# AN EVALUATION OF CLINICAL GOVERNANCE WITHIN A PRIVATE RADIOLOGY ORGANISATION IN DURBAN KWAZULU-NATAL

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## DECLARATION

I, Morgan Keir Wedderburn-Maxwell, the researcher, hereby declare that this research is my own original work. All the sources used in this research have been presented and acknowledged with utmost integrity. This research does not, in its entirety or in part, exist within someone else's work.

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# ABSTRACT

South African health care organisations are required to adhere to the National Health Act, 61 of 2003 which contains the national core standards. Clinical governance is a key domain within the national core standards and is directly involved with a health care organisation's ability to deliver quality care services. It can be described as a framework that ensures doctors and health care employees collaborate to provide superior quality health care services and create clinical accountability.

The aim of this research was to evaluate the role of clinical governance within a private radiology organisation in Durban, KwaZulu-Natal (KZN). The goals of this research was to identify and explore the challenges that are associated with clinical governance within a private health care organisation in Durban, KZN. Furthermore, to evaluate the importance and implications of clinical governance for a private radiology organisation in Durban, KZN. The objectives of this research was to investigate how the private radiology organisation is managing clinical governance and to identify whether there is a common understanding of the concept among its members. The research adopted a qualitative approach where semi-structured interviews were conducted to obtain the data that enabled the goals and objectives of this research to be attained.

The results indicated that clinical governance is a key factor to the private radiology organisations long-term sustainability. Clinical governance is vital for health care organisations to deliver quality health care services. The private radiology organisation places a significant emphasis among its members to deliver superior quality health care services. As a result, the organisation utilises the key elements within the clinical governance framework to continuously increase the quality of care that it provides and abide to the legally binding standards. The results support the notion that there is a need for the clarity of the definition, roles and responsibilities of clinical governance. The findings of this research suggest that further research is required to identify the contribution that clinical governance makes to improving the quality of care within South African health care organisations. Furthermore, research identifying employees' perceptions of clinical governance within the private health care sector in South Africa is recommended.

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| | |
|---|---|
| UK | - United Kingdom |
| KZN | - KwaZulu-Natal |
| NZ | - New Zealand |
| NHS | - National Health Service |
| NDoH | - National Department of Health |
| GDP | - Gross Domestic Product |
| WITS | - University of the Witwatersrand |

# 1. INTRODUCTION

## 1.1 OVERVIEW

The aim of this research was to evaluate the role of clinical governance within a private radiology organisation in Durban, KZN. With an ever-changing business environment, significant emphasis is being placed on the impact that clinical governance has on ensuring the sustainability and success of modern day health care organisations. Early critics demurred, indicating that it was a new fad, unpractical and required a cultural change more significant than what the literature had proposed (Braithwaite and Travaglia, 2008). Criticism aside, there is a considerable body of literature supporting the development of clinical governance in health care organisations (Braithwaite and Travaglia, 2008). Markar and O'Sullivan (2012; p.276) recognise that the future of these organisations will be to deliver a service that is patient-centered, needs-based, safe and of the highest quality. Clinical governance was formally defined by the United Kingdom (UK) Department of Health in 1998 to address concerns surrounding the quality of health care (Scally and Donaldson, 1998; Braithwaite and Travaglia, 2008; Brennan and Flynn, 2013). Public scrutiny and empirical evidence shaped the impetus towards the rapid adoption of clinical governance (Travaglia, Debono, Spigelman and Braithwaite, 2011). This inspired the UK labor government to adopt a major health policy that aimed to increase the quality of care that was provided by the National Health Service (NHS) (Doherty, 2013).

Clinical governance can be described as a framework that ensures health care employees and doctors collaborate to provide a superior quality of health care and create clinical accountability (Scally and Donaldson, 1998; Starey, 2001; Wilkinson, Rushmer and Davies, 2004; Brennan and Flynn, 2013; Sidin and Pasinringi, 2014). Clinical governance frameworks are commonly used around the world, predominantly within high-income countries (Doherty, 2013). The concept has been a significant factor behind health care improvements over the last decade (Travaglia et al., 2011). South African health care organisations are required to comply with the National Core Standards presented by the National Department of Health (NDoH), to ensure that the best quality of care is provided to patients (NDoH, 2011). As a result, health care organisations are held accountable to meet the minimum standards of clinical governance to continuously improve the quality of care that is delivered. The concept

should be embedded within the daily operations of these organisations and be viewed as a shared, positive, multidisciplinary activity (Campbell and Sweeney, 2002; Crook, 2002).

## 1.2 RESEARCH SETTING

This research is situated within a private radiology organisation in Durban, KZN. The organisation provides diagnostic radiology services from two interlinked premises. There are four radiologists within the organisation who ensure employees are aligned to the organisations strategic objectives. The employees consist of seventeen radiographers, eight front desk employees, a practice manager, an accountant, four account employees, three porters, five admin assistants and three cleaners. The organisation is affiliated to a hospital that provides the patient referrals.

## 1.3 IMPORTANCE OF THIS RESEARCH

Numerous authors including including Lewis, Sanders and Fenton (2002), Staniland (2009), Gauld, Horsburg and Brown (2011) and Brennan and Flynn (2013) have identified a gap between the concept of clinical governance in literature and what is being practiced within health care organisations. The understanding of clinical governance amongst doctor's and health care employees' is largely unexplored (Som, 2009). Research surrounding doctor's and health care employees' perceptions regarding clinical governance practices is thus required (Greenfield, Nugus, Fairbrother, Milne and Debono, 2011). The lack of evidence of clinical governance practices within a South African context emphasise the need for further research (Doherty, 2013).

## 1.4 STRUCTURE OF THIS RESEARCH REPORT

Chapter 2 of this report contains a literature review that provides an analysis of clinical governance found within the available body of knowledge. The chapter includes identifying clinical governance within a South African context. The definition, characteristics, elements of the framework, challenges and roles of clinical governance are discussed.

Chapter 3 presents the research methodology that was adopted for this report. In doing so, the purpose and importance of this research is described. The research aim,

goals, objectives and questions are presented. The procedure and technique used to conduct this research is given. The chapter is concluded by a discussion on the ethical considerations and limitations of this research.

Chapter 4 describes the results that were obtained from the research questions. Chapter 5 is a discussion of the results that were analyzed and compared with the available literature to address the research aim, goals and objectives.

Chapter 6 contains the recommendations and conclusion of this research.

## 1.5 CONCLUSION

This chapter provided a background of the research outlining the concept of clinical governance. The importance of the research is described and the structure of the report is given. The subsequent chapter discusses the literature that was reviewed for the purpose of this research.

# 2. LITERATURE REVIEW

## 2.1 INTRODUCTION

Notwithstanding over a decade's worth of quality improvement strategies, the adoption of clinical governance frameworks can be attributed to the increasing awareness amongst the public in the UK of patients receiving poor quality care within NHS facilities coupled by numerous incidents that compromised patient safety (Doherty, 2013). Despite the critical role that sound clinical governance plays in providing good quality health care services, literature regarding the private health care sector is scarce within the public domain (Doherty, 2013). The aim of this research was to understand and evaluate clinical governance practices and beliefs within a private radiology organisation in a South African context. The purpose of the following literature review is to evaluate the body of knowledge in the light of this research. The necessity of clinical governance for health care organisations within a South African context is explored. In doing so, clinical governance is defined and the key concepts are identified. An overview of the concept's characteristics is provided and a detailed description of the elements of the clinical governance framework is given. The challenges that are associated with clinical governance are discussed and finally the roles and responsibilities within a private radiology organisation pertaining to clinical governance are presented. For the purpose of this research clinical governance will be viewed in the light of private radiology organisations within a South Africa context.

## 2.2 CLINICAL GOVERNANCE IN A KWAZULU NATAL CONTEXT

South African health care organisations are required to adhere to the National Health Act, 61 of 2003 which contains the established health care standards (NDoH, 2011). The act stresses the importance for health care organisations in South Africa to deliver quality health care services (NDoH, 2011). The NDoH (2011p.10) provides a definition for quality care and a benchmark for health care organisations to be assessed and appraised. Health care organisations that comply with the mandatory standards are presented with a national certification of compliance (NDoH, 2011). Clinical governance is a key domain within the National Core Standards and is regarded as a domain that is directly involved with a health care organisation's ability to deliver

quality services (NDoH, 2011). The standards and criteria laid out by the NDoH for clinical governance can be found in Appendix 1.

The private health care sector within South Africa contributes roughly the same towards the nations gross domestic product (GDP) as the public sector, despite catering to less than twenty percent of the population (Naidoo, 2012). Private health care organisations within South Africa are perceived to provide a superior quality care service than their counterparts within the public sector (Doherty, 2013). Doherty (2013; p.34) suggests that the difference in the quality of care can be attributed to the way in which private health care organisations address the needs of their patients on an individual basis as apposed to meeting the needs of the majority of the population as is the case with the public sector. Doctors working within private health care organisations are regarded as independent practitioners who have significant autonomy over the quality of care that is delivered to their patients (Doherty, 2013). With scarce literature surrounding effective clinical governance practices within private health care organisations, doctors may underestimate the demand and level of management needed to deliver a better quality service (Phillips, 2002). The importance of clinical governance within South Africa has been recognized through the development of the Clinical Governance Initiative at the University of the Witwatersrand (WITS University) which is, according to WITS University, the first academic institution to research, develop and teach the concept in South Africa (University of the Witwatersrand, 2015).

## 2.3 DEFINING CLINICAL GOVERNANCE

The term clinical governance arose in the UK during the late 1990's as a result of patients receiving inadequate quality care from NHS facilities that compromised on patient safety (Doherty, 2013). The UK Department of Health (1998; p.33) defined clinical governance as

> a framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence of clinical care will flourish.

Variations of this definition have since been adopted across the globe and have been integrated into numerous countries' health systems (Brennan and Flynn, 2013). According to Braithwaite and Travaglia (2008; p.11), the Australian government defines clinical governance as

> a systematic and integrated approach to assurance and review of clinical responsibility and accountability that improves quality and safety resulting in optimal patient outcomes.

This definition highlights the notion that clinical governance is not a set of long-term outcomes but rather a framework that is continuously operationalised in a coordinated and methodical manner (Braithwaite and Travaglia, 2008). Galbraith (1998; p.2) provides a simple definition for clinical governance as 'corporate accountability for clinical performance'. Within South Africa, the NDoH (2010; p.1), for example adopts a similar definition to the UK Department of Health and defines clinical governance as

> a system through which health service organisations are responsible and accountable for continuously improving the quality of their services, safeguarding high standards of care and ensuring the best clinical outcomes for patient care by creating an environment in which excellence in clinical care will flourish.

Clinical governance has been cited widely as an umbrella concept that has often been found challenging to comprehend (Scally and Donaldson, 1998; Balding, 2005; Braithwaite and Travaglia, 2008; McSherry and Perace, 2011; Brennan and Flynn, 2013). The concept's definition lacks clarity within South African and international literature (Doherty, 2013). Maynard (1999; p.6) suggests, a satisfactory definition for clinical governance does not exist. The definition attempts to integrate all quality activities under a singular umbrella term, linking both administrative and clinical elements to provide a framework for clinical accountability (Brennan and Flynn, 2013). Goodman (2002; p. 243) argues that the concept of clinical governance is vague. Brennan and Flynn (2013; p.9) propose a new definition for clinical governance in an attempt to give the concept more clarity, explaining it as

> Structures, systems, and standards applying to create a culture, and direct and control clinical activities. Clinical accountability and responsibility, a sub-set of clinical governance, involves the monitoring and oversight of clinical activities, including regulation, audit, assurance and compliance by governors (such as the boards of directors), regulators (such as governments and professional bodies), internal auditors and external auditors

Clinical governance is a modern term for numerous interrelated and long-standing activities that are used to improve the safety and quality of health care (Travaglia et al., 2011). It has been designed to consolidate, universalise and codify clear policies and approaches that create organisations in which the accountability for clinical governance rests with the owner of the health care organisation (Scally and Donaldson, 1998). According to Brennan and Flynn (2013; p.2), a concern surrounding the definition of clinical governance is that it integrates external quality assurance (the governance, involving vertical accountability) with internal quality improvements (the management, with internal service development). The concept of clinical governance is broad in that multiple roles and responsibilities need to be understood, undertaken and aligned within the scope of a health care organisation. Brennan and Flynn (2013; p.1) argue that the concept of clinical governance needs to not only be outlined very clearly but must also be understood adequately by doctors and health care employees who are responsible for maintaining good practice and clinical governance itself. Despite the difficulties in the understanding of the definition for clinical governance, the importance of the concept within health care organisations has been identified in the literature (Freeman, 2003; Som, 2004).

## 2.4 CLINICAL GOVERNANCE CHARACTERISTICS

Early critics demurred clinical governance, indicating that there was no evidence to suggest that the concept increase the quality of care that a health care organisation provides (Thomas, 2002). The concept of clinical governance has since gained popularity and been referred to as an innovative approach that highlights and emphasises professional, organisational and clinical improvements (Braithwaite and Travaglia, 2008). Within health care organisations, traditional quality strategies are typically known to be fragmented and driven through a top-down or self-regulation process (Doherty, 2013). According to Singh (2009; p.189), clinical governance can be seen in a similar manner to "quality assurance", with the additional emphasis on accountability. Initially, clinical governance literature was future-orientated that attempted to address safety and quality issues (Travaglia et al., 2011). Wright, Barnett and Hendry (2001; p.32) in New Zealand (NZ) have compared the development of clinical governance to that of previous quality initiatives within health care

organisations, namely the emphasis on corporate accountability for clinical quality, organisational quality strategies and the organisational culture. The intent of clinical governance is for health care organisations to progress beyond single strategies (for example clinical audit, education or risk management) towards approaches that are systematic and multifaceted (Phillips, Pearce, Hall, Travaglia, Lusignan, Love and Kljakovic, 2010). According to Wall, Geranda, Conlon, Ombler-Spain and Warner (2006; p.30),

> clinical governance aims to raise patient's expectations about the quality and safety of their care, to improve collaborative relationships and efficiency within and across clinical teams; to make clinicians more accountable for their actions; to increase job satisfaction for professionals; to improve clinical outcomes and reduce significant incidents and errors.

Clinical governance requires an integrated system for managing, monitoring and leading clinical process that promotes a culture where managers, leaders and doctors are accountable and transparent towards achieving clinical excellence (Doherty, 2013). A systematic approach is therefore needed (White, 2010). Within a health care organisation's approach to quality improvement, emphasis is placed on simplifying, preventing unfavorable outcomes and improving the process of care (Scally and Donaldson, 1998). Clinical governance thus aims to improve the standard of clinical performance and promote good practice (Onion, 2000; Starey, 2001; Brennan and Flynn, 2013). Furthermore, the concept has been described as a vehicle for continuously increasing the quality of care provided by a health care organisation to maintain high standards (Scally and Donaldson, 1998).

An important distinction can be made between clinical governance and corporate governance as several characteristics iterate between the two concepts (Braithwaite and Travaglia, 2008). Corporate governance is concerned with the management of organisations, the fiscal responsibilities, increasing returns on investments, the control and direction of executives and the systems that ensure effective decision-making that result in the achievement of organisational goals (Braithwaite and Travaglia, 2008). Corporate governance is thus concerned about transparency, ethical organisations and fairness (Braithwaite and Travaglia, 2008). Links can be made between the two concepts with regards to the focus on accountability, effective utilisation of resources and providing a framework for appropriate behaviors and decision-making within an

organisation (Braithwaite and Travaglia, 2008). The essential difference between the concepts is that clinical governance is directed towards departments, wards and doctors whereas corporate governance is directed towards the boardroom (Braithwaite and Travaglia, 2008). Braithwaite and Travalglia (2008; p.13) identified four key characteristics of clinical governance, namely its utilisation to advance safety and quality, the implementation of clinical governance systems and structures to increase safety and quality, the effective utilisation of data and the adoption of a patient-centered culture within the organisation. Three sets of factors if addressed properly will enhance successful clinical governance practices within a health care organisations, namely the frameworks for clinical governance that are being used, the employees' responsible for initiating clinical governance and employees adopting clinical governance as part of a daily routine (Campbell and Sweeney, 2002).

Clinical governance requires the commitment of management and doctors within a health care organisation (NDoH, 2011). The goal of clinical governance is to change the shared culture amongst doctors and health care employees within an organisation where quality improvements become a routine service (Plochg and Klazinga, 2005). In this regard, Scally and Donaldson (1998; p.2) state for example that "the feature that distinguishes the best health organisations is their culture". Good clinical governance requires positive organisational cultures and clinical leadership (Scally and Donaldson, 1998). The culture change should ensure that medical professionals are working towards continuous quality improvement and utilising a system of regulation to avoid unacceptable care (Plochg and Klazinga, 2005). Clinical governance demands that there is effective teamwork, the management of health care risks and organisational effectiveness to achieve continuous improvement of a health care organisation's performance (Brennan and Flynn, 2013). The culture, tools and accountability within an organisation play a key role in facilitating a whole team and patient-focused approach used to improve the quality of care that is provided by the organisation (Campbell and Sweeney, 2002).

An investigation into health care organisations in the UK identified numerous characteristics associated with delivering poor quality care (Doherty, 2013). Within these organisations, problems relating to the quality of care have been known and have remained unaddressed for several years (Doherty, 2013). This resulted in

frequent mistakes due to preventative and innovative measures not being established based on prior experiences (Doherty, 2013). Significant barriers existed with the disclosure of quality issues (Doherty, 2013). A negative culture is present where health care employees are scrutinised for their mistakes (Doherty, 2013). Training and development is either nonexistent or inadequate and the appropriate monitoring and reporting systems are not implemented (Doherty, 2013). Lastly, accountability within organisations with poor clinical governance was undefined and often misunderstood (Doherty, 2013). Poor quality care should be identified through the use of clinical governance frameworks and be regularly reported on (Starey, 2001).

The key to good clinical governance practices is to initiate and facilitate an environment where clinical excellence flourishes (Hacket, Lilford and Jordon, 1999). Implementing clinical governance successfully demands a multi-level approach where changes are aligned among the individuals, teams and organisation (Campbell and Sweeney, 2002). Doherty (2013, p.7) identifies several characteristics within health care organisations with superior clinical governance. These organisations will use frameworks in a manner that increases the quality of care provided (Doherty, 2013). This requires the support from all stakeholders and making sufficient resources available (Campbell, 2002). The emphasis on delivering a quality service is shared where doctors and health care employees are aligned to a positive organisational culture (Doherty, 2013). Improving the quality of care is generally a key component within these health care organisations strategy and goals (Doherty, 2013). The accountability for clinical governance is established and communicated throughout the organisation (Doherty, 2013). This requires that there is clarity of the responsibilities and roles amongst all stakeholders (Campbell, 2002). Lastly, the national clinical governance standards and guidelines are adhered too (Doherty, 2013).

## 2.5 THE ELEMENTS OF THE CLINICAL GOVERNANCE FRAMEWORK

Braithwaite and Travaglia (2008; p.11) state that "what is meant by a clinical governance framework is a set of initiatives designed to enhance care, and the promotion of a productive culture and climate within which care can thrive". A key component of clinical governance is thus to improve and monitor professional

performance which includes identifying and managing underperformance, constant development and appraisals (Brennan and Flynn, 2013). A clinical governance cycle can be described by three functional domains, namely accountability, assurance and innovation (Peak, Burke, Ryan, Wratten, Turnock and Vellenoweth, 2005). According to Nicholls, Cullen, O'Neil and Hailigan (2000; p.172), "clinical governance can be viewed as a whole system cultural change which provides the means of developing the organisations capability to deliver sustainable, accountable, patient focused, quality assured health care". The structures and systems of clinical governance require the alignment of the elements that aim to increase the quality and safety of care that is provided by a health care organisation (Starey, 2001). According to Starey (2001; p.2) clinical governance comprises of six key elements, namely clinical effectiveness, risk management, education, research and development, clinical audit and openness (as seen in Figure 1). These elements are discussed in more detail in the following section.


*Figure 1: The six elements of the clinical governance framework (Starey, 2001; p.2).*

## 2.5.1 The six key elements of clinical governance

### *2.5.1.1 Clinical effectiveness*

Clinical effectiveness can be defined as "a measure of the extent to which a particular intervention works" (Starey, 2001; p.4). Three key factors play a role in clinical

effectiveness, namely obtaining evidence, implementing systems based on the evidence presented and evaluating the change within the health care organisation (Sidin and Pasinringi, 2014). Obtaining evidence involves doctors and health care employees to view current research and evaluate patient preferences towards quality care (Sidin and Pasinringi, 2014). Within modern health care organisations, strategies need to be refined based on the emerging evidence of effectiveness (Starey, 2001). Clinical effectiveness ensures that aspects of efficiency and safety from the patient's perspective are considered (Starey, 2001). A limitation of clinical effectiveness is the lack of measurement for qualitative aspects of quality care which the broad definition of clinical governance encompasses (Starey, 2001). The qualitative aspects include care that is sensitive to the individual patient's needs which requires a holistic analysis (Starey, 2001).

*2.5.1.2 Risk management*

Clinical risk management strategies are an important element within the clinical governance framework (Bunch, 2001). Private health care organisations provide a service that encounters ample risks involving the patients, doctors and owner of the organisation on a daily basis (Starey, 2001). These risks need to be effectively managed as part of any quality assurance program (Starey, 2001). Effective clinical governance requires the implementation of risk management processes that seek to identify system deficiencies with transparency, rather than blaming individuals (Delaney, 2015). Travaglia et al. (2011; p.67) identified risk as a central concept and theme that is associated with the improvement of quality services. It is a process that attempts to identify potential problems or current faults due to human error (Sidin and Pasinringi, 2014). Risk management thus implies that the organisation's members need to be able to identify and address risk in order to provide services that are efficient and effective in a safe manner. Effective risk management has been a major challenge among health care organisations which has often been attributed to the lack of education and training that the employees, management and doctors receive (Sidin and Pasinringi, 2014). Within any quality strategy, systems must be implemented to mitigate risks (Starey, 2001). Risks must be identified and given priority including those that can't be eradicated (Cowan, 2002).

Health care organisations can reduce risks by ensuring policies, procedures and systems are well designed towards employment practices and performance reviews (Starey, 2001). Compliance with the modern statutory regulations and patient complaint evaluations contributes towards minimising the risks to patients (Starey, 2001). Risks to the doctors include ensuring that employees are working in a safe environment and are up to date with current quality assurance practices (Starey, 2001). Doctors and health care employees must work within a safe environment where infectious diseases are contained and not transferred (Starey, 2001). According to Schemele (1996; p.126), risk management aids the protection of financial assets, helps to prevent patients and staff from any injuries and improves the quality of health care. Private health care organisations require risk management systems to improve cost effectiveness, adequately address patient safety and reduce inefficiencies. They must reduce the risks associated with the daily operations, thus an integrated approach must be undertaken that results in high quality employment practices, a safe environment and policies that produce desirable effects (Starey, 2001).

*2.5.1.3 Education*

With the modern health care industry rapidly evolving, it is imperative that doctors and health care employees continue learning, as many training techniques become outdated (Starey, 2001). It is essential that a health care organisation's workforce is competent and skilled to provide quality health care (Braine, 2006). The skills and knowledge of both doctors and health care employees must therefore be effective, appropriate and up to date (Braine, 2006). Regular lectures and meetings improve both the radiologists and health care employee's capability to conduct appropriate examinations that incorporates modern techniques, interpretations and technology (Knechtges and Carlos, 2007). Health care employees through education can learn to effectively manage an organisation's resources (Knechtges and Carlos, 2007). A study conducted in NZ identified that education and training is pivotal to ensure effective clinical governance (Gauld and Horsburgh, 2015b). Health care employees should be provided with systems that allow for continuous education and are embedded within the organisation's culture (Braithwaite and Travaglia, 2008). Continuous education allows the organisation to be exposed to new technologies,

ideas and practices that contribute significantly to increasing the quality of care (Braithwaite and Travaglia, 2008).

*2.5.1.4 Research and development*

Effective clinical governance entails making changes based on evidence that has been conducted from research (Starey, 2001). Clinical governance requires significant planning to develop and advance the quality of care that is provided to patients (Halligan and Donaldson, 2001). The plan requires substantial research surrounding the needs of individual patients, potential clinical risks, employee capabilities and the current performance of the organisation in relation to its agreed standards (Halligan and Donaldson, 2001). Starey, (2001; p.6) states that "good professional practice has always sought to change in the light of evidence from research". Research and development therefore involves critical appraisals of the current literature, project management and the establishment of protocols, guidelines and implementation strategies (Starey, 2001). Health care organisations need to ensure that they reduce the time lag between identifying new evidence and implementing changes accordingly (Starey, 2001).

*2.5.1.5 Clinical audit*

For decades' health care organisations have been utilising clinical audits to ensure effective clinical practice (Starey, 2001). According to Cowan (2002; p.220), clinical audits are indispensable and key to clinical governance. A clinical audit is regarded as a cyclical process that contributes towards the improvement of the quality of care that is delivered by a health care organisation (Starey, 2001). It can be defined as a process that aims to increase outcomes and patient care through systematic evaluations that are measured against an agreed criteria and result in the initiation of change (Buetow and Roland, 1999; Cowan, 2002). Clinical audits involve the selection of a topic, agreement of the standards, a performance measurement based on the standards, reviewing standards against the performance measurement and adjustments to the system before the cycle is repeated (Starey, 2001). In other words, it assesses what is being practiced against what should be occurring (Braine, 2006). It can therefore be referred to as a performance review that is measured against

agreed standards, enabling health care organisations to realign their operations towards the continuous improvement of the quality of care that is provided (Starey, 2001). Clinical audits are crucial for quality improvements, being referred to as a tool that is used within organisations to promote action and coordinate activities towards clinical effectiveness (Starey, 2001; Braine, 2006). Successful clinical audits are multidisciplinary and embedded within the health care organisations daily operations (Ayres, Wright and Donaldson, 1998).

Health care organisations must have access to their data containing the procedures that have been undertaken, referral letters and the demographic profiles of their patients (Phillips et al., 2010). Transforming data into information can be challenging within health care organisations, therefore a unified system that codifies and extracts the information is essential (Braithwaite and Travaglia, 2008; Phillips et al., 2010). The guidelines and standards behind the retrieval and storage of data must be robust (Cowan, 2002). Patient confidentiality throughout the audit is also paramount (Cowan, 2002). Clinical audits have the potential to incorporate risk management, however resource constraints often hinder this process (Cowan, 2002). Facilitating and integrating risk management within clinical audits enhances the process of improving safety and the quality of care that a patient receives (Cowan, 2002). Inevitably, clinical audits will identify flaws within health care organisations, indicating where patients have received care that is below the standards of the agreed criteria (Cowan, 2002). The owner of the health care organisation must ensure that employees and facilities are conducive towards clinical audits (Cowan, 2002). This entails the establishment of team objectives within the departments and an annual plan that is aligned to the organisation's objectives forming the basis for review and evaluation of the progress that has been made (Wright, Smith and Jackson, 1999:461). According to Wright et al. (1999; p.462), the clinical audit should follow a consistent framework as it combats the tendency of employees submitting "reams of uninformative details".

*2.5.1.6 Openness*

A health care organisation that aims to provide high quality care must meet the needs of its individual patients. Information obtained from patient feedback is essential for employee performance reviews and organisational shortfalls (Braine, 2006).

According to Wright et al. (1999; p.461), a significant amount of effort must be put into discovering what the patient values- a process which requires health care employees to be open, accessible and utilise interpersonal and communication skills. Knowledge management strategies that ensure the use, sharing and promotion of information are essential for a health care organisation's ability to adopt new systems, structures and technologies (Braithwaite and Travaglia, 2008). The quality of care that is provided by an organisation is positively shaped by a supportive environment where there is excellent communication between the doctors and health care employees (Wright et al, 1999). Sanderson (2000; p.52) identifies three important information factors that help to ensure quality care is delivered, namely:

I. That doctors and patients have information regarding the policies, guidelines and procedure options.
II. Information regarding the quality of care is provided by health care employees
III. Information regarding the clinical governance procedures and systems is made available and is comprehendible

The effective use of data and information enables health care organisations to promote a culture where clinical governance thrives and employees are patient-centered (Halligan and Donaldson, 2001; Braine, 2006). As Starey (2001; p.6) states, "open proceedings and discussion about clinical governance issues should be a feature of this framework". Wright et al. (1999; p.461) suggest that clinical governance should be a bottom-up initiative, as trying to monitor and control different teams and professionals requires a significant amount of resources. However, health care employees should be continuously informed as to where quality improvements within the organisation can be made (Halligan and Donaldson, 2001). This requires effective and open communication amongst all members of a health care organisation.

## 2.6 CHALLENGES ASSOCIATED WITH CLINICAL GOVERNANCE

The clinical systems and process within a health care organisation are extraordinarily unpredictable and inherently complex (Doherty, 2013). A patient entering a health care organisation for a diagnosis is significantly different to another patient, requiring dissimilar procedures that vary according to the contextual features, making it difficult to standardise the quality of care that is provided to a patient (Doherty, 2013). The

management of the organisations resources must therefore adapt to the ever changing circumstances (Doherty, 2013). Decisions relating to clinical governance must be responsive and individualised (Doherty, 2013). Clinical governance is predominately viewed as a positive process but can be challenging to implement (Campbell and Sweeney, 2002). Strategies that are used for clinical governance relying solely on guidelines have proven to be ineffective in the past (Phillips et al., 2010). According to Campbell and Sweeney (2002; p.15), it is likely that some elements of clinical governance will work where others may fail. Plochg and Klazinga (2005; p.42) acknowledge that it is possible to examine the reasons why a number of quality-focused initiatives directed at both doctors and managers fail and to provide solutions regarding the paradox between management and medicine that is embedded in the term clinical governance. The empirical evidence on effective interventions is, however, scarce (Shekelle, 2002; Alvanzo, Cohen and Nettleman, 2003; Plochg and Klazinga, 2005).

Another central challenge with implementing and effectively managing clinical governance is the lack of clarity and consensus surrounding the concept's meaning and practical implications (Phillips et al., 2010). Research conducted in Australia, for example, identified the need for clarity surrounding the definition of clinical governance amongst doctors and health care employees (Phillips et al., 2010). Peak et al. (2005; p.99) discovered within a health care organisation in the UK that employees did not share a common understanding of the roles and responsibilities of clinical governance. An observation made by Wright et al. (1999; p.462) is that there is a natural tendency within the composition of clinical governance teams for medical dominance, resulting in a lack of shared responsibility and collaborative effort within the departments of a health care organisation. Doherty (2013; p.6) supports this notion and states that "one misconception of the term is that it aims to achieve governance by clinicians (especially doctors) and therefore medical dominance". Clinical governance in the past has had a tendency to be idiosyncratic due to a traditional doctor culture that emphasises clinical autonomy (Plochg and Klazinga, 2005; Sheps, 2006). Justifiably, a primary concern amongst health care employees is the over-governance by the doctors as apposed to the adoption of strategic approaches that improve the quality of care (Phillips et al., 2010). Clinical governance is a poorly understood concept, often associated with medical dominance or bureaucratic control (Phillips et al., 2010). A

study conducted by Greenfield et al. (2011; p.12) identified that employees within a health care organisation perceived management's approach towards clinical governance as reactive as apposed to proactive. The findings also highlighted the notion that health care employees do not share a common understanding of the concept (Greenfield et al., 2011).

Despite the contention of managements involvement within clinical governance practices in an organisation, Davies and Harrison (2003; p.646) argue that the disintegration of health care delivery, coupled with poor quality care and societal problems have legitimised management's involvement and inclusion within health care organisations. These issues suggest that there is an increasing need for management's oversight (Sheps, 2006). Doctors have been found to be apprehensive towards clinical governance as the changes required are often deemed unnecessary (Starey, 2001). Sheps (2006; p.142) stresses that the divide between managers and doctors with regards to quality of care is significant, real and not to be underestimated. The concept of clinical governance needs to be outlined carefully and understood adequately by health care employees and doctors who hold the responsibility of maintaining clinical governance and good practice (Brennan and Flynn, 2013). As Sheps (2006; p.141) suggests, the dialogue between managers and clinicians needs to increase. Peak et al., (2005; p.99) recognise that poor communication and lack of engagement can result in the organisation's view of clinical governance differing significantly to its own employees' perceptions. Having said this, the understanding of clinical governance amongst health care employees is largely unexplored in much of the literature (Som, 2009).

A significant barrier to good clinical governance within a health care organisations exists where a blame culture is present, undermining the attempt to foster shared learning and openness (Campbell and Sweeney, 2002). Health care employees that have been apprehensive towards clinical governance have expressed concerns that it is utilised to monitor weak performance as apposed to fostering quality improvements (Campbell and Sweeney, 2002). The confusion surrounding the concept often results in resistance among health care employees (Greenfield et al., 2011). These employees are predominately disengaged with quality improvement strategies within the organisation (Campbell and Sweeney, 2002). Other challenges

that have been noted to occur within health care organisations surrounding the concept of clinical governance include insufficient support and logistical issues (Campbell and Sweeney, 2002). Gauld and Horsburgh, (2015b; p.5) identified that a lack of time amongst doctors and health care employees was a significant factor that impeded good clinical governance. According to Freeman (2004; p.336) quality improvement has been overshadowed at the expense of both accountability and structure. Accountability often overshadows a fundamental principle of clinical governance, namely the ability to implement the shift in cultural change that results in continuous quality improvement (Peak et al., 2005).

## 2.7 THE ROLES AND RESPONSIBILITY OF CLINICAL GOVERNANCE

Health care organisations with sound clinical governance benefit significantly as it provides organisations with the opportunity to achieve an equitable distribution of their resources (Wright et al., 1999). Strategies can also be used to move health care employees beyond their comfort zones and create a challenging organisational culture that stimulates continuous learning (Nicholls et al., 2000). This in turn allows for organisations to maximise the skills and talents of their employees (Nicholls et al., 2000). Travaglia et al., (2011:62) state that "clinical governance is said to provide the overarching structure within which health systems, clinicians and staff work towards, and are held accountable for, the safety and continuous quality improvement of their service". Doctors and health care employees have experienced significant difficulties developing roles and distinguishing levels of responsibility when implementing clinical governance processes and systems (Campbell and Sweeney, 2002). Authors Braine (2006) and Greenfield et al. (2011) acknowledge that there is a lack of empirical research on clinical governance practices amongst health care employees. Campbell and Sweeney (2002; p.13) identified that employees at a practice level share a basic understanding of clinical governance, however the focus is generally narrower than that shared by the organisation. This has been attributed to the ambiguity surrounding the concept, the roles that are required and the impact on the individual undertaking the role (Campbell and Sweeney, 2002; Peak et al., 2005). Research surrounding health care employee's perceptions of clinical governance is thus required (Som, 2009; Greenfield et al., 2011).

### 2.7.1 Doctors

Within much of the literature, emphasis has been placed on clinicians to make decisions that improve the quality of care within a health care organisation (Doherty, 2013). The term clinician has traditionally been viewed as synonymous to that of doctors, however growing literature has highlighted differences amongst these terms (Doherty, 2013). The term clinician can be defined as a health professional that is involved in diagnostic procedures to identify health problems, select appropriate treatments, participating in and overseeing the quality of care that a patient receives and to conduct the necessary procedures (Doherty, 2013). For the purpose of this research, a narrow interpretation of the term clinician is used, relating directly to doctors also known as physicians who work in radiology departments- commonly known as radiologists (Knechtges and Carlos, 2007). The traditional role of a physician who specialises as a radiologist using imaging techniques to diagnose, interpret and treat patients has become outdated (Knechtges and Carlos, 2007). The rapid advancement in information technology and imaging has resulted in radiologists needing to become an integral part in patient care beyond the application of diagnostic imaging (Knechtges and Carlos, 2007). Radiologists need to increase their accountability and responsibility with regards to the improvement of the quality of care, the safety of patients and the appropriate management of information (Knechtges and Carlos, 2007).

Much of the literature identifies and explains that a doctor's authority is derived from her/his specialised knowledge as apposed to his/her position within the management hierarchy (Doherty, 2013). This highlights the notion that a significant amount of decision-making regarding the quality of care that is provided is beyond the control of health care managers and health care employees, occurring outside a boardroom setting (Doherty, 2013). According to Doherty (2013; p.5), doctors tend to utilise a different leadership style and approach towards clinical governance to that of managers. Effective doctors are trained to prioritise quality patient care and are accountable for decision-making (Doherty, 2013). Plochg and Klazinga (2005; p.44) state that "doctors themselves have to solve the lack of coordination in medical work". A real partnership between the patients and doctor must be at the center of clinical governance (Wright et al., 1999; Nicholls et al., 2000). Doctors are able to divide and coordinate their working process due to the nature and exclusiveness of medical work

(Plochg and Klazinga, 2005). The senior doctor will be in the position of authority to drive clinical governance and ensure that it is in line with both national and local priorities (Wright et al., 1999). Legal and financial structures should be supported and integrated within each department (Plochg and Klazinga, 2005). This entails the assignment of roles to different clinical disciplines such as education, audit, risk management, research and development as well as clinical effectiveness. Accountability arrangements must be organised and communicated in detail (Scally and Donaldson, 1998). Mechanisms facilitating clinical governance amongst health care employees must also be established (Campbell and Sweeney, 2002). Within recent international research the evidence is convincing that the engagement of doctors is essential for the improvement of clinical governance within health care organisations (Doherty, 2013).

Doctors have the responsibility to provide systems that are safe and promote quality improvements within a health care organisation (Peak et al., 2005). Doctors are responsible for initiating, facilitating and monitoring clinical governance but require the support of their employees who play an integral role in providing strong leadership, commitment and direction (Wright et al., 1999). Doctors must ensure that they balance funding constraints, accountability and adherence to the national core standards of clinical governance (Doherty, 2013). According to Doherty (2013; p.5) there are poor relationships between doctors, managers and health care employees as a result of different training, perspectives and backgrounds. A better understanding of the importance of clinical governance has resulted in greater attempts to advance relations between doctors and health care employees (Doherty, 2013). Doctors who adopt clinical governance roles must, however, ensure that administrative and managerial tasks are not duplicated (Huntington, Gillam and Rosen, 2000).

### 2.7.2 Health care employees

Traditionally, management reforms have occasionally aggravated the poor relationships between doctors and health care employees by raising concerns of financial soundness and efficiency over the demand of delivering good quality care (Doherty, 2013). Research has shown that doctors have been found to resent health care employees (mainly managers) for under-emphasising the importance of quality care where as health care employees have been found to be frustrated by the doctor's approach towards clinical governance practices (Doherty, 2013). Effective clinical

governance requires the involvement of members from all levels within a health care organisation (Degeling, Maxwell, Iedema and Hunter, 2004). As previously mentioned, there is a natural tendency for medical dominance within the composition of clinical governance teams (Doherty, 2013). Clinical governance requires that responsibility is shared within the groups or departments to gain a wider and collaborative effort (Wright et al., 1999). It demands processes and structures to integrate quality improvement strategies in a manner that results in the engagement of all members within a health care organisation (Degeling et al., 2004).

According to Baker, Lakhani, Fraser and Cheater (1999; p.782), a health care organisations employees are unlikely to possess the required time and skills that clinical governance demands. Poor performance amongst health care employees is a risk to patients, colleagues and the organisation (Braine, 2006). As Wright et al. (1999; p.458) state, "the quality of care a patient receives depends on the care of a whole chain of people and doctors are just one link to that chain". Health care employees thus play a vital role in ensuring the delivery of superior quality care (Som, 2009). The concept of clinical governance reinforces the need for health care employees to be held accountable for the services that they provide to patients (Gottwald and Lansdown, 2014). Clinical governance can be seen as a mechanism used to asses and address poor performance amongst health care employees (Braine, 2006). Due to the complexity of clinical governance, all members of a health care organisation must ensure that trust is established, relationships are good and that there is sound communication (Huntington et al., 2000). Good teamwork is essential for an effective medical practice (Wright et al., 1999). Not all employees can be leaders, however all employees must ensure that they are users of clinical governance for patients to be beneficiaries of the systems and processes that are implemented (Campbell and Sweeney, 2002). A "mind shift" is required to transform and align priorities of both doctors and health care employees where a shared responsibility for quality care is the main priority for a health care organisation (Doherty, 2013). Employees within the audit department, for example, must transform from conducting small project-based audits to a central coordinating role that supports clinical governance groups and collects data to collate the information that in turn will drive change (Wright et al., 1999).

## 2.8 CONCLUSION

Clinical governance is a continuous approach to improving the quality within a health care organisation. It provides a framework through which health care organisations are held accountable for the continuous improvement of quality care. The concept of clinical governance aims to integrate and codify approaches that measure and increase the quality of care delivered by a health care organisation (Campbell and Sweeney, 2002). Research conducted in the United States identified three key areas that are vital for quality improvements within health care organisation (Huntington et al., 2000). Firstly, the culture change that is necessary to ensure effective clinical governance requires that the values and beliefs of the health care organisation enable constructive and open reflection (Huntington et al., 2000). Secondly, the health care organisation's employees should have the skills and tools to be effective in their work and therefore technical development must be continuous (Huntington et al., 2000). Lastly, the systems and committees must be developed to monitor and coordinate clinical governance within the health care organisation (Huntington et al., 2000).

The vagueness associated with the definition of clinical governance provides little direction to assess whether a health care organisation has successfully implemented clinical governance (Campbell and Sweeney, 2002). According to Greenfield et al. (2011; p.9), the implementation and interpretation of clinical governance processes varies significantly in different locations. Doherty (2013; p.6) identified that there is a need for research surrounding clinical governance within private health care organisations. Several authors have suggested that there is a gap between the literature and what is being practiced (Lewis et al., 2002; Staniland, 2009; Gauld et al., 2011; Brennan and Flynn, 2013). The purpose of this research as previously stated was to evaluate clinical governance within a private radiology organisation in South Africa. In doing so, the literature reviewed highlighted the importance of clinical governance within a South African context through the identification of the National Core Standards presented by the NDoH. The key characteristics of clinical governance discussed provide guidance to identify clinical governance practices within a health care organisation. The elements of clinical governance identify the systems and structures that are required for clinical governance within a private health care organisation to be practiced appropriately. These elements include clinical

effectiveness, risk management, education, research and development, clinical audit and openness. Numerous challenges surrounding the implementation and maintenance of clinical governance have been identified within the existing literature. The central challenge surrounding the concept is the ambiguity of the term that has resulted in significant research identifying a lack of understanding of the roles and responsibilities of clinical governance among doctors and health care employees. The roles and responsibilities of clinical governance are therefore explored using the available literature. The subsequent chapter will provide an overview of the methodology that was used for this research.

# 3. RESEARCH METHODOLOGY

## 3.1 INTRODUCTION

The aforementioned chapters evaluated the body of knowledge that exists within literature surrounding the concept of clinical governance. The following chapter provides an outline of the methodology that was utilised to obtain the data that enabled the research to be conducted. In doing so the research goals, aim, objectives and questions are distinguished. The procedure and technique relating to the research paradigm, population and sample, interview questions, data collection procedure and analysis of the data is described. Finally, this chapter includes the ethical considerations and limitations of the research.

## 3.2 Purpose of the study

As previously discussed numerous authors have identified that a gap exists between clinical governance literature and what is being practiced within health care organisations (Lewis et al., 2002; Staniland, 2009; Gauld et al., 2011; Brennan and Flynn, 2013). In addition, literature surrounding the understanding of clinical governance amongst health care employees is scarce (Som, 2009). It is however growing gradually, providing health care organisations with a strong rationalisation for adopting the concept as a founding principle (Gauld and Horsburgh, 2015a). Research has identified and highlighted the importance and benefits of clinical governance; despite this the concept requires more extensive research (Gauld and Horsburgh, 2015a). The definition and scope of clinical governance still requires clarity for health care professionals to effectively implement processes and systems that improve the quality of health care organisations (Brennan and Flynn, 2013; Gauld and Horsburgh, 2015a). Without this clarity health care organisations may adopt their own versions of clinical governance that could result in mistakes that have previously occurred elsewhere (Gauld and Horsburgh, 2015a). Authors Greenfield et al. (2011; p.9) have identified a need for additional research surrounding doctor's and health care employee's perceptions of clinical governance practices. Doherty (2013; p.8) highlights the need for clinical governance research within a local context due to the lack of available literature. There is scare evidence of doctors and health care employee's beliefs and practices of clinical governance within a private radiology organisation in Durban, KZN. This research is essential due to the scarcity of the

available literature surrounding the importance of the concept to health care organisations. This research identifies similarities and differences to the available literature highlighting important features and identifying the role of clinical governance within a private radiology organisations in Durban, KZN.

## 3.3 RESEARCH AIM, OBJECTIVES AND QUESTIONS

The aim of this research was to evaluate the role of clinical governance within a private radiology organisation in Durban, KZN. The questions that were answered by the participants were designed to collect data that facilitated with the achievement of the goals, objective and aims of this research. The goals pertaining to this research were to:

*Goal 1: Evaluate the importance and implications of clinical governance for a private radiology organisations in Durban, KZN.* In order to do so the researcher analysed and interpreted the data that was obtained. Several questions were asked to obtain the data that was required to achieve this objective. This included the respondents' beliefs regarding their organisations competitive advantage and core values, the emphasis that their organisation places on delivering a quality health care service and the importance of the concept for their organisations long-term sustainability. The benefits perceived by radiologist's and health care employees for good clinical governance within the private radiology organisation highlights the importance of the concept for the health care organisation.

*Goal 2: To identify and explore the challenges associated with clinical governance.* These included both organisational and conceptual challenges. Key themes were identified (analysis of the data obtained) and compared against clinical governance literature within the discussion. The questions asked ensured that the respondents identified the challenges of clinical governance and as a result key challenges could be identified.

The objectives of the research are:

*Objective 1: To investigate how a private radiology organisations is managing clinical governance within Durban, KZN.* The objective is to identify the policies, procedures and systems that facilitate and ensure sound clinical governance. This requires an

understanding of the beliefs amongst radiologists and health care employees as to who is responsible for driving and implementing clinical governance within a private radiology organisation. In doing so, an understanding of the positions that are held accountable for clinical governance within the organisation was required. Furthermore, the communication among the members of the organisation surrounding the concept of clinical governance was evaluated.

*Objective 2: To identify whether the members within a private radiology organisations have a common understanding of clinical governance.* This enabled the researcher to identify gaps and similarities between the findings of the research and available literature. The meaning and beliefs of clinical governance among the radiologists and health care employees was therefore required for this objective.

## 3.4 PROCEDURE AND TECHNIQUE

### 3.4.1 Research paradigm

The paradigm representing a "worldview" which this research adopted was a post-positivism approach (Guba and Lincoln, 1994; p.110). As a result, the ontological view of this research was critical realism where "reality is assumed to exist but to be only imperfectly apprehendable" (Guba and Lincoln, 1994; p.110). The epistemology of this research was modified/objectivist in order to determine the correlations between the research findings and the pre-existing body of knowledge (Guba and Lincoln, 1994). The methodology that was utilised for this research aimed to conduct inquiries that resulted in situational information derived from a natural setting (Guba and Lincoln, 1994). Consequently, the proposed research adopted a qualitative approach.

### 3.4.2 Population and sample

The research utilised purposive sampling as a small subset of a larger population could be easily identified (Babbie, 2014). The reason for doing so is that enumeration of the whole subset was not feasible in such a study (Babbie, 2014:200). Purposive sampling can be defined as the selection of individuals or organisations that is based specifically on providing answers to the researcher's questions (Teddlie and Yu, 2007). This form of sampling is a technique that facilitates comparability between the interviewee's (Teddlie and Yu, 2007). Purposive sampling generally has a small

sample size that seeks transferability (Teddlie and Yu, 2007). The sample in this study included five respondents from a private radiology organisation. The respondents included radiologists, radiographers and a practice manager. The radiologists are the owners of the business and as a result drive the operations of the organisation making strategic decisions. The radiologists' primary duties are the interpretation of images, supervising the operations of the department, consulting external physicians and ensuring effective clinical governance systems (Dhanoa, Dhesi, Burton, Nicolaou and Liang, 2013). Radiographers are required to give a detailed explanation to the patient regarding the procedure and process that is to be conducted, to take preliminary images and assist the radiologist when required (Ehrlich and Coakes, 2013). Lastly, practice managers are responsible for ensuring there is a high quality of patient care through procedures, systems and policies that shape the organisation's culture (Parand, Dopson, Renz and Vincent, 2014). The researcher acknowledged that the respondents may have been hesitant to provide personal information and thus confidentiality was essential. Obtaining permission from the respondents prior to the interviews being conducted was therefore a prerequisite of this research.

### 3.4.3 The research interview questions (Appendix 2)

The research data was obtained through face-to-face, semi-structured interviews using open-ended questions. The research purpose was to explore the beliefs, motivations, experiences and views of the respondents with regards to the concept of clinical governance (Gill, Stewart, Treasure and Chadwick, 2008). According to Gill et al. (2008; p.291), interviews are most commonly used in health care research. By using this type of qualitative method as opposed to a quantitative method, it enabled the researcher to gain a deeper understanding of clinical governance practices within the organisation (Gill et al., 2008). Semi-structured interviews allowed the researcher to ask key questions that ensured that the interviewee's responses were directed towards the aim, objectives and goals of this research (Gill et al., 2008). Having said that, semi-structured interviews are also flexible which allowed the researcher to diverge from the key questions that were asked in the interview, gain a more detailed response and discover important information from the participants that may not have been previously thought of (Gill et al., 2008). The use of open-ended questions allowed for the respondents to contribute fully towards their viewpoint (Turner, 2010). The

researcher used follow-up questions to responses (such as "can you elaborate on that?") which facilitated in obtaining additional data beyond the predetermined questions (Gill et al., 2008). Applications that provided video chat services such as Skype and FaceTime were used to conduct an interview when requested by the respondent. The interview consisted of ten questions which were designed to yield significant information surrounding the concept of clinical governance within a private radiology organisation. The interview questions that were easiest to answer by the respondents were asked first, as this structure contributed towards the participants building confidence and being at ease (Gill et al., 2008). The length of an interview with the respondent averaged twenty minutes.

### 3.4.4 The data collection procedure

According to Gill et al. (2008; p.293), respondents must be informed about the research topic and ethical considerations such as confidentiality and anonymity. This enables the participants to gain a better understanding of what is to be expected from the interview and is a fundamental feature of gaining informed consent (Gill et al., 2008). In preparation for this, the respondents received an introductory email, a summary of the research topic and an attached consent form that was required to be signed and returned to the researcher prior to the interview (Appendix 3). Correspondence occurred between both parties thereafter to finalise the logistics of the interview and ensure that the participants had a thorough understanding of the research that was to be conducted. Research interviews should occur in an environment that is conducive for the participant and with little distractions (Gill et al., 2008). The interviews began with the researcher providing the participants with a brief summary of the purpose of the research. The respondents were then asked if they had any questions pertaining to the research. Following this, ten open-ended questions were asked. Upon completion of the questions the researcher thanked the participants for their time and asked if feedback was wanted.

### 3.4.5 Analysis of the data

The use of open-ended questions to obtain rich data from the participants necessitated that there was coding of the responses prior to them being processed (Babbie, 2014). The interviews were digitally recorded and then processed into transcripts in order to

ensure a precise record of the information that was used for analysis. Recording the interviews allowed the researcher to focus on the interview and probe with further questions while effectively capturing the data (Jamshed, 2014). The analysis required the interpretation of the meaning of responses, identifying the possibility of misunderstanding and acknowledging the potential for researcher bias (Babbie, 2014). Thematic analysis was used to scrutinise the interview data so that common themes could be identified and compared to the current body of literature which helped to identify similarities and gaps (King and Horrocks, 2010). Thematic analysis is a flexible research tool that provides a researcher with a detailed interpretation of the data (Vaismoradi, Turunen and Bondas, 2013). The criteria for clinical governance as laid out by the NDoH which establishes the minimum standards of clinical governance that is required within health care organisations in South Africa was used to discuss the results.

## 3.5 ETHICAL CONSIDERATIONS

There were a number of ethical considerations that were taken into account before the qualitative open-ended interviews occurred. DiCicco-Bloom and Crabtree (2006; p.319) identified four ethical issues that relate directly to the interview process as seen below:

1. The reduction of risks occurring from unanticipated harm;
2. The protection of the respondent's information;
3. Informing the respondents effectively regarding the nature of the research, and
4. reducing exploitation

These ethical issues were considered and as a result all respondents received a summary of the research and informed consent form before the interviews were conducted. The respondent's questions pertaining to the study were addressed and then each were thanked for their participation and given the option to receive feedback. The researcher acknowledged the sources of internal invalidity - namely history, testing, maturation, instrumentation, selection bias, experimental mortality and demoralisation – which are important to address quality issues surrounding research design (Babbie, 2014). The researcher was aware of the concerns surrounding confidentiality, subjectivity, bias and ensuring permission was granted. The names of the participants and organisation was kept confidential, as a result pseudonyms were

used (for example R1-RT). Due to the research being qualitative in nature, subjective judgment had to be taken into account (Babbie, 2014). To address these issues the researcher was aware of personal values and preferences but adhered to the established techniques with regards to data collection and analysis (Babbie, 2014). The researcher obtained ethical clearance from the Rhodes Business School's internal committee as seen in appendix 2.

## 3.6 LIMITATIONS OF THIS RESEARCH

According to Bryman (2015; p.399), there are a number of potential limitations that are associated with qualitative research. Generalization was a potential limitation of this study as a small sample size was used, where critics have argued that it's not possible to generalise findings to other settings (Bryman, 2015). It is important to note that this research used a qualitative approach to generalise the theory, not the population (Bryman, 2015). This research made linkages and comparisons with the available literature and as a result was subject to *moderatum generalization* (Bryman and Bell, 2015). A common limitation associated with qualitative research is the frequent lack in transparency as to how the research was conducted (Bryman 2015). The lack of transparency is often attributed to how participants were chosen, the process of analysing the data and how it was conducted (Bryman, 2015). Limitations of this study include a small sample size and geographical limitations. As mentioned previously whilst discussing the research paradigm- population and sample, interview questions, data collection process and analysis of the data for this research was clearly outlined and justified.

## 3.7 CONCLUSION

The data that was collected enabled the researcher to gain adequate information to evaluate clinical governance within a private radiology organisation in Durban, KZN. The purpose and importance of this research was outlined and the aims, objectives and goals were clearly defined. The procedure and technique that was used to obtain the data for this research was provided. Lastly, the ethical considerations and limitations of the research were identified and discussed. The subsequent chapter contains the results of the data that was obtained for this research.

# 4. RESULTS

## 4.1 INTRODUCTION

Chapter 4 presents the results of the data that was collected from the semi-structured interviews. The respondents consisted of doctors and health care employees working within a private radiology organisation. Their pseudonyms and job position seen in Table 1 ensure anonymity, a prerequisite for this research.

*Table 1: The respondents of this research.*

| **Name:** | **Job position:** | **Key:** |
|---|---|---|
| Respondent 1: | Radiologist | R1-RT |
| Respondent 2: | Radiologist | R2-RT |
| Respondent 3: | Practice manager | R3-PM |
| Respondent 4: | Radiographer | R4-RG |
| Respondent 5: | Radiographer | R5-RG |

Key:

R= respondent

RT= radiologist

PM= practice manager

RG= radiographer

The five respondents seen in Table 1 consisted of two radiologists, two radiographers and a practice manager within a private radiology organisation in Durban, KZN. The analysis of the data obtained from the responses to the interview questions (Appendix 3) is presented in the subsequent section.

## 4.2 RESULTS FROM THE SEMI-STRUCTURED INTERVIEW QUESTIONS

### 4.2.1 The organisations competitive advantage and values (Question 1)

R1-RT:

The respondent identified that their private radiology organisation's competitive advantage is "having an affiliation to a hospital that provides a continuity of service

from referring doctors". Their organisations core value is to provide higher quality care than competitors who are believed to be more volume driven. The respondent believes that their organisation provides higher quality reports by ensuring "in depth reporting, extracting comprehensive and accurate data". The respondent believes that by using the most advanced equipment and machinery their organisation is able to provide patients with the best resources that enable a quality care service superior to their competitors to be delivered.

R2-RT:

The respondent identified that their organisations has "a good business plan which distinguishes their core values". According to the respondent their business core value is to provide "a quality care service". It is believed that staying up to date with rapid technology changes by using sophisticated machinery and equipment, their organisation can provide a higher quality service than its competitors. The respondent identified that their organisations competitive advantage is their high caliber medical and non-medical employees who adopt a patient centered approach to the diagnostic services that are provided.

R3-PM:

The respondent identified that their organisation was not volume driven, rather providing a quality care service is viewed as a core value within their organisation. It is believed that clear concise reporting enables their organisation to gain a competitive advantage to provide superior quality care services.

R4-RG:

The respondent identified that their organisations core value and competitive advantage is their employees adopting a patient centered approach within their daily operations. The respondent identified that the radiologists of the organisation demand a high standard of quality work from the radiographers.

R5-RG:

The respondent believes that their organisations "core value and competitive advantage is providing a quality care service". It is believed that their organisations image quality and final reports are superior to competitors. The respondent believes that this is what the members within their organisation pride themselves on.

Table 2 presents a summary of the respondent's perceptions towards their private radiology organisation's competitive advantage and core values.

*Table 2: The competitive advantage and core values.*

| Name: | Competitive advantage and values: |
|---|---|
| R1-RT: | • Hospital affiliation<br>• Quality care service |
| R2-RT: | • Quality care service<br>• Patient centered approach adopted by high caliber medical and non-medical employees |
| R3-PM: | • Quality care service |
| R4-RG: | • Patient centered approach |
| R5-RG: | • Quality care service |

4.2.2 Emphasis the private radiology organisation places on delivering a quality service (Question 2)

R1-RT:

The respondent believes that their organisation places a "significant emphasises on the importance of adopting a patient centered approach among its employees". The employees within the organisation are responsible for making the patients feel welcome and taken good care of. The respondent believes that their organisations protocols and systems ensure that employees provide a quality service. The respondent identified that "education and training is provided by the organisation to ensure that employees are specialised, well trained and informed". The respondent identified that their employees are provided with in-house training and sponsored to further their education. It is believed that this enables the organisation to stay up to date with medical and technological changes. According to the respondent their organisation utilises risk management strategies, clinical audits and performance reviews to ensure continuous quality care improvements.

R2-RT:

The respondent believes that their organisation "fields a workforce that is capable of providing a high quality service delivery". The respondent identified that their organisation places significant emphasis on education and training, specifically academic research, adopting patient centered approaches and utilising appropriate

management strategies. According to the respondent their organisation "aims to provide a service that exceeds their patient's expectations".

R3-PM:

The respondent believes that their organisation carefully selects experienced employees and provides comprehensive education and training. The respondent suggested that this enables the organisation to reduce the risks associated with inexperienced employees so that their organisation can provide superior quality care services. The respondent believes that the radiologists within their organisation prioritise in depth reporting.

R4-RG:

The respondent believes that the employees within their organisation are specialised, well trained and competent to do what is required. The respondent identified further that "effective education and training process enable their employees to deliver a service at the highest quality".

R5-RG:

The respondent believes that their organisation places an emphasis on "providing patients with in depth reports". The respondent identified that their systems within the organisation ensure that their patients receive the highest quality of care.

*Table 3: The emphasis placed on delivering quality care services.*

| **Name:** | **How the organisation emphasis quality care services** |
|---|---|
| R1-RT: | • Patient centered approach<br>• Specialised workforce<br>• Education and training<br>• Clinical audits<br>• Performance reviews<br>• Risk management strategies |
| R2-RT: | • Education and training<br>• Specialised workforce<br>• Patient centered approaches |
| R3-PM: | • In-depth reporting<br>• Specialised workforce |

| | |
|---|---|
| | • Education and training |
| R4-RG: | • Education and training<br>• Specialised workforce |
| R5-RG: | • In-depth reporting |

A summary of the respondent's perception towards the way their organisation places an emphasis on delivering a quality care service is seen in table 3.

4.2.3 Defining clinical governance (Question 3)

R1-RT:

"Acting in the best interests of the patients, acting ethically in all instance and putting the patients needs at the forefront. Making decisions based on the patient's best interests with the minimum radiation dose. To treat all staff members fairly according to the laws of the country. To do all accounts fairly and not have any form of fraud or theft".

R2-RT:

"A systematic approach and framework through which health care service providers are accountable and responsible for improving the quality of patient care within a health system and safeguarding high standards of care by creating an environment of excellence in clinical care".

R3-PM:

"It is a way of keeping good practice, similar to corporate governance but within a medical context. Its is a framework that ensures all health care organisations within South Africa work towards the same goals, purpose and set of standards. It provides guidelines for accountability and responsibility for the operations within a health care organisation".

R4-RG:

"I have no idea".

R5-RG:

"How the market is evolving, how the community is evolving and the fact that people are demanding a lot more. Usually complaints and criticism are used to work out how to improve your service and go from there".

4.2.4 The benefits associated with clinical governance (Question 4)

R1-RT:

The respondent believes that "it sets benchmarks for employees, which allows them to know what standards they need to achieve". The respondent suggests that their organisation assumes that new employees are unaware of the meaning of clinical governance and therefore require the appropriate education and training.

R2-RT:

According to the respondent, "it addresses structures, systems and processes that assure quality, accountability, transparent responsibility and proper management of a health care organisations operation and service delivery". The respondent believes that it creates positive values and attitudes about safety and quality by reinforcing accountability, continual improvement of services, increased capabilities of clinical employees, assurance of quality and a focus on ethics.

R3-PM:

The respondent believes that it "provides a framework for health care organisations to adhere to". The respondent identified that it ensures the safety of the patient and protects the organisation from legal issues, a win-win situation. The respondent further believes that it facilitates openness among all employees within a health care organisation.

R4-RG:

The respondent believes that their "procedures, policies and guidelines ensure all employees deliver high standards of quality care".

R5-RG:

The respondent identified that it helps their organisation to identify problems and make the appropriate changes to continuously improve the quality of care that is provided to their patients. The respondent believes that it provides an appropriate framework to conduct their patient evaluations.

4.2.5 The importance of delivering quality care for the private radiology organisation's long-term sustainability (Question 5)

R1-RT:

The respondent believes that a health care organisation providing quality care services will be successful and sustainable within the existing industry. The respondent identified that if the quality of care provided is below market expectations

their organisation will slowly wither and eventually fail. According to the respondent this is the nature of health care organisations within a competitive industry. The respondent identified that their organisation is regulated to some extent by referring doctors, who provide feedback on the quality of their reports that are received. Furthermore, any quires and complaints are openly discussed and resolved with the parties involved. The respondent believes that their organisations asses its quality in terms of meeting patient expectations, making use of patient and employee questionnaires.

R2-RT:

The respondent believes that the most important aspects of building and maintaining a sustainable and successful business is attracting new customers and retaining existing ones. According to the respondent quality care and customer satisfaction are critical for their organisations long-term success. It is believed that patients within the modern business environment demand high quality care services. The respondent identified that their stakeholders expect their organisation to provide a high quality care service.

R3-PM:

The respondent believes that "providing quality care services is key to their organisations long-term sustainability". The respondent believes that their organisations success is determined by its reputation that it has obtained over the past two decades. The respondent believes that their organisation has a reputation for providing high quality care services. The respondent identified that their employees are aware of what is expected of them. Furthermore, it is believed that providing a quality care service is embedded within their organisation's culture.

R4-RG:

The respondent believes that with the increasing health care costs to the consumer, a higher quality care service is expected. The respondent believes that their organisations ability to provide superior quality services is essential for its long term sustainability.

R5-RG:

The respondent believes that in order for their organisation to survive the quality of care that they provide must continuously improve. The respondent believes that their organisation focuses purely on quality as apposed to volume. The respondent identified that volume is still needed but at the highest quality. Furthermore, the

respondent believes that their organisation has built a reputation for providing high quality services among its stakeholder.

4.2.6 The policies, procedures and systems (Question 6)

R1-RT:

According to the respondent the reporting conducted by the radiologists is reviewed by peers and contrasted with similar cases. The respondent identified that mistakes are addressed before reports are finalised. Furthermore, the radiologists are required to read academic journals when reviewing cases to investigate and describe findings. The respondent believes that the quality systems within their organisation ensure that employees are provided with continuous education and training. The respondent believes that their organisation has a good review system that is based against agreed standards and protocols. According to the respondent this ensures that insubstantial work is repeated to meet the expectations of their stakeholders. The respondent identified that their organisation has meetings with employees. The respondent identified that clinical audits are used and benchmarked against their guidelines and standards. Furthermore, risk management systems within their organisation predominantly focus on the equipment and machinery.

R2-RT:

The respondent identified that their information management of patient records including proper collection, storage, and the assessment of patient records is used to assist with the improvement of the quality of the health care service that their organisation provides. Furthermore, research and development within their organisation involves the development and implementation of protocols and standards that promotes high quality care. According to the respondent their organisation promotes continuous education so that doctors and health care employees remain up to date with medical advancements. The respondent identified that clinical audits and peer reviews are conducted where all members of their organisation participate with confidentiality being maintained. The respondent believes that patient complaints enable their organisation to improve its performance. Furthermore, their patients are informed and communicated with openly surrounding the procedures that are conducted and diagnosis.

R3-PM:

The respondent identified that their organisation is developing job descriptions within as they are currently outdated. The respondent believes that this will enable the organisation to distinguish their employee's responsibilities. According to the respondent performance reviews are used to evaluate the employees within their organisation. Furthermore, their organisation provides all employees with the opportunity to continuously undertake education and training.

R4-RG:

The respondent is unaware of any within the organisation currently.

R5-RG:

The respondent identified that their organisation uses reject analysis to identify where employee skills are needed to develop further. The respondent believes that this enables their organisation to implement effective education and training policies. According to the respondent risk assessments are conducted and focus on the health and safety of their patients. Furthermore, meetings are conducted among the members of their organisation but are irregular. The respondent believes that their organisation promotes openness among its stakeholders.

A summary of the policies, procedures and systems that were identified by the respondents to continuously improve quality care within their organisation is seen in Table 4.

*Table 4: The policies, procedures and systems.*

| **Name:** | **Policies, procedures and systems used to continuously improve quality care:** |
|---|---|
| R1-RT: | • Peer review among the radiologists<br>• Continuous education and training<br>• Agreed standards, benchmarks and protocols<br>• Meetings<br>• Clinical audits<br>• Risk management |
| R2-RT: | • Information management of patient records<br>• Research and development<br>• Continuous education |

| | |
|---|---|
| | • Clinical audits<br>• Peer reviews<br>• Complaint management<br>• Openness |
| R3-PM: | • Job descriptions<br>• Performance reviews<br>• Education and training |
| R4-RG: | • Unaware of any |
| R5-RG: | • Reject analysis<br>• Education and training<br>• Risk assessment<br>• Meetings<br>• Openness |

4.2.7 Responsibility for ensuring quality care improvements (Question 7)

R1-RT:

The respondent believes that the responsibility for ensuring quality care improvements is shared among the radiologists, chief radiographer and practice manager within their organisation. The respondent identified that performance reviews are used to asses whether the agreed standards have been met.

R2-RT:

The respondent believes that their practice manager and radiologists are responsible for driving quality care improvements.

R3-PM:

According to the respondent the practice manager is responsible for quality care improvements and is required to develop the employees within their organisation. The respondent identified that it involves seeking the appropriate training programs that employees can undertake. Furthermore, the focus is placed on up skilling the employees within their organisation to provide them with the tools that will enable continuous quality care improvements.

R4-RG:

The respondent believes that the practice manager is responsible for ensuring the quality of care that is provided is continuously reviewed and improved. Furthermore,

the chief radiographer supports the practice manager with implementing quality care improvement strategies.

R5-RG:

The respondent was unaware of who is held responsible for continuously improving the quality of care that is provided by their organisation.

A summary of the respondent's beliefs regarding the individuals responsible for ensuring the improvement of the quality of care that is provided within their private radiology organisation is seen in Table 5.

*Table 5: Responsibility for driving quality care improvements.*

| **Name:** | **Job position:** |
|---|---|
| R1-RT: | Radiologists, chief radiographer and practice manager |
| R2-RT: | Radiologists and practice manager |
| R3-PM: | Practice manager |
| R4-RG: | Practice manager and chief radiographer |
| R5-RG: | Unaware |

4.2.8 Positions held accountable for providing quality care services (Question 8)

R1-RT:

The respondent believes that all doctors and health care employees within their organisation are held accountable for providing quality care services. According to the respondent the chief radiographer is expected to provide and maintain the logs of all the equipment used within their organisation. The respondent identified that the logs are provided to the health professions council and radiation board. The respondent believes that the radiologists are responsible for addressing patient complaints with the assistance of the practice manager. According to the respondent every employee within their organisation is held accountable for their patients. The respondent believes that employees are therefore required to treat all patients with respect and dignity. The respondent believes that their organisation ensures all labour laws are adhered to. The respondent identified that employee disputes are resolved through an outsourced law organisation.

R2-RT:

The respondent believes that all members within their organisation are held accountable and in charge of ensuring quality care improvements. The respondent identified that a framework is used within their organisation to assess the agreed standards. According to the respondent their organisation tries to provide alternative dispute resolution methods before disciplinary action occurs. Furthermore, their practice manager implements mechanisms to report any adverse events and improve existing quality processes and identifies any shortcomings.

R3-PM:

The respondent believes that every member within their organisation is held accountable for providing a quality care service.

R4-RG:

According to the respondent every employee is held accountable to meet the agreed standards that are established within their organisation. The respondent identified that the protocols used within their organisation need improvement as they are not clearly established.

R5-RG:

The respondent believes that all employees are held accountable within their organisation. The respondent identified that the radiologists and chief radiographer within their organisation ensure their employees are accountable for the work that they produce.

#### 4.2.9 Communication and openness (Question 9)

R1-RT:

The respondent identified that their organisation has protocols, rules and standards available for all members of their organisation to read. The respondent is unaware of whether all members have read these files.

R2-RT:

The respondent believes that clinical governance practices are discussed in meetings where the goals and aims are established and entrenched. The respondent believes that the performance of their employees is communicated openly. The respondent believes that this is achieved through systems of appraisal, performance reviews and clinical supervision. The respondent identified that improving the quality of care within

their organisation can only be achieved through continuous education and training among all the members of their organisation.

R3-PM:

The respondent identified that clinical governance practices are discussed in meetings held fortnightly among non-clinical employees and radiographers. The respondent believes that performance appraisals are used to assess whether the standards are being achieved.

R4-RG:

The respondent believes that their business has not communicated to its employees the concept of clinical governance.

R5-RG:

The respondent identified that their business has not communicated to its employees the concept of clinical governance.

#### 4.2.10 The challenges associated with clinical governance (Question 10)

R1-RT:

The respondent believes that a significant challenge within their organisation was having too many policies in place results in employees not being aware of all the procedures to follow. The respondent believes that the communication between the radiologists and health care employees is insufficient. Furthermore, the respondent believes that their organisation has a blame culture which inhibits good clinical governance practices. Furthermore, the respondent believes that the members of their organisation avoid and divert responsibility. The respondent believes that time management is their organisations biggest challenge. According to the respondent their patients have high expectations and want their diagnosis immediately. It is believed that the organisations patients are often unaware that their diagnosis may take some time. According to the respondent, patient expectations are based on how quickly the reports can be produced opposed to the quality of the report. The respondent also identified that their organisation has not paid attention to management strategies with the majority of their time devoted to clinical duties. According to the respondent the radiologists keep up to date within the field of radiology but not with management research and practice.

R2-RT:

According to the respondent the biggest challenge that their organisation faces is for policies and systems to translate into implementable actions. The respondent attributes this to several employees being dissatisfied. The respondent believes that evaluating and determining clinical governance performance indices is challenging for their organisation.

R3-PM:

The respondent believes that a number of employees within their organisation are dissatisfied, as a result the organisations goals are hard to achieve. The respondent attributes this to their employees not being aware of why certain policies are implemented.

R4-RG:

According to the respondent the radiologists who make the strategic decisions for their organisation are too busy to make informed decisions. The respondent believes that time management and openness is their organisations biggest challenges.

R5-RG:

The respondent believes that the older employees within their organisation can be resistant to change. The respondent identified that effective time management is their organisations biggest challenge, trying to balance management responsibilities with clinical work. The respondent identified that management strategies are challenging to implement due to clinical employees not having business education and training.

A summary of the challenges that the private radiology organisation faces with understanding and implementing clinical governance systems, policies and procedures is seen in Table 6.

*Table 6: Challenges associated with clinical governance.*

| **Name:** | **Challenges:** |
|---|---|
| R1-RT: | • Too many procedures and policies can be unrealistic for health care members to be aware of each standard and regulation.<br>• Poor communication<br>• A blame culture that avoids and shifts responsibility<br>• Time management<br>• Patient expectations |

| | |
|---|---|
| | • Business management skills |
| R2-RT: | • Ability to implement and drive changes<br>• Employee satisfaction<br>• Evaluating and determining clinical governance performance standards |
| R3-PM: | • Staff satisfaction<br>• Openness |
| R4-RG: | • Time management<br>• Openness |
| R5-RG: | • Employees resistant to change<br>• Time management<br>• Business management skills |

## 4.3 CONCLUSION

The results were obtained from semi structured interviews with five respondents consisting of ten questions that was used to achieve the aim, goals and objectives of this research. The results of each question from the respondents was provided in this chapter. These results are discussed in the subsequent chapter where the research questions are answered and compared with the available literature.

# 5. DISCUSSION

## 5.1 INTRODUCTION

The results of this research were presented in chapter 4 which described the respondent's beliefs of clinical governance within their private radiology organisation. These results are discussed within the following chapter drawing on comparisons from the existing literature.

## 5.2 THE DEFINITION OF CLINICAL GOVERNANCE (QUESTION 3)

Literature surrounding doctors and health care employees understanding of clinical governance is largely unexplored (Som, 2009). The results obtained in chapter 4 suggest that three out of the five respondents within the private radiology organisation are able to provide a definition of clinical governance that incorporates several key elements from definitions available within the existing literature (Galbraith, 1998; Scally and Donaldson, 1998; Starey, 2001; NDoH, 2010; Brennan and Flynn, 2013; Sidin and Pasinringi, 2014). The focus of these member's definitions however is predominantly narrower than the definitions within the available literature, coinciding with research conducted by Campbell and Sweeney (2002; p.13). The results indicate that there are members within this private radiology organisation that are unaware of the definition for clinical governance. The results therefore support the notion that a shared understanding of clinical governance among the members of a health care organisation is not present (Peak et al., 2005; Phillips et al., 2010 and Greenfield et al., 2011). Overall, the results suggest that there is ambiguity among the members of the private radiology organisation surrounding the definition of clinical governance. This research therefore supports the notion that there is a lack of clarity surrounding the definition of clinical governance (Doherty, 2013). Furthermore, the research supports the notion that members within a health care organisation find the definition of clinical governance challenging to comprehend (Scally and Donaldson, 1998; Balding, 2005; Braithwaite and Travaglia, 2008; Brennan and Flynn, 2013).

## 5.3 THE IMPORTANCE OF CLINICAL GOVERNANCE FOR THE PRIVATE RADIOLOGY ORGANISATION

### 5.3.1 Quality as a competitive advantage and core value (Question 1)

It is evident from the results that there is consensus among the respondents that providing a quality care service is the organisations competitive advantage and viewed as a core value. The results suggest that providing a quality care service is embedded within the organisations culture. Existing research suggests that health care organisations with good clinical governance practices view quality care as a key component within their strategy and goals (Doherty, 2013). The results suggest that the way the organisation provides superior quality services is through in depth reporting, adopting a patient centered approach and utilising the most advanced equipment and machinery.

### 5.3.2 Emphasis placed on delivering a quality service (Question 2)

The results indicate that the predominant belief among the respondents as to the manner in which the organisation places an emphasis on delivering a quality care service is by ensuring their members are specialised. The results suggest that the education and training of the organisations employees is a priority. The private radiology organisation is therefore aligned with the notion that it is imperative for health care organisations workforce to be qualified, experienced, skilled, up to date and competent (Braine 2006). The results indicate that the organisation is aware that education and training plays a vital role in their ability to deliver quality care services, (Starey, 2001; Braine, 2006; Knechtges and Carlos, 2007; Gauld and Horsburgh, 2015a). The results indicate that the organisation adopts a patient-centered approach within their daily operations to provide quality care services (Campell and Sweeney, 2002). This suggests that the organisation aims to create an environment where clinical governance can flourish (Hacket et al., 1999). Furthermore, it suggests that there is a belief among the members of the organisation that providing a patient-centered services at the highest quality will result in its success (Markar and O' Sullivan, 2012). It is evident from the results that in depth reporting is believed to increase the quality of care that is provided by the organisation. It is clear that the organisation places an emphasis on delivering a quality care service through the use

of several key elements within the clinical governance framework namely education, clinical audits and risk management (Starey, 2001).

### 5.3.3 The importance of continuous quality improvements for the organisations long-term sustainability (Question 5)

The results indicate that the members of the private radiology organisation believe that providing quality care services is essential for their organisations long-term sustainability. It is evident that these members believe customer satisfaction and their organisations reputation will enable the business to achieve sustainable growth. This supports the notion that continuous quality improvement is vital for the long-term success of health care organisations within the ever-changing business environment (Markar and O' Sullivan, 2012). The results suggest that providing a quality care service is a key goal embedded within the organisations culture to ensure long-term sustainability (Doherty, 2013).

### 5.3.4 The benefits of clinical governance (Question 4)

The results suggest that despite the ambiguity surrounding the definition of clinical governance among several members of the organisation it is clear that there is a consensus that clinical governance practices improve the quality of care that is provided by a health care organisation (Travaglia et al., 2011). The results suggest that these members of the organisation are aware that the purpose of clinical governance is to improve the quality of care that is provided through a framework that establishes benchmarks and standards which must be adhered to (NDoH, 2011). It is also evident that members within this organisation are aware that clinical governance ensures patient safety, accountability, openness, and helps the organisation to identify and overcome quality shortcomings (Braithwaite and Travaglia, 2008; Travaglia et al., 2011).

## 5.4 CLINICAL GOVERNANCE WITHIN A PRIVATE RADIOLOGY ORGANISATION

### 5.4.1 The clinical governance policies, procedures and systems utilised (Question 6)

It is clear from the results that the organisation policies, procedures and systems are aligned with the six key elements of the clinical governance framework (Starey, 2001).

The use of benchmarking, performance appraisals, reject analysis and adherence to the agreed standards and protocols indicate that the organisation is striving for clinical effectiveness, where efficiency and patient safety is considered (Starey, 2001). The results indicate that education and training within the organisation is prioritised. This is key to effective clinical governance as seen in a study conducted in NZ (Gauld and Horsburgh, 2015b). Clinical audits are used within the private radiology organisations to ensure access to patient data (Phillips et al., 2010) and the agreement of the standards that measure performance (Starey, 2001). The results suggest that the organisation uses risk management systems to monitor, manage and improve their policies, procedures and systems preventing adverse events (NDoH, 2011). According to Travaglia et al. (2011; p.67), risk management is essential for quality care improvements to occur. The results suggest that the organisation attempts to ensure openness through meetings, peer reviews and making information of the protocols, rules and guidelines available to employees (Sanderson, 2000). It is clear that the organisation has systems that ensure research and development that identifies the needs of their patients to establish appropriate standards (Halligan and Donaldson, 2001). Openness was also evident within the organisations as peer reviews are utilised (Braine, 2006), meetings discussing the concept occur (Sanderson, 2002) and patients participate with the process (Wright et al., 1999).

The minimum standards that the private radiology organisation must comply with, seen in appendix 1 comprises of six sub-domains (NDoH, 2011:10). It is clear from the results that the private radiology organisations policies, procedures and systems are aligned to the national core standards (NDoH, 2011:10). The results suggest that the organisation utilises protocols and procedures that ensure patients receive care that enhances health outcomes (NDoH, 2011:10). The results also indicate that the organisation has systems in place that analyses data to address shortcomings (NDoH, 2011:10). Furthermore, the organisation is formulating clear job descriptions that will outline accountability among its members (NDoH, 2011:10).

5.4.2 Position responsible for ensuring clinical governance (Question 7)

The results suggest that the members of the private radiology organisation do not have a shared understanding of the individuals that are deemed responsible for

continuously improving the quality of care that is provided to patients. The results support the notion that doctors and health care employees experience difficulties distinguishing levels of responsibility (Campbell and Sweeney, 2002:13). The lack of consensus surrounding the person who is responsible for ensuring clinical governance can be attributed to the ambiguity of the definition that results in different interpretations of the concepts meanings (Peak et.al, 2005:99). Marshall (1999; pp167) identified that ambiguity surrounding the roles and responsibilities among the members of a health care organisation was a significant barrier to continuous quality health care improvements. There was no expressed concern among health care employees of over-governance by the doctors within the organisation towards clinical governance approaches, identified within existing research (Phillips et al, 2010 and Wright et al, 1999). The results suggest that radiologists, radiographers and managers play a key role in ensuring quality of care is continuously improved within the private radiology organisation. This suggests that several members of this organisation believe there is a need for management's inclusion within quality care improvement strategies (Davies and Harrison, 2003 and Sheps, 2006).

### 5.4.3 Accountability for clinical governance (Question 8)

There is a consensus among the members of the private radiology organisation that all doctors and health care employees are held accountable to deliver quality services (Travaglia et al., 2011). The results therefore contradict the notion that clinical governance policies and approaches create organisations where accountability rests with the owner of the health care organisation (Scally and Donaldson, 1998).

### 5.4.4 Communication regarding clinical governance (Question 9):

The results suggest that the communication surrounding clinical governance within the private radiology organisation is insufficient. The results support the notion that there is a gap between the concept of clinical governance within literature and the understanding among the members of what is required (Lewis et al., 2002; Staniland, 2009; Gauld et al., 2011). This is prominent with several members being unaware of the standard of quality of care their organisation strives to achieve and its clinical governance activities. The results suggest that the meetings occurring within the

organisation are not sufficient as all members are not informed of quality care improvements that can be made (Halligan and Donaldson, 2001).

## 5.5 THE CHALLENGES EXPERIENCED WITH CLINICAL GOVERNANCE PRACTICES (QUESTION 10)

The results suggest that the private radiology organisation experiences significant challenges surrounding the concept and implementation of clinical governance. It is evident that the lack of consensus surrounding the definition of clinical governance is a central challenge that has resulted in the ambiguity surrounding the roles and responsibilities that are required and the policies, systems and structures that must be implemented and continuously improved (Peak et al., 2005; Phillips et al., 2010). The results suggest that there is a negative culture within the organisation towards clinical governance practices as employee dissatisfaction and a blame culture is identifiable. The results support the notion that effective time management is a significant challenge within health care organisations, balancing clinical and managerial responsibilities (Gauld and Horsburgh, 2015b). Several members within these organisations identified that a lack of managerial skills constrained good clinical governance practices. These employees therefore do not underestimate the level of managerial skills that is required to deliver clinical governance practices as suggested by Phillips (2002; p.84), rather are aware of their shortfalls with their current skillset to implement and meet clinical governance goals.

The results coincide with belief that staff dissatisfaction towards clinical governance is a result of the members of a health care organisation believing changes are unnecessary which could be attributed to the confusion surrounding the concept (Greenfield et al., 2011; p.17) or the lack of communication that is being experienced (Peak et al., 2005; p.99). The results confirm that a negative culture within these organisations is a barrier to good clinical governance (Doherty, 2013). The results support the notion that health care organisations experience difficulties evaluating clinical governance performance standards (Starey, 2001). It is evident that clinical governance practices are challenging to effectively implement (Campbell and Sweeney, 2002).

## 5.6 CONCLUSION

This chapter discussed the results in the light of the research goals and objectives. The understanding of the definition of clinical governance among the members of the private radiology organisations was discussed. The importance of clinical governance for the private radiology organisations is outlined. Finally, the manner in which the organisation is managing clinical governance and the challenges that are being experienced was identified.

# 6. CONCLUSION AND RECOMMENDATIONS

The aim of this research was to evaluate the role of clinical governance within a private radiology organisation in Durban, KZN. The results indicate that the understanding of the definition for clinical governance among the members of the private radiology organisation is not shared. Consequently, the identification of the systems, policies, structures, roles and responsibilities of clinical governance within the organisation differ among its members. The lack of clarity surrounding the concept of clinical governance contributes towards the gap between what is being practiced and what is required (Lewis et al., 2002; Staniland, 2009; Gauld et al., 2011; Brennan and Flynn, 2013). The concept needs to be outlined clearly and understood by all the members of a health care organisations (Brennan and Flynn, 2013). The challenges experienced within the private radiology organisation emphasise the need for clarity surrounding the concept of clinical governance. This research therefore supports the notion that there is a need for consensus and clarity surrounding the definition and role of clinical governance (Phillips et al., 2010; Brennan and Flynn, 2013). According to Brennan and Flynn (2013; p.8), clarity surrounding the term clinical governance may lead to more effective practices that ensure quality of care continuously improve within a health care organisation.

Despite the lack of clarity, the results suggest that the organisation researched strives to provide superior quality care services, to gain a competitive advantage within the private health care sector in Durban, KZN. The organisation therefore places a significant emphasis among its members to deliver superior quality care services. It is clear from the results that specialised doctors and employees within a health care organisation are essential for quality health care services to be delivered (Crook, 2002). The importance of clinical governance is recognised among the members of the private radiology organisation. The benefits that were identified by the respondents suggest that clinical governance is viewed as a positive process within the organisation. It is evident that the organisation uses the six key elements within the clinical governance framework to continuously improve the quality of care that is provided. The clinical governance framework enables the organisation to adhere to the national core standards for health care establishments within South Africa. Clinical

governance therefore plays a key role in a health care organisations ability to deliver quality care services, ensuring patient safety and accountability.

Within a local context it may be beneficial for additional research to identify the contribution that clinical governance activities make to quality care improvements (Doherty, 2013). Research surrounding whether health care organisations in South Africa are abiding to the minimum standards of clinical governance would contribute significantly to the existing body of knowledge (NDoH, 2011). This may help to identify additional challenges that are being experienced and whether or not these organisations are able to effectively implement clinical governance policies, procedures and processes. It would be beneficial to identify if differences exist between private and public health care organisations approaches towards clinical governance practices. This may help to identify an effective approach for health care organisations to implement and manage clinical governance practices within a South African context. Further research is required into the perceptions of clinical governance among the members of health care organisations (Som, 2009; Greenfield et al., 2011). In conclusion, this research provides awareness of the role of clinical governance within a private health care organisation in Durban,KZN.

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# APPENDICES

## Appendix 1: Clinical Governance National Core Standard for Health Establishments in South Africa

| Sub-domain | Standard | Criteria |
|---|---|---|
| **2.1 Patient care** | 2.1.1 Patients receive care and treatment that follows nursing protocols, meets basic needs and contributes to their recovery | 2.1.1.1 Procedures are in place to ensure delivery of basic care that optimises health outcomes |
| | | 2.1.1.2 There is evidence that care provided optimises health outcomes |
| **2.2 Clinical management of priority health conditions** | 2.2.1 Care provided contributes positively to national priorities, including the United Nations Millennium Development Goals for maternal and child health, HIV and Tuberculosis | 2.2.1.1 The latest guidelines are available for implementing strategic priority programmes or health initiatives |
| | | 2.2.1.2 There is evidence that the health establishment implements priority programmes or health initiatives according to the latest guidelines available |
| | | 2.2.1.3 A system is in place to regularly collect and analyse data on priority programmes/health initiative outcomes and to address any shortcomings |
| **2.3 Clinical leadership** | 2.3.1 Doctors, nurses and other health professionals constantly work to improve the care they provide through proper support systems | 2.3.1.1 Health professionals are appointed as heads of department/sections, with clear job descriptions and lines of accountability |
| | | 2.3.1.2 There is a formal supervision programme for health professionals |
| | | 2.3.1.3 Health professionals are responsible for setting up and managing a quality committee for the health establishment |
| | | 2.3.1.4 Quality committee reviews are used by health professionals to continuously improve patient care |
| **2.4 Clinical risk** | 2.4 1 Clinical risk identification and analysis takes place in every ward to prevent patient safety incidents | 2.4.1.1 A clinical risk policy and protocol for the health establishment is available which highlights the health establishment's approach to the management of clinical risk |
| | | 2.4.1.2 A system is in place to monitor clinical risk and ensure control measures are carried out |
| | 2.4.2 Patients with special needs or at high risk, such as pregnant mothers, children, the mentally ill or the elderly, received special attention | 2.4.2.1. Procedures are in place for the care of patients who are terminally ill |
| | | 2.4.2.2 The manager of the health establishment ensures that where patients require observation for 72 hours the Mental Health Care Act No 17 of 2002 is complied with |
| | | 2.4.2.3 Frail and aged patients receive risk assessments, special observations and care as needed |
| | | 2.4.2 4 Patients belonging to high-risk groups, including violent, suicidal and mentally challenged patients, are kept safe |

| Sub-domain | Standard | Criteria |
|---|---|---|
| | | 2.4.2.5 High risk maternity patients are kept safe |
| | | 2.4. 2.6 Newborns and children are kept safe and secure |
| | 2.4.3 Safety protocols are in place to protect patients undergoing high risk procedures such as surgery, medication administration, blood transfusions or resuscitations | 2.4.3.1 Patients transferred between departments and to other health establishments are kept safe |
| | | 2.4.3.2 Appropriate safety measures are carried out in the operating theatre before and during surgery |
| | | 2.4.3.3 The safety of patients requiring resuscitation is assured |
| | | 2.4.3.4 The safety of patients receiving medication is assured |
| | | 2.4.3.5 Blood and blood products are administered safely |
| | | 2.4.3.6 Appropriate safety measures are in place for acutely ill patients in intensive care units |
| 2.5 Adverse Events | 2.5.1 Adverse events or patient safety incidents are promptly identified and managed to minimise patient harm and suffering | 2.5.1.1 The health establishment's adverse events policy and procedure is available and in place |
| | | 2.5.1.2 The health establishment actively encourages reporting of adverse events |
| | 2.5.2 Adverse events are routinely analysed and managed to prevent recurrence and learn from mistakes | 2.5.2.1 A system is in place to monitor adverse events and carry out control measures |
| | | 2.5.2.2. Recommendations to prevent adverse events recurring are implemented and monitored |
| | | 2.5.2.3 Staff are constantly aware of risks in the environment |
| | | 2.5.2.4 The number of adverse events in the health establishment is monitored against relevant targets |
| 2.6 Infection prevention and control | 2.6.1 An Infection Prevention and Control Programme is in place to reduce health care associated infections | 2.6.1.1. An infection prevention and control policy outlines the health establishment's approach to managing health care associated infections |
| | | 2.6.1.2 A qualified health professional is responsible for infection control |
| | | 2.6.1.3 A formal surveillance and reporting system is in place |
| | | 2.6.1.4 A formal system is in place to monitor infection prevention and control and ensure appropriate actions are taken to minimise infection rates |
| | | 2.6.1.5 The health establishment reports health care associated infections and notifiable diseases to appropriate public health agencies |
| | | 2.6.1.6 Staff and patients and, as appropriate, family and other caregivers, are educated on infection control practices |

| Sub-domain | Standard | Criteria |
|---|---|---|
| | 2.6.2 Specific precautions are taken to prevent the spread of respiratory infections | 2.6.2.1 A programme for the prevention and control of respiratory infections is in place (eg for tuberculosis) |
| | 2.6.3 Standard precautions are applied to prevent health care associated infections | 2.6.3.1 Standard precautions to prevent health care associated infections are actively implemented and applied in all clinical areas of the health establishment |
| | | 2.6.3.2 Sharps are safely handled and disposed of |
| | | 2.6.3.3 Effective hand washing is used to limit the spread of health care associated infections |
| | | 2.6.3.4 Appropriate facilities are provided for patients with hazardous infections to reduce the risk of transmission |
| | | 2.6.3.5 Equipment used by infected patients is safely disinfected |
| | 2.6.4 Strict infection control practices are observed in the designated infant feed preparation areas | 2.6.4.1 Infant feeds are prepared to ensure safety of infants |

Source: NDoH (2011; p.22).

## Appendix 2: Ethical standards

RHODES UNIVERSITY
*Where leaders learn*

Ethics Approval Application – HUMAN SUBJECTS

Approved L Greyling April

### ETHICAL STANDARDS: RESEARCH PROTOCOL

| Departmental Research Ethics Committee Review (Official Use Only) | |
|---|---|
| **Track Number:** | 2016 (YEAR) RBS (DEPARTMENT) 36 (NUMBER) |
| **Date Received:** | |
| **Resolution:** | ☑ Approved<br>☐ Refer to Ethical Standards Committee |
| **Resolution Date:** | April 2016 |
| **Authorized by:** | L. Greyling |

| Instructions |
|---|
| Any project in which **humans** are the subject of research requires completion of this form and submission, for approval, to the appropriate **Departmental Research Ethics Committee** or where such committee does not exist or cannot unanimously approve the research protocol, to the University's **Ethical Standards Committee**<br><br>**Note:** Ethical clearance is required **before** any research participants are involved or consulted! |
| **Please read the following documents:**<br>1) Ethical Guidelines: Human Subjects<br>2) Ethical Standards Policy: Human Subjects<br>3) Ethical Standards Procedures: Human Subjects<br>Available from http://www.ru.ac.za/research/research/ethics/ |
| **How to fill in this form:**<br>1) Complete all sections in typescript. Handwritten forms will **NOT** be accepted.<br>2) Append all necessary documentation.<br>3) Hand the signed copy and all attachments to the Departmental Research Committee representative. |

| General Particulars | |
|---|---|
| Title of project: | **An Evaluation of Clinical Governance within Private Radiology Departments in South Africa.** |
| Name of principal investigator(s): | Morgan Wedderburn- Maxwell |
| Contact details: | Institution: Rhodes University<br>Department: Rhodes Business School<br>Address: **20 Burleigh Crescent, KZN, South Africa**<br>Email: g10w1254@campus.ru.ac.za<br>Telephone: 0718852158 |
| Name of supervisor(s): | Kevin Rafferty |
| Contact details: | Department: Rhodes Business School<br>Address: **Rhodes Business School, Top Floor Rhodes, , Cnr. Somerset and Prince Alfred Streets Grahamstown South Africa**<br>Email: K.Rafferty@ru.ac.za<br>Telephone: 0829334221 |
| Research type: | National, MBA mini thesis |
| Funding: | None |
| Purpose of research: | To evaluate the implications of clinical governance for private radiology departments in South Africa. |

| Methodology |
|---|
| Briefly state the methodology and the procedures in which participants will be asked to participate:<br>The research will be conducted by face-to-face, semi-structured interviews and the questions will be formulated based on the minimum standards for clinical governance as laid out by the National Department of Health. The interviews will be conducted with radiologists and radiographers within Private Radiology Departments. Thematic analyses will be used to analyse the interviews in order to identify common themes to compare to the current body of literature. |
| State the minimum and maximum number of Participants needed:<br>Min: 10<br>Max: 20 |
| Justify the numbers in terms of the methodology chosen and proposed data analysis requirements:<br>The research aims to evaluate at least three private practices. A minimum of three participants from each private practice is required consisting of one radiologist and two radiographers. This will ensure that there is sufficient data in order to identify key themes. It is limited to twenty as it is not feasible to do more. |

| **Information to Subject** |
|---|
| What information will be afforded to participants **before** they consent to participate?<br>The participants will receive a letter that contains information surrounding the topic of the interviews, confidentiality of their responses and the procedures to be followed in the interviews. The letter will conclude by asking for consent to participate in the research. |
| Who will provide this information?<br>The researcher |
| Will the information provided be complete and accurate? Yes<br>If NO, describe the nature and extent to which it will not be complete:<br>Click here to enter text. |

| **Participant Groups (Sample)** |
|---|
| Are particular characteristics of any kind required in the participant group (e.g. age, cultural derivation, background, physical characteristics, disease states, etc.)? No<br>If YES, specify the characteristics:<br>Click here to enter text. |
| Are participants drawn from Rhodes student body at large? No |
| Are Participants drawn from specific groups of Rhodes students? No<br>If YES, specify the groups:<br>Click here to enter text. |
| Are Participants drawn from a school population? No<br>If YES, identify school:<br>Click here to enter text. |
| Are Participants drawn from an institutional population (e.g. Hospital, Prison, Mental Institution)? No<br>If YES, identify institution: |
| Will any records be consulted for information? No<br>If YES, specify source of records:<br>Click here to enter text. |
| Will participants know their records are being consulted? Not applicable<br>State how these records will be obtained and whose permission is required:<br>Click here to enter text. |
| Are all participants over 18 years of age? Yes<br>If NO, justify the inclusion of minors:<br>Click here to enter text. |

| Risks and Benefits of Project |
|---|
| Is there any risk of harm, embarrassment or offence, however slight or temporary, to the participant, to third parties, or to the community at large? No, all participant's information will be keep confidential with full anonymity.<br>If YES, specify: |
| Are all risks reversible? Not Applicable<br>If NO, specify:<br>Click here to enter text. |
| Are remedial measures available, if risks are not reversible? Not Applicable<br>If YES, specify: |
| Has the person administering the project previous experience with the particular risk factors involved? Not Applicable |
| Are any benefits expected to accrue to the participant personally (e.g. improved health, mental state, financial, etc.)? N/A<br>If NO, specify:<br>Click here to enter text. |
| Will you be using equipment of any sort? No<br>If YES, specify:<br>Click here to enter text. |
| Will any article of property, personal or cultural, be collected in the course of this project?<br>No<br>If YES, specify:<br>Click here to enter text. |

| Consent of Participants |
|---|
| Is consent to be given in writing? Yes<br>If NO, state reason why not:<br>Click here to enter text. |
| Do any participants suffer from a legal disability preventing them from giving effective informed consent (e.g. under 18 years, declared insane by a court of law, unconscious, etc.)? No<br>If YES, indicate what measures will be taken to obtain informed consent:<br>Click here to enter text. |
| Do any participants operate in an institutional environment which may cast doubt on the voluntary aspect of consent? No<br>If YES, specify: |
| Will participants receive remuneration for their participation? No<br>If YES, state the basis on which remuneration is calculated, and indicate what measures have been taken to ensure that it cannot be considered a persuasive incentive:<br>Click here to enter text. |
| Do you require consent of an institutional authority for this project? No<br>if YES, specify: |

## Privacy, Anonymity and Confidentiality of Data

Are provisions made to protect participant's rights to privacy and anonymity and to preserve confidentiality with respect to data? Yes
If YES, specify:
All information will be confidential and no names will be disclosed. Each private department will be given a dummy name eg practice A, Practice B, Practice C

Will mechanical methods of observation be used (e.g. one-way mirrors, recordings, videos, etc.)? Yes
If YES, specify:
Recording devices for interviews

Will participants' consent to such mechanical methods of observation be obtained? Yes
If NO, give reasons:
Click here to enter text.

Will data collected be stored in any way? Yes
If YES, specify: 1) by whom, 2) how many copies, 3) for how long, 4) for what reasons, and 5) how will subject's anonymity be protected:

1) Researcher 2) One 3) Three Months) Evaluation of interview data 5) No names are disclosed; dummy names will be used.

Will stored data be made available for re-use? Yes
If YES, how will participants consent be obtained for such re-usage:
In writing before the interview.

Will any part of the project be conducted on private property (includes shopping centres)? Yes
If YES, state how consent of property owner is to be obtained:
Written consent will be required before any interviews

## Feedback

Will feedback be given to participants? Yes
If YES, state whether this is to be given to each individual immediately after participation; to each participant after the entire project is complete; to all participants in a group setting; or other manner and specify whether feedback will be written, oral or by other means:
Once the research project is complete each participant will receive a condensed copy of the findings and the thesis will be made available if requested. .

If you are working in a school or other institutional setting will you be providing teachers, parents, school authorities or equivalent a copy of your results and/or report? Not applicable
If YES, specify:
Click here to enter text.

## Declaration

If any changes are made to the above arrangements or procedures, we will bring these to the attention of the chairperson of the ethical standards committee or appropriate Departmental

Human Ethics Committee.

The undersigned declare themselves accountable to the ethical standards committee for conducting this research project in the manner herein described and in accordance with the spirit of the ethical guidelines of this university. We undertake to assume responsibility to advise the ethical standards committee promptly of any deviations, waivers, irregularities or harm occurring during the conduct of this research project.

| Principal investigator | Supervisor |
|---|---|
| Signature: **MKWM** | Signature: |
| Name: Morgan Wedderburn-Maxwell | Name: Click here to enter text. Kerri Rafferty |
| Date: 14 March 2016 | Date: Click here to enter a date. 25 April 2016 |

## Appendices

In order to avoid delays in the processing of this application, please ensure that all the appropriate information (if applicable) is attached to your application:

1) Research instruments (e.g. questionnaires, interview questions, etc.)
2) Informed consent form
3) Written information given to participants prior to participation (e.g. invitation to participate)
4) Institutional permissions

## Appendix 3: Informed consent form


MASTER OF BUSINESS ADMINISTRATION

Researchers details:
Morgan Wedderburn-Maxwell
Cell: 071 885 2158
Email: g10w1254@campus.ru.ac.za

Dear participant

Thank you for showing interest in my Masters of Business Administration dissertation entitled, "An evaluation of clinical governance within a private radiology organisation in Durban, KZN".

The purpose of the current research is to evaluate the implications and importance of clinical governance within a private radiology organisation. The research will investigate how the private radiology organisation is managing clinical governance. The challenges associated with clinical governance will be identified and explored. Lastly the research will identify whether doctors and employees within the private radiology organisation have a common understanding of the concept of clinical governance.

Procedure:

You will be required to answer an open ended interview either in person or through a teleconference call such as skype. All data collected will remain anonymous and at no time will any names be used. The interviews will be recorded and transcribed in order to identify key themes amongst the data received from the respondents. The data will be stored for the purposes of only the research. Following the completion of the dissertation a summary of the results will be provided to the respondents if requested.

Informed Consent:

I, …… have been informed of the research dissertation entitled:

**An evaluation of clinical governance within a private radiology organisation in Durban, KZN.**

I have read and understood the information surrounding the research above and will participate in an interview. I am aware that all information received from this research will be treated confidentially, that my business and I will remain anonymous at all times and the data obtained may be used and published. The procedure of the interviews has been explained to me and I am aware that I may receive a summary of the findings if requested

| | |
|---|---|
| Signed by participant (Print name) | Date |
| Signed by researcher | Date |

## Appendix 4: Semi-structured interview questions

Interview questions for the research on:

**An evaluation of clinical governance within a private radiology organisation in Durban, KZN.**

All information provided by respondents will be kept confidential. The names of the respondent and place of employment will not be disclosed; pseudonyms will be used. Information will therefore be protected from disclosure, use and unauthorised access. The respondents will receive feedback in the form of a condensed summary of the findings of the research. If requested a final copy of the thesis will be made available to respondents.

**Interviewee Number:**

**Job Position:**

**Date of Interview:**

**Interview questions**

1. Please explain your business competitive advantage and core values?
2. Can you describe the way your business places an emphasis on delivering a quality care service?
3. How would you define clinical governance?
4. What do you believe are the benefits of clinical governance?
5. Can you explain to me the importance of delivering quality care for your organisations long-term sustainability?
6. Can you please explain the policies; procedures and systems used within your organisation that ensures quality care is continuously improved?
7. Who is in charge of ensuring quality care improvements and what are their responsibilities?
8. Which employee positions are held accountable for quality care within your organisation and how are they held accountable?

9. How has your organisation communicated with all employees the concept of clinical governance?
10. What challenges does your organisation experience with understanding and implementing clinical governance systems, policies and procedures?