharmacy's services are not always efficient (statement 11, related to responsiveness) or always accurate (statement 12, related to assurance). Moreover, some nurses do not think that pharmacists always perform their service in a friendly manner (statement 13, related to empathy) or that pharmacists are a helpful resource for medicine related information (statement 15, related to assurance). Notwithstanding the general positive appreciation that nurses have of the pharmaceutical services, these doubts seriously call into question the quality of pharmaceutical services delivered by the pharmacists.

There is an uncertainty that nurses expressed, with regards to the pharmacists' capability to contribute more to patients' treatment and well being (statement 2, related to assurance), that pharmacists are better informed about medicine-related patients' rights (statement 3 related to assurance), that pharmacists should go on ward rounds to check prescription charts with the option of making suggestions related to patients' prescribed medicines (statement 4, related to assurance) and that pharmacists always provide an accurate service (statement 12, related to assurance). This uncertainty may render the pharmacists' ability to be knowledgeable and to inspire confidence and trust dubious for those nurses.

It is clear that the nurses' biggest concern is the lack of timely delivery of pharmaceutical services, understandably so because pharmaceuticals are the main components of the patients' therapy. Also, for pharmaceuticals to be effective they are to be given at certain regular times. With a concerted effort and cooperation, from both pharmacists and nurses, these concerns by nurses can be surmounted. In fact recognition of a problem area and deliberation over it is a starting point towards preventing, avoiding or overcoming any misunderstanding that it may cause. Undoubtedly, the committed participation by both

pharmacists and nurses during the research process is suggestive that they are committed to provision of quality services.

4.4.3 Patients' perceptions of pharmaceutical services

More and more, the recognition of patients' level of satisfaction with the quality of services they receive is becoming an essential aspect of quality of care. It is this satisfaction, especially with the experience of the quality of services that is predictive of future conduct such as compliance with treatment (Salomon, 1999). Any efforts intended to improve health care service provision have to consider the sensitivity of patients in this regard, because patients are the eventual and important consumers of the services.

It is pertinent to mention here that interaction between pharmacists and patients is very limited in the hospitals of the group of private health care providers. Perhaps, the perceptions expressed may be from external influences like advertising or they may be based on expectations. It is therefore necessary to bear in mind that patients' perceptions and priorities will invariably differ. Figure 4.4 will be analysed with this in mind

Fig.4.4: Patients' perceptions of pharmaceutical services [N=40]
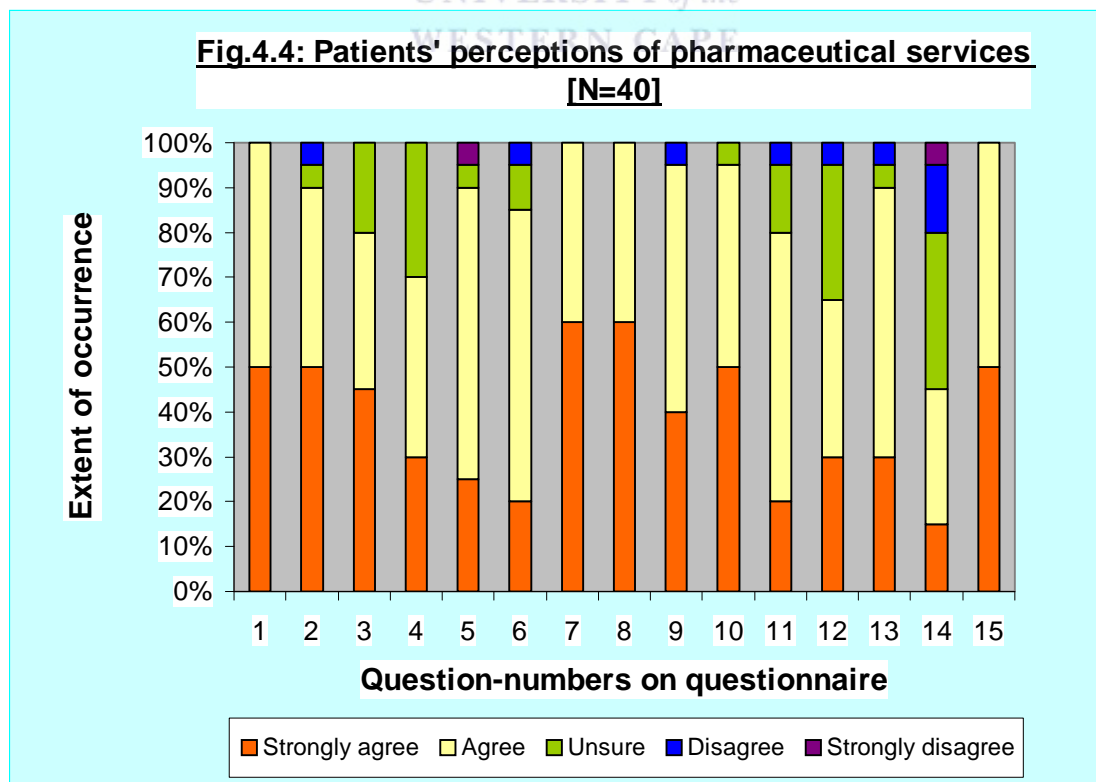
The general impression of Figure 4.4 is that patients are in agreement with the questionnaire statements. In particular, it shows congruence with regards to the essential role played by pharmacists of ensuring that medicines are available at all times in the hospital (statement 1, related to tangibles). Patients are also in total support of having means to voice their dissatisfaction with the pharmacy service provided (statement 7, related to empathy), that there should be increased cooperation amongst health care providers especially doctors, nurses and pharmacists regarding patients' medicines and treatment options (statement 8, related to reliability). Furthermore, they are in agreement that pharmacists are a helpful resource for medical related information (statement 15, related to assurance). To these patients, the pharmacists' abilities to care and display compassion towards clients and to perform the service offered, appear to be very important.

There are other patients who disagree that pharmacists can contribute more to patients' treatment and well being by doing more than just dispensing medicines (statement 2, related to assurance). Perhaps this stems from their lack of understanding of skills that pharmacists have or is based on the narrow understanding of the pharmacists' abilities, dispensing being one of them. They most probably think that dispensing is the main function of the pharmacists in the hospital, which seems to be the impression that some pharmacists create about their function, the so-called "count and pour, lick and stick" function. Others dispute the pharmacists' abilities to perform the service provided by disagreeing that pharmacists always provide a service as expected, whilst others disagree that pharmacists always deliver their service on time (statements 6 and 14, related to reliability). In fact, a few patients strongly disagreed with the latter statement. Still on the reliability factor, few patients disagree that pharmacists should inform them when they are discharged about the names of their medicines, indications, storage, how to take them, costs and possible side effects (statement 9). Nurses are the ones who give part of this information to patients when they are discharged from the wards. They might be thinking that pharmacists are infringing on the nurses' territory by taking over their function, hence the resistance. There is a link between disagreement with statement 9 and statement 5, which is related to responsiveness – willingness to assist clients. Some patients are strongly opposed to having the option of requesting pharmacists to counsel

them regarding their prescribed medication, most likely for the same reason as for statement 9.

Notwithstanding the general agreement with the statements, there is the uncertainty albeit of varying levels, that patients expressed to most of the statements. This uncertainty may be the consequence of the limited contact that pharmacists have with patients, and that hospital pharmacists have not promoted their role to the patients enough, if at all.

4.4.4   Doctors' opinions of pharmaceutical services

In private hospitals, medical practitioners are primarily responsible for admitting patients. It so happens that a patient who has a medical problem consults a doctor, in his/her consulting room, and then the doctor may take a decision to admit the patient in hospital for residential treatment. In a way, this arrangement puts the doctor overall in charge of the patient's treatment in hospital. In spite of this, the patient's treatment is a team effort, involving nurses, pharmacists and other paramedical professionals and as such every member of this multidisciplinary team is accountable for his/her actions as pertaining to the patient's treatment. So, doctors are an important part of the private hospital business set-up because they are responsible for bringing patients who are paying to be treated in hospital. The doctors are not employees of the private health care provider group *per se*, but make use of its facilities and services like the pharmaceutical services, which are paramount to the patients' treatment. It is this utilisation of facilities and services plus the fact that they are part of the business set-up that makes medical practitioners customers of the private health care provider group.

As valuable customers, the opinion of medical practitioners was requested with regards to factors affecting pharmaceutical services provided by pharmacists in hospitals of a private health care provider group. Figure 4.5 is an illustration of the responses to the questionnaire statements. The general impression created by Figure 4.5 is that of accord with the importance of the factors as expressed in the questionnaire statements. In fact there is strong agreement that pharmacists play an important role in the hospital by ensuring that medicines are available at all times (statement 1), also that when patients are discharged, pharmacists should inform them about the names of their medicines, indications, storage, how to take them, costs and possible side effects (statement 9,

related to reliability). There is also no doubt or dispute amongst the doctors that once discharged, patients should be able to contact the pharmacist on duty with queries related to their discharge medicines (statement 10, related to reliability). This stems from the assurance that pharmacists are a helpful resource for medicine related information (statement 15, related to assurance). Doctors also concur that clients should have means to voice their dissatisfaction with the pharmacy service provided. This latter point is a vital aspect to ensuring quality service provision since it serves as a feedback mechanism to the service provider.

There is least agreement amongst doctors that pharmacists provide efficient and accurate services (statements 11 and 12, related to responsiveness and assurance respectively). According to the doctors, this actually renders the pharmacists' willingness to assist clients and the pharmacists' ability to be knowledgeable, inspire confidence and trust suspicious. This suspicion is most probably related to how the service is provided rather that being related to the pharmacists' academic professional knowledge because the doctors agree that pharmacists are a helpful resource for medicine related information (statement 15, related to assurance).

Fig.4.5: Doctors' opinions on pharmaceutical services [N=10]

71
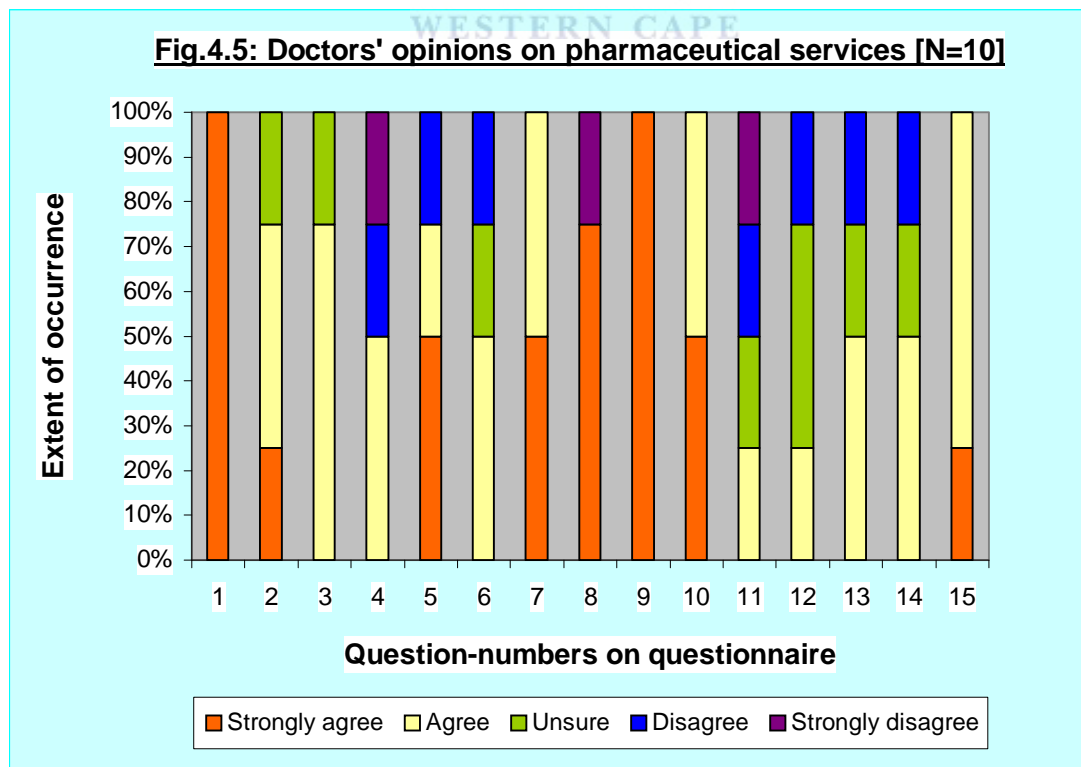
Some doctors are strongly opposed to pharmacists getting involved in the planning of the patients' treatment. They are against the ideas that pharmacists should go on ward rounds to check prescription charts with the option of making suggestions related to patients' prescribed medicines (statement 4, related to assurance) and that there should be increased cooperation amongst health care providers regarding patients' medicines and treatment options (statement 8, related to reliability). This discord, as well as that to the other statements, may emanate from the viewpoint that doctors are overall in charge of the patients' treatment and therefore prefer to solely decide on the treatment necessary for the patient.

Chapter 5

Conclusion and Recommendations

This chapter presents the lessons learned from the research, conclusions reached and recommendations to contribute towards quality pharmaceutical service improvement efforts in hospitals of a private health care provider group.

5.1   Lessons learned

Since the health care delivery sector is dynamic and that consumers and providers continue to be influence it alike, further lessons may still be inferred from the project. The following are broad lessons, not necessarily exhaustive, surmised from the research process:

- Delivery of quality health care services to its citizenry and maintenance of good health care is amongst the contentious challenges facing South Africa since the dawn of the new political dispensation. The challenge stems partly from ineffective health care delivery inherited from the previously fragmented and discriminatory race based system;

- The public and private health care delivery systems have existed side by side in South Africa for some time, with the private health care and private hospital sectors having shown steady growth over time and such growth still being considerable;

- The debate relating to the significance of the private health care sector goes as far back as the early 1990s. It is set against a backdrop of extensive resource-constraints, over-utilisation of public health care services, poverty and the fact that the country is largely inundated with a burden of communicable diseases. The existing disparity in terms of facilities, personnel and financial support between the public and private health care sectors continues to invigorate such a debate;

- Despite the fact that the state pays for about 40% of all expenditure on health care, provincial health departments and local authorities have to provide public health care services to 80% whilst the private sector provides for the remaining 20% of the population;

- Left to their own devices the private health care sector adversely affected the public health care sector as members of private "institutional" financing intermediaries, who could no longer carry on contributing financially for their medical costs to be covered, found themselves excluded by these private "institutional" financing intermediaries. As a result they relied on the already over-burdened public sector for continued medical treatment;

- One approach that government employed in order to influence private health care sector behaviour was to amend the law and then promulgate regulations of the Medical Schemes Amendment Act 62 of 2002 and the Medicines and Related Substances Amendment Act 90 of 1997.

- In view of the fact that amendments to the law, especially in terms of the Medicines and Related Substances Amendment Act 90 of 1997 and its regulations, pharmacists' practice models as well as operating practices in private hospitals and their profitability will continue to be challenged. More than ever before in South Africa, the pharmacy profession is faced with the question of whether or not its role, seen as a "distributive function" adds any value to the health care team;

- To further compound the challenges facing pharmacists and their profession, especially in the private health care hospitals, which are run along commercial lines, regulations of the new legislation expound pricing regulations, which forbid profiteering from the transaction of medicines;

- The challenge for pharmacists is to develop and expand their practice models to go beyond the so-called "count and pour, lick and stick" function so that they may earn their compensation in exchange for advice, products and professional services that are not necessarily attached to the supply of medicines *per se*. As such, the emphasis in the paradigm of pharmacy practice has to shift so as to boost the worth of the medicines and / or other treatment that patients receive.

5.2   Conclusion

Knowledge acquired from the research recognises the following factors as influencing service delivery, determines the appreciation of quality service delivery and verifies customers' anticipation with regards to services rendered. Furthermore, it assists to create a point of reference for quality service delivery in hospitals of a private health care provider group.

To identify key factors that influence pharmaceutical service delivery in a private sector hospital group.

These factors, deemed to impact on service delivery, were elicited from customers' contributions:

- Availability of pharmaceuticals as well as infrastructure to ensure procurement, save keeping and correct dispensing of pharmaceuticals

- Ability of the service provider to perform the services offered reliably

- Readiness of the service provider to assist customers with consideration

- Capacity of the service provider to be knowledgeable also to inspire confidence and trust in customers

- Ability of the service provider to care and display empathy towards customers

To establish the understanding of quality pharmaceutical service delivery in a private sector hospital group.

The following insight was elicited from pharmaceutical service providers:

- Performing one's work with passion and sincerity instead of as a contractual obligation is essential towards delivering quality pharmaceutical service

- Ethics, fluency in one's work and willingness to learn, rate as important elements of quality pharmacy services for pharmacists

- As regards challenges in the provision of quality pharmacy services, the main point was firstly to recognise challenges as such and then to use them as inspiration to perform better. Adherence to hospital protocols, rigid time frames and maintaining uniformity of standards throughout the hospital are challenges to provision of quality services.

- The level of fulfilment that customers experience when their expectations are matched by the experience of the service they received is a crucial point for quality service delivery. More importantly is for that level of fulfilment to be measurable

- The pharmacy profession is dynamic, customers' expectations change, and thus the need to continually keep abreast with developments to deliver quality services rate as impetus for continuing professional development for pharmacists.

- A leadership approach that seeks to guide others and allow them an opportunity to contribute positively and freely as professionals instead of by coercion is vital in the quest to deliver quality service

- Interaction of pharmacists and members of other health care professions involved in the multidisciplinary team is needed for the benefit of the patient. It is also needed for continued cooperation and professional development of the health care team. Good interpersonal communication style is invaluable to achieve this.
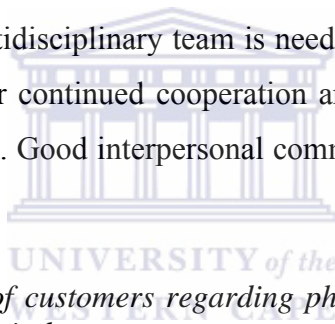
To establish the expectations of customers regarding pharmaceutical services rendered delivery in a private sector hospital group.

- Health care consumers require for treatment explained in a manner that is caring and takes into consideration their cultural background and consent.

- They also expect to be treated in a scientific approach based on expert knowledge that offers them beneficial results that exceed the risks involved in their treatment.

5.3   Recommendations

The value of the research results will only be fully appreciated by making use of the knowledge generated.

- Management should enable all pharmaceutical service providers to continually develop themselves in the profession by availing the necessary resources and encouraging them through relevant incentives.

- Management should welcome input on how to improve service provision from providers as well as consumers.
- Customers should be treated in a professional manner and allowed an opportunity to freely express any dissatisfaction without anxiety of unfair treatment.
- The outcomes of the research should be appreciated by management and communicated to the rest of the employees.
- Further research in the field of quality pharmaceutical service delivery should be encouraged.

UNIVERSITY *of the*
WESTERN CAPE

Bibliography

- Afrox Healthcare Limited. (2001). *Annual report and financial statements.* Johannesburg.

- Afrox Healthcare Limited. (2002). *Annual report and financial statements.* Johannesburg.

- Asuboteng, P., McCleary, K.J., and Swan, J.E. (1996). SERVQUAL revisited: A critical review of service quality. *A Journal of Service Marketing.* 10(6): 62-81.

- Babakus, E., and Boller, G.W. (1992). An empirical assessment of the SERVQUAL scale. *Journal of Business Research.* 24: 253-268.

- Babakus, E., and Mangold, W.G. (1992). *Adapting the SERVQUAL scale to hospital services: An empirical investigation.* Health Services Research. 26(6): 767-786.

- Bill of Rights. (1996). *The Constitution of the Republic of South Africa. Act 108 of 1996.* Government Gazette Nō. 17678. Pretoria.

- Brook, R.H., and Appel, F.A. (1973). Quality of care assessment: Choosing a method for peer review. *New England Journal of Medicine.* 288: 1323-1329.

- Brook, R.H., McGlynn, E.A., and Shekelle, P.G. (2000). Defining and measuring quality of care: a perspective from US researchers. *International Journal of Quality in Health Care.* 4: 281-295.

- Brook, R.H., Ware, J.E., and Rogers, W.H. (1983). Does free care improve adults' health? Results from a randomised controlled trial. *New England Journal of Medicine.* 309: 1426–1434.

- Brysland, A., and Curry, A. (2001). *Service improvements in public services using SERVQUAL.* Managing Service Quality. 11(6): 389-401.

- Carman, J.M. (1990). Consumer perceptions of service quality: An assessment of the SERVQUAL dimensions. *Journal of Retailing.* 66(1): 33-55.

- Chan, C., Entrekin, L., and Anderson, C. (2003). *Psychometric assessment of the perception of service quality.* Research and Practice in Human Resource Management. 11(1): 65-74.

- Chassin, M.R., Kosecoff, J., and Park, R.E. (1987.) Does inappropriate use explain geographic variations in the use of health care services? *Journal of American Medical Association.* 258: 2533–2537.

- Cheng, S., Yang, M., and Chiang, T. (2003). Patient satisfaction with and recommendation of a hospital: effects of interpersonal and technical aspects of hospital care. *International Journal for Quality in Health Care.* 15: 345-355

- Cornell, J., Goudge, J., McIntyre, D., and Mbatsha, S. (2001). *National Health Accounts: The private sector report*. Pretoria: Department of Health

- Creswell, J. W. (1998). *Qualitative inquiry and research design: Choosing among five traditions.* Thousand Oaks, London: Sage.

- De Nicola, T. (2000). Changing practice models pays dividends. *The Journal of Modern Pharmacy. 9: 9.*

- Deming, W.E. (1986). *Out of crisis. Massachusetts Institute of Technology Center for Advanced Engineering Study*. Massachusetts: Cambridge.

- Denzin, N.K., and Lincoln, Y.S. (2001). *Handbook of qualitative research*. Thousand Oaks, CA: Sage.

- Department of Health annual report 2002/2003. Pretoria. South Africa.

- Doherty, J., Thomas, S., Muirhead, D., and McIntyre, D. (2002). Health care financing and expenditure in post-apartheid South Africa, 1996/97-1998/99. Centre for Health Policy, University of Witwatersrand and Health Economics Unit, University of Cape Town.

- Dubois, R.W., Rogers, W.H. and Hoxley, J.H. (1987). Hospital inpatient mortality: is it a predictor of quality? *New England Journal of Medicine*. 317: 1674-1680.

- Els, L. and du Plessis, H. (2003). *Continuing professional development: a great big, buzzing, booming confusion?* Pharmaciae. 11: 10-11.

- Finn, D.W., and Lamb, C.W. (1991). *An evaluation of the SERVQUAL scales in a retailing setting.* Advances in Consumer Research. 18: 338-357.

- Gabbie, O., and O'Niell, M.A. (1996). *SERVQUAL and the Northern Ireland hotel sector: A comparative analysis – Part 1*. Managing Service Quality. 6(6): 25-32.

- Gaster, L. (1995). *Quality in Public Services*. Buckingham: Open University Press.

- Headley, D.E., and Miller, S.J. (1993). Measuring service quality and its relationship to future consumer behavior. *Journal of Health Care Marketing*. 13(4): 32-41.

- Hepler, D.D., and Strand, L.M. (1989). American Journal of Pharmaceutical Education. 53:7S–15S.

- Heslop, K. (2003). *How to plan and construct questionnaires*. Postgraduate and throughput programme workshop notes. Bellville: University of the Western Cape.

- Hurst, K.L., Croker, P.A., and Bell, S.K. (1994). *How about a lollipop? A peer recognition program.* Nursing Management. 25: 68-72.

- Institute of Medicine of The National Academies. (1990). *Crossing the quality chasm: The IOM Health Care Quality Initiative.*
  URL:
  http://www.iom.edu/focuson.asp?id=8089
  (Accessed 15 June 2004)

- Jiang, J.J., Klein, G., and Carr, C.L. (2002). *Measuring information system service quality: SERVQUAL from the other side*. MIS Quarterly. 26(2): 145-166.

- Jiang, J.J., Klein, G., and Crampton, S.M. (2000). *A note of SERVQUAL reliability and validity in information system service quality measurement*. Decision Science. 31(3): 725-744.

- Juran, J.M. (1989). *Juran on Leadership for Quality*. New York: Free Press

- Kaldenberg, D., Becker, B.W., Browne, B.A., and Browne, W.G. (1997). *Identifying service quality strengths and weaknesses using SERVQUAL: A study of dental services*. Health Marketing Quarterly. 15(2): 69-86.

- Katzenellenbogen, J.M., Joubert, G., and Karim, S.S.A. (1997). *Epidemiology: A manual for South Africa*. London: Oxford University Press.

- Kruger, R.A. (1998). *Focus groups: a practical guide for applied research*. New York: Sage.

- Kvale, S. (1996). *Interviews: an introduction to qualitative research interviewing*. New York: Sage.

- Lam, S.S.K., and Woo, K.S. (1997). *Measuring service quality: A test-retest reliability investigation of SERVQUAL*. Journal of Marketing Research Society. 39(2): 381-396.

- Lau, R.R., Williams, H.S., and Williams, L.C. (1982). Psychosocial problems in chronically ill children: physician concern, parent satisfaction, and the validity of medical records. *Journal of Community Health*. 7: 250-261.

- Lohr, K., Brook, R.H., and Kamberg, C. (1986). *Use of medical care in the RAND Health Insurance Experiment: diagnosis- and service-specific analyses in a randomised controlled tria*l. Medical Care. 24: S1–S87

- Mariampolski, H. (1984). *The resurgence of qualitative research*. Public Relations Journal. 40 (7): 21-23

- Mbeki, T. (2001). ANC Today. *Health for the poor is a fundamental human right*. 1: 6.
  URL:
  http://www.anc.org.za/ancdocs/anctoday/2001/at06.htm
  (Accessed 08 May 2004)

- McAlexander, J.H., Kaldenberg, D.O., and Koenig, H.F. (1994). Service quality measurement: Examination of dental practices sheds more light on the relationships between service quality, satisfaction, and purchase intentions in a health care setting. *Journal of Health Care Marketing*.   26(3): 34-40.

- Medical Schemes Amendment Act 131 of 2001. Government Gazette 22369. Pretoria.

- Medicines and Related Substances Control Amendment Act 90 of 1997. Government Gazette. Pretoria.

- Mills, C.A. (1989). *The Quality Audit. A management evaluation tool*. New York: McGraw-Hill, Inc.

- Morgan, G. (1983*)*. Exploring choice: Refraining the process of evaluation*. In: G, Morgan (ed). *Beyond method: Strategies for social research*. Beverly Hills: Sage: 392-404.

- Mosby's medical, nursing and allied health dictionary. (1990). Missouri: The CV Mosby Company.

- MRC News August (2000). *Health policy research: The 'why' and 'how' of policy change*. 31: 4.

- National Drug Policy of South Africa. (1996). Pretoria: Department of Health.

- Orwig, R.A., Pearson, J., and Cochran, D. (1997). *An empirical investigation into the validity of SERVQUAL in the public sector*. Public Administration Quarterly. 21(1): 54-68.

- Parasuraman, A., Berry, L.L., and Zeithaml, V.A. (1991). *Refinement and reassessment of the SERVQUAL scale*. Journal of Retailing. 7(4): 420-450.

- Parasuraman, A., Zeithaml, V.A., and Berry, L.L. (1988). *SERVQUAL: A multiple-item scale for measuring consumer perceptions of service quality*. Journal of Retailing. 64(1): 12-40.

- Patton, M.Q. (1989). *How to use qualitative methods in evaluation*. London: Sage.

- People's Health Movement. (1978). *Declaration of Alma-Ata. International Conference on Primary Health Care*. Alma-Ata: USSR.
  URL:
  http://www.phmovement.org/charter/almaata.html
  (Accessed 20 September 2004

- Punch, K.F. (1998). *Introduction to social research: Quantitative and qualitative approaches*. London: Sage.

- Reinhardt, U. (1998). *Quality in consumer-driven health systems*. International Journal for Quality in Health Care. 10 (5): 385-394.

- Rubin, H.J., and Rubin, I.S. 1995. *Qualitative interviewing. The art of hearing data*. London: Sage.

- Salomon, L., Gasquet, I., Mesbah, M. and Ravaud, P. (1999). *Construction of a scale measuring inpatients' opinion on quality of care.* International Journal for Quality in Health Care. 11 (6): 385-394.

- Schiffman, L.G., and Kanuk, L.L. (2000). *Consumer behavior.* Prentice Hall International, Inc.

- Smith, M., and Engelbrecht, B. (2001). *Health Systems Trust Guide to assessing client satisfaction at district hospitals.* Durban.

- Sofaer, S. (2002). *Methodology matters: qualitative research methods.* International Journal for Quality in Health Care. 14: 329-336.

- *South African yearbook 2001/2002 8th Edition.* Pretoria: Universal printers

- Teas, R.K. (1994). *Expectations as a comparison standard in measuring service quality: An assessment of a reassessment.* Journal of Marketing. 58: 132-139.

- The Concise Oxford Dictionary. (1990). R.E, Allen (ed). London: Oxford University Press.

- Tshabalala-Msimang, M. (2003). Health minister calls for better results in SA. BUANews.
  URL:
  http://www.hst.org.za/news/20030323
  (Accessed 02 March 2004)

- Tshabalala-Msimang, M. (2004). Pricing of medicines. South African Pharmaceutical Journal. 71:1.

- Van Iwaarden, J., van der Wiele, T., Ball, L., and Millen, R. (2003). Applying SERVQUAL to web sites: An exploratory study. *International Journal of Quality and Reliability Management.* 20: 919 – 935.

- Wagner, C., De Bakker, D.H., and Groenewegen, P.P. (1999). A measuring instrument for evaluation of quality systems. *International Journal for Quality in Health Care.* 2: 119-130.

- Whittaker, S., Green-Thompson, R.W., Mccusker, I., and Nyembezi, B. (2000). Status of a health care quality review programme in South Africa. *International Journal for Quality in Health Care.* 12: 247-250.

Appendices

Appendix 1

COPY OF CONSENT LETTER

TO INTERVIEW PHARMACY MANAGERS

Faculty of Natural Sciences

School of Pharmacy

Date

The Pharmacy Manager

……………………………..

Address

Dear

Re: Request for interview for quality improvement purposes at Afrox Healthcare
pharmacies

This serves to introduce myself as a postgraduate student at the University of the Western
Cape (UWC) and pharmacist intern. I am involved in research to investigate factors
affecting pharmaceutical service and their relation to delivery of quality pharmaceutical
service in the Afrox Healthcare Limited (AHL) pharmacies. Afrox Pharmacy
Management Service (APMS) is sponsoring my research.

The project that I am involved in is part of the overall continuous quality improvement
efforts by APMS. To ensure that the voice of AHL customers is heard in the development
of this tool, I will involve as many as possible in order to gain insight of how they
experience the service and welcome any suggestions and contributions towards service
improvement.

I therefore request to interview you in your office at your earliest convenience for not
more than 45 minutes.

Thanking you in anticipation

Sincerely yours

…………………………

Appendix 2

COPY OF CONSENT FORM

TO INTERVIEW PHARMACY MANAGERS

CONSENT FORM

Researcher: …………………………………………   Ref. Nō: ……

Supervisor: …………………………………………

Research Title: Investigation into factors influencing pharmacy services and their relation to delivery of quality pharmacy services in hospitals of a group of private health care provider group.

Pharmacy Manager's name: ………………………………………………………………

Name of pharmacy: ……………………………………………………………….…

Tel. nō: ……………………….…   e-mail address: ….…………………………….…

Basis of taking part:

Afrox Healthcare Limited (AHL) holds quality as a top priority and strives to encourage quality awareness throughout the company. As part of these efforts, the purpose of this research is to establish a common understanding of quality within the group.

Pharmacy managers will be interviewed to elicit their views, opinions insights and understanding of service provision. The interviews will be tape-recorded, and notes written, to facilitate analysis by the researcher.

All information gathered will be held in strict confidentiality. No respondent will be identified by personal name or facility name.

Thank you.

I, the undersigned, agree to participate in this research by consenting to this interview.

Respondent: ……………………….   Date: ……………………
          (Signature)

_____
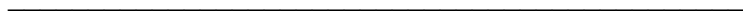
I, the undersigned, have fully explained the relevant details of this research to the above

named respondent.

Researcher: ……………………….....   Date: ……………………
          (Signature)   UNIVERSITY *of the*
                                WESTERN CAPE

Appendix 3

INTERVIEW QUESTIONS

FOR PHARMACY MANAGERS

A. TANGIBLES – The infrastructure and availability of pharmaceuticals

1   Does the pharmacy layout permit a logical flow of work?

2   Referring to easy access to all items for staff depending on area of work:

- Are fast-liners/frequent-use items less than an arm's length away from the point of dispensing?
- Are all items in need equal to or less than five walking steps away from area of dispensing?
- Is there room for all staff members in the dispensary?
- Is there room for all stock in the dispensary? Do you find the working space is crammed with boxes around

3   Is the facility easily cleanable?

4   With regards to effective communication:

- Is there a telephone present in the facility?
- Is there a fax machine in the facility?
- Is the noise level in the facility sufficient to allow each staff member and patient to hear the next person quite clearly?

5   Comment on your Stock Control procedure.

6   Explain how pharmaceuticals are procured.

7   What system is in place to monitor the performance of the suppliers?

8   How do you deal with out-of-stock situations?

ACCESS AND SECURITY

1   What security system is in place to ensure that only authorised person have access to the dispensary?

2   Referring to how legal requirements for control of access to different schedules of medicines are met.

- Are there facilities to ensure that schedule 5 and 6 substances are kept locked up?

- Does the pharmacist only have access to the locked up schedule 5 and 6 substances?

3   Comment on the health and safety procedures in place.

STORAGE SPACE –

---

2.   Does the storage area accommodate all stock received?

3.   Referring to the storage of thermolabile pharmaceuticals.

- Does the facility have a refrigerator committed to the storage of thermolabile pharmaceutical products only?

- Is the refrigerator equipped with a maximum/minimum thermometer?

- Is the refrigerator capable of storing products at temperatures between 2ºC and 8ºC?

- What method is used to ensure that the refrigerator is cleaned, defrosted and checked periodically by a responsible person?

4.   Explain how expired or damaged stock is disposed of.

RELIABILITY – The ability to perform the services offered

---

1   How long have you worked for Afrox?

2   What is it about your work at Afrox that you enjoy?

3   What are the challenges of working in a setting like yours?

4   How would you describe the service that you, as an individual, provide?

5   Are there specific written Standard Operating Procedures (SOPs) followed by staff concerning their day-to-day duties?

6.   Describe your management style.

7.   Describe the range of activities in a typical day.

8.   Do you plan your on-duty day?

9.   Comment on your interpersonal communication skills.

RESPONSIVENESS – Willingness to assist clients / customers

1. How do you ensure that clients receive a service that satisfies them?

2. What features of the service you are offering impact negatively on the clients?

3. Comment on the waiting time / turnaround time for scripts.

4. Is there system of self-monitoring for the performance of the facility with regards to responsiveness?

5. How are the motivation levels of the staff members addressed?

ASSURANCE – Ability of the service provider to be knowledgeable and to inspire confidence and trust

1. Are there any Continued Professional Development (CPD) programmes that you, as an individual, are involved in?

2. What ways do you have of knowing that clients are satisfied with the service that you offer?

3. How are patients made aware of their rights?

4. What is your understanding of a quality service that is envisaged by your company?

5. What would you say makes your present system effective?

6. What are the essential elements of providing a pharmaceutical service?

7. Is there written information in existence that will allow a *locum* pharmacist to operate in the facility?

EMPATHY – Ability to care and display compassion towards clients

1. Is there a private area for the purpose of counselling patients?

2. Is there any means for the patients / clients to voice their dissatisfaction with service provided?

3. What can patients do when they have questions with regards to their prescribed medication, once they have been discharged?

Appendix 4

PHARMACY MANAGERS'

INTERVIEW TRANSCRIPTS

(* = Tape recording inaudible, **** = names withheld, *italic text* = interviewer's probes, text in brackets = interviewees question, itali*c* text in brackets = interviewer's clarification)

PHARMACY A

TANGIBLES – The infrastructure and availability of pharmaceuticals

---

1   Does the pharmacy layout permit a logical flow of work?

Yes. I feel strong(ly) (that) it does

2   Referring to easy access to all items for staff depending on area of work:

▪   **Are fast-liners / frequent-use items less than an arm's length away from the point of dispensing**?

Yes

3   Are all items in need equal to or less than five walking steps away from area of dispensing?

Yes, on ethicals. Our surgicals, not always.
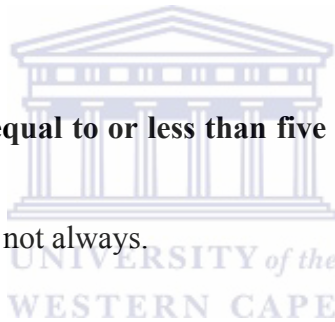
How come?

Mainly it's the space constraints. So we have our ethical items in a "u" shape-in front, behind and to the side of you, but there is no space there for the surgical items and often on a d-chart (*drug-order chart*) we'll get vacoliters like 50ml saline, recons to go with the IV's (*intravenous solutions*) and those we have to walk to fetch and TTO (*to-take-out*) dressings we have to walk to fetch

4   Is there room for all staff members in the dispensary?

Yes

5   Is there room for all stock in the dispensary?

(Prompt) Do you find the working space is crammed with boxes around?

Not really. I like it because we don't have to walk too far and also the fact that space is a constraint means we don't carry too much stock. We're carrying about just over a month's stock and supply so that is adequate stock and I think the tendency is if you had more space you'd carry more stock because the more stock the easier life is

6   Is the facility easily cleanable?

I wouldn't say it is easily cleanable, no. We have lyno floors and these have to be *, sand them almost and apply vanish and to do that we need to have a pharmacist present and because of the amount of walking we do we have to do it after hours. So to clean the floors is a problem. Just a sweep is easy but at least twice a year we have to condition the lyno and that's a problem. Also with surfaces because we have limited space there's stuff on all the surfaces so to clean surfaces you have to unpack and then clean. So with the surgicals its fine we can get cleaners in and they unpack and clean and we pack, but with the drugs, in the contract they are not to touch the drugs, so we have to unpack, they wash the shelves and we have to pack the shelves back. So cleaning is a problem there.

So how do you go about to address the issue of cleanliness?

The floors, we make a date twice a year for housekeeping in to come and clean and one of the pharmacists' stays late. With shelves, on the surgicals its not a problem they come in once a month and clean, but with drugs its as we get time. So it can be quite dusty before we get there

7   With regards to effective communication:

▪   **Is there a telephone present in the facility?**

Yes

▪   **Is there a fax machine in the facility**?

Yes

▪   **Is the noise level in the facility sufficient to allow each staff member and patient to hear the next person quite clearly?**

Yes

8   Comment on your Stock Control procedure.

We have on our computer system an auto-order system, which we are only starting with now its not functional yet but otherwise with surgicals we have order cards. So **** will do a count once a week of his stock and then look at the movement and order according to the movement. With ethicals we replace on a daily basis to our stock level unless there's an upsurge in movement in which case we order more but it's not that we have maximum/minimum stock levels on our ethicals it's really just a feel

What happens from the time you feel there is a need to order?

Our stock is ordered from the wholesalers, we don't really order from the manufacturers. All our stock is ordered from the wholesalers, so we have either once daily or twice daily delivery, so its not a really an issue. If it's a new product and we don't have it we always borrow from **** (other hospital in the group) or **** (neighbouring pharmacy) or buy from them and replace; so we make sure before the end of the day we issue patients with what they need, we don't leave without issuing to the patient

9   Explain how pharmaceuticals are procured.

We have an order book on the drug side and we write down, as we need an order. The order is then captured on the computer and we print a hard copy. The hard copy is either faxed or the order from the hard copy, with the order number is faxed through to the company or we phone through

10   What system is in place to monitor the performance of the suppliers?

None. Either they supply or they don't. If they don't supply we phone. We don't have a system

So how do you deal with the situation whereby they are not playing their part, you wait too long – how do you go about keeping tabs on them?

We have never had a problem with ethical supplies. We get a daily delivery or twice daily delivery. Most companies it's a twice-daily delivery. I think maybe once in my whole life did we not get a delivery. We had an incident a month ago we tried to use our electronic ordering system Surgi-com® and our order did not go through and those orders did not arrive. But by the afternoon – you know when your deliveries are going to be in – so when those deliveries did not arrive, we phone and say 'where is the stock' and they said 'we did not get your order' so you'll get it later in the day or early the next morning

11   How do you deal with out-of-stock situations?

We look for an alternative supplier, as we buy most of our stock from wholesalers so say IHD does not have it then we would try Zenith or UPD. That's our first line of resource and if that does not work we will try other hospitals in the group, the closest hospitals

first and then e-mail to other hospitals in the group. If we still can't get then we phone the doctor to ask for a substitute.

At that time what happens to the patient – the patient is waiting of the script

It rarely happens that we wouldn't have, because we have stock on our shelves, so we'd know that we have at least 48 hours' supply and that gives us the time always to be able to sought for more. That's why we hold a certain amount on our shelves and we order back to that level. If we order back to that level we can't, if you get to that level you start looking already.

ACCESS AND SECURITY

---

1   What security system is in place to ensure that only authorised person have access to the dispensary?

We have a slam door with 4 keys one held by me, one by ***, one by my permanent locum and one kept at *** (neighbouring hospital). We have an alarm system. That's how we control access

2   Referring to how legal requirements for control of access to different schedules of medicines are met.

▪   **Are there facilities to ensure that schedule 5 and 6 substances are kept locked up?**

Everything in the pharmacy is kept locked up after hours, but schedule 5s are not kept locked up when the pharmacy is open. Schedule 6 and 7 are kept in a locked cupboard, unless you asking about in the rest of the hospital, because in the rest of the hospital schedule 5s are kept in the schedule 5-drug cupboard, which is a lockable cupboard.

▪   **Does the pharmacist only have access to the locked up schedule 5 and 6 substances?**

Schedule 5 is not locked up, schedule 6 is locked up and yes only the pharmacist has the key, that's kept between other pharmacist and I. In fact it hangs on a hook, but there is always a pharmacist present in the pharmacy

100

3   **Comment on the health and safety procedures in place.**

We have a health and safety representative, other pharmacist, and she would check about once every couple of months to see that we don't have like wiring that's hanging loose or puddles next to the electrical main. We also have, between facility A and facility B, a health and safety nurse – sister (*registered nurse*) and she does an inspection about once a year. So she will come through and have a good check that everything is right. In fact, the pharmacy is not that old, when I planned the pharmacy and we set it up, she came and gave us a very good inspection to make sure that all the wiring has been done accurately, that the floor was even, that we don't trip and bump into things. That's one of the reasons we have these rubber mats so you don't sit on your chair and slide out. That was one of our health and safety things.

But I think there is always a risk in the pharmacy because we have things stacked on shelves and yes if you try and get something heavy from the top shelves, there is a chance always that an accident can happen, but there is not enough space that you can everything low.

We have a lockable metal cupboard for our flammables, so those are locked away. The drugs are kept out of the way of the rest of the non-qualified pharmaceutical staff so they don't have access to it. So basically the pharmacist has access to the items that could become poison hazard or dependency hazard or something like that whereas the other staff don't really have access. They can walk in but you will notice it immediately because there always a pharmacist in the dispensing area.

In that way, but not one is protected from items because of weight like in case of vacolitres, they can be heavy.

STORAGE SPACE –

---

1   **Does the storage area accommodate all stock received?**

Yes. All stock is stored in the pharmacy. We don't have a store anywhere else in the hospitals, if that's what you mean. Some pharmacies will have a store under the stairs or store in the garage. All our stock is in one area, the pharmacy

Here in the pharmacy is there enough space to accommodate all the stock?

Yes there is, but one would always like to have more space

2   Referring to the storage of thermolabile pharmaceuticals:

▪   **Does the facility have a refrigerator committed to the storage of thermolabile pharmaceutical products only?**

Yes

▪   **Is the refrigerator equipped with a maximum/minimum thermometer?**

Yes

▪   **Is the refrigerator capable of storing products at temperatures between 2ºC and 8ºC?**

Yes

▪   **What method is used to ensure that the refrigerator cleaned, defrosted and checked periodically by a responsible person?**

None, before we get an inspection, I quickly defrost the fridge

How do you ensure that it remains between 2ºC and 8ºC?

We have a thermometer and we check it everyday and we have a little book that we write in the daily temperature of the thermometer. That's one of (the other pharmacist's) jobs

3   Explain how expired or damaged stock is disposed of.

We have a stock transfer voucher book so any damaged or expired stock is written up in the stock transfer voucher book. We have a waste-tech container so items are placed in there.

If it's damaged stock that is supplied damaged from the company, we'll keep that separately because they need to replace the stock. So that will not be entered into the stock transfer books because we will not write it off.

When our waste-tech container is full, it's sealed and we have a schedule that we fill in and it's then collected by the housekeeping department and signed for by them, sent off to the waste removal company.

Schedule 5, 6 and 7 are kept in the schedule 5, 6 and 7 cupboard and when we get an inspector – we get an inspector about once or twice a year – we ask him to write anything off from our schedule 6 and 7 and now with the new Act 90 we do schedule 5 as well. What we do is to put the item in a packet and write the page number on so when the

102

inspector comes he can find the item and where we wrote it off in our register and just sign.

<div style="border:1px solid">

RELIABILITY – The ability to perform the services offered

</div>

1   How long have you worked for Afrox?

We were taken over by Afrox, I think about two years now.

2   What is it about your work at Afrox that you enjoy?

I love being a pharmacist. * I find it always interesting, always new, and I like being occupied. This is a job that keeps you occupied – 105% of the day

So you are satisfied with your job

I love my job, yes.

3   What are the challenges of working in a setting like yours?

To me the challenges are mostly that we are not an isolated unit, we are part of the whole. We are the pharmacy in the hospital so we interrelate with the other units and as a pharmacy we have very strict codes. To ensure that the hospital operates at the same level of codes that we demand, that I find difficult especially with nursing staff at the moment, we get a lot of temporary staff. So you might get someone who comes in for a day, that does not give you enough time to train them to the sort of ethical, moral and friendliness standards that we would like in our hospital.

5   How would you describe the service that you, as an individual, provide?

I would say consistent, ethical I think we provide a good service and I think we tend to provide almost too good a service in that we tend to help out in other areas in the hospital so that things are at the standards that the pharmacy want to work at. So we almost * to a certain extent. Maybe there is a need to step back and say 'do it yourselves', but we tend to go out and help because we like to have certain standards in the pharmacy so we would like the whole hospital to operate on that same standard.

If everyone operates on the same standard, life's easier, in that you don't get side swiped that often e.g. I think a problem in each hospital is stock in theatre, because the tendency is, three, four, five times a day for theatre to phone or shout and say the patient is on the table we need this. We'll say to them is (that) there are certain items, you have a list of

items that are your responsibility, pharmacy does not keep backup, you have to make sure you have enough of that stock and inevitably they don't. So, we are slowly getting there, where theatre has a dedicated person in theatre looking after stock and the results are starting to come through. It's like going home at night and you make sure – this is a private hospital – we have standards, everyone gets their medicines before you go home. If a patient is in theatre and needs something, we will get it. If we have to stay the night yet, drive ourselves, go fetch it in Zimbabwe and bring it back, we do it. This is a private hospital and the patients' demand and have a right to the best service. That's a challenge.

6   Are there specific written Standard Operating Procedures (SOPs) followed by staff concerning their day-to-day duties?

There are JPMs (Joint Performance Management) so I together with each individual staff member have drawn up a list of what they need to do. Twice a year the staff takes their lists and they will look at each item and say 'have I performed here' and I do the same. Then we meet and together decide what the operational level is.

7   Describe your management style.

I have a little tendency to be authoritative but I think I'm quite consultative. I am quite a hard taskmaster because I want things done correctly. I can remember when I was studying one of my lecturers saying to me "You only got 70% in your exam, does that mean you killed 30% of your patients because you did not know what you were doing?" I think we deal in a business were the element of risk is very * you can't make a mistake, you have to be accurate, you have to be careful, you have to be conscientious. So on that – doing things accurately – I'm quite a hard taskmaster. But on more less exacting tasks, I'm think I'm quite open to discussion and negotiation and my staff quite often tell me how they would like to do it as long as they meet the standard. If they want to do it standing on their heads, that's fine as long as don't

8   Describe the range of activities in a typical day.

For me, because we are a small hospital with one pharmacist and myself, quite a bit of my day is dispensing. So I would come in the morning, I visit each unit in the hospital just to say good morning, just to say hallo and make sure everything is functioning alright, if they are having any problems, any issues, we try and resolve that first thing in the morning. So before 8 o'clock I do a round in the hospital and chat to everyone. I

normally stop at my matron's and to say 'hi'. Sometimes it's just 'hi'; sometimes she wants something qualified or solved or whatever. So we will have a quick discussion. Then we start dispensing.

Between my pharmacist and I there certain jobs that have to be done. So we replace the emergency cupboard, we place our orders on the computer, I fax them off or phone them through – those are our early morning orders. The d-charts (*drug-order charts*) for patients start coming in about 8:30 - 9 usually, so those as they come in we do them. I try and open and sort my e-mail at least 3 times a day so those I try and clean out.

On a Monday, Wednesday and Friday we replace stock to all the units, so those drugs have to be issued and signed into registers in the units. (We are now doing bin counts) so on a Tuesday and Thursday all the units and pharmacy staff give me their bin and I try to resolve any problems with them individually to get the bins to have as low a variance as possible.

On a daily basis nearly there are reports that have to be done to head office. I try to do them ahead so it's not always a crisis. Four times a year we do stock-take.

Now you mentioned bins, what are those?

Each shelf or each measurable area is called a bin and the items in that bin are captured on a stock take page. So what Afrox is saying to us is that if you can have a variance on your bins of less than 2% then you don't have to do the interim stock-takes you would then just do the financial year end stock-take. So everyday we will take a little section, we will count the stock on that, we'll process it, the computer will come up with a variance on what you bought and what you sold, therefore how much you should leave on your shelf. So you try and resolve problems, maybe an invoice was not captured. So over a month you have gone through all the stock in the pharmacy. It's a lovely measurement tool because you can pick up early – theft, incorrect counting techniques. We found at one stage we were way over on our Adcock products and then we found that we credited because Adcock had duplication order, so we credited the stock but had not put the credit through on the computer. So it was sought of a wake up call – when you credit stock remember to capture it on the computer, but we write it in the book and send it off and get everyone sign but we were not capturing it on the computer. So it's an early warning

system, and we are doing it quite strictly in pharmacy now and we are introducing it into the hospital as well.

9   Do you plan your on-duty day?

I don't have a written plan. I have my list of what reports have to be in on which dates. So I know I have to do certain reports during the day. I try to plan so I can dispense with *** (other pharmacist), get the dispensing done, the replacements to *** (neighbouring hospital), the replacements to the emergency cupboard and the replacements to the patients so that in the afternoon I can do my reports. So in that way I'm planned but you always get something, which you did not plan for.

10   Comment on your interpersonal communication skills.

I understand myself, so I think they are pretty good

How do you communicate with others, how do they perceive your way of communicating with them?

We don't have formal meetings. We have a Friday formal green meeting, which inevitable falls by the way side because of work pressure. So I tend to speak to people individually or in a group, because it's a small pharmacy you can stand in one area and cover the whole staff. So as things arise, you'll say look we have a problem with this or this is happing or here is a notice. It's a difficult question.

I think I'm pretty friendly but I'm quite demanding as well, so yeah authoritative.

How do the others perceive that?

I think they perceive me as being a little bit authoritative.

RESPONSIVENESS – Willingness to assist clients / customers

1   How do you ensure that clients receive a service that satisfies them?

Ok. If we divide it up in the different categories, with the patients in the hospital we don't have an overlap really in that we dispense to the nursing staff, to the RNs (*registered nurses*) in the wards and they issue stock to the patients. The only time we dispense directly to the patient is when the patient goes home on a TTO (*to take out / discharge medicines*) and we don't see all those patients we see some that come pass pharmacy. We

(are) trying to introduce that they all come pass pharmacy during pharmacy hours so then we would relate to or interrelate with patients. Patients on the wards we issue them with a little pharmacy service card, which gives our phone number, it gives their hospital admission number and our specific names so if a patient goes home and they have a problem with their medicine or query on dosage or interactions or anything like that and they have not seen us in hospital they can phone.

With doctors; we are a surgical hospital so most doctors are in theatre, we have a hatch between us and theatre and if the doctors want to see us they tap on the hatch. So we see the doctors often through the hatch, so they have a forum to communicate with us.

With the nursing staff, I see all the in-charges every morning in the hospital so they have a way of communicating with me. Then we have a Friday morning, once a month, nursing meeting (nursing staff - in-charges and Matron) and they communicate with the pharmacy managers there as well. Formally, other than that nothing really, but they phone us all day long. If they have a problem they tell us straight away.

To ensure that we give them good service, we deliver stock to patients on the hour. So we have an on-the-hour delivery. For stock to the wards we are same day same part of the day, so if we get an order in the morning we will deliver it before lunch, if we get an order after lunch we'll deliver it before we go home.

Our service level on our service level forms that we fill in from head office where you capture the number of lines that were ordered versus the number of lines that you issued, our service levels are about 96% - 97%, so that's pretty good. That's to the wards.

Reps (*pharmaceutical company sales representatives*) service levels to what they want and what we offer, probably quite a wide chasm there. I only see reps after 2 o'clock in the afternoon because we found the day became too fractured, none of us in the pharmacy got work done because there was always a rep to see us. After 2 o'clock I'm here they can see me, they can see (store man) as well.

2   What features of the service you are offering impact negatively on the clients?

On patients, we don't interact with patients enough, that's definitely a problem, but we are constraint by the number of staff, we are two pharmacists in an 80-bed hospital. So I

think to have more access to patients, more time with patients, would be a benefit to us and to the patients.

Doctors; I don't believe doctors really want to see us, unless they have a problem and we are freely available then they have a problem. They would phone me at home if they have a problem and they want to get hold of me.

With staff; I don't think we have a problem with the hospital staff at all. Again on the other hand I see everyone in the morning so any problems that come up they are discussed there and if it's a problem that needs privacy or anything like that then I or whoever in the pharmacy will go up to discuss it with the person

3   Comment on the waiting time / turnaround time for scripts.

It can be from 61 minutes to 190 minutes. We collect charts on the half hour and then we deliver on the half hour. So if you put the chart down just before we picked it up, before 8H29 you will get it back by 09H30, that's like an hour and one minute but if you put it down by 08H00 you will still get it by 09H30. Why we do that is because we only have one person to do deliveries, store-man has got to do the stock ordering, the picking and the deliveries. So I would like to give a better service, we asked for a shoot system but the expense involved is too great

4   Is there system of self-monitoring for the performance of the facility with regards to responsiveness?

Not for self-monitoring. What we have is each unit has a hard cover book and they write down the date, the patient's name and the time that the chart is put in the pharmacy slot and when the medicines return they sign it off with the time. So they can tell us if the chart has been in the pharmacy for an unacceptable period of time or if a collection was not done.

So that's then how you will monitor your performance

Yeah they monitor us we don't monitor ourselves.

5   How are the motivation levels of the staff members addressed?

Every now and then I bring a cake or we got out for a lunch. I try and manage on a system where you congratulate or you thank someone when they do well and when they are not performing you simply leave it little bit. So I try to work on the positive and not

the negative so much, but there are some times when you have to say look we have to address the negative.

In a way my staff are all adults. There is a certain amount of self-motivation that I think is called for when you are above 20 (years), but from a clerking side it can be monotonous because you are doing the same job over and over again so I try and spread the nice to do job a little bit with the not-so-nice to do jobs. So the clerk who captures invoices all day long, she picks for the wards she wants to so she gets the first choice on which wads she wants to pick stock for so she can get up and something different for a portion of the day.

How do you as manager keep your motivation levels up?

I think if you enjoy what you are doing it's a natural. I have targets that I have to meet and when I meet those targets I feel good in myself. So if I don't meet those targets I don't feel good in myself. So for me to feel good in myself I know I have to meet those targets.
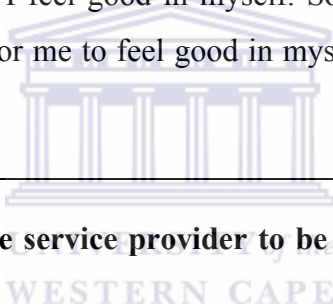
ASSURANCE – Ability of the service provider to be knowledgeable and to inspire confidence and trust

---

1   **Are there any Continued Professional Development (CPD) programmes that you, as an individual, are involved in?**

No

2   **What ways do you have of knowing that clients are satisfied with the service that you offer?**

From the wards, on our service levels, so I can measure how well we are doing in supplying stock to the wards. To someone like a doctor it's very easy to if you are not meeting their needs because they throw things at you.

I don't actively measure but you listen to complaints if you get complaints you know you are not offering a good service but it's a bit nebulous I understand that there nothing that I can actually say well I've done well today nobody shouted at me. But keep your ears to

the ground and listen, that's how I measure. I get verbal confirmation that we doing a good job or we are doing a poor job.

It's a highly female business and females, 90% of the time they'll tell you exactly how they feel abut your service.

3   How are patients made aware of their rights?

No nothing as far as I know.

4   What is your understanding of a quality service that is envisaged by your company?

I think we were on conference; the head of the nursing services put it very clearly. To her from a nursing side a good service is where your patient comes first and the telephone conversation to your friend does not come first. So to me quality service is where the customer comes first, that really is a quality service. If my customers want to see me at 10 o'clock at night, then I should be available. That would be a perfect service. We would then have to negotiate a more equitable time but within limits to give your customer what they want, that is a good service, not what you want.

5   What would you say makes your present system effective?

To be honest it makes it effective because we perceive as effective because we don't measure it. We have no way of qualitatively saying it's good or bad. You're working on feelings and perceptions. I think what makes the service effective to the extent that we have is the people we employ. We have service providers, especially in pharmacy, who go 101%.

6   What are the essential elements of providing a pharmaceutical service?

To me firstly to ensure that your patients have what they need, and the clients. If the doctor is in theatre and wants to use a particular suture to perform his job, he should have that item on hand in a quantity that he needs, of the quality that he needs and when he needs it.

The same thing goes to the wards because if you are a patient in a hospital, you are sick and you are under the supervision of a doctor. So can't say I have a headache I'm going to take my own Panado®. You need the doctor to write the Panado® to get it. So if you are patient in the ward you should be getting your prescribed drugs on time, in the quantities, at the strength and yes at an effective cost as well. When you need it must be there, it

must be of an excellent quality, it must be in a quantity that you want, at an affordable price and preferable with a smile. And it has to accurate; it has to be the right thing.

7   Is there written information in existence that will allow a locum pharmacist to operate in the facility?

I have a permanent locum, and she has actually made a booklet, I don't have one I have SOPs and I have operating procedures but they need to be updated so they are not 100% now but (permanent) locum has made her own operating procedures. They are available to her only, so if a strange locum came in I would have to give her the slightly outdated manual. But we never leave a locum on their own, it would either be the other pharmacist with the locum or me with the locum. So the locum is always supervised.

EMPATHY – Ability to care and display compassion towards clients

---

1   Is there a private area for the purpose of counselling patients?

Yes we have. I have an office where we can counsel patients, but the understanding being that most of our patients are in bed; they are post-surgery, so we very, very seldom called on to counsel patients

Those on TTOs who are on the way out?

No, we counsel them in an open area; we don't take them aside. For that there isn't a private area with a door that you can close.

2   Is there any means for the patients / clients to voice their dissatisfaction with service provided?

Yeah, we have our patient cards, which are patient call-in cards with the name of the pharmacist who looked after you on it, your hospital reference number and our telephone number. These go out with all our TTOs and the patient can then phone in to say either well done or I didn't like my medicines or whatever.

3   What can patients do when they have questions with regards to their prescribed medication, once they have been discharged?

They can contact us individually, then have a record of our names, their reference number and our phone number, so they phone us using the patient call-in cards.

PHARMACY B

TANGIBLES – The infrastructure and availability of pharmaceuticals

---

1   Does the pharmacy layout permit a logical flow of work?

No, unfortunately it doesn't in this respect because we are on two floors, this is the disadvantage and I don't think there are any other pharmacies in Afrox that are on two floors. So there are steps to be climbed all the time while the store-men and personnel go from downstairs to upstairs; if they want something in the vacuum shuttle, they've got to fetch it upstairs, come downstairs. So stock goes up and down, it's not really ideal.

But other aspects in the ethical dispensing department where the drugs are dispensed there I think it's fine, in the store room itself, I think the flow is fine but the two are not connected on the same floor, that's the disadvantage.

What are these two floors?

This floor here where the surgicals are and upstairs where the medicines are. They should be on one floor.

2   Referring to easy access to all items for staff depending on area of work:

▪   **Are fast-liners / frequent-use items less than an arm's length away from the point of dispensing?**

Yes they are.

•   **Are all items in need equal to or less than five walking steps away from area of dispensing?**

Yes, in both upstairs and downstairs – in the surgicals, because they have a central counter and you can walk 5 steps in any direction, same upstairs.

3   Is there room for all staff members in the dispensary?

(To work or to sit or to relax or what?).

To work?

Yes

4   Is there room for all stock in the dispensary?

Yes

5   Do you find that the working space is crammed by the stock on the floor?

No, not at all, we have quite a free flow of work because there's nothing on the floor, it's all on the shelves, there's plenty of space in between.

6   Is the facility easily cleanable?

Absolutely.

7   With regards to effective communication:

▪   **Is there a telephone present in the facility?**

Yes, there is more than one.

▪   **Is there a fax machine in the facility?**

Yes

▪   **Is the noise level in the facility sufficiently low to allow each staff member and patient to hear the next person quite clearly?**

Yes we have no noise pollution whatsoever in our dispensary

8   Comment on your Stock Control procedure.

Well we follow the company protocol which is set out quite clearly right from the point the where the stock is ordered. The purchase order is kept until the stock is received, its matched up against the purchase order and signed by somebody who receives it, not the person who ordered it. The receipt is then given to the data capturer who calls up the purchase order and will then find this order on the screen and the confirm that this what has come or makes an adjustment if there is a backorder.

Stock is then unpacked onto the shelves; the invoice is signed into a book so that at the end of the day the data capturer can make sure that he has received and captured all the invoices that have come into the dispensary on the day. So there is a control of what came in and what did he capture.

Then we look at security: the front door and back door is locked and can only be accessed by code known to the pharmacist only; a bell if people want to enter which is then opened by a pharmacist or in the storeroom by one of the store people.

We do cycle counts now on a regular basis. That picks up loses if they are not due to incorrect charging we could then probably identify that there's is theft.

I have lists of all the stock on consignment in the hospital; I have lists from the companies that supply it and every 3 months I check that they have arrived and they are counted on stock take although they are not captured, they are counted *

When we provide stock to the wards each day for the replenishment of their ward stock, once they have received the stock, they sign the requisition and send it back to us as proof that they have received the stock that we send them.

When we dispense meds on direct dispensing we stick a summary label on the back of the d-chart, which is proof that we have dispensed it.

The last thing would be stock sold to people passing by, outpatients, is a proof list which prints and is like an invoice. They are given that to go and pay at reception and when they get the receipt they come back and they are given the stock.

So those are some of the main points.

9   Explain how pharmaceuticals are procured.

Ok, of course all the stock that we procure is been okayed by the procurement department head office, Johannesburg. It must comply with 3 things: it must be an approved supplier, in other words, it mustn't be a grey pharmaceutical market selling stolen goods; it then could be a preferred supplier, where we are given the name of one or two companies who give a good discount or which have good service or whatever, we can choose which one we prefer but preferably of one of the 2 or 3 and the third category it could be formulary product where we are restricted to buy from that company only, so that is determined by head office.

Then the procedure of buying is outlined as I explained in the previous question where someone creates a purchase order on the computer based on an automatic order system looking at the history of your purchasing and your billing over the last year and then gives you a calculated, suggested order and you can edit that and you can add to it. Then the purchasing system goes into gear and then the rest follows like I've explained.

10   What system is in place to monitor the performance of the suppliers?

We don't really have a system here. My buyers just report to me when there's too many backorders or when stocks are late or the service is bad and then we either phone head office if we can't get any joy out of the local supplier's office anywhere, we would deal with it ourselves, but there is no system to monitor except from daily observations and

trends and then we go about trying to sort it out. However head office have got a once a year analysis or review of the performance of the suppliers and we are all asked to fill in questionnaires they then choose the top 5 from those. So they've got a sort of annual review, but we don't really have a system in place.

11   How do you deal with out-of-stock situations?

Well the first thing would be to try and secure the product from one of our company hospitals and have the stock transferred but failing that we would try to buy it out from another hospital which is not part of the group, failing that we would try to purchase it out from the local retail pharmacy close to us. If it is not all that urgent we would then wait a day or two and re-order. We would certainly ascertain first is it something that has to be got or can it wait. If it has to be got we will then go through the procedures that I have just outlined.

ACCESS AND SECURITY

---

1   What security system is in place to ensure that only authorised persons have access to the dispensary?

This I have mentioned above. We have locked doors back and front and with security code on the front door, which only the pharmacist knows. The back door has a bell for anyone to ring; they are then allowed access if it's known who it is.

2   Referring to how legal requirements for control of access to different schedules of medicines are met:

- **Are there facilities to ensure that schedule 5 and 6 substances are kept locked up?**

We have what was then known as the schedule 7, just until last month or so, known as schedule 7cupboard so our old schedule 7 and what they call schedule 6 would be in a locked cupboard. Schedule 5s are not locked up in a cupboard

3   Does the pharmacist only have access to the locked up schedule 5 and 6 substances?

Yes

115

4   Comment on the health and safety procedures in place.

We have a health and safety sister in hospital who oversees health and safety matters in general. We e.g. not boxes lying on the floor, that spills are cleaned up by the house keeping staff if it happens. We have a policy that should we see any rodents or vermin we should contact her that's also policy. We have a flammable steel cupboard in the pharmacy for storing alcohol and other flammable liquids and it has the proper signage on it as well and it has a file of documents relating to each of the contents within the cupboard indicating the effects of ingestion and the procedures to follow should somebody be poisoned.

Sharps and broken ampoules and things are put into the prescribed containers and also medicines to be disposed are put into prescribed containers and at strategic places we got a required number of fire extinguishers which are checked on a yearly basis by an authority.

STORAGE SPACE

---

1   Does the storage area accommodate all stock received?

Yes it does

2   Referring to the storage of thermolabile pharmaceuticals:

▪   **Does the facility have a refrigerator committed to the storage of thermolabile pharmaceutical products only?**

Yes

▪   **Is the refrigerator equipped with a maximum/minimum thermometer?**

Not with a minimum/maximum thermometer but just with a plain ordinary thermometer which we monitor once a week and is registered in a book. Currently we are doing it everyday because we have some trail going on in the hospital with some drugs that have been asked to be kept at a certain temperature and they've asked that we monitor daily, but normally is monitored weekly.

▪   **Is the refrigerator capable of storing products at temperatures between 2ºC and 8ºC?**

Yes

- **What method is used to ensure that the refrigerator cleaned, defrosted and checked periodically by a responsible person?**

Well I must confess that probably has been done once or twice while I've been here. It's something that I just never think of doing. That is something I can look at.

3   Explain how expired or damaged stock is disposed of.

Well currently the company that has been contracted supply you with 2 different bins; one for sharps and broken glass (ampoules, etc.) and the other one for medicines. You may dispose of any type of medicine – liquids, solids, tablets, capsule, etc. The only requirement is that schedule 5 and upwards are actually recorded on a prescribed form, which then I sign off as pharmacy manager and it goes along with this bin and the company accepts responsibility then that they have within that bin they've got schedule 5 or 6 substances. They then dispose of it.

RELIABILITY – The ability to perform the services offered

---

1   How long have you worked for Afrox?

Me personally? Well the company only owned us since beginning of last year, so it's nearly a year and a half. We were only bought by the company in April of 2002.

As a pharmacist?

I've worked for this hospital for 7 seven years but for the company, they have only owned us for a year and a half

2   What is it about your work at Afrox that you enjoy?

Well I enjoy the hospital, I mean I must comment it's not really the company that is the question I think it's my job, and the hospital and the people. I find the varied nature of a pharmacy manager very nice. There's a bit of administration, there is financial, there is stock control, there is human resource management, there is a little bit of IT management, there is little bit of dispensing. I enjoy the whole cross section because it's so varied it's not just one aspect all the time, whether it's the company or any other it does not matter, I'm talking about the hospital.

3   What are the challenges of working in a setting like yours?

I think the challenges especially now under the company, because they are such an organised, well run machine in terms of controls and protocols, is to actually try and manage it for them because if it's done properly it obviously is a superb system and I think the challenges are just to able to understand and to manage all the protocols that they have put which are superb.

4   How would you describe the service that you, as an individual, provide?

(Me as a pharmacy manager – service to the public or to the patient, to the ward? Who?)

To the hospital

I'm not sure what we are getting at here. You mean the nature of the service as in I provide stock control for the company, or I provide the management of work?

Well the job that you are doing as a pharmacist

Technically my main job is to manage one of the biggest assets the hospital has i.e. stock. If you really boil it down to one thing, it's really the management of stock. That's my prime service because in there is not only the assurance that there will be stock for the doctors and surgeons to use but there is a huge percentage of the revenue and the margin that the hospital requires to exist is in the pharmacy. So all boils down basically to my service is the management of the most important asset next to staff namely stock.

5   Are there specific written Standard Operating Procedures (SOPs) followed by staff concerning their day-to-day duties?

Yes

6   Describe your management style.

I would start off by saying what I am not. I am not a dictatorial manager. I am not good at delegating either. I tend to be a working type of manager where I, and that's also wrong, tend to want to do lots of things myself, to get involved, but I have a good relationship with people and I really think I managed to secure lots of cooperation from all sectors of the hospital because I just have a good relationship with people and can build relationships easy and I think that's how we get things done and you don't really have to be a tyrant. So I would say a "I'll show you how to do it" type of thing rather than "I'll tell you how to do it" is really probably how I do things.

7   Describe the range of activities in a typical day.

It's general look at are my staff ok, is everybody here, did anyone get sick, anybody looking down, is there a problem. It's human resource management first, then it's a huge amount of time on e-mail, an extraordinary amount of time spent on reading, replying to, deleting, dealing with e-mail it's astounding. I dispense, here and there, on an ad hock basis when somebody is sick, when somebody is on lunch or whenever that's need, I do a lot of management up in the wards, I visit almost everyday one or more of the wards to help stock controllers with the stock control. The I've got massive amounts of admin – reports, stats to be compiled, there's daily reports to be done and weekly reports that are required by the company to manage stock. So it's financial, it's human relations, a lot of computer work; it's a teaching and instructing ward clerks and lots of medical aid queries – why has this been rejected? Is it right? Have we billed it correctly? And then general computer stock maintenance; inventory maintenance, takes a considerable amount of time to do it. Then meetings; being in this management level, always you've got to attend a number of meetings and that is really, the day goes by.

8   Do you plan your on-duty day?

(My on duty day, meaning?)

When you come on-duty do you have a plan that this is what I'll be doing

Not particularly, no. I sometimes, when things there's a lot of things, I make a list and try to work through them, but I don't normally work on a daily writing out and tick them off. They seem to be stuck in my head in terms of priority.

9   Comment on your interpersonal communication skills.

I think they are very good. I think that's one thing I do well. I get on well with people, I've got lots of patience, if people don't understand, I'll do anything, I'll sit with them until they understand. It compensates for my other lack in delegation.

RESPONSIVENESS – Willingness to assist clients / customers

1   How do you ensure that clients receive a service that satisfies them?

I suppose ensuring that my staff actually adheres to the protocol and standard operating practices because that's after all if they are doing that then they should be giving a proper service. I keep my ear to the ground for complaints filtering through from ward secretaries or unit managers or billing people saying Mrs. so and so is unhappy or whatever, just listening and then follow it up with saying to the relevant person when this happened what did you do, did you notice this and so on. In terms of dealing with outside patients, I come from a retail background, so I'm very aware that so-called golden moment when people walk into your pharmacy or come to the desk, that first 30 seconds either makes your hospital or breaks it, because in our case here we are the last people to see the person going out of the hospital because he collects his TTOs and his off and there if they have to wait or if someone is rude to them, that can just write-off the hospital, no matter what good service they've had. When they come in they see the receptionist and when the receptionists are bad then they write-off the hospital. On their way out after 3 or 4 days and if they've had a bad service at the pharmacy they also write-off the hospital. So I think that I really am strong on that. People have got to be exceptionally over the board good and nice to people. That I give lots of example myself, they can hear how I address people, how I speak to people because I come from retail. You've got to do that.

2   What features of the service you are offering impact negatively on the clients?

Perhaps in the retail sphere we don't do retail prescriptions, we do them but we don't have * a real up and running retail I'll-claim-your-script-from medical-aid-for-you system, it's a cash only basis and they must claim and they don't always like that. But we don't have very few people coming, so it's not really of much impact.

3   Comment on the waiting time / turnaround time for scripts.

We have a system whereby we collect and deliver scripts and medicines on the hour every hour. So if you collected something at 10 o'clock, you should be giving it back by 11. However, if the person has just left after picking up the scripts and a quarter past

somebody puts in something in the basket, then it will be collected by 11 and returned by 12. So because you can't run up and down, so in effect it should never be longer than 2 hours before they can get their meds. If they need it urgently they can phone for one of the shuttles and we send it up immediately or if it's a pre-med or something. Theoretically what ever is collected on the hour will be back on the hour, but of course there is sometimes a stagger if you end up by missing the collection on the hour, but not longer than 2 hours.

4   Is there system of self-monitoring for the performance of the facility with regards to responsiveness?

Yes, I think what you mean is, is there a way of measuring this. We have a delivery/receipt book in every ward and the patient's name and number is written in as the chart is placed in the basket and when they are collected the runner writes the time that he collects it and when he returns it he writes down the time so there is a way of monitoring the responsiveness.

5   How are the motivation levels of the staff members addressed?

We have a weekly green areas meeting, every Wednesday for an hour. We discuss business of the week; each one has a chance to say if there is anything that is worrying them, they each have a chance to say what they like. That's for grievances. They are always complemented, if there is anything they need to be complemented on at that meeting.

For stock takes when they stay late in the evenings, I then give them extra time off in the month – they can take it over weekends, hours extra – just to motivate them that I know they work late, and they can have a bit of extra. So those are the sorts of things. And then we have arranged a meal or two outside

---

ASSURANCE –Ability of the service provider to be knowledgeable and to inspire confidence and trust

---

1   Are there any Continuing Professional Development (CPD) programmes that you, as an individual, are involved in?

(In teaching them, presenting them or attending them?)

Attending them

No

I did a lecture at the nursing college, they asked me to do a lecture for the nursing group. A thing on antibiotics, it will probably become regular in the future. Other than that, no.

2   What ways do you have of knowing that clients are satisfied with the service that you offer?

Well they collect their TTO on their way out and that's the time for us to talk and if there is any concern they bring it up there. We have a little slip designed by the pharmacist at the other hospital with the TTO to say if you have any problems I'm the one who dispensed your medicine my name is so-and-so, please call me if you have any queries. So there is a link set up there.

3   How are patients made aware of their rights? I am referring to a patient's rights charter.

I have no idea. I will imagine if there is anything that can be done should be done through the administration on admission

4   What is your understanding of a quality service that is envisaged by your company?

I think it's a whole lot of things. This thing that they usually use in the wards: The right medicine at the right time to the right patient at the right price, quickly, and they must have recourse should they be unhappy.

Of course they must feel really like they would want to come back, not because they want to get sick, but should they feel they want to come back to hospital they would come back here.

So it's the correct standard operating practices that must be followed, there must be a human element in that you must have contact with people. They must see something other than the health care, they must see a personal interest in them by the staff and they need to want to come back to this hospital if they had to go back to hospital.

5   What would you say makes your present system effective?

From the pharmacy point of view the only contact that we have with the patients is on their way out when they collect their TTOs.

Whilst they are in the wards, the service that you provide them

In a sense we don't provide them with the service directly. We provide service to the nursing staff who then dispenses the medicines at certain times to the patients. We really service the ward and then the nursing staff services the patient. We service them indirectly really except when they meet us on their way out and that's when we have the discussion about their TTO, their medicine and side effects.

I do every now and again try to do a bit of a ward round and be visible to people and that is what we try to have the new pharmacist involved with. Not so much the clinical ward round with the doctors, but just to visit "Mrs Jones – how is she, is the medicine okay, is she happy with the side effects, if not we must talk to the doctor or whatever".

6   What are the essential elements of providing a pharmaceutical service?

Number one you need highly ethical staff, you need people who know their job or who are willing to learn the job. There is no place for half-baked people who just bungle on. So they must be ethical, they must be trained or willing to be trained and they must go the extra mile. I just need people to show me they can go the extra mile.

7   Is there written information in existence that will allow a locum pharmacist to operate in the facility?

Yes all SOPs are here. It's not all that easy because they are electronically filed or I've got (it's a bit out of date now) the one that I compiled everything into one book, it needs to be updated. I would find that as a locum trying to read through that book to be a bit daunting because you need to have the work done. I think it is there for reference. But I think good teaching from your other staff to the locum preparing them for their job here is probably practically better that to give them a manual say go and look it up but there are things should we need.

However my staff should know operating procedures and I think good communication and teaching ability or a willingness to teach a person with patience is probably more valuable to a locum than giving them a book

1   Is there a private area for the purpose of counselling patients?

There is s semi private area outside the dispensary which is got some easy-chairs and a screened off partially from people entering, but it is not completely private.

2   Is there any means for the patients / clients to voice their dissatisfaction with service provided?

Yes there is a little insert/pamphlet that we put into the TTO to say I am so-and-so, I dispensed your medicine, please call me if.

Would that also allow them to voice their dissatisfaction on the service provided?

Yes because they would phone in and say look I have a problem or a question and then you could then say are there any other problems that you have. They are told they can phone in with any queries or ant concerns.

3   What can patients do when they have questions with regards to their prescribed medication, once they have been discharged?

They can phone in on the number provided on the pamphlet

PHARMACY C

1   Does the pharmacy layout permit a logical flow of work?

At present no. Firstly because the pharmacy is a bit small to permit easy logical flow, but otherwise the way the items have been placed on the shelves, in an alphabetical order, which does assist in the logical work

2   Referring to easy access to all items for staff depending on area of work:

▪   **Are fast-liners/frequent-use items less than an arm's length away from the point of dispensing?**

No, they are placed in alphabetical order. Depending on the name it could be farther away, it's not at an arm's length, you have to walk**.**

- **Are all items in need equal to or less than five walking steps away from area of dispensing?**

They are not 5 walking steps away; it won't be possible, even with our small dispensary and small surgical area, it's more than 5. If you wanted a bigger area for a logical flow, *.

3   Is there room for all staff members in the dispensary?

* The area is too small

4   Is there room for all stock in the dispensary?

5   Is the facility easily cleanable?

Because of the size it is not easily cleanable and also because of the age, it is an old building, the flooring is all old, it's not easily cleanable. It has to be scrubbed with machine

6   With regards to effective communication:

- **Is there a telephone present in the facility?**

Yes

- **Is there a fax machine in the facility?**

Yes

- **Is the noise level in the facility sufficiently low to allow each staff member and patient to hear the next person quite clearly?**

Yes, that's fine.

7   Comment on your Stock Control procedure.

We have all our stock computerized. The ideal is to have the minimum order quantity on the shelf and also to have an order level or a quantity order, we haven't got that implemented fully yet, that's the ideal, but we have the computer program to allow that, it's just that we have to set up the limits, which must still be done.

With the surgical side it's much easier, we can do that. With the ethical side it's not that easy because we also have the retail pharmacy, and that's a bit difficult to have a minimum/maximum level. So at the moment we have all our ethical stock coming to the hospital side and as we dispense on the retail side it's taken off. We have an interface between the hospital and retail pharmacy, so everything dispensed is drawn off from the system and so we can see our usage from the retail side and in that way we can re-order. So there is a control of the ordering and the usage of the stock.

125

If you want to know stock control as far as pilferage, theft – you want to look at that as well?

Yeah

We have an area where stock is received and one who person signs for that. All invoices are checked right there and signed; stocked checked in this particular area and then the invoices are passed on to the data capturer. And this is both for the surgicals and the ethicals were all invoices are delivered to a certain area and then checked by a person individually.

This stock that comes in is it both for the hospital and retail pharmacies?

Yes. But they have separate areas, for the retail side, the front shop, that will be receipted at another area to the hospital ethicals and surgicals.

8   Explain how pharmaceuticals are procured.

We have two buyers, an ethical buyer and a surgical buyer. The ethical buyer will look at the ethical stock and would separately order the ethicals. At the moment Afrox has the system, it's not working with us, an online ordering system, we are in the process of upgrading it. So at the moment orders are generated on the system but placed telephonically, not via our surgical system.

We are not using the surgi-com™ to order on-line, which is the ideal they're working on. We have problems with our surgi-com™ and in next month they are actually coming down to talk about that again. So at the moment the ethicals are generated on the system but then the orders are phoned through, not sent through electronically. With the surgicals it's generated on-line, with the ethicals not because we had a problem that with the ethicals there is a distributor like IHD so there's different companies that distribute via IHD. And what happens is when they order, one order number is generated on different invoices, and the data capturer was saying she had a problem in capturing it – different invoices with one order number. So we are looking at how we can correct that

9   What system is in place to monitor the performance of the suppliers?

We have a system were we monitor what is our orders to the wards, so that if there's something out-of-stock, one can pick it up right away. We are looking at our service level

to the wards. So from there one can pick, if we are not 100%, why. Then we can look and say we don't have stock and that will lead back to the supplier.

10   How do you deal with out-of-stock situations?

If it is an item that we use all the time and there's no equivalent, then we try to buy it out from other Afrox hospitals, otherwise one would look at an alternative generic or supplier. But that would be a last resort, especially in the light of Afrox having their preferred providers, so one would first try the preferred providers before going to one of the other suppliers. In the event that none of the preferred suppliers has stock then one will buy from somebody else, but that would really be the last resort.

ACCESS AND SECURITY

---

1   What security system is in place to ensure that only authorised persons have access to the dispensary?

We have a notice board up saying: "Authorised persons only" but it is not that effective because people still disobey it. So it's not easy to implement that. Especially when I say authorised persons, you find that nursing staff they would see themselves as being authorised and would walk through, although they are not authorised to go through the dispensary.

2   But now you saying there is no real system in place to curb that?

No, except for the board that we have and word of mouth, trying to say nobody must come through into the dispensary. But our layout of the pharmacy also makes it difficult because the ethicals, the injectables, that's at the back of the dispensary and in order fro somebody to come and get them they must go through the dispensary. So if one sticks to the strict system, you might have to say sorry you must wait here and the pharmacy personnel will have to go and fetch it for them.

At the moment they come in, go through the dispensary and they go to the back to go and fetch from the ordering clerk. If we say you can't go through the dispensary it means they will have to ask the pharmacist or pharmacist assistant to go and fetch it for them. So that comes back to the layout of the dispensary. If the layout is correct, ideal, then one could enforce that.

3   **Referring to how legal requirements for control of access to different schedules of medicines are met:**

▪   **Are there facilities to ensure that schedule 5 and 6 substances are kept locked up?**

Yes the pharmacy is completely separate to this unit, so the pharmacy is locked after hours so that no access is there. During office hours of course it's not under lock and key, well with the old schedule 7, 6 and 7 used to be under lock and key schedule 5 used to be on the shelf. At the moment schedule 5 is still on the shelf I don't know with the new laws if schedule 5 will also have to be under lock and key.

▪   **Does the pharmacist only have access to the locked up schedule 5 and 6 substances?**

Yes, the pharmacist has, the old schedule 7s that are locked up, only the pharmacist has access

4   **Comment on the health and safety procedures in place.**

Firstly we do have a health and safety committee for the hospital, which meets regularly to look at he various aspects of health and safety and where we don't comply they try to rectify that. Each department has a representative on this health and safety committee so they can bring to the committee those instances were they don't comply. So as far as possible we try and look at the health and safety of the staff at all times; the inflammable items placed off the floor separately. One of the recommendations was to place the inflammable s in a steel cabinet, but we don't have that, but it's placed separately and it's also marked. As far as clothing is concerned, we do have protective clothing, the pharmacist assistants, they do mix, they do have, they use gloves to protect them from any ingredients. So we are aware of health and safety.

5   **Are there regular inspections that go on to check for the safety of the facility?**

Yes. The committee that we have looking at it all the time on a regular time, on a monthly basis they meet and they bring it to the attention of everybody where we don't comply or where things have to be corrected. Like even if they have a broken tile, at the entrance to the lift, that will also be highlighted and every month the * is replaced. So there is in place a system of checking.

1   Does the storage area accommodate all stock received?

No. Again the facility being an old place is too small at the moment so it is a problem when big orders come in.

2   Referring to the storage of thermolabile pharmaceuticals:

▪   **Does the facility have a refrigerator committed to the storage of thermolabile pharmaceutical products only?**

Yes, we have a refrigerator and it's also (I see the other questions); it has a minimum/maximum thermometer and we do have a system in place were we check the thermometer everyday and we do record it.

▪   **Is the refrigerator equipped with a maximum/minimum thermometer?**

▪   **Is the refrigerator capable of storing products at temperatures between 2ºC and 8ºC?**

Yes

▪   **What method is used to ensure that the refrigerator cleaned, defrosted and checked periodically by a responsible person?**

3   Explain how expired or damaged stock is disposed of.

Afrox has a company that's contracted to, who supply us with different containers for different products. If something is expired we take off our system and we place it into these containers. The containers are different for the different hazardous substances; and the health and safety officer will then get the company in at certain times to come get these containers and have them disposed.

1   How long have you worked for Afrox?

I've been with Afrox since they've taken the hospital, which is 3 years.

Well as a pharmacist?

As a pharmacist for Afrox, 6 years.

2   What is it about your work at Afrox that you enjoy?

Well it's difficult to say * with Afrox it's something that will be for as a pharmacist you'll enjoy working with people. With Afrox one finds that they have a very rigid system – a rigid system especially for the pharmacy manager, a rigid system for reporting, stick to times – that makes it a bit difficult, but it gets one to watch your time and to be more able to implement time management. So that will be the challenges.

But then for the enjoyment still?

I can't say that I can separate it and say that because it's Afrox there's something to enjoy, whether it be with another group it would be the same, there's nothing specific that I can say with Afrox.

3   What are the challenges of working in a setting like yours?

4   How would you describe the service that you, as an individual, provide?

As an individual one tries to comply with all the requirements of your position and try to provide to the best of your ability and within the environment to comply.

5   Are there specific written Standard Operating Procedures (SOPs) followed by staff concerning their day-to-day duties?

Yes we have Standard Operating Procedures written down which we also review regularly as circumstances change. We review them and staff are informed about them.

6   Describe your management style.

Well my management style, I've been told is one is too soft. Actually I had an exit interview with one of the pharmacists that left, one of her comments was that I am too soft, sometimes one has to relook at that and change it but at the moment the management style perhaps one may say it's too loose.

7   Describe the range of activities in a typical day.

My activities will perhaps differ from the pharmacy managers of the other Afrox hospitals because we have this retail pharmacy and I am required sometimes to go and assist in the retail pharmacy as the load increases. But most of the time is spent in the admin function looking at the admin side – stock, reports, looking at complying with the formulary requirements, having contact with the nursing staff * looking at their over and under recovery, all that – but because of the retail side one can't, I can't spend all my

time on *. I've actually put in a proposal that we have another half-day pharmacist to ease my task.

8   Do you plan your on-duty day?

Yes, because I also help with the after hour service that we provide in the pharmacy, I do plan my on-duty day when I'm on call, when I have to work overtime. As far as the daily duties, I have a system were you come in the morning and you write down the activities that you plan to do for the day, but invariably you find out that it does not work because as you start something else happens, somebody phones, though you planned it you have to change it. So I try to tick off what I've done and take over to the next day what was not completed

9   Comment on your interpersonal communication skills.

I must comment on my own – I think that is one of my weak points that I've been criticized on, being honest. My immediate line manager is always saying that I am not communicating well, I'm not coming back, I tend to leave things; and that I'm working on, to communicate straight away. You know one tends to leave things to the next day and to the next day. Perhaps also because of the workload that you find that you want to do something and then you leave it and then it passes and then it slips your mind and you do it the day after that.

But they are talking about skills, what I was saying now is that I fail in communicating, * part of the skills. What I've learned with communication in our particular set-up we've had a bit of a problem in that there's communication breakdown especially between pharmacy and nursing. I think it's one of the reasons why we've had a high turnover or pharmacists in that the communication has not been that smooth. The fact that I'm still here says that perhaps I'm coping.

It's normal that people react, somebody speaks to you and they raise their voice you react and raise your voice. And I try to change that and be proactive in my communication. I think in the past year I've tried to adopt that skill to be proactive and I have found that it has worked in that there is less conflict

RESPONSIVENESS – Willingness to assist clients / customers

1 How do you ensure that clients receive a service that satisfies them?

When we talk about clients are we talking about the retail clients, the patients, the doctors, those are our clients?

In fact if you could go through all the different categories

With the retail side customers we try and offer a service that if we don't have a particular medication we offer to order and send it to them, so that we can get them to come back again. We try and give a service not to irritate them; we try not to get them to wait too long in the pharmacy. That is why I'll get the pharmacist allocated to do the hospital scripts to come and help in the retail side if we get too busy, so that the retail customer does not stand and wait there too long, because who do find that there were times when the retail customer would walk out because they became inpatient standing and waiting. So we actually got additional computer workstation so that 2 pharmacists could work and in that way try and help them quickly and give the best service.

With the patients in the hospital, there also we try to satisfy them by ensuring that we have the correct medication given to them. We have a system were we check that everything that leaves is correct. Also when they are discharged we also try to get the TTOs to them as soon as possible. Also if we don't have the item we offer to send to them *. The last resort would be to say the customer must take their script to their own pharmacy.

With the doctors we also communicate with them all the time, inform them of any changes like formulary changes, try and get them to comply with formulary standards set by Afrox. If there is any out-of-stock situation we also inform them. So we have the communication with them, so they are always aware. Even with this new legislation were the pharmacist can now dispense generics without informing the doctor we still satisfy our doctor by saying to him whatever he has prescribed that is what he will get, otherwise we'll contact him. So he does not have to fear that they prescribe one thing and their patients get something else

2   What features of the service you are offering impact negatively on the clients?

Well one of the things would be that when the hospital is busy and the retail is busy, then somebody will have to wait. And that is when we impact negatively on one of the sides. The problem is that when the people are right there they see you; you tend to help them first and then you get that the wards then phone saying where is their medication it's been a long time. So, the pharmacy being the heart of the hospital, if the hospital is busy, then every ward is busy, it is difficult to meet the requirement to get * in time. We offer the service that we want to get a turnaround time of half an hour to the wards and in each ward we have a book as a control wherein our runner, when he goes up to fetch the scripts, writes the time he takes them and when he returns them. So there is a control to see how long a particular medication has taken to get to the ward, and one finds that there are times when we are longer than half an hour.

3   Okay I think that even answered the next question. So you saying you are looking at 30 minutes?

For the wards, yes.

4   Comment on the waiting time / turnaround time for scripts.

5   Is there system of self-monitoring for the performance of the facility with regards to responsiveness?

(Well in terms of what?)

In terms of this responsiveness

The system we have was that book I mentioned, that is placed in the wards and the time is recorded there, so we can actually look at that and see. There one can also see which times when it is when we are not complying. We have found that it's normally between 12 and 2 when our runner goes on lunch or one of the pharmacists goes on lunch, because then the pharmacist assistant must go and fetch the scripts and in the meantime the pharmacist is alone. So if we are busy, the pharmacist assistant needs to stay to stay to help the pharmacist then there is nobody to run to fetch the scripts.

We have looked at that to get one of the other store people to, in that time, take the place of the runner.

133

So in that case would they still be responsible to take the medicines back to the wards?

That's right, because that person would act as a runner and not take their lunch at that time.

6   How are the motivation levels of the staff members addressed?

Well we have regular meetings were we talk (about) various issues. We have this appraisal system were we meet staff one a one on one and talk about their various tasks.

In a way does that help keep the motivation…

Yes * one can see that it's has helped with the front shop staff, or most of the staff because they have all been here for a long time. The only people we can't motivate are the pharmacists. We have had a high turnover of pharmacists. There could be two reasons; one reason is the communication problem between pharmacy and the nursing. To answer the question 'how is it addressed', I have spoken to the hospital manager to ask that we get someone from outside, a motivational speaker perhaps to come and talk to (the people involved); it hasn't been addressed yet.

The other side could be the remuneration package for the pharmacist, it also demotivates them. It seems once they get a better outside that they leave.

ASSURANCE –Ability of the service provider to be knowledgeable and to inspire confidence and trust

---

1   Are there any Continuing Professional Development (CPD) programmes that you, as an individual, are involved in?

Not on an ongoing regular day monthly programme, but occasionally there is a programme provided by the pharmaceutical society or one of the other drug companies *, but not on a regular basis. Perhaps if they bring in a system they have with the general practitioners or doctors were they have certain number of CPD points, then one would be obliged or forced to follow such a programme, but at the moment *.

2   What ways do you have of knowing that clients are satisfied with the service that you offer?

At the moment we don't have a system in place to monitor that. Last year they had with the pharmacy week they came out with a little pamphlet to give to the patient saying who the dispenser is or who the pharmacist is and saying if you have any problems contact us and you have the number. But we did not sustain that; now with pharmacy week coming up we're looking at that again. If we can do that on a continual basis; in each packet put in a little pamphlet saying who the dispenser was and your number and saying are you satisfied with our service

3   How are patients made aware of their rights? Here I'm referring to the patient's right charter.

The main thing will be with this generic dispensing. We would then at all times inform the patient that there are generic medications and its their right whether they want generics or not.

That would apply in the retail side?

In the hospital side we have that on the chart when they are admitted *. (But) we don't do any ward rounds at the moment to inform the patients, but that is where we are lacking, we should do that. The reason that we don't do that our pharmacists are not available to go to ward rounds. * our proposal that we get an additional person to free the pharmacist to be able to do that.

4   What is your understanding of a quality service that is envisaged by your company?

Quality service is that you provide a service to your patient or to your customer that will satisfy them, that will ensure that they get the correct medication, ensure that they are satisfied with the time – they get their medication on time – and is correct. That they are satisfied.

5   What would you say makes your present system effective?

Well our system at the moment is not * as it should be because of not having ward rounds were we can go to the patients and inform them of their rights. That would be the additional assurance that they are getting the right thing. One would find that often times

people when they come into hospital they have had perhaps the medication before. So now they are coming in and they get something and it may look different and they may think they are getting the wrong medication, where if we could do the ward rounds we would inform them that this is the correct medication, its just a generic.

So at the moment our system is not that effect to ensure this quality that we wan to give to the patients

6   What are the essential elements of providing a pharmaceutical service?

Perhaps we mentioned these as we went along. The essential element is that the customer, the patient has the assurance that they are receiving the correct medication that which has been prescribed that is what they receive. And that they are satisfied that they are getting the correct pharmaceutical service.

7   Is there written information in existence that will allow a locum pharmacist to operate in the facility?

Besides our standard operating procedures, we don't have anything else. So at present it's just word of mouth, it's not literal
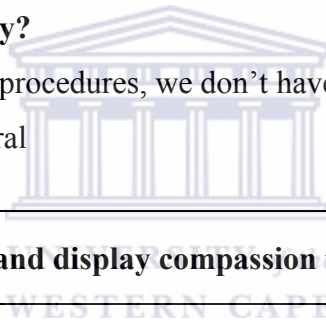
---

EMPATHY – Ability to care and display compassion towards clients

---

1   Is there a private area for the purpose of counselling patients?

We do have this in our retail system, were we could take a patient and have a private consultation. With the patients in the wards we are not doing that. But one will be able to close off the *.

2   Is there any means for the patients / clients to voice their dissatisfaction with service provided?

They do have in the hospital a quality questionnaire that is given to the patient, which they will complete on leaving the hospital. We do get feedback on that

3   What can patients do when they have questions with regards to their prescribed medication, once they have been discharged?

Once we comply with the requirement were we put in a little pamphlet in each medication package saying who the dispenser was with the telephone number, then they would know who directly they can speak to.

At the moment the number is available on the label, so they could just phone in and ask to speak to the pharmacist. But it would be more personal once we put in the other pamphlet, then they would know who dispensed their medication.

PHARMACY D

TANGIBLES – The infrastructure and availability of pharmaceuticals

1   Does the pharmacy layout permit a logical flow of work?

I would definitely say so, originally it was not so. What we have done is we have actually moved these shelves with the surgicals right to the back and we have rearranged all the stock. The stock that we use most is here, underneath here and one or two steps into the shelves and the stock that we use least is right at the back. So for the guys packing the stock its easy access. It is in alphabetical order and is in categories. So it's easy to find, someone coming in starting a new job will find his way easy here. It was also developed by the storemen themselves, they got together, decided where they want their stock to be, what will make their lives easier. So they are happy

With the girls as well, also it was not right. We have now created a new workstation. If you walk in you will see this big island here, that's a new thing too. We have also moved all the tablets to the shelf right next to the workstation, so they can actually sit there and grab the tablets. They do not have to get up to go get the tablets.

Again we have utilised our space effectively, we have managed to get rid of three shelves, so we have packed the stock cleverly. Again they were in charge of what decisions to make. We have also put the printers on the workstations, so everything is accessible to them. They can sit and everything is around them within grabbing distance, so I will say it permits lots of flow.

2   Referring to easy access to all items for staff depending on area of work:

▪   **Are fast-liners/frequent-use items less than an arm's length away from the point of dispensing?**

Yes

- **Are all items in need equal to or less than five walking steps away from area of dispensing?**

Yes

- **Is there room for all staff members in the dispensary?**

Yes

- **Is there room for all stock in the dispensary?**

Yes. As you can see in the front of the pharmacy, all our vacolitres we have moved here now (you should have been here a month ago, it was totally different). The guys' desks were in this corner here, the vacolitres, which are our heaviest stock, was along this wall, the guys would pick the stock on a shelf in the back corner, the guy ordering the stock would be here, so the people were in total opposite directions.

- **Is the facility easily cleanable?**

Yes

4   With regards to effective communication:

- **Is there a telephone present in the facility?**

Yes. We have 3 telephones; we've got one by the storeman, which is on his desk next to the computer – easily accessible, there is one put on the workstation for the pharmacist so it's right there; and we've got two on the sides of pharmacy – one next to the computer for ordering, for the auto-ordering.

- **Is there a fax machine in the facility?**

Yes, a new nice fax machine, it's working well

- **Is the noise level in the facility sufficiently low to allow each staff member and patient to hear the next person quite clearly?**

It's not sufficiently low. We've got this printer VP-1 outside here as you can hear it's very very loud and that's not nice to work in an environment like that, so it will be nice to move that, but where do we move it to, that's the problem.

But it's not loud that you can't hear the person speak, it's just an irritation

5   Comment on your Stock Control procedure.

We've got very strict stock control procedures. Our cycle counts we do everyday, so we are doing stock takes everyday and we investigate variances to find out why do we have a variance; where do we go wrong and we correct our mistakes.

Then we obviously got segregation of duties – that the person ordering the stock is not the one receiving the stock and the person receiving the stock is not the one to put the purchase orders with the invoices together. So we've got our steps to check.

We've also got a stock-receiving bay, which is separate to the pharmacy where the stock comes in and it sits there until it is checked. Once it is checked it is moved to the shelves.

6   Explain how pharmaceuticals are procured.

The pharmacists order the ethicals and the storeman orders the surgicals. Some of them are auto-ordered but that is not working very well at the moment, so we do auto orders, we phone and we fax our orders through. The ethicals are phoned through I think at this point in time, we have started our auto-orders but it has not worked so we are doing it slowly only major vendors are we doing on our computers.

Every order is put through our computer so there is a computer generated purchase order for every item of stock we get and that then is kept in a concertina file; when the stock comes the invoice is taken from the concertina file, picks up the order form and that then is *

But when do you decide to buy more stock?

Ok, unfortunately that's where the person, the storeman, who is responsible for ordering, he will go through the shelves on a daily basis and check the levels of the stock, which is not the best thing to do. That's why they want us to do auto-orders because the computer will generate what stock to order. But that's not a full proof system either because we've done that and then it has duplicated orders, and it does not give us the correct information. So we trust our eyes at this point in time.

Does it also apply for the ethicals?

Yes. We've got on the shelves suggested levels next to every item, so they pick that up and they know what to order. So if a new person would have to come to start it would be easier for them because they know normally you keep 10 of these and there are only 5 so I can order 5 and we won't be overstocked

7   What system is in place to monitor the performance of the suppliers?

Basically the performance of the suppliers we needn't do it all the time. I think it is the out-of-stocks would tell us whether they are performing or not, whether they have out-of-

stocks or not. And the storeman would let me know if the supplier is out of stock. He will try to source it somewhere else. But I think it's just verbal communication at this point in time.

So there is no system as such?

No. We had a form that we to filled in – if something was out of stock we'd put it on the form, and he would e-mail it to me. That takes him 5 minutes where he could just pop his head in the door and say "they are out of stock again" and then I know and could act on it quickly.

8   How do you deal with out-of-stock situations?

We try to source it from another company. I will e-mail head-office and let them know that the supplier is out-of-stock, so that they know when they are going to think again to renew the formulary. Wee had an instance were our suction liners from a particular company, were out-of-stock, for the 3rd time this year. So I escalated it to head office and it's nice because they then put pressure on the suppliers from their side, I then phone the rep. I put pressure on him, so he gets pressure from his boss and me, so he would fly it in for us.
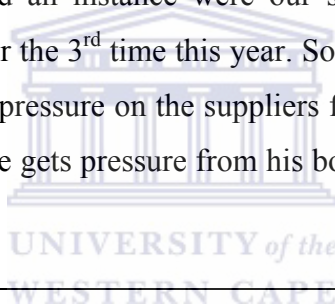
ACCESS AND SECURITY

---

1   What security system is in place to ensure that only authorised persons have access to the dispensary?

Only the pharmacist has the key to the dispensary, number one. They sign for those keys, so if a locum was going to be on call then one of the pharmacists will give her the keys, but she will sign in her diary that the locum has the keys.

There is an alarm to the premises, (whose) code is changed regularly, I'm not going to say monthly because I feel it's not necessary to do it monthly but our security wants us to change it monthly. I changed it first month but I have not been able to change it as such then. I have in the meantime though e-mailed the security company to give me the master code so I can change it from our side. I am in the process of changing code again, but the code was last changed in the 7th month so its 2months ago. So it is changed regularly.

Then we have a buzzer and the gate is kept locked all day. So people who wanted to come in will press the buzzer, we'll have a look to see if they are authorised and then we can press the button anywhere in the pharmacy to let them in. So no unauthorised persons can get access to the pharmacy.

2   Referring to how legal requirements for control of access to different schedules of medicines are met:

▪   **Are there facilities to ensure that schedule 5 and 6 substances are kept locked up?**

Yes. We have our schedule 7s locked-up in a metal cupboard and again only the pharmacist has the key to that cupboard which remains locked at all times unless the pharmacist wants to take something out. The schedule 7s are balanced every week, so every week we do a stock take of our stock in there and there must be zero variances, which there are, and I sign those variances off so I check that it's been done. That way we make sure we can account for everything in that cupboard.

Then our schedule 5s are not kept in a locked cupboard, it's not legally required, we have moved them to a separate shelf. So we've got a schedule 5 shelf with our schedule 5 * and schedule 5 tablets are kept, so they are separate to the rest of our drugs, and they are opposite to the schedule 7 cupboard, so they are right there in the same area.

▪   **Does the pharmacist only have access to the locked up schedule 5 and 6 substances?**

3   Comment on the health and safety procedures in place.

We have a health and safety representative of the pharmacy. She keeps her file up-dated, she lists in there anything we have problems with – an air con not working or something that's broken, she will report it in there – we'll send the slip to maintenance for repair and she will * progress there.

We had a talk at our last green areas meeting, we have green area meetings weekly on a Monday morning, and there I went through the incident reporting – reporting of incidents like * safety, health. They are educated in what our safety protocols are. They have all signed for a safety booklet that they have. So I think that we are quite fine.

We have a regular cleaning schedule. The cleaner comes in twice a day and cleans the floors, the shelves; we've got her dusting the shelves now as well. We've also got a separate cleaner who comes in and checks our bins that go for incineration.

STORAGE SPACE

---

1   Does the storage area accommodate all stock received?

Yes, ethicals and surgicals

2   Referring to the storage of thermolabile pharmaceuticals:

▪   **Does the facility have a refrigerator committed to the storage of thermolabile pharmaceutical products only?**

Yes, not food is kept in the refrigirator

▪   **Is the refrigerator equipped with a maximum/minimum thermometer?**

Yes

▪   **Is the refrigerator capable of storing products at temperatures between 2ºC and 8ºC?**

Yes

▪   **What method is used to ensure that the refrigerator is cleaned, defrosted and checked periodically by a responsible person?**

What we do is we monitor the refrigerator temperature daily and that gets written up on a form, and we also do a cycle count of the refrigerator every month. So every month that stock is counted and when you count you clean. So it's all packed neatly in their bin in alphabetical order. Anything that's not meant to be in there is taken out, and so that how I say it will be done, and the pharmacist will be responsible for the cycle count.

3   Explain how expired or damaged stock is disposed of.

We've got a protocol in place for our damaged and expired stock. One of the personnel my * is the only one responsible for writing off any expired items. Her and myself do it. The pharmacists would bring the items * on the shelves to be expired and she will then write it off under expired items, she will then do an adjustment on the system. That will then be put on the black bins which is controlled by * to be incinerated, she'll fill in the form that goes with the bins and to be incinerated. Then when they do incinerate it, they

will bring the form back because it's so often file forms that we fill out, so they will bring it back and we just staple it together in our file.

Is it a form that says that the items have been incinerated?

Yes

RELIABILITY – The ability to perform the services offered

---

1   How long have you worked for Afrox?

One and a half years

2   What is it about your work at Afrox that you enjoy?

I enjoy the culture of the hospital. I enjoy the management team, they are very excellent at what they do. They've got excellent communication skills, interpersonal skills. So I get great support from them, because I couldn't do my job if I wasn't getting support from the nursing staff. And I find if the * management is stressing it's because the nursing staff. And I enjoy the hospital, just everything about it. I am happy here.

3   What are the challenges of working in a setting like yours?

I would say the challenges are doctors' preferences. I have to ensure that a formulary is maintained and that they are buying the correct stock from the correct supplier, or when a doctor comes and he wants item x which is not on the formulary, I've got to explain or persuade him why he should not use that item. And often doctors get upset because they don't like to be told what to use. So for me that is the most challenging.

But do you succeed in persuading them?

Not all the time (laugh)

4   How would you describe the service that you, as an individual, provide?

I can just say the best that I can do, because I come in at 07H30, I don't take my tea (breaks), I don't take my lunch breaks, I leave at 16H30 – 17H00. I put in a as much energy as I can into my work. I think if I put in energy they will see it and try to catch it. I look at myself to see how well they are performing and then I'll know how well I am. If they are not performing then it's a reflection on me.

In a nutshell what would you say is the essence of your work as a pharmacy manager?

Ok, we've got targets obviously this is what is expected of you during the course of the year, and am I performing or not – you look straight into my JPM (joint performance document). I would say 90% of my targets have been met this year so I'm very happy that I come from a year previously where non of my targets were met, now I'm achieving at least 90%, so I believe my job performance to be good when measured against my JPM because our stock cover is lower than it should be, our GP is just under target but I think it's explainable, our formulary compliance is on target. The major things that count, but my boss may disagree (laugh), that's for her to negotiate my JPM.

5   Are there specific written Standard Operating Procedures (SOPs) followed by staff concerning their day-to-day duties?

Yes, we've got out SOPs as well as their job performance documents, where it tells me exactly what their job is signed off and agreed on those certain duties. So the staff should know exactly what is expected of them so that they know what they are measured on

6   Describe your management style.

I am not necessarily the correct one to have, everybody manages differently, but I really look at what I've done over the last year and I drive from the back. I'm like the scrum half I push form the back. They have to stick with me, if they don't I'm gonna run back and push them. So my staff they have to work fast, they have to work hard, they have to work smartly. They've got to get things done. I'm driving them all the time. I don't stand back and say: "you must get there and you must do this, come here this is where you should be". I actually push them from the back. That's not necessarily the good way but my staff is happy.

In the morning I come and greet everybody that's important. When I leave I greet everybody. No one is less important that anyone else. I try to communicate with them on a regular basis, go out to them where they are working, see if I can help with anything. So if someone is taking strain I will go and do transfers with them, or I'll and bill with them, and I've been told before no other manager has done that in the past, that they are not managing just shouting, whereas I'll go and help them and drive with them and we'll get it done together.

7   Describe the range of activities in a typical day.

Ok, I'll come in at 07H30 and have a cup of coffee, because I can't exist without my coffee, and then I'll do my stock cover template where I'll print my revenue report and my purchases for the day before, then I have got to start a template where I'll go and punch in this information to see how am I buying how am I selling – am I buying too much to what I'm selling and I monitor my revenue how well I do. It's like an owner of a shop who will come in and count his money you know, that's my 10 minutes of the day.

Then I'll go in and everybody will come to work, we'll start working. I'll have my invoices here from the day before - Ashley will leave the invoices - on my desk, so I'll authorise invoices, I'll sign and check them, roughly. He also leaves a copy of the rebate report with the day before's purchases which gives me what was bought at what price, what price it should have been bought and what's our * price and what's our discount and I'll go and check that, make sure there are no discrepancies, I'll follow that up with him.

Then I will attend meetings, I will do my reports, I will do some report checks, I will meet with reps, meet unit managers, then the cycle counts will come to me during the day and we'll investigate variances if there are variances I will help them, we'll sign the cycle counts off.

When do you end your day and how do you end it?

When I feel drained up (laughing). Basically what I do is, I'll get requests from doctors and from nursing staff and then I'll follow up to see if it's on formulary, if it's not on formulary I'll do some *, things like that during the day. So when my desk is clear enough do go, because my desk piles up exceptionally quick with problems and queries and things, so when I feel like I got through most of it, tomorrow I can come in and my desk will be clear and I can start the day.

Ok that's perhaps all.

8   Do you plan your on-duty day?

You mean my Monday to Friday?

Yeah like everyday when you come in do you say I'm going to do this and that?

Yes, I basically follow my dairy closely, check my meetings, cycle counts in the wards, I get involved a lot as well, so I do them. Sometimes I'll come and my diary is clear then I know I can do invoice queries and things that I have not gotten to. But I do plan my day

9   Comment on your interpersonal communication skills.

I think it's important to me because there is no way you can get your job done if you don't get buy-in from the people around you So you've got to make sure your that your communication is first of all clear, consistent, that you're not giving different messages all the time, that you remain constant. (And) I think that I don't bring anything from home to work, there's no person place in a work place for any problems that you have. So it's strictly professional at all times. I deal with my staff, if there's disciplinary or counselling I need to do, I must do that, it's not personal and they understand it and they appreciate it.

I think it's important to understand the person that you are working with. I had a staff member blow up at me, scream and shout at me in front of my staff, and I was ready to say, "Listen if you don't like it there's the door, go right now, don't talk to me like that". But for me that was not a choice, so I said to him, "Listen there is a problem here and we need to talk". "Yes, yes we need to talk" he said, "you always picking on me, blah, blah, blah…" So I said, "okay, we'll meet in my office 16H00". I knew it was only 10H00 in the morning, so he had the whole day to sit and think about what I was going to do to him, so it gave him time to reflect on what's actually going on, why he's reacted like this. We've got lovely management support where it comes to documents, protocol, and disciplinary procedures. I read through that to get an idea of where my mind set should be, because the moment I am upset, I don't want to be personal, and I read through what do with confrontations. And then I set him down and said, very polite, but very professional, "What are your grievances because obviously you have grievances, that's why you are unhappy, that's why you screamed at me? I am not going to say anything you are just going to list them" So he said, he's not happy about this so I just wrote it down, I said okay what's the next one? He said am I not going to comment or say anything? Ok well I'm also unhappy about this. I wrote it down and said what else? So all these things that he had, he had different views on, different expectations to me on certain things. He thought one thing and I thought another, so he was upset with me on few

146

things. So we sat and I said okay now you had your time to talk about what you are unhappy about and I'm going to explain to you what I'm expecting, what I thought and what I imagined to be, this is. So we went through everyone and I explained you thought this, this and this, but I've done this, this and this. So how can you think that…? "Oh yes, no, on, ok…" he agrees. So you agree that's not a problem anymore? "Yes". So we went through each and every one of them. And by the end of the day he was thanking me and saying he feels so good now, he is happy in his work. So that's how I dealt with that one and then I said at the end you must sign this disciplinary because I won't accept that it's wrong and you should never do that, and I won't have it again. I will assess you in three months time. He was happy to sign. That's how I deal with my staff and I think interpersonal communication is extremely important because it must always be positive, always motivational, and always constructive. My staff makes errors and I explain to them and I try to assist them not to make errors again. They make an error again then we have a problem.

RESPONSIVENESS – Willingness to assist clients / customers

---

1   How do you ensure that clients receive a service that satisfies them?

Communication: are they happy at the end of the day, are they satisfied. I've got to ask them, I've to make sure the end results are positive.

2   What features of the service you are offering impact negatively on the clients?

I think we don't go up and counsel on TTO medication, so that the patients up there are not getting good counselling, I mean, we normally the tablets are put in their shaving kits and they find them when they get home, you know. So I would like to offer the service when we go up and counsel on TTOs. It's impossible to do it now, it's resources, it's just not a possibility, but that would be very nice.

3   Comment on the waiting time / turnaround time for scripts.

Our turnaround time as promised is an hour; I would like to shoot that person who made it an hour, I think it should be an hour and a half. But we try to stick to it. We had a problem previously, not good service at all, our turnaround time was shocking. And we

tried everything we just could not get it right. So what we do now is when a script comes in, we've got a box with shelves in it that can come out. We used to have shelves * we used to put it in the ward. But then how do you know who's first come and first serve? But ICU and ICU neonates want theirs first, so we put theirs on top and we always take from theirs. But if they are busy then we are not getting to the other wards *, a chart can stand there for 4 hours and no one would know because we've missed it. Then we put first come first served, but that was not working either because the * were complaining that they were taking so long.

So now we've changed it to time. We've got time slots. Because also the wards would phone and say I've been waiting for charts since 8 o'clock this morning, it's 3 o'clock and I've not received it yet. And we'd say but there's nothing here, so it did not come down at 8. So now we have hourly slots, so as soon as the porter brings it, he puts it in that time slot and they know if it's 10 o'clock there should be nothing in the 8 to 9 (o'clock) slot, that must be clear, and they are actually managing it that way and the wards are definitely *. I would definitely suggest that anyone problems with time.

4   Is there system of self-monitoring for the performance of the facility with regards to responsiveness?

Well, yes, that time slots, that helps us monitor our performance because we can see if we are left behind or not and we also have the customer service template where we fill in how many lines (items) were ordered how many were issued and how many we are missing, so that gives us a percentage at the end of the month. We aim at 95%.

5   How are the motivation levels of the staff members addressed?

What I've implemented is an hour every week on Mondays from 8 to 9 we are closed. When the nursing staff were screaming and shouting saying: "We want you open till 8 o'clock at night everyday" I said: "no, we are not going to open a minute later than 6 o'clock and you know what, we are going to close for an hour on Mondays between 8 and 9". Somehow we got that right, I don't know how. So we all come to work on Monday 8 o'clock and that hour is our time and that is my motivational time were we do our green areas, were we discuss problems were are experiencing as a facility; were we get speakers from outside; *** our psychologist has done hospitality training for 4 weeks and next week a speaker from the Western Province Blood Transfusion Service is coming

in and she's bringing a doctor to give us a talk on blood transfusion, blood products and things like that. So they will use that time to learn, to gain experience when it comes to personal skills, life skills * training, and our own house keeping. So I think that is dealt a lot.

I also have implemented "employee of the month" so there is a certificate that we put up there, we display for a month, it's a nice certificate for them and they get a R50gift voucher to go with. We've a box as well over there were everyone gets a chance to vote for someone hey think has performed extra special his month and F and I will go through the votes and we will choose someone and at the next green areas meeting, the first of the month we will award the person.

ASSURANCE – Ability of the service provider to be knowledgeable and to inspire confidence and trust

---

1   **Are there any Continuing Professional Development (CPD) programmes that you, as an individual, are involved in?**

(As a pharmacy manager?)

Yes

Yes we have our certain courses we are expected to go on like disciplinary skills, recruitment, (and) things like that, so that I have attended. I have recently attended the disciplinary and advanced disciplinary process skills.

I have not gone to any pharmaceutical, no, other than the Wednesday morning doctors meetings. The doctors have a meeting every Wednesday m, they have a breakfast and they discuss cases and they get their CPD points and I would attend a few those. It's not really pharmaceutical related, it's more doctor related. I get to talk one-on-one with the doctors to hear about the cases, which is very interesting, but it's more doctor related rather that pharmacy related.

We have reps come in and give talks now and again, unfortunately we have not done that a lot lately. I think with the changes in pharmacy and the stock take and moving of our stock we haven't had time to invite reps around. So I must actually get on that. And then I use these Monday morning meetings to bring people in to discuss

2   What ways do you have of knowing that clients are satisfied with the service that you offer?

We don't. With the wards as our clients yes we do. I meet with them regularly, on a daily basis and we always discussing pharmacy related issues and nursing related issues. So I make sure the unit managers are happy at all times. So I know when they are happy and they are happy with the service then I am happy. So there's continual walk around to the units, I am forever up in the units making sure they are happy. That's the way I test the pharmacy.

Also if they don't complain, and they really complain very easily. At the beginning I was often called in to unit managers meetings to discuss problems that they had, and I have not been called to these meetings for a while now *. The last one that I had was with the month end times that did not suit them, so we sorted that out.

So I think close verbal communication with the wards as clients but when it comes to patients waiting at the hatch, its difficult, I can't really measure that, but now how I have designed my pharmacy, I can sit here now (*in office*) and there's no more shelving in the way, I can see my pharmacists work station, I can see the hatch. So I am better equipped to know what's going on in the pharmacy, where previously there were around the corner and they did not see the hatch, now they are positioned right in front of the hatch. So if a person comes in front of the hatch they will see the pharmacist immediately and the pharmacist will see them immediately.

3   How are patients made aware of their rights?

I've got that up on a certificate in front of the pharmacy. I also have this * from the PSSA, there's one of them already up, which is an old one. And I've also got pamphlets on generic medication * that also available to them. We also give that out to the pre-admission clinics now, we've decided we are going to give them pamphlets on generic medications to them, so that when people get admitted they can now what to ask for.

Are generics part of the company's formulary?

Yes

4   **What is your understanding of a quality service that is envisaged by your company?**

A quality service is very important to the company; I mean that's part of their major drives. We have just started a quality initiative program now a hospital one and the company one is staring in December-January (*2003/2004*). So we are running two quality initiatives here were I have a whole slide show that I will present to my staff. Then we are getting big posters with a bull's-eye-board on it were we'll put our minds on – what quality initiatives have my staff thought up during that month goes on there. So we're continuously working on how to improve the quality by using quality initiative programs.

5   **What would you say makes your present system effective?**

It's forever changing; the fact that new initiatives are consistently thought up makes people remember that they need to constantly think about what service they are providing and how that can improve on it. The fact that we have changed a whole pharmacy now is all quality initiative driven. We start off by saying we are not happy with the quality we are providing, how can we make life easier for us to provide better quality? How can we make our lives easier that we can dispense the correct stock that, we can manage our stock correctly, that we can provide service to the wards, how can we manage the hatch correctly because we wan to improve quality * things like that. So we consistently, on really weekly basis, looking at quality.

6   **What are the essential elements of providing a pharmaceutical service?**

Obviously, I would say the dispensing of medication, but the correct dispensing, accurate dispensing, dispensing with counselling, patient oriented counselling, patient oriented dispensing. Our pharmaceutical service is to the ward to the sisters there, to the patients, to the doctors, and also to our suppliers. So essential elements of providing a pharmaceutical care is then 4-fold, we've got to ensure that the staff are happy so * are we giving them the drugs that they need, are we giving them the stock that they need, the turnaround time is important, education – are we educating them? It's nice when we have an intern, she gets to go up and give talks* so there's that continuous element of education. And then to the doctors are we also providing them with the quality stock that they want – the generics that they don't want, are we looking after that *. And then again to the suppliers * I see reps on a regular basis.

151

7   Is there written information in existence that will allow a locum pharmacist to operate in the facility?

Yes, we have SOPs for everything we do so they can go to the protocol book and read on how to transfer stock, *, how to do stock transfer between hospitals and so on.

EMPATHY – Ability to care and display compassion towards clients

---

1   Is there a private area for the purpose of counselling patients?

No, that is a legal requirement, we don't exactly have. How I got by it the last audit was I told them we don't do TTO counselling, which we don't. It's done at ward level. So we rarely counsel patients, I mean patients don't come to the hatch. We are strictly a hospital pharmacy, we are not a retail pharmacy, we don't have a retail system and we don't do retail scripts.

We do retail scripts for staff members, we put it then on their accounts, and if they require counselling then we can bring them in and there's a room that they can use, its got stock in, but we can put two chairs in and they sit and can talk about *. There is a private area we can use for that facility but we never counsel.

Are you saying even in the wards were TTOs are done you don't counsel?

You see private patients in a private ward would be easier but if there is a full ward… not that I know. I think they just counsel at the bedside. I am sure they have facilities upstairs when a patient wants to talk privately, they can do that.

2   Is there any means for the patients / clients to voice their dissatisfaction with service provided?

Yes. Now clients, who are you talking about? Are you talking about people in the hospital, in the beds?

Well the wards, the sisters the doctors and patients

We do surveys, the doctor ones, were the doctors, twice a year were the doctors get to answer pharmacy question and they get to discuss their dissatisfaction or satisfaction. So that's how the doctors would, or they would just phone me and say this is incident

happened and I'm really unhappy with your pharmacist, and then I can talk to her about that. Nursing staff as well, it's just verbal at the moment nothing in writing.

We have incident reports, the yellow cards. So if they are dissatisfied with the pharmacy they will fill in a yellow card, they will come down to me, I will investigate it. As like we would send yellow cards to the wards when we are dissatisfied with theirs. Yeah I would say the yellow card system is specifically for the nursing staff and I suppose the doctors may also use it

3   What can patients do when they have questions with regards to their prescribed medication, once they have been discharged?

We've got cards now that say I am so-and-so I dispensed your TTO medication and your visit number is so-and-so, if your have any queries phone me there's my telephone number. So that's filled in and sent with their TTO medication, they just need to look at the card, phone us give us their number.

Appendix 5

FACTORS INFLUENCING PHARMACEUTICAL

SERVICES IDENTIFIED FROM
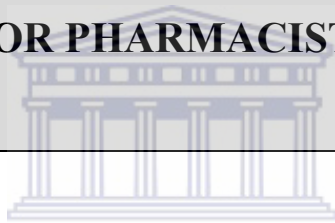
PHARMACY MANAGERS' INTERVIEWS

- Job satisfaction

- Important elements of quality pharmacy services

- Challenges in the provision of quality pharmacy services

- Client satisfaction

- Continuing professional development

- Management style

- Interpersonal communication style

Appendix 6

FOCUS GROUP DISCUSSIONS GUIDE

FOR PHARMACISTS

Introduction

Good day and welcome. Thank you for taking time off to join our discussion on quality pharmaceutical services in hospitals of a private health care provider group. My name is ****; I am a postgraduate pharmacy student. *** is sponsoring my research project because they believe it will help them get some information about how their employees feel about the quality of pharmaceutical services they offer. They want the information to help them improve the services they provide. This is the first in a series of three groups like this that we are doing.

You have been invited because you are the people involved with offering the services everyday. We want to tap into those experiences and your opinions about the pharmaceutical services you are offering. There are no right or wrong answers. We expect that you will have different points of view. Please feel free to share your point of view even if it differs from what others have said.

We are tape-recording the session and also taking notes because we don't want to miss any of your comments. No names will be included in any reports. Your comments are confidential and may I request that you maintain confidentiality within the group as well. Keep in mind that we are just as interested in negative comments as positive comments, and at times the negative comments are the most helpful.

Don't feel like you have to respond to me all the time. Feel free to have a conversation with one another about these questions. I am here to ask questions, listen, and make sure everyone has a chance to share.

Let us begin.

Discussion questions

1.   Opening questions
i).   Let's find out some more about each other by going around the room one at a time. Tell us your name, how long you have been a pharmacist and how long you have been working for Afrox Healthcare.

2.   *Introductory questions*

i).   What is your understanding of providing pharmaceutical services in the private sector?

3.   *Transition questions*

i).   What is the first thing that comes to mind when you hear the phrase "quality pharmaceutical services"?

4.   *Key questions*

i).   Share with us what you like and /or dislike about your work.

ii).   In your opinion, what are the important elements of quality pharmacy services?

iii).   Share with us what you consider to be challenges in your work place that may hinder your provision of quality services.

iv).   From your experience, what would you say are the clients' (doctors, nurses and patients) expectations and their appreciation of the services offered?

v).   How can pharmacists accept responsibility for maintenance and self-assessment of competence throughout their professional working lives?

vi).   In what way does the way your pharmacy is managed affect the services that you provide?

vii).   Tell me about the ways the other units in the hospital rate the services that the pharmacy offers.

viii).   The pharmacy is one of several units in the hospital providing healthcare. How do you ensure that you have a common understanding of quality pharmaceutical services with the other units?

5   *Ending questions*

i).   We have talked about several of the elements that make up a quality pharmaceutical service viz. (list some of them). How would you rank them in terms of importance? Of all the questions we discussed, which one is most important to you?

ii).   Is there anything that we should have talked about but did not? Are there additional issues that you would like to raise?

Summary

Let me briefly give a summary of the main issues that we discussed and may I ask if you think that the summary is accurate. Are there any additions or changes that you would like to make? The aim of the discussion is to gather information that will help to measure and improve the quality of pharmaceutical services that you offer. Have we missed anything?

This is the first in a series of three discussions that we are conducting. Do you have any advice for how we can improve on the discussions?
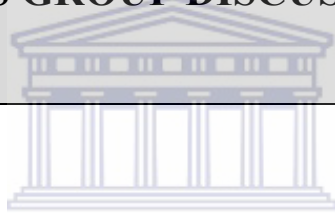
Conclusion

Once again thank you for your participation in the discussion and giving us this valuable information. Please join us for some refreshments.

Appendix 7

TRANSCRIPT OF

FOCUS GROUP DISCUSSION 1

Introduction

Good day and welcome. Thank you for taking time off to join our discussion on quality pharmaceutical services in hospitals of a private health care provider group. My name is ***; I am a postgraduate pharmacy student. *** is sponsoring my research project because they believe it will help them get some information about how their employees feel about the quality of pharmaceutical services they offer. They want the information to help them improve the services they provide. This is the first in a series of three groups like this that we are doing.

You have been invited because you are the people involved with offering the services everyday. We want to tap into those experiences and your opinions about the pharmaceutical services you are offering. There are no right or wrong answers. We expect that you will have different points of view. Please feel free to share your point of view even if it differs from what others have said.

We are tape-recording the session and also taking notes because we don't want to miss any of your comments. No names will be included in any reports. Your comments are confidential and may I request that you maintain confidentiality within the group as well. Keep in mind that we are just as interested in negative comments as positive comments, and at times the negative comments are the most helpful.

Don't feel like you have to respond to me all the time. Feel free to have a conversation with one another about these questions. I am here to ask questions, listen, and make sure everyone has a chance to share.

Let us begin.

Discussion questions

1. Opening questions

i). Let's find out some more about each other by going around the room one at a time. Tell us your name, how long you have been a pharmacist and how long you have been working for Afrox Healthcare.

My name is *** (name withheld), I've worked for Afrox for about 4½ years and I've been a Pharmacist (*for*) 12 years.

My name is *** (name withheld) I've been a pharmacist for 3 years and have worked for Afrox for 2 years.

My name is *** (name withheld) I've been a Pharmacist for 6 years, that is including my internship, and I've been working for Afrox for just over 2years.

2.   Introductory questions

i).   What is your understanding of providing a pharmaceutical service in the private sector?

It's basically providing service to the hospital, which includes your patients; providing them with everything necessary for the improvement of their health, which is disinfectants, medication, surgicals, the works and doing it as best possible.

You need to focus on good service because the people are paying for it, which is important. They are expecting a good service because they are paying for it.

3.   Transition questions

i).   What is the first thing that comes to mind when you hear the phrase "quality pharmaceutical service"?

Accuracy:

Accuracy in dispensing; making sure that you are giving a professional accurate service to your patient so that they get the correct medication and we do it at the best possible cost, and whatever…. So accuracy and professionalism.

Efficiency

I also think efficiency. It's also quite important sometimes to the patients how fast they get their medication - the doctor wants something for the patient now. Sure they don't want it at the end of the day. They would like to start their therapy as soon as possible. I think time also plays an important factor in quality.

4.   Key questions

i).   Share with us what you like and dislike about your work.

Interacting with other professionals, with patients and with other staff members within the pharmacy. So, it's the interaction that I enjoy. Now and again in (*the*) private (*sector*) you do actually get asked for some clinical input, not as much as in state (*public hospitals*). In (*the*) private (*sector*) that is important and I think you feel a level of satisfaction when you can actually provide a clinical input not just dispensing. Sometimes

162

we get so involved in the dispensing of the medication and the clinical bit gets left behind, so when we now and again get asked for that, it is satisfying.

(Don't ask me what I don't like).

I also enjoy the interaction with people. Sometimes I feel that I don't get enough interaction with people, because you are stuck in a hole. I get the opportunity to give continuing educational talks to some of the staff, which is also enjoyable; you get to research a bit, (*to*) do something different. I also enjoy the fact that I get opportunities to do extra courses, which through the company I get the time to be able to do those, which is also enjoyable.

I agree. I like the opportunities that you get, for example courses. They see basically potential in a person or some skill that needs to be developed and (*the*) opportunity is given for you to be able to go for training for something and that's nice. That is one of the traits of Afrox that I admire, that there are always courses that you can go on.

What I don't like is the fact that, I think maybe in any hospital, there is always this barrier between the nursing staff and pharmacy. Now over the years, over the past two years, our pharmacy has become more stable where staff is concerned. So with some of the nursing staff, we have developed a relationship, but because of the charisma   * (tape inaudible) the staff doesn't know it. Sometimes they become agitated, they don't know how you work, and * and tempers can *.

So those kinds of situations; the fact that the nursing staff is not consistent is what I don't really like. Whereas the pharmacy has become consistent they know what to expect from us, but we don't always know what to expect from the nursing staff, from the agency staff.

Can I just reiterate that because we have also noticed in our hospital that there is an increase in (*nursing*) agency staff; and they don't know the processes of how things are done, how the charts get there, how long it takes, (*and*) what's the process to follow.

We don't have the barrier that some hospitals have. We have quite a good relationship, but when you have agency staff, I feel (*that*) they are not as committed to the environment as maybe permanent staff, so the wards seem less stable, our wards definitely seem less stable. I don't have a problem personally relationship-wise with

163

them, but there definitely seems to be more mistakes creeping in from their side or less commitment or something from their side, and it impacts on us it impacts on everybody, (*and*) on the patient too.

ii).   Share with us what you consider to be challenges in your work place that may hinder your provision of a quality service**.**

One of the big challenges is communication at work – that is a big challenge because if you miscommunicate or people don't think that you are communicating what you want to get across properly, there are huge discrepancies, and that's how they do build up barriers as well.

(Prompt): Is it a question of the communication lines not being clear?

Sometimes they are not as clear and that can cause a barrier because people become irritated and patients become irritated because they don't have their medication, the nurses become irritated because they don't think you are doing your job properly. They become irritated because the message was not communicated to you properly. It's just a negative cycle.

Another challenge is also the fact that private hospitals very much rely on budgets and making a profit, and sometimes I think it's at the cost of good quality service and also the cost of the patients' happiness.

I think our health too because we try to provide the best service we can, but I feel that we are getting more and more, and our managers are also complaining that there is more and more admin (*administrative*) work that is coming pharmacy's way. Dispensing and patient communication and ward communication is actually suffering to a certain degree because we have to do certain counts or certain checks and so on. That takes a lot of time. I understand that it is a private hospital, I understand the budget and profit, but I think the focus is really shifting away from pharmacy, traditional pharmacy and more burden is making sure we are getting our GP (gross profit) and all that, at the expense of the staff's happiness and providing a service.

I can basically just carry forward what Natalie is saying there. I think a challenge definitely is maintaining a quality service to your patients, where in the morning, for example with us we have a one-hour turnaround time where the patient's chart comes in

164

and the chart must be out of the pharmacy to the ward within that hour. Now in the morning everyone starts their duties, I'm just giving an example, and this one does his cycle count, that one does his ward stock, that one does that. One person does the dispensing. The person has to attend to the hatch, maintain a friendly face at our hatch people coming in off the road or with prescriptions, and that person has got to dispense as well. Another person has to leave what they are doing, maybe not do a good job of whatever they are doing there and try to turn around the charts. In the end everybody becomes so stressed, at the end of the day you don't care anymore. You just want to let the work go on, at the peril of the pharmacist. You are basically put in a position where you want to just get done at the end of the day, almost like you can't worry anymore to find out whether the patient needs this or that or whatever.

(And) I don't think it's bad organisational skills in the pharmacy. I think that there are things we have to do and that there are things they are expecting us to do, added on. (And) I think we have to, as Afrox and as pharmacists, remember that at the end of the day we have to be accurate, we have to make sure our patients get * service, good service. Those counting and those other things, reporting that they seem to be so keen on has to take a back seat. But we get the impression from our line managers that that has to take the front seat that they have to be given priority at the expense of the general dispensing. That is hard because you are trying to balance that all day.

iii). In your opinion, what are the important elements of a quality pharmaceutical service?

(Prompt): You have mentioned accuracy and efficiency…

Also being friendly to the patients, listening to their needs and worries, providing good instructions on their medication when they leave, listening to any worries that they have or any questions they may ask or have about their medication that you issue to them.

Also supporting the nursing staff because sometimes doctors' instructions are not clear, or we don't write instructions so clear. That also takes time in your day to make sure the nurse knows what to do. Our patients are not just our customers, our working colleagues are, the nursing staff and the doctors. Those are also people we have to take care of.

(Prompt): Do you feel that at the moment because of the way things are structured in the pharmacy you do not have the chance to do all that?

165

I think that we are able to do it but I think there is a shift and becoming a worsening situation where the admin and the reporting seems to be taking much of the priority in the pharmacy.

I think that also basically a question of you know you are always told about time management, but in pharmacy it's quite difficult because anything can pop-up at anytime. You don't know when you have to do chemo (*chemotherapy*) (*that*) the doctor has written up; it messes up the whole apple pie. This one has to leave that and do that. There is no consistency in our kind of work. That affects quality as well.

(*Clarification*)*:* Is the lack of consistency a challenge or is it just part of working in a pharmacy?

I wouldn't say it's a challenge.

No

When you have minimum staff to get through the day, it becomes a challenge then.

iv).   From your experience, what would you say are the clients' expectations and their appreciation of the services offered?

I have never ever gotten any appreciation from any doctors.

Neither do I

I get appreciation from the nurses.

I think every hospital is different. It depends on the relationship you have with them. At the hospital where I work I think there is a very good relationship between the nursing staff and pharmacy and I think that has a lot to do with our manager. He tries to ensure that there is a good relationship, and I have gotten a complaint with that. Doctors don't generally appreciate.

(*Clarification*): But then what are their expectations?

They expect accurate and quick service; they want it, they want it yesterday.

(*Clarification*): Even if you do that, there is no form of appreciation?

No that is what is expected of you.

Not over and above what should be done that exceeds the expectation of you.

I find that if you do things for doctors, for their personal things; you know, I mean we don't only provide services for their patients, they also have their own accounts or their

166

own things that they want, and if you do things for them personally then they appreciate it, but they don't generally appreciate what you do for their patients.

v). Assuming that a knowledgeable service provider inspires confidence and trust in the clients of the service how can pharmacists accept responsibility for maintenance and self assessment of competence throughout their professional working lives?

Well they are going to make it easy for us because we are going to have to do that CPD points. So we are going to have to carry on going to lectures or talks to get the points so that at the end of the day you can be registered.

(*Clarification*): Is that for pharmacists in general or Afrox pharmacists?

It's not in yet

It's for pharmacists in general.

(*Clarification*): Well what about at the moment?

I suppose any new product that comes on the market you will be advised by the reps (*pharmaceutical company representatives*) and it's your responsibility to know what's new. We have an hour every week to ourselves, which we can choose to have our green areas meetings or training sessions, which we arrange ourselves with the reps. I think at the moments, it's just your own initiative.

vi). How does the way your pharmacy is managed affect the service that you provide?

Well I think it would be quite a big influence if your pharmacy is well managed; the service you provide is better because if it is poorly managed nobody has any structure and therefore the service that you give can't be that structured.

(*Clarification*): I mean in the respective pharmacies that you work in, how does the management style there affect the service that you provide?

We have quite a relaxed management style, which suits all of us. We tend to allocate certain things to certain people. If you are allocated to do certain things you've got to do it. You are not checked all the time. And that just suits us. I think everybody works differently.

We also have quite a relaxed atmosphere. I think we have extremely good management. She is not very strict and I think it works very well.

Some people work better under structure and some people work better if left alone to do the work. So it depends on who you working with and how you work. I suppose every

167

pharmacy is different, but in our pharmacy we have our own jobs, we help one another where we can. For instance cycle counting we'll do in teams; we take turns to do it is what I mean; shared work, but it's not shared work that is enforced on a daily basis.

With us as well, we have a nice structure going where everybody is allocated certain duties as well as certain responsibilities. We work on a roster basis, whereby it changes every two weeks so (*that*) we don't become trapped.

vii).   Perhaps the other units in the hospital rate the service that the pharmacy offers according to the time it takes to fill scripts: What is your take on that perception?

Yes actually at our hospital we did a survey and we scored well on everything except delivery time.

Same here. You can never be quick enough.

I think every sister sending a chart thinks (*that*) she is the only one sending a chart. They forget that there were charts there or things happen, people go to lunch. We stick to our hour turnaround time also and we are able to do that but we're still not quick enough for them

I don't think we can ever be quick enough for them

They want like 15 minutes turnaround time.

(And) we also have things that are priority that we try to give if the sister phones and she needs something urgently, we give that priority. But they think everything must come back in 15 minutes. Definitely delivery time is an important thing.

viii).   The pharmacy is one of the various units in the hospital involved in giving healthcare. How do you ensure that you have a common understanding of quality pharmaceutical services with the other units?

I think it definitely can't be totally common because the care that we give to the patient and what the nursing staff gives is different. (But) I think overall we all are there to ensure that the patient gets the best quality healthcare, which includes pharmaceutical care as well. (Because) for them it would be a matter of making the patient as comfortable as possible, doing their regular checks, I don't know what they call that…

Observations.

I think their perception of what they do for the patient is different, which is correct, and our perception is different as well.

168

Yeah I think they know that we want to give quality care because if they phone and ask questions or enquire about things we are willing to help them and they know we are willing to help them. They feel free to phone and ask for information or if we can get hold of some new product or information about products. They really don't hesitate to phone, so they know that we are willing to help them in that sense.

And our pharmacy manager goes to the unit manager's meeting every week so any grievances that come up or problems that come up it's discussed there because we get feedback. You know if they are not happy with something we are doing it's brought up there or we are not happy with something they are doing, it gets sorted there. At least there is open communication.

(*Clarification*): That question comes up especially after you have mentioned that you scored low in that survey. As far as you are concerned you are doing your best but they don't seem to agree with that. So is there a way of communicating to them to understand where you come from or will they forever just mark you down?

Oh no look, we try to explain it to them but sometimes they want you to see their point of view as well which is…you can see their point of view, but they must also understand your point of view, which is sometimes difficult, especially with turnaround time

It's a question that our in-house psychologist had with that, because we have explain the situation to her as well about the understanding between the nursing staff and the pharmacy staff not being on par, she said why don't you get a person from each unit to spend the day in the pharmacy and just watch the running of what happens in the pharmacy, why that chart is not done, you know, like a robot is not doing it every time, because there are other factors involved. So it's something that was brought up, an idea, but the practicality of it I don't think will be favourable for the units to spare a person out of there for the whole day.

It's hard to change the perceptions of people, you know. It can be brought up by managers – one manager to another. We don't know what follow up happens from unit managers to nursing staff. Plus there's all the agency staff coming in everyday, and they are not sure about how processes of each pharmacy work. So that's the perception that you are just doing their chart.

5 Ending questions

i).   Is there anything that we should have talked about but did not?

Summary

Due to time constraints a summary was not given. Advantageously, this will serve as motivation to start the next session with a summary of the previous one. That summary will act as a reminder of the previous discussions and a bridge into the new discussion. Also a more meaningful summary will be presented after a proper review of the transcripts.

Conclusion

Once again thank you for your participation in the discussion and giving us this valuable information. Please join us for some refreshments.

UNIVERSITY *of the*
WESTERN CAPE

170

Appendix 8

TRANSCRIPT OF

FOCUS GROUP DISCUSSION 2

Summary of previous FGD

Thank you and welcome.

What I would like to do is to give a summary of where we were last time and then you can either add, delete or * (tape inaudible).

I think we will agree that your work experience as pharmacists is between 3 and 12 years. For the company is it between two and 4½ years. When I ask the question of what does provision of pharmaceutical service mean in the private sector, I got an idea that it was more (of) making sure (that) the patient received whatever is necessary to improve their health and (that) it is done as best possible. (And) the emphasis of value-for-money was added, people are paying for *, there has to be an emphasis on good service.

When it comes to what then quality pharmaceutical service would be, ideas of accuracy in dispensing came up, of professionalism, efficiency - (that) things should be done fast. (And) later on when I asked what are the important elements of *, friendliness towards patients, listening to their queries, giving good instructions on the (*TTO*) packets when they go home (*when discharged*).

Then I asked about job satisfaction - your likes and dislikes. One thing that came out was the interaction with other professionals within pharmacy, and others - doctors and nurses. (And) the fact that when you are given a chance to contribute, especially not only in dispensing but when you give talks or when asked for your clinical opinion, that is part of the satisfaction. (And) the fact that sometimes the company allows you to go on courses where you keep on improving your knowledge. One of the dislikes that came up was the apparent barrier in communication between nurses and pharmacy. (But) I think that came up also because there is an increase in the number of nursing agency staff that are used and they are probably not as committed to the company as the permanent staff. (And) that can cause a bit of a problem, because one of the problems was in the turnaround time. Probably they don't understand how things work.

The other challenge was the business side of working here because it appears that there is more administrative work coming towards pharmacy and the "traditional way" of doing pharmacy (work) is taking a back seat whereby you don't talk to patients anymore (instead) you are just "pushing paper". That was one of the challenges.

172

Another point of elements in quality pharmaceutical services was the support that you would give to nursing staff. An example was made where you explain to them instructions that were written up by a doctor, and explain to them how the drugs are supposed to be given. Another one was that it appears that sometimes there is a lack of consistency. People (*pharmacists*) would come in the morning and do particular tasks but as the day progresses then you're asked to leave the task. Sometimes it is half-done and you have to do something else and you are not even done with that you are asked to do something else. It becomes a challenge when you are short-staffed, but other than that you can cope because throughout the day you try to balance that *. As far as what client expectations are, I did not get much as far as that is concerned, but the appreciation was that there is little appreciation coming from the doctors' side unless you do something on their personal accounts, but the nurses are the ones who appreciate your work.

Other than that the question of continuing professional development, it was just when you make yourself available to attend these courses. I think you said it was more personal – it was more you asking to go on these courses, otherwise *. (And) then company reps (*pharmaceutical company sales representatives*) are the ones who would come and give you more information on the new products on the market.

The management style you find to be very relaxed, it was a professional relationship (in) that you will be given a task, continue with it and you will not be checked on.

One of the biggest problems was the turnaround time. The example of the survey that was done by (pharmacists) – the pharmacists say they were marked down on the turnaround time compared to the other area *.

That is basically a summary of where we were the last time, I think if you would like to add or change anything.

No.

Discussion

Now today is a session for clarification really. Last time I had set questions (for discussion) but today I need to clarify.

The first question relates to pharmaceutical services. The last time it was more a question of making sure the patient gets the drugs. I want to find out isn't there more to pharmaceutical service especially quality pharmaceutical service?

Well there are different aspects to it, other than getting the drugs to the patient. Explaining (how to take the drugs) is the biggest thing, showing compassion and empathy towards the patient is very important. (And) I suppose making sure that there is enough stock of drugs otherwise the hospital cannot run efficiently. So stock-control is very important there.

(And) also we are actually trained to provide that pharmaceutical service, so it's expertise that also come into it. It's not anybody else other than a pharmacist or a qualified (pharmacist) assistant that actually can provide that service. So when we talk about quality we must also realise that we are supposedly experts in the field and that is specific or unique to us. (So) I think the importance of pharmacists sometimes is neglected in terms of the hospital environment. You know we are not just dishing out pills, we are actually checking scripts, looking to see if those scripts are viable. That is also part of the service. The quality of it is unique to us.

Yes and also I think supplying information to doctors when they request your expertise. That is also part of the quality service – so that they prescribe the right thing, so that the patients don't get things that are not actually necessary.

What is it that you are doing then (We are working) (*laughing*) that would make you say, "There I think I gave a quality service"? Would you find yourself sometimes saying, "I just gave a service" and "I gave a quality service"? I am asking that question because the term quality is so nebulous *.

But remember (that) we are dealing with people's lives so every time we dispense or provide a service it should be quality because if you are just dispensing without actually checking the patients' histories or (drug) interactions or doses, then it's providing just a service. But if you are providing a quality service which you should do everytime because you should be checking everything you are trained to do. (And) that should be quality everytime.

Yes and also if you are unsure of something that is written up that you question it, you query why it is being written, and if this is the correct thing to do. (Because) you could

just as well give it out and think oh well it must be right. That is not necessarily quality service because you could see that it is wrong or being misused. (So) You need to also check up on things and report back or get feedback from *.

I think if we do everything we are supposed to do that we are trained to do including all that was mentioned – checking scripts, doses and all those things and liasing with doctors – if we do that everytime, then we are providing a quality service.

(*Comment*) Like I said everybody is saying quality out there and I realise that people need to define quality for themselves and I think you are defining that quality for yourselves.

One of the points that I want to clarify is this one of communication. Seeing that, it appears that there is an increase in the number of agency nursing staff, how could you prevent the communication barrier?

Well it cannot only come from us; it has to come from both sides. That you become more receptive to the other person; listen and hear their point of view. But they must also be willing to do the same, which is sometimes not always the case. I think also, increased workload, the pressure to get things done in a specific time does not always allow you sufficient time to listen to the other person and what the other person's complaint or misunderstanding is.

It's a difficult situation because we have people coming in today on a shift and then not next week on a shift. So unless you are on ward level or unless there is a specific complaint, we do struggle with that because we are not able to see all the problems in the wards. There are things happening in our wards; doses not being given and signed for and things like that are starting to come out that pharmacy was not aware of before. Maybe more presence in the ward is the solution; to be on the ward round, to see when the nurses are giving out medication to the patients on their medicine rounds. (But) if we are not told of the problems then we are isolated in the pharmacy. We could do our job perfectly well and it could still mess up in the ward.

When it's permanent staff, maybe there is better relationship there and it's easier to solve problems, maybe they are more keen to ask questions because they know us, maybe things get solved before it happens, it's easier that way. (But) when it s agency staff; we

don't know them, they don't know us (absolutely) and it rotates all the time. Things are slipping through; my feeling is that with more and more agency staff, there's less and less relationship, and more and more problems occur

And also with the agency staff you don't have the permanence of: "Well I'll be here tomorrow," so (that) you can follow-up tomorrow or the next day because they are there one day and then they won't be back for another two to three weeks. (And) they don't have to take responsibility of any follow-ups because they won't be there the next day to be responsible for it, which is also a problem.

I think what is good is that you have identified it as a problem, one of the biggest problem is how do you go about either trying to prevent or overcome…

I think the solution is to be visible in the wards; but that is where we have a problem because we also have to be in the pharmacy too. In the wards we could be checking the charts but in the pharmacy you could do the same thing, if you want to interact with the nursing staff and see what they actually do and how the medication is given to the patient; I mean we've had Kloref® (Potassium bicarbonate/citrate effervescent tablets) not being given (dissolved) in water…

There's even a better one – inhalant capsules; here you swallow it, instead of using the device.

(But) those are practical things that we can't see unless we are there and we can advice. Maybe we are not aware of all the problems that are occurring, I don't just mean (with) agency staff, I mean all staff. I would help, but you see the *** comes down to is that pharmacy staff are operating on a minimum level. So…

Minimum level … meaning?

Minimum amount of staff. We don't actually have extra time (manpower) to go up to the wards.

Yeah, manpower is the issue when you are trying to…. If it's the educating role and the counselling role in the wards with the nurses and the patients; who's going to dispense in the pharmacy? So that's what we struggle with, we've been trying to get it off the (take off) take off. (And) it's hard you know because it does not suit the nurses to come; now it does not suit us; we can't go on a round with you and we can't because this one has gone on lunch; so it's a problem of manpower I think.

And also one of the problems I think as well like say with the Kloref® and inhalant capsules, we assumed, and maybe we shouldn't have, that the sisters on the ward level know how to use it or how to give it and they don't always. I mean with the inhalant capsule, the doctor wrote give orally, so she gave it orally. She didn't realise that she had to put it in the pump, which was also the doctor's mistake. The big problem there was assumption; I assumed that she knew how to use it.

But the other thing is also, from our point of view, if you are in the pharmacy the best way you have to communicate is your labels. Your label is your best way of communication and we find that they don't read our labels. They're looking at he chart and following from the charts, they are not actually reading from the labels and maybe we said on the label "dissolve in water" on the label but they never read the label. So that is also a means of communication that we should highlight with our nurses. (It's true they don't read the labels). It's fine to say get on the phone, go to the ward and be more visible; if they are not reading the label, you know we are doing our best at the label level; we don't have all the people to be picking up the problems before hey happen if you are not reading the labels.

So you reckon that is one way of make a difference. I think you mentioned that a well-written label is part of * (absolutely). (But also a well-read label is * (laughing)

Something that you mentioned – workload / minimum level of staff (We feel that way) You mentioned that it appears that there is more work especially as far as reporting / paperwork is concerned. How does that really influence how you operate?

Well the more cycle-counting you have to do the less time you have to be visible in the wards or able to counsel or anything, and it's been made quite clear that those kind of things – cycle counting, getting ready for stock-take, and all those issues (written policies have to be done…) so if that is your priority then your counselling, your nurse and patient loose out. That's where I feel….

That's the downfall of it. You do profitable things because the cycle counting is to check stock loses and if there is any theft and corrections, so you are looking at the profit base but the counselling goes down the drain.

But it is said that pharmacy has both, the clinical side and the business side. Do you feel they giving more weight to the business side?

The business side, yes (definitely…) this is a profit organisation; they work on (making) profit.

I've been here now for almost five years (and) there has been a definite shift away from the ward and the patient, to making sure you looking at the profit or you minimising the dead stock and the profit loss. We spend a lot of time trying to sell stock or buying correctly or check stock or…

But do you raise these (issues) with management?

Well it's difficult to raise the problems. I mean I raise it with my manager and she says she can't actually do anything about it because it comes from regional office. (And) basically once regional office or head office has said well this is what we are doing (then) that's it – that is what we are doing. It's understandable that they have to look at the profit point of view; I mean you have to look at the bottom line otherwise none of us will be making money - well getting a salary. (But) I also think that they should realise that manpower is needed

Because you know they are very quick to – when a problem patient comes back or there is a query or there was a mistake or somewhere in the ward even – then they want to look at what can we do differently should we have more emphasis in the wards; but I mean they are the ones who shifted us away from that and only when the problem actually arises that could have been prevented then they say maybe we should get more people in the wards. (And) so they have talked about it and we try to get into the wards, but that same work is still there, so I don't know how are we supposed to spread ourselves so thinly that we can do everything

(Because) I definitely think it will be a benefit for everybody if we could get up to the wards. I mean none of the patients up in the hospital know us, so say they have a problem with some of their medication or they feel there is something wrong, they actually wouldn't know what I look like. How could they feel comfortable asking my opinion or talking about a problem to me and asking for advice about it because I'm not seen in the wards, they don't know who I am?

178

(But) then where does this scenario leave you as a pharmacist because you work here as a pharmacist? It's almost as if, like somebody said previously, you get to a stage where you just want to get done with what you are given to do. Is that the feeling that you get at the end of the day?

Sometimes you do because they push you so hard. You know people are so easy to complain. At the end of some days they've complained so much and pushed you so hard that you think, well my efforts are actually not worth it anymore because they just want to pick up the phone and complain.

And the yellow carding system or whatever it's called doesn't help. I doesn't make relations better, because … (you might have to put the persons name on it) and also I always think dealing with the problem before it gets written down (on the yellow cards) is easier for everybody (involved) to swallow, as long as the patient does not suffer in the process. If you pick up a problem that I've done, let me know; I'd like to know. But if I get bombarded with yellow cards all day it's bound to make my morale go down a bit. So I don't know about that system of yellow carding, I don't think it's the best. I think we are all professional enough to want to know where we make mistakes and preventing ourselves from making mistakes, but the whole system of… (keeping a record of it basically) yeah.

So they can, what I don't understand this, come back to you and say you've made 25 mistakes in the last two months, what's wrong (*laughing*)?

Yes, you see because we are not all sure what the motive is for that. If it is to pick up a problem then I'm all for it (*but*) if it is to throw it in my face three months down the line, then I'm not sure *. It does not help morale.

The next question that I want to pick up on is continuing professional development. Last week you went on a course. Who decides or how do you decide on going on a course?

Every hospital does it differently.

Well how do you do it?

Well for this course that I'm on now (front line management), I was nominated for it. (And) then I had to either accept it or decline, and I chose to accept it. But I know a couple of months or about two months ago, they sent around forms of the possible training courses that they had available and they wanted to know who would like to do

179

what type of course. (They didn't even give us that; I've never seen that) And so that's when we decided that maybe this person should think of doing this course, this person is a health and safety person they should do a health and safety (related) course. But we have not had feedback on that, as yet.

I think it depends on your manager (Absolutely…). I mean you must pick up things and take initiative yourself but if it comes directly to your manager and they don't pass it on, how are you supposed to know about them? And that is what I find sometimes in our pharmacy, you don't get told *. I'm not sure what the motive for that is, I think probably my manager is worried who's going to do the work when we are gone. (My manager sends me everything). My manager, and I don't think it's malicious or anything, I just think he forgets.

I just wanted you to agree with me that there is a higher chance that a competent person will give a better service than the one who is not competent. So if they cannot link the fact that they need to be encouraging people to go on courses or even approve of people suggesting that they want to go on courses…

Absolutely and I think keeping yourself stimulated and keeping your mind active is very important

I think first of all the course must be related to your job. Maybe there should be a different way of letting us all know about upcoming courses because doing it through pharmacy managers isn't the best way because it depends on your manager for you to know about the course and for you to get approval to go to the course. I don't know, I find that it depends on your manager; if he is not aware of it or if he did not open his email for 3 days, and in the end pharmacy loses out.

Now on that score, the management in the pharmacy, not the manager necessarily, do you have an input in how things should be done? Is there input from people around as to can't we do things like this around here?

(To a certain extent). To a certain extent. It depends on what you are referring to. What kind of things? How we do things or what we do?

How things are done?

We can give our input and give our suggestion if we think that something is not working correctly or is not efficient and you can think of something more efficient way of doing

things. I know my manager will be open to suggestions to make things work better because at the end it benefits everybody and it also prevents wasted time and frustration.

Our manager will also use us as a sounding board for things. "What do you think of this?" So yes we do get consulted on things like that.

Now all in all how do you see pharmacy moving forward from now onwards? How do you see the future of pharmacy, especially in the private sector?

It will become more clinical based.

It will become more clinical based?

They will have to otherwise they will not survive.

We will have to become more clinical based and become more involved at ward level. I think that is the way it will move forward, eventually

But you say it will not survive, if you say they are doing well as far as business is concerned…

Not with the new legislation that has come out. If we can only charge a dispensing fee of a certain percentage or up to maximum R26 or whatever and we don't take the advantage of using the consulting fee, which you can charge (for) if you consult, then I think they will lose out as in terms of finance. So I think they will start pushing us into more clinical positions, but they've got to get more people to dispense. Maybe a lesser qualified person to do the dispensing; they will definitely need more bodies

Assistants, pharmacy assistants – they can dispense then you just actually need one person in the pharmacy to check what they have done.

One pharmacist to check what they have done and the rest to do clinical work, which is probably the best way forward.

Would pharmacists be prepared for such a role?

Well, I think they would have to probably have a quick… (*laughing*). No I think they would. They would have to get used to it, because they are not used to it. I think everybody else will also have to get used to it because most of the people in these hospitals are not used to you giving your input at ward level. I mean in some hospitals pharmacists do go on ward rounds with doctors or they go on ward rounds during the day and they can pick up mistakes and the doctors are receptive to the pharmacist saying this

181

is prescribed wrong or this interacts with this. But in a setting where it has never happened before everybody will have to get used to it.

I think the nurses would love that but I think the doctors are the ones to get used to it. In state hospitals you have a big ward round were every profession gives an input, but in private the doctor goes on his own little round, so when do you say doctor this or doctor that? So in private the doctors have a very big say. They are less keen to take your advice, that is the truth (It's true). So it will be a shift in attitude of everybody from pharmacists to; pharmacists you have never worked in a hospital and going on a ward round – that is very daunting. But I think that is the only way hospital pharmacists will survive.

Appendix 9

COPY OF QUESTIONAIRE
FOR CONSUMERS
(Medical practitioners, nurses and patients)

Service delivery questionnaire   **Ref. Nō: ………**

Dear clients,

Based on your experience of the service offered by pharmacists at this hospital, please indicate whether you strongly disagree, disagree, are unsure, agree or strongly agree with the following statements by placing an (X) on the corresponding number. You may choose only one number per statement. Please do not place your name on this form, as this information will be treated confidentially.

Thank you.

	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
1. Pharmacists play an important role in the hospital by ensuring that medicines are available at all times	1	2	3	4	5
2. Pharmacists can contribute more to patients' treatment and well-being by doing more than just dispensing medicines	1	2	3	4	5
3. Pharmacists are better informed about medicine-related patients rights	1	2	3	4	5
4. Pharmacists should go on ward rounds to check prescription charts with the option of making suggestions related to patients' prescribed medicines	1	2	3	4	5
5. Patients should have the option of requesting pharmacists to counsel them regarding their prescribed medication	1	2	3	4	5
6. Pharmacists always provide a service as expected	1	2	3	4	5
7. Clients should have means to voice their dissatisfaction with the pharmacy service provided	1	2	3	4	5

8. There should be increased cooperation amongst health care providers especially doctors, nurses and pharmacists, regarding patients' medicines and treatment options	1	2	3	4	5
9. When patients are discharged, pharmacists should inform them about the names of their medicines, indication, storage, how to take them, costs, and possible side effects.	1	2	3	4	5
10. Once discharged, patients should be able to contact the pharmacist on duty with queries related to their discharge medicines	1	2	3	4	5
11. Pharmacists always give an efficient service	1	2	3	4	5
12. Pharmacists always provide an accurate service	1	2	3	4	5
13. Pharmacists always perform their service in a friendly manner	1	2	3	4	5
14. Pharmacists always deliver their service on time	1	2	3	4	5
15. Pharmacists are a helpful resource for medicine related information	1	2	3	4	5

185

Appendix 10

TWENTY – TWO STATEMENTS

OF THE SERVQUAL INSTRUMENT

Directions:

This survey deals with your opinions of _____ services. Please show the extent to which you think firms offering _____ services should possess the features described by each statement. Do this by picking one of the seven numbers next to each statement. If you strongly agree that these firms should possess a feature, circle the number 7. If you strongly disagree that these firms should possess a feature, circle 1. If your feelings are not strong, circle one of the numbers in the middle. There are no right or wrong answers. All we are interested in is a number that best shows your expectations about firms offering _____ services.

1. They should have up-to-date equipment.
2. Their physical facilities should be visually appealing.
3. Their employees should be well dressed and appear neat.
4. The appearance of the physical facilities of these firms should be in keeping with the type of services provided.
5. When theses firms promise to do something by a certain time, they should do so.
6. When customers have problems, these firms should be sympathetic and reassuring.
7. These firms should be dependable.
8. They should provide their services at the time they promise to do so.
9. They should keep their records accurately.
10. They shouldn't be expected to tell customers exactly when services will be performed. (-)
11. It is not realistic for customers to expect prompt service from employees of these firms (-)
12. Their employees don't always have to be willing to help customers. (-)
13. It is okay if they are too busy to respond to customer requests promptly. (-)
14. Customers should be able to trust employees of these firms.
15. Customers should be able to feel safe in their transactions with these firms to do their jobs well.
16. Their employees should be polite.
17. Their employees should get adequate support from these firms to do their jobs well.
18. These firms should not b expected to give customers individual attention. (-)
19. Employees of these firms cannot be expected to give customers personal attention. (-)
20. It is unrealistic to expect employees to know what the needs of their customers are. (-)
21. It is unrealistic to expect these firms to have their customers' best interests at heart. (-)
22. They shouldn't be expected to have operating hours convenient to all their customers. (-)

Appendix 11

COPY OF INVITATION LETTER FOR CONSUMERS

TO PARTICIPATE IN QUESTIONNAIRE SURVEY

Faculty of Natural Sciences

School of Pharmacy

DATE

HOSPITAL

Dear Doctor / Nurse / Patient

Re: Service delivery questionnaire for quality improvement purposes at   Afrox Healthcare pharmacies

This serves to introduce myself as a postgraduate student at the University of the Western Cape (UWC) and pharmacist intern. I am involved in research to investigate factors affecting pharmaceutical service and their relation to delivery of quality pharmaceutical service in the Afrox Healthcare Limited (AHL) pharmacies. Afrox Pharmacy Management Service (APMS) is sponsoring my research.

The project that I am involved in is part of the overall continuous quality improvement efforts by APMS. Based on your experience of the service offered by pharmacists at this hospital, please indicate on the attached questionnaire whether you strongly disagree, disagree, are unsure, agree or strongly agree with the following statements by placing an (X) on the corresponding number. You may choose only one number per statement. Please do not place your name on this form, as this information will be treated confidentially.

Thanking you in anticipation

Sincerely yours

Moeketsi Thobeli

………………………………