

**A QUANTITATIVE AND QUALITATIVE AUDIT EVALUATION OF A
PROVINCIAL HOSPITAL SERVICE FOR HOSPICE PATIENTS**

By

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ABSTRACT

Background

Hospice-in-the-West is situated in Krugersdorp on the West Rand. There is no hospice dispensary and the patients must, of necessity, obtain their terminal care medications from the Yusuf Dadoo Provincial Hospital. The hospital has a policy protocol in place that must be followed by all patients attending the hospital in order for them to obtain their monthly supply of medications. This policy has been in place for the past eight years. An evaluation of the provincial hospital's policy protocol was undertaken in an attempt to identify areas for possible improvement.

Method

A quantitative and qualitative method of clinical audit evaluation was used. This audit study collected data from a specially prepared questionnaire, answered by a purposeful sample of hospice patients. Information was also obtained from hospice nursing sisters pertaining to comments made to them by the hospice patients, relating to the policy protocol they were obliged to follow.

Results

A meeting was held with the authorities of the Yusuf Dadoo Provincial Hospital, once all the study data had been collected and then presented. Discussion resulted in a revised hospital policy protocol being introduced for the hospice patients to follow.

Conclusion

The success of this clinical audit research study resulted in a vastly improved standard of policy protocol being introduced by the Yusuf Dadoo Provincial Hospital, to the great satisfaction of all the terminal care patients of Hospice-in-the-West.

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1. INTRODUCTION

Palliative care is the active total care of patients whose disease is incurable. Control of pain, of other symptoms, and of psychological, social and spiritual problems is paramount. The goal of palliative care is achievement of the best possible quality of life for patients and their families. (Wilkes 1991)

Palliative care arose out of a desire to improve the quality of care of patients with advancing disease and their families. The newness of the speciality coupled with skepticism or reluctance to support this form of care often resulted in many of the early evaluations of palliative services, which compared hospice, home, and hospital care. Therefore palliative care often led the way in developing methods of examining the quality of care and sought to influence those working in oncology and other professions. (Higginson 1993a)

Hospices and palliative services provide novel therapies, such as new treatments for symptoms, support and counseling services, or complementary therapies. However, new therapies and approaches must be evaluated and audited to determine if and to whom these are useful. Otherwise, hospice resources and patients time will be wasted. (Higginson 1993a)

Active patient and family involvement in decision-making is a basic tenet of palliative care. Thus, it is important to adopt a comprehensive approach in the

development of audit for palliative care rather than focusing on single symptoms. (Higginson 1993a)

Palliative care is a multidisciplinary activity taking place in hospital wards, palliative care units such as "Hospice-in-the-West", or at home with a specialized team advising the general practitioner and the domiciliary nursing service. A requirement of such a multidisciplinary activity implies that audit measures are in place, whereby good practice is regularly achieved. (Wilkes 1991)

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2. BACKGROUND

Hospice-in-the-West is situated in Krugersdorp on the West Rand and the Hospice-in-the-West dream was initiated by a group of people some ten years ago who collectively felt a need to become actively involved in a community service. Some of the group members were at that time actively involved in assisting people suffering from cancer, and the author of this audit project, a semi-retired general medical practitioner, in private practice of some twenty-five years standing, was a member of this founding group.

The author had no real medical expertise in the treatment of patients suffering from the various forms of terminal disease, other than to refer those unfortunate patients to the various medical specialists who had a greater knowledge of these diseases and could offer a greater degree of medical expertise to these sufferers.

Hospice-in-the-West became a reality and grew from the most humble beginnings into a wonderful viable centre, administering palliative care for many terminally ill patients – all on a voluntary basis. Even at this time the hospice is totally dependant for its financial viability on fundraising, donations, gifts and bequests.

The hospice healthcare personnel consist of:

- (i) A voluntary part-time medical practitioner,

- (ii) Four full-time professional nursing sisters who do the required field work, which covers a very large area on the West Rand, and
- (iii) Voluntary counselors, fully trained in the counseling of hospice patients.

The essential daily medications required by the hospice patients cannot be supplied nor funded by these patients or their families, nor by the hospice. Hospice-in-the-West is therefore greatly indebted to the generosity of the Yusuf Dadoo Provincial Hospital, also situated in Krugersdorp, for taking care of this essential service to the patients and their families.

Due to the lack of funding the hospice has no in-patient unit at present. Those patients needing in-patient palliative care treatment are either referred to the hospice in Johannesburg, which has an in-patient unit, or are admitted to the Yusuf Dadoo Provincial Hospital, also situated in Krugersdorp. Ambulatory terminal hospice patients are visited in their homes by fully trained terminal care nursing sisters.

Because the hospice has no in-patient unit, there is no dispensing pharmacy and as a result, the hospice patients are required to obtain their palliative care medications from the Yusuf Dadoo Hospital's dispensing pharmacy. The hospital has an official policy protocol in place which applies to all patients attending the hospital in order to receive their medication allowance. Cancer or AIDS sufferers receive no special privileges above those of other patients

as a result of their disease status, while attending the provincial hospital to obtain their medications.

Provincial Hospital Policy Protocol

South African Pharmaceutical directives state that no daily prescription medications may be given to a patient in excess of thirty days duration. Prescriptions may include repetitions of the same medication but only a thirty-day supply may be given to a patient at any one time. Either a repeat prescription or a new prescription is to be produced by the patient for further supply of their medication. Thus, the hospice patients were required to attend the provincial hospital on a monthly basis. If they personally failed to attend each month they would not be supplied with their essential medications for that following month. Pain is one of the most significant parameters of all symptoms for terminal end stage disease.

Prior to this audit evaluation study being completed, all Hospice-in-the-West patients made every effort to attend, since none of them could afford to be without their essential medications. A specific provincial hospital policy protocol was in place, that all patients attending the provincial hospital as outpatients were obliged to follow, in order for them to obtain their monthly medications. This also included the hospice patients, who were not offered any special considerations in easing the long queues they had to be part of, or the long hours they had to spend, while obtaining their medications.

The following is the format of the hospital protocol that was initially being used by hospice patients when obtaining their monthly palliative care medications:

- (i) The patients were required to find their own ways and means to the hospital, arriving as early as possible.
- (ii) They would then form into queues to draw their hospital files, and once they had received their files,
- (iii) They then moved to another queue in order to see a designated hospital doctor, handing the doctor their file. The doctor would carry out a brief examination and return the file to the patient after the doctor had written the patient's monthly medication script. At the same time the patient was given a number for the dispensary.
- (iv) The patients then moved to the dispensary department and formed queues at the dispensary to wait for their numbers to be called, and to be given their medications.
- (v) The patients would then return home with their monthly supply of medications.

Problems Reported by Patients

The author was initially made aware of various problems that the hospice patients were experiencing while having to attend the provincial hospital to obtain their monthly supply of terminal care medications. The problems were brought to the author's attention by the senior hospice nursing sister. The problems had apparently been simmering for a long period of time and had

resulted in added patient stress and unhappiness directly related to the patients having to follow the provincial hospital's above stated protocol, which apparently is hospital policy in all provincial hospitals, for all patients, irrespective of their disease status as noted above.

Patient complaints reported to the nursing sisters by the patients, included:

- (i) Patients required to arrive early at the provincial hospital meant very early rising in all types of weather, especially during the winter months.
- (ii) When having to wait for long hours in the respective queues, the only seating consisted of hard wooden benches.
- (iii) Those patients needing morphine syrup as part of their terminal care medications, required for the specific purpose of breakthrough cancer pain, had to return to the hospital later, or on another day to collect their morphine supply since it was not being prepared by the hospital dispensary, but by an outside dispensing company, and only on prescription from the hospital doctor. Some of the patients did not return for their morphine supply because of the time constraint.
- (iv) The ethical aspect of embarrassment and loss of dignity felt by some patients due to the disfigurement and /or malodorous ulcerating lesions caused by their cancer or AIDS conditions, having to spend so much time among the public.
- (v) The period spent away from the comfort of their homes was felt more by the elderly and weak, and those suffering from advanced disease.

- (vi) Some patients had to go without their essential medications if they were unable to get to the hospital for any reason, e.g. no transportation available on the day; no finance to pay for their transport; no assistance from the family or friends, and the deteriorating status of their disease or other illness.

These complaints had not received any attention previously, primarily because the nursing staff felt the hospice patients might be further compromised should any complaints be lodged with the Yusuf Dadoo hospital authorities. Besides, hospice staff was only too thankful that the provincial hospital was providing the patients with essential medications that the hospice could not hope to fund or provide. With the hospice being an outpatient and daycare centre with no pharmacy it was essential the patients obtained their medications from the provincial hospital.

The standard of service set by the provincial hospital's present protocol, as described above was deemed by the author to be an unacceptable standard of care for the hospice terminal care patients.

These patients form a very special group, in that they are all in the terminal phase of their disease process, and as such, live daily lives associated with hardship and duress caused by ongoing pain and other symptoms, together with social, psychological and spiritual dilemmas. Any additional and unnecessary suffering, which could possibly be relieved or removed, needed to be investigated. Such an investigation would establish the following:

- (i) Was the present provincial hospital protocol a valid cause of the hospice patients' added stress and unhappiness?
- (ii) If yes, was it possible to find an improved standard of provincial hospital protocol which the hospice patients could follow that would relieve their above noted burdens and anxieties.

Investigators may choose to evaluate a service from various perspectives using different methods such as:

- (i) Controlled trials,
- (ii) Quantitative or qualitative studies, or a combination of both,
- (iii) Surveys, or
- (iv) Audits.

The author chose to use clinical audit to address the problem.

3. LITERATURE REVIEW

A medical audit has been described as a systematic, critical analysis of the quality or standard of medical care, including the procedures used for diagnosis and treatment, the use of resources and the resulting outcome for the patient. (Rodgers, Barclay and Todd 1998)

Medical audit is a form of measuring tool or investigative mechanism, which aims to improve care for patients and their families by assessing whether we are doing the right thing well. Therefore to carry out an audit:

- (i) First we have to know what we are trying to achieve,
- (ii) Second we must have a way of observing practice to assess whether we achieve the goals or standards, and
- (iii) Third we must change practice to improve patient care. (Doyle, Hanks and MacDonald 1998)

Effective audit is a cycle. Standards for the delivery of patient care are agreed. Then practice is observed and compared with the standards. This often demonstrates successes, but also failings and a need for change. The results are then often fed back and examined so that new or modified standards can be set. The audit cycle is then repeated anew. The cycle can be entered at any point; for example, it is possible to begin by observing practice and acting on the results, and then proceed to setting standards. (Shaw 1989)

The audit cycle has been described as having distinct phases:

- (i) Setting a standard,
- (ii) Measuring practice against that standard,
- (iii) Identifying what needs changing and why,
- (iv) Planning the change needed,
- (v) Implementing the change,
- (vi) Modifying the standard if necessary, and
- (vii) Re-assessing against the standard. (Higginson 1993b)

There are various forms of audit (medical, clinical, quality assurance, review) among others.

Clinical or medical audit is usually described as one part of a quality assurance programme. (Doyle, Hanks and MacDonald 1998)

Quality assurance implies a planned programme involving the whole unit of health services, it is the definition of standards, the measurement of their achievements and the mechanisms to improve performance, whereas medical audit is the systematic, critical analysis of the quality of medical care (procedures, diagnosis and treatment) resulting in the outcome and quality of the life of the patient. This involves doctors only. (Doyle, Hanks and MacDonald 1998)

Clinical audit is like medical audit, but involves all professionals and volunteers rather than only doctors. Thus, clinical or medical audit is usually described as one part of a quality assurance programme, since they are included as a part of a planned programme involving the whole of the health services. (Doyle, Hanks and MacDonald 1998)

Clinical audit is the systematic critical analysis of the quality of clinical care including the procedures used for diagnosis and treatment, the use of resources, and the resulting outcome and quality of life for the patient.

Audits of palliative care can help to improve palliative care in the following ways:

- (i) Review of the quality of work and identification of ways of improving it should mean that future patients and families will not suffer the same failings.
- (ii) Identification of areas where care is effective and where it is not could allow services to be better targeted and will mean that patients and families receive the most up to date care.
- (iii) Prospective audits with systematic assessments of patients and families during care can help to ensure the following:
 - a) Aspects of care are less likely to be overlooked;
 - b) There is a more holistic approach to care;
 - c) New staff has a clearer understanding of what they should assess.

- (iv) Audit can help most patients and families receiving palliative care because it looks at routine practice rather than a few "special" cases. Quite apart from mistakes, sub-optimal care may be due to professional or administrative problems, which tend to escape anecdotal case reviews. (Shaw 1998)

Audit is important for education and training, because the structured review allows analysis, comparison and evaluation of individual performance; it also promotes adherence to local clinical policies and offers opportunity for publication of results. Educational programmes can be constructed to meet the demonstrated needs of individuals or groups. (Shaw 1993)

The audit can be prospective, where the standards and measures are agreed at the start and are recorded for patients and families during their care, or retrospective, where the care of patients is reviewed after their discharge or death, either by extracting the information from the clinical notes or by asking families. (Doyle, Hanks and MacDonald 1998)

The audit presently being undertaken is a clinical type audit. The measurement of the standard of service i.e. the hospital protocol being offered by the provincial hospital is part of a total quality management programme for the hospice terminal care patients, which involves both the Hospice-in-the-West and the Yusuf Dadoo Provincial Hospital. Their maximum working effectiveness and efficiency are being evaluated with respect to the nursing

care they are offering the hospice terminal patients. Thus, to emphasise what was noted above, applying an audit to palliative care implies the following:

- (i) Know what we are trying to achieve, i.e. goals or standards.
- (ii) Have a way of assessing and reassessing whether we achieve the goals or standards.
- (iii) Change practice to ensure that any deficiencies are corrected. (Doyle, Hands and MacDonald 1998)

Further literature relative to the topic of this evaluation study was not found. An in-depth search was done using the Pubmed database, which included all records indexed in Medline from 1966 to the present. The search was not limited to years. Twenty-four specific searches were carried out which involved eliminating the duplicates. Here are some examples of the phrases used in the search:

- (i) Search terminal care patient and (collect or obtain or dispense or administer) and (medicine or medication or drug or pharmaceutical) and local provincial hospital.
- (ii) Search (policy or procedure or protocol or method) and (medicine or medication or drug or pharmaceutical) and hospice patients.
- (iii) Search hospice patient and (medication or drug or pharmaceutical) and (hospital or clinic) and province.
- (iv) Search hospice patient and (medication or drug or pharmaceutical) and (dispense or protocol or procedure). Sort by publication date.

A search was done on the internet using the Google search engine to review literature relative to accessibility of medications for hospice or cancer patients in general.

A short overview article noted, "Problems in gaining access to palliative medications, particularly for rural and remote patients was being addressed through work being undertaken by the Australian and New Zealand Society of Palliative Medicine." (Online: www.rah.sa.gov.au/cancer/pltvcare.php)

No further literature was found using the following phrases:

- "access to palliative care"
- "hospice patients access to medications"
- "problems involved in access to palliative medications"
- "provincial hospital cancer patients"
- "palliative medications"
- "patients access to palliative medications"
- "who – access to palliative medication"
- "SA constitution to equity of access to health care"
- "acquisition to hospital medications"

4. AUDIT EVALUATION STUDY

An audit evaluation study was chosen and initiated, as the investigative instrument to evaluate the hospice patients' problems being experienced, while following the provincial hospital's protocol. The audit was to evaluate the present provincial hospital policy protocol, by answering the following question.

"Is it possible for terminal hospice patients to obtain their palliative care medications from the Yusuf Dadoo Provincial Hospital with greater expediency and patient comfort?"

Data for this audit study was to be collected from the following sources:

- (i) A questionnaire consisting of twelve pertinent questions directly relating to the patient's problems being audited, which each of the participating hospice patients were requested to answer, this being the primary source of the quantitative data,
- (ii) Qualitative information that the participating patients had personally reported to the nursing sisters over a period of months relating to their problems, and
- (iii) A secondary source of qualitative information, obtained telephonically, from the senior nursing sisters of several similar outlying sister hospices.

The final questions contained in the questionnaire were considered to be:

- (i) Relevant and to the point.
- (ii) Directly related to the topic being audited.
- (iii) Non-ambiguous and easy to understand.
- (iv) Easy to answer and pertinent.

The author initially drew up twelve questions. These questions were then discussed with the hospice nursing sisters, and some changes made. The questionnaire was the instrument used for data collection. All participating hospice patients were requested to complete the questionnaire.

The questionnaire was presented to each of the participants in their official home language, i.e. Afrikaans, English or Tswana. Examples of the questionnaires are included in the Appendix.

5. ETHICAL ASPECTS

Specific ethical issues in this study were given close scrutiny when the study was initially considered. It was accepted that ethical considerations would play a major role in any form of research or audit study. The ethical issues that emerged, that needed careful consideration included the following:

- (i) *The purpose of the study* – the study objectives to improve the patient's quality of life were deemed to have a low risk of causing any harm to the participating hospice patients while the benefits of participating in a successful study could be rapidly realized, particularly in improving the standard of nursing care in the present mode of medicine collection.
- (ii) *Vulnerability of the patients* – the patients were all ill, exhausted, stressed, often unhappy and depressed, but none were thought to be vulnerable to being harmed in any way, or to experience any increased suffering as a result of answering the questionnaire, which was carried out in the presence of the healthcare personnel.
- (iii) *The competence of the patients* – all of the study sample patients appeared fully competent, to the nursing staff and author, at the time of the study, although no formal testing was carried out. The patients all gave informed consent and fully understood and accepted the purpose of the study; in fact they were the same patients who first drew attention to the fact that the problems existed. In addition, the hospice nursing sisters were present to explain any questions not understood by any of the patients, and to assist in writing in any patient's answers

should they have felt too unwell to do so. The questionnaire was offered to each of the patients in their official home language.

- (iv) *The age of the patients* - this was not considered an ethical stumbling block. No patient was excluded from the study because of age, and the healthcare team assisted any aged patient if assistance was deemed necessary as noted above.
- (v) *Confidentiality* – this played an important role for all hospice patients participating in this audit study for the following reasons:
- It was made known to each hospice patient that some of their private and / or personal particulars would be made known to any person outside of those personally involved in the study, and
 - Assurance was given to all the hospice patients by the author and hospice nursing staff that every possible avenue of investigation would be pursued by them in an endeavour to bring some positive relief to their present hardship and unhappiness, resulting from the provincial hospitals' present policy protocol.

The study protocol for this audit evaluation needed to be submitted for acceptance to and by the Ethics Committee of the University of Cape Town, before the audit evaluation study could proceed. This acceptance was issued and the author informed accordingly.

6. AUDIT PATIENT PARTICIPANTS

The following hospice patients were included in the audit evaluation study and completed the private and confidential questionnaire.

PATIENT	AGE	DIAGNOSIS	PRESENT DISEASE STATUS
1. GM	29 yrs	Aids	<ul style="list-style-type: none"> • Severe weight loss and thrush. • Very weak. • Lives +/- 20 km from the hospital.
2. AG	55 yrs	Ca. lung and liver	<ul style="list-style-type: none"> • Brain metastases with confusion. • Nursed in nappies.
3. GVZ	75 yrs	Ca. liver	<ul style="list-style-type: none"> • Wheelchair bound. • Pressure sores x 4 on back.
4. PR	80 yrs	Ca. lip and lung Diabetic	<ul style="list-style-type: none"> • In-dwelling catheter. • Too weak to walk any significant distances.
5. CB	35 yrs	Ca. chest	<ul style="list-style-type: none"> • Suppurating, metastatic spread. • Malodour of fungating lesions. • Dyspnoeic.
6. EH	69 yrs	Ca. chest	<ul style="list-style-type: none"> • Dyspnoeic.
7. LM	62 yrs	Ca. abdomen	<ul style="list-style-type: none"> • Weight loss. • Not able to sit for long. • No taxi fare.
8. SDP	70 yrs	Ca. bowel Large incisional hernia Emphysema	<ul style="list-style-type: none"> • Emaciated due to malnutrition. • No family members. • Old Age Home frail care.
9. GVW	85 yrs	Inoperable ca.	<ul style="list-style-type: none"> • Frail. • Fungating lesion with malodour.
10. KDV	80 yrs	Ca. colon	<ul style="list-style-type: none"> • Resides +/- 60 km from hospital. • Incontinent. • Bedsore on L. ankle.

7. QUESTIONNAIRE

This audit evaluation study was carried out using data collected from a prepared questionnaire. The hospice participants involved in the audit evaluation study were requested to answer the questions, after giving informed consent to becoming part of the audit evaluation.

The data given by the participating hospice patients in answering the questions contained in the prepared questionnaire consisted of figures and percentages, which by definition made the questionnaire data quantitative in nature.

Sampling techniques used in quantitative research are based upon statistical probabilities and inferential statistics. They have to meet assumptions of the statistical tests to be used.

Quantitative researchers define and select their samples in advance and use random sampling methods so that generalizations can be made. The size of the sample is determined prior to the onset of data collection and models for calculation adequate sampling size have been developed. The researcher aims at a large representative sample. (Brink 1991)

In qualitative research the researcher must have control over the composition of the sample, i.e. he controls who is selected to be interviewed and he can decide whether to continue with the interview. Qualitative researchers select

their samples according to the needs of the study and to specific qualities. Information about phenomena they seek to understand may not be evenly distributed in the population. Random sampling is thus not appropriate for qualitative research.

The qualitative researcher does not define and select his sample in advance. He identifies potential types of persons, events or processes to be sampled, depending on the needs of the study and according to specific qualities. The required sample size is not predetermined. In contrast to quantitative research the number of subjects in the study is necessarily small. (Brink 1991)

The author's sample size was very small, being ten in number, but was limited to and by the total number of hospice patients presently obtaining their terminal care medications from the Yusuf Daddoo provincial hospital. No statistical probabilities could be derived from the quantitative data of the questionnaire, since the sample was too small. However, the small sample was deemed to be practical and possibly acceptable for quantitative assessment in view of the nature of the audit evaluation being undertaken.

Because the sample consisted of all the available hospice patients at the time the audit study was undertaken, age and gender played no role in choosing the sample. The sample was, therefore, deemed to be a purposeful type sample.

The only qualification for inclusion into this purposeful type sample was that the participants had to qualify as patients of Hospice-in-the-West, who were presently obtaining their terminal care medications from the Yusuf Dadoo provincial hospital on a monthly basis, and in so doing were obliged to follow the provincial hospital protocol presently in place.

Quantitative researchers use a highly structured approach for data collection, and do not get involved. They establish a theory identifying all key concepts, constructs and hypothesis before beginning to collect the data and operationalise the concepts so that the hypothesis may be tested. (Brink 1991)

Data collecting methods and techniques usually consist of randomized experiments, laboratory studies, questionnaires, bio-physiological measures and rating scales. (Brink 1991)

Data collection in qualitative research requires a minimum of research-imposed structure and a maximum of research involvement. The researcher himself is the primary instrument for data collection. He focuses on the subject's interpretation of events.

The data are collected in a natural field situation, which may be a hospital ward, casualty department, antenatal classes, school etc. Data collection methods are observation, in depth face-to-face interviewing, document or

record review, written or verbal self-reports and other non-reactive measures. He focuses on the subject's interpretation of things. (Brink 1991)

The particular questions being asked, and the wording of each question of the questionnaire was thoughtfully put together in an endeavour to determine to what degree the hospice patients felt they were being compromised, while having to follow the provincial hospital policy protocol.

All twelve questions were answered by all the hospice patients involved in the study, each in their own official home language, i.e. English, Afrikaans or Tswana, for ethical considerations. Copies of the questionnaire are included in the Appendix together with other information and instructions that were given to the participants, during the period of the audit study.

A quantitative evaluation of patient answers to the questions contained in the questionnaire, although not statistically viable because of the small cohort of participants, left no doubt in the author's mind that all ten of the participating hospice patients had a legitimate complaint of experiencing duress and hardship during hours spent at the provincial hospital, while obtaining their essential medications, and that the questionnaire proved an acceptable instrument for the data collection, in this audit study.

The questionnaire was answered as follows:

Question 1

At present, are the hospital services adequate (Yes/No)?

100% of patients answered "No".

All the patients agreed independently that the standard of hospital services was not adequate for the purposes of obtaining their monthly terminal care medications.

Question 2

How do you get to hospital to obtain your medicines?

80% of the patients relied on family and friends. 20% of the patients received transport from the nursing sisters.

The majority of the patients relied on family and friends for their transport, which could be a possible source of feeling obligated, especially toward friends.

Question 3

What time do you leave home to get to the hospital?

Answers varied depending on where the patient lived relative to the hospital and with whom they lived, i.e.

- (i) Those living further away had to leave earlier in the mornings, as did those who had to use taxis for transport. Times varied between 5 am and 6.30 am.
- (ii) Two patients lived in an old age home and were transported by the sisters of the frail care section of their respective homes. Others lived with family who did the transporting. Those patients left later, between 6 and 7 am.

Overall, 10% of patients left home at 5 am, 40% at 6 am, 30% at 6.30 am and the remaining 20% at 7 am.

All the patients had to leave home early, which, on cold winter mornings could prove unpleasant for sickly people, especially terminal patients.

Question 4

What does it cost you to get to hospital and back home?

80% of patients live with family or in old age homes and thus incurred no traveling expenses, while 20% required taxi transport, of which one patient traveled from Kagiso township to the Yusuf Dadoo Hospital at R8 return. The other patient traveled from Munsiville township at a cost of R7 return.

For the patients responsible for their own transport costs, the further away from the hospital they lived, the greater was the cost, which they did not always have.

Question 5

How long do you wait for your file?

30% of patients waited for only thirty minutes and 70% waited for sixty minutes. The mean waiting period for files was 51 minutes.

The majority of patients had to wait an hour to get their file, while further waiting was to come.

Question 6

How long do you wait to see the doctor?

40% of patients waited for ninety minutes while 60% waited two hours to see the doctor, giving an average waiting time of 1 hour, 48 minutes.

The patients could wait for up to two hours to see the doctor in order to get their prescription, which could take less than ten minutes, once they were seated in front of the doctor.

Question 7

How long do you wait at a dispensary for your medicines?

40% of patients waited two hours for their medications and 60% queued for three hours.

The mean waiting time for medications was 2 hours, 36 minutes.

Times varied depending on how early the patient arrived at the hospital. The earlier they arrived, the shorter the waiting period. The shortest waiting period was in the queue waiting for the files while the longest wait proved to be at the dispensary. Thus, on average the waiting period hospice patients were spending at the hospital, to obtain their monthly medications, was 5 hours, 15 minutes. This is a very long time particularly for these patients who are suffering from various terminal diseases, some of which were far advanced.

The majority of patients could wait for three hours just to be given their medications from the dispensary. This, after they had already queued for their file and again to see the doctor.

Question 8

Do you take anything to hospital with you to eat or drink?

60% of patients answered "Yes" and 40% answered "No".

The majority of patients needed to take some form of sustenance, since none was supplied by the hospital, unless the patients could fund it themselves.

Question 9

Do you need to take medicines for pain during your visit to the hospital?

100% of patients answered "Yes".

All the patients experienced some degree of pain while attending the hospital, which required ongoing analgesic treatment.

Question 10

Do you feel your disease status embarrasses you in any way?

50% of patients answered "Yes" due to the stage and status of their disease, and 50% answered "No".

Half of the patients attending the provincial hospital felt embarrassed at being among the public due to their disease status – malodour and/or disfigurement.

Question 11

Do you need any aids at hospital e.g. walker, wheelchair, ring cushion?

60% of patients answered "Yes", with one patient having his own wheelchair while the remaining 40% answered 'No'.

The majority of patients required some form of aid during the time spent at the hospital such as a wheelchair, a walker or ring cushion.

Question 12

Do you receive any special privileges because of your disease status compared to other hospital patients?

100% of patients answered "No".

All the hospice patients were treated the same as the other hospital outpatients.

They received no favours or considerations due to their deteriorating disease status, other than that revealed in question 11 above.

8. OUTLYING SISTER HOSPICES

The author thought it significant to approach a number of outlying sister hospices who function under the same or similar circumstances to that of Hospice-in-the-West. Those hospices have no internal pharmacy to supply their outpatients with their terminal care medications; their patients receive their medications from the specific local provincial hospitals.

The purpose for this undertaking was to explore the possibility that some of these hospices may have in place a better standard of service whereby their patients obtain their terminal care medications, compared to the policy protocol presently being followed by Hospice-in-the-West patients. If this proved to be the case, then Hospice-in-the-West could probably introduce the same standard of service for their terminal patients.

This enquiry was carried out as a secondary qualitative objective to the quantitative questionnaire of the audit evaluation. The senior nursing sister of each of several outlying hospices was contacted telephonically and each was asked the same question:

“What form of protocol or method is in place whereby your hospice patients obtain their terminal care medications?”

The following hospices were contacted for the required relevant information:

- (i) Rustenburg Hospice
- (ii) Klerksdorp Hospice
- (iii) Tshepang Hospice
- (iv) Howick Hospice
- (v) Vryheid Hospice
- (vi) Hospice-in-the-West (Johannesburg & Leratong)

These hospices all appear to follow a similar protocol according to the information obtained from each of the various senior sisters, in fact they differ minimally from the protocol presently being followed by Hospice-in-the-West terminal patients, because it is the respective provincial hospitals in the specific hospice areas that supply the medications to these hospice patients. Thus, it appears that all provincial hospitals follow the same protocol, which appears to be a standard provincial hospital policy procedure.

9. YUSUF DADDOO HOSPITAL MEETING

Having collected and analysed the data, the next step was to contact the Yusuf Daddoo Hospital authorities to determine whether, with their assistance, the following question could be answered:

“Is it possible for terminal hospice patients to obtain their palliative care medications from the Yusuf Daddoo Provincial Hospital with more expediency and patient comfort?”

A joint meeting was initiated and held at the provincial hospital between the author, the senior hospice sister and the Yusuf Daddoo Hospital authorities, two joint hospital superintendents and the senior hospital secretary.

The data of the questionnaire was tabled and discussed in detail in a most cordial atmosphere. Both superintendents reacted sympathetically and suggested a revised hospital protocol for hospice patients only, to be initiated as soon as arrangements could be finalised with those hospital staff, which would be implicated in the new protocol change.

It was agreed that a three-month trial period for the revised hospital protocol should be in force, after which the situation would need to be re-assessed from the point of both parties. The author and hospice nursing staff were highly satisfied with the new proposed hospital protocol. The new protocol would consist of the following hospital directives, which the hospice patients

would now follow, in obtaining their terminal care medications from the Yusuf Daddoo hospital:

- (i) The Hospice-in-the-West doctor (the author) would maintain contact with patients via the hospice sisters in the field, examining all new hospice patients and those patients with special problems at the hospice clinic or at their homes, if required, and then issue new, repeat or updated scripts accordingly.
- (ii) A hospice sister would then take these scripts to the secretary of the hospital superintendent's office.
- (iii) The secretary would then draw the hospice patient's files and deliver these to a provincial hospital doctor designated to handle the hospice patients' scripts, as per the hospice doctor.
- (iv) The designated hospital doctor would then duplicate the scripts into the patient's files and send these files to the hospital dispensary.
- (v) The dispensary would then make up the respective scripts and also arrange for any morphine syrup scripts to be made up at outside premises named Prepak, for those patients needing to relieve breakthrough pain. These essential morphine medications were then sealed with the respective patients' other medications.
- (vi) The hospice sister would then collect these patient medications from the dispensary after two days and immediately deliver them to the respective patients via her team of sisters and volunteers.

Thus, no hospice patients would be required to further attend the provincial hospital in order to obtain their palliative care medications, unless specifically referred by the hospice doctor, and accompanied by his referring note, addressed to the respective hospital doctor, on the day of the appointment (e.g.) oncologist, radiologist etc. In such cases the patient would be accompanied by a hospice nursing sister, or a hospice volunteer, and transported to and from the hospital.

If this revised hospital protocol would prove to be successful, then:

- (i) A new improved standard of nursing care would be in place for the hospice patients, while obtaining their hospital medications, against which further standards of nursing care would be measured.
- (ii) The causes of their added hardship and unhappiness identified in the data and revealed by the audit would have been confirmed and removed.
- (iii) The question the audit evaluation set out to answer i.e. “ is it possible for terminal hospice patients to obtain their palliative care medications from the Yusuf Daddoo Provincial Hospital with more expediency and patient comfort?” would have been answered positively.
- (iv) The audit evaluation study would have proved highly successful and the outcome worthy of the investigation on behalf of the hospice patients.

10. REPORT BACK MEETING

After the three month trial period, previously agreed to at the initial meeting, between the author and the Yusuf Dadoo hospital authorities, a report back meeting was held in order to determine the resultant outcome of the revised provincial hospital protocol, presently being followed by the hospice patients.

The meeting was held at the Hospice-in-the-West home, and the instrument used was one of open discussion between the parties present. The following were invited to be present at the discussion:

- (i) All the initial participating hospice patients, except three of the patients who had demised in the interim period.
- (ii) Those hospice patients who most recently had become part of the new hospital protocol, but were not part of the original study.
- (iii) The senior hospital secretary who was representing the provincial hospital authorities (superintendents).
- (iv) The author and nursing staff of Hospice-in-the-West.

The attending hospice patients all agreed that the new hospital protocol now being followed was totally acceptable. No further dissatisfaction or complaints were made known by the hospice patients. They were all happy and relieved at no longer having to personally attend the provincial hospital on a regular basis, to obtain their medications.

Because the patients medications were now being delivered to the respective patients by the hospice nursing staff, the sisters were satisfied that no hospice patients were now being left without their essential medications, as had happened on frequent previous occasions, when the hospice patients failed to attend the hospital due to ill-health or other reasons.

The provincial hospital secretary reported the hospital superintendents being satisfied that no official provincial hospital policy was being infringed upon, and that those provincial hospital staff members involved with the revised protocol changes, were coping adequately. As a result, the authorities were prepared to adopt the revised protocol proposal on an ongoing basis, on the proviso that periodic meetings between the hospice and the Yusuf Daddoo hospital be called for further assessment if any problem areas arose, and also in the event of a new superintendent of the hospital being appointed; i.e. should a new incoming superintendent have any official dissatisfaction with the new hospital protocol, which was presently in place.

11. AUDIT REVIEW

On completion of this clinical audit evaluation study a review was felt necessary, to ensure that all the phases of an audit had been adequately covered.

Phase 1: Setting a Standard of Service

The Yusuf Daddoo provincial hospital offered a service for Hospice-in-the-West terminal patients by which they could obtain their monthly medications. To make use of this service the hospice patients were obliged to follow the directives of a provincial hospital policy protocol. This protocol was the cause of the patients' unanimous dissatisfaction and unhappiness.

The audit study required a standard to be set, against which further practice would be measured. The standard the author set was patient satisfaction that they could obtain their palliative care medication with more expediency and comfort.

Phase 2: Measuring Practice Against the Set Standard

A palliative questionnaire consisting of twelve questions was drawn up by the author and nursing staff of the hospice and used as the data to determine whether current practice meets the standard required for this study.

All of the hospice participants were requested to answer all twelve questions after agreeing to be part of the study. Their answers to the questionnaire revealed to the author the degree of dissatisfaction and unhappiness experienced by the patients.

It was against this unhappiness that further practice was to be measured. The questionnaire also identified the current hospital protocol as being the cause of their dissatisfaction.

Phase 3: Planning the Changes Needed

The current hospital protocol was discussed at length at a meeting held at the Yusuf Dadoo hospital as was noted above. At this meeting, a completely revised hospital protocol was planned and put into practice. The changes introduced were accepted by both the hospice nursing staff and their patients, as well as the provincial hospital authorities.

Phase 4: Implementing the Changes

The provincial hospital authorities agreed to implement the newly revised policy protocol as soon as they could fully inform all the hospital staff members, who would be involved with the changes resulting from introducing the revised protocol. The revised hospital protocol would only affect the hospice patients when their next monthly prescriptions were due. By that time the revised hospital protocol would have been implemented.

Phase 5: Further Modifying the Standard

This phase of the audit cycle was not necessary, since 100% of the hospice patients were satisfied with the new protocol compared to 100% dissatisfaction with the previous protocol.

The resulting standard of the changes were totally adequate. The goal was achieved and no further modifying of the standard is necessary. The questions were answered positively and the audit cycle was completed successfully.

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12. DISCUSSION

A clinical audit evaluation study was the method selected to investigate the hospice patients' problems, which had been brought to the attention of the author. This method was felt to be best suited to the investigation due to the standards to be set and the goals to be achieved.

The method of audit was to evaluate a provincial hospital policy protocol against a set standard and then make the necessary changes to that protocol in order to meet the standard.

Following the current hospital protocol resulted in the hospice patients having to spend long hours in various queues until they could eventually obtain their essential medications. This led to a lot of discontent and unhappiness for the hospice patients, in addition to their deteriorating health situations. These terminal care hospice patients were not offered any concessions or considerations by the provincial hospital authorities in easing the long hours they were required to spend standing in queues waiting for their medications.

A clinical audit evaluation study was initiated by the author and hospice nursing staff in order to establish the following:

- (i) Was the service of the current hospital protocol being followed by the hospice patients resulting in further hardship for these patients, above

and beyond that caused by the deteriorating status of their respective diseases?

- (ii) If this was indeed the case, then what particular aspects of this protocol were responsible for the problems?
- (iii) Once identified, would it be possible to set a standard that would change or eliminate the causes identified?
- (iv) If so, how could these changes be introduced in order to eliminate the hospice terminal patients problems.
- (v) And finally, to agree to a set period of time, after which this set standard would be re-assessed, in order to determine whether our goal had been achieved.

If this indeed proved to be the outcome, then this audit evaluation would have been a successful study, and would have positively answered the question, which this clinical audit undertook to answer:

“Is it possible for hospice patients to obtain their terminal care medications from the Yusuf Dadoo Provincial Hospital with more expediency and patient comfort?”

A carefully prepared questionnaire, which all the participating hospice patients were requested to answer, provided the quantitative data for this audit study. Further data, of a qualitative nature, was provided by the hospice patients' personal reports to the hospice nursing staff, and secondary information obtained telephonically from several outlying similar sister hospices. This

data identified the problem areas causing the hospice patients distress, and resulted in a meeting being called between the hospice nursing staff and the provincial hospital authorities, during which the audit question was addressed.

The outcome of the meeting resulted in a completely revised provincial hospital protocol being introduced, which all hospice patients would be obliged to follow in order to obtain their terminal care medications. The revised protocol was to be in force for a three-month period, after which a "report back" meeting was convened to determine any further problem areas that might have developed. Thus a re-assessment of the revised hospital protocol was undertaken to determine if our set standard had been adequate or not.

At the "report back" meeting both the hospice patients and the provincial hospital authorities had nothing but praise for the revised hospital protocol. The decision was unanimous to continue with the newly revised hospital protocol. Should any problem areas arise in the future, for either the provincial hospital authorities or the Hospice-in-the-West patients, then further re-assessments would be initiated.

The set standard that resulted in the introduction of the revised hospital protocol led to the following changes:

- (i) The hospice patients were no longer required to personally attend the Yusuf Daddoo hospital to obtain their monthly medications.

- (ii) All the discontent and unhappiness of the hospice patients, which the previous hospital protocol created, ceased forthwith.
- (iii) No hospice patient now went without obtaining their essential monthly supply of terminal care medications.
- (iv) The initial question the audit evaluation study set out to answer, "is it possible for terminal hospice patients to obtain their palliative care medications from the Yusuf Dadoo Provincial Hospital with more expediency and patient comfort?" had been positively answered with a resounding YES!
- (v) The improved standard of nursing care being sought for the hospice patients by the audit study had been achieved.
- (vi) The audit evaluation study had successfully covered all the stages of an audit.

13. CONCLUSION

All terminal stage patients are in the twilight phase of their earthly existence. This is a phase, which involves various combinations of physical pain, emotional, psychosocial and spiritual dilemmas that these patients and their loved ones share on a daily basis. Any additional sources of unhappiness, worry, hardship or concerns that add to the above-mentioned modalities need to be addressed with vigour.

The author, as the leading authority of the nursing staff of Hospice-in-the-West, felt it was important that the hospice patients' ongoing discontent needed to be addressed, once it had been brought to his attention.

The source of the patients discontent as was identified by the audit evaluation data was deemed to be resulting from the provincial hospital policy protocol, which the hospice patients were obliged to follow, in order to receive their monthly terminal care medications.

The only approach was felt to be one of direct contact with the provincial hospital authorities to make them aware of the hospice patients' problem. It was realized, and accepted, that all government managed provincial hospital policies are rigidly maintained, and unless direct contact with the responsible authorities was to be made, progress would be slow, if any.

The Yusuf Daddoo provincial hospital superintendents were approached and the hospice patients' dilemma was made known at a specially arranged meeting. The hospital authorities were very sympathetic and helpful, once they were made aware of the hospice patients' problem.

The outcome of this meeting led to the hospital authorities introducing a totally revised hospital policy protocol, which applied only to the hospice patients. This revised hospital protocol proved wholeheartedly acceptable to the hospice patients, without infringing on any provincial administrative hospital policy. The revised protocol resulted in the removal of all the hospice patients' discontent, when having to obtain their monthly terminal care medications, since they were no longer obliged to personally attend the provincial hospital on a monthly basis.

The author and nursing staff on behalf of Hospice-in-the-West are most grateful to the valuable input and assistance being given to their patients by the Yusuf Daddoo provincial hospital authorities.

Thus we can report that the original question asked, which prompted this audit evaluation study, i.e. "Is it possible for terminal care hospice patients to obtain their palliative care medications from the Yusuf Daddoo provincial hospital with more expediency and patient comfort?" has been answered with a definite "Yes".

This positive outcome was made possible by the conscientious, well meaning input and effort on the part of all parties involved in this audit study, to the great benefit of our terminally ill patients. This audit study has resulted in an improvement in the standard and quality of life of the patients, present and future, of Hospice-in-the-West, which is what palliative care is all about.

The provincial hospital protocol as put forward in this audit evaluation study, which was approved by the Yusuf Daddoo provincial hospital, will be offered to other hospices functioning under circumstances similar to Hospice-in-the-West. It is recommended that those hospices explore by an audit evaluation, whether a similar protocol would be practical in their particular setting.

The new provincial hospital protocol as introduced by the Yusuf Daddoo hospital has played a large role in bringing great relief to the manner in which our terminal patients now obtain their palliative care medications.

14. EPILOGUE

When one tries to understand and feel with the person suffering from an incurable terminal disease, when one develops empathy rather than sympathy for a dying person and attempts coming to terms with the feelings that make up the daily existence of such a person, then one enters a new realm of learning. Not much thought is given by most of us to this phenomenon, until we become personally involved. To share the thoughts, fears, anger, pain and suffering of a terminal disease sufferer, teaches one to become humble in the presence of a situation which you cannot fully understand nor comprehend, unless you yourself have been there before, unless a similar situation has previously touched you personally, of which the author has had experience.

To be instrumental in playing an active role in assisting a terminal phase patient to "live" until they die; to be there for them, their families and loved ones, allows the patient to enter a new realm of living, never before experienced. The experience of time and effort worthily spent, the knowledge, that to an initial stranger you have had meaning of a total unselfish nature, which allowed that stranger to die with dignity, love and at peace with the world, without judgment or condemnation.

These are some of the unspoken benefits one derives from being part of Hospice-in-the-West, a most beautiful haven for those who know they are

dying, but are in need of being loved, understood and accepted irrespective of person or disease status.

University of Cape Town

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APPENDIX

Appendix 1

Afrikaans questionnaire and instruction to respondents

Appendix 2

English questionnaire and instruction to respondents

Appendix 3

Tswana questionnaire and instruction to respondents

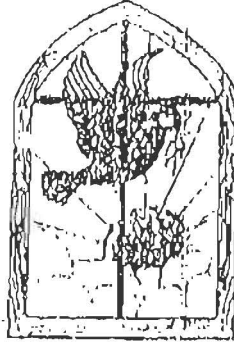
Appendix 4

English, Afrikaans and Tswana information re the purpose of the audit to respondents

Appendix 5

English, Afrikaans and Tswana consent forms to respondents

Shanti



Nilaya

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SUPPORT CENTRE
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KRUGERSDORP 1740
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Fax: (011) 953-4738

Hospice-in-the-West

Welfare Registration No.: 003-986

PRIVAAT & VERTROUlike VRAELYS:

Pasiënt Voorletters: _____

Geboorte Datum: _____

Ouderdom: _____

Geslag: _____

VOLTOOI ASSEBLIEF DIE VRAELYS IN SODAT ONS DIENS VERBETERING KAN VERSEKER.
LET WEL DIE IS 'n VERTROUlike VRAELYS.

1. Is die Hospitaal dienste tans geakik? Ja: _____ Nee: _____
2. Hoe kom U by die Hospitaal om U medisyne af te haal?

3. Hoe lank vertrek U van U huis af om Hospitaal toe te gaan?

4. Hoeveel kos dit U om Hospitaal toe gaan en terug huis te kom?

5. Hoe lank het U vir U lêer by die Hospitaal gewag?

6. Hoe lank wag U voor U die Dokter sien?

7. Hoe lank wag U by die Apteek om U medisyne te ontvang?

8. Neem U enige iets saam Hospitaal toe om te eet of drink?

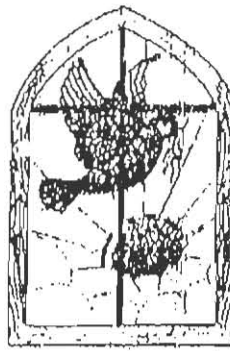
9. Het U enige pyn medikasie nodig gedurende U besoek aan die Hospitaal?

10. Voel U dat U siektes toestand U in verleentheid bring?

11. Benodig U enige mediese toerusting tydens U besoek aan die Hospitaal, bv. ringkussing, rolstoel?

12. Verkry U enige spesiale voorregte as gevolg van U siektes toestand in vergelyking met ander Hospitaal pasiënte?

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Hospice-in-the-West

Welfare Registration No.: 003-986

PRIVATE AND CONFIDENTIAL QUESTIONNAIRE:

Patients Initials: _____	D. O. B: _____
Age: _____	Sex: _____

PLEASE COMPLETE THIS DOCUMENT IN ORDER THAT WE MAY INVESTIGATE SERVICE IMPROVEMENT. ALL INFORMATION IS CONFIDENTIAL.

- At present are the Hospital services adequate? Yes: _____ No: _____
- How do you get to Hospital to obtain your medicines?

- What time do you leave your home to get to the Hospital?

- What does it cost you to get to Hospital and back home?

- How long do you wait for your file?

- How long do you wait to see the Doctor?

- How long do you wait at the dispensary for your medicines?

- Do you take anything to Hospital with you to eat or drink?

- Do you need to take medicines for pain during your visit to the Hospital?

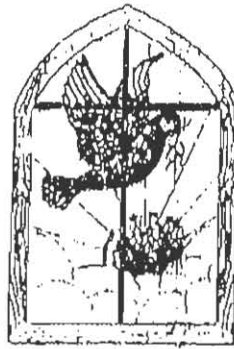
- Do you feel your disease status embarrasses you in any way?

- Do you need any aids at Hospital e.g. walker, wheelchair, ring cushion?

- Do you receive any special privileges because of your disease status compared to other Hospital patients?

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LE KWALO LA SEPHIRI (POTSO):

Mokudi enisheale: _____	Letsatsi la tswalo: _____
Bogolo: _____	Boleng (Mona/ Mosadi): _____

TLATSA KA BOTLALO

1. O nagana gore sepatela se betere kampo jang? Yes: _____ No: _____
2. O tsamaile ka eng gore o kereye dithlare ko sepatela?

3. O tlogile ka nako mang go tloga mogae go ya sepatela?

4. O patitse bokae mo sepalamong go ya le go boa?

5. O dutse nako e kae go emela faele ya gago?

6. O dutse nako e kae go emela ngaka?

7. O dutse nako e kae go emela dithlare mo chemisting?

8. O tsamaya le dijo tba go ja le sengwe sa go nwa na?

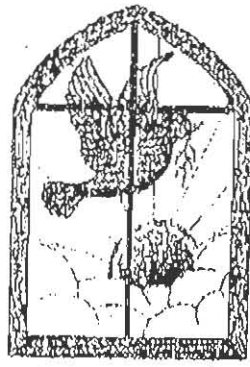
9. A go a thlokafala go nwa dipilisi tse dingwe le tse dingwe kampo jang?

10. A o thlabiwa ke ditlhong go bua ka bolwetsi ba gago?

11. A go a thlokafala gore o ka kereya wheelchair kampo crutches mo sepatela?

12. A o bona tlhokomelo e botoka mo sepatela ka gore o molwetsi?

Shanti



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Hospice - Home - in - the - West

Welfare Registration No.:003-986

Dear Patient,

The purpose of this research project is to investigate ways & means for you the patient, to obtain your terminal care medications from the Provincial Hospital with less discomfort and in a shorter time period than occurs at present.

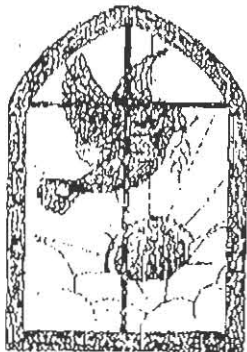
Geagte Pasient,

Die doel van die studie is om te probeer vasstel of die Provinsiale Hospitaal die medikasie op 'n makliker wyse aan terminale pasiente kan toedien.

Balwetsi,

Ka project eua ya rona re kopa kgakollo ka balwetsi ba rona gore re dire eng gore ba seka ba leta nako e telle go bona ngaka kampo ditlhare tsa bona ka bonkao utle le go leta sebaka se se telele.

Shanti



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Hospice - Home - in - the - West

Welfare Registration No.:003-986

1. I, _____ HEREBY GIVE MY FULL CONSENT TO TAKING PART IN THE AUDIT AND TO ANSWER THE REQUIRED QUESTIONAIRE.

SIGNED: _____

DATE: _____

2. IF YOU DO NOT WISH TO PARTICIPATE, OR SHOULD YOU WITHDRAW FROM THIS AUDIT PROJECT, IT WILL IN NO WAY AFFECT THE QUALITY OF YOUR PRESENT HOSPICE TERMINAL CARE TREATMENT.

SIGNED: _____

DATE: _____

1. EK, _____ GEE HIERMEE MY VOLLE TOESTEMMING OM DEEL TE NEEM IN DIE VRAELYS.

GETEKEN: _____

DATUM: _____

2. INDIEN U ONTREK OF NIE WIL DEELNEEM IN DIE VRAELYS NIE, SAL DIT OP GEEN MANIER DIE TERMINALE SORG VAN HOSPICE BELEMMER NIE.

GETEKEN: _____

DATUM: _____

1. NNA, _____ KE FANA KA TUMELLANO YA GORE O TLATSE FOMO ENA KA BOTLALO.

O SAENE LEBITSO LAGAGO LE KGWEDI: _____

LETSATSI: _____

RE TSAYA TSHWETSO YA GO, GO THUSA GA O SA BALE GO TLATSA.

O SAENE LEBITSO LAGAGO LE KGWEDI: _____

LETSATSI: _____