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**ROLE COMPETENCIES OF FIRST-LINE NURSE MANAGERS IN
COMMUNITY HEALTH CENTRES: A DELPHI STUDY**

By

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**A dissertation submitted in fulfilment of the requirements of the
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ABSTRACT

This study was conducted to determine the role competencies required of first-line nurse managers of Community Health Centres (CHC) in South Africa with the implementation of the district health system and the corresponding delegation of authority and responsibility to lower levels of management.

A Delphi technique was utilised, which involved a panel of 24 senior nurse managers. The panellists were drawn from the National Health Department, Provincial Health Departments, Local Authority Health Departments and Academic institutions involved in nurse management training. A survey questionnaire consisting of 169 competencies was used. Responses from each round were collated and returned to participants for re-evaluation. Data from the third round was used to develop the required role competencies. Factor analysis and Spearman rank correlation analysis was used to identify a variety of role dimensions.

The results indicate that senior nurse managers and academics have identified the broad and comprehensive nature of the first-line nurse manager position which has changed from an administrative task orientated position to a relationship orientated managerial position. Panellists removed and added competencies and a final list of 173 competencies was compiled from the study, (160 competencies were considered part of the management component of the position and 13 competencies were determined to encompass the clinical component). The competencies were divided into four categories namely: Patient Care Management, Functional Management, Human Resource Management and Leadership. These competencies were used to delineate the role of the first-line nurse manager within the community health centres. The strength of panellists' acceptance of the managerial aspects of the role is heartening, however a number of managerial components of the role either were weakly loaded or did not load on either of the correlation analysis. Concern is expressed as to whether the appropriate authority and responsibility has been devolved to the position, enabling the first-line nurse manager to carry out this managerial role. In addition, the results also indicate that the first-line nurse managers' position may consist of a purely managerial role or a blended managerial-clinical role, which is dependant on the number of staff being managed in the CHC.

**To my husband Graham
and my children
Sean and Lynda**

University of Cape Town

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ABBREVIATIONS

ANA	:	American Nursing Association
ANC	:	African National Congress
AONE	:	American Organisation of Nurse Executives
CBO	:	Community Based Organisation
CHC	:	Community Health Centres
DENOSA	:	Democratic Nursing Organisation of South Africa
FUNDISA	:	Forum of University Nursing Departments in South Africa
ICN	:	International Council of Nurses
NGO	:	Non Governmental Organisation
NHS	:	National Health Services
NQF	:	National Qualification Framework
PHC	:	Primary Health Care
RSA	:	Republic of South Africa
SANA	:	South African Nursing Association
SANC	:	South African Nursing Council
SAQA	:	South African Qualifications Authority
WHO	:	World Health Organisation

GLOSSARY OF TERMS

Accountability: The expectation that each employee accepts credit or blame for the results achieved in performing assigned tasks (Booyens 1996: 149).

Authority: The right conferred on an individual to make decisions, command resources, issue orders or impose sanction (Gillies 1989: 596).

Community Health Centres: These are units that provide promotive, preventative, curative and rehabilitative care. The CHC is responsible for health in a defined area and dependant on needs and resources will also include satellite clinics and mobile clinics (ANC 1998: 28)

Community nursing: "...is concerned with the total community, and its activities are aimed at the population as a whole. As practised it integrates the concepts and methods of the public health sciences with those of nursing so as to promote, maintain and restore the health of the community; it uses the concepts and methods of epidemiology to diagnose the health care needs of the urban and rural populations, maintains surveillance over health trends in those populations, and identifies through its diagnosis groups or series of groups of individuals sharing the same health needs. It is also responsible for the planning and carrying on preventative activities at all three level, including direct primary care, and for mobilising the individual and collective resources of the community to help achieve higher community health levels. Lastly it assesses the effects of its activities on their objective" (Dreyer 1984, cited by Brouwer, Dreyer, Herselman, Lock & Zeelie 1997: 1,2)

Competencies/skills: These are derived from an assessment of the knowledge skills and attitudes needed to perform in a professional role (Broski, Alexander, Brunner, Chidley, Johnson, Karas, Rothenberg 1997:39).

Correlation Coefficient: Indicates the strength of a relationship between two or more variables (Robbins 1993: 721).

Delphi technique: A system of non-interactive group decision-making in which a series of anonymous questionnaires and summaries of questionnaire results are used to reach consensus (Gillies 1989: 598).

Direct nursing care: Care given by nursing staff members while working in the patients' presence and related specifically to his/her physical, social and psychological needs (Gillies 1989: 598).

First-line manager: An entry-level manager.

Health System: Combination of resources, organisation, financing and management that culminate in the delivery of health services to the population (Roemer 1993: 31).

Leadership: The ability to influence a group towards the achievement of goals (Robbins 1993: 724).

Management: The process of getting things done through people. It involves planning, directing, organising, leading and controlling the activities within a predetermined area or programme (Robbins 1993: 3).

Managers' scope of practice: The extent to which the manager is involved in management and/or direct patient care.

Managers: These are individuals that achieve goals through other people. "They make decision, allocate resources, and direct the activities of others to attain goals." (Robbins 1993: 3).

Organisation: A consciously co-ordinated social unity, composed of two or more people that functions on a relatively continuous basis to achieve a common goal or set of goals (Robbins 1993: 3,725).

Paradigm shift: Indicates a change in the model or a transition to a new model (Kerfoot 1996: 181).

Participative management: A method of institutional direction that is characterised by the distribution of responsibility and authority throughout all layers of organisational hierarchy (Gillies 1989: 601).

Primary Health Care: “Primary health care is essential care based on practical scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their participation and at a cost the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part of both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community to the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing care service.” (WHO 1999, as cited by Dennill, King, Lock, Swanepoel 1995: 2).

Quality of Care: The provision of nursing care in accordance with the predetermined standards (Gillies 1989: 602).

Reliability: The degree of consistency with which a device measures what it is designed to measure (Gillies 1989: 602).

Response group: Refers to the organisations selected to participate in the study, from whom participants were nominated.

Responsibility: The obligation or commitment of a manager to carry out the assignment according to received instructions (Booyens 1996: 149).

Role conflict: A situation in which an individual is conformed by divergent role expectations (Robbins 1993: 726).

Role expectations: How others believe a person should act in a given role (Robbins 1993: 726).

Role identity: Certain attitudes and behaviours consistent with the role (Robbins 1993: 726).

Role: A set of expected behaviour pattern attributed to someone occupying a given position in a social unit (Robbins 1993:726).

Span of control: The number of people reporting to a manager (Aldina & Funke-Furber 1988:34).

Transformation: A major change in an organisation involving a break with existing routines and a shift to new kinds of competencies that challenge organisational knowledge (Aldrich 1999:165).

Validity: The degree to which a research study is measuring what it is claiming to measure (Gillies 1989: 603).

Chapter 1

Introduction

The advent of the new democratically elected government in South Africa in 1994 has had a profound impact on every facet of life in the country. The resultant socio-political changes have also impacted on the delivery of services within the country through a process of transformation. The overriding principle of human rights, defined in the Constitution, has spearheaded transformation within the country.

The principle that health care is a basic human right has driven transformation within the health services, which is reflected in the adoption of Primary Health Care (PHC) as the underlying philosophy of health care delivery within the public sector. The adoption of PHC has impacted on the way services are delivered and these changes are noted in Table 1.1:2.

PHC Services in community settings aim to provide for the basic health care needs of the South African population. This is in contrast to the previous model of health care, which focused on curative care in tertiary hospitals. The provision of community based care using the PHC approach requires not only a change in approach, from the previous hospital based care, but also new skills for those who provide this care. The nurse in charge of the unit also requires new skills from that of the hospital based nurse. The nurse in-charge of the unit has to ensure the implementation of a PHC service that is accountable and responsible to the community as well as ensure that the service achieves clinical outcome within a framework of high quality and low cost (Fox, Fox, Wells 1999: 12). To achieve this the nurse in charge of the unit is required to organise and maintain the rules, communications and relationships within the working environment (Duffield 1992: 51) in consultation with the community (ANC 1994: 21).

The Health Services	
Past situation	New situation
<i>Focus:</i> Tertiary medical care	<i>Focus:</i> Primary Health Care
Services at arms length	Services close to the community
Service delivery fragmented, inaccessible and unequal along racial lines	Co-ordinated services that are accessible and provide equitable care.
Doctor-led care	Nurse- led care
Provincial and local authority structure	District health model
Individualised care	Individual seen in the family and community context.
Disease/condition specific units which were hospital based	Comprehensive service inclusive of Health promotion and maintenance; disease prevention; curative and rehabilitation

Table 1.1: The health services: Past and New (adapted from Coetzee 1998, and Guay cited by Hadley, Cooper, Dale, Stacy 1987: 8,9).

The unification of the fragmented health service into a National Health Service (NHS) has resulted in the development of a three tiered health system. The National Health Department being responsible for policy development; the Provincial Health Departments being responsible for implementation of the policies, including the appropriate assignment of health service functions to local government; the Local Authority Health Departments (also called a Municipal Health Department) being responsible for the implementation of the devolved PHC function, through the District Health System (ANC 1994: 27; Department of Health and Social Services – Provincial Administration Western Cape 2000: 1). In order to ensure that the local governments are continuous and cover the entire country, the boundaries of local authorities have been changed through the Local Government, Municipality Demarcation Act (Act 27 of 1998). The promulgation of this act ensures that the

District Health System can be implemented “seamlessly” throughout the country. The PHC function at a local government level includes preventive, promotive, curative and rehabilitative services, which are provided to communities through the District Health System. The PHC services within each district form the foundation for the entire health service (Department of Health and Social Services – Provincial Administration Western Cape 2000: 21). The delivery of these PHC services is through Community Health Centres (CHC’S), satellite clinics and mobile clinics. The guideline used for CHC’s is that they will serve an average population of approximately 50,000, dependant on the density of the population, transport, access and other health services in the district (ANC 1994: 28). At present provinces are in the process of formulating a core package of services for each level of the PHC system. The core package is being phased in over time and is dependent upon needs and resources. Therefore at present the services offered within the PHC system vary between and within provinces, between and within districts and between CHC’s (Department of Health and Social Services – Provincial Administration Western Cape 2000: 16).

The variety of PHC services offered within CHC’s and the provision of services based on a number of different criteria has resulted in CHC’s ranging in size; from small units offering basic PHC services to large units offering a comprehensive 24-hour service that may also involve satellite clinics and/or mobile clinics. The provision of services may also include collaboration with lay health workers linked to Non Governmental Organisations (NGO’s) and Community Based Organisations (CBO’s) who are involved in service delivery (Department of Health and Social Services – Provincial Administration Western Cape 2000: 17).

The adoption of the PHC approach has also impacted on the practice of registered nurses and these changes are noted in Table 1.2.

Practice of registered nurses	
Past situation	New Situation
<i>Paradigm:</i> Disease- based care model	<i>Paradigm:</i> Health-based model
Doctors make diagnosis and prescribe treatment therefore nurses have a more dependent role.	Nurses are required to promote health and make clinical diagnosis and decisions concerning treatment and referral.
Often required to carry out doctor's instructions	Required to initiate and supervise care
Delivery of care is reactive and task orientated	Continuity of care across settings and over time that is proactive
Provision of care based on professional responsibility.	Provision of care based on a shared responsibility.
Multi-disciplinary team co-ordinator	Collaboration within inter-disciplinary and dispersed inter-sectoral contexts.
The public and family were tolerated with minimal involvement	Collaboration with family members and the public participates in the delivery and management of care.
Place of work is confined to the clinic often with limited responsibility	Place of work extends to the context which is closer to more people in the community.
Units tended to run on traditions of hierarchy with clear "rules", with a Human Resources team to deal with problems	Each nurse now requires interpersonal skills including team building, negotiating, motivational, facilitation, counselling and networking skills
Research holds low priority	Research awareness and research acumen is required to carry out research and ensure the implementation of research based practice.

Table 1.2: Practice of registered nurses: Past and New (adapted from Coetzee 1998, and Guay cited by Hadley et al 1987: 8,9).

The change from a Tertiary Care Model to PHC and the corresponding changes to the practice of registered nurses had also impacted on the nurse in charge of the CHC.

One of the main principles of the PHC approach is that services are accountable to community structures at national, provincial, district and local level. Accountability is achieved through the process of community participation where responsibility and authority are appropriately devolved to the different tiers within the system. (ANC 1994: 21). The responsibility and authority for the implementation of the PHC

function is vested in the local authority via the District Health Service and devolved to CHC's, which are the interface between the community and the health system.

In order that authority and responsibility can be devolved to the CHC's, the centre requires the services of a person, who is responsible for making decisions within the centre, allocating resources and directing the activities of those working in the centre, in other words a manager (Robbins 1994: 3). The person in this position is an entry-level manager and as such it is the first management position in a person's career (Stevens 1980: 218). The first-line nurse manager is responsible for the day to day operations of a defined work unit, its' employees and effective utilisation of its' resources. It is the position where plans are put into action, and failure at this level of management results in organisational failure (Stevens 1980: 213).

The key focus of the first-line nurse manager is to ensure the delivery of high quality care, resulting in the desired clinical outcomes within the available resources (Sovie 1994: 30; Searle 1988, cited by Evertse 1991: 35). The responsibility to improve quality of care is challenged by the need to achieve this within an environment of continual cost containment (Sovie 1994: 30; Henry, Hamram, Lorensen 1995: 11). In order to ensure the best quality of care, first-line nurse managers are required to act as a resource person, co-ordinator, clinical coach and professional role model (Duffield 1992: 49). The standard of quality of care is directly determined by the quality of the nursing management (Stevens 1980: 2022; Wainwright, Brimelow, Camper 1986: 32).

Internationally the debate among nurses regarding the role of first-line nurse manager, is whether the position is primarily that of a clinician (Roscher 1980: 3), a manager (Casteline 1996: 312; Carr 1982a, cited by Duffield 1992: 39) or a blended role (Bray 1981:9). Senior managers agree that this debate has not been documented in South Africa. This is because the position has traditionally focused on the clinical aspect of the role that included an administrative rather than a managerial function. How decentralisation will impact on the role has not yet been determined (Alexander 1998).

The diversity of the South African environment as noted above has impacted on the first-line nurse manager position. Those that are afforded the title of first-line nurse manager range from, those working with two nursing staff providing basic PHC services during office hours, to those who are responsible for managing a multidisciplinary team comprising as many as 30 staff, that provide 24 hour service that includes trauma, emergencies, obstetrics and general outpatient facilities (Department of Health and Social Services – Provincial Administration Western Cape 2000: 19).

This study was undertaken to identify the competencies that first-line nurse managers require so that the position can be used in a strategic manner to achieve the maximum level of benefit for both the health service and the professional.

The aim of this study was to create an understanding of the new and expanded role and functions of the first-line nurse managers of CHC's within a changed health care environment.

Study objectives

- 1. To identify the role competencies expected of first-line nurse managers in Community Health Centres in South Africa.**
- 2. To provide recommendations for the training of the first-line nurse manager based on the identified role competencies.**

The literature review, recorded in Chapter 2, encompasses four main sections. The first section examines the historical background to the South African health care system and its management, and gives an overview of nursing during that period. The second section examines transformation brought about by the socio-political and health care reforms with the advent of the new government, and the effects that these changes have had on health care delivery and its management. The effect that the transformation process has had on the labour arena is discussed in the third section. Finally the role of the first-line nurse manager is reviewed.

The research design is discussed in Chapter 3. The reasons for using a consensus seeking method are given, as well as the reasons for selecting the Delphi technique. The process for identifying response groups and the nomination of participants is also documented. The evolution of the questionnaire and how the questionnaire was administered over three rounds are discussed. The criteria for establishing consensus and the implementation of these criteria are also recorded in this chapter.

The data are analysed in Chapter 4. The analysis involves the rating patterns over the three rounds followed by an analysis of the third round data. Chapter 5 includes the adaptation of the competency list for first-line nurse managers. Chapter 6 discusses the methodological implications of the study and determines the role of the first-line nurse manager based on the competencies identified in the study. The discussion uses both qualitative and quantitative data. The recommendations are recorded in Chapter 7. This chapter also discusses the limitations of the study as well as the recommendations for further research. The conclusions of the research are discussed in Chapter 8, together with the final list of competencies required by first-line nurse managers of CHC's that has been compiled from this research study.

Chapter 2

Literature Review

2.0. INTRODUCTION

This literature review explores from an International and South African perspective, the changing role of the first-line nurse manager. The socio-economic and political changes in South Africa since 1994 have impacted particularly on the health care delivery system. In addition, the radical changes to the labour legislation have added impetus to the changes facing health care workers. A background to the understanding of the impact of these changes, from both an international and local perspective is provided, emphasising the changing role of the first-line nurse manager.

Initially, the literature review explores material related specifically to first-line nurse managers in nursing and health, using electronic data systems as the search method. This process was later expanded to include firstly, specific references in South African literature and secondly, more general management issues as they relate to the position of the first-line manager.

The researcher was particularly interested in obtaining published material relating to developing countries, especially those at a similar development level to South Africa, but unfortunately very little data was available. The same problem was experienced in identifying published material that focused on the role of the first-line nurse manager in Community Health Centres in both developed and developing countries. The published material focused mainly on the role of the nurse manager within a hospital environment.

2.1. HISTORICAL REVIEW

2.1.1. Health care system during the apartheid era

During the apartheid era, health care delivery in South Africa, was based on the western model of curative medicine delivered in a hospital setting. This resulted in extraordinary inequalities in service delivery to the general population of the country. The curative emphasis placed little attention on the promotion of health and the prevention of disease. Inequalities in resource allocation resulted in urban areas with more services than rural areas and tertiary academic institutions with considerably more resources than non-academic institutions (Paterson 1993: 29).

The inequalities were also reflected in personnel, services and facilities, which were disproportionately distributed between different racial groups. The differences were evident in the provision, availability, accessibility, attainability and quality of the health services. These differences ultimately resulted in the unequal utilisation of services (van Rensburg, Fourie 1994: 95; Benatar 1991: 213).

The inequalities according to van Rensburg "...are indeed a mere reflection of the socio-economic, racial and political disparities in the broader societal context, where access to wealth and political power so far has been regulated by a white political elite" (van Rensburg et al. 1994: 96). Kale (1995: 1119) describes the South African health care system as an "...artificial paradox of the best of the First World medicine and the worst of the Third World medicine within a few miles of each other which resulted in extreme inequality in the health profile of the country."

The structural inequalities in the health care system have primarily been seen to be the result of the apartheid system that lead to a fragmented health service, with the absence of a central health policy for all racial groups (van Rensburg et al. 1994: 98; Benatar; 1991: 213). The health care service was fragmented due to the split in responsibilities across fourteen different departments (Ntsaluba, Pillay 1998: 33); homelands (also called bantustans) each had their own health department, as did the White, Coloured and Indian groups (ANC 1992: 393). These structural inequalities were influenced by additional factors that included:

- The dominance of the medical profession resulting in a curative bias to health care with a corresponding lack of teamwork and community participation (Rispel 1995: 232; Kale 1995: 1307).
- The prominent role of the free market system with its reinforcement of profit-taking principles which resulted in the mechanism of provision, financing and spending that lacked planning and co-ordination. This policy also encouraged a large fee for-service-paying sector that focused on curative rather than preventative health care (van Rensburg et al. 1994: 98; Benatar 1991: 213).
- The socio-cultural make-up of South Africa has led to the emergence of two contrasting medical and health cultures namely, the traditional and western models. These contrasting cultures impact on the health, illness and consumption behaviour of people by determining people's concept of health and illness, what is considered appropriate health care and whom they consult when ill. These factors have affected the degree of acceptance of the Western health care system (van Rensburg et al. 1994: 98; Kale 1995: 1182).

2.1.2. Nursing in the apartheid era

South Africa was the first country in the world to implement professional recognition and control of the nursing profession (Storey 1991: 14). This was achieved in 1891 through the introduction of a system of state registration of nurses (DENOSA 1999: 15). The affairs of the profession were directed by the South African Nursing Council (SANC) and the South African Nursing Association (SANA), which were duly constituted under the Nursing Act (Act 45 of 1944).

The main function of the SANC was to control and exercise authority over the education, training and practice of nurses. Separate registers for different population groups were kept and until 1978 only white nurses served on the Council. This practice changed, with the passing of the Nursing Act (Act 50 of 1978), which enabled all population groups to serve on the Council, but the number of elected nurses in each population was stipulated and nurses could only elect nurses of the same population group (DENOSA 1999: 15).

SANA was also constituted on racial lines, which resulted in its withdrawal from the International Council of Nurses (ICN) in 1973. The withdrawal was in anticipation of expulsion due to racial discrimination (DENOSA 1999: 21). Until 1982 the leaders of the organisation emphasised correct conduct within the profession with particular emphasis on non-involvement in party-politics and upholding the laws of the country (DENOSA 1999: 16).

The policy of separate development was also prominent in the education of nurses. Separate training schools were available for black and white students. All students however followed the same curriculum, as prescribed by SANC and wrote the same examinations also set by SANC (DENOSA 1999: 39). Black nurses were further disadvantaged, as nursing education was not presented in their home language and in many instances inferior facilities existed at their training institutions.

The racial policies also affected the salary structures and promotion opportunities of nurses. Salary parity was only achieved in 1986 and the policy that black nurses could not be senior to white nurses resulted in the latter, with fewer qualifications and less experience, being promoted at the expense of their black colleagues (DENOSA 1999: 43). Yet, ironically nursing continued to be viewed by black women as the most prestigious occupation in the twentieth-century (Marks 1997: 29,33).

2.1.3. Health management systems in the apartheid era

The Commission of European Communities (Slabber 1993: 13) characterised the past health care system in South Africa, as undemocratic and lacking in accountability with rigid and hierarchical management systems. Slabber (1993: 13,14) summarises the way health management operated in the previous government:

- Management ignored the external environment when making decisions about the provision of health care. This can best be illustrated by the inequalities in the provision of health care, where management and health professionals were aware of these inequalities, but chose to ignore them.
- Planning was re-active and short-term with past trends projected into the future and planning focusing on single issues. Management styles were autocratic and management decision making was centralised.
- Health personnel and communities were not involved in making policies and decisions that directly affected them.
- Health professionals in management positions were untrained in management practices.
- There was a distinct lack of financial discipline and control.
- Information was collected as a matter of routine and not influenced by planning and management needs.
- The management and control of stores and fixed assets were inefficient, resulting in inadequate repairs and maintenance as well as loss of stock.
- The working methods and procedures were extensive and unwieldy which made decision making slow thereby creating the need for personnel to find ways to circumvent the rules and regulations.

The policies that promoted a specific race, sex and profession was reflected in the health management structures, which consisted mainly of white, male doctors. The power, prestige and privilege found in the health sector was held by the predominately male medical profession (Rispel 1995: 232), which saw nursing as subordinate to medicine (Mavundla, Mabandla 1997: 74).

In addition, the public service regarded men as the breadwinner and as such men were given better benefits and promotional opportunities. Married women generally could not retain permanent positions and had to resign on becoming pregnant (DENOSA 1997: 46).

Nurses formed and still form the largest professional group in the health service sector in South Africa (Thompson 1988: 167). Nursing was (and still is) almost

totally the preserve of women, with the majority of these black women (Marks 1997: 28) resulting in a profession which was undervalued and where promotion to management positions was very limited (Gourley 1995: 2).

Likert's management theory describes four types of management systems ranging from totally authoritarian to totally democratic (Marriner-Tomet 1992, cited by Booyens 1993: 117). Evaluating the management system used by the health sector, during the apartheid era, it was established that the exploitative-authoritarian system was used. This system ensured that top managers made all the decisions and employees were expected to implement the decisions without any form of consultation (Alexander 1998).

2.1.4. Models of nurse management practice

The nursing practice models describe the way nurses provide care, whatever the environment, ward or community centre. These models also focus on the method of personnel assignment, which determines the staffing, and skill mix requirement. The differing roles of the first-line nurse manager within each model are also noted (Booyens 1993: 298; Rotkovitch 1983: 18). The five models are the Functional, Team, Case, Primary and Modular nursing models.

The Functional (also called the Traditional) model, uses an assembly-line method of assigning nurses to one or more nursing functions (Booyens 1993: 299). The role of the first-line nurse manager is described as that of a sergeant major sitting behind the desk directing the activities of the unit. Different tasks are assigned to the staff at the beginning of each shift. This method causes fragmented patient care that is "... disjointed and at variance with the philosophy about people, patients and the role of nurses that the new generation of professional nurses bring with them..." (Rotkovitch 1983: 18). The nurse manager has a wide span of control and authority and responsibility flows from the nurse manager position to the other staff in the unit (Booyens 1993: 299).

The Team model was developed to solve the problems experienced using the functional model. Staff are divided into groups consisting of different categories of

health workers, with the most competent registered nurse designated team leader. "The team leader is accountable for the total care of all the patients in her group and is responsible for delegating patient care to the members of her team " (Booyens 1993: 301). The role of the first-line nurse manager was similar to that found in the traditional model, except that the team leaders supervised the staff and reported to the first-line nurse manager (Rotkovitch 1983: 19). Neither the functional method nor the team nursing is viewed by nurses as conducive to the provision of quality care (Rotkovitch 1983: 20).

The Case (also called the Professional Nursing) model involves the allocation of a registered nurse, who is responsible for the entire nursing care of a group of patients and for co-ordinating the other members of the health care team providing care to those patients. This method is used extensively in intensive care units (Booyens 1993: 300; Rotkovitch 1983: 19).

The Case method is sometimes referred to as Primary Nursing. There are differences between these two concepts that relate to the amount of time the nurse is responsible for the group of patients under his/her care. In the Case method the nurse is responsible for the duration of the shift. In Primary Nursing, however "...responsibility is for 24 hours irrespective of whether the nurse is on duty or not " (Rotkovitch 1983: 25). The core philosophy of primary nursing is to deliver comprehensive, continuous and co-ordinated care with the professional nurse being accountable for the planning, delivery and outcomes of that care (Booyens 1993: 302).

The first-line nurse manager in both the Case and Primary nursing models is seldom behind a desk, which makes it possible for the person " ...to attend to the responsibilities related to direct patient care and the supervision of nursing staff " (Rotkovitch 1983: 25). A further adaptation of these two models occurs in the Modular Nursing model. This involves the allocation of patients to a team, based on the layout of the ward. The nurse manager in this model is responsible for co-ordinating the work in the unit and supervising the nursing care of all patients (Booyens 1993: 305).

The use of the different models is based on the number and type of patients, the number and skill-mix of the available nurses, the policy of the institution and whether there is a focus on staff job satisfaction and professional growth (Booyens 1993: 305).

2.2. TRANSFORMATION IN THE PUBLIC HEALTH SECTOR

Aldrich (1999: 165) defines transformation as “a major change in an organisation involving a break with existing routines and a shift to new kinds of competencies that challenge organisational knowledge.” Levy (1988) describes second order change as an alteration of the system’s basic governing rules, which irreversibly shifts the system as a whole to a new paradigm (cited by Ashburner, Ferlie, FritzGerald 1996: 2). Transformation is a deliberate action that changes the shape and form so radically that it becomes another entity (Rosen 1997: 68). The underlying motivation for transformational change is not to solve specific problems, but rather as a vehicle to express a commitment to a particular ideology (Ashburner et al. 1996: 4).

Aldrich (1999: 165) reports that transformation, which involves major or substantive changes in organisations, occurs along three dimensions namely: goals, boundaries and activities systems. These definitions will now be explored in relation to the current South African situation.

2.2.1. Goal transformation

Two types of goal transformation are reported, firstly those that refer to the domain claimed by the organisation and secondly to the breadth of the organisation. Domain relates chiefly to the market or target population. The Constitution of South Africa signed in 1996, impacts on the domain of the health service by entrenching the right to life and the right to basic health and social services (Clarke, Gray 1999: 5). Changes in the breadth of the organisation’s goals relate to changes from “specialism to generalism” (Aldrich 1999: 166). The changes in the health service

to provide equal access to all also radically changes the breadth of the organisation's goals (ANC 1992: 392).

2.2.2. Boundary transformation

Transformation of organisational boundaries occurs through either expansion or contraction (Aldrich 1999: 166). There has been extensive expansion of boundaries within the health service with the adoption of the PHC approach. This approach emphasises the social origins of disease, which ensures that health services are provided within the context of the community. The health service's accountability to the community ensures the appropriateness and relevance of the service. (ANC 1994: 26)

The boundaries of the health service have been further affected by the integration of the vertical health programmes into a comprehensive and co-ordinated health service. The comprehensive health service incorporates services not previously included or managed within the health arena. The co-ordination of service through a tiered referral system, from primary to tertiary levels, incorporates a continuum of care. (ANC 1994: 26; Department of Health and Social Services- Western Cape 1995: 18). The implementation of this comprehensive and co-ordinated service requires multi-disciplinary, multi-sectorial and multi-skilled teams not previously used within the health service (Department of Health and Social Services- Western Cape 1995: 18).

2.2.3. Transformation of activity systems

Aldrich reports that the extent of the impact of boundary changes on the organisation depends on the scope of the changes in relation to the size of the organisation and how rapidly the changes are implemented. In reviewing the reconstruction and development of the health system in the first thousand days of the new government, it was reported that the fragmented structures had been

rationalised and that a national health department together with nine provincial health departments had been established. Equity was being achieved through equitable funding to the provinces and the promotion of PHC with access to health "codified as a right in the Constitution" (Ntsaluba et al 1998: 34). These reported changes highlight the extensiveness of the change that had occurred over a relatively short period of time.

Activity systems are the mechanism used by people to accomplish work. Changes in administrative systems, human resource management systems and major technological innovations have been cited as further examples of transformation in activity systems (Edelman 1990, cited by Aldrich 1999: 167; Yetton, Kim, Johnston, Craig 1994, cited by Aldrich 1999: 166,167). The administrative system changes in South Africa have involved the restructuring of the health service into a national health system divided into national, provincial and district health services and the formulation of the roles and responsibilities of each level (ANC 1994: 50).

The changes in the human resource management system involved the adoption by government of The Labour Relations Act (Act 66 of 1995); The Basic Conditions Of Employment Act (Act 75 of 1997); The Employment Equity Act (Act 55 of 1998) and The Skills Development Act (Act 97 of 1998).

Technological change refers to the incorporation of innovations into the work environment, which is having a major impact on traditional occupations by challenging them to take advantage of these new technologies (Sunter 1999: 14). The role of technology is to improve the way we do things and in health care it included machines, equipment, procedures and drugs. The aims of technology is reported to be "...to promote health as well as to prevent and manage disease, with the ultimate purpose of ensuring a better quality of life for all individuals in society " (Jaros, Bunn 1999: 1166). The use of computers within CHC's is but one example of the use of technology to change the workplace. The incorporation of computers has been reported to reduce the workload of nurses by as much as 35% thereby lightening the administrative burden, freeing nurses to focus on quality of care and providing management with accurate and timely information (Mc Donald 1999:16).

Applying Aldrich's dimensions of transformation to the South African situation, it is possible to conclude that the South African health system has undergone substantive transformation.

2.2.4. The management of transformation

Traditionally management in the public service involved the supervision of standardised practices and procedures. Managers used power-wielding techniques that were associated with dominance and not vision (Maddock 1999: 31,35). The apartheid philosophy in South Africa, where people were governed by different laws based on racial differences, was transported into the workplace. Different opportunities and levels of empowerment were given to people based on race (Mabaso 1998: 16). Employees generally, but black employees specifically, were "...given instructions or told what to do and how to do it " and this approach stifled innovation and creativity (Teke 1997: 29). White employees however were empowered to be somewhat more creative and were encouraged to use critical thinking, but were protected from international trends and competition (Mabaso 1998: 17).

The viability of any organisation is dependent upon the ability of the managers to direct and control resources. The resources refer to the "people, space and buildings, raw material, money, plant and machinery" (Kemp 1998: 14). People are generally regarded as the most important and primary resource because the other four resources are dependent on the performance and skill of the people within the organisation. Therefore the primary responsibility of managers is to direct human effort, through stimulation and motivation, in harmony with the objectives of the organisation (Kemp 1998:14).

Managers have a pivotal role in supporting transformation. Successful transformation involves mainly leadership with a limited amount of management (Herbst 1998: 33). The magnitude of the changes that are required today demands not only effective leadership, but also new ways of leading (Kotter 1990, cited by April, Macdonald 1998: 15).

Senge (1990: 3) states that the key to leadership today is not to break apart tasks and subjects into fragments as it prevents people from seeing the consequences of their actions, but to view these subjects and tasks within the context of the larger whole. Senge (1990: 69) believes that “systems thinking is needed more than ever because we are becoming more overwhelmed by complexity.” The systems thinking approach requires a paradigm shift “from seeing parts to seeing wholes, from seeing people as helpless reactors to seeing them as active participants in shaping their reality, from reacting to the present to creating the future” (Senge 1990: 69). The need for health care delivery to be integrated, continuum based and multifocal is forcing health care to be more systematic and connected to ensure sustainability. This is requiring health care services to review the infrastructure and explore new types of leadership (Porter-O’Grady 1999: 42).

The way that organisations are able to adapt to the ever-changing environment and harness the people within the organisation is through a “learning organisation”. This type of organisation requires that the organisation is in a constant state of learning and people are continually expanding their capacity. The learning is achieved “through monitoring the environment, assimilating information, making decisions, and flexible restructuring in order to compete in the environment” (Noe, Hollenbeck, Gerhart, Wright 1994: 68).

Managing change requires not only the ability to manage existing operations but also imaginative skills, a more flexible approach and leadership (cited by Maddock 1999: 35). Saunders (1998: 32) states that a successful leader “can optimally combine meaningful intrinsic rewards with the attainment of organisational objectives through the sincere effort to know, understand and care about people.” Handy (1989, cited by Maddock 1999: 36) states that leaders must be able to listen, communicate, have vision, encourage and inspire staff, reinforce and confirm others, identify skills and problems as well as be able to build a team.

The essence of effective health care management is being able to balance the environmental demands with the ability to provide quality of care that patients, their families and the community deserve. This means a shared collaborative approach that builds effective relationships at the same time as it focuses on results (Dixon 1999: 20).

Managers who use a transactional or transformational leadership style are better able to achieve this balance. Transactional leaders are described as “ leaders who guide or motivate their followers in the direction of established goals by clarifying role and tasks requirements” (Robbins 1993: 391). Transformational leaders on the other hand are described as “leaders who provide individualised consideration and intellectual stimulation, and who possess charisma” (Robbins 1993: 391). Robbins (1993: 391) notes that there is a stronger correlation between transformational leadership and lower staff turnover, greater productivity and higher employee satisfaction.

The frontline supervisors are among the opinion leaders of an organisation and critical to the implementation of change, because of their influence on the attitudes and behaviours of others (Larkin, Larkin 1996: 95,102).

2.3. HEALTH CARE REFORM – THE DISTRICT SYSTEM

The African National Congress (ANC) adopted policy guidelines on health, at their National Convention in May 1992, and these have formed the foundation for the transformation of the health system in South Africa. The overriding principle of the policy is that access to health care is a basic human right and the broad framework of the health policy emphasises that health should not be seen in isolation, but within the context of empowerment and development of individuals and communities. Thus provision of services such as housing, sanitation, water and food supply, which impact on health are considered important for improving the health status of the population (ANC 1992: 392; Ncayiyana 1994: 55; ANC 1994: 22,23,24).

The services provided in South Africa, by the new health care system, have therefore focused on the need to be accessible, acceptable, affordable, efficient, effective and equitable (Department of Health 1998: 19,20,21; Department of Health and Social Services – Western Cape 1995: 3).

Accessibility not only refers to the distance, travel time and mode of transportation to the health care unit, but also the basic level of health care provided to the entire population (Department of Health 1998: 21; ANC 1992: 392; Slabber 1992: 389 Laffrey, Page 1989: 1045). Acceptable refers to the involvement of the community in the planning and implementation of health care. The service must be affordable to individuals, as well as the country as a whole (Department of Health 1998: 23; Slabber 1992: 389). Equity attempts to address the gross inequalities of the past that not only relate to services but also to vulnerable groups e.g. children, pregnant women, and rural communities (Department of Health 1998: 21; ANC 1992: 392; Slabber 1992: 392; Department of Health and Social Services – Western Cape 1995: 4). In order for the service to be efficient and effective, a number of different criteria have been identified which include:

- Services must focus on "... true needs and health problems of the community and not those perceived by health workers " (Slabber 1992: 390).
- A comprehensive service based on the PHC approach must be able to achieve a balance between promotion, prevention, rehabilitation and curative services. (Department of Health 1998: 20,21; Slabber 1992: 390; Department of Health and Social Services – Western Cape 1995: 3; ANC 1992: 392).
- The services must promote inter-sectoral co-operation by involving related sectors e.g. education, housing and agriculture (ANC 1994: 21-23; Slabber 1992: 390; ANC 1992: 393; Department of Health and Social Services – Western Cape 1995: 4).
- The service must be based on health research and relevant experience (Slabber 1992: 390).
- The services must promote the independence and participation, of both the community and individual, in the planning and implementation of care and services. (Department of Health 1998: 23; Department of Health and Social Services – Western Cape 1995: 9; ANC 1992: 392).
- The services must have an appropriate referral system (Slabber 1992: 309; Department of Health and Social Services – Western Cape 1995: 8)

- The services must rely on both professional and non-professional health workers as part of the health team as well as appropriate utilisation of different categories of manpower (Slabber 1992: 388).

The cornerstone of the new health care system which addresses the issues of accessibility, acceptability, affordability, efficiency, effectiveness and equity is “a district health system offering a package of primary health care provided by a district health authority” (Kale 1995: 1397). In order to implement the district health system, the fourteen health departments that formed part of the previous health system, needed to be rationalised and integrated into a National Health Department with nine provincial health departments. The provincial health departments’ have in turn devolved decision making to the local authority and the establishment of health districts. This has enabled management authority and responsibility to be decentralised and delegated thereby maximising community participation. The reallocation of resources from tertiary to primary health care was the only way that PHC could be implemented at a district level (Ntsaluba et al. 1998: 34; Kale 1995: 1119,1399).

These changes have occurred within the context of greater demand for health care, which has been aggravated by the granting of free health care for pregnant women and children under 6 years and the increase in HIV/AIDS (Kale 1995: 1120; Clarke, Gray 1999:5). The restructuring of the health service has also occurred at a time of diminishing financial resources, which has compounded the problem (Rasool 1998: 31).

Health care reform is not unique to South Africa. Countries increasingly have to balance limited budgets for health care with spiralling costs and greater demand for complex health care services. (ICN 1990: 10). Changes are made to health systems, organisations and structures which then impact on nursing structures and services which cannot remain static when the overall structure and function of the health service changes (ICN 1990: 15). Duffield (1988: 125,126), describing the Australian context, highlighted an adverse economic climate, the rise in consumerism, the increased use of technology, the privatisation of health care and the transfer of basic nurse education into tertiary education as the main factors that

place pressure on the effective provision of health care. In the United States, economic pressures, growth in technology, changing demographics, social changes and shortage of nurses are identified as factors stimulating profound change in health care provision. (Dienemann, Shaffer 1992: 40; Mark 1994: 40; Kerfoot, Luquire 1993: 321; ANA 1995: 48). Greater public demand for health care, financial constraints and the restructuring of the National Health System (NHS) have been identified as factors affecting health care provision in England. (Blake, Towel 1982: 309; Tross, Cavanagh 1996: 143). In Ghana the need to improve access to health services, quality of care as well as efficiency, prompted health care reform (Cassels, Janovshy 1996, cited by Agyuepong 1999: 59).

While each country describes varying factors that have influenced the provision of health care, common responses are documented. These include:

- Decentralised organisational structures (Eubanks 1992, cited by McGillis Hall, Donner 1997: 15; Evenson-Bates 1992: 32; Dienemann et al. 1992: 40; Hodges, Knapp, Cooper 1987: 39; Forrest 1983: 140; Agyuepong 1999: 59).
- Nurse managers being given a greater degree of accountability and responsibility (Evenson-Bates 1992: 32; Hodges et al. 1987: 39; Hodges et al. 1988:11; Shaffer, Kobs 1997: 41; Forrest; 1983: 140).
- A move away from institutional to community focused health care (Matrone 1996: 1; ANA 1995: 3; Duffy, Fairchild 1989: 16).

2.4. THE NURSE'S ROLE IN PRIMARY HEALTH CARE.

The PHC approach moves away from the bio-medical care model that focuses on the treatment of diseases and moves towards the health care model. The health care model focuses on prevention of disease and promotion of health in order to reduce the total amount of illness (Ntoane 1993: 35; Gourley; 1995: 23). Improved hygiene, housing, sanitation, food and community health services including

immunisation can improve the overall standard of health care (Pick 1994, cited by Kale 1995: 1308).

Nurses are reported to constitute 67,8% of all health workers. It is therefore not surprising that nurses form the backbone of the health service (Dennil, King, Lock, Swanepoel 1995: 45). Nursing education, which traditionally centred on curative, hospital-based care, has undergone a shift to a more community-orientated approach (Dennil et al 1995: 45). This shift has been achieved with the introduction of community health into the basic nursing curriculum with the advent of the integrated nursing programme, which is a positive development for the implementation of PHC (Rispel 1995: 232).

Kale (1995:1307) states that, "South African nurses are well trained and many of them are trained to deal with medical problems independently". Post basic training that enables nurses to diagnose and treat minor ailments has further enhanced the nurses' role in PHC (Dennill et al 1995:46). The high level of skill amongst nurses is confirmed by Kirsch (Kale 1995:1309) who would prefer to employ a South African trained nurse, who speaks an indigenous language and understands the patients cultural background, to employing foreign trained doctors.

The PHC approach places great emphasis on community participation and the empowerment of individuals to take responsibility for their own health. The hierarchical nature of traditional nursing with its affinity for bureaucracy and its emphasis on prescribed roles, duties and procedures can hinder the full participation of both the community and the client (May 1995: 28). Nursing training, while incorporating sociology, the principles of PHC and community work in the curriculum tends to emphasise the individual rather than the social origins of ill health. Rispel (1995: 232), believes that "... this results in a victim-blaming attitude towards patients, with mothers commonly being accused of stupidity and neglect when they bring their malnourished infants to health centres or hospitals". As a result of this emphasis, nurses experience difficulty in facilitating the empowerment of individuals and communities. It is clear that the PHC approach challenges traditional attitudes and values of nurses (Ntoane 1993: 35).

Ncayiyana (1994: 55) believes that history shows that governments do not easily relinquish power and this tends to frustrate the decentralising of management down to the community level. He believes that delegation of responsibility does not pose problems, but the same cannot be said about the delegation of authority, especially relating to staff matters. The delegation of responsibility and authority is also being affected by the lack of trained personnel and the resistance of some nurses to be empowered without an equivalent increase in financial or authority rewards (Blout, Nagigan 1998: 27; Alexander 1998).

PHC also challenges the traditional nursing attitude that excluded the work of other professionals from the nursing domain. PHC requires a multi-disciplinary and inter-sectoral approach; it requires effective decision making and problem solving skills as well as the need to be flexible and innovative (Rispel 1995: 232, Ntoane 1993: 36). These changes require nursing practices to move from task orientation to the use of critical thinking that will enable nursing to fit into integrated health care delivery systems which relate to the "continuity of care across settings and over time" (Beyers, Bright, Disser, Halley-Boyce, Orto, Ringer 1996: 8). Unfortunately nursing education has traditionally been rigid and authoritarian and encouraging of conformity (Rispel 1995: 232).

Nurses, in South Africa, are responsible for a larger slice of the PHC service compared with developed countries (van Niekerk, Brown 1989: 525). A number of factors have contributed to the increase in responsibilities of nurses. The vast number of nurses, many of whom can independently deal with medical problems, are better able to meet the personnel requirements to implement PHC. The increase in the scope of practice of nurses has placed greater demands on the quantity and quality of the nurses' talents (van Niekerk et al. 1989: 525). Ntoane (1993: 38) states that "successful Primary Health Care will require social consciousness, flexibility, problem solving ability and various other attributes not necessarily guaranteed by previous academic achievement". The skewed distribution of doctors in favour of urban areas, academic institutions and the private sector have resulted in rural areas and black townships having too few doctors. The long and expensive process of training doctors, as well as the high cost of paying doctors' salaries has also contributed to the expansion of the nurses' role (Kale 1995: 1307).

Lindeman (1982, cited by Mavundla & Mabandla 1997: 73) believes that the ability of the nurses to deliver health care is limited by the image of nursing within a community. Nurses as individuals, patients, the public and other health professionals interacting with nurses, control the image of nurses and nursing. Nursing is a profession that is undervalued because it is almost totally the preserve of women and men's jobs are traditionally regarded as more important (Gourley 1995: 2). The reality that nursing is subordinate to medical practice, and nurses' being generally viewed as assistants to doctors and not independent practitioners are factors contributing to the poor image of nurses. Whatever the cause of this poor image, the effect is that it directly impacts on the nurse's ability to implement PHC (Mavundla et al. 1997: 74).

2.5. TRANSFORMATION IN THE LABOUR ARENA

South Africa's political changes have resulted in a change in direction and structure of labour legislation. There have been key pieces of legislation initiated by the new government since 1994, these include: The Labour Relations Act (Act 66 of 1995); The Basic Conditions Of Employment Act (Act 75 of 1997); The Employment Equity Act (Act 55 of 1998) and The Skills Development Act (Act 97 of 1998).

2.5.1. The Labour Relations Act of 1995

The Labour Relations Act (Act 66 of 1995) made sweeping changes to the existing labour and employment legislation impacting on the interaction between the employer, the employee and the trade union. The Act is consistent with the fundamental rights of the individual founded in the Constitution and the International Labour Organisation conventions. Historically, South African labour laws did not cover the public service and the introduction of this act enabled public service employees, which includes nurses, to receive the same rights, structures and procedures as found in the private sector (Finnemore 1996: 148; Paton 1997; 1,2; Healy 1999:1,2).

The fundamental principles underlying the Labour Relations Act are "... to advance economic development, social justice, labour peace and the democratisation of the workplace" (Finnemore 1996: 150). This is achieved by ensuring that the employment relationship between employer and employee is fair, by affording rights and obligations to both parties. Employees are given freedom of association in unions, which are also bound by rights and obligations and are included in the employment relationship. The major role of the union is to protect the rights of the employee and job applicants seeking employment and to promote collective bargaining and employee participation (Finnemore 1996: 150).

In order for the nursing profession to benefit from the Labour Relations Act, the Nursing Act (Act 50 of 1978), which enforced nurse's membership of the South Africa Nursing Association (SANA) and prevented union membership, had to be repealed. The Nursing Act was amended (Act 50 of 1978 as amended by Act 21 of 1992), which afforded freedom of association to nurses. The Nursing Act was further amended (Act 50 of 1978 as amended by Act 145 of 1993) to permit the dissolving of SANA. After a lengthy consultation process with the members of the association, it was decided that the role of SANA should change to that of a professional association and union with the resultant adoption of the name, Democratic Nursing Organisation of South Africa (DENOSA) (Geyer 1999).

Nurses, who were previously denied access to formal industrial relations structures, are affected by the Labour Relations Act (Act 66 of 1995) as it provides a vehicle for collective bargaining, employee participation, as well as the ability to strike, as long as essential services for the community are maintained (Geyer 1999). This is in contradiction to the earlier policy statement issued by SANC (1994) on the "Rights of the Nurse" (cited by Kotze 1997: 52). SANC, from its position as the representative professional council, produced the policy statement, which excluded the right to strike as well as the right to withdraw services from patients in order to negotiate in a dispute between the employer and the nurse. The withholding of services from a patient was considered a breach of contract, which constituted unethical behaviour (Kotze 1997: 52).

These changes, together with the fundamental rights of the individual enshrined in the constitution, have resulted in nurses being made more aware of their rights as citizens, employees and nurses (Kotze 1997: 51). This has challenged the relationship of the nurse to the nurse manager. Nurse managers are reported to feel dis-empowered by the legislation, because they have little knowledge and understanding of the legislation (Geyer 1999). These feelings of empowerment of employees and dis-empowerment of managers are consistent with those felt by managers in other industries and sectors (Nell 1999).

2.5.2. The Basic Conditions of Employment Act of 1997

This act sets out the minimum conditions of employment. The aim of the legislation is to promote fair labour practice by establishing and enforcing basic conditions of employment as stipulated in the Constitution. The Basic Conditions of Employment Act of 1982, excluded state and other employees from the jurisdiction of the Act (Bendix 1996: 139). The Basic Conditions of Employment Act (Department of Labour Act 75 of 1997) however, ensured that state employees are also covered by this legislation (Geyer 1999).

Provisions are made in the Basic Conditions of Employment Act (Act 75 of 1997) for hours of work, overtime and overtime pay, work on Sundays and public holidays, contracts of employment and the termination thereof, annual and sick leave, protection from victimisation of employees as well as the requirements of record keeping by employers. An important aspect of this Act is that failure of employers to comply with the provisions as laid down in the Act, is a criminal offence (Finnemore 1996: 153,154; Bendix 1996: 140-144).

The major implication of this legislation on the public sector has been the financial cost, with the health and police services being particularly affected. The requirement to pay employees for work carried out on Sundays, public holidays and overtime has been chiefly responsible for the increased cost. An additional requirement is the obligation to pay employees, who have resigned, for leave not

taken (Paton 1997: 2). The main impact for nurses has been the effect on the shift system by which nurses used to work seven nights on and take seven nights off. The new legislation requires that nurses work a maximum of five nights on duty and are then required to take a break (Geyer 1999).

This legislation has affected nurse managers by limiting flexibility and placing pressure to cover shifts with the corresponding increase in cost brought about by the payment schedule for public holidays, Sundays and overtime. Nursing agencies, who were previously viewed as employment brokers, are now required to register as employers and offer the same benefits and procedures to employees as traditional employers (Geyer 1999).

2.5.3. The Employment Equity Act of 1998

The fundamental principle underlying this legislation is to achieve equity in the workplace. This is to be attained by promoting equal opportunity and fair treatment for all employees while at the same time redressing the disadvantages experienced by certain designated groups and implementing affirmative action. The designated groups include all people of colour, women and those with disabilities. Another aspect of the legislation is that no unfair discrimination is permitted in any employment practice or policy (Joubert, Hendrikse and Associates 1998: 3; Healy 1999: 1).

This legislation (Act 55 of 1998) challenges the previous mechanisms used to appoint and promote staff which emphasised the appointment of the best person for the job or the promotion of employees with long service. The criteria for finding a suitable candidate has been expanded from formal qualifications to include prior learning, relevant experience or the capacity to acquire, within a reasonable time, the ability to do the job. Implementation therefore requires that the minimum skills, knowledge and attitudes for each position are carefully reviewed and documented (Joubert et al. 1998: 6).

Nurses have developed a culture of 'always learning', which has its origins in the practice of rewarding learning with salary adjustments. While the practice of monetary rewards has stopped, the culture of learning is still present and additional qualifications are viewed as a means of promotion and/or improved status within the organisation. The 'learning' focuses on the achievement of qualification rather than the utilisation of the competency, with no ongoing review and has resulted in many nurses having qualifications that have never been used (Geyer 1999).

2.6. THE FIRST-LINE NURSE MANAGER

2.6.1. The role of the first-line nurse manager

Many different titles have been used for the first-line managers, the North American literature refers to Head Nurse, Nurse Unit Manager, Nurse Manager, Unit Director, Co-ordinator and Patient Care Co-ordinators (Duffield 1991: 1247; Del Bueno, Chaney, Snyder-Halpern, Hoidal, Kotal 1990: 5; Weaver, Byrnes, Dibella, Huges 1991: 33; Hodges et al. 1987: 41); In the United Kingdom the terms Ward Sister, Ward Manager, Nursing Manager and Unit Manager are used (Duffield 1991: 1247; Balogh, Bond 1993: 7); Australia refers to Unit Manager, Charge Nurse or Charge Sister (Duffield 1991:1247); Israel uses the title Unit Head Nurse. (Bergman, Strockler, Shavit, Shron, Feinberg, Danon 1981: 248; Bergman, Strockler, Shavit, Shron, Feinberg, Danon 1981: 123;); In South Africa the title Senior Professional Nurse (SPN), Nursing Service Manager, Head Nurse and Charge Nurse are commonly used (Booyens 1991: 39; Oosterhuizen 1998: 18; Alexander 1998). Del Bueno et al. (1990: 5) comments that the variety of titles used for the first-line nurse manager position reflects the confusion and diversity of expectations associated with this role.

Published research has not been able to establish consensus on the work of the first-line nurse manager because of inconsistent reporting of research methods and results, as well as differences in research design, instrumentation and sampling techniques (Carroll, Adams 1994: 16). Research designs range from anecdotal

case study reports (Johnston 1983, cited by Carroll et al 1994: 16; Del Bueno, Walker 1984, cited by Carroll et al 1994: 16), to comparison of functions and responsibilities within a defined health care system (Beaman 1986: 6-9; Dienemann et al. 1992: 40-45). Other research designs range from quantitative surveys (Hodges et al. 1987: 39-44), to ethnographic analysis (Everson-Bates 1992: 32-37). Methods used to evaluate work function range from questionnaires (Beaman 1986: 6-9), to checklists of competencies (Duffield 1989: 997-1001) and the use of semi-structured open-ended interviews (Everson-Bates 1992: 32-37). Sampling techniques include panels of experts (Duffield 1993: 227-237) as well as formal and informal work sampling (Johnston 1983, cited by Carroll et al 1994:16; Del Bueno, Walker 1984, cited by Carroll et al 1994:16).

Carroll et al. (1994: 17), in their review of published research that focused on defining the role of the first-line nurse manager, highlighted the fact that the research "is fraught with methodological problems". The reviewers therefore focused on the least flawed studies and reached the following conclusions:

- Studies that compared the work of the first-line nurse manager in different hospital settings found differences in the perception of the role of the first-line manager.
- Lists of tasks, functions and competencies that reflect existing practice were produced by descriptive studies.
- Ethnographic analysis identified the change of focus of the position from task to process and technical management skills to interpersonal skills (Carroll et al 1994: 17).

"In the past, the primary responsibilities of the nurse manager were clinical, management skills were secondary" (Mark 1994: 48). The old style ward sister was responsible for all the diverse forms of patient care and the socialisation of student nurses (Roscher 1980: 3), the quality of patient care was considered of greater importance than the ability to administer the ward. The patient care focus was because the management of resources fell under the responsibility and authority of higher management levels (Searle 1980: 4).

The more recent development of the role of the first-line nurse manager has resulted in an expansion of the functions of this position from a narrow unit-based head nurse model to a position with 24-hour responsibilities for one or more units or programmes. (Mark 1994: 48; Phillips, Carson, Huggins, Wade 1993: 28). The expanded functions imply that the responsibility for the unit is located in the position whether the manager is on duty or not. The first-line nurse manager is now seen as a pivotal leadership position, which focuses on administration of quality nursing services, within an organisation (Eubanks 1992, cited by McGillis Hall et al. 1997: 15; Alidina, Funke-Furber 1988: 34). Dieneman et al. (1993: 17) describe the nurse unit manager as a person who supervises those who provide the direct patient care at the same time being responsible for the overall functioning of the unit. A unit on the other hand is described as a cost centre, with a defined staff and space within a health service (Dieneman et al. 1993: 17). The first-line nurse manager has therefore been afforded the authority and responsibility for the management of all the resources within a designated area (Dieneman et al. 1993: 17).

The importance of the first-line nurse manager position has been further emphasised by Stevens (1980: 213) who believes that it is the position where administrative plans are converted into action. Furthermore if the first-line nurse manager fails, all higher level planning becomes meaningless.

Most changes in the role and the importance of this position have occurred as a result of organisational and structural changes. Other contributing factors include changes in the delivery of health care, which have had a direct impact on nursing structures and nursing management roles and functions (ICN 1990: 3; Del Bueno et al. 1990: 5). In South Africa the role changes have been brought about by the adoption of the PHC approach that uses a decentralised management structure and the democratisation of labour relations with the adoption of the new labour legislation. (Department of Health and Social Services 1995: 11; Finnemore 1996:48).

The role of the first line nurse manager is also seen as a role that suffers from the 'disease of middle-ness' (Darling, McGarth 1984, cited by Sanders, Davidson, Price

1996: 42). The middle role, which is considered to be the most difficult of all the managerial positions, requires the person to be both player and coach. The coach component requires a broad overview and the player component requires detailed knowledge and the ability to be directly involved (Uyterhoeven 1989, cited by Sanders et al 1996: 42).

A number of key management functions have been identified by Henry Lorensen, Hirschfield (1992: 2), which includes planning, organising, operating and evaluating the people and programmes within a given environment. Hendry, Hamar, Lorensen (1995: 14,15), define management as “planning and obtaining human and material resources and administrating them effectively”. This definition is consistent with the key functions of the role being cited as patient care, human resources, operational and fiscal management. (Buehlein-Telutki, Bilaky, Merrick, Reich, Stein 1993: 49).

Stevens (1974, cited by Duffield; 1991: 1247), describes the role of the first-line nurse manager as the balance between “...the use of self, use of staff and the use of delivery systems”. Interpretations of this broad definition of first-line nurse managers vary. Therefore, in order to create the boundaries for this role, authors have described the role within the context of a defined health care system in specific countries, for example; Israel (Bergmann et al. 1981: 123-127), India (Esau 1986, cited by Duffield 1991), Korea (Kim 1976, cited by Duffield 1991), America (Beaman 1986: 6,7), and Australia (Duffield 1994: 63) or more specifically in single hospitals (Duckett, Brunette 1985: 6). A contrasting approach is the use of a generic model that can be applied in any hospital or health system (ANA 1995: 8,9; ANA 1978: 6; Ferguson, Brunner 1982, cited by Duffield 1991: 1247,1248).

Whether these different approaches have any effect on the final definitions of the role of the first-line nurse manager is questionable. Duffield (1991: 1248) evaluates the different approaches and makes the point that there are few differences in the functions and roles as developed using either a defined health care system or a generic approach.

2.6.2. The first-line nurse manager's span of control

Span of control refers to the number of people reporting to a manager. It is considered an important management concept because it determines the structure of the nursing division and has financial, human resource and quality of care implications. General management literature reflects the span of control as five to seven subordinates reporting to one manager. Alidina, Funke-Funke (1988: 35) challenge this viewpoint and reflect that the span of control, in nursing, is influenced by a number of factors and by understanding these factors, the span of control of the first-line nurse manager can be optimised:

2.6.2.a. Patient Profile:

Patient characteristics influence the span of control of the nurse manager e.g. type of illness, the degree of complexity and duration of care. Emergency wards would require a smaller span of control because of the acuteness of the patients condition, the immediacy of decisions which requires more co-ordination of health professions and a high level of patient turnover. (Alidina et al. 1988: 35). Community health services would therefore require a larger span of control because the services focus on the prevention, promotion and maintenance of health with limited curative service (Department of Health and Social Services –Western Cape 1995: 19).

2.6.2.b. Manager's Profile:

"The skills, experience and training of the nurse manager influences their supervisory capacity" (Alidina et al. 1988: 35,36). Nurse managers with job knowledge and appropriate training are capable of supervising a larger number of subordinates (Booyens 1996: 148). Changes in the manager's role that afford the manager greater authority and responsibility will not only require additional training, but also a smaller span of control while they gain the necessary experience (Department of Health and Social Services – Western Cape 1995: 31).

2.6.2.c. Job related factors:

The similarity of jobs requires a wider span of control than jobs that are dissimilar (Booyens 1996: 147). The greater the difference of the tasks performed, the more time is spent in co-ordinating and less in supervising (Alidina et al. 1988: 37). The integration of vertical programmes and the development of a generalist approach in community health nursing have increased the similarity of the jobs performed by the staff (Department of Health and Social Services – Western Cape 1995: 18; Kaiser, Rudolph 1996: 157). Conversely the adoption of the PHC approach has expanded the services using an inter-sectoral and multi-disciplinary approach requiring managers to co-ordinate the different services (ANC 1994: 21; Slabber 1992: 388).

2.6.2.d. Support Systems:

The amount of support staff and the extent of delegation of responsibilities can broaden a manager's effectiveness. (Alidina et al. 1988: 37). This was confirmed by a research study that assigned clerical tasks to an administrative assistant and the nurse manager was able to dramatically shift from focusing on clerical to clinical activities (Bassler, Goedde 1993: 64). The resources available within organisations as well as the "the existence of policies, procedures and systems for the provision of patient care simplifies a nurse manager's job" (Alidina et al. 1988: 37) and enables a wider span of control (Booyens 1996: 147; Bouwer et al. 1997: 126). Duffield (1992: 49) confirms this by stating that the effectiveness of the first-line nurse manager is dependent on a good managerial infrastructure that offers support.

2.6.2.e. Employee Profile:

The extent of staff mix, i.e., professional versus non-professional, level of training and competence are also considered important. It has been found that the higher the level of education the greater number that can be supervised, with professional staff not needing close supervision (Alidina et al. 1988: 37). Mintzberg (1998: 146) confirms this by reporting that

professionals require little direction and supervision, but do require protection and support. CHC's incorporate the use of professionals, students and non-professionals. The non-professionals include the Community Health Worker (CHW) who helps to bridge the gap between the health service and the community (Clarke 1992: 118). Both the non-professionals and students require closer supervision than skilled professionals (Booyens 1996: 147).

2.6.2.f. Nursing Care programme:

The different nursing care delivery systems will affect the nurse manager's span of control. For example in primary care nursing, " the professional nurses whose judgements are critical to the quality of patient care" (Alidina et al. 1988: 36). The nurse manager will have a smaller span of control because of the greater involvement in professional nurse evaluation and competency assessment.

2.6.3. The scope of practice of the first-line nurse manager

The scope of practice of the first-line nurse manager relates to the extent that the person is involved in management and/or direct patient care. There is divergent opinion as to whether the position is purely management or management and clinical.

Organisations that propose a purely management role for the position, are reported to use either nurses (Carr 1982a, cited by Duffield 1992: 39) or non-nurses as unit managers (Carruthers 1983: 53; MacDonald 1987: 53). The more common approach however is for nurses to manage nurses (Rawson 1986, cited by Duffield 1992: 40). Some authors propose a nurse manager with no clinical role (Castledine 1996:312).

Another approach proposes the blending of care management and nurse management roles (Duffy et al .1989: 17; Bray 1981: 9; Phillips et al. 1993: 26). The adoption of the blended role raises the question as to the extent to which the

first-line nurse manager is involved in providing direct patient care and the factors that influence the level of involvement (Kramer 1990, cited by Duffield 1992: 39). Nurse managers in community health centres are reported to spend more time on direct patient care than nurse managers' working in hospitals (Dienemann et al. 1992: 43). However, the factors that influence the degree of involvement are the span of control, the size of the unit, the degree of decentralisation within the organisation, the philosophy of the organisation as well as the extent to which the nurse manager wishes to remain a practitioner.

The number of people reporting to a nurse manager i.e., the span of control, directly impacts on the manager's scope of practice. The smaller the unit the fewer the staff reporting to the manager the greater the nurse manager would be involved in direct patient care (Barrett 1990, cited by Mark 1994: 52). Conversely, the larger the unit, the greater the number of staff and the greater the management role, with corresponding reduction in involvement with direct care (Booyens 1996: 148).

The degree of decentralisation of nursing organisational structures also impacts on the extent to which the nurse manager is involved in patient care. The more the financial, operational and human resource management functions are devolved to the unit manager, the greater the management role and the smaller the patient care role. Conversely, the more the management functions are retained by higher levels of management, the greater the nurse managers' involvement in direct patient care (Duffield; 1992: 39; McGillis Hall et al. 1997: 15, Alexander 1998).

The philosophy of the organisation determines the extent to which managers are involved in patient care, by defining the structures within which such care is provided (Rotkovitch 1983: 16).

Each manager individually determines the extent to which they wish to be involved in direct patient care. The traditional route of rewarding clinical nurses by promoting them to the first-line manager position not only reinforces the blended role approach, but also ensures a high level of involvement in direct patient care (Phillips et al 1993: 26). Stevens (1980: 219) reports however, that not all people are able to blend both roles.

Excellence in direct patient care helps nurse managers as it is a source of power to influence as well as a source of judgement for quality of care (Calkin 1982: 33). The nurse managers with relevant management knowledge and experience will be better able to adjust to the blended role (Alexander 1998).

2.6.4. Factors that influence the first-line nurse manager position

Duffield (1991: 1247-1251) and McGillis Hall et al (1997: 14-30), while reviewing the literature on the subject of first-line nurse managers identified decentralisation as having a significant impact of the role and function of the first-line nurse manager. Decentralisation refers to the delegation of responsibility and authority with the corresponding accountability for all aspects within the unit/s. Decentralisation of organisational and nursing structures forces the first-line nurse manager to become more of a manager than clinician (Newchurch and Co, cited by Edmonstone 1998: 22; Mark 1994: 48; Del Bueno et al. 1990: 5).

Human resource management now forms a major part of the functions of this position (Chase 1994: 61; Weaver et al 1991: 36) and involves the recruitment and selection of staff, staff job satisfaction, including the quality of the worklife of staff (Hodges et al. 1987: 43; Mark, 1994: 52; Frisch, Dembeck, Shannon, cited by McGillis Hall et al. 1997: 15). Reports indicate that nurse managers holding this position have a direct impact on staff wastage and rates of staff turnover (Duffield; 1992: 50), which in turn impact on patient care (Kerfoot, Neuman 1992: 424). The nurse managers' behaviour also influences job satisfaction, productivity and organisational commitment of those working in the unit (Flarey 1991: 41). This was reported to be particularly evident when managers recognised good work, were supportive of staff, showed ability to solve problems and deal with conflict on the unit (Mc Neese Smith 1997: 53).

Decentralisation is reported to have had an influence on the management style of the first-line nurse manager. These trends are listed below.

- The move from a responsive to pro-active management (Blake et al 1982: 310).
- Supervision of staff is replaced with participatory decision-making (Hodges et al 1987: 39).
- The use of motivational and problem solving techniques (Blake et al 1982: 314; Chase 1994: 58).
- Greater emphasis on team building and communication (Chase 1994: 58; Everson-Bates 1992: 35).
- Being able to facilitate change management (Chase 1994: 58; Everson-Bates 1992: 34).
- Vertical hierarchies are replaced with horizontal spans of control and management (Kerfoot 1993: 49)

The above trends in management style reinforce the argument that the position has moved from a clinical focus to a management focus (Mark 1994: 48).

2.6.5. Managerial competencies of the first-line nurse manager position

The terms 'competency' and 'skill' are used interchangeably in the literature. Goodrich (1982, cited by Duffield 1989: 997), defines competency as the ability to perform, at least adequately, in a defined situation. Sheridan, DiJulio, Vivenzo, McGarth, McKinley-Cole (1984, cited by Duffield 1989: 997), defines skill as the ability to use knowledge in performance. "Competencies are derived from an assessment of the knowledge, skills, and attitudes needed to perform in a professional role" (Broski, Alexander, Brunner, Chidley, Johnson, Karas, et al. 1997: 39). Competencies are therefore stated in behavioural terms and if a first-line nurse manager is able to adequately perform against pre-set criteria, the nurse manager would demonstrate an acceptable standard of competency (Sheridan et al. 1984, cited by Duffield 1989: 997; Broski et al. 1997: 39). Mulholland (1994: 161), expands the concept of competency to include "the ability to transfer skills

and knowledge to a new situation within an occupational area". Katz (1974: 91) believes that skills can be developed and are not necessarily inborn and are "manifested in performance, not merely potential". Jameton (1984, cited by Duffield 1991: 56), states that "to function competently, the role and scope of practice must be congruent with the individuals skill for the job."

Katz (1974: 90) was instrumental in shifting opinion to what constitutes a good manager away from personality traits to the observable skills demonstrated by the manager. Katz created the link between knowledge and practice by defining skill "as an ability to translate knowledge into action" (Katz 1974: 94). This approach involved the identification of the observable skills and dividing these skills into three distinct categories. The skill categories were called technical, human and conceptual and constitute the framework to determine the hierarchy of management and management skill mix:

- **Technical skill:** "...an understanding of, and proficiency in, a specific kind of activity, particularly one involving methods, processes, procedures, or techniques" (Katz 1974: 91).
- **Human skill:** primarily focuses on working with people. This skill is recognised by the way in which an individual perceives or relates to others of the same or different levels of management on an individual or group basis (Katz 1974: 91).
- **Conceptual skill:** involves the ability to view the organisation as a whole and being able to see how the different parts relate and the mutual dependence of the parts (Katz 1974: 93).

Technical skills, involve the ability to apply specialised knowledge, are of greatest importance at the entry-level management. At senior management level, technical skills become less important provided the manager has skilled staff (Katz 1974: 91). Human skills, which focus on the ability to work with, understand and motivate both individuals and groups, are essential at all levels of management. However, they are considered most important at the entry-level management where contact between the different management levels and subordinates are greatest (Katz

1974: 95). Conceptual skills involve the ability to analyse and diagnose complex situations, increasing in importance at the higher levels of management (Katz 1975: 96). Guglielmino (1979: 12) confirmed this theory and found that the skill mix of first-line managers was 47% technical, 35% human and 18% conceptual.

Duffield (1994: 66), identified 156 competencies, from an initial list of 168, expected of first-line nurse managers in New South Wales, Australia. The 156 competencies were classified using Katz's (1974: 91-93) classification scale, which resulted in 49% being technical, 34 % human and 17 % conceptual. Duffield was able to conclude that the higher percentage of technical skills was consistent with Katz's definition of first-line managers. The high percentage of human skills supported Katz's belief that the position requires more personal contact than other levels of management.

Duffield (1989: 997), whilst reviewing the literature pertaining to first-line nurse managers highlighted the fact that few studies have focused "...on the role as it is and the requisite skills needed to perform" the role.

The following studies have focused on identifying the managerial competencies:

- Beaman (1986: 8) carried out a study in acute care hospitals in Los Angeles County, California, to identify the managerial tasks expected of first-line nurse managers. A list of 31 items was generated. The items were later grouped together according to similarity, which resulted in a composite list of 19 tasks.
- Chase (1994: 56) carried out a study to identify the behavioural competencies that were considered important to the effectiveness of first-line nurse managers in hospitals. Katz's three skill approach of technical, human and conceptual was used and expanded to include leadership and financial. Fifty-three competencies identified in the literature were rated on two scales namely: "need for knowledge and understanding" and the "ability to implement and/or use" the skill (Chase 1994: 58). The results identified human and leadership competencies as the most important with financial, technical and conceptual competencies being ranked lower.

- In another study in Australia, Duffield (1989: 999) identified the twenty most important competencies of first-line nurse managers. The results highlighted the fact that two of the three most important items ranked related to patient care. Items related to structuring of the workplace were ranked second. Duffield concludes that the most important items chosen reflected the health care trends in Australia and that further study was required to establish if the identified competencies were reflected in the currently performed functions of the first-line nurse manager.

These authors have identified the competencies required for the position, which are used to describe the responsibilities or characteristics of the nurse manager. These studies were also carried out in Australian and American hospitals and may not reflect the nature of issues in community health centres in South Africa.

Katz's classification framework focuses on the hierarchy of management by associating different skill mixes to different levels of management. While the tendency to examine nurse managers in relation to these skills remains evident in published research, the focus of the studies have changed so that the competencies that are identified are used to define the role rather than the management level (Duffield, Donoghue, Pelletier 1995: 18-21).

Mintzberg (1975: 49-61) used observable behaviour to determine management roles and identified ten inter-related roles attributed to managers. The extent to which the ten managerial roles formed part of the position was dependent on the position itself and the prevailing circumstance (Mintzberg 1993, cited by Bouwer, Dreyer, Herselman, Lock, Zeelie 1997:135). These ten roles are concerned with interpersonal relationships, transfer of information and decision making. The interpersonal role included figurehead, leadership and liaison activities. The information role included monitoring, disseminating and spokesperson activities. The decisional role included those that of entrepreneur, disturbance handler, resource allocator and negotiator (Mintzberg 1975: 54-59).

Applying Mintzberg management roles to the management of comprehensive health care systems in South Africa, the roles were found to be relevant. The roles found to be of particular importance were leader, entrepreneur and negotiator (Bouwer et al. 1997: 135).

2.6.6. Factors impacting on the effectiveness of the first-line nurse manager

The literature describes many different and varying factors influencing this effectiveness. The transition from care provider to decision maker has been cited as a factor causing first-line nurse managers to experience role conflict and role confusion (Donner, Wylie 1995, cited by McGillis Hall et al. 1997: 20). The person in the position has to balance the demands of management, the workforce and the requirements of the job (Sasser, Leonard 1980: 113). The need to be credible with the staff, under his/her supervision and management, as well as to those to whom he/she reports, has been identified as one of the causes of role conflict (Swaffield 1987: 25). Another cause is the reducing budget, which has resulted in quality of care being determined increasingly on the basis of cost and not need (Singh 1998: 1, AONE 1993: 26).

Robbins (1993: 297) defines role conflict as “ a situation in which an individual is confronted by divergent role expectations”. First-line nurse managers experience confusion about whether their role also includes direct patient care. Duffield has noted that with the introduction of the clinical nurse specialist, clinical expertise is no longer relevant in the first-line nurse manager’s role, due to role overlap (Duffield et al. 1994: 63). Other authors note that direct patient care is self-affirming for first-line nurse managers, while administration is associated with physical and emotional stress (Westmoreland 1993: 61; Sanders et al. 1996: 45; Donner, Wylie, cited by McGillis Hall et al. 1997: 21). These attitudes reflect an immaturity amongst the nurse managers who need to be self-affirmed by their patients. Maslow’s hierarchy of needs would place these attitudes within the social category of needs (Robbins 1993: 206). Madden and Manthey (1987, cited by Phillips et al. 1993: 27) state that many nurse managers believe that “...clinical means their own hands-on patient care and managerial means paperwork”. They challenge this way of thinking and propose that nurse managers view clinical skills, within the context of management, as the “overall quality of hands-on care provided by staff” and managerial skills as “the ability to get things done through people”. The problem of role conflict is further aggravated by the fact that nurses are often promoted into the first-line manager position because of clinical expertise and efficiency rather than management skills (Hodges et al. 1987: 40). The criteria of

formal education, professional experience and technical expertise are traditionally used for the promotion of nurses to managers. A pilot study found that qualities like self-confidence, high achievement orientation, analytical thinking and persuasive skills were more important determinates of success (Dubnicki, Sloan 1991: 40).

De Bueno et al. (1990:5), state that the “skills and knowledge previously acquired and mastered are often not relevant for first-line management positions” Lees (1980: 215,337), suggests that many nurses are inadequately prepared by their previous experience to carry out these new roles. Dysfunctional attitudes from student nurse training carry over into their managerial work. These attitudes include the tendency of student nurses to be encouraged to accept authority uncritically, to follow rituals and practices without question and to emphasise nursing solidarity (Blake et al. 1982: 311). Lees (1980: 215,337) believes that these attitudes may prove a handicap in producing managers who are able to encourage staff innovation and development.

Managers experience difficulty changing when they work in an environment, “which encourages compliance and responses diametrically opposite to those currently desired” (Maddock 1999: 38). The effects of an oppressive work environment on staff and working habits impact on the managers' ability to take initiative (Maddock 1999: 38).

Gender role socialisation also severely impacts on the development of leaders, by assigning certain personality traits, based on gender, thus women are expected to be passive, subjective and tender as opposed to men who are expected to be aggressive, objective and dominant (Hardy 1984: 12). Many traditional cultures have socialised women as humble and deferential beings. The response of women to this powerlessness has been to avoid confrontation and responsibility by appearing to be humble and helpless (Maddock 1999: 46). Hardy (1984: 12), believes that gender role socialisation is reinforced in nursing by senior nurses who have gender role expectations that are projected onto students; the teaching methods tend to discourage questioning and thinking and that students accordingly develop a desire to be liked and accepted by seniors and colleagues.

Mintzberg (1994: 31), however believes that nursing, unlike medicine, is management and that, "nurses may, in fact, move more easily into management and often make better and more natural managers than doctors because of their predisposition to a caring approach". The nurse's role, which is to provide nursing care for patients and the management of nursing, reflects this (Armstrong 1993: 11). Hancock (1989: 106), confirms this by stating that, "nursing in fact is a paradigm of general management, a model of what general management means". This concept has been incorporated in England where qualified nurses are referred to as managers of care (Department of health and Social Services 1991, cited by Mulholland 1994: 163).

Goleman (1998: 94) highlights the fact that different leaders have different ways of directing a team and different situations call for different types of leadership, but all effective leaders have a high degree of emotional intelligence. Emotional intelligence comprises self-awareness, self-regulation, motivation, empathy and social skill. Research and practice demonstrate that not only is there a genetic component to emotional intelligence, it can be learned with nurturing and maturity playing a role (Goleman 1998: 97). Nursing is a nurturing role and women by their very biological nature are brought up to nurture. These two factors would tend to imply that nurses could have a high degree of emotional intelligence, which might lead to leadership skills. Emotional intelligence would register high on Maslow's hierarchy of needs, whereas the need for patient self-affirmation would be lower (Robbins 1993: 206).

Insufficient supervision, guidance and support is available to managers with many having to learn the skills required for the position on the job (Blake et al. 1982: 311; McSherry, Browne 1997: 70). This is reported to be particularly evident when organisations are restructuring as the resultant pressures often hamper proper consideration for the revised role of the first-line nurse managers (Carruthers 1983: 53). The organisation must have a good management infrastructure that offers support, if the first-line nurse managers are to be effective (Duffield 1992: 49).

The restructuring of organisations not only changes the work, but also how the work is organised. Long-term job security is replaced with part-time or contract

work and positions are declared redundant, causing employees to have to either lose their jobs or move into unfamiliar jobs. The first-line nurse managers find themselves “in the middle, balancing organisational demands and staff needs” (Donner, Wheeler, Waddell 1997: 14).

2.6.7. Management training of first-line nurse managers

The need for management training that focuses on the different levels of management (Henry, Lorensen, Hirschfeld 1994: 155) and within the context of the overall health system is advised (Hendry, Lorensen, Hirschfeld 1992: 11). There is no definite academic preparation for this role in nurse management training (Bray 1998, cited by Del Bueuno 1990: 5). The expectations of the position far exceed the preparation of a nurse in management education and the need for a curriculum, at graduate level, specifically designed to prepare first-line nurse managers, is considered a more cost effective approach (Hodges et al. 1987: 43).

Henry (1989: 6), in reviewing the nursing administration education in America stated that “nurses were not educated to cope with the problems of providing health services in complex organisations, or to consider themselves accountable for the costs of the care”. There is general agreement that nurse managers have inadequate educational preparation for a management role (Duffy et al. 1989: 17). Education has traditionally focused on primary patient care and clinical issues. Nurse managers need a more global understanding of issues surrounding the health care system, more leadership and administration skills (Kalo, Jutte 1996: 86; Gluck, Charter 1980, cited by Adams 1991: 16). This view is confirmed by Beyers et al. (1996: 9), who states that managers should have a better understanding of the extent of change required in the nurses role to meet the expectations of care of patients, family and the community.

A study among nurse leaders in PHC found there was a gap between the management knowledge and skills required and what was currently held by the incumbents (Lorensen, Lichtenberg, Sinkkonen, Jensdottir, Hamram, Engfeldt,

Johansson 1997: 9). The study was repeated in the Nordic countries with the same results (Lorensen, Engfeldt, Hamram 1997: 3). A process of providing continual assessment against the required competencies is considered an effective way to not only determine a performance baseline for the position and the manager, but also to act as a vehicle for continuous learning (Anderson, McCafferty 1996: 3)

Some institutions have developed management-training programs to prepare first-line nurse managers to assume their new role (Hodges et al. 1987:39). Bevan (1982: 1487) challenges the viewpoint that sending nurses on first-line manager training will make competent managers. In order for training to be effective, senior nurse managers need to be involved in the training programme and the working environment must be supportive by encouraging those in training to apply their learning, monitored by the senior nurse managers. Klemp (1997, cited by Maynard 1996:14) confirms this by emphasising the point that skills obtained during the educational experience does not guarantee competence in the work environment. Competence is initiated by the education process and developed through experience.

2.6.8. License to practice as a registered nurse manager

The existing mechanism for defining professional performance is the licensing or registration system. In the United States of America (USA), individual states control the licensing procedure and proof of license is required for use of the title "registered nurse" (Scrima 1987: 41). In South Africa, SANC, through the Nursing Act (Act 50 of 1978 as amended by Act 94 of 1991, Act 21 of 1992, Act 145 of 1993, Act 5 of 1995 Act 19 of 1997, Act 35 of 1999) controls the licensing of nurses, using the same requirement to use the title "registered nurse".

Speciality practice has developed as technology and skill requirements have increased. The method for certification seems to vary. In the USA, non-governmental agencies like the American Nurses Association (ANA) are responsible for predetermining standards for speciality practice and awarding appropriate accreditation (Scrima 1987: 41). In South Africa, speciality practice is

also controlled by the SANC through the Nursing Act (Act 50 of 1978 as amended by Act 94 of 1991, Act 21 of 1992, Act 5 of 1995 Act 19 of 1997, Act 35 of 1999).

There is much debate as to the value of a one-time licensing system for nursing practice, as the system neither promotes continual learning nor does it ensure that the appropriate knowledge, skills and attitude are present to enable the professional to perform the required role (Scrima 1987: 42). The SANC are currently reviewing the one-time licensing system, but it is unclear at this stage as to the new format (Geyer 1999)

Nursing Administration/Management is a specialist course offered in most countries, yet nurses promoted into positions of management are not always required to be licensed accordingly or to have acquired any other management training (Alexander; 1998).

2.7. CONCLUSION

It is clear from the literature, which mainly focuses on hospitals within a first world environment that the role of the first-line nurse manager is changing and will continue to change in a dynamic health environment. The first-line nurse manager has been reported to play a pivotal role in ensuring quality of care as well as influencing the quality of worklife experienced by the staff that she/he manages. The circumstances around community health within South African nursing may not reflect the same trend and this research is being carried out to identify the trend within these circumstances.

Chapter 3

Research Design

3.0. INTRODUCTION

This chapter describes the aims and objectives of the study. The research design and methodology used in the study is discussed, including the development of the questionnaire, the pilot studies as well as the procedures used for each round of the research process. The criteria used for establishing consensus and how these criteria were applied to this study are also described.

3.1. AIMS AND OBJECTIVES

The aim of this study was to create an understanding of the role and function of the first-line nurse manager of Community Health Centres within the changed health care environment in South Africa. In order to achieve this goal a consensus seeking research design was required.

The objectives of the study are:

1. To identify the role competencies expected of first-line nurse managers in Community Health Centres in South Africa.
2. To provide recommendations for the training of the first-line nurse manager based on the identified role competencies

3.2. METHODOLOGY

3.2.1. Consensus-seeking research methods

Four different consensus-seeking methods were identified and each was evaluated to establish appropriateness for this study. The consensus methods identified were Nominal group technique, Glaser's state-of-the-art approach, Schutte Scale needs assessment technique and the Delphi technique.

3.2.1.a. Nominal group technique

Nominal group technique is "A group decision making method in which individual members meet face-to-face to pool their judgements in a systematic but independent fashion" (Robbins 1993: 351). This technique restricts discussion during the decision making process. The need for the participants to meet and the lack of anonymity are considered limitations to the method.

3.2.1.b. Glaser's state-of-the art approach

Glaser's approach involves the researcher inviting a core group to participate, and this group in turn nominates others. The group produces a position paper that is subjected to rounds of critiques by other reviewers. The need for participants to nominate others was considered a limitation as the process could prevent the establishment of a group with diverse opinions. The approach has also not been widely used and is considered too complex (Fink, Kosecoff, Chassin, Brook 1984: 980).

3.2.1.c. Schutte Scale needs assessment technique

A research technique whereby first-line nurse managers developed their own list of competencies was also explored. This research technique, known as the Schutte Scale needs assessment technique, was originally developed to help communities determine and prioritise needs using a developmental approach that enabled the quantification of qualitative responses (Moss 1996: 18; Snyman 1996: 14; Schutte 1995: 21). The method was considered for the following reasons:

- It would enable the first-line nurse managers to identify the required competencies rather than the competencies being identified by others.
- The competencies would be listed using familiar terminology.
- The influence of previously compiled lists would be removed.
- The interaction of the group would prevent participants listing competencies without relating them to the work environment.

The Schutte Scale technique was rejected as a data collection tool. The assumption was made that many first-line nurse managers had previously only worked in a centralised hierarchical system and would have little knowledge, experience and understanding of a decentralised system. It was further assumed that the competency list that would be generated using this technique might not reflect the changing role of the first-line nurse manager.

3.2.1.d. Delphi technique

The Delphi technique is a survey method of research that was originally developed by the Rand Corporation, as a forecasting tool. The first significant usage of the technique was during the 1950's in order to predict the effects of atomic warfare on America (Limestone, Turoff 1975: 11). The technique has developed into a means of achieving group consensus by structuring group opinion and discussion (Goodman 1987: 729; Duffield 1993: 227).

The Delphi technique has been applied to many different fields namely industry, social planning at community level, evaluation of research projects, educational innovation (Lindeman 1975: 434-441) and marketing (Nel, Pitt, Marks, Nel 1989: 2-9). In the field of nursing the technique has been used to establish nursing research priorities (Bond, Bond 1982: 565-575; Lindeman 1975: 434-441); nurses' perceptions of communication problems of cancer care patients (Hitch, Murgatroyd 1983:413-422); curriculum planning (Sullivan, Brye 1983: 187-198) and determining nursing competencies (Misener, Alexander, Blaha, Clarke, Cover, Felton, Fuller 1997: 47-51; Duffield 1993: 227-237).

Linstone and Turoff (1975: 3) characterised the Delphi technique “ as a method for structuring group communication process so that the process is effective in allowing a group of individuals, as a whole, to deal with a complex problem”. Structured communication is achieved by:

- Feedback of individual contributions.
- Assessment of group judgement.
- Opportunity for participants to revise their views.
- Some degree of anonymity of individual responses.

3.2.2. Reasons for choosing the Delphi technique

Linstone and Turoff (1974: 4) have identified a number of research issues that would benefit from using the Delphi technique and many of these factors are relevant to this study.

- The problem can benefit from collective subjective judgements rather than the use of precise analytical techniques. Collective subjective judgements were required to enable the development of a comprehensive list of competencies for first-line nurse managers as the role was in the process of being revised.
- Those required to participate have a history of inadequate communication and represent a diversity of experience and/or expertise. The nursing profession by its very nature represents a diversity of experience and expertise.
- Frequent group meetings are not feasible from a time and cost point of view. The participants would not be able to spend the amount of time that would be required, when using a group communication process, to develop a comprehensive list of competencies for first-line nurse managers, due to work pressures. There were also not sufficient funds to cover the transportation and related cost of a group communication as the research was planned as a national project over an extended time period.

- The communication process requires anonymity because of divergent opinions. The hierarchical nature of nursing reinforced the need for participants to be anonymous so that the opinions of each participant could not be influenced by the status of the other participants but rather by the opinion itself.
- Validity of the results can only be assured when the heterogeneity of the participants can be retained. Strong personalities influencing or dominating the opinion of the group, which would affect the validity of the results, needed to be prevented.

The Delphi technique was therefore considered the most appropriate, as it was a well-known approach that enabled the participants to express their views anonymously at the same time providing group generated information, from a group of experts, through a series of intensive questionnaires with controlled opinion feedback. (Loppopolo 1999: 173; Goodman 1987: 729; Duffield 1993: 228). Participants from all over the country could be used which would not only impact on the quality of the participants, but also help to ensure that the study results represent many different environments, cultures and societal issues. This in turn could enhance generalisability of the findings.

3.2.3. Characteristics of the Delphi Technique

There are four characteristic features of the Delphi technique, which distinguish it from other group consensus methods, which are:

- anonymity
- iteration with controlled feedback
- statistical group response
- expert input

3.2.3.a. Anonymity

Guaranteed anonymity of participants and their responses encourages the expression of opinions that is not affected by peer pressure or other extrinsic factors. Sackman (1975, cited by Goodman 1987: 730) suggests that

anonymity may encourage lack of accountability, with participants making snap judgements because of not being answerable for the expressed opinions. Goodman (1987: 730) believes that this is unlikely in the Delphi technique, as participants are recruited on the basis of their willingness to participate and share their knowledge.

3.2.3.b. Iteration

Iteration with controlled feedback is achieved through sequential questionnaires. Respondents receive feedback in the form of statistical mean results together with a summary of comments, following each circulation of the questionnaire. The repeated feedback enables participants to keep abreast of the collective group opinion as well as giving the opportunity to re-evaluate their viewpoint. The process of controlled feedback facilitates the development of group consensus and is considered complete when there is a convergence of opinion or until a point of diminishing returns is reached or until the changes are statistically insignificant (Goodman 1987: 730; Duffield 1993: 228; Erffmeyer, Erffmeyer, Lane 1986: 121).

A study to evaluate the optimal number of rounds to be included in a Delphi study used the premise that the number of rounds "would be the minimum number of rounds necessary to reach an acceptable level of accuracy". The recommended number of rounds was found to be four or unless the point of stability has been reached at an earlier stage (Eeffmeyer et al. 1986: 121, 126).

3.2.3.c. Statistical group response

The statistical group response provides a vehicle for feedback to the respondents in successive questionnaires. A Likert-type scale is used to enable respondents to express their opinion. Median, mean or percentage scores are calculated for the group responses and participants are able to assess where their opinion lies in relation to that of the whole group (Goodman 1987: 730).

3.2.3.d. Expert Input

Since there are difficulties in defining an expert and there are circumstances for which there is no obvious expert, most Delphi studies use informed advocates or individuals that have relevant knowledge on the pertinent issue. The selection criteria and procedure for recruiting participants is important for validity. If those participating can be shown to be representative or knowledgeable, content validity can be assumed (Goodman 1987: 730; Duffield 1993: 229).

3.3. SAMPLE

3.3.1. Sampling methods

In the context of research, a population or universe refers to “the total number of people, objects or events of a particular type who could be included in the study “ (Brink 1986: 16). The size of any given population is generally too large and researchers therefore use a proportion of the defined population which is called a sample. The process of obtaining the sample is called sampling, which is defined as “ the process of selecting a portion of the population to represent the entire population“ (Polit, Hungler 1983: 411).

The Delphi technique requires the sampling of experts or informed advocates. To achieve this, non-probability purposive sampling methods are used.

Non-probability sampling involves the use of non-random sampling methods (Brink 1989: 17). Purposive sampling is the method used for a special situation that includes the selection of unique cases that are considered particularly informative, the identification of cases for in-depth investigation, as well as the selection of difficult-to-reach specialised populations (Neuman 1997: 206).

3.3.2. Expert Input

Fink et al. (1984: 1981) when discussing the selection of participants recommended that participants “should qualify for selection because they are representative of their profession, have power to implement the findings or because they are not likely to be challenged as experts in the field “. These factors were taken into consideration when designing the process to be used to identify experts for the study.

Since there were no obvious experts for this study, due to the changing role of the first-line nurse manager, the researcher used informed advocates, who are also referred to in the literature as knowledgeable informants. This approach was used in accordance with Goodman (1987: 730,731), who reports that, if participants can be shown to be representative or knowledgeable, content validity can be assured.

In order to facilitate the identification of informed advocates, five response groups were identified. A number of different criteria were used to identify response groups to be considered for inclusion in the study. Different organisations were selected to meet the different criteria. Different criteria were used to identify different response groups so as to ensure a broad representation, which would facilitate the development of a representative response group.

CRITERIA REQUIRED FOR RESPONSE GROUP	RESPONSE GROUP IDENTIFIED
The organisations were required to be involved with ensuring the implementation of PHC	National Health Department Nine Provincial Health Departments
The organisation needed to be involved with implementing PHC in many different communities and be employers of nurses involved with the management of CHC's	The largest local authority in each of the nine province.
The organisations needed to be involved with the training of nurses for management	The academic institutions involved in nurse management training
The organisations needed to be involved in the setting and maintaining of nursing standards	The statutory bodies namely SANC and DENOSA.
Organisations needed to be able to implement the research findings	All organisations were in a position to meet the criterion.

Table 3.1: Criteria required for response groups and the response groups identified for the study.

The organisations were contacted and asked if they wished to participate in the study and if approval was granted the organisation was requested to nominate a person using the following criteria for selection:

- A senior nurse manager.
- Knowledge of management of community health centres.
- Have an interest in the research being carried out.

3.3.3. Response groups

The public sector was targeted for participation, because the private sector has only recently become involved with rendering Primary Health Care (PHC) services and the vast majority of the PHC services belong to the public sector.

Once the five response groups had been identified, a letter was forwarded to the departmental head of each organisation, together with an abstract of the proposed research. The letter requested that the organisation consider participating in the research by nominating a senior nurse manager using the criteria outlined in Section 3.3.2: 57. The organisation was requested to forward the name of the nominated person to the researcher by a specified date.

3.3.3.a. National Health Department

The National Health Department was contacted and asked to participate in the study by nominating an appropriate participant. The National Health Department was approached because the department had developed the vision of PHC in South Africa and as such would have understanding of the philosophy and its management. The National Health Department agreed to participate.

3.3.3.b. Provincial Health Departments

All nine Provincial Health Departments were contacted and asked to participate in the research by nominating an appropriate participant. The principle of saturation was used to ensure equal representation and thereby facilitating acceptance and implementation of the findings. These senior nurse managers were considered important to include not only because of their ability to implement the findings, but because it was assumed that they had an understanding of the vision of PHC and its management, as well as insight and experience of many different Community Health Centres. Their greater understanding of the decentralised approach that is being implemented within a district health system was another factor supporting their nomination and selection.

Of the nine Provincial Health Departments contacted one declined to participate and one did not respond to the request. At the onset of the study, there were seven nominated participants from this response group.

3.3.3.c. Academic Institutions

A list of all academic institutions involved in nurse management/administration education was obtained from the South African Nursing Council (SANC). This list however was found to be incomplete as it only included the academic institutions offering the one-year diploma course. Further contact was made with the SANC who advised the researcher that there was no comprehensive list of academic institutions that offered nursing administration /management as part of a degree. A list of universities compiled by the Forum of University Nursing Departments in South Africa (FUNDISA) was obtained from the University of Cape Town Nursing Department.

The list obtained from SANC consisted of 13 institutions of which 3 agreed to participate and 4 declined to participate and the balance (6) did not respond.

The list obtained from FUNDISA consisted of 15 university Nursing Departments, of which 5 were also found on the SANC list. Of the remaining 10 institutions, the University of Cape Town was not contacted as the research was registered with that department. Of the remaining institutions, 6 agreed to participate and 3 did not respond.

A total of nine academic institutions agreed to participate and nominate a participant. The nine academic institutions included only universities. The Nursing Colleges that were involved with management/administration training that did respond declined to participate because courses had been cancelled or because the colleges were undergoing restructuring. Technikons did not give reasons for non-participation.

The academic institutions were requested to nominate a lecturer involved in nurse management training within the context of Community Health Centres

because of their knowledge of the subject both from a local and international perspective and their ability to implement the findings within training programmes.

3.3.3.d. Statutory Bodies

SANC and Democratic Nursing Organisation of South Africa (DENOSA) were contacted. SANC was included because it is the professional governance body. DENOSA was included as it is the nursing association registered with the International Council of Nurses (ICN) as well being an industrial body. Both organisations were contacted to nominate a person with an interest in the research question.

SANC declined to participate and DENOSA was unable to find an appropriate participant at the time the research commenced. There were therefore no participants from this response group participating in the research.

Participants from this response group were considered appropriate because SANC is responsible for setting the standards for nursing practice and its participation could facilitate the implementation of the results by recommending the standards for nurse management education.

DENOSA on the other hand, as an association and industrial body would be involved with the support and advise to nurses in practice. Both institutions, however, requested that the results of the research be forwarded to them on completion of the study.

3.3.3.e. Local Authority Health Departments

The research proposal did not include this response group, which was added on the recommendation of the University of Cape Town's Ethics Committee. The research proposal was submitted for approval and the inclusion of the Local Authority Health Departments was one of the committees recommended changes.

The need to ensure that all tiers involved with implementation of PHC were included in the response groups was considered important to increase the reliability of the findings.

The largest local authority from each of the nine provinces was selected and requested to participate. The assumption was made that the largest local authority would reflect the diversity of Community Health Centres within the province.

The provincial administration health departments were contacted by telephone and asked to identify the largest local authority in each province. Four of the nine provinces reported that metropolitan councils were the overall co-ordinators of the health services in those largest cities. One of the four metropolitan councils however was not involved in health care delivery and advised the researcher which local authority to contact, within that metropolitan council's jurisdiction.

Of the nine local authorities contacted two declined to participate and seven agreed to participate.

3.3.4. Procedure used for selecting participants

Once the five response groups were identified, a letter was forwarded to the departmental heads of each organisation, together with an abstract of the research proposal. The letter requested that the organisation consider participating in the research by nominating a senior nurse manager using the criteria mentioned in Section 3.3.2: 57. Each organisation was requested to forward the name of the nominated person to the researcher by a specified date.

On the specified date, only four of the 43 organisations had responded. The remaining 39 organisations were contacted by telephone or facsimile and asked whether the initial correspondence had been received. Five organisations had not received the original letter and required the letter to be forwarded and this was

carried out by facsimile. Six organisations requested more information, which was forwarded by facsimile. Only one of these six institutions did not nominate a participant once the additional information was supplied. Much time and effort was spent to ensure that response groups were equally represented and that the provinces were represented either by the local authority, academic institution or provincial health department.

DISTRIBUTION OF PARTICIPANTS BY PROVINCE			
PROVINCE/ NATIONAL	HEALTH DEPARTMENT	ACADEMIC INSTITUTION	LOCAL AUTHORITY
National	1	1	
Gauteng	1	2	1
Western Cape	1	1	1
Eastern Cape	1		
Mpumalanga	1		1
Northern Province		1	1
Free State	1	1	1
Kwa-Zulu Natal	1	2	1
North West		1	
Northern Cape	1		1
TOTAL	8	9	7

Table 3.2: Distribution of participants by province.

Once the names of the nominated participant were received a letter was sent to each participant explaining the research process and assuring the participant of

anonymity by supplying the participant with an allocated research number. Participants were also advised that participation was voluntary and participants could withdraw at any stage of the process. All nominated participants agreed to participate.

The total number of participants at the onset of the research was 24 out of a potential 43, which represented 55.8%.

3.4. RELIABILITY

Reliability is defined as “the degree of consistency or dependability with which an instrument measures the attributes it is designed to measure” (Polit et al. 1983: 621).

“The reliability of the instrument is not the property of the instrument, but rather of the instrument when administered to a certain sample under certain conditions” (Polit et al. 1983: 386). When applying this to the Delphi technique, Fink et al. (1984: 980), state that “reliability increases with the size of the group and the number of rounds”. The problem of co-ordinating large research groups over several rounds can be very complex and expensive. Participants’ fatigue after two or three rounds is also reported to be a limitation of the Delphi technique (Starweather, Gelwicks, Newcomer 1975, cited by Fink et al 1984: 980).

A pilot study can improve the reliability of an instrument. This enables researchers to test an original instrument or use an instrument developed by another researcher and make the necessary changes to the instrument (Neuman 1997: 141).

3.4.1. Methods used to increase reliability

The questionnaire developed by Duffield (1989: 999; 1993: 229, 230; 1994: 66; Duffield et al. 1994: 55, Duffield et al. 1995: 15,16) had been used in a number of different studies related to first-line nurse managers. The repeated use of the questionnaire confirmed that the instrument measured the competencies of first-line nurse managers. (Refer to Section 3.7: 70 - Development of the questionnaire)

In order to increase the reliability of the instrument pilot studies were carried out. The pilot studies highlighted the need to change the instrument thereby increasing its reliability. (Refer to Section 3.7.1: 72 - First Pilot Study and Section 3.7.2: 74 - Second Pilot Study).

Fink et al. (1984: 980) reflects on reliability associated with the Delphi technique and states that 'reliability increases with the size of the group and the number of rounds'. The size of the response groups was increased after the second pilot study to increase reliability through the larger number of response groups and the larger number of nominated participants. The initial proposal was for the response groups to consist of nurse managers from the National Health Departments, the nine Provincial Health departments, the academic institutions involved with management training and the nursing statutory bodies. The response group was expanded to include the local authority health departments, which not only enabled a broader representation of nurse managers from different tiers of health care delivery, but also increased the number of potential participants from 20 to 43.

The number of rounds was also considered important for reliability. The research proposal projected a maximum of four rounds, but noted the need to prevent participants' fatigue. The use of at least three rounds was considered important for reliability. The results of all three rounds were evaluated against three different criteria and it was determined that consensus had been reached after the third round. A fourth round was therefore not carried out. (Refer to Section 3.9: 81 – Establishing consensus)

3.5. VALIDITY

Validity is “the degree to which an instrument measures what it is intended to measure” (Polit et al. 1983: 624).

The Delphi technique itself uses three processes that contribute to the validity of the instrument. These are iteration, anonymity of participants and selection of experts.

Iteration requires a multi-staged approach, with each stage building on the results from the previous stage (Hitch et al. 1983: 414). The anonymity of the participants and their responses is another factor, but there is a danger of lack of accountability of panellists. Mullen (1983, cited by Goodman 1987: 732) suggests that Likert-type scales, reduces this risk, as panellists are able to express a degree of preference without justification. The Delphi techniques strong claim to validity is centred on the method's ability to scrutinise and accurately reflect the research subject, because the nature and content of the study is produced and dictated by the participants (Goodman 1987: 731).

The composition of the research sample group is a key factor for validity when using the Delphi technique. Goodman (1987: 731) states that “if the panellists participating in the study can be shown to be representative of the group or area of knowledge under study then content validity can be assumed”.

3.5.1. Methods used to increase validity

The expansion of the composition of the response group to ensure representation by all three (3) tiers of service delivery was carried out to increase validity. The process of requesting that the response groups nominate a participant was also carried out to increase validity. Both processes were carried out to ensure that the selected participants were representative of senior nurse managers who, it was assumed would have a knowledge of the management of CHC's, with a broad understanding of the vision of PHC.

Anonymity of participants was assured with each selected participant being allocated a number in order to increase validity. All documentation forwarded to participants and comments made by participants were referenced using the allocated number. The researcher was the only person who knew which identification number allocated to each participant.

The iteration process that enables participants to re-evaluate their responses in relation to that of the group was carried out using a numerical and written format. The use of a Likert-type scale increased validity by enabling participants' to state their preference in numerical terms without justification. However participants wishing to justify their preference were able to do so using the written format. The inclusion of both forms of iteration increased the validity of the research, from a South African perspective, by ensuring that the results were produced by the participants and were a reflection of their opinions.

3.6. ETHICAL CONSIDERATIONS

The research proposal was submitted to the Faculty of Health Sciences' Ethics Committee of the University of Cape Town, prior to commencement of the research. The proposal was submitted to this ethics review committee to ensure that ethical reasoning and ethical principle had been applied. This process was carried out to ensure that participants were protected from research risks (Schrock 1991: 30) and to ensure a fair balance between the pursuit of knowledge and the rights of those participating in the research (Neuman 1997: 443).

3.6.1. Ethical principles used to protect participants

The following ethical principles were considered:

- privacy
- anonymity
- confidentially
- truthworthiness
- informed consent

3.6.1.a. Privacy

Privacy ensures that no private details are shared (Neuman 1997: 452). In this research study senior management nominated participants. Participants' privacy was maintained when participants' voluntarily withdrew from the research process by not informing senior management of their withdrawal.

3.6.1.b. Anonymity

Anonymity means that participants remain nameless and their identity is protected (Neuman 1997: 452). The anonymity of participants has been maintained throughout the research process. This has been achieved through the allocation of an identification letter and number to each participant. The researcher has assured anonymity by being the only person who knows the identity of all the participants.

3.6.1.c. Confidentiality

Confidentiality means that information cannot be associated with specific participants (Neuman 1997: 453; Schock 1984: 34). The referencing of participants' statements used in the questionnaires and the research document used the allocated identification letters and numbers, thereby retaining confidentiality.

3.6.1.d. Truthworthiness

This requires the researcher to ensure that all information noted in the research process and the findings are reflected truthfully and honestly (Schock 1984: 36; Neuman 1997: 456). Every effort has been taken by the researcher to attain this ethical principle.

3.6.1.e. Informed consent

This requires the researcher to ensure that participants have a clear understanding of the research process and what is required from each participant at all stages of the research process (Neuman 1997: 264,245; Schock 1984: 34). The researcher communicated with each participant prior

to implementation of the research and with each questionnaire providing details of the participants' requirement. Participants were also advised that participation was voluntary and participants could voluntarily withdraw at any stage of the research process

3.6.2. Ethical principles used to ensure mutual benefit

The following principles were considered to insure there was a balance between the need for knowledge and the participants.

3.6.2.a. Obtaining the necessary permission

Permission to carry out the research was required to protect participants (Neuman 1997: 459,460). This protection was required because participants offer time that may impact on other work obligations and the research findings may be detrimental. Permission to conduct the research was obtained by asking senior managers to nominate an appropriate person to participate in the research study.

3.6.2.b. Research involved replication not duplication

The need for research to add to the body of knowledge was achieved by replicating rather than duplicating research (Schock 1984: 33,34). This research study replicated a research study within another context thereby adding to the body of research.

3.6.2.c. Feedback of research findings

The body of knowledge is enhanced through feedback that is as inclusive as possible (Neuman 1997: 465,466). The feedback process is to be initiated once the research document has been approved. A summary report will be submitted to each organisation that nominated a participant. All participants' that were involved at the onset of the research process will also receive the report. Organisations that did not nominate a participant, but requested a report of the research findings will receive the same report. The findings will be made available to the broader nursing community through publication in relevant journals.

3.7. DEVELOPMENT OF THE QUESTIONNAIRE

Three different questionnaires that explored nurse management competencies were identified through the literature. Contact was made with the authors of all three questionnaires, which enabled the researcher to obtain a greater understanding of the tools.

The first tool that was examined was used in a survey to identify the importance of knowledge and skills for top-level nurse managers in the Nordic Countries (Henry, Hamran, Lorensen 1995: 12,13). Contact was made with the authors who forwarded the tool and detailed reports on the implementation of the tool in the Nordic countries (Lorensen, Lichtenberg, Sinkkonen, Jensdottir, Hamran, Engfeldt, Johansson 1997: 2-8; Lorensen, Engfeldt, Hamran 1997: 2-9). This tool consisted of 67 competencies that were divided into 12 sub-categories.

This questionnaire was developed specifically for top-level nurse managers and not considered adaptable to first-line nurse managers. The questionnaire was not considered for this research study.

The second tool that was examined was forwarded by Henry to the researcher and consisted of an unpublished rating scale for head nurses and clinical nurse specialists that had been adapted from the above-mentioned tool, but had as yet not been tested (Henry 1996: 1-7). This tool was divided into three categories of competencies that apply to:

- both head nurses and clinical nurse specialist,
- head nurses specifically,
- clinical nurse specialists specifically.

These three categories were further divided into four sub-categories with a corresponding list of competencies in each sub-category.

Since determining the role competencies of the clinical nurse specialist was not one of the objectives of the proposed research study, the questionnaire was considered inappropriate.

The third tool, which was developed by Duffield (1989: 999) identified the competencies required for first-line nurse managers working in a hospital environment. In developing the tool, Duffield uses the premise that "the role can be delineated and defined by identifying the skills expected" (Duffield 1991: 56). The competencies that were included in the tool were obtained through an extensive search of the literature. The criteria for inclusion in the tool were:

- That the skills related specifically to first-line nurse managers in nursing, health or business,
- That the skills were generally required of all nurse managers,
- That the literature was in English and available in Australia or from overseas via inter library loan.

Duffield's (1991: 56) review explored 279 articles of which 131 articles were found to be suitable and used in the development of the tool. A list comprising 168 competencies was compiled. These competencies were organised into four major categories namely Functional Management, Staff Management, Patient Care Management and Leadership. These four categories were further developed into 15 sub-categories (Duffield 1989: 999).

Duffield has used this tool for many different studies of first-line manager competencies that include: an evaluation of the literature (1991:55-62); defining the role of the first-line nurse manager (1994: 63-67); establishing the expected competencies in Australia (1989: 997-1001); a comparison of results of competencies using two expert panels (1993: 227-237); establishing role overlap between clinical nurse specialists and nursing unit managers (Duffield, Pelletier, Donoghue 1994: 54-63); to determine the perception of competencies of clinical nurse specialists (Duffield, Donoghue, Pelletier 1995: 13-22).

Although the tool has been tested in Australia, it was developed using international literature and therefore not specific to a country or health system. It was assumed that the pilot studies would be able to assess whether the tool could be used within the South African and community health contexts. Contact was made with Duffield to obtain permission to use the tool and this was given after completion of the first pilot study.

The completion of a second pilot study confirmed the need to change and adapt Duffield's questionnaire. These changes resulted in the questionnaire being more reflective of the South African context and language. The changes are detailed in Section 3.7.2: 74 - Second Pilot Study.

3.7.1. First Pilot Study

The first pilot study used a questionnaire that was devised using a combination of the tool developed by Duffield (1991:55-62) and the tool developed by Henry et al (1995: 12.13).

The questionnaire consisted of the 168 competencies listed by Duffield (1994: 64), which were categorised under the 12 headings identified by Henry et al (1995; 12,13). (Refer to First Pilot Study Questionnaire – Appendix A: 195). The questionnaire was compiled using this format, as the competencies identified by Duffield were considered more comprehensive and appropriate. Duffield's questionnaire design indicating the categories and sub-categories was not available at the time of the pilot study. The researcher therefore used the 12 categories found in the Henry et al (1995: 12.13) to categorise Duffield's 168 competencies.

At this early stage of the research process it was proposed to obtain the data directly from the first-line nurse managers as well as the senior managers and compare the results. The selection of the participants for the pilot study consisted of a convenience sample made up of four participants. The participants consisted of two recently retired first-line nurse managers of CHC's, a senior manager

currently responsible for the management of first-line nurse managers and a nurse from an academic institution involved in management training.

Participants carried out one round of the questionnaire and gave the following comments :

- That they were unsure of the meaning of some of the listed competencies;
- That the listed competencies were based on a hospital setting and were not relevant to community health centres.
- That there were too many listed competencies, which resulted in the process being too long and laborious.
- That the competencies were based on first world circumstances and were therefore not applicable to the South African situation.

The researcher held discussions with 5 senior nurse managers from health departments of 2 different local authorities to discuss the results of the pilot study. The senior nurse managers highlighted the fact that the health services had not completed the restructuring and decentralisation process. This could mean that the revision of the role and function of the first-line nurse manager had either not been completed or those in the position had not yet become familiar with this new role.

It was also discovered that there were differing opinions among senior nurse managers, within the health departments and between the different health departments, as to the role and function of the first-line nurse manager within CHC's.

As a result of the comments from the First Pilot study and the discussions with the senior nurse managers, it became clear that the response groups needed to change. It was decided to target senior management and academics on the assumption that they would have an understanding of the changing vision of the first-line nurse manager with the corresponding devolution of authority and

responsibility and have some knowledge and experience of the role competencies being researched. It was assumed that the senior managers were in positions that could facilitate the implementation of the findings because of their influence on nursing structures and job descriptions. The assumption pertaining to the academics was that they were in a position to influence the development of appropriate management training for first-line nurse managers based on the competencies.

Subsequent to the first pilot study, the questionnaire used by Duffield was obtained, which enabled the re-designing of the questionnaire using the same format.

3.7.2. Second Pilot Study

The sample questionnaire that had been forwarded to the researcher by Duffield was used for this pilot study. No changes were made to the questionnaire for the second pilot study. (Refer to Second Pilot Study Questionnaire – Appendix B: 204).

A convenience sample was used to select 2 different participants from those used in the first round. A nurse from an academic institution involved with management training and a senior nurse manager from a CHC were included in the pilot study. The participants were asked to determine whether the items were unambiguous, whether the instrument had face validity, whether the instructions were clear and easy to understand and whether the listed competencies were applicable to the South African and community health settings. Participants were also asked to recommend any changes to the wording of competencies that would make them more applicable to community or public health and South African terminology.

Participants from the first and second pilot studies were not included in the subsequent research study.

Participants carried out one round and gave detailed feedback and recommended some alteration to the questionnaire.

The overall feedback was:

- The meaning of each of the listed competencies was clear and would be understood by senior nurse managers and academics.
- The list of competencies was applicable to the South African context.
- Whilst the list of competencies was long, the use of categories and sub-categories facilitated easy reference.
- Whilst some of the competencies reflected hospital-based care these should not be removed as they provided participants the opportunity to exclude non-relevant competencies.

The following additions and/or changes were recommended:

- Provide participants with the opportunity to generate additional competencies thereby ensuring the addition of competencies specific to CHC's.
- An additional competency to be added under Patient Care Management namely:
92. Facilitating multidisciplinary team communication
- The broadening of the patient concept to include client e.g. Patient/client, would be more appropriate.
- Change the word "unit" to "centre".
- The rating scale to be included on each page for ease of reference.
- Providing participants with a space to comment at the end of each sub-category was a good idea. However, providing participants with an example would ensure that participants' would know what is expected of them.
- Participants should be advised of the one-hour time commitment to complete each questionnaire.

- Change the wording of the following competencies to :

COMPETENCY NUMBER	ORIGINAL WORDING OF COMPETENCY	COMPETENCY NUMBER	CHANGES TO WORDING OF COMPETENCY
8	<i>Understanding utilisation statistics</i>	9	<i>Relating utilisation (use of centre)statistics to budget</i>
46	<i>Terminating staff</i>	46	<i>Termination of Employment</i>
76	<i>Maximising human resources</i>	76	<i>Best use of human resources</i>
97	<i>Controlling nursing practice</i>	98	<i>Controlling (supervising) nursing practice</i>
101	<i>The use of motivational dynamics</i>	102	<i>Able to motivate</i>
103	<i>Negotiating order models</i>	104	<i>Able to negotiate</i>
114	<i>Delegation</i>	115	<i>Ability to Delegate</i>
120	<i>Administering nursing division policies and procedures</i>	121	<i>Administering nursing oriented policies and procedures</i>
127	<i>Co-operating with affiliated education programmes</i>	128	<i>Co-operating with affiliated educational programmes e.g. nursing colleges/ technikons.</i>
144	<i>Interacting with multiple divisions</i>	145	<i>Interacting with other departments and sectors</i>
155	<i>Decision making</i>	156	<i>Decision making skills</i>
156	<i>Power knowledge</i>	157	<i>A knowledge of power relations</i>
158	<i>Problem solving</i>	159	<i>Problem solving skills</i>

Table 3.3: Changes to wording of competencies

The above mentioned changes and comments were implemented in the questionnaire which was used in the first round of the research study. (Refer to First Round Questionnaire – Appendix C: 214)

3.8. PROCEDURES USED FOR EACH ROUND

3.8.1. Round One

The first questionnaire together with instructions was sent to all 24 nominated participants. Each questionnaire was identified with the allocated identification number. The allocated numbers included a letter that indicated the response group the participant represented;

- M represented local authority health departments
- P represented provincial/national health departments
- A represented academic institutions

Sequential numbers were allocated to each letter. All the questionnaires were printed on yellow paper to facilitate identification of the first round questionnaire.

Participants were requested to return the questionnaire by a specific date, which was four weeks from the date of postage, either via the self-addressed envelope that was forwarded with each questionnaire, facsimile or electronic mail. On the specified date eighteen (18) questionnaires had been received and the six (6) remaining participants were contacted by telephone or facsimile; of these only one participant did not respond. A 95.8% response rate was recorded in the first round. (Refer to Questionnaire Round 1- Appendix C: 214).

The participants' ratings for each competency were recorded using Microsoft Excel 1998 Edition. Three (3) of the participants did not rate all listed competencies and these participants were contacted by facsimile and requested to rate those competencies that were omitted. The participants were requested to return the information to the researcher by facsimile. The 3 participants rated the competencies that were left out and returned the scores to the researcher. A mean was calculated for each of the competencies once all the completed questionnaires were returned.

All comments written on the questionnaires were collated under each sub-category and identification of the comment was made by way of the participant's allocated number. All comments were placed in number order and response group categories on the second round questionnaire.

The participants added nineteen additional competencies to the questionnaire. The researcher did not amend or remove any competency from those listed by the participants. The additional competencies are listed in Table 3.4.

QUESTIONNAIRE NUMBER	ADDITIONAL COMPETENCIES
170	<i>Transcultural Nursing</i>
171	<i>Ethical issues included management, environment and bio-ethical.</i>
172	<i>Organisational culture</i>
173	<i>Nursing Service Management</i>
174	<i>Supplementary Services</i>
175	<i>Inter Departmental Services</i>
176	<i>Community Discipline towards Health Equipment</i>
177	<i>Listening Skills</i>
178	<i>Empathy</i>
179	<i>Trust</i>
180	<i>Sensitive to needs of others</i>
181	<i>Friendliness</i>
182	<i>Public Speaking</i>
183	<i>Meeting Procedure</i>
184	<i>Commissioning of new centre</i>
185	<i>Knowledge of strategic planning</i>
186	<i>Ethics in Nursing</i>
187	<i>Participating in community development projects</i>
188	<i>Managing Diversity</i>

Table 3.4: List of additional competencies

3.8.2. Round Two

The second round consisted of the original questionnaire on which the group mean results as well as the participant's own numerical responses were indicated. A summary of all participants' comments was placed under each competency sub-category. The participants were asked to review their response in the light of the documented first round responses. The additional competencies were listed at the end of the questionnaire and participants were asked to rate these competencies using the same rating scale. (Refer to Example of the format of the questionnaire - Appendix D: 225).

The second questionnaire was printed on blue paper as a means of identification. A covering letter was attached to the questionnaire giving details to all participants on how to complete the second round questionnaire and requesting that the questionnaire be returned by a specific date using the self-addressed envelope that was supplied. The return date was calculated as four weeks from the date of posting the questionnaire.

A total of 23 questionnaires were forwarded. One of the participants had not returned the questionnaire from round one and a second questionnaire was not forwarded to that participant. On the predetermined date nineteen (19) participants had returned their questionnaire and the remaining four (4) participants were contacted by telephone and facsimile. Two of the participants had not received the questionnaire, which was forwarded and returned by facsimile. The two participants that did not receive the questionnaire responded, but the other two participants did not respond. Of the original 24 participants there was an 87.5% response rate. The following up of participants resulted in a four-week delay in sending out the third round of the questionnaire.

Two of the participants had not rated the additional competency section of the questionnaire. Telephone and facsimile contact was made with both participants. One participant rated the additional competencies and forwarded these ratings to the researcher by facsimile. The other participant was not available and, because waiting would further delay the research, the participant's scores were not

recorded. The mean for each of the additional competencies was calculated out of 20 participants. The mean for all the other competencies was calculated out to 21 being the number of questionnaires that were returned after the second round.

3.8.3. Round Three

The Third round questionnaire consisted of the original questionnaire on which the mean of each of the competencies from the second round, together with the participants' own rating and a summary of second round comments were indicated. (Refer to Example of the questionnaire format – Appendix D: 225)

A total of 21 questionnaires were forwarded to the participants who had returned the second round questionnaire. A covering letter was included with the questionnaire that requested participants to review their rating of each of the competencies in the light of the group rating. The questionnaires were printed on green paper for ease of reference. Participants were asked to return the questionnaire by a specific date, using the self addressed envelope that was supplied. The two participants that had previously not received their questionnaire were contacted by telephone one week after the date of posting to ascertain whether the questionnaire had been received. The participants confirmed receipt of the questionnaires.

On the predetermined date, only 5 of the 21 participants had returned their questionnaire. It was subsequently discovered that of the remaining 16 questionnaires, 5 had been returned prior to the due date, but had not been received. The delay was attributed to a national postal strike. Three of these participants had kept copies in anticipation of the problem and two participants agreed to redo the questionnaire and forward the questionnaire by facsimile. The remaining 11 participants were contacted and reported work pressures as the cause of the delay in returning the questionnaires. One participant reported that she was not able to complete the questionnaire due to work pressure.

Of the original 24 participants at the onset of the research, 20 participants completed all three rounds resulting in an 83% response rate. The 20 participants that completed all three rounds formed 46.5% of the initially identified potential group of 43.

A letter was sent to all participants who completed all three rounds, advising them that the research process was completed and thanking them for their contribution.

3.9. ESTABLISHING CONSENSUS

3.9.1. Introduction

The key to research that uses consensus-seeking methods is the setting of criteria to establish the point at which consensus is reached. The establishing of the criteria at the onset of the study made decision-making easier by ensuring a less random and subjective approach. Three criteria were set prior to the implementation of the research. These criteria involved:

- The setting of a baseline for inclusion and exclusion of items (Duffield 1993: 228).
- The conversion of opinions reflected in a declining standard deviation (Goodman 1987: 730).
- The reducing number of returned questionnaires (Goodman 1987: 730).

The three chosen criteria were based on other Delphi research (Duffield 1993: 228, Goodman 1987: 730) and all three criteria were used to enhance the validity of the established consensus.

3.9.2. Criteria used for establishing consensus

3.9.2.a. Inclusion and exclusion of items

Duffield (1993: 228) reported that consensus of opinion had not been defined by previous researchers when using the Delphi technique. Researchers had however determined cut-off points for inclusion and exclusion of items. Duffield (1993: 230) applied this approach which led to the definition of consensus “as the point at which 10% or less of the competencies move from above to below the mean of 3.00 (the point of acceptance or rejection of competencies) or the reverse, from below to above the mean of 3.00 on a round” The above 3.00 value indicates a high level of consensus.

Applying this definition to this research study, in the first round 11 of the original 169 competencies fell on and below the mean of 3.00, this represented 6.5% of the competencies. In the second round, 9 of the original 169 competencies fell on or below the mean of 3.00, which represented 5.32% of the total number of competencies. In the third round 8 of the 169 competencies fell on or below the mean of 3.00, which represented 4.73% of the original competencies. Despite the high baseline mean of 3.00 for inclusion and exclusion (out of a maximum of 4.00), 151 (89%) achieved a mean of 3.500 or more.

Applying Duffield's definition to the expanded competency list of 188 (made up of the original 169 competencies plus the 19 additional competencies that were included by the participants in the first round), 11 competencies fell on or below the mean of 3.00 in the second round (5.32%). In the third round 10 competencies fell on or below the mean of 3.00 (5.31%).

3.9.2.b. Convergence of opinion

Goodman (1987: 730) reported that consensus is reached when there is a convergence of opinion or until a point of diminished returns is reached. The standard deviations for the entire list of competencies, as well as the 15 sub-

categories were used to establish the statistical convergence. The data from the 20 participants, who completed all three rounds, was used to calculate the standard deviations.

3.9.2.b.i. Statistical convergence of the competency list

The calculation of the standard deviation for the competency list included all 169 competencies. The standard deviations for all 169 competencies for the three rounds are reflected in Table 3.5.

ROUND	STANDARD DEVIATION
1	0.391
2	0.357
3	0.352

Table 3.5: Standard deviation for all competencies for each round

This table shows a progressively declining standard deviation with each round, indicating a growing consensus as the variance of opinion decreases. A marginal change in consensus was gained in the third round.

3.9.2.b.ii. Statistical convergence of the sub-categories

The standard deviations for the 15 sub-categories reflect three different trends:

- Those that progressively declined.
- Those that declined in the second round and increase in the third round.
- Those that reflected a divergence of opinion.

The progressive decline of the standard deviation with each round as noted for all competencies is also seen in 6 of the 15 sub-categories, which is reflected in Table 3.6. **Staff Communication** recorded the same distribution in the second and third rounds.

Sub-category	Standard deviation			Rank order
	Round 1	Round 2	Round 3	
Financial Management	0.389	0.323	0.317	7
Employee Relations	0.369	0.318	0.270	2
Staff Development/Employee growth	0.360	0.340	0.294	4
Staff Communication	0.299	0.284	0.284	3
Discipline and termination	0.547	0.399	0.381	12
Leadership Activities	0.388	0.240	0.228	1

Table 3.6: Sub-categories that recorded a declining standard deviation over the three rounds

Six sub-categories reflected a decline in the second round and an increase in the third round, with the third round measurement at a lower value to that recorded in the first round. The decline in the standard deviations between the first and third rounds indicates a decrease in the variance of opinion and growing consensus. These trends are noted in Table 3.7.

Sub-category	Standard deviation			Rank order
	Round 1	Round 2	Round 3	
Equipment /Supplies Expenses	0.388	0.340	0.344	9
Evaluation	0.407	0.320	0.327	8
Staffing Patterns	0.367	0.339	0.349	10
Role Model	0.347	0.292	0.298	5
Communication	0.350	0.288	0.303	6
Decision Making	0.409	0.342	0.358	11

Table 3.7: Sub-categories that recorded a declining standard deviation in the second round and an increase in the third round.

The declining standard deviation of 12 of the 15 sub-categories confirmed the growing consensus.

The remaining three sub-categories indicated an increased variance of opinion because the third round measurement was higher than that recorded in the first round. These three sub-categories indicate a lack of consensus amongst participants. The lack of consensus is also reflected in the fact that these three sub-categories recorded the highest rank order value as shown in Table 3.8.

Sub-category	Standard deviation			Rank order
	Round 1	Round 2	Round 3	
Standard of Care	0.391	0.415	0.397	13
Patient care Activities	0.553	0.622	0.651	15
Research	0.522	0.531	0.539	14

Table 3.8: Sub-categories that recorded an increased standard deviation in the third round.

Participants' comments indicated a diversity of opinion and uncertainty as to the role and function of the first-line nurse

manager with the competencies listed in these sub-categories. This diversity of opinion could have influenced the variance of opinion.

3.9.2.c. Diminished returns

Referring to the principle of diminished returns, as stated by Goodman (1987: 730) the researcher found that the participants took the longest period to return the third round questionnaires. Whilst only one participant dropped out of this round, participants were reporting fatigue with the iteration process as a great deal of time and effort had already been put into the questionnaires. It was concluded that a fourth round would result in fewer returns with limited benefit.

3.9.3. Establishing consensus

Evaluating the results over the three rounds using the three criteria enabled the researcher to conclude that consensus had in fact been reached and the research process would not benefit from a further fourth round. The rating patterns for each round are recorded in Chapter 4, together with the analysis of the third round data.

3.10. METHODS OF ANALYSIS

Two types of data analysis were carried out:

3.10.1. Descriptive Analysis

The first involved analysis of descriptive statistics using Microsoft Excel version 1998, involving all three rounds. Descriptive statistics are defined as 'statistics used to describe and summarise the researcher's data set (e.g., mean, standard deviation)' (Polit et al. 1983: 613). These results were used to provide the mean rating of each competency, sub-category and category, which were then presented in tables and bar graphs.

3.10.2. Correlation Analysis

Correlation analysis was carried out, in order to describe the relationship between variables. A significant correlation does not in itself prove a cause-effect relationship. It only measures how variables vary in linear relation to each other (Underhill, Bradfield 1994: 267, Carter 1991: 141, Polit et al. 1983: 612).

Correlation analyses were carried out using third round data with the aid of STATISTICA 5.1 1998 edition. The correlation between the 15 sub-categories involved two different types of analysis. The relationships among the sub-categories were examined by looking at their inherent correlation structure. The Spearman rank correlation was calculated due to the possible deviations of the data from the normal distributions. In addition Factor Analysis were used to reveal further structures/clustering among the sub-categories based on their underlying correlation.

3.10.2.a. Factor Analysis

Factor analysis was the analysis method first selected because it would identify the most highly correlated sub-categories into clusters (factors). Factor analysis explains the relationships amongst the variables based on the assumption that these variables may be explained by a few unobserved variables, called factors. Factor loading gives the correlation between the original variables and the factors. Association among variables, or clustering of variables is illustrated by sub-groups of variables having high factor loading with a specific factor. Meaning is acquired from the overall pattern of factor solution that develops from the relationship of sub-categories (Neuman 1997: 170, Polit et al. 1983: 549-555).

Not only could sub-categories cluster into meaningful factors, but also those sub-categories that did not contribute in the solution were considered to be single entities measuring uniqueness or regarded as not important and discarded. The maximum likelihood loading was used and subjected the factors to a normalised Varimax rotation. A loading of 7.00 or above was

used to indicate a high correlation to a specific factor. The factor matrix is presented in Table 4.9: 101.

3.10.2.b. Spearman rank correlation

The Spearman Rank Correlation was carried out between all pairs of sub-categories and tested whether these correlations were significantly different from zero. The analysis involved a clustering of sub-categories based on high pairwise correlation. The results of the Spearman rank correlation are presented in Table 4.11: 103.

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Chapter 4

Analysis of data

4.0. INTRODUCTION

The analysis of the data that has been obtained through this research process is incorporated into two stages. The first stage involves the rating patterns over the three rounds of the categories, sub-categories and competencies. The second stage deals with the analysis of the final round results and this analysis explores the correlation between the 15 sub-categories and the inclusion and exclusion of competencies.

4.1. ANALYSIS OF RATING PATTERNS

4.1.1. Introduction

The Likert scale rating for each competency from each participant was recorded using Microsoft Excel. The mean scores for each competency were calculated. In round one, the number of returned questionnaires was 23, in round two it was 21 and in round three 20. The mean scores for each of the four categories and fifteen sub-categories were also calculated and these calculations are in figures and tables, which also indicate the rating movement over the three rounds. The mean rating for each competency for each round are listed in Appendix E: 227.

This analysis focuses on the rating patterns for the categories, sub-categories and individual competencies over the three rounds. The analysis of the rating patterns

Patient Care Management is the category that recorded one of the greatest levels of change during the process, however it consistently achieved the lowest agreement rating of the four categories.

4.1.2.b. Competency Sub-categories

The four major categories were divided into a total of 15 sub-categories. The number of sub-categories range from two (2) in Functional Management, three (3) in Patient Care Management, and five (5) each in Leadership and Staff Management.

The rating pattern for each of the 15 sub-categories are reflected in Table 4.1: 92. The level of agreement progressively increased in 14 of the 15 sub-categories. Patient Care Activities was the only sub-category that recorded a change in this trend. All sub-categories reflected above average levels of agreement, with Staff Communication recording the highest level (3.845) and Research the lowest (3.551). 14 of the 15 sub-categories reflected a greater percentage change from the first to the second round. Research was the sub-category that recorded a change in this trend by recording a greater percentage change from the second to the third round.

Competency categories & sub-categories	Round one Mean	Round two Mean	Round three Mean	% Change From round 1 to 2	% Change From round 2 to 3	% Change From round 1 to 3
FUNCTIONAL MANAGEMENT						
Financial Management	3.296	3.460	3.579	4.76%	3.80%	8.37%
Equipment/Supplies Expenses	3.626	3.733	3.752	2.87%	0.51%	3.36%
	3.369	3.505	3.621	3.88%	3.20%	6.95%
STAFF MANAGEMENT						
Employee Relations	3.658	3.728	3.762	1.86%	0.90%	2.76%
Evaluation	3.557	3.686	3.705	3.51%	0.51%	3.99%
Staff Development/employee growth	3.662	3.741	3.776	2.39%	0.90%	3.28%
Staff Communication	3.682	3.845	3.845	4.26%	0%	1.24%
Discipline and Termination	3.217	3.286	3.365	2.08%	2.36%	4.40%
	3.605	3.690	3.722	2.31%	0.84%	3.12%
PATIENT CARE MANAGEMENT						
Standards of Care	3.476	3.590	3.638	3.18%	1.31%	4.45%
Staffing Patterns	3.559	3.680	3.738	3.30%	1.55%	4.79%
Patient/client care activities	3.187	3.171	3.398	-0.49%	6.66%	6.21%
	3.387	3.453	3.572	1.92%	3.33%	5.18%
LEADERSHIP						
Leadership activities	3.598	3.726	3.771	3.44%	1.20%	4.49%
Role Model	3.672	3.806	3.832	3.52%	0.66%	4.18%
Communication	3.604	3.770	3.807	4.42%	0.96%	5.33%
Decision-making	3.649	3.790	3.833	3.72%	1.14%	6.03%
Research	3.360	3.429	3.551	1.99%	3.45%	5.38%
	3.600	3.735	3.781	3.61%	1.22%	4.79%

Table 4.1: Categories and sub-categories mean score for each round and the percentage change between rounds

4.1.2.b.i. Functional Management

Financial Management and Equipment/Supplies Expenses are the two (2) sub-categories that form part of this category.

The rating pattern details are shown in Table 4.1: 92 and Figure 4.2.

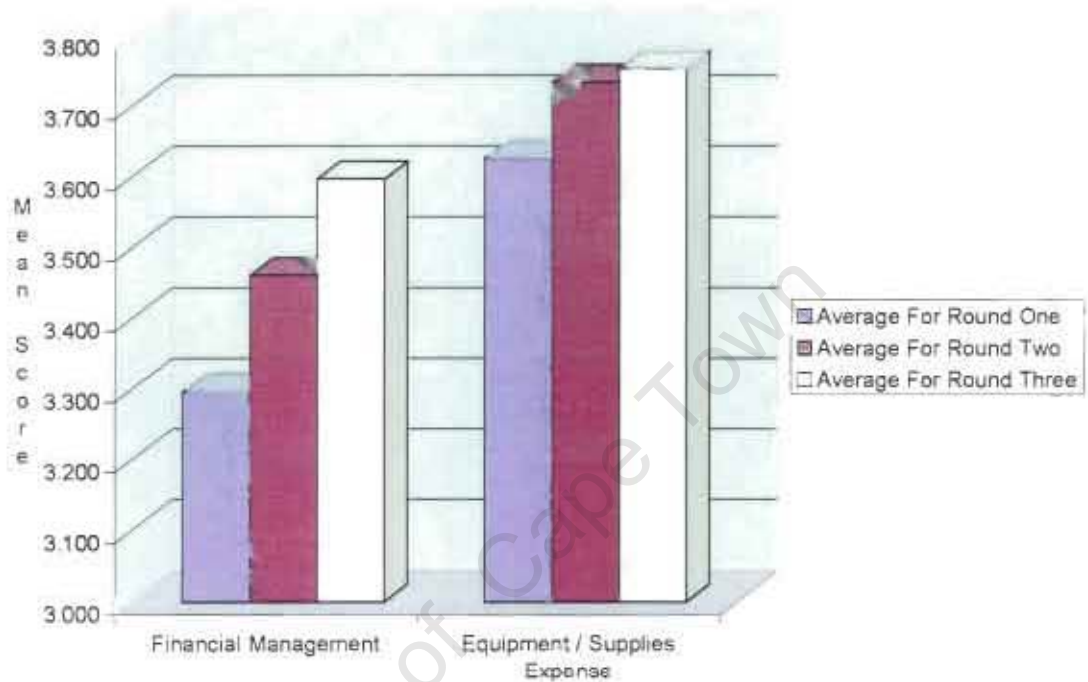


Figure 4. 2: Comparing sub-categories within Functional Management

Financial Management while obtaining the second lowest (the lowest being Research) mean rating (3.579) in the third round had the highest percentage change (8.37%) over the three rounds.

Equipment/Supplies Expense recorded the fourth lowest percentage movement over the three rounds (3.36%), the lowest being Staff Communication (1.24%)

4.1.2.b.ii. Staff Management

This category consists of 5 sub-categories namely:

- Employee Relations
- Evaluation
- Staff development/employee growth
- Staff Communication
- Discipline and Termination.

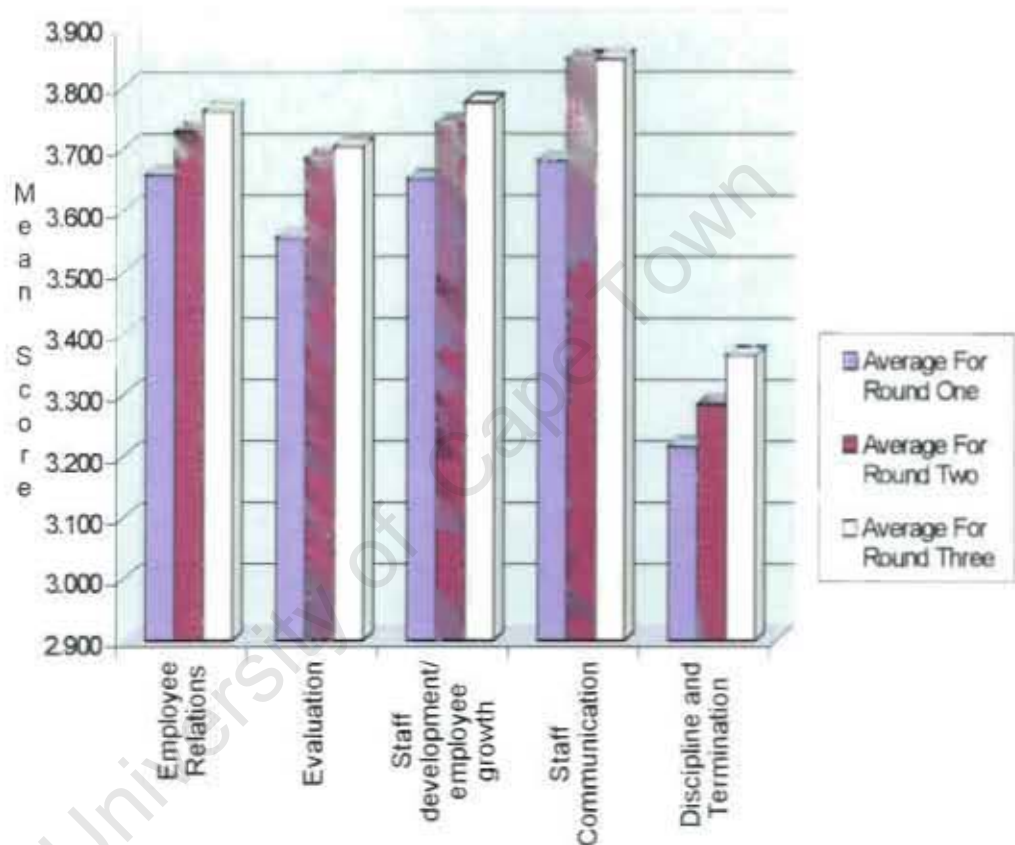


Figure 4. 3: Comparing sub-categories within Staff Management

The rating patterns for each of the sub-categories are shown in Table 4.1: 92 and Figure 4.3.

The sub-categories Staff Communication, Employee Relations and Evaluation were the sub categories that recorded the lowest percentage change of all sub-categories over the three rounds. It

is interesting to note that Staff Communication achieved the highest mean score (3.845) in the third round, with the smallest percentage change (1.24%) over the three rounds.

4.1.2.b.iii. Patient Care Management

The three sub-categories that form part of this category are:

- Standard of Care
- Staffing Patterns
- Patient/client Care Activities

The rating patterns for the sub-categories are noted in the Figure 4.4 and Table 4.1:92.

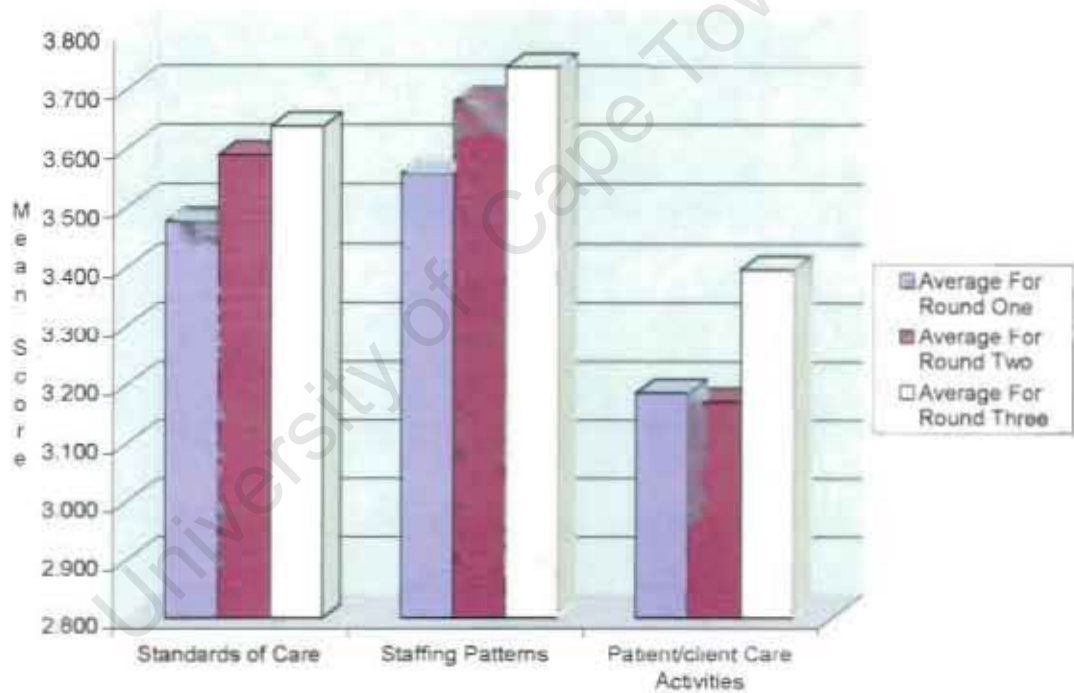


Figure 4. 4: Comparing sub-categories within Patient Care Management

The level of agreement for the sub-category Patient Care Activities did not consistently rise over the three rounds as has

been noted in all other sub-categories. The drop in the level of agreement in the second round (-0.49%), followed by rise in the third round (6.66%) reflects a change in trend.

4.1.2.b.iv. Leadership

This category was divided into five sub-categories. The rating patterns for the sub-categories are reflected in the Figure 4.5 and Table 4.1: 92.

- Leadership Activities
- Role Model
- Communication
- Decision Making
- Research

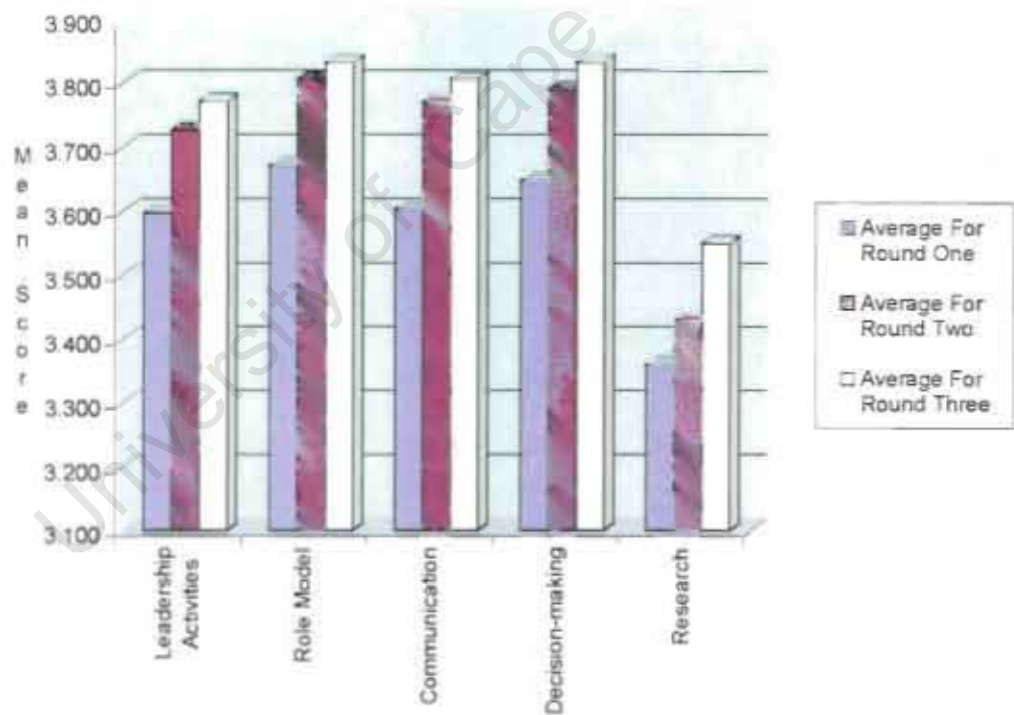


Figure 4. 5: Comparing sub-categories within Leadership

Research recorded the lowest mean score in the third round (3.551). The other sub-categories mean scores ranged from 8.33 for Decision-making to 3.771 for Leadership Activities.

4.1.2.c. Rating pattern for individual competencies

The percentage changes for all competencies over the three rounds are noted in Appendix E: 227.

4.1.2.c.i. Range of movement over the three rounds

The Table reflects the range of movement of the original 168 competencies over the three rounds. The movement is reflected in percentages and placed into percentage categories for ease of reference.

PERCENTAGE MOVEMENT OF INDIVIDUAL COMPETENCIES OVER THREE ROUNDS				
0% and less	1-4%	5-9%	10-14%	15% or more
7(4.14%)	82(48.52%)	66(39.05%)	12(7.1%)	2(1.18%)

Table 4.2: Percentage movement of individual competencies over three rounds

More than half of the competencies (52.66%) recorded a negative to 4% movement and 88% recording a 1 to 9% movement.

4.1.2.c.ii. Competencies recording the greatest positive movement

The competency that recorded the greatest percentage change over the three rounds was *Transcribing written orders of doctors*. This rating pattern is shown in Table 4.3.

Competency	Round 1 Mean	Round2 Mean	Round 3 Mean	% Change over 3 rounds
<i>Transcribing written orders of doctors</i>	2.174	2.143	2.810	22.62%

Table 4.3: Rating pattern for the competencies that recorded the greatest positive movement

It is interesting to note that even though this competency recorded the greatest positive movement over the three rounds, the competency recorded a rating of 2.810. Since this rating is below 3.00 the competency is considered not part of the role of the first-line nurse manager and is excluded from the final competency list.

4.1.2.c.iii. Competencies recording the second highest positive movement

The seven competencies that recorded between 9% and 15% change are located in three sub-categories. Four are from the Financial Management, two from the Patient Care Activities and one from Staff Patterns sub categories.

The competencies found in the Financial Management sub-category are shown in the Table 4.4.

Competency	Round 1 Mean	Round 2 Mean	Round 3 Mean	% Change over 3 rounds
<i>Controlling the centre budget</i>	3.174	3.524	3.714	14.55%
<i>Understanding cost effective analysis</i>	3.217	3.524	3.667	12.25%
<i>Understanding cost benefit ratios</i>	2.957	3.190	3.381	12.55%
<i>Using management information systems.</i>	3.217	3.333	3.476	13.04%

Table 4.4: Financial Management competencies that recorded 10 % and > movement.

The two competencies from the Patient Care Activities sub-category are shown in Table 4.5.

Competency	Round 1 Mean	Round 2 Mean	Round 3 Mean	% Change over 3 rounds
<i>Implementing orders of doctors</i>	2.435	2.238	2.762	11.84%
<i>Informing staff of changes to patients/client</i>	3.043	3.095	3.429	11.23%

Table 4.5: Patient Care Activities competencies that recorded 10 % and >movement.

Implementing orders of doctors, while significantly increasing in value over the three rounds, remained excluded throughout.

The one competency that is found in the Staffing Patterns sub-category is shown in Table 4.6.

Competency	Round 1 Mean	Round 2 Mean	Round 3 Mean	% Change over 3 rounds
<i>Daily patient/client-staff assigning</i>	3.087	3.381	3.524	12.40%

Table 4.6: Staffing Patterns competencies that recorded 10% and > movement.

4.1.2.c.iv. Competencies recording a negative movement

The five competencies that recorded a negative percentage change over the three rounds were:

- *Conflict Management*
- *Recruiting of staff*
- *Interviewing and Selecting of staff*
- *Teaching staff*
- *Acting as a liaison between staff, doctor, patient/client and family*

The four competencies that form part of the Staff Management category are shown in Table 4.7, which also reflects the sub-categories.

Competency	Round 1 Mean	Round2 Mean	Round 3 Mean	% Change over 3 rounds
Employee Relations				
<i>Conflict Management</i>	3.826	3.714	3.810	-0.43%
<i>Recruiting of staff</i>	3.435	3.476	3.429	-0.18%
<i>Interviewing and Selecting of staff</i>	3.739	3.619	3.476	-7.56%
Staff Development				
<i>Teaching staff</i>	3.565	3.476	3.524	-1.18%

Table 4.7: Staff Management competencies that recorded a negative movement.

The competency that forms part of the Patient Care Management category is shown in Table 4.8.

Competency	Round 1 Mean	Round2 Mean	Round 3 Mean	% Change over 3 rounds
Patient Care Activities				
<i>Acting as a liaison between staff, doctor, patient/client and family</i>	3.522	3.238	3.476	-1.31%

Table 4.8: Patient Care Management competencies that recorded a negative movement

4.2. ANALYSIS OF THIRD ROUND DATA

4.2.1. Factor Analysis

The factor analysis resulted in the clustering of sub-categories cluster in four (4) meaningful factors and are recorded in Table 4.9. However, those sub-categories that did not contribute in the solution were considered to be single entities measuring uniqueness or regarded as not important and discarded. The maximum likelihood method was used to estimate the factor loading and subjected the factors to a normalised Varimax rotation.

Variable	Factor 1 Loading	Factor 2 loading	Factor 3 Loading	Factor 4 loading
Financial Management	0.228	0.249	0.298	0.708
Equipment/ Supplies expenses	0.802	0.153	0.396	0.395
Evaluation	0.131	0.142	0.717	0.069
Staff Communication	0.628	0.047	-0.025	0.152
Standard of Care	0.162	0.927	0.090	0.296
Staffing Patterns	0.487	0.289	0.063	0.794
Patient Care Activities	0.284	0.747	0.180	0.445
Role Model	0.149	0.296	0.290	0.822
Communication	0.498	0.174	0.151	0.806
Decision-Making	0.097	0.262	0.129	0.881
Research	0.048	0.224	0.781	0.564

Table 4.9: Factor Loading (maximum likelihood extraction, Varimax normalised)

Correlation Key Red = high correlation Blue = correlation

Using a loading of 0.7 or above to indicate high correlation to a specific factor resulted in the clearest clustering of sub-categories. The results are presented so as to separately highlight loading >0.7, and loading between 0.6 and 0.7. Sub-categories with a significant loading of 0.7 and above create the factors of the first-

line nurse manager role and are shown in Table 4.9. Sub-categories that had a correlation of 0.5 and below are listed separately in Table 4.10. The factor analysis reveals how value is assigned to different components of the role of first-line nurse manager.

Four factors were identified explaining 75% of the variance. The fourth factor explained 31% of the variance. A high correlation was noted between five sub-categories namely Financial Management, Staffing Patterns, Role Model, Communication and Decision-Making.

The first factor titled explained 14% of the variance and reflects a correlation between Equipment/Supplies and Staff Communication.

The second factor explained 10% of the variance and recorded a high correlation between Standard of Care and Patient Care Activities.

The third factor titled explained 15% of the variance and recorded a high correlation between Evaluation and Research.

Three sub-categories that did not factor are shown in Table 4.10. Analysis of these sub-categories using the Spearman rank correlation was carried out before determining whether these sub-categories were single entities or unimportant and therefore able to be discarded.

Variable	Factor 1 loading	Factor 2 loading	Factor 3 loading	Factor 4 loading
Leadership Activities	0.096	0.467	0.430	0.565
Employee Relations	0.207	0.065	0.506	0.490
Staff Development	0.544	0.463	0.423	0.085
Discipline & Termination	-0.035	0.404	0.334	0.134

Table 4.10: Sub-categories that did not load onto any factor

4.2.2. Spearman rank correlation

A shaded Spearman correlation matrix was developed and is shown in Table 4.11, with darker shades illustrating high correlation.

	DECMAK	ROLMOD	COMMUN	STAFPAT	FINMAN	LEADER	RESEARCH	EMPREL	PATCARE	EQPEXP	STANCARE	STAFCOM	DISTERM	STAFDEV	EVAL
DECMAK	1														
ROLMOD	0.77	1													
COMMUN	0.79	0.78	1												
STAFPAT	0.71	0.69	0.69	1											
FINMAN	0.65	0.69	0.64	0.66	1										
LEADER	0.58	0.55	0.49	0.57	0.45	1									
RESEARCH	0.67	0.72	0.59	0.44	0.69	0.68	1								
EMPREL	0.43	0.66	0.33	0.41	0.59	0.30	0.49	1							
PATCARE	0.62	0.76	0.63	0.68	0.63	0.64	0.67	0.36	1						
EQPEXP	0.43	0.51	0.41	0.57	0.50	0.52	0.49	0.44	0.58	1					
STANCARE	0.60	0.64	0.49	0.66	0.54	0.66	0.59	0.37	0.91	0.54	1				
STAFCOM	0.25	0.33	0.18	0.27	0.25	0.26	0.30	0.29	0.43	0.74	0.35	1			
DISTERM	0.25	0.32	0.47	0.19	0.35	0.57	0.46	0.23	0.40	0.25	0.40	-0.1	1		
STAFDEV	0.24	0.49	0.32	0.41	0.23	0.33	0.32	0.34	0.55	0.74	0.54	0.55	0.22	1	
EVAL	0.22	0.49	0.18	0.34	0.46	0.50	0.71	0.54	0.43	0.55	0.36	0.38	0.34	0.38	1

Correlation Key

>=0.9 appears in bold black on sha
 >=0.7 appears in bold black
 >=0.6 appears in blue
 >= 0.5 appears in pink
 >=0.4 appears in green
 <=0.4 appears in red

Matrix Key

DECMAK = Decision-Making
 ROLMOL = Role Model
 COMMUN = Communication
 STAFPAT = Staffing Patterns
 FINMAN = Financial Management
 LEADER = Leadership Activities
 RESEARCH = Research
 EVAL = Evaluation
 EMPREL= Employee Relations
 PATCAR = Patient Care Activities
 EQPEX = Equipment Expenses
 STANCARE = Standard of Care
 STAFCON = Staff Communication
 DISTERM= Discipline Termination
 STAFDEV= Staff Development

Table 4.11: Spearman correlation matrix

Factor 4 that reflects a correlation between Decision-making, Role Modelling, Communication, Staffing Patterns and Financial Management is also noted in the Spearman Matrix.

Factor one (Equipment and Supplies Expenses and Staff Communication) has been expanded in this analysis to include Staff Development.

Factor two (Standard of Care and Patient Care Activities) is also reflected in this analysis.

Factor three (Evaluation and Research) has also been expanded to include Patient Care Activities

The analysis identifies a number of correlations unique to the Spearman Matrix, which are:

- Communication with Staffing Patterns
- Staffing Patterns with Financial Management, Patient Care and Standard of Care
- Financial Management with Research
- Leadership Activities with Research and Standard of Care
- Research with Patient Care and Evaluation

The inclusion of Staff Development determines that it is not a unique item and can be considered a component of the first-line nurse manager's role.

The sub-categories that did not load in any of the two types of analysis are Employee Relations and Discipline and Termination. These sub-categories are considered separate entities and a component of the role of first-line nurse manager.

4.2.3. Competencies identified for inclusion and exclusion

The baseline for inclusion and exclusion of competencies was established at the onset of the study to make decision making easier and less random and selective.

The point of exclusion was set at a mean of 3.00. The excluded competencies are therefore all those that were valued at 3.00 and below in the third round. The exclusion rating awarded competencies implies that the senior nurse managers who took part in this study believe that these functions do not form part of the role of the first-line nurse manager.

4.2.3.a. Functional Management

This category consisted of 20 items, with 15 items related to financial management and 5 items related to resource management. The competency *Accounting and financial skills* (3.0) was excluded at the end of the third round.

4.2.3.b. Staff Management

26 competencies were included in this category and divided amongst the five sub-categories.

- Employee Relations = 5 items
- Evaluation = 5 items
- Staff development/employee growth = 7 items
- Staff Communication = 4 items
- Discipline and Termination. = 3 items

The competency *Termination of Employment* (2.381) received an excluded rating.

The high level of agreement afforded Staff Management as reflected in Table 4.12, is also reflected in the competencies that achieved the highest rating in the third round, with 3 competencies achieving top ten status.

Ranking	Competency sub-category	Competency	Final mean Rating
1st	Employee Relations	<i>A knowledge of complaints procedure</i>	4.000
2nd	Employee Relations	<i>A knowledge of personal management (industrial issues, labour relations, personnel policies)</i>	3.952
2nd	Staff Communication	<i>Informing staff of organisational change</i>	3.952

Table 4.12: Competencies within the Staff Management category that achieved the highest mean score rating in the third round

4.2.3.c. Patient Care Management

This is the second largest category consisted of 52 competencies that were allocated amongst three sub-categories.

- Standard of Care = 18 items
- Staffing Patterns = 14 items
- Patient Care Activities = 20 items

This category while recording the lowest level of agreement (Refer to Table 4.1: 92) also recorded the largest number of excluded competencies (5), all of which came from the Patient Care Activities sub-category. The excluded competencies were *Transcribing written orders of doctors (2.810)*, *Implementing doctors orders (2.762)*, *Teaching patients and family (3.0)*, *Discharge planning (2.857)* and *Arranging follow up (2.905)*.

4.2.3.d. Leadership

Leadership is the largest category and the variety of behaviours is reflected in these competencies. 71 competencies were divided into five sub-categories that make up the Leadership category. The number of competencies allocated to each sub-category were:

- Leadership Activities = 20 items
- Role Model =15 items
- Communication = 17 items
- Decision Making =12 items
- Research =7 items

At the end of the research process only one competency in this category was excluded. The excluded item *Using power and status to achieve goals for patients staff and centre*, which forms part of the Leadership Activities sub-category, recorded a mean score rating of 2.619 in the third round.

The level of agreement afforded the Leadership category (Refer to Table 4.1: 92) is further supported by the fact that 6 out of the 10 competencies that achieved the highest rating are located in this category, which are reflected in Table 4.11: 103

Ranking	Competency sub-category	Competency	Final mean Rating
2 nd	Leadership Activities	<i>Participative decision making</i> <i>Creating and maintaining a favourable work environment</i> <i>Allocating responsibility and authority appropriately</i> <i>Exacting accountability from work by staff and self</i>	3.952
2 nd	Role Model	<i>Initiating personal (own) and professional growth and development</i> <i>Maintaining own professional identity</i>	3.952

Table 4.13: Competencies within the Leadership category that achieved the highest mean score rating in the third round

4.2.4. Additional Competencies

In the first round participants were given the opportunity to add competencies that, in their opinion, were considered relevant for the position and were not covered within the 169 listed competencies. 19 competencies were listed and these additional competencies together with the mean scores at the end of the third round are listed in the Table 4.14.

These competencies were added to the second round questionnaire without editing, to ensure that the researcher did not misinterpret or misrepresent any of these additional competencies. The competencies were placed under the heading additional competencies. Participants were asked to rate the competencies using the same rating scale. The additional competencies were included in the second and third round questionnaires.

Participants' were also given the opportunity to comment at the end of this sub-category. Participants who listed additional competencies were not asked to give reasons as to why they considered it necessary to add the competency. Participants were also not asked to evaluate the additional competencies against the original list.

Competency	Final Mean score
<i>Transcultural Nursing</i>	3.650
<i>Ethical issues including management, environment & bio-ethical</i>	3.550
<i>Organisational culture</i>	3.500
<i>Nursing Service management</i>	3.350
<i>Supplementary Services</i>	3.100
<i>Inter Departmental Services</i>	3.150
<i>Community Discipline towards Health Equipment etc</i>	2.950
<i>Listening skill</i>	3.650
<i>Empathy</i>	3.750
<i>Trust</i>	3.700
<i>Sensitive to needs of others</i>	3.750
<i>Friendliness</i>	3.600
<i>Public Speaking</i>	3.650
<i>Meeting Procedure</i>	3.700
<i>Commissioning of a new centre</i>	3.550
<i>Knowledge of strategic planning</i>	3.750
<i>Ethics in Nursing</i>	3.650
<i>Participating in community development projects</i>	3.700
<i>Managing diversity</i>	3.750

Table 4.14: Additional competencies and the third round mean score rating.

The competency *Community discipline towards health equipment* (2.950) was the only additional competency excluded in the third round.

4.3. SUMMARY OF FINDINGS

Participants' at the end of the third round retained 179 competencies, with each retained competency achieving a rating of above 3.00. These competencies consisted of 161 of the original 169 competencies together with the 18 additional competencies. The strength of the participants' acceptance of the competencies is noted in that only three (3) rounds were required. However a number of components of the role, identified by the sub-categories, either loaded weakly or did not load on either of the correlation analyses.

Chapter 5

Adapting the list of competencies

5.0. INTRODUCTION

The list of competencies at the end of the third round included;

- 161 of the original 169 original competencies.
- 18 additional competencies generated by participants. The additional competencies are listed in Table 4.14: 110. The competency *Community discipline towards health equipment* was the only additional competency excluded by participants.

The researcher has adapted the 18 additional competencies as follows;

- Additional competencies excluded by researcher.
- Additional competencies retained.
- Additional competencies wording adjusted.
- Additional competencies consolidated.

To facilitate the reading of this chapter, individual competencies are recorded in italics and competency sub-categories are recorded in bold.

5.1. ADDITIONAL COMPETENCIES EXCLUDED BY RESEARCHER

The researcher has excluded the competencies *Supplementary Services (3.1)* and *Inter Departmental Services (3.15)*. Participants' comments reflected a lack of understanding as to the meaning of these additional competencies. These items were interpreted by participants as meaning knowledge of other services and therefore considered by the researcher as being part of competencies already listed, namely; *Interacting with other departments/sectors* and *Co-ordinating between area (units and departments)*.

Participants' comments also reflected a lack of understanding as to the meaning of *Nursing Service management (3.350)*. This item was interpreted by one participant as being a summary of the entire list of competencies. The researcher agreed with this interpretation and therefore removed the item from the list of competencies.

5.2. ADDITIONAL COMPETENCIES RETAINED

The five competencies that were retained without any changes are listed in Table 5.1. The statistical rating of each of these competencies reflects the strength of agreement amongst participants.

Retained Additional Competencies	Final mean score
<i>Public speaking</i>	3.650
<i>Meeting procedure</i>	3.700
<i>Participating in community development projects</i>	3.700
<i>Commissioning a centre</i>	3.550
<i>Knowledge of strategic planning</i>	3.750

Table 5.1: Retained Additional competencies and the third round mean score rating

Public speaking and *Meeting procedure* reflect the focus on community participation that is necessary when implementing the PHC approach, where services are required to be accountable to community structures and incorporate a developmental approach (ANC 1994: 21). These competencies are vehicles used for accessing the community and facilitating participation and are supported by other competencies within the **Communication** sub-category. These competencies are *Participating on committees*, *Public relations* and *Acting as a unit spokesperson*, which further reflect the unit manager's role in interacting with the community and ensuring that the services meet the needs of the community. As a result, these competencies have been added to the **Communication** sub-category.

The competency *Participating in community development projects* also supports the PHC approach which emphasises the social origins of disease and is grounded in the philosophy that the health of communities is improved through development (ANC 1994: 26,27). Clarke (1992: 118-126) identified five gaps created between the formal health service and the community being served. These gaps are socio-economic, language, culture, education and time and the only means available of bridging these gaps is to involve the community. This involvement is best achieved through community participation and development, which is usually implemented through projects, carried out by Non Governmental Organisations (NGO's) and Community Based Organisations (CBO's) in conjunction with staff from CHC's. The inclusion of this competency is also directly in line with the new preventative model of care as opposed to the curative model. This competency has been included in the **Patient Care Activities** sub-category since involvement will be associated with health related projects and would be supported by the competencies *Assessing community health resources* and *Facilitating multi-disciplinary team communications* which are part of this sub-category.

Commissioning of a centre also needs to be viewed within the context of the new health system that emphasises the necessity for services to be accessible, acceptable, affordable, efficient, effective and equitable (Department of Health

1998: 19,20,21; Department of Health and Social Services – Western Cape 1995: 3). The *Commissioning of a centre* is therefore considered a relevant competency and has been retained and placed in the sub-category **Decision-making**.

The incorporation of *A knowledge of strategic planning* and the strength of agreement amongst participants (3.750) is interesting in light of the fact that strategic planning is usually carried out at more senior levels of management and the lower management levels are usually involved with the implementation of the plans. Participants' raised awareness brought about by the transformation process that has required the development of strategic plans could have influenced the inclusion of this item. However, the development of district management teams and the inclusion of first-line nurse managers into the teams have probably had a greater impact on participants to include this competency. This competency has been included in the **Leadership Activities** sub-category.

5.3. ADDITIONAL COMPETENCIES WORDING ADJUSTED

The additional competency *Organisation culture* was found to lack clarity and the title was changed to *Fostering a positive organisational culture*. The inclusion of this competency needs to be viewed within the context of the transformation process and the important role that first-line nurse managers have in facilitating the adoption of new organisational cultures and ensuring the maintenance of organisational culture on an ongoing basis. The inclusion of this competence reinforces the leadership aspects of the position. The competency has been placed in the **Role Model** sub-category.

5.4. ADDITIONAL COMPETENCIES CONSOLIDATED

The additional competencies that have been consolidated are shown in Table 5.2.

Additional Competencies	Mean Score in Round 3	Adjusted competency title	Adjusted final rating
<i>Listening skills</i>	3.650	Interpersonal Skills	3.690
<i>Empathy</i>	3.750		
<i>Trust</i>	3.700		
<i>Sensitive to others</i>	3.750		
<i>Friendliness</i>	3.600		
<i>Trans cultural Nursing</i>	3.650	Managing Diversity	3.700
<i>Managing Diversity</i>	3.750		
<i>Ethical issues including management, environment & bio-ethics</i>	3.550	Knowledge of Ethics	3.600
<i>Ethics in nursing</i>	3.650		

Table 5.2: Consolidation of additional competencies and the adjusted mean score ratings.

Closer scrutiny of finds that *Listening skills, Empathy, Trust, Sensitivity to others* and *Friendliness* can collectively be termed *Interpersonal skills* which is a competency. The use of the term *Interpersonal skills* facilitates the consolidation of the competencies at the same time using accepted management terminology. The average for the five additional competencies has been used as the rating for this competency. The average rating of 3.69 was calculated. The inclusion of *Interpersonal skills* reinforces the importance given to communication and the management of staff. The competency has been placed in the **Communication** sub-category.

Trans-cultural Nursing and *Managing Diversity* have also been consolidated into one listed competency namely *Managing Diversity*. This approach has been used because *Trans-cultural Nursing* primarily focuses on the relationship between

nurses and their patients. *Managing Diversity* on the other hand deals with all aspects of differences found amongst people being managed be the person employee or patient. The awareness of differences is a key aspect of management in communities that are characterised by multiplicity. *Trans-cultural nursing* is seen as a component of *Managing Diversity*. *Managing Diversity* has been incorporated into the competency list in the **Leadership Activities** sub-category. The rating value of 3.7 has been given to the consolidated competency. This value is an average of *Trans-cultural nursing* and *Managing Diversity*.

The additional competencies *Ethical issues including management, environment and bio-ethics* and *Ethics in Nursing* have also been merged into one competency under the title *Knowledge of Ethics*. Nursing ethics has formed the foundation of clinical practice through the establishment of behavioural standards for nurses. The advances in technology have created bio-ethical issues, which are increasingly impacting on nurses. The introduction of the ethical issues associated with management and the environment highlight the change in the nurse managers' role and the greater focus on the management aspect of the position. The merging of the additional competencies ensures that no specific aspect of ethics receives more attention. *Knowledge of Ethics* has been placed in the **Role Model** sub-category. A rating of 3.6 has been used which is an average rating of the two additional competencies.

5.5 CONCLUSION

The list of competencies after the adjustments, consists of 161 of the original competencies together with 9 additional competencies resulting in a list of 170 competencies. The list of competencies together with the third round agreement rating is noted in Table 5.3.

ADAPTED LIST OF COMPETENCIES	
FUNCTIONAL MANAGEMENT	
Financial Management	
1	Needs Assessment
2	Setting financial priorities
3	Financial forecasting
4	Preparing a centre budget
5	Controlling of centre budget
6	Monitoring of centre budget
7	Using budget data to make decisions
8	Understanding statistics related to all resources
9	Relating utilisation (use of centre) statistics to budget
10	Cost Control
11	Understanding cost-effective analysis
12	Understanding cost benefit ratios
13	Using management information systems
14	Using computers
Equipment/Supplies Expense	
15	Identifying equipment that is needed
16	Ensuring equipment is present
17	Scheduling of equipment
18	Monitoring use of equipment
19	Ensuring protection of equipment
STAFF MANAGEMENT	
Employee Relations	
20	A knowledge of complaints procedure
21	A knowledge of personnel management
22	Conflict management
23	Recruiting of staff
24	Interviewing and selecting of staff
25	Promoting of staff
26	Identifying and resolving personnel problems of staff
Evaluation	
27	Job evaluation
28	Developing standards of performance
29	Developing criteria for staff performance
30	Evaluating staff performance
31	Perceiving barriers to staff performance
Staff Development/ employee growth	
32	Identifying and facilitating learning needs of staff
33	Assisting staff to maintain skills
34	Providing opportunities for staff development
35	Orientation of new staff
36	Teaching staff
37	Identifying and developing staff potential
38	Assisting individuals to set goals
Staff Communication	
39	Informing staff of organisational change
40	Using constructive confrontation skills
41	Handling grievances
42	Providing a forum for staff communication
Discipline and Termination	
43	Implementing disciplinary action
44	Counseling employees as to their performance
PATIENT CARE MANAGEMENT	
Standards of care	
45	Linking management with nursing care
46	A knowledge of care delivery systems.
47	Developing standards of patient/client care
48	Identifying patient/client problems
49	Making patient/client care decisions
50	Using the nursing process
51	Developing nursing care plans
52	Planning safe, cost –effective patient care
53	Providing care based on research.
54	Evaluating nursing care
55	A knowledge of changes in nursing care practice
56	Supervising patient/client care
57	Understanding the legal implications of nursing practices
58	Understanding of privacy issues relating to patient/client records
59	Providing known monitoring systems for patient/client care
60	Ensuring quality care is provided
61	A knowledge of quality assurance activities
62	Assessing charts and documentation for accuracy
Staffing Patterns	
63	Organising of centre
64	A knowledge of staffing models
65	A knowledge of measures of efficiency
66	Identifying work to be done
67	Determining staff mix
68	A knowledge of patient/client classification systems.
69	Estimating patient/client workload (quantifying care)
70	Ensuring staffing reflects workload (workforce planning)
71	Scheduling of staff to reflect work load
72	Daily patient/client-staff assigning
73	Co-ordinating work activities on the unit
74	Best use of human resources
75	Monitoring activities on the unit
76	Perceiving workload pressures on staff
Patient/client Care Activities	
77	Providing technical skills and patient/client care as required
78	Receiving and delivering reports
79	Undertaking patient/client rounds
80	Infection control
81	Maintaining adequate records
82	Questioning doctors' when in doubt
83	Acting as a liaison between staff, doctor, client & family
84	Informing staff of changes to patients/client
85	Acting as a patient/client advocate
86	Implementing emergency procedures

Table 5.3: Adapted list of competencies (cont.)

87	Facilitating multi-disciplinary team communication	129	Initiating personal & professional growth & development
88	Participating in team conferences	130	Developing & maintaining personal professional identity
89	Assessing community health resources	131	Maintaining own professional identity
90	Assessing quality of care	132	A knowledge of ethics
91	Controlling (supervising) nursing practice	133	Fostering a positive organisational culture
92	Participating in community development projects	Communication	
LEADERSHIP		134	A knowledge of communication techniques and theory
Leadership Activities		135	Communication skills, written and oral
93	Knowledge of management behaviour and theories	136	A knowledge of communication channels
94	Knowledge of organisational behaviour and theories	137	Providing feedback to administration
95	Seeing the organisation as a whole	138	Participating on committees
96	Able to motivate	139	Developing collegial relations
97	Management by objective	140	Interviewing skills
98	Able to negotiate	141	Counseling skills
99	Participative decision making	142	Acting as unit spokesperson
100	Marketing activities (promotional)	143	Understanding group dynamics
101	Planning of activities, long and short term	144	Team building/group process skills
102	Program planning	145	Interacting with other departments/sectors
103	Creating and maintaining a favourable work environment	146	Dealing with bureaucracy
104	Controlling staff members	147	Co-ordination between areas (units and departments)
105	Supervising nursing staff	148	Information handling and processing
106	Identifying stress in staff and self	149	Ceremonial duties
107	Developing and maintaining staff moral	150	Public relations
108	Developing staff support	Decision-making	
109	Ability to delegate	151	Defining centre's philosophy
110	Allocating responsibility and authority appropriately	152	Setting centre's goals
111	Exacting accountability for work by staff and self	153	Formulating centre's objectives
112	Managing Diversity	154	Developing centre's policies
113	Interpersonal Skills	155	Developing centre's procedures
114	Knowledge of strategic planning	156	Decision making skills
115	Public speaking	157	A knowledge of power relationships
116	Meeting procedure	158	Political knowledge
Role Model		159	Problem solving skills
117	Interpreting organisational goals	160	Time management skills
118	Implementing organisational goals	161	Maintaining an awareness of socio-political and economic trends
119	Administering nursing oriented policies and procedures	162	Setting priorities (patients/clients, staff, centre)
120	A knowledge of change theory	163	Commissioning a new centre
121	Initiating change	Research	
122	Facilitating change	164	Knowledge of research process
123	Acting as a teaching role model	165	Participating in research
124	Teaching techniques	166	Conducting research
125	Acting as a resource person	167	Interpreting research findings
126	Co-operating with affiliated education programmes	168	Applying research findings
127	Providing guidance in planning care development	169	Involving staff in research
128	Ability to cope under stress	170	Knowledge of research grants available

Chapter 6

Discussion of results

6.0. INTRODUCTION

This chapter comprises two sections. The first section discusses the methodological implications of the research design as used in this study. The second section identifies and discusses the different roles of a first-line nurse manager in the light of the final list of competencies identified in this study. The different roles of the first-line nurse manager are also discussed in relation to the transformation of the health services and its impact on health service delivery.

To facilitate the reading of this chapter, competency categories and sub-categories are written in bold. Individual competencies are recorded in Italics and comments from participants are also recorded in Italics and quotation marks.

6.1. METHODOLOGICAL IMPLICATION

The Delphi technique as applied to this study used the statistical group response and feedback of participants' comments to facilitate decision-making enabling participants to achieve consensus. Participants may at times have been sensitive to the comments of others, which could have influenced them to adjust their opinion. At other times participants' may have compared their rating with the group mean score and adjusted their score accordingly. These processes were the same as those reported by Duffield (1993: 234) and not only influenced the acceptance and rejection of competencies, but also the increasing or decreasing of the competencies group mean rating.

To illustrate this process it is noted that in the second round the competency *Conflict Management* obtained a lower mean (3.714) rating than in the first round (3.826). As there were no comments from participants the change in opinion, reflected in the changed mean score, most probably occurred as a result of participants comparing their rating of the competency with that of the group mean score. In the third round however, the following comment was feedback to participants “ *Conflict management is one of the key components of management... The first-line nurse manager should be able to manage conflict and provide the (an) environment that prevents conflict situations before they ever occur.*” The mean score increased in the third round (3.810). There is no way of concluding whether mean scores or comments influenced a change in opinions. The use of the mean scores as well as the participants' comments ensured that participants had as much information as possible to make an informed decision.

The increase and decrease in the variance of opinion reflected in the changed standard deviations are also noted in the comments of participants. To illustrate the decrease in the variance of opinion, the sub-category **Leadership Activities** recorded a decrease in the standard deviation from 0.388 in the first round to 0.228 in the third round. Participant comments reflected support for leadership. On the other hand the sub-category **Patient Care Activities** recorded the largest increase in the standard deviation from 0.553 in the first round to 0.651 in the second round reflecting a divergence of opinion. This divergence was also noted in participants comments reflecting a range of opinions related to first-line nurse managers' involvement in direct patient care. Some comments proposed no involvement, others proposed non-involvement but reinforced the need for managers to maintain competence and others proposed selective involvement.

It is also noted that while some participants' comments facilitated the understanding and/or interpretation of competencies, other comments, while aiming to clarify participants' understanding and/or interpretation did not appear to influence the group mean rating.

The establishing of criteria to determine consensus at the onset of the study made decision-making easier by ensuring a less random and selective approach. The

criteria that were established involved the setting of the baseline of 3.00 for inclusion and exclusion of competencies (Duffield 1993: 230), the statistical convergence of opinion reflected in a declining standard deviation as well as the reduction in the number of returned questionnaires (Goodman 1987: 730). The use of the three criteria resulted in the need for three rounds to be completed before consensus was determined.

It is interesting to note that Duffield's research, on which this study is based, used only one criterion to determine consensus. This criterion determined "...consensus as the point at which a change of opinion, reflected as a percentage of competencies moving above or below the mean score set as the point of inclusion" (Duffield 1993: 235). Applying this single criterion to this research study would have resulted in consensus being achieved after two rounds. The notable difference between the second and third round results in this study was the overall increase in the mean rating of the competencies and the overall declining standard deviations. Other differences are the exclusion of the competency *Nursing process* in the second round and the re-inclusion in the third round, as well as a change in the ten competencies that recorded the greatest strength of agreement. The additional competencies benefited the most from the extra round since these competencies were given the opportunity to be rated twice having only been included in the second round questionnaire.

The systematic increasing in the level of agreement of the competencies, sub-categories and categories raises the question as to whether participants were not perhaps affected by fatigue brought about by the iteration process. The use of three to four rounds however is noted for ensuring stability of the responses (Linstone, Turoff 1975: 229; Eefmeyer et al. 1986: 126). Since this research involved three rounds, these results could be viewed as the best judgement, in other words a compromise position where the significance of extreme or conflicting positions is not present (Mitroff, Turoff 1975: 22).

Providing participants with the opportunity to list additional competencies in the first round ensured the inclusion of competencies relevant to the South African situation as well as the PHC service. The adding of the 19 competencies without editing was

carried out to prevent misinterpretation and misrepresentation. Those who listed the additional competencies were not asked to give reasons as to why they considered it necessary to include these competencies. This resulted in the listing of competencies that lacked clarity. Participants did use the opportunity when commenting to indicate a lack of understanding, question relevance and highlight duplication of these additional competencies. Those that listed the additional competencies however, did not respond and this lack of response is interpreted as lack of accountability brought about by the anonymity of the panellist, which is considered one of the pitfalls of the Delphi technique (Sackman 1975, cited by Goodman 1987: 730).

While the Likert scale used in the study recorded the strength of agreement for the inclusion or exclusion of competencies, the different ratings given to the competencies seem to indicate the level of importance that participants afforded the competencies. Competencies that achieved high ratings were generally supported by comments that stressed the importance of the competency. Conversely the competencies that achieved low ratings were supported by either no comment or a comment that stresses the low level of importance afforded the competency. The researcher, when discussing the results of the study, has interpreted the level of agreement as the level of importance.

6.2. DEFINING THE ROLE

The final list of 170 competencies indicates that senior managers and academics expect the first-line manager to possess a wide range of managerial competencies. The extensiveness of the list confirms that the functions and the responsibilities of the position have expanded from an administrative position to a managerial position with a corresponding change in emphasis. The importance of the role now focuses on ensuring effective and efficient management of the centre. The identification of the skills that are required by first-line nurse managers in CHC's

enables delineation of the role that encompasses **Patient Care Management, Functional Management, Human Resource Management and Leadership** (Duffield 1989: 999).

6.2.1. Patient Care Management

The relatively low level of agreement afforded this category (3.591) and the increasing divergence of opinion, reflected in the standard deviations of the **Standard of Care** and **Patient Care Activities** sub-categories (Table 3.7: 85), is both surprising and confusing. The responsibility for overseeing patient care is noted in the literature to “fall directly on the shoulders of the first-line nurse manager” (Fox, Fox, Wells 1999: 12). Inherent in this responsibility is the expectation of achieving clinical outcomes within the framework of high quality and low cost.

In order to understand why the patient care component of the position achieved the lowest level of agreement and by implication the lowest level of importance, the individual competencies within the category were carefully scrutinised. Two distinct and different roles were noted amongst the competencies. The first role related to the management of care and the second role related to the nurse manager as a practitioner directly delivering care. These competencies were scrutinised to determine if the two roles jointly or severally impacted on the level agreement. **Patient Care Management** comprised 52 items, 15 items relating to the practitioner role achieving an overall mean of 3.20 in the third round and the remaining 37 items relate to the management role, achieved a mean of 3.722. This clearly indicates that there was greater agreement amongst participants regarding the nurse manager's role of managing care. The divergent opinion relating to the practitioner role reflected in the low level of agreement and participants' comments.

The level of agreement/importance achieved by the **Patient Care Management** category was clearly affected by the nurse practitioner component of the position. The lack of consensus noted in the **Patient care Activities** and **Standard of Care** sub-category was also influenced by the nurse practitioner role. These two distinct and different roles need to be explored.

6.2.1.a. Patient care management role

Closer scrutiny of the research findings has determined that the role of the first-line nurse manager is to ensure effective and efficient patient care, which is achieved through the management of others. Quality of care is an important outcome for first-line nurse managers, and this component of the role is also noted in the literature (McGillis Hall 1997: 22). The depth and breath of the management aspect of the position is noted in the competencies that direct, co-ordinate and monitor the delivery of care as well as those that offer staff support.

The directing component of management was noted in the competencies that provide proper practice models: *Developing standards of patient/ client care (3.762)*, *Planning safe, cost effective patient care (3.476)*, *Estimating patient/client workload (3.762)* and *Assessing community health resources (3.857)*. The co-ordinating component is noted in the competencies *Organising of centre (3.667)*, *Identifying work to be done (3.857)*, *Scheduling staff to reflect workload (3.810)* and *Facilitating multi-disciplinary team communication (3.714)*. Monitoring was noted in *Evaluating nursing care (3.810)*, *Supervising patient/client care (3.679)*, *Monitoring activities on the unit (3.810)* and *Controlling (supervising nursing practice (3.810)*.

The nurse managers' ability to effectively direct, co-ordinate and monitor the delivery of patient care is related to the level of responsibility and authority afforded the position. The greater the level of authority and responsibility the more the nurse manager is able to respond to change, which directly impacts on the provision of effective, efficient and appropriate care, and the greater the manager's accountability (Booyens 1996: 150). While the competencies associated with the management of care imply a high level of responsibility, authority and accountability, anecdotal evidence indicates that nurse managers' have little responsibility and no authority to effect changes to patient care delivery systems. If this is found to be true, it is doubtful whether managers can be made accountable for the delivery of quality care.

The competencies that are supportive of staff give credence to the view that caring for caregivers impacts on quality of care. The competencies *Perceiving workload pressures of staff (3.810)*, *Ensuring staff reflects workload (3.762)*, *Scheduling staff to reflect workload (3.810)* and *Best use of human resources (3.857)* highlight this supportive role. The optimal utilisation of staff is becoming increasingly important in the environment of shrinking budgets, staff shortages and increasing patient loads. All too often these pressures impact on the quality of work-life of staff that is exacerbated when support and care for caregivers is not provided (Shindul-Rothschild, Long-Middleton, Berry 1997: 35,41). If quality of care is to be a central focus of the nurse managers' role, then cognisance must be taken of the importance of staff support and the influences that a well-supported staff has on the delivery of quality care.

The level of agreement given to *Understanding the legal implications of nursing care (3.952)* and by implication a high level of importance, reflects both the socio-political and health care delivery changes in South Africa. Managers are being challenged to place greater emphasis on the rights of the patients and ensure that health care provision reflects those rights (Kotze 1997: 51). There is also a perception amongst nurses of the increasing number of complaints lodged against them and the corresponding rise in litigation. Duffield (1989: 1000) also reported a high level of importance for this competence, which would indicate that the level of importance is not unique to South Africa, but increasingly a reflection of international trends.

6.2.1.b. Practitioner role

Scrutiny of the third round data of the included items that related to the nurse practitioner role found that 47.5% (95) of items were excluded by 65% (13) of participants. This indicates a polarisation amongst panellists as to the first-line nurse managers' scope of practice. The inclusion of some items and exclusion of other items also indicates confusion and a lack of clarity regarding the nurse practitioner role. This role confusion is noted in the

exclusion of the items *Teaching patient and family (3.000)*, *Discharge planning (2.857)* and *Arranging follow-up (2.905)* and the inclusion of the item *Providing technical skills and patient/client care as required (3.286)*. These findings indicate that some panellists believe that the role is purely managerial and others believe it is a blended role that incorporates both management and clinical aspects. While those that supported the management role recorded their opinion both statistically and in comments, those that supported the blended role only used statistical ratings to reflect their opinion. This may indicate that those that promote the management focus of the position had a clearer and stronger opinion than the other panellists. The 'all or nothing' approach to the nurse practitioner role, reflected in the inclusion and exclusion of competencies, could however be a reflection of the study design, which did not afford participants the opportunity to identify specific circumstances for inclusion or exclusion of items. Refer to Figure 6.1: 126.

Non-involvement in direct patient care uses the business model of management where unit managers are not involved in production and often do not have the necessary skills and expertise. An example of this is distribution managers who manage the drivers but do not actually drive or service the vehicles. The underlying principle inherent in this model is that direct involvement detracts from the management focus of the position and can contribute to role conflict and confusion (Donner, Wylie 1995, cited by McGillis Hall et al 1997: 20,21).

Traditionally, unit managers' positions have focused on the clinical aspect of the position that also included an administrative component. The practice of promoting clinically competent nurses to unit manager position reinforced this clinical focus. However, the decentralisation of responsibility and authority to unit level has resulted in greater emphasis being placed on the management component of the position with a corresponding decrease in the clinical aspect (Duffield 1992: 39).

It is doubtful whether it would be possible to unilaterally adopt a solely management or blended role approach. A more pragmatic and balanced approach is needed that determines the scope of practice based on the span of control. The adoption of this approach, which clarifies the role based on the span of control, would result in some first-line nurse managers only managing care and others incorporating a blended role. If this approach is used the list of competencies would need to be adjusted to exclude nurse practitioner competence in the case of a management only position.

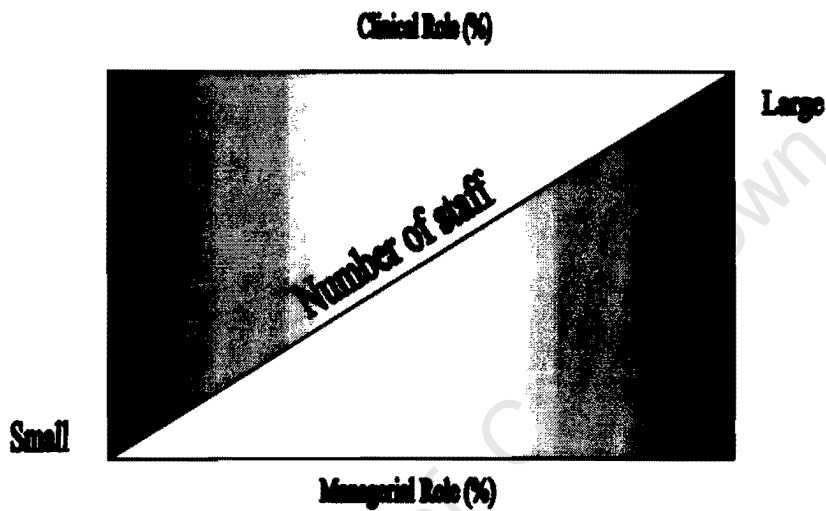


Figure 6.1: The balance between the clinical and managerial roles as influenced by staff numbers

A role that includes both management and clinical components is probably more realistic given the South African context. However, the balance between the managerial and clinical role will be dependent on the number of staff working in the unit. The larger the staff complement the greater the managerial role and conversely the smaller the staff, the greater the clinical role. Refer to Figure 6.1. Other factors that will also influence this balance are the profile of the patients, the manager and the employees (Alidina and Funke-Funke 1988:35).

The adoption of a blended role approach requires the inclusion of the patient care competencies. Since participants have excluded some of these competencies, it is necessary to determine whether any excluded patient care competencies are relevant for the practitioner role and therefore require re-inclusion. The competencies *Transcribing written orders of doctors'* (2.810) and *Implementing doctors orders* (2.762) need to be viewed within the context of the PHC approach that focuses on nurse based provision of care. It is therefore doubtful whether these competencies are relevant to those that provide care within CHC's. It is noted that in Duffield's (1993: 234, 235) research these two competencies were also excluded. The exclusion is therefore not based on the PHC approach, but more a reflection of the international trend of managing care using a multi-disciplinary approach. The competencies *Teaching patients and family* (3.0), *Discharge planning* (2.857) and *Arranging follow up* (2.905), which were also excluded are required to ensure the delivery of care and therefore should be re-included into the list of competencies when implementing a blended role approach.

The inclusion of the competency *Providing technical skills and patient/client care as required* (3.286), albeit with a low level of importance, could lead to the interpretation that nurse managers are required to include the role of clinical specialist into their portfolio. The adoption of the generalist approach with the incorporation of the vertical health programme into a comprehensive health service and the subsequent loss of clinical specialist could contribute to this interpretation (Department of Health and Social Services – Western Cape Province 1995: 18).

The management competencies that have been identified in this research are both extensive and complex and the inclusion of the clinical specialist component to the role would require a "super-nurse". This raises the question as to who should take over the clinical speciality responsibility. Anecdotal evidence indicates that no position has been created to give support to the nurse managers and staff, which has caused stress amongst managers already burdened by the expanded role. If clinical excellence is to

be considered important for the delivery of effective and efficient outcome based care then greater attention must be placed on the provision of appropriate support structures. Some countries have introduced the clinic nurse specialist as a means of addressing this issue and retaining experienced nurses in clinical areas (Duffield et al 1995: 19). Whether this approach is relevant and appropriate to South Africa is unclear, but cognisance must be taken of this issue and an appropriate solution found.

The correlation analyses involved both the management and practitioner components of the role. Factor 2 (Table 4.9: 101) identified a high correlation between **Patient Care Activities** and **Standard of Care**. These findings not only support the managers role of managing care through others, it also suggest that the panellists may consider the first-line nurse managers' role to also include providing care. This interpretation would support the blended role approach previously discussed. While the Spearman rank correlation supported this finding, surprisingly lower correlation coefficients were noted (Table 4.10: 102). The rank correlation however expanded to include both **Staffing Patterns** and **Financial Management**. While these findings support the management focus of the position, the lower correlation coefficients may suggest a lack of clarity as to the level of responsibility and authority that has been afforded the position to directly impact on patients' outcomes.

The provision of quality of care, at an affordable cost using the resources that are available, is an important outcome for all nurse managers and participants have indicated that this component of the role reflects the emphasis placed on it in the literature (Sovie 1994: 30; Fox et al. 1999: 12. Blake et al. 1982: 310).

6.2.2. Functional Management

Functional management encompasses resource management and focuses on the managers' role of organising and maintaining the working environment. This role involves ensuring the provision of an infrastructure to facilitate efficient and

effective care. Resource provision includes staff patterns, which directly influence the decision making processes and procedures used by managers. It is therefore not surprising that there was a correlation between **Financial Management, Staffing Patterns** and **Decision-making** together with **Role Model** and **Communication**, in both correlation analyses. This reinforces the role of the first-line nurse manager to determine the staffing, equipment and funding resources necessary to deliver appropriate and adequate care. These findings are consistent with those obtained by Duffield (1992: 51).

6.2.2.a. Financial role

The inclusion of financial management as a role, implies that CHC's are considered cost centres and the first-line nurse manager requires financial and business related skills in order to manage the centre.

There is however a polarisation amongst participants' as to the first-line nurse manager's role in financial management, that is reflected in the comments and ratings. While the mean rating in the final round confirmed the role, participants' comments do not always concur. *" It is the responsibility of the administrative staff member to prepare, control and monitor the budget, to allow the CPN to delegate her attention to the delivery of patient care, planning and strategic planning of staff."* Reviewing the third round data confirms this polarisation by indicating that 33.9% (95) of the retained items in the financial management sub-category scored 3 and under on the Likert scale, by 85% (17) of participants. This indicates a majority belief, that the first-line nurse manager should not be involved in financial management. The remaining 15% (3) support the financial management component of the role.

The polarisation of the financial management role was not expected as the district health system proposes decentralisation of authority and responsibility to the lower levels of management (Ntsaluba et al. 1998: 34). Also the international trend is to devolve financial management to the first-line nurse manager position (McGillis Hall et al 1997: 15). While the

polarisation may reflect confusions about the role responsibilities they could also indicate old attitudes amongst participants that support centralised management structures. Another possibility is that some senior managers do not believe that the first-line nurse managers have the skills required for financial management.

The lack of role clarity is further noted in the exclusion of the competency *Accounting and financial skills* and the lower levels of agreement/importance afforded *Financial forecasting* (3.333), *Understanding cost benefit ratios* (3.381) and *Using management information systems* (3.471), which are all key components of cost centre management. It is interesting to note that *Accounting and financial skills*, *Financial forecasting* and *Understanding cost benefit ratios* were excluded in Duffield's research (1993: 234). This raises the question as to whether there is a lack of understanding as to the level of competence required for these specific competencies since they are all relevant for effective and efficient financial management.

The lack of a clear understanding of cost centre management is further noted in the comments relating to competence *Using computers*, "...they (unit managers) are seldom computer literate or have a computer to use." While the comment reflects workplace realities, financial management cannot be achieved without the necessary computer related skills and equipment. The use of management information systems is also affected by computer access. It is however important to note that with spiralling costs and shrinking budgets, managers are increasingly being challenged to find effective and efficient ways of providing health care without compromising the quality of care. Information technology has been reported to play a major role in reducing the administrative burden of nurses by as much as 35% (Mc Donald, Chapman, MacKenzie 1994, cited by Mc Donald 1999: 16).

6.2.2.b. Resource management role

In the current climate of continual cost containment, it is surprising that the link between financial and resource management was not reflected in the

loading in either correlation analyse. The nurse managers' role in the control and supervision of facilities, equipment and supplies is well-established (Booyens 1996: 281). The importance of resource management and the link between resources, patient care and standard of care was noted in the Spearman matrix and this link has traditionally been considered part of the responsibilities of the managers and nurse practitioners (Regan 1975, cited by Gillies 1989: 571). The identification and prioritising of resources has always been considered essential for the provision of effective and efficient care.

Resource management was also linked with **Staff Communication** and **Staff Development** in the Spearman matrix. The nurse managers' role of informing staff and being informed by staff of resource related issues are essential aspects to ensure effective decision-making that directly impacts on the standard of care. The training of staff to ensure effective utilisation of resources also ensures good quality patient care. These findings that identify the nurse managers' role as facilitating communication related to resources and ensuring the ongoing training of staff have also been reported in the literature (Gillies 1998: 571).

The resource management role has been summarised in a participant's comment. *"Each clinic should have a 3-5 year equipment updated/replacement plan and annual maintenance programme to ensure efficiency and safe patient care. Three month inventory check – proper control of equipment of a daily basis...Training on correct use of equipment on a planned year basis."*

6.2.3. Human Resource Management

The first-line nurse manager role of 'getting things done through people' is clearly noted in the high level of agreement/importance afforded management of human resources in the overall mean of 3.687 for the category. The level of agreement/importance is also reflected in four of the sub-categories that recorded

a mean of 3.702 and above. This finding that human resource management is considered one of the major functions of the position is consistent with other research findings (McGillis Hall et al. 1997: 15). It is interesting to note that panellists did not consider the necessity to add competencies that specifically relate to the management of staff, and only removed one of the items. The implication of this is that the human resource role is similar if not the same as the hospital based role identified by Duffield (1992, 1993).

6.2.3.a. Role of structuring a harmonious workplace

The competencies listed in the **Employee Relations** focus on the structuring of a harmonious workplace by determining the staff resources that are required to deliver adequate and appropriate care. It is therefore surprising that **Employee Relations** did not load with **Staffing Patterns**, in either of the two analyses. While the inclusion of all the competencies listed in this sub-category indicates that the role of the first-line nurse manager involves all components, further scrutiny of these competencies indicates a dichotomy.

The competencies *Interviewing and selecting of staff* (3.476) and *Recruiting of staff* (3.429), were afforded relatively low ratings in light of the importance afforded the human resource component of the position. Reviewing the third round data on both these competencies, it is noted that in the case of the competency *Interviewing and selecting of staff*, 40% (8) of the participants' scores recorded a rating of 3 and below and *Recruiting of staff*, 50% (10). This polarisation is surprising since responsibility for delivery of care is vested in the position, which is achieved through the delegation and co-ordination of others. These findings raise the question as to who is responsible for the selection and recruitment of staff if the nurse manager is not. One participant commented that the nurse manager should be involved, but did not give a clear indication as to where the authority and responsibility was to be vested. This polarisation could be a reflection of centralised authority and responsibility associated with the recruitment and selection of staff. More research would be required to support or reject this

interpretation. Whatever the results of those findings, it is important to note that if managers are expected to be responsible for the outcomes of a centre the responsibility and authority for the recruitment and selection of staff must be vested in the position.

The very weak correlation between **Employee Relations** and **Staff Communication** was also surprising given the high ratings afforded the competencies *A knowledge of complaints procedure (4.00)*, *A knowledge of personnel management (3.952)* and *Identifying and resolving personnel problems of staff (3.905)* which require a communication role for implementation. These high ratings are possibly more a reflection of the changes in the labour legislation that has focused on the democratisation of the workplace by emphasising the rights of the employee and the need for managers to follow procedures in accordance with the law. The unionisation of nurses could also have influenced the level of agreement/importance. The changes in the structure and function of the workplace and the increase in industrial militancy have been reported to cause the dis-empowerment of managers (Geyer 1999; Nel 1999). The high rating afforded these specific competencies could also be a reflection of this, by requiring managers to have a high level of competence to ensure appropriate application in accordance with the legal requirements.

The high level of agreement/importance afforded *Informing staff of organisational change (3.952)* however, highlights the impact of change on the nurse managers' role. This influence is also noted in a participant's comment, "*During times of change..., it is of the utmost importance to keep staff informed about what is going on at all times – otherwise staff lose confidence and trust in the organisation.*"

The key component of management is getting things done through people, which require a high level of communication especially associated with staff. It is therefore surprising that the **Staff Communication** sub-category only loaded once and that was with **Equipment/ Supplies expense**. These findings are confusing and disappointing as a loading with **Patient Care**

Activities, Functional and Human Resource Management were expected. The interpretation for this lack of loading is that the position is not considered amongst participants as a link between management and patient care, which is achieved by "organising and maintaining the working environment's structure of rules, communications and relationships" (Duffield 1992: 51). Further research will have to be carried out to confirm or reject this interpretation, but cognisance must be taken of the large amount of time nurse managers spend talking to others so that they are able to carry out their different roles (Baxter 1993, cited by McGillis Hall et al 1997: 25).

6.2.3.b. Staff Evaluation role

This sub-category was afforded the second lowest level of agreement within the **Staff Management** category. Scrutiny of the third round data indicates that 30 items within **Staff Evaluation** scored 3 on the Likert scale, by 60% (12) of participants. This indicates a polarity amongst participants regarding the staff evaluation role of the nurse manager, which seems to relate to the extent to which the authority and responsibility has been devolved to the position. This deduction has been made based on participants' comments, which are summarised in this comment. *"Maintenance of standards and evaluation of performance is an integral part of the management function and the actual implementation depends on the delegated authority."* Comments also indicate the involvement of middle managers and human resource managers, but as previously noted there is lack of clarity amongst participants as to where the ultimate responsibility lies.

Implicit in this sub-category is the use of performance appraisal and how these appraisals are used. However, management literature supports the involvement of the line manager in the evaluation role (Gerber, Nel, van Dyk 1987: 443). While there is a growing trend of performance related rewarding of employees, cognisance must be made of the role that evaluation plays in the training and development of staff. The staff evaluation role of the first-line nurse manager is particularly relevant in the light of the Skills

Development Act (Act 97 of 1998) that requires skills analysis and development plans for each employee (Nell 1999). It is therefore surprising that **Staff Evaluation** and **Staff Development** did not load in either the factor analyses or the Spearman rank correlation.

6.2.3.c. Staff Development role

Acceptance of the staff development role, which includes responsibility for orientating, teaching and developing staff potential, is noted in the overall rating for the sub-category (3.776). However, the fact that the competency *Teaching staff* (3.524) received the lowest rating of all the competencies in the sub-category, is surprising. The third round raw data also indicates that 40% (8) participants recorded a 3 and below rating on the Likert scale, which implies that some participants believe that teaching is not part of the role.

All the competencies listed with the **Staff Development** sub-category need to be viewed within the context of the Skills Development legislation that not only requires the documentation of the skills, knowledge and abilities of each position, but also a skills analysis and development plan for each employee (Nell 1999). This legislation challenges the once-off licence system and promotes appropriate and relevant learning on a continual basis. The daily involvement of the nurse manager with those working in the centre reinforces the need for this development role. Access to resources that can assist the nurse manager in the development of staff is of the utmost importance since it is unrealistic to expect the manager to be competent in everything, but the authority and responsibility needs to be vested in the position.

6.2.3.d. Disciplinary role

The competency *Termination of employment* (2.381) was not considered part of the role with 85% (17) of participants in the third round, affording a rating of 3.00 and below. . Whilst participants' fear of repercussion from unions due to the labour legislation was noted in comments, the fact that this finding is consistent with that of Duffield (1993: 234) seems to indicate that

Termination of employment is generally not considered part of the role of the first-line nurse manager.

However, participants have shown acceptance of the nurse managers' disciplinary role, but indicate the need for organisations to give support and guidance through policy, procedures and management structures. The need for nurse managers to be provided with peer and supervisory support is also noted in the literature (McGillis Hall et al. 1997:29, 30).

A perusal of the third round raw data of the **Staff Management** category, indicates that 25 of the 26 items in this category scored 3 and under on the Likert scale, by 90% (18) of participants. This polarisation is also noted in participants' comments, which centre on the nurse manager involving others in carrying out the different roles. The implication of this finding is that the responsibility for managing the people within the centre is not vested in the position and this is of particular concern. While managers need to access resources that offer assistance and guidance when necessary, the ultimate responsibility must be vested in the position. Affording managers the appropriate responsibility is supported by Senge (1990: 62) who reports that learning to manage people involves time and commitment and the burden should not be shifted to Human Resource Specialists but retained at the line management position. This dichotomy however could reflect the centralised management system that has not devolved the responsibility to the position as well as participants' attitudes that either reflect the previous system or indicate a believe that the nurse managers' do not have the necessary skills.

6.2.4. Leadership

Leadership is defined as "the ability to influence a group towards the achievement of goals" (Robbins 1993: 724). The variety of behaviours reflected in the competencies listed in this category claim to reflect leadership and focus on the organisation, staff and the nurse manager. These three foci are noted throughout

the five sub-categories indicating an overall leadership role and a more specific professional and research role.

The increasing importance of leadership for nurses in all roles has been reported (Krejci, Malin 1997: 235) as well as the importance of leadership in times of transformation (Kotter 1990, cited by April, McDonald 1998:15). While cognisance must be taken of the international nursing trends when interpreting the high level of agreement/importance afforded leadership in the study, transformation has possibly had the greater impact. The concept of transformation brought about by the socio-political and health care reform has profoundly impacted on the workplace environment, which requires people to redefine their goals, boundaries and activity systems (Aldrich 1999: 166,167). Those given the responsibility for managing have had to manage existing operations using 'old' modus operandi, whilst instituting substantive changes requiring quite different leadership skills than previously required.

6.2.4.a. Research role

The inclusion of research albeit with a low level of support (3.551) is interesting as anecdotal evidence suggests that nurse managers do not perceive this as part of their role. A perusal of the raw data indicates that all seven items in this section scored 3 and below, by 60% (12) of the participants. While these findings give credence to the anecdotal evidence there is clearly a polarisation of the view of the first-line nurse managers' role in respect of research. The majority (60%) believed that the nurse manager should not include research as part of the role. The increasing divergence of opinion is also noted in the standard deviation that reflects a low level of consensus (Table 3.7: 85). The precise research role of the first-line nurse manager therefore requires further research.

However, the South African nursing profession is striving to develop a research base of its own. It is therefore important that nurse managers in their leadership role acknowledge the importance of research. The Spearman matrix (Table 4.11, 103), confirmed the link between **Leadership**

Activities (0.68), **Patient care Activities** (0.67), **Standard of Care** (0.59), and **Research** albeit with a low coefficient, indicating a very broad perception of the nurse managers' role in research. Not only are they required to *Participate in research* (3.714), but they are also required to *Apply research findings* (3.714) and *Interpret* (3.381) research, which impacts on the standard of care. Participants also indicated that as leaders nurse managers should not only have a *Knowledge of the research process* (3.524) but also *Involve staff in research* (3.762) and to a lesser extent assist in obtaining grants by knowing the sources of these funds. This leadership role is of particular relevance since nurses' historic involvement in research is that of data collection on behalf of others.

The implementation of research within units presupposes the required skill base amongst nurse managers, which is reflected in the item *Knowledge of research process* (3.524), as well as the appropriate support systems and services within organisation. While education providers are well equipped to address the research competence of the nurse managers, it is unclear whether organisations have the capacity to provide support systems and services for managers and staff to carry out research. Organisational support is essential for the successful implementation of research at a unit level and managers will not be able to effectively carry out this research role if the necessary support is not provided.

The high correlation between **Research** and **Staff Evaluation** noted in the Factor 3 (Table 4.9: 101) is confusing. Perusal of the competencies listed within these sub-categories leads to the interpretation that the evaluation of staff includes the research related components of their role as defined by their job description. The Spearman matrix (Table 4.11: 103) reaffirmed the **Research** and **Staff Evaluation** link, but expands it to include **Patient Care Activities**. This link makes more sense as it reinforces the managerial focus of the position to ensure the provision of research based patient care which is monitored through the staff evaluation process.

6.2.4.b. Role Modelling

The competencies that are included within this sub-category highlight the three foci for leadership, the organisation, staff and the nurse manager. No competency was excluded in the third round competency list and *A knowledge of ethics (3.6)* and *Fostering a positive organisation culture (3.5)* were added from the additional list. The high level of agreement/importance afforded this role was supported by the fact that the competencies *Initiating personal (own) and professional growth and development (3.952)* and *Maintaining own professional identity (3.952)* were part of the ten competencies that achieved the highest rating in the third round.

One of the foci within the role model dimension is professionalism, which is achieved through professional development of the nurse manager and the unit staff. The nurse manager's leadership role is reflected in the items *Initiating personal (own) and professional growth and development (3.952)* and *Maintaining own professional identity (3.952)* and *Developing and maintaining personal (own) professional competence (3.905)*. The high level of agreement/importance given to these competencies while reinforcing the lead by example principle, needs to be seen within the context of the substantive changes that have occurred and the position acquiring greater responsibility and authority. These factors have challenged managers to not only find new ways of managing people but also to behave in a manner commensurate with the management focus of the position.

While women are notable for focusing on personal and career development (Maddock 1999: 39), health care professionals are constantly being challenged to improve and update their skills to meet the need of an ever-changing environment (Basford, Downie 1991: 57). The nurse manager's focus on professional development will facilitate improved management and delivery of care through their own practice and the effect that their behaviour has on their staff.

The role of the nurse manager in facilitating the professional development of staff is also noted through *Co-operating with affiliated education programmes (3.857)*, *Acting as a teaching role model (3.905)* and *Acting as a resource person (3.857)*. The inclusion of these items needs to be viewed within the context of the management focus of the position, which implies that the role of the manager is to facilitate the professional development of those being managed. The fact that the correlation analyses have not recorded a link between **Role Model** and **Staff Development** is surprising as a link was anticipated, since the items listed in each sub-category appear to be complimentary. However, the extent to which the nurse manager is to be directly involved with the professional development of staff must be dependant upon access to education and training resources, the scope of practice of the manager, the managers' own skills and the diversity of skills amongst unit staff.

Leadership that focuses on the organisation is noted in the competencies that place the unit within the organisation as a whole and the nurse managers' role as a change agent. The organisational role is noted in the competencies *Interpreting (3.875)* and *Implementing organisational goals (3.810)*, *Administering nursing orientated policies and procedures (3.762)* and *Fostering a positive organisational culture (3.5)*. The nurse managers' role in leading the team and facilitating the unit's inclusion into the larger organisation is evident in these competencies. Situating the unit within a larger structure directly impacts on the nurse managers' decision-making, which also impacts on patient care through the implementation of policies and procedures. Communication is key to successfully lead this process. The Spearman matrix (Table 4.11: 103) confirmed the link between **Role Model, Communication, Decision-making and Patient Care Activities**.

The changes that have been very evident in the country over the last few years could have accounted for the high levels of agreement/importance afforded the competencies *A Knowledge of change theory (3.857)*, *Initiating (3.810)* and *Facilitating (3.810) change*. While the pace of change during the

transformation process has been exponential, organisational change is ongoing and is influenced by both internal and external factors. The implementation of change requires communication and impacts on decision-making and patient care and these links confirm the Spearman Matrix (Table 4.11: 103).

Knowledge of ethics (3.6) is also associated with role modelling. The need for managers to exhibit ethical standards and thereby become role models within the organisation requires a clear knowledge and understanding of ethics. The 'lead by example' principle sets the ethical tone that enables managers to raise the overall level of ethical behaviour (Robbins 1993: 366).

The moral and ethical fabric of South African society has been profoundly affected by the apartheid system. On the one side the government of the day institutionalised an immoral system and used the law and the institutions to enforce the system. On the other side opponents of apartheid often used unjustifiable measures to challenge this system. The erosion of moral values has continued with the defeat of the apartheid system with an increased reporting of corruption (Mthombothi 2000: 29). These circumstances reinforce the need for strong moral leadership at all levels of society and the workplace.

The adding of the competency *Knowledge of ethics (3.6)*, within the nursing context is interesting in view of the fact that nursing being a profession implies ethical behaviour. Ethics being the practical outworking of the personal, cultural and professional values of the individual presuppose the development of moral reasoning skills. Since ethics define the right and wrong conduct, the adding of this competency suggests a problem in the development of moral reasoning amongst nurses as well as a lack of understanding of nursing ethics. This interpretation is supported by Botes (1999: 66) who found when carrying out a critical analysis of case studies, that the survival phase, where people care about themselves and not others, was evident in the practices of those nurses involved in the study. The

nurse manager role in ensuring ethical practice is carried out in the unit is a key leadership role.

6.2.4.c. Leadership role

Leadership is about persuasion, influence and inspiration, not control and encompasses both organisational behaviour and human resource management (Biscoe 1997:11).

At the time of this study there was strong anecdotal evidence regarding the high stress levels amongst staff and the corresponding low morale brought about by the transformation processes that resulted in constant and rapid changes. The high ratings given to the staff support competency *Creating a favourable work environment* (3.952) supports this view. This competency is further supported by the relatively high rating given to *Identifying stress in staff and self* (3.875), *Developing and maintaining staff moral* (3.875) and *Developing staff support* (3.875). The nurse managers are seen as mentors to those working in the unit, which is an important role for those required to provide leadership in times of crisis. Only time will tell whether these high stress levels and the corresponding low morale amongst staff will continue thereby requiring the nurse manager to maintain the crisis leadership role. Anecdotal evidence is beginning to surface reporting that staff shortage, lack of appropriately skilled staff and workload pressures have replaced the transformation process as the sources of stress amongst staff.

Managing Diversity (3.7) also reflects the transformation process. South Africa is a society that is often referred to as the "rainbow nation", which is a title that is used to describe the diversity of cultures, ethic, language, racial groups and first/third word mix. These differences are reflected in the diverse values, beliefs and behaviours found amongst its peoples. The transformation process has forced the integration of these different groupings and challenged first-line nurse managers to interact with patient, staff and colleagues who mirror this diversity. *Managing Diversity* requires a new repertoire of skills and is challenging managers for greater tolerance

and creativity (Martins 1999: 30). The need to find new ways of getting things done through people is reinforced in the high level of agreement/ importance given to *Participative decision-making (3.952)*, *Allocating responsibility and authority appropriately (3.952)* and *Exacting accountability for work by staff and self (3.952)*. The inclusion of *Interpersonal Skills (3.690)* as a competency further supports the consultative role that is required of managers.

The organisational behaviour items reflect a broader awareness of the place of individuals and the centre in which they work within the organisation. The nurse managers' competencies in relation to organisational behaviour and working within a bureaucracy are reflected in the competencies *Knowledge of management (3.762) and organisational (3.762) behaviour and theories*, *Able to motivate (3.857) and negotiate (3.857)*, *Management by objective (3.810)*, *Co-ordination between areas (units and departments) (3.905)* and *Dealing with bureaucracy (3.714)*. The importance of organisational factors on the nurse managers' role is noted in the link between **Leadership Activities** and **Standard of Care** reflected in the Spearman matrix (Table 4.11: 103).

Leadership that facilitates the unit being positioned as part of a larger organisation is noted in the items *Seeing the organisation as a whole (3.857)*, *Interpreting (3.857) and Implementing (3.810) organisational goals* and *Fostering a positive organisational culture (3.5)*. Leadership that positions the unit within the broader community is noted in the items *Political knowledge (3.762)* *A knowledge of power relationships (3.810)* *Maintaining an awareness of socio-political and economic trends (3.810)*, *Knowledge of strategic planning (3.7)* and *Developing collegial relations (3.810)*. Inherent in these competencies that position the unit within a broader context is a 'systems approach' (Senge 1990: 3). A 'systems approach' facilitates the provision of services based on the health needs of the people within a community and recognises interdependency, which is inherent in the PHC philosophy. The variety of skills required that would enable nurse managers

to effectively implement a 'systems approach', are broad, varied and complex.

Services are being challenged to be integrated, continuum based and multi-focal that emphasise quality of care at an affordable cost (Porter-O'Grady 1999: 42). All these requirements are both overwhelming and complex and a "systems approach" is recognised as the best way of leading the process (Senge 1990: 69). The nurse manager is not able to achieve this without the support of all unit staff. Leadership is achieved through involvement of staff in decision-making and the high level of agreement/importance given *Participative Decision-making (3.952)* would support the incorporation of a "systems approach".

One of the key elements of decision-making is access to information, which is noted in the communication competencies that are particularly associated with groups. It is therefore not surprising that there was a loading between **Decision-making and Communication** in the Spearman matrix correlation (Table 4.11: 103). The communication skills involve different and varied types of communication while including both *written and oral skills (3.857)*, the communication involves *Providing feedback to administration (3.810)*, *Participating on committees (3.762)*, *Interacting with other departments (3.905)* and *Public relations (3.810)* at the same time *Acting as a unit spokesperson (3.857)*. The diversity of groups, with whom the nurse manager is to communicate, range from senior management to community structures and colleagues. It is therefore not surprising that the nurse manager is required to have *A knowledge of communication channels (3.905)* and *A knowledge of communication techniques and theory (3.810)* at the same time *Understanding of group dynamics (3.857)* and *Team building/group process skills (3.810)*. The support shown for these skills reinforces those skills required in order to communicate with staff. It is therefore surprising that no correlation was recorded between **Staff Communication and Communication** in any of the correlation analyses.

Participative decision-making (3.925), which reinforces the involvement of staff in decision-making, is notably one of the competencies that achieved a top ten rating in this study. This competence highlights the involvement of staff in decision-making thereby empowering them to take responsibility and to shape their own reality. The empowerment of clients and their families as well as the community through decision-making also needs to be seen as part of participative decision-making. The need for the manager to be *Able to motivate (3.857)*, *negotiate (3.857)* and *delegate (3.857)* reinforces this empowerment role. The requirement of managers to use a more proactive approach when making decisions is also reflected in the competencies *Setting priorities (patient/client, staff, centre) (3.857)* and *Planning of activities, long and short term (3.857)*.

The managerial focus of the first-line nurse manager position is also reflected in the nurse manager being able to make decisions that relate to *Defining centre's philosophy (3.857)*, *Setting centre's goals (3.857)*, *Formulating centre's objectives (3.810)* and *Developing centre's policies (3.810) and procedures (3.857)*. Decisions that are related to these aspects guide further managerial decisions such as resource allocation including the human resources. However, the extent to which the nurse manager will be able to make these decisions will be based on the extent to which responsibility and authority has been devolved to the position. It is not clear from this research as to the extent to which the nurse manager is able to make these decisions.

The competency *Using power and status to achieve goals for patients, staff and centre* was the only competency excluded from this category at the end of the third round. The exclusion was influenced by participants' negative perception of power as reflected in comments. This negative interpretation could be viewed as a reaction to the rigid hierarchical management systems previously used in South Africa (Slabber 1993: 14) and employees unwillingness to tolerate rigid control and rule by coercion (Saunders 1998: 32). This competency however was also excluded in Duffield's (1993: 235),

study based in Australia, which broadens this interpretation. Managers' that use power-wielding techniques that are associated with dominance are not unique to South Africa, which would account for the exclusion of the competency in Duffield's study (Maddock 1999: 35). The exclusion of the competency in this study is probably more a response to the management styles and systems previously used within nursing.

6.4. Conclusion

This Delphi study has shown that senior managers in both provincial and local health departments as well as educators, that participated in this study, have incorporated a wide range of competencies for the first-line nurse manager positions. Only three rounds were required and that indicates a high level of consensus amongst participants as to the role competencies of the first-line nurse manager in CHC's. These role competencies reflect a paradigm shift from an administrative task orientated position to that of a managerial relationship orientated position. However, polarisation amongst participants reflected in individual ratings and comments indicate that some participants are at differing stages within the paradigm shift. This study set out to facilitate the paradigm shift by enabling participants to clarify the role through the feedback process that recorded the ideas and attitudes of all involved.

The final list of competencies that have been developed from this study relates to first-line nurse managers of CHC's within the current South African health environment (Table 8.2: 164,165). It is interesting to note that this list of competencies is similar to those identified by Duffield (1994: 64) in a hospital-based study conducted in Australia.

The similarity of finding, one relating to hospital-based care in Australia, and the other to community-based care in South Africa, suggests that the role changes are more a reflection of international health care trends than local transformation efforts.

Chapter 7

Recommendations

7.0. INTRODUCTION

The implementation of research findings is often the greatest challenge facing researchers and the implementation of these research findings is no exception. This chapter will make recommendations for the implementation of the redesigned first-line nurse manager role within the PHC service. These recommendations will be discussed under the following headings:

- Implementing the redesigned role
- Responsibility for implementation
- Providing support for first-line nurse managers
- The incorporation of the managerial and clinical roles
- Competency-based education and training
- Targeting training
- Appropriate remuneration
- Out-come based incentives
- Education preparedness

7.1. IMPLEMENTING THE REDESIGNED ROLE WITHIN THE PHC SERVICE

The goal of any health service is to provide quality care based on available resources, and developing the management skills of the first-line nurse managers is one way of maximising a valuable resource and improving the quality of care. However, the learning of new skills is not sufficient to take on this expanded role.

The concept of transformation brought about by the socio-political and health care reform has profoundly impacted on the workplace environment, which requires people to redefine their goals, boundaries and activity systems (Aldrich 1999: 166,167). Therefore present incumbents of these positions will be required to abandon certain attitudes and values previously held dear and incorporate new ways of interacting with staff and the community to ensure participative decision-making whilst at the same time implementing outcome focused quality care. The patient-centred microfocus used in direct patient care must change to incorporate a more global view of issues concerning the entire organisation and the community. Also this new role will require nurse managers to rely less on positional authority for controlling others and more on interpersonal skills.

The final list of competencies that has been developed from this research study (Refer to Table 8.2: 164,165) are expansive and varied, and incorporate a new repertoire of skills previously not required of first-line nurse managers of CHC's. The method used to introduce the list to the different levels of management is crucial as this will impact on the way the list of competencies is viewed by all concerned. If the list of competencies is used as a framework for carrying out a skills analysis assessment on all first-line nurse managers it may result in dis-empowerment and resistance because those in the position may find a low level of competence in many of the listed skills. Middle and senior managers may also feel dis-empowered and resistant since the first-line nurse manager will be required to carry out many of the tasks currently considered part of their role. Also a low level of competence may be found amongst these managers in many of the listed competencies. These new competencies need to be introduced as a changing role spearheaded by the adoption of the PHC approach, but reflecting international trends of devolving decision-making to the lowest management level. The list should not and must not be presented as a checklist against which people are evaluated.

Implementing a redesigned role in any situation is difficult, and a role as pivotal as that of a first-line nurse manager, which impacts on the organisation as a whole and the community of health care providers, will be particularly challenging.

Cognisance must also be taken of the fact that this role change is part of the transformation of the health service and represents a paradigm shift, (Refer to Table 8.1: 161). Transformation which requires the redefining of the goals, boundaries and activity systems involves a break with existing routines and a shift to new kinds of competencies that challenge organisational knowledge (Aldrich 1999:165). Paradigm shift (Kerfoot 1996: 181) on the other hand is reflected in the change from an administrative task orientated position to that of a managerial relationship orientated position. These factors will impact on the implementation process, and it is therefore important to find ways that facilitate the implementation, which include;

- Providing learning/studying opportunities to acquire the skills /competencies that are needed to carry out the redesigned role.
- Encouraging self-evaluation to facilitate the first-line nurse manager's own understanding of her/his strengths and weaknesses.
- Realising that the implementation may be vehemently challenged.
- Being aware that those resistant to the redesigned role will use many different methods to show resistance.
- Accepting that the changes will impact on organisational life. Every effort must be made to facilitate the transition by providing appropriate support systems and services.
- Practising effective communication since this is crucial for keeping people informed about the process, as well as creating the opportunity for positive and negative feedback.
- Ensuring that key players are proactively consulted and involved in the implementation process
- Ensuring that enough time is given to the planning process.
- Realising that the process will take time, involve much effort and will not be easy.
- Ensuring that those involved with the implementation are given time away from their daily activities and the appropriate authority to implement the redesigned role.

7.2. RESPONSIBILITY FOR IMPLEMENTATION

The inter-relationship between the different tiers within the health system with reference to the training and development of staff is reflected in Figure 7.1. (ANC 1994: 60; Department of Health and Social Services – Provincial Administration Western Cape 2000: 9).

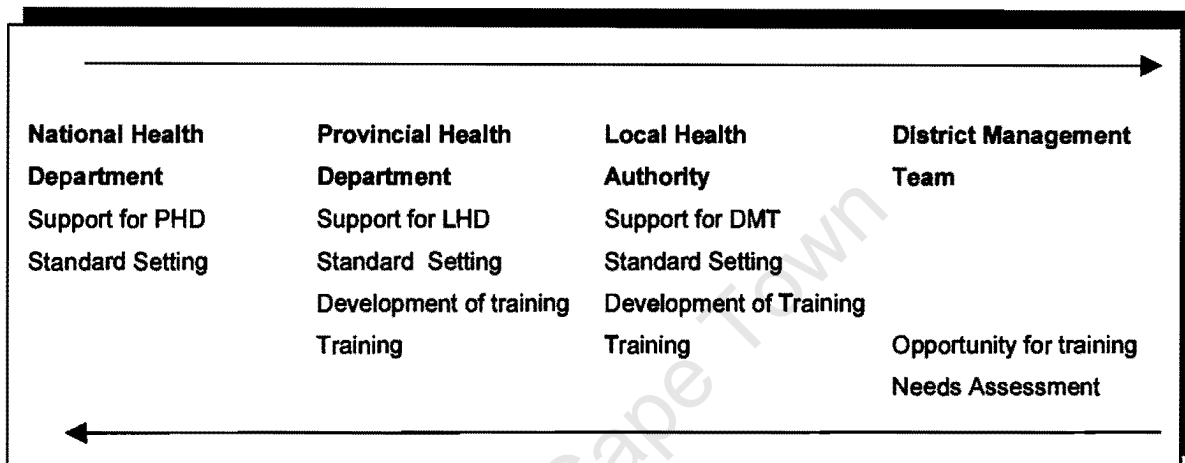


Figure 7.1: The inter-relationship between the different tiers within the health system

The responsibility for implementing lies with the local authority health departments. Whilst the local authority health department must formally agree to the redesigned role and provide the necessary resources, the District, being the central focus of the PHC system, seems to be the best place to implement the redesigned role, through the District Management Team. The District Management Team, being the next level of management in the hierarchy, is responsible for the overall management of each district and the implementation of this new role needs be vested in this team. Whilst the composition of the District Management Teams will vary, those in the team are able to direct the development of each first-line nurse manager and provide appropriate support, within the context of the needs of the district. Also whilst the Team as a whole will be responsible for implementing the training and developmental strategy for the first-line nurse managers, a person on the team needs to be identified to take on the specific responsibility on behalf of the team.

Whilst the District Management Team is responsible for implementing the new role, the first-line nurse managers within the district should be directly involved with identifying the training needs and the development of a strategy for implementation. The involvement of the first-line nurse managers at this early stage will ensure that these managers take responsibility for their own professional development, which will reduce potential resistance.

7.3. PROVIDING SUPPORT FOR THE FIRST-LINE NURSE MANAGERS

Implementation of the new roles is not only difficult for the implementers, but also for those that are required to take on the new role. The new role will require both the learning of new skills and practice in the new ways of doing things. The development of a peer support group within each district, that will provide managers with a forum for discussion of common management dilemmas and provide for group problem solving will facilitate this role transition. This group could provide valuable networking opportunities that would go a long way to decreasing feelings of isolation because similar problems and frustrations are identified. The support group is also a means of promoting nurse managers' professional development. While the responsibility for maintaining professional competence belongs to each first-line nurse manager, the employing authority needs to initiate staff development programmes by facilitating continuous education. The support group can also be used as a vehicle for continuous education and development. However, while the group can offer support and motivation, it also has the capacity to retard and restrict the transition especially if a number of those participating in the support group are resistant to the changing role. Successful implementation of a support group is directly related to the facilitation skills of the person co-ordinating the group. Therefore great care should be taken when selecting a senior manager to co-ordinate the support group.

7.4. THE INCORPORATION OF THE MANAGERIAL AND CLINICAL ROLES

While the first-line nurse managers' role identified by this research is mainly managerial, there is recognition that a clinical component exists, and that this component varies from centre to centre, and is influenced by a number of factors, but more especially the number of staff employed. However, since the clinical component of the position is currently an important role in most CHC's, the incorporation of the extended managerial role needs to be phased in over a period of time. The phased inclusion of the extended managerial role will also help those in the first-line position to slowly delegate some of the clinical components of the role in order to provide the time needed on the extended management role. While most centre managers will include some clinical role, the amount of time involved will vary based on the size of the clinic, the type and variety of services provided and the skill base of the staff and the manager. The phased extension of the managerial role and the corresponding delegation of the clinical role will facilitate the transition for all those current incumbents of the first-line nurse manager position, since the transition from care giver to decision-maker has been cited as a factor causing role conflict and role confusion. (Swaffield 1987: 25).

7.5. COMPETENCY BASED EDUCATION AND TRAINING

Over the past few years South Africa has changed the focus of education and training from an emphasis on acquisition of knowledge to an outcome-based learning. A component of this strategy is to determine the competencies, which are stated in 'behaviours' terms. These 'behaviours' or indices are not only observable but also measurable and reflect the knowledge, skill and attitudes needed to perform in a professional role (Broski, Brunner, Chidley, Johnston, Karas & Rotherberg 1977:39). The adoption of this outcome-based education has resulted in the need for education and training programmes to be written within the format as laid down by National Qualifications Framework (NQF), who determines the appropriate level required to perform a professional role. All education and training

programmes require approval and accreditation from the South African Qualifications Authority (SAQA) prior to implementation. The identification of the competencies required for first-line managers in this research study facilitate the development of appropriate education and training for first-line nurse managers using the outcome-based approach.

While the process used to implement competency-based education and/or training programme may vary, a number of elements are found to be common. Cognisance must be taken of these elements when developing education and/or training programmes.

- Competencies are known to all concerned. Students, teachers and managers are informed as to the behaviours that are to be mastered at the onset of the process.
- The achievement of competence is evaluated against pre-determined criteria.
- While the performance standards are held constant, the instruction time varies, as the process is self-paced.
- Mastery of the prerequisite behaviours needs to be demonstrated, before moving forward.
- Instruction is organised in modules that either focus on a specific competence or set of competencies.

7.6. TARGETED TRAINING

The use of a training and development plan for each first-line nurse manager acknowledges different levels of experience and education. However, since all first-line nurse managers have the same level of inexperience associated with this new role, one might be tempted to use the same training programme for all concerned. While this process may be the most cost-effective method, the benefit is short term

and does not take into account the education differences amongst the first-line nurse managers. Also the elements of competency-based training as previously noted indicate a process that is driven by each individual concerned.

The list of competencies that have been identified in this research study can be used in a number of different ways.

1. To identify the levels of preparedness of each of the first-line nurse managers for the management role and simultaneously establishing a skills development plan for each first-line nurse manager, which is a requirement of the Skills Development Act of 1999. This will also enable the employers to claim training costs from the training fund, since the development of first-line nurse managers would be considered ongoing training and development.
2. The list allows for prioritisation of certain functions and the targeting of special training workshops, which permits the gradual introduction of the different roles and functions. The rating score given to each of the competencies, while indicating the level of agreement also indicates the level of importance afforded the competency by the participants, and those competencies with high ratings can be used to target training. For example the two competencies from **Employee Relations** that achieved high ratings are *A knowledge of complaints procedure (4.00)* and *A knowledge of personal management (3.952)*. These two items together with the other five items within the **Employee Relations** sub-category could be targeted so that those in the position can focus on the role of structuring a harmonious workplace. Conversely, the first-line nurse managers within each district can prioritise the list themselves for the purpose of targeting training. Whatever the process that is used to prioritise, it is important to remember that those who are to attend the training must indicate that the targeted workshops are both relevant and appropriate, since perceptions of training needs often differ.

The training programmes must also include well-structured and supervised field experiences as it not only demonstrates the application of knowledge, but also provides for professional mentors that facilitate communication and support.

7.7. APPROPRIATE REMUNERATION

The process of developing each first-line nurse manager within each district and local authority will be time consuming, involve much effort from all concerned and could prove to be costly. However, the benefits of improved effectiveness in management will more than offset the initial costs. Once the new role has been implemented, the remuneration for those in the position will require an adjustment commensurate with the management focus of the position and the level of authority and responsibility. All too often nurses are required to take on additional roles and responsibilities without appropriate remuneration, and failure to deal with this issue at the onset of the process, will retard implementation. Conversely recognition of the need to adjust the remuneration at the onset of the process could act as a catalyst for those in the position thereby enhancing implementation and acceptance of the extended role of those managers.

7.8. OUTCOME-BASED INCENTIVES

Consistent with the need to offer appropriate remuneration, is the need to introduce incentives that emphasise the team performance of the centre to achieve outcome-based quality care. These incentives need to reflect the goals and objectives of the district and the local authority health department. While incentives are usually seen as a monetary reward, the problem of spiralling costs and shrinking budgets has reduced the availability of the funds that would be required to implement monetary incentives. Rewarding can however take other forms e.g. sending managers to conferences either locally or internationally, which not only acts as an incentive, but also encourages professional development. Employers need to explore creative ways of rewarding managers who achieve high quality outcome-based care.

7.9. EDUCATIONAL PREPARATION

The large number of competencies identified in this study reinforces the need for advanced educational preparation for future first-line nurse managers. Again the

competency list identified in this study can be used as a conceptual framework for the curriculum for the training of nurse managers. It may be argued that the educational courses currently offered are not designed to focus on the first-line nurse manager position, but higher levels of management. This may be true, but the list of competencies identified in this study are considered core competencies and, as such, are required in varying degrees, at all levels of management. Therefore these competencies can form the foundation of nursing management training courses.

Consideration should be given to the fact that while many of these competencies may already be included in the post basis Nursing Administration courses currently offered at universities, the "management" paradigm is not apparent in the course designs. It is therefore recommended that the curriculum for Nursing Administration undergoes a radical re-examination to not only ensure that all competencies are reflected in the course design, but also that the course changes from an administrative to a managerial focus. This change in focus needs also to be reflected in the name of the course and it is recommended that the title Nurse Administration be changed to Service Management once the relevant changes to the course design are made.

Nursing Administration courses have traditionally been developed and implemented by nurses who have limited knowledge and understanding of business management. The development of a Service Management programme that is multidisciplinary will not only facilitate the required change in focus of the course, but will also help to develop nurses with a better understanding of management outside the health services. This would facilitate the promotion of nurses into other management positions both within and outside of the health service.

7.10. RECOMMENDATIONS FOR FURTHER RESEARCH

The results of this study point to a number of areas for further research.

- The final list of competencies (Table 8.2: 164,165) that has been identified by this research study indicates two main changes. The first is that the position has changed in focus from an administrative task-orientated position to a relationship orientated managerial position. Secondly, that the person in the position is required to not only be knowledgeable, but also be able to demonstrate competence. It is doubtful whether the current training programmes that focuses on nursing administration and learning of information adequately equips nurses for this position. While it is accepted that management training is an ongoing process, it is important the courses that are designed to facilitate the process are designed appropriately. Follow up research is required to determine whether all competencies are incorporated into the curricula and whether that competency-based training is implemented in a manner that also reflects the philosophy changes.
- This is an depth study on the role competencies of first-line nurse managers within CHC's and the components used to determine the role were based on the researcher's interpretation. Each component needs further investigation to clarify the importance of the different aspects of the role.
- The study results reflect a change in the role competencies previously required for first-line nurse managers of CHC's. However, once the new role has been implemented, further evaluative research is required to determine whether the competencies identified are reflected in the functions performed by the first-line nurse managers of CHC's.
- The instrument used in this study was developed to identify the managerial competencies of the first-line nurse manager and these competencies were confirmed in this study for nurse managers of CHC's. However, further research is required to not only establish the managerial competencies for

first-line nurse managers of hospitals, and also to ascertain the similarities and/or differences of the managerial competencies between the hospital and community setting. This research would need to take cognisance of the different hospital sizes i.e. small, medium and large. The results of this research would facilitate the development and implementation of training programmes that prepare nurses for most first-line nurse manager positions.

- This study established a nurse manager role that involved either a purely management role or a blended role, based on the number of staff within the unit. Further research is required to not only to confirm this finding but also to establish the ratio of staff to manager that determines the managerial or blended role.
- The incorporation of a blended role for nurse managers has the propensity to cause role conflict and confusion. Once the dual role of manager and clinician is implemented, research is required to determine whether the nurse manager's are able to effectively implement both roles and the factors that facilitate and retard the incorporation of the blended role.

7.11. LIMITATIONS OF THE STUDY

- Although this study begins to give greater clarity to the changes in role of the first-line nurse manager, the findings must be viewed within the context of the methodological constraints and a changing health care environment.
- The Likert scale used in the study and the inflexible approach used to either include or exclude competencies, prevented competencies being identified for inclusion or exclusion based on circumstances. This was particularly evident when determining whether the nurse practitioner role should be considered part of the role of the first-line nurse manager or not. This

resulted in the researcher having to determine the practitioner role based on the qualitative data and this interpretation could have bias.

- Giving panellists the opportunity to add competencies was carried out to ensure that the final list of competencies was appropriate to the PHC service and the South African situation. However, use of the agreement scale prevented panellists from properly evaluating these added competencies, which resulted in the researcher having to decide how to incorporate these competencies into the final list of competencies. The inclusion of the additional competencies is therefore the researcher's subjective interpretation and not a reflection of the panellists' attitudes and perception.
- The data for this study was generated from a group of nominated, informed advocates, as no experts were available and it was assumed that the sample group represented senior nurse managers. Although participants were selected and nominated by organisations, no data were available to ensure that this sample was truly representative of the senior nurse manager population, that has a knowledge and understanding of community health centre management. The findings are therefore a representation of the attitudes and perceptions of those that formed the sample population.
- The population of senior nurse managers may have introduced a bias that reflected traditional attitudes and perceptions to unit management rather than the more modern and appropriate management skills required within PHC services.
- The role competencies of first-line nurse managers identified in this study reflect the attitudes and perception of those senior nurse managers who were nominated. These identified role competencies may be different from those identified by the first-line nurse managers themselves. The opinions of the first-line nurse managers need to be tested concerning the appropriateness of the list of competencies.

Chapter 8

Conclusions

This Delphi study used an expert panel to identify the competencies required of a first-line nurse manager of Community Health Centres (CHC's) in South Africa. The resultant list of 173 (Table 8.2: 164,165) competencies enabled the role dimensions of the first-line nurse to be compiled indicating a significant change in the way panellists conceptualised the position. This paradigm shift, from a tertiary medical care model for health care delivery in South Africa, to a Primary Health Care (PHC) model is well recognised.

The organisational changes required for operational management to ensure effective implementation of the PHC approach, and the corresponding changes in the role and responsibilities of those rendering the service are also well recognised. This research, while redefining the role and responsibilities of the first-line nurse manager of CHC's, clearly provides factual evidence for the paradigm shift noted in the adoption of the PHC approach that emphasises the devolvement of decision-making to the lowest management level and service accountability to community structures. These results specifically relate to the changes in focus and orientation of the position, from a task orientated administrative role to a management role that focuses on relationships, indicating yet another paradigm shift. Since paradigm shifts are noted for causing uncertainty, confusion and conflict within organisations and amongst those most affected, the implementation of the new first-line nurse manager role will therefore require time, effort and patience. The full extent of the changes that have been highlighted by this research are reflected in Table 8.1: 161. The final list of competencies identified through this research is similar to the list of competencies compiled for first-line nurse managers in Australian hospitals. This indicates that the role of the first-line nurse manager in CHC's is very similar to that found in another country, health system and setting and that the paradigm shift is not unique but reflects international trends.

First-Line Nurse Manager of Community Health Centres	
Past Role	New Role
Paradigm: Public Administration oriented management style.	Paradigm: Business Management principles blended with public administration principles.
Focus: The functional aspects of Administrative and Clinical practice	Focus: Management and Leadership, which may or may not include clinical practice. The relational aspect potentiates the functional aspects.
Style: Autocratic, patriarchal, rigid and generally non-participatory with attempted movement towards being more inclusive.	Style: Transactional or Transformational, flexible and participatory and inclusive of community.
Centralised decision-making with limited responsibility and authority.	Decentralised decision-making with greater responsibility and authority.
Accountable to employer for implementation of policy.	Accountable to employer for outcomes.
Limited accountability to community structures	Accountable to community structures for outcomes
Area of responsibility confined to unit and the staff working in the unit.	Responsibility extended to geographical area in which unit operates for providing a comprehensive service, within an organisational framework.
Unit finances centrally controlled with limited involvement	Unit managed as a cost centre requiring budgeting as well as financial management skills.
Responsible for the control and supervision of facilities, equipment and supplies allocated by senior management	Responsible for the planning and effective utilisation of human resources, facilities, equipment and supplies within an approved budget and organisational framework.
Co-ordinate the resources within the unit, allocated by senior managers, within a pre-determined framework.	Organise and maintain the working environment's rules, communications and relationships within an organisational framework.
Staff related issues centrally managed with limited involvement	Staff are managed at unit level with support from senior managers or human resource specialists.
Role modelling used to encourage conformity.	Role modelling used in leadership by example, and encouraging professionalism and professional development
Position used to control	Position used to persuade, influence and inspire.
Responsible for co-ordination of staff.	Shared responsibility for clinical outcomes within a framework of high quality and low cost.
Acting as a clinician an important aspect of the position	The main responsibility is the management of patient care, which may include a clinical role and is dependent on the number of staff working within the unit.; The higher the management staff ratio, the greater the amount of time spent on management.

Table 8.1: The first-line nurse manager of Community Health Centres: Past and new roles

However, this research has noted that the required authority has at this stage not been devolved to the position, thereby retarding the implementation of the new role and preventing the first-line nurse managers from effectively carrying out this new role. The reasons for the position not being afforded the appropriate authority is unclear, but two reasons have been postulated. The first is that those currently in the position do not have the required skills to ensure appropriate utilisation of the authority. Secondly, there is a tradition amongst health authorities of requiring nurses to be responsible and accountable, but not awarding the authority commensurate with the role. Whatever the reason, if health authorities are serious about health services needing to be accountable to the people at grassroots, then decision-making must be decentralised which requires the devolving of appropriate authority to the first-line position and providing structures that support and compliment these nurse managers.

The change in the role of the first-line nurse manager and the corresponding change in focus and orientation will not only impact on those in the position, but all levels of staff and management, including everyone that interfaces with the CHC's as well as the organisation as a whole. Prior to implementing this new role, care must be taken to review the full implication of the new roles for all concerned.

The final list of competencies comprises 160 managerial competencies and 13 competencies that specifically relate to the nurse practitioner role. The inclusion of the clinical competencies enables the adoption of a blended role in units with a small staff compliment and a purely managerial role in larger units (Figure 6.1: 127). The final list of competencies is recorded in Table 8.2: 166.167 the practitioner role competencies are identified in Italics. The final list of competencies also reflects the global trend of unit management within health services.

This study provides useful information for educators planning nursing management curricula and for employers planning in-service training and development. Since nurse managers have to rely less on positional authority for controlling others and more on interpersonal and financial management skills, these programmes need to shift emphasis to provide better role preparation. Furthermore, the way that this

new multidimensional role is implemented and the level of support given to those in the position will directly impact on the nurse managers' ability to ensure the provision of outcome based quality care and the ability to create a harmonious workplace.

University of Cape Town

FINAL LIST OF COMPETENCIES	
FUNCTIONAL MANAGEMENT	
Financial Management	Discipline and Termination
1 Needs Assessment	43 Implementing disciplinary action
2 Setting financial priorities	44 Counseling employees as to their performance
3 Financial forecasting	PATIENT CARE MANAGEMENT
4 Preparing a centre budget	Standards of care
5 Controlling of centre budget	45 Linking management with nursing care
6 Monitoring of centre budget	46 A knowledge of care delivery systems.
7 Using budget data to make decisions	47 Developing standards of patient/client care
8 Understanding statistics related to all resources	48 Identifying patient/client problems
9 Relating utilisation (use of centre)statistics to budget	49 Making patient/client care decisions
10 Cost Control	50 Using the nursing process
11 Understanding cost-effective analysis	51 Developing nursing care plans
12 Understanding cost benefit ratios	52 Planning safe, cost –effective patient care
13 Using management information systems	53 Providing care based on research.
14 Using computers	54 Evaluating nursing care
Equipment/Supplies Expense	55 A knowledge of changes in nursing care practice
15 Identifying equipment that is needed	56 Supervising patient/client care
16 Ensuring equipment is present	57 Understanding the legal implications of nursing practices
17 Scheduling of equipment	58 Understanding of privacy issues relating to patient/client records
18 Monitoring use of equipment	59 Providing known monitoring systems for patient/client care
19 Ensuring protection of equipment	60 Ensuring quality care is provided
STAFF MANAGEMENT	61 A knowledge of quality assurance activities
Employee Relations	62 Assessing charts and documentation for accuracy
20 A knowledge of complaints procedure	Staffing Patterns
21 A knowledge of personnel management	63 Organising of centre
22 Conflict management	64 A knowledge of staffing models
23 Recruiting of staff	65 A knowledge of measures of efficiency
24 Interviewing and selecting of staff	66 Identifying work to be done
25 Promoting of staff	67 Determining staff mix
26 Identifying and resolving personnel problems of staff	68 A knowledge of patient/client classification systems.
Evaluation	69 Estimating patient/client workload (quantifying care)
27 Job evaluation	70 Ensuring staffing reflects workload (workforce planning)
28 Developing standards of performance	71 Scheduling of staff to reflect work load
29 Developing criteria for staff performance	72 Daily patient/client-staff assigning
30 Evaluating staff performance	73 Co-ordinating work activities on the unit
31 Perceiving barriers to staff performance	74 Best use of human resources
Staff Development/ employee growth	75 Monitoring activities on the unit
32 Identifying and facilitating learning needs of staff	76 Perceiving workload pressures on staff
33 Assisting staff to maintain skills	Patient/client Care Activities
34 Providing opportunities for staff development	77 Providing technical skills and patient/client care as required
35 Orientation of new staff	78 Receiving and delivering reports
36 Teaching staff	79 Undertaking patient/client rounds
37 Identifying and developing staff potential	80 Infection control
38 Assisting individuals to set goals	81 Maintaining adequate records
Staff Communication	82 Questioning doctors' when in doubt
39 Informing staff of organisational change	83 Acting as a liaison between staff, doctor, client & family
40 Using constructive confrontation skills	84 Informing staff of changes to patients/client
41 Handling grievances	85 Acting as a patient/client advocate
42 Providing a forum for staff communication	86 Implementing emergency procedures

Table 8.2: Managerial and clinical competencies (bold) identified for first-line nurse manager of CHC's (cont.)

87	<i>Teaching patients and family</i>	131	Ability to cope under stress
88	Facilitating multi-disciplinary team communication	131	Initiating personal & professional growth & development
89	Participating in team conferences	132	Developing & maintaining personal professional identity
90	Assessing community health resources	133	Maintaining own professional identity
91	<i>Discharge planning</i>	134	A knowledge of ethics
92	Assessing quality of care	136	Fostering a positive organisational culture
93	<i>Arranging follow-up</i>	Communication	
94	Controlling (supervising) nursing practice	137	A knowledge of communication techniques and theory
95	Participating in community development projects	138	Communication skills, written and oral
LEADERSHIP		139	A knowledge of communication channels
Leadership Activities		140	Providing feedback to administration
96	Knowledge of management behaviour and theories	141	Participating on committees
97	Knowledge of organisational behaviour and theories	142	Developing collegial relations
98	Seeing the organisation as a whole	143	Interviewing skills
99	Able to motivate	144	Counseling skills
100	Management by objective	145	Acting as unit spokesperson
101	Able to negotiate	146	Understanding group dynamics
102	Participative decision making	147	Team building/group process skills
103	Marketing activities (promotional)	148	Interacting with other departments/sectors
104	Planning of activities, long and short term	149	Dealing with bureaucracy
105	Program planning	150	Co-ordination between areas (units and departments)
106	Creating and maintaining a favourable work environment	151	Information handling and processing
107	Controlling staff members	152	Ceremonial duties
108	Supervising nursing staff	153	Public relations
109	Identifying stress in staff and self	Decision-making	
110	Developing and maintaining staff moral	154	Defining centre's philosophy
111	Developing staff support	155	Setting centre's goals
112	Ability to delegate	156	Formulating centre's objectives
113	Allocating responsibility and authority appropriately	157	Developing centre's policies
114	Exacting accountability for work by staff and self	158	Developing centre's procedures
115	Managing Diversity	159	Decision making skills
116	Interpersonal Skills	160	A knowledge of power relationships
117	Knowledge of strategic planning	161	Political knowledge
118	Public speaking	162	Problem solving skills
119	Meeting procedure	163	Time management skills
Role Model		164	Maintaining an awareness of socio-political and economic trends
120	Interpreting organisational goals	165	Setting priorities (patients/clients, staff, centre)
121	Implementing organisational goals	166	Commissioning a new centre
122	Administering nursing oriented policies and procedures	Research	
123	A knowledge of change theory	167	Knowledge of research process
124	Initiating change	168	Participating in research
125	Facilitating change	169	Interpreting research findings
126	Acting as a teaching role model	170	Interpreting research findings
127	Teaching techniques	171	Applying research findings
128	Acting as a resource person	172	Involving staff in research
129	Co-operating with affiliated education programmes	173	Knowledge of research grants available
130	Providing guidance in planning care development		

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APPENDIX A

FIRST PILOT STUDY QUESTIONNAIRE

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First Pilot Study Questionnaire

**COMPETENCIES REQUIRED BY FIRST LINE NURSE MANAGERS OF A
COMMUNITY HEALTH CENTER**

INSTRUCTIONS: Please indicate your opinion of the competencies (skills) you believe a Nurse Manager of a Community Health Center requires, by circling the most appropriate number for the 168 listed competencies. Space has also been provided to add any additional competencies you consider relevant.

COMPETENCY RATING SCALE

1	2	3	4	5
Not	Slightly	Moderately	Important	Very
Important	Important	Important		Important

Questionnaire Number _____

1. Determining Organisational Structure & Policy

1. Knowledge of complaints procedure	1	2	3	4	5
2. Organising of the unit	1	2	3	4	5
3. A knowledge of staffing models	1	2	3	4	5
4. A knowledge of levels of efficiency	1	2	3	4	5
5. Developing unit policies	1	2	3	4	5
6. Defining unit philosophy	1	2	3	4	5
7. Other (write in and rate) _____					
_____	1	2	3	4	5

2. Understanding Health Systems and Need

1. Needs Analysis	1	2	3	4	5
2. Formulating unit objectives	1	2	3	4	5
3. Seeing organisation as a whole	1	2	3	4	5
4. Assessing community health resources	1	2	3	4	5
5. Linking management with nursing care	1	2	3	4	5
6. Knowledge of care delivery systems	1	2	3	4	5
7. Using the nursing process	1	2	3	4	5
8. A knowledge of changes in nursing care practices	1	2	3	4	5
9. Understanding the legal implications of nursing practice	1	2	3	4	5
10. A knowledge of patient classification systems	1	2	3	4	5
11. Maintaining an awareness of socio-political and economic trend	1	2	3	4	5
12. Understanding utilisation statistics	1	2	3	4	5
13. Other (write in and rate) _____ _____	1	2	3	4	5

3. Budgeting and Accounting

1. Setting fiscal priorities	1	2	3	4	5
2. Financial forecasting	1	2	3	4	5
3. Preparing a unit budget	1	2	3	4	5
4. Controlling a unit budget	1	2	3	4	5
5. Monitoring a unit budget	1	2	3	4	5
6. Using budget data to make decisions	1	2	3	4	5
7. Relating utilisation statistics to the budget	1	2	3	4	5
8. Cost control	1	2	3	4	5
9. Understanding cost-effectiveness analysis	1	2	3	4	5
10. Understanding cost benefit ratios	1	2	3	4	5
11. Accounting and financial skills	1	2	3	4	5
12. Other (write in and rate) _____ _____	1	2	3	4	5

4. Planning for resources and programs

1. Identifying resources needed	1	2	3	4	5
2. Ensuring resources present	1	2	3	4	5
3. Resource scheduling	1	2	3	4	5
4. Monitoring use of resources	1	2	3	4	5
5. Resource protection	1	2	3	4	5
6. Allocating responsibility and authority appropriately	1	2	3	4	5
7. Delegation	1	2	3	4	5
8. Developing nursing care plans	1	2	3	4	5
9. Planning safe, cost-effective patient care	1	2	3	4	5
10. Identifying work to be done	1	2	3	4	5
11. Determining staff mix	1	2	3	4	5
12. Estimating patient workloads (quantifying care)	1	2	3	4	5
13. Ensuring staffing reflects workload (workforce planning)	1	2	3	4	5
14. Participating in team conferences	1	2	3	4	5
15. Other (write in and rate) _____					
_____	1	2	3	4	5

5. Research

1. A knowledge of the research process	1	2	3	4	5
2. Participating in research	1	2	3	4	5
3. Conducting research	1	2	3	4	5
4. Interpreting research findings	1	2	3	4	5
5. Applying research findings	1	2	3	4	5
6. Involving staff in research	1	2	3	4	5
7. Providing care based on research	1	2	3	4	5
8. A knowledge of research grants available	1	2	3	4	5
9. Other (write in and rate) _____					
_____	1	2	3	4	5

6. Setting Standards and Quality Improvement

1. Administering nursing division policy and procedures	1	2	3	4	5
2. Interpreting organisational goals	1	2	3	4	5
3. Implementing organisational goals	1	2	3	4	5
4. Setting unit goals	1	2	3	4	5
5. Management by objective	1	2	3	4	5
6. Developing unit procedures	1	2	3	4	5
7. A knowledge of quality assurance activities	1	2	3	4	5
8. Assessing quality of care	1	2	3	4	5
9. Developing standards for patient care	1	2	3	4	5
10. Ensuring quality care is provided	1	2	3	4	5
11. Arranging continuity of care	1	2	3	4	5
12. Controlling nursing practice	1	2	3	4	5
13. Evaluating nursing care	1	2	3	4	5
14. Identifying patient problems	1	2	3	4	5
15. Making patient care decisions	1	2	3	4	5
16. Undertaking patient rounds	1	2	3	4	5
17. Using power and status to achieve goals for patients, staff and unit	1	2	3	4	5
18. Exacting accountability for work by staff and self	1	2	3	4	5
19. Performing under stress (stress management)	1	2	3	4	5
20. Infection control	1	2	3	4	5
21. Maintaining adequate records	1	2	3	4	5
22. Transcribing doctors written orders	1	2	3	4	5
23. Questioning doctors' when in doubt	1	2	3	4	5
24. Other (write in and rate) _____	1	2	3	4	5

7. Administering : Allocating resources and supervising

1. Setting priorities (patient, staff, unit)	1	2	3	4	5
2. Programme planning	1	2	3	4	5
3. Planning activities, long and short term	1	2	3	4	5
4. Co-ordinating work activities on the unit	1	2	3	4	5
5. Scheduling of staff to reflect workload	1	2	3	4	5
6. Maximising human resources	1	2	3	4	5
7. Daily patient-staff assignments	1	2	3	4	5
8. Providing guidance in planning care	1	2	3	4	5
9. Supervising patient care	1	2	3	4	5
10. Time Management	1	2	3	4	5
11. Discharge planning	1	2	3	4	5
12. Implementing doctors orders	1	2	3	4	5
13. Implementing emergency procedures	1	2	3	4	5
14. Acting as a resource person	1	2	3	4	5
15. Other (write in and rate) _____					
_____	1	2	3	4	5

8. Ensuring Information flow

1. Informing staff of organisational changes	1	2	3	4	5
2. Information handling and processing	1	2	3	4	5
3. Providing feedback to administration	1	2	3	4	5
4. Knowledge of communications channels	1	2	3	4	5
5. Communications skills, written and oral	1	2	3	4	5
6. Communication techniques and theory	1	2	3	4	5
7. Marketing activities	1	2	3	4	5
8. Using management information systems	1	2	3	4	5
9. Using Computers	1	2	3	4	5
10. Understanding privacy issues related to computer usage	1	2	3	4	5
11. Receiving and delivering reports	1	2	3	4	5
12. Informing staff of changes to patients	1	2	3	4	5
13. Other (write in and rate) _____					
_____	1	2	3	4	5

9. Personnel Administration

1. A knowledge of personnel management (industrial issues, labour relations, personnel policies)	1	2	3	4	5
2. Interviewing and selecting staff	1	2	3	4	5
3. Interviewing skills	1	2	3	4	5
4. Recruiting Staff	1	2	3	4	5
5. Job evaluation	1	2	3	4	5
6. Promoting staff	1	2	3	4	5
7. Terminating staff	1	2	3	4	5
8. Developing standards of performance	1	2	3	4	5
9. Developing criteria for staff performance	1	2	3	4	5
10. Counselling employees as to their performance	1	2	3	4	5
11. Perceiving barriers to staff performance	1	2	3	4	5
12. Providing a forum for staff communication	1	2	3	4	5
13. Handling grievances	1	2	3	4	5
14. Implementing disciplinary action	1	2	3	4	5
15. Identifying and resolving personnel problems	1	2	3	4	5
16. Identifying stresses in staff and self	1	2	3	4	5
17. Developing staff supports	1	2	3	4	5
18. Developing and maintaining staff morale	1	2	3	4	5
19. Creating and maintaining a favourable work environment	1	2	3	4	5
20. Team building/ group processing skills	1	2	3	4	5
21. Conflict Management	1	2	3	4	5
22. Supervising nursing staff	1	2	3	4	5
23. Controlling staff members	1	2	3	4	5
24. Perceiving workload pressure on staff	1	2	3	4	5
25. The use of constructive confrontation skills	1	2	3	4	5
26. Counselling skills	1	2	3	4	5
27. Providing technical skills and patient care as required	1	2	3	4	5
28. Other (write in and rate) _____	1	2	3	4	5

10. Training and Development

1. Orientation of new staff	1	2	3	4	5
2. Identifying and developing staff potential	1	2	3	4	5
3. Perceiving barriers to staff performance	1	2	3	4	5
4. Assisting individuals to set goals	1	2	3	4	5
5. Evaluating staff performance	1	2	3	4	5
4. Initiating personal and professional growth and development	1	2	3	4	5
5. Providing opportunities for staff development	1	2	3	4	5
6. Assisting staff to maintain skills	1	2	3	4	5
7. Teaching techniques	1	2	3	4	5
8. Teaching staff	1	2	3	4	5
9. Identifying and facilitating learning needs of staff	1	2	3	4	5
10. Acting as a teaching role model	1	2	3	4	5
11. Teaching patients and family	1	2	3	4	5
12. Developing and maintaining personal professional competence	1	2	3	4	5
13. Maintaining professional identity	1	2	3	4	5
12. Other (write in and rate) _____	1	2	3	4	5

11. Co-ordination

1. Acting as a patient advocate	1	2	3	4	5
2. Acting as a liaison between staff, doctor, patient and family	1	2	3	4	5
3. Acting as a unit spokesperson	1	2	3	4	5
4. Interacting with multiple divisions	1	2	3	4	5
5. Co-ordination between areas (units and departments)	1	2	3	4	5
6. Dealing with bureaucracy	1	2	3	4	5
7. Public relations	1	2	3	4	5
8. Ceremonial duties	1	2	3	4	5
9. Participating on committees	1	2	3	4	5
10. Developing collegial relations	1	2	3	4	5

11. Co-operating with affiliated education programmes 1 2 3 4 5
12. Other (write in and rate) _____
 _____ 1 2 3 4 5

12. Monitoring and Development

1. Political Knowledge 1 2 3 4 5
2. Power knowledge 1 2 3 4 5
3. A knowledge of change theory 1 2 3 4 5
4. Knowledge of organisational behaviour
and theories 1 2 3 4 5
5. Knowledge of management behaviour
and theories 1 2 3 4 5
6. Negotiating order models 1 2 3 4 5
7. Decision Making 1 2 3 4 5
8. Understanding group dynamics 1 2 3 4 5
9. The use of motivational dynamics 1 2 3 4 5
10. Problem-solving 1 2 3 4 5
11. Participative decision-making 1 2 3 4 5
12. Initiating change 1 2 3 4 5
13. Facilitating change 1 2 3 4 5
14. Monitoring activities of the unit 1 2 3 4 5
15. Providing known monitoring systems for
patient care 1 2 3 4 5
16. Assessing charts and documents for accuracy 1 2 3 4 5
17. Other (write in and rate) _____
 _____ 1 2 3 4 5

13. General

Comments _____

Thank you for your participation in this study

APPENDIX B

SECOND PILOT QUESTIONNAIRE

University of Cape Town

Second Pilot Study
Questionnaire Number _____

QUESTIONNAIRE TO IDENTIFY THE COMPETENCIES REQUIRED BY FIRST-LINE NURSE MANAGERS OF COMMUNITY HEALTH CENTRES.

Instructions: Please answer the following statement and indicate by circling the number in accordance with the rating scale listed below, for each of the 168 competencies. Space has been provided at the end of each category to give you the opportunity to give comments supporting your position.

Statement: First-line managers of Community Health Centres need to be competent in.....

COMPETENCY RATING SCALE

0	1	2	3	4
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

FUNCTIONAL MANAGEMENT

Budgeting

1. Needs Assessment	0	1	2	3	4
2. Setting financial priorities	0	1	2	3	4
3. Financial forecasting	0	1	2	3	4
4. Preparing a unit budget	0	1	2	3	4
5. Controlling a unit budget	0	1	2	3	4
6. Monitoring a unit budget	0	1	2	3	4
7. Using budget data to make decisions	0	1	2	3	4
8. Understanding utilisation statistics	0	1	2	3	4
9. Relating utilisation statistics to budget	0	1	2	3	4
10. Cost Control	0	1	2	3	4

Comments;

Use of information systems

11. Understanding cost-effective analysis	0	1	2	3	4
12. Understanding cost benefit ratios	0	1	2	3	4
13. Accounting and financial skills	0	1	2	3	4
14. Using management information systems	0	1	2	3	4
15. Using computers	0	1	2	3	4

Comments;

Resource Management

16. Identifying resources needed	0	1	2	3	4
17. Ensuring resources present	0	1	2	3	4
18. Resource scheduling	0	1	2	3	4
19. Monitoring use of equipment	0	1	2	3	4
20. Resource protection	0	1	2	3	4

Comments

STAFF MANAGEMENT

Staff Maintenance

21. A knowledge of complaints procedure	0	1	2	3	4
22. A knowledge of personnel management (industrial issues, labour relations, personnel policies)	0	1	2	3	4
23. Conflict management	0	1	2	3	4
24. Recruiting staff	0	1	2	3	4
25. Interviewing and selecting staff	0	1	2	3	4
26. Promoting staff	0	1	2	3	4
27. Identifying and resolving personnel problems	0	1	2	3	4

Comments;

Staff Performance

28. Job evaluation	0	1	2	3	4
29. Developing standards of performance	0	1	2	3	4
30. Developing criteria for staff performance	0	1	2	3	4
31. Evaluating staff performance	0	1	2	3	4
32. Perceiving barriers to staff performance	0	1	2	3	4

Comments: _____

Staff development

33. Identifying and facilitating needs of staff	0	1	2	3	4
34. Assisting staff to maintain skills	0	1	2	3	4
35. Providing opportunities for staff development	0	1	2	3	4
36. Orientation of new staff	0	1	2	3	4
37. Teaching staff	0	1	2	3	4
38. Identifying and facilitating learning needs of staff	0	1	2	3	4
39. Assisting individuals to set goals	0	1	2	3	4

Comments: _____

Staff Communication

40. Informing staff of organisational change	0	1	2	3	4
41. Using constructive confrontation skills	0	1	2	3	4
42. Handling grievances	0	1	2	3	4
43. Providing a forum for staff communication	0	1	2	3	4
44. Implementing disciplinary action	0	1	2	3	4
45. Counselling employees as to their performance.	0	1	2	3	4
46. Termination of employment	0	1	2	3	4

Comments: _____

PATIENT CARE MANAGEMENT

Knowledge of and provision for delivery of care

47. Linking management with nursing care	0	1	2	3	4
48. A knowledge of care delivery systems.	0	1	2	3	4
49. Developing standards of patient/client care.	0	1	2	3	4
50. Identifying patient/client problems	0	1	2	3	4
51. Making patient/client care decisions	0	1	2	3	4
52. Using the Nursing process	0	1	2	3	4
53. Developing nursing care plans	0	1	2	3	4
54. Planning safe, cost –effective patient/client care .	0	1	2	3	4
55. Providing care based on research.	0	1	2	3	4
56. Evaluating nursing care	0	1	2	3	4
57. A knowledge of changes in nursing care practice	0	1	2	3	4
58. Supervising patient/client care	0	1	2	3	4
59. Understanding the legal implications of nursing practices	0	1	2	3	4
60. Understanding of privacy issues relating to patient/client records	0	1	2	3	4
61. Providing known monitoring systems for patient/client care	0	1	2	3	4
62. Ensuring quality care it provided	0	1	2	3	4
63. A knowledge of quality assurance activities	0	1	2	3	4
64. Assessing charts and documentation for accuracy	0	1	2	3	4

Comments:

Unit staffing and workload

65. Organising of unit	0	1	2	3	4
66. A knowledge of staffing models	0	1	2	3	4
67. A knowledge of measures of efficiency	0	1	2	3	4
68. Identifying work to be done	0	1	2	3	4
69. Determining staff mix	0	1	2	3	4
70. A knowledge of patient/client classification systems.	0	1	2	3	4
71. Estimating patient/client workload (quantifying care)	0	1	2	3	4
72. Ensuring staffing reflects workload (workforce planning)	0	1	2	3	4
73. Scheduling of staff to reflect work load	0	1	2	3	4
74. Daily patient-staff assigning	0	1	2	3	4
75. Co-ordinating work activities on unit	0	1	2	3	4
76. Maximising human resources	0	1	2	3	4
77. Monitoring activities on unit	0	1	2	3	4
78. Perceiving workload pressures on staff	0	1	2	3	4

Comments: _____

Team communication

79. Providing technical skills and patient/client care as required	0	1	2	3	4
80. Receiving and delivering reports	0	1	2	3	4
81. Undertaking patient/client rounds	0	1	2	3	4
82. Infection control	0	1	2	3	4
83. Maintaining adequate records	0	1	2	3	4
84. Transcribing written orders of doctors	0	1	2	3	4
85. Implementing orders of doctor	0	1	2	3	4
86. Questioning doctors' when in doubt	0	1	2	3	4
87. Acting as a liaison between staff, doctor, patient/client and family	0	1	2	3	4
88. Informing staff of changes to patients/client	0	1	2	3	4
89. Acting as a patient/client advocate	0	1	2	3	4
90. Implementing emergency procedures	0	1	2	3	4
91. Teaching patients and family	0	1	2	3	4

Comments: _____

Quality of care

92. Participating in team conferences	0	1	2	3	4
93. Assessing community health resources	0	1	2	3	4
94. Discharge planning	0	1	2	3	4
95. Assessing quality of care	0	1	2	3	4
96. Arranging follow up	0	1	2	3	4
97. Controlling (supervising) nursing practice	0	1	2	3	4

Comments: _____

LEADERSHIP ACTIVIES 1

Organisational behaviour

98. Knowledge of management behaviour and theories	0	1	2	3	4
99. Knowledge of organisational behaviour and theories	0	1	2	3	4
100. Seeing the organisation as a whole	0	1	2	3	4
101. The use of motivational dynamics	0	1	2	3	4
102. Management by objective	0	1	2	3	4
103. Negotiating order models	0	1	2	3	4
104. Participative decision making	0	1	2	3	4
105. Marketing activities	0	1	2	3	4
106. Planning of activities, long and short term	0	1	2	3	4
107. Programme planning	0	1	2	3	4

Comments: _____

Human resource management

108. Creating and maintaining a favourable work environment	0	1	2	3	4
109. Controlling staff members	0	1	2	3	4
110. Supervising nursing staff	0	1	2	3	4
111. Identifying stress in staff and self	0	1	2	3	4
112. Developing and maintaining staff moral	0	1	2	3	4
113. Developing staff support	0	1	2	3	4
114. Delegation	0	1	2	3	4
115. Allocating responsibility and authority appropriately	0	1	2	3	4
116. Exacting accountability for work by staff and self	0	1	2	3	4
117. Using power and status to achieve goals for patients, staff and centre	0	1	2	3	4

Comments: _____

Professionalism

118. Interpreting organisational goals	0	1	2	3	4
119. Implementing organisational goals	0	1	2	3	4
120. Administering nursing oriented policies and procedures	0	1	2	3	4
121. A knowledge of change theory	0	1	2	3	4
122. Initiating change	0	1	2	3	4
123. Facilitating change	0	1	2	3	4
124. Acting as a teaching role model	0	1	2	3	4
125. Teaching techniques	0	1	2	3	4
126. Acting as a resource person	0	1	2	3	4
127. Co-operating with affiliated education programmes.	0	1	2	3	4
128. Providing guidance in planning care	0	1	2	3	4
129. Ability to cope under stress	0	1	2	3	4
130. Initiating personal and professional growth and development	0	1	2	3	4
131. Developing and maintaining personal professional competence	0	1	2	3	4
132. Maintaining own professional identity	0	1	2	3	4

Comments: _____

LEADERSHIP ACTIVIES 2

Group communication

133. Communication techniques and theory	0	1	2	3	4
134. Communication skills, written and oral	0	1	2	3	4
135. A knowledge of communication channels	0	1	2	3	4
136. Providing feedback to administration	0	1	2	3	4
137. Participating on committees	0	1	2	3	4
138. Developing collegial relations	0	1	2	3	4
139. Interviewing skills	0	1	2	3	4
140. Counselling skills	0	1	2	3	4
141. Acting as unit spokesperson	0	1	2	3	4
142. Understanding group dynamics	0	1	2	3	4
143. Team building/group process skills	0	1	2	3	4
144. Interacting with multiple divisions	0	1	2	3	4
145. Dealing with bureaucracy	0	1	2	3	4
146. Co-ordination between areas (units and departments)	0	1	2	3	4
147. Information handling and processing	0	1	2	3	4
148. Ceremonial duties	0	1	2	3	4
149. Public relations	0	1	2	3	4

Comments: _____

Unit decision-making

150. Defining unit philosophy	0	1	2	3	4
151. Setting unit goals	0	1	2	3	4
152. Formulating unit objectives	0	1	2	3	4
153. Developing unit policies	0	1	2	3	4
154. Developing unit procedures	0	1	2	3	4
155. Decision making skills	0	1	2	3	4
156. Power knowledge	0	1	2	3	4
157. Political knowledge	0	1	2	3	4

158. Problem solving	0	1	2	3	4
159. Time management skills	0	1	2	3	4
160. Maintaining an awareness of socio-political and economic trends	0	1	2	3	4
161. Setting priorities (Patients/clients, staff, centre)	0	1	2	3	4

Comments: _____

Research

162. Knowledge of research process	0	1	2	3	4
163. Participating in research	0	1	2	3	4
164. Conducting research	0	1	2	3	4
165. Interpreting research findings	0	1	2	3	4
166. Applying research findings	0	1	2	3	4
167. Involving staff in research	0	1	2	3	4
168. Knowledge of research grants available	0	1	2	3	4

Comments: _____

General comments:

Thank you for your participation.

APPENDIX C

FIRST ROUND QUESTIONNAIRE

University of Cape Town

Questionnaire Number _____

Round 1

QUESTIONNAIRE TO IDENTIFY THE COMPETENCIES REQUIRED BY FIRST-LINE NURSE MANAGERS OF COMMUNITY HEALTH CENTRES.

Instructions: Please can you advise Erica Greathead once you have received the questionnaire to prevent delays due to non receipt. Tel: (021) 683-1995, Fax: (021) 64-2982. On completion of the questionnaire and prior to posting, please make a copy to prevent the need to redo the questionnaire in the event of postage loss. **Please ensure that the questionnaire is returned by the 23rd April.**

Please answer the following question and indicate your response according to the rating scale provided.

Question: Nursing Unit Managers (first-line) of Community Health Centres, should be competent in

A competency, for the purposes of this research study, is obtained from an assessment of the knowledge, skills and attitudes needed to perform in the position of Nursing Centre Manager.

Please note that a Community Health Centre refers to a Primary Health Care Clinic.

Space has been provided at the end of each sub category and the end of the questionnaire to give you the opportunity to support your position.

Example: Financial Management

Comment

10. Cost Control in today's environment of budget constraints is very important

Financial management is important but not at the expense of patient/client care.

At the end of the questionnaire space has also been provided to enable you to add any additional competencies that you believe have been left out.

COMPETENCY RATING SCALE

0	1	2	3	4
Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree

1. FUNCTIONAL MANAGEMENT

a) Financial Management

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
1. Needs Assessment	0	1	2	3	4
2. Setting financial priorities	0	1	2	3	4
3. Financial forecasting	0	1	2	3	4
4. Preparing of centre budget	0	1	2	3	4
5. Controlling of centre budget	0	1	2	3	4
6. Monitoring of centre budget	0	1	2	3	4
7. Using budget data to make decisions	0	1	2	3	4
8. Understanding statistics related to all resources (human, material, financial)	0	1	2	3	4
9. Relating utilisation (use of centre) statistics to budget	0	1	2	3	4
10. Cost Control	0	1	2	3	4
11. Understanding cost-effective analysis	0	1	2	3	4
12. Understanding cost benefit ratios	0	1	2	3	4
13. Accounting and financial skills	0	1	2	3	4
14. Using management information systems	0	1	2	3	4
15. Using computers	0	1	2	3	4

Comments:

b) Equipment / Supplies Expense

16. Identifying equipment that is needed	0	1	2	3	4
17. Ensuring equipment is present	0	1	2	3	4
18. Scheduling of equipment	0	1	2	3	4
19. Monitoring use of equipment	0	1	2	3	4
20. Ensuring protection of equipment	0	1	2	3	4

Comments:

Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
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2. STAFF MANAGEMENT

a) Employee Relations

21. A knowledge of complaints procedure	0	1	2	3	4
22. A knowledge of personnel management (industrial issues, labour relations, personnel policies)	0	1	2	3	4
23. Conflict management	0	1	2	3	4
24. Recruiting of staff	0	1	2	3	4
25. Interviewing and selecting of staff	0	1	2	3	4
26. Promoting of staff	0	1	2	3	4
27. Identifying and resolving personnel problems of staff	0	1	2	3	4

Comments:

b) Evaluation

28. Job evaluation	0	1	2	3	4
29. Developing standards of performance	0	1	2	3	4
30. Developing criteria for staff performance	0	1	2	3	4
31. Evaluating staff performance	0	1	2	3	4
32. Perceiving barriers to staff performance	0	1	2	3	4

Comments:

c) Staff development/ employee growth

33. Identifying and facilitating learning needs of staff	0	1	2	3	4
34. Assisting staff to maintain skills	0	1	2	3	4
35. Providing opportunities for staff development	0	1	2	3	4
36. Orientation of new staff	0	1	2	3	4
37. Teaching staff	0	1	2	3	4

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
38. Identifying and developing staff potential	0	1	2	3	4
39. Assisting individuals to set goals	0	1	2	3	4

Comments:

d) Staff Communication

40. Informing staff of organisational change	0	1	2	3	4
41. Using constructive confrontation skills	0	1	2	3	4
42. Handling grievances	0	1	2	3	4
43. Providing a forum for staff communication	0	1	2	3	4

Comments:

e) Discipline and Termination

44. Implementing disciplinary action	0	1	2	3	4
45. Counselling employees as to their performance	0	1	2	3	4
46. Termination of employment	0	1	2	3	4

Comments:

3. PATIENT CARE MANAGEMENT

a) Standards of Care

47. Linking management with nursing care	0	1	2	3	4
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	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
48. A knowledge of care delivery systems.	0	1	2	3	4
49. Developing standards of patient/client care	0	1	2	3	4
50. Identifying patient/client problems	0	1	2	3	4
51. Making patient/client care decisions	0	1	2	3	4
52. Using the nursing process	0	1	2	3	4
53. Developing nursing care plans	0	1	2	3	4
54. Planning safe, cost –effective patient care	0	1	2	3	4
55. Providing care based on research.	0	1	2	3	4
56. Evaluating nursing care	0	1	2	3	4
57. A knowledge of changes in nursing care practice	0	1	2	3	4
58. Supervising patient/client care	0	1	2	3	4
59. Understanding the legal implications of nursing practices	0	1	2	3	4
60. Understanding of privacy issues relating to patient/client records	0	1	2	3	4
61. Providing known monitoring systems for patient/client care	0	1	2	3	4
62. Ensuring quality care it provided	0	1	2	3	4
63. A knowledge of quality assurance activities	0	1	2	3	4
64. Assessing charts and documentation for accuracy	0	1	2	3	4

Comments:

b) Staffing Patterns

65. Organising of centre	0	1	2	3	4
66. A knowledge of staffing models	0	1	2	3	4
67. A knowledge of measures of efficiency	0	1	2	3	4
68. Identifying work to be done	0	1	2	3	4
69. Determining staff mix	0	1	2	3	4
70. A knowledge of patient/client classification systems.	0	1	2	3	4
71. Estimating patient/client workload (quantifying care)	0	1	2	3	4
72. Ensuring staffing reflects workload (workforce planning)	0	1	2	3	4
73. Scheduling of staff to reflect work load	0	1	2	3	4
74. Daily patient/client-staff assigning	0	1	2	3	4

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
75. Co-ordinating work activities on the unit	0	1	2	3	4
76. Best use of human resources	0	1	2	3	4
77. Monitoring activities on the unit	0	1	2	3	4
78. Perceiving workload pressures on staff	0	1	2	3	4

Comments:

c) Patient/client Care Activities

79. Providing technical skills and patient/client care as required	0	1	2	3	4
80. Receiving and delivering reports	0	1	2	3	4
81. Undertaking patient/client rounds	0	1	2	3	4
82. Infection control	0	1	2	3	4
83. Maintaining adequate records	0	1	2	3	4
84. Transcribing written orders of doctors	0	1	2	3	4
85. Implementing orders of doctor	0	1	2	3	4
86. Questioning doctors' when in doubt	0	1	2	3	4
87. Acting as a liaison between staff, doctor, patient/client and family	0	1	2	3	4
88. Informing staff of changes to patients/client	0	1	2	3	4
89. Acting as a patient/client advocate	0	1	2	3	4
90. Implementing emergency procedures	0	1	2	3	4
91. Teaching patients and family	0	1	2	3	4
92. Facilitating multi-disciplinary team communication	0	1	2	3	4
93. Participating in team conferences	0	1	2	3	4
94. Assessing community health resources	0	1	2	3	4
95. Discharge planning	0	1	2	3	4
96. Assessing quality of care	0	1	2	3	4
97. Arranging follow up	0	1	2	3	4

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
98. Controlling (supervising) nursing practice	0	1	2	3	4
Comments:	<hr/> <hr/> <hr/>				

4. LEADERSHIP

a) Leadership Activities

99. Knowledge of management behaviour and theories	0	1	2	3	4
100. Knowledge of organisational behaviour and theories	0	1	2	3	4
101. Seeing the organisation as a whole	0	1	2	3	4
102. Able to motivate	0	1	2	3	4
103. Management by objective	0	1	2	3	4
104. Able to negotiate	0	1	2	3	4
105. Participative decision making	0	1	2	3	4
106. Marketing activities (promotional)	0	1	2	3	4
107. Planning of activities, long and short term	0	1	2	3	4
108. Programme planning	0	1	2	3	4
109. Creating and maintaining a favourable work environment	0	1	2	3	4
110. Controlling staff members	0	1	2	3	4
111. Supervising nursing staff	0	1	2	3	4
112. Identifying stress in staff and self	0	1	2	3	4
113. Developing and maintaining staff moral	0	1	2	3	4
114. Developing staff support	0	1	2	3	4
115. Ability to delegate	0	1	2	3	4
116. Allocating responsibility and authority appropriately	0	1	2	3	4
117. Exacting accountability for work by staff and self	0	1	2	3	4

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
118 Using power and status to achieve goals for patients, staff and centre	0	1	2	3	4

Comments:

c) Role Model

119. Interpreting organisational goals	0	1	2	3	4
120. Implementing organisational goals	0	1	2	3	4
121. Administering nursing oriented policies and procedures	0	1	2	3	4
122. A knowledge of change theory	0	1	2	3	4
123. Initiating change	0	1	2	3	4
124. Facilitating change	0	1	2	3	4
125. Acting as a teaching role model	0	1	2	3	4
126. Teaching techniques	0	1	2	3	4
127. Acting as a resource person	0	1	2	3	4
128. Co-operating with affiliated education programmes e.g. nursing colleges / technikon	0	1	2	3	4
129. Providing guidance in planning care	0	1	2	3	4
130. Ability to cope under stress	0	1	2	3	4
131. Initiating personal (own) and professional growth and development	0	1	2	3	4
132. Developing and maintaining personal (own) professional competence	0	1	2	3	4
133. Maintaining own professional identity	0	1	2	3	4

Comments:

d) Communication

134. A knowledge of communication techniques and theory	0	1	2	3	4
135. Communication skills, written and oral	0	1	2	3	4

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
136. A knowledge of communication channels	0	1	2	3	4
137. Providing feedback to administration	0	1	2	3	4
138. Participating on committees	0	1	2	3	4
139. Developing collegial relations	0	1	2	3	4
140. Interviewing skills	0	1	2	3	4
141. Counselling skills	0	1	2	3	4
142. Acting as unit spokesperson	0	1	2	3	4
143. Understanding group dynamics	0	1	2	3	4
144. Team building/group process skills	0	1	2	3	4
145. Interacting with other departments/sectors	0	1	2	3	4
146. Dealing with bureaucracy	0	1	2	3	4
147. Co-ordination between areas (units and departments)	0	1	2	3	4
148. Information handling and processing	0	1	2	3	4
149. Ceremonial duties	0	1	2	3	4
150. Public relations	0	1	2	3	4

Comments:

e) Decision-making

151. Defining centre's philosophy	0	1	2	3	4
152. Setting centre's goals	0	1	2	3	4
153. Formulating centre's objectives	0	1	2	3	4
154. Developing centre's policies	0	1	2	3	4
155. Developing centre's procedures	0	1	2	3	4
156. Decision making skills	0	1	2	3	4
157. A knowledge of power relationships	0	1	2	3	4
158. Political knowledge	0	1	2	3	4
159. Problem solving skills	0	1	2	3	4
160. Time management skills	0	1	2	3	4
161. Maintaining an awareness of socio-political and economic trends	0	1	2	3	4

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree
162. Setting priorities (patients/clients, staff, centre)	0	1	2	3	4
Comments:	<hr/> <hr/> <hr/>				

f) Research

163. Knowledge of research process	0	1	2	3	4
164. Participating in research	0	1	2	3	4
165. Conducting research	0	1	2	3	4
166. Interpreting research findings	0	1	2	3	4
167. Applying research findings	0	1	2	3	4
168. Involving staff in research	0	1	2	3	4
169. Knowledge of research grants available	0	1	2	3	4
Comments:	<hr/> <hr/> <hr/>				

Additional Competencies:

<hr/>	0	1	2	3	4
<hr/>	0	1	2	3	4
<hr/>	0	1	2	3	4
<hr/>	0	1	2	3	4

General comments:

Thank you for your participation

APPENDIX D

EXAMPLE OF FORMAT USED FOR

SECOND AND THIRD ROUND

QUESTIONNAIRES

Questionnaire Number _____

	Average For Round One						Your Score
		Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	
1 FUNCTIONAL MANAGEMENT							P07
a) Financial Management							
1 Needs Assessment	3.609	0	1	2	3	4	3
2 Setting financial priorities	3.565	0	1	2	3	4	3
3 Financial forecasting	3.130	0	1	2	3	4	2
4 Preparing of centre budget	3.435	0	1	2	3	4	2
5 Controlling of centre budget	3.174	0	1	2	3	4	3
6 Monitoring of centre budget	3.435	0	1	2	3	4	3
7 Using budget data to make decisions	3.348	0	1	2	3	4	3
8 Understanding statistics related to all resources (human, material, financial)	3.565	0	1	2	3	4	4
9 Relating utilisation (use of centre) statistics to budget	3.348	0	1	2	3	4	3
10 Cost Control	3.609	0	1	2	3	4	4
11 Understanding cost-effective analysis	3.217	0	1	2	3	4	3
12 Understanding cost benefit ratios	2.957	0	1	2	3	4	3
13 Accounting and financial skills	2.609	0	1	2	3	4	3
14 Using management information systems	3.217	0	1	2	3	4	4
15 Using computers	3.217	0	1	2	3	4	4

Comments:

- M01 Very important for the manager to co-ordinate and control the financial provision i.e. capital & operational to ensure efficient use of resources & that services remain in the 'budget'. To be able to forecast long term financial planning of projects as this enables planning according to anticipated growth projections.
- M02 This function will need decentralisation and make every clinic unit manager e.g. training a cost centre enables planning according to anticipated growth projections. Training in financial management is an area that is neglected.
- M03 In an institution where there are accountants most of the financial management should be done by them. Yes a first line manager has to understand reasonable.
- M05 Undecided 12-15. It would be useful to have the above, but first line managers can manage their budgets quite effectively without being competent in the above.
- M07 A team of officials employed exclusively for non-nursing duties including financial management.
- P01 For any nurse manager to provide effective services, financial management is extremely important.
- P02 Financial management is essential to management.
- P04 It is the responsibility of the administrative staff member to prepare, control and monitor the budget to allow the CPN to delegate her attention to the delivery of patient care, planning and strategic planning of staff.
- P05 It is good to have skills and knowledge of financial management in order to monitor, control the unit finances efficiently and effectively with understanding and also control misuse.
- P07 Usually historically budgets therefore difficult to prepare or to forecast. Totally dependant on what National gives Provinces. The Sister-in-charge should be able to plan and modify plans according to what she is given usually done by organisation.
- A01 5 & 10 could have an overlap. 11 & 12 would not necessary mean doing it themselves
13 need not be of advanced level – there are specialists.
14 & 15 need only be on an elementary level – to prevent them spending all their time in front of the computer instead of where the action is and managing
- A02 They are seldom computer literate or have a computer to use
- A03 If she/he really cares, then he/she will be cost sensitive!
- A05 The nurse can only utilise what has been allocated
- A07 All these aspects are becoming more important for managers.
- A09 Detailed financial analysis should be done by finance personnel.

Additional Comments

APPENDIX E

MEAN SCORE FOR EACH COMPETENCY FOR

EACH ROUND ANDPERCENTAGE

CHANGE BETWEEN ROUNDS

	Average for Round 1	Average for Round 2	Average for Round 3	Rank Order for Round 3	% Change Between Rounds 1 & 2	% Change Between Rounds 2 & 3	% Change Between Rounds 1 & 3
FUNCTIONAL MANAGEMENT							
Financial Management							
1 Needs Assessment	3.609	3.762	3.905	11	4.07%	3.66%	7.58%
2 Setting financial priorities	3.565	3.714	3.762	86	4.01%	1.27%	5.23%
3 Financial forecasting	3.130	3.143	3.333	156	0.40%	5.71%	6.09%
4 Preparing a centre budget	3.435	3.571	3.714	102	3.83%	3.85%	7.53%
5 Controlling of centre budget	3.174	3.524	3.714	102	9.93%	5.13%	14.55%
6 Monitoring of centre budget	3.435	3.476	3.571	130	1.19%	2.67%	3.83%
7 Using budget data to make decisions	3.348	3.476	3.619	125	3.69%	3.95%	7.49%
8 Understanding statistics related to all resources	3.565	3.667	3.714	102	2.77%	1.28%	4.01%
9 Relating utilisation (use of centre)statistics to budget	3.348	3.476	3.667	121	3.69%	5.19%	8.70%
10 Cost Control	3.609	3.810	3.857	22	5.27%	1.23%	6.44%
11 Understanding cost-effective analysis	3.217	3.524	3.667	121	8.70%	3.90%	12.25%
12 Understanding cost benifir ratios	2.957	3.190	3.381	153	7.33%	5.63%	12.55%
13 Accounting and financial skills	2.609	2.857	3.000	162	8.70%	4.76%	13.04%
14 Using management information syste,s	3.217	3.333	3.476	139	3.48%	4.11%	7.44%
15 Using computers	3.217	3.381	3.571	130	4.84%	5.33%	9.91%
Average for sub category	3.296	3.460	3.597		4.76%	3.80%	8.37%
Equipment/Supplies Expense							
16 Identifying equipment that is needed	3.696	3.762	3.714	102	1.76%	-1.28%	0.50%
17 Ensuring equipment is present	3.783	3.857	3.905	11	1.93%	1.22%	3.13%
18 Scheduling of equipment	3.435	3.714	3.714	102	7.53%	0.00%	7.53%
19 Monitoring use of equipment	3.652	3.667	3.714	102	0.40%	1.28%	1.67%
20 Ensuring protection of equipment	3.565	3.667	3.714	102	2.77%	1.28%	4.01%
Average for sub category	3.626	3.733.	3.752		2.87%	0.51%	3.36%
AVERAGE FOR CATEGORY	3.369	3.505	3.621		3.88%	3.20%	6.95%

STAFF MANAGEMENT**Employee Relations**

21 A knowledge of complaints procedure	3.783	3.857	4.000	1	1.93%	3.57%	5.43%
22 A knowledge of personnel management	3.783	3.952	3.952	2	4.30%	0.00%	4.30%
23 Conflict management	3.826	3.714	3.810	57	-3.01%	2.50%	-0.43%
24 Recruiting of staff	3.435	3.476	3.429	145	1.19%	-1.39%	-0.18%
25 Interviewing and selecting of staff	3.739	3.619	3.476	139	-3.32%	-4.11%	-7.56%
26 Promoting of staff	3.478	3.714	3.762	86	6.35%	1.27%	7.54%
27 Identifying and resolving personnel problems of staff	3.565	3.762	3.905	11	5.23%	3.66%	8.70%

Average for sub category	3.658	3.728	3.762		1.86%	0.90%	2.76%
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Evaluation

28 Job evaluation	3.565	3.571	3.571	130	0.17%	0.00%	0.17%
29 Developing standards of performance	3.652	3.714	3.714	102	1.67%	0.00%	1.67%
30 Developing criteria for staff performance	3.348	3.571	3.619	125	6.26%	1.32%	7.49%
31 Evaluating staff performance	3.652	3.810	3.857	22	4.13%	1.23%	5.31%
32 Perceiving barriers to staff performance	3.565	3.762	3.762	86	5.23%	0.00%	5.23%

Average for sub category	3.557	3.686	3.705		3.51%	0.51%	3.99%
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Staff Development/ employee growth

33 Identifying and facilitating learning needs of staff	3.826	3.857	3.857	22	0.81%	0.00%	0.81%
34 Assisting staff to maintain skills	3.696	3.762	3.762	86	1.76%	0.00%	1.76%
35 Providing opportunities for staff development	3.652	3.762	3.810	57	2.92%	1.25%	4.13%
36 Orientation of new staff	3.565	3.762	3.810	57	5.23%	1.25%	6.41%
37 Teaching staff	3.565	3.476	3.524	135	-2.56%	1.35%	-1.18%
38 Identifying and developing staff potential	3.609	3.762	3.810	57	4.07%	1.25%	5.27%
39 Assisting individuals to set goals	3.652	3.810	3.857	22	4.13%	1.23%	5.31%

Average for sub category	3.652	3.741	3.776		2.39%	0.90%	3.28%
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Staff Communication

40 Informing staff of organisational change	3.870	3.952	3.952	2	2.10%	0.00%	2.10%
41 Using constructive confrontation skills	3.652	3.714	3.714	102	1.67%	0.00%	1.67%
42 Handling grievances	3.783	3.857	3.857	22	1.93%	0.00%	1.93%
43 Providing a forum for staff communication	3.826	3.857	3.857	22	0.81%	0.00%	0.81%

Average for sub category	3.682	3.845	3.845		4.26%	0.00%	4.24%
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Discipline and Termination

44 Implementing disciplinary action	3.522	3.667	3.810	57	3.95%	3.75%	7.55%
45 Counselling employees as to their performance	3.783	3.857	3.905	11	1.93%	1.22%	3.13%
46 Termination of employment	2.348	2.333	2.381	169	-0.62%	2.00%	1.39%

Average for sub category	3.217	3.286	3.365		2.08%	2.36%	4.40%
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AVERAGE FOR CATEGORY	3.605	3.690	3.772		2.31%	0.84%	3.12%
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PATIENT CARE MANAGEMENT**Standards of care**

47 Linking management with nursing care	3.609	3.762	3.810	57	4.07%	1.25%	5.27%
48 A knowledge of care delivery systems.	3.696	3.810	3.810	57	2.99%	0.00%	2.99%
49 Developing standards of patient/client care	3.609	3.762	3.762	86	4.07%	0.00%	4.07%
50 Identifying patient/client problems	3.130	3.286	3.429	145	4.73%	4.17%	8.70%
51 Making patient/client care decisions	3.000	3.095	3.143	160	3.08%	1.52%	4.55%
52 Using the nursing process	2.913	3.000	3.048	161	2.90%	1.56%	4.42%
53 Developing nursing care plans	3.304	3.381	3.381	153	2.27%	0.00%	2.27%
54 Planning safe, cost –effective patient care	3.348	3.381	3.476	139	0.98%	2.74%	3.69%
55 Providing care based on research.	3.304	3.429	3.571	130	3.62%	4.00%	7.48%
56 Evaluating nursing care	3.739	3.857	3.810	57	3.06%	-1.25%	1.85%
57 A knowledge of changes in nursing care practice	3.696	3.810	3.857	22	2.99%	1.23%	4.19%
58 Supervising patient/client care	3.261	3.476	3.619	125	6.19%	3.95%	9.90%
59 Understanding the legal implications of nursing practices	3.870	3.952	3.952	2	2.10%	0.00%	2.10%
60 Understanding of privacy issues relating to patient/client records	3.739	3.810	3.857	22	1.85%	1.23%	3.06%
61 Providing known monitoring systems for patient/client care	3.435	3.667	3.714	102	6.32%	1.28%	7.53%
62 Ensuring quality care it provided	3.652	3.714	3.762	86	1.67%	1.27%	2.92%
63 A knowledge of quality assurance activities	3.652	3.714	3.714	102	1.67%	0.00%	1.67%
64 Assessing charts and documentation for accuracy	3.609	3.714	3.762	86	2.84%	1.27%	4.07%
Average for sub category	3.476	3.590	3.638		3.18%	1.31%	4.45%

Staffing Patterns

65 Organising of centre	3.609	3.762	3.667	121	4.07%	-2.60%	1.58%
66 A knowledge of staffing models	3.435	3.524	3.619	125	2.53%	2.63%	5.09%
67 A knowledge of measures of efficiency	3.609	3.667	3.714	102	1.58%	1.28%	2.84%
68 Identifying work to be done	3.739	3.810	3.857	22	1.85%	1.23%	3.06%
69 Determining staff mix	3.522	3.667	3.762	86	3.95%	2.53%	6.38%
70 A knowledge of patient/client classification systems.	3.391	3.429	3.429	145	1.09%	0.00%	1.09%
71 Estimating patient/client workload (quantifying care)	3.565	3.714	3.762	86	4.01%	1.27%	5.23%
72 Ensuring staffing reflects workload (workforce planning)	3.739	3.762	3.857	22	0.61%	2.47%	3.06%
73 Scheduling of staff to reflect work load	3.565	3.667	3.810	57	2.77%	3.75%	6.41%
74 Daily patient/client-staff assigning	3.087	3.381	3.524	135	8.70%	4.05%	12.40%
75 Co-ordinating work activities on the unit	3.739	3.857	3.857	22	3.06%	0.00%	3.06%
76 Best use of human resources	3.696	3.810	3.857	22	2.99%	1.23%	4.19%
77 Monitoring activities on the unit	3.522	3.714	3.810	57	5.18%	2.50%	7.55%
78 Perceiving workload pressures on staff	3.609	3.762	3.810	57	4.07%	1.25%	5.27%
Average for sub category	3.559	3.680	3.738		3.30%	1.55%	4.79%

Patient/client Care Activities							
79 Providing technical skills and patient/client care as required	3.217	3.190	3.286	159	-0.84%	2.90%	2.08%
80 Receiving and delivering reports	3.304	3.286	3.429	145	-0.57%	4.17%	3.62%
81 Undertaking patient/client rounds	3.261	3.333	3.524	135	2.17%	5.41%	7.46%
82 Infection control	3.348	3.476	3.714	102	3.69%	6.41%	9.87%
83 Maintaining adequate records	3.348	3.381	3.476	139	0.98%	2.74%	3.69%
84 Transcribing written orders of doctors	2.174	2.143	2.810	166	-1.45%	23.73%	22.62%
85 Implementing orders of doctor	2.435	2.238	2.762	167	-8.79%	18.97%	11.84%
86 Questioning doctors' when in doubt	3.130	3.143	3.429	145	0.40%	8.33%	8.70%
87 Acting as a liaison between staff, doctor, patient/client & family	3.522	3.238	3.476	139	-8.76%	6.85%	-1.31%
88 Informing staff of changes to patients/client	3.043	3.095	3.429	145	1.67%	9.72%	11.23%
89 Acting as a patient/client advocate	3.522	3.571	3.714	102	1.39%	3.85%	5.18%
90 Implementing emergency procedures	3.304	3.238	3.333	156	-2.05%	2.86%	0.87%
91 Teaching patients and family	2.957	2.810	3.000	162	-5.23%	6.35%	1.45%
92 Facilitating multi-disciplinary team communication	3.522	3.619	3.714	102	2.69%	2.56%	5.18%
93 Participating in team conferences	3.435	3.429	3.619	125	-0.18%	5.26%	5.09%
94 Assessing community health resources	3.522	3.762	3.857	22	6.38%	2.47%	8.70%
95 Discharge planning	2.739	2.524	2.857	165	-8.53%	11.67%	4.13%
96 Assessing quality of care	3.565	3.714	3.810	57	4.01%	2.50%	6.41%
97 Arranging follow up	2.870	2.524	2.905	164	-13.70%	13.11%	1.21%
98 Controlling (supervising) nursing practice	3.522	3.714	3.810	57	5.18%	2.50%	7.55%
Average for sub category	3.187	3.171	3.398		-0.49%	6.66%	6.21%
AVERAGE FOR CATEGORY	3.387	3.453	3.572		1.92%	3.33%	5.18%

LEADERSHIP

Leadership Activities

99 Knowledge of management behaviour and theories	3.652	3.762	3.762	86	2.92%	0.00%	2.92%
100 Knowledge of organisational behaviour and theories	3.652	3.762	3.762	86	2.92%	0.00%	2.92%
101 Seeing the organisation as a whole	3.696	3.810	3.857	22	2.99%	1.23%	4.19%
102 Able to motivate	3.739	3.857	3.857	22	3.06%	0.00%	3.06%
103 Management by objective	3.609	3.762	3.810	57	4.07%	1.25%	5.27%
104 Able to negotiate	3.478	3.714	3.857	22	6.35%	3.70%	9.82%
105 Participative decision making	3.739	3.857	3.952	2	3.06%	2.41%	5.40%
106 Marketing activities (promotional)	3.435	3.429	3.571	130	-0.18%	4.00%	3.83%
107 Planning of activities, long and short term	3.696	3.857	3.857	22	4.19%	0.00%	4.19%
108 Programme planning	3.696	3.857	3.857	22	4.19%	0.00%	4.19%
109 Creating and maintaining a favourable work environment	3.870	3.905	3.952	2	0.90%	1.20%	2.10%
110 Controlling staff members	3.435	3.381	3.476	139	-1.59%	2.74%	1.19%
111 Supervising nursing staff	3.609	3.810	3.905	11	5.27%	2.44%	7.58%
112 Identifying stress in staff and self	3.565	3.810	3.857	22	6.41%	1.23%	7.57%
113 Developing and maintaining staff moral	3.739	3.905	3.857	22	4.24%	-1.23%	3.06%

Role Model								
119	Interpreting organisational goals	3.696	3.857	3.857	22	4.19%	0.00%	4.19%
120	Implementing organisational goals	3.696	3.810	3.810	57	2.99%	0.00%	2.99%
121	Administering nursing oriented policies and procedures	3.609	3.762	3.762	86	4.07%	0.00%	4.07%
122	A knowledge of change theory	3.652	3.810	3.857	22	4.13%	1.23%	5.31%
123	Initiating change	3.652	3.714	3.810	57	1.67%	2.50%	4.13%
124	Facilitating change	3.652	3.762	3.810	57	2.92%	1.25%	4.13%
125	Acting as a teaching role model	3.783	3.857	3.905	11	1.93%	1.22%	3.13%
126	Teaching techniques	3.391	3.619	3.714	102	6.29%	2.56%	8.70%
127	Acting as a resource person	3.696	3.857	3.857	22	4.19%	0.00%	4.19%
128	Co-operating with affiliated education programmes	3.609	3.762	3.762	86	4.07%	0.00%	4.07%
129	Providing guidance in planning care development	3.522	3.571	3.667	121	1.39%	2.60%	3.95%
130	Ability to cope under stress	3.696	3.905	3.857	22	5.36%	-1.23%	4.19%
131	Initiating personal (own) and professional growth and development	3.826	3.952	3.952	2	3.20%	0.00%	3.20%
132	Developing & maintaining personal (own) professional identity	3.783	3.905	3.905	11	3.13%	0.00%	3.13%
133	Maintaining own professional identity	3.826	3.952	3.952	2	3.20%	0.00%	3.20%
Average for sub category		3.672	3.806	3.832		3.52%	0.66%	4.18%
Communication								
134	A knowledge of communication techniques and theory	3.609	3.762	3.810	57	4.07%	1.25%	5.27%
135	Communication skills, written and oral	3.696	3.857	3.857	22	4.19%	0.00%	4.19%
136	A knowledge of communication channels	3.783	3.905	3.905	11	3.13%	0.00%	3.13%
137	Providing feedback to administration	3.696	3.810	3.810	57	2.99%	0.00%	2.99%
138	Participating on committees	3.522	3.619	3.762	86	2.69%	3.80%	6.38%
139	Developing collegial relations	3.522	3.762	3.810	57	6.38%	1.25%	7.55%
140	Interviewing skills	3.609	3.762	3.810	57	4.07%	1.25%	5.27%
141	Counselling skills	3.696	3.857	3.857	22	4.19%	0.00%	4.19%
142	Acting as unit spokesperson	3.609	3.857	3.857	22	6.44%	0.00%	6.44%
143	Understanding group dynamics	3.609	3.857	3.857	22	6.44%	0.00%	6.44%
144	Team building/group process skills	3.652	3.810	3.810	57	4.13%	0.00%	4.13%
145	Interacting with other departments/sectors	3.739	3.905	3.905	11	4.24%	0.00%	4.24%
146	Dealing with bureaucracy	3.478	3.714	3.714	102	6.35%	0.00%	6.35%
147	Co-ordination between areas (units and departments)	3.783	3.905	3.905	11	3.13%	0.00%	3.13%
148	Information handling and processing	3.609	3.667	3.810	57	1.58%	3.75%	5.27%
149	Ceremonial duties	3.217	3.286	3.429	145	2.08%	4.17%	6.16%
150	Public relations	3.435	3.762	3.810	57	8.70%	1.25%	9.84%
Average for sub category		3.604	3.770	3.807		4.42%	0.96%	5.33%

Decision-making								
151	Defining centre's philosophy	3.739	3.857	3.857	22	3.06%	0.00%	3.06%
152	Setting centre's goals	3.739	3.810	3.857	22	1.85%	1.23%	3.06%
153	Formulating centre's objectives	3.696	3.762	3.810	57	1.76%	1.25%	2.99%
154	Developing centre's policies	3.609	3.762	3.810	57	4.07%	1.25%	5.27%
155	Developing centre's procedures	3.609	3.762	3.857	22	4.07%	2.47%	6.44%
156	Decision making skills	3.652	3.762	3.810	57	2.92%	1.25%	4.13%
157	A knowledge of power relationships	3.522	3.810	3.810	57	7.55%	0.00%	7.55%
158	Political knowledge	3.391	3.667	3.762	86	7.51%	2.53%	9.85%
159	Problem solving skills	3.783	3.905	3.905	11	3.13%	0.00%	3.13%
160	Time management skills	3.739	3.857	3.857	22	3.06%	0.00%	3.06%
161	Maintaining an awareness of socio-political and economic trends	3.565	3.714	3.810	57	4.01%	2.50%	6.41%
162	Setting priorities (patients/clients, staff, centre)	3.739	3.810	3.857	22	1.85%	1.23%	3.06%
Average for sub category		3.649	3.790	3.883		3.72%	1.14%	6.03%
Research								
163	Knowledge of research process	3.435	3.429	3.524	135	-0.18%	2.70%	2.53%
164	Participating in research	3.478	3.571	3.714	102	2.61%	3.85%	6.35%
165	Conducting research	3.174	3.190	3.333	156	0.52%	4.29%	4.78%
166	Interpreting research findings	3.217	3.381	3.381	153	4.84%	0.00%	4.84%
167	Applying research findings	3.435	3.524	3.714	102	2.53%	5.13%	7.53%
168	Involving staff in research	3.565	3.667	3.762	86	2.77%	2.53%	5.23%
169	Knowledge of research grants available	3.217	3.238	3.429	145	0.64%	5.56%	6.16%
Average for sub category		3.360	3.429	3.551		1.99%	3.45%	5.38%
AVERAGE FOR CATEGORY		3.600	3.735	3.781		3.61%	1.22%	4.79%
Additional competencies								
170	Transcultural Nursing	-	3.474	3.650			4.83%	
171	Ethical issues including management, environment & bio-ethical	-	3.474	3.550			2.15%	
172	Organisational culture	-	3.368	3.500			3.76%	
173	Nursing Services management	-	3.211	3.350			4.16%	
174	Supplementary Services	-	3.000	3.100			3.23%	
175	Inter Departmental Services	-	3.053	3.150			3.09%	
176	Community Discipline towards Health Equipment Etc	-	2.947	2.950			0.09%	
177	Listening skills	-	3.579	3.650			1.95%	
178	Empathy	-	3.684	3.750			1.75%	
179	Trust	-	3.632	3.700			1.85%	
180	Sensitive to needs of others	-	3.737	3.750			0.35%	
181	Friendliness	-	3.632	3.600			-0.88%	
182	Public speaking	-	3.632	3.650			0.50%	
183	Meeting Procedure	-	3.632	3.700			1.85%	
184	Commissioning of new centre	-	3.316	3.550			6.60%	
185	Knowledge of strategic planning	-	3.579	3.750			4.56%	
186	Ethics in Nursing	-	3.632	3.650			0.50%	
187	Participating in community development projects	-	3.526	3.700			4.69%	
188	Managing Diversity	-	3.684	3.750			1.75%	

APPENDIX F

SUMMARY OF PARTICIPANTS COMMENTS

FOR EACH ROUND

SUMMARY OF PARTICIPANTS' COMMENTS FOR EACH ROUND

1 FUNCTIONAL MANAGEMENT

a) Financial Management

Round One:

M01 Very important for the manager to co-ordinate and control the financial provision i.e. capital & operational to ensure efficient use of resources & that services remain in the 'budget'. To be able to forecast long term financial planning of projects as this enables planning according to anticipated growth projections.

M02 This functions needs decentralisation and make every clinic unit manager a cost centre, which enables planning according to anticipated growth projections. Training in financial management is an area that is neglected.

M03 In an institution where there are accountants most of the financial management should be done by them. Yes a first line manager has to understand reasonable.

M05 Undecided 12-15. It would be useful to have the above, but first line managers can manage their budgets quite effectively without being competent in the above.

M07 A team of officials employed exclusively for non-nursing duties including financial management.

P01 For any nurse manager to provide effective services, financial management is extremely important.

P02 Financial management is essential to management.

P04 It is the responsibility of the administrative staff member to prepare, control and monitor the budget to allow the CPN to delegate her attention to the delivery of patient care, planning and strategic planning of staff.

P05 It is good to have skills and knowledge of financial management in order to monitor, control the unit finances efficiently and effectively with understanding and also control misuse.

P07 Usually historically budgets therefore difficult to prepare or to forecast. Totally dependent on what National gives Provinces. The Sister-in-charge should be able to plan and modify plans according to what she is given usually done by organisation.

A01 5 & 10 could have an overlap. 11 & 12 would not necessary mean doing it themselves. 13 need not be of advanced level – there are specialists. 14 & 15 need only be on an elementary level – to prevent them spending all their time in front of the computer instead of where the action is and managing

- A02** They are seldom computer literate or have a computer to use
- A03** If she/he really cares, then he/she will be cost sensitive!
- A05** The nurse can only utilise what has been allocated
- A07** All these aspects are becoming more important for managers.
- A09** Detailed financial analysis should be done by finance personnel.

Round Two:

M01 I still feel very strong about nurse managers being in possession of financial skills with the ever shrinking health service budget, managers need business skills if they are to function effectively.

M03 Agree with comment A09 financial personnel should do but a nurse manager has to prepare/do needs assessments and set financial priorities for his/her section. This information may then be forwarded to finance personnel for the entire department.

M04 Point 1 I wrongly interpreted. The right interpretation is assessment of the needs, which is really first step in planning and budgeting.

M07 Submissions done in order of priority. Team of specialists finalises accordingly. Print out sent out to nurse manager for information so that she can see how much was spent on the needs as per item.

P02 Financial management is a fundamental need for a manager to have in order to ensure that institutions are cost effective and sustainability.

P04 The clinic manager may or may not be the CPN (Chief Professional Nurse). However if the CPN is in charge, then he/she together with a clinic management team must take responsibility of financial management in order to use funds wisely according to priorities, planned developments in serve delivery, training etc.

A01 A05: That is the real issue – if the nurse manager does not have a say in what is allocated, others will keep deciding what is needed and they are usually not nurses?

A02 The use of computers are becoming very important.

A08 Financing and budgetary control is essential for quality care at the point of service. If this is allocated to some personnel, it takes away the authority of the nurse.

A09 I still maintain the status that accounting and financial skills have there own discipline in education. Understanding these in simple terms could be sufficient for the unit manager.

Round Three:

M01 I support P02 because as I have stated previously we are expected to function effectively and efficiently with a shrinking budget in order to do so one would benefit greatly if one has some financial skills especially with the new trends of decentralisation of budgets to the units.

M03 Understanding financial management is very important for nurse managers responsible for a budget in their institution. It is very important to keep accurate records and monitor use of budget to control and prevent over and under expenditure.

M05 13 Only need to know the basics of accounting and finance in own departments to do their own budgets.

15 Use of computers is helpful but not all-nursing staff are computer literate.

P04 The clinic manager may not be a nurse manager in the future. However clinic manager leads the clinic team of managers (e.g. CHC) and will not be doing actual accounting /costing her/himself, but each member of the clinic management must know how/why is spent or when and why funds are transferred to another object eg to implement another element for the core package. Clinic Health Committees are also to be supplied with all financial information.

P05 The manager should have skills on finances in order to utilise budget according to needs, to teach the staff about economy. The manager needs to know business economics and computer skills.

A03 No. 13 The nurse manager should use a qualified accountant to do the accounting function.

A06 In today financial climate, it is essential that not only the manager, but also the employees have to be trained to do financial management. It is only then that they will understand how important budgeting is and help with saving money and be sustainable.
Q6 The manager has to monitor the centre's budget, but she also has to do this with the financial personnel for the entire department.

A08 Financial control must be discipline specific.

b) Equipment / Supplies Expense

Round One:

M01 Availability of suitable functioning appropriate equipment ensures smooth running of the service and also ensures efficient practice of staff.

M02 This can be done by the clinic managers supervisor as part of the inventory and stock control process.

M03 One of the main functions of the first line manager.

M04 Good equipment is needed for screening of patients and making diagnosis on the basis of results from screening.

P01 Ensuring proper usage and storage can be a delegated function.

P05 The knowledge and control of sufficient equipment based on needs renders effective services is crucial, this leads to prevention of health hazards to the community served, promotes job satisfaction to the employees.

P08 With regard to 17 to 20: Although these functions could be delegated or outsourced so that the nurse manager does not expend time that could be put to better use on these functions, the nurse manager, nevertheless have to be skilled in these functions so that he/she is capable of assessing the standard at which someone else is fulfilling these functions and make improvement interventions if necessary.

A01 Does 19 relate to how well it is being used or whether staff know how to use it (33&34)?

A05 The first line manager in the clinics depends on the supply from the local hospital.

A06 With team and delegation.

A07 Important for management and cost effectiveness.

Round Two:

M03 I am asking the same question as A01.

M07 A01 comment NO.

P04 Each clinic should have 3-5years equipment updated/replacement plan and annual maintenance programme to ensure efficiency and safe patient care. Three monthly inventory check – proper control of equipment on a daily basis e.g. baumanometer, diagnostic sets. Training on correct use of equipment on a planned year basis.

A03 For cost control all the items are important for a manager.

A08 The future function of the nurse manager has to move beyond the administrative duties. The supplies and equipment are the sole function of the nurse manager.

A09 I concur with P01 these items can be a delegated function

Round Three:

M03 Nurse managers generally know what is needed but staff at the operational level are responsible for identifying equipment sometimes through forward planning (estimates) or simply making orders through the manager.

P04 Clinic manager should be competent in all aspects of equipment use/care, so that she can delegate functions appropriately and trains as needed.

P05 The manager should know her/his unit, xxx the inventory and its procedures, motivating of, xxxx and ordering of equipment. Overall skills and knowledge of equipment. The manager must give a full report to all staff newly employed, going on leave etc. Teach the others their functions. In one of the occasions the manager must find her/himself confronted with a procedure or motivation of the equipment.

A03 Standardisation of equipment?
Providing education/training to use the equipment?
Maintenance of equipment?

2 STAFF MANAGEMENT

a) **Employee Relations**

Round One:

M01 Through a sound knowledge of industrial relations in accordance with conditions of service and all relevant regulations, e.g. bill of rights, Basic equity and employment act etc, a manager is able to create a positive climate conducive for staff development and self-actualisation of all employees – in plain terms a good workforce.

M02 There should be total integration of services e.g. recruitment is done by the personnel department. The nursing unit manager needs to be involved in the process.

M03 Points 24 - 26 is the function of the senior managers.

M05 Point 27. Only if it impacts on the work. Recruitment and selection are done with middle management and therefore first line managers acquire competence by assisting in the processes. NB! Must have a participation in the selection of staff who work in the centre.

P01 Staff management is a key component of a nurse managers tasks.

P05 This aspect strengthens employer/ employee trust, maintains respect, co-operation to one another, sensitises and motivates job commitment.

P07 This is dependant on "power" handed down.

P08 I am hesitant to agree that this skill is absolutely required by the nurse manager, since one would not want to belabour these professionals with too may expectations. I think it would be sufficient for the nurse manager to know that these procedures are in place and under which circumstances they should be applied, and also who the specific specialists within the organisation are to contact should the circumstance arise.

A01 Is the disciplinary procedure included in 22? Should it not also be separate as in the grievance procedure (21), seeing that so many problems specifically arise from disciplinary steps taken?

A03 Do you mean grievance procedures?

A04 As for Q 27 she should provide assistance if appropriate. Personal problems are not the manager's responsibility, but they usually affect the employee's performance.

A05 Some problems cannot be resolved by the first line manager, but can be referred appropriately.

A08 Ability to fire and employ staff will empower the managers and improve the standards of nursing care.

A09 Recommend for promotion.

Round Two:

M01 Promotion of staff not necessarily a function of line manager, but input on how a staff member functions can assist the H/R Department.

M03 Conflict management is one of the key components of management which should start or be initiated at the clinic. The first line nurse manager should be able to manage conflict and provide the environment that prevents conflict situations before they even occur. See M01.

M04 Point 21-27 is managed in liaison with management (Personnel Dept.) Staff management is most important function of person in-charge of the unit/ clinic for job satisfaction and contentment of the staff have direct influence on overall functioning on the unit. Point 24 - involvement in screening of applications, preparing of short list. Point 25 – member of interviewing team and input in selection. Point 26 – Motivating for promotion and upgrading of post to industrial council.

M05 26 Do not have the power to do so. Can recommend promotion, but sometimes there is no approved mobility for staff within an organisation eg no rank promotion.

P02 Centre personnel recruitment and utilisation should be placed at the centre manager. Reason manager's goal depends upon motivated and willing personnel. Manager should take the responsibility for the personnel recruited rather than using the centre as a bumping place of burnout staff.

P04 Clinic managers will not necessary be nurses in the future. Clinics are health care units within the district, there both district and clinic managers need to be involved in most aspects of staff management, although day by day minor problems/discipline/grievances must be handled by the appropriate supervisor.

A01 A08 With the labour law we have hiring and especially firing is basically very far from the first-line nursing unit managers powers. Q27 refers to personnel problems, not personal problems. Q 24 does not necessary only refer to formal recruitment. The best recruiters are you present staff (e.g. job satisfaction, caring environment etc.).

A03 Q27: Problem related to work – not personal problems of staff. Again all the aspects are important for a manager specific No. 22 in the current health service very important. Q21: Again do you refer to grievance procedure? If so then it is of the utmost importance.

A06 Q27 some problems can't be resolved.

A08 She still has to be knowledgeable about this issue otherwise she will be dis-empowered.

Round Three:

M01 I support M03, because in today's work climate it is of grave importance that one is familiar with the Labour Relations Laws and all they encompass in order to function in mutual harmony with staff in order to realise organisational goals and objectives.

M03 Previous comment still stands

M05 Should not go out of her way to identify personnel xxx of the staff – unless it impacts on the work. 26 Only recommend how promotion only done through competence interview.

P04 24: Need to departmental rules, procedures to be followed in order access staff.
25: Staff need to be selected to organisational goals – there needs to be a matching between clinic service needs and staff. Clinic manager needs to interview and select staff.

26: Most know the correct procedure to facilitate appropriate promotion.

A01 M05 – if the nurse centre manager doesn't have the power to do this, who has

A03 Staff management (heading) should rather be Human Resource management (more up to date)
25 this is the CPN's function.

A08 If nurses cannot develop standards at the point of service, then the nurse managers are not in control of their job.

b) **Evaluation**

Round One:

M01 Together with the human resources department can do job evaluation and development criteria for staff performance, but the main function of the manager would be to ensure that standards are maintained and to guide and assist employees by setting the right climate, providing the right equipment etc. So that their job performance can be advanced and through continuous evaluation corrective measures can be employed.

M03 As a person who is at the operational level more that administrative, first line manager is the best person for job evaluation.

M05 Standards and criteria are developed by the training and personnel departments with input from the staff. Good to have knowledge and insight of the procedures.

P01 Developing standards and criteria for performance should be done with other colleagues.

P05 Job satisfaction depends on evaluation which lead to measure the standard of performance and strive towards the best service and educational platform and renders promotional opportunities.

P07 Depends on organisations standards, may be predetermined same applies to criteria

A02 Job evaluation and standards are formulated by middle managers.

A04 Q 30 in conjunction with staff. Q 28 If job evaluation entails job analysis and job description as according to Gillies 1989:167 then response is 4. On the other hands it implies putting a monetary value to the position then response 3.

A05 The above will improve relationships and thus improve productively.

A07 Don't know if all this can be done with all the other responsibilities.

Round Two:

M01 All the above functions can effectively be performed by the line manager together with the Human Resource Department.

M03 Support P01.

M04 Point 29-30 EDL and Standard treatment guidelines, treatment protocols are set by the Department of health procedure file worked out and standardised by all clinic staff. Point 31 – Evaluation staff performance is done by senior sister (not line manager on operational level) together with nursing service manager input. Point 32 – Not properly understood. Reconsidered to 3. Maintenance of standards of care is major goal

of the clinics and sister-in-charge must be sensitive to the needs of the staff and the barriers, which hinder the staff performance.

P02 First line manager is the best person to do evaluation, but objectivity, transparency must prevail in all the evaluation.

P04 Roles performed during transformation are also as important as the actual job to be performed.

A01 Job evaluation is much more than job analysis as it is done to determine wage and salary structures. This needs a specific expertise, but the nurse manager should know what it entails and could be part of such a committee.

A03 I think too much emphasis on performance appraisal in the current health service. Teamwork should play a stronger role in nursing. The development of teamwork rather than individual performance should be emphasised.

A08 Maintenance of standards and evaluation of performance is an integral part of the management functions and the actual implementation depends on the delegated authority.

A09 The person should develop positive self-regard towards other personnel in order to maximise the standards of performance. To portray a good role model, advocacy, etc.

Round Three:

M01 I tend to disagree with A03 about the importance of performance evaluation. Once proper performance systems are introduced it is going to be very important that all line managers familiarise themselves with the process. It is therefore important to teach and monitor staff about setting goals re personal in line with the unit and eventually organisational goals, so that one of these systems are in place staff would not xxxxx on them as punitive but as systems to help and develop them.

M04 A03 comment I fully appreciate and support. In clinic situation sharing the knowledge and experience, exchanging views about diagnosis and treatment, helping each other to develop expertise is the aim of today's health care situation and therefore development of teamwork rather than individual performance is emphasised.

P04 Personnel performance should be seen within the context of the individual and the team work. Personnel performance procedures should be short to the point and users friendly. Not a long essay.

A03 Evaluation of team function – should be included. I agree with A01, this is the function of the CPN or an expert!

c) Staff development/ employee growth

Round one:

M01 Very important for a manager to create a positive climate conducive for self-development and self-actualisation of all employees. Helps to create career paths for them.

M02 Collaboration with clinic managers/ supervisors, personnel department training as well as the provincial department, private sector etc.

M05 Some institutions have staff development and training section who are responsible for this, but yes a first line manager may help with 35,36, 37 & 39.

P01 Unit supervisors and staff development officers should work together to make effective decisions.

P05 The health of the community depends on skills and knowledge of the staff in the unit, thus effective health promotion and prevention depends on staff with full confidence in the application of their competency.

P07 38/39 Usually out of the ambit of the Sister- in-Change, usually the district manager.

A01 Does 34 relate to on the spot teaching specifically? Because it could be included in 35, or what is the difference in 37? Would developing of staff potential not be included in 35?

A03 All very important!

A05 It depends on the motivation of staff to set realistic goals.

A07 Education role important for quality service.

A09 Orientation of new staff should delegate to others.

Round Two:

M01 The nurse manager who invests in the continuous development of her staff gets better patient care results and more job satisfaction for her staff.

M03 Should be able to continuously assess staff needs and expose staff accordingly to their needs. Should create environment conducive to self-development and recommend staff for appropriate training.

M04 Point 38 – Identifying the staff with talents e.g. delivery of health education for groups, creating of posters for exhibitions, writing articles on health issues for the local newspaper. Point 30 – Helping the staff to set attainable goals and projects for the year.

P02 Staff development should be planned according to the need and to serve as a motivating factor for staff.

P04 Development is essential to all – but should promote/facilitate the achievement of the overall organisational objectives and ensure adequate service delivery. A lot of staff feel that only their personal objectives are important.

A01 I agree that 36 can be delegated and be available to help if necessary, Q33: Learning needs are usually identified during performance appraisals – which is usually the responsibility of nurse managers. Q34 & 37 can be delegated.

A03 All very important for the nurse manager.

A08 Efficient running of the clinic depends on all of the above

A09 Manager to participate in the development of orientation programmes, then delegate.

Round Three:

M02 This is done in conjunction with the Human Resource Department.

M03 This is the first-line managers' key function.

P01 Agree with M01 in involving continuous development for better patient care and job satisfaction.

P04 The manager sets the tone, standards, but will obviously not be involved everyone's development, unless the clinic is very small,

P05 The manager responsibilities depends on the sake, accurate application of knowledge and skills in the community served. This identification and providing opportunities for staff development is crucially recommended. Staff should be given the opportunity to upgrade, update themselves in institutions, attend in-service and workshops. The manager also conducts the latter in the institution and supervises them.

A03 All very important

A09 No. 37 however is not a pre-requisite.

d) Staff Communication

Round One:

M01 Create a climate through communication on a regular basis – informing employees about changes, consult with employees as to how things are to be done i.e. up down communication – set up forums which the employees would not find intimidating.

M03 Whilst handing grievances first line managers should be careful not to be barriers for staff to take their grievances further if not satisfied.

M04 Sound communication lines in the clinic is the basis for effective functioning of staff and clinic.

P01 Well informed staff can be very supportive to management.

P05 Preparation of staff prior to implementation of changes is crucial to the functioning of staff and clinic. applicable, this will promote individual adjustment and co-operation and raise recognition to the staff.

P07 Grievances: depend about whom – must have knowledge to handle and know when to refer. Often they sit on a problem without seeking help until it explodes.

A01 Conflict management has been included in 23, would 41 not be included there? Would 42 not fit in with 21

A03 Open door policy!

A06 What about negotiations?

A07 Communication NB!

A08 Vital for communication between various levels.

Round Two:

M01 “80% of Top level executives time spent on communication. 16% reading,9% writing, 30% speaking and 45% listening ” This clearly indicates the importance of good open channels of communication in order to foster not only a good working relationship, but a well run unit.

M03 The department/ organisation may be committed to open door policy, have existing grievance procedures and encourage up-down communication but it is the duty of all personnel in management to ensure that these are implemented within their units. It is of no value if managers are not committed to their organisational goals.

M04 Very important.

P02 Communication should be an honest and open to ensure participative management and to build team spirit.

P04 Communication very important – effective communication difficult to attain especially in the districts in which clinics are built in outlying areas. Staff also needs to take some responsibility to ensure they get information e.g. follow up on meetings that others have attended.

A01 P07, If the grievance procedure is followed as stipulated, this should not happen. The problem usually arises if there is no procedure, even though it must be there legally.

A03 Nurses always complain of closed communication channels. Do you mean open communication channels by No 43? What about listening.

A06 Informing about governmental policy changes. Open door policy. Knowledge of organisational climate.

A09 Item 43 very important. Managers don't want to be questioned.

Round Three:

M01 During the times of change i.e. transformation as is so often referred to, it is of the utmost importance to keep staff informed about what is going on at all times – otherwise staff lose confidence and trust in the organisation.

M02 The personnel and Human Resources department is in charge of this function.

M03 All very important for the nurse manager.

P05 The effect of co-operation in the unit, community, employer depends on the clear, relevant communication on the daily basis. The manager handles different union movements, thus negotiations through communication solves problems,

A01 There are other options for staff communications than “confrontation”

A03 Listening skills of unit manager is very important.

A08 Communication provides a climate for productivity.

e) **Discipline and Termination**

Round One:

M01 Follow correct disciplinary procedures – deal with issues immediately using corrective measures that are suitable to the transgression.

M03 Point 46 have no power to terminate employment but may recommend termination where there is gross negligence of main responsibility or proof of unsafe practice that is detrimental to health.

M05 46 Can keep incidence report to back up disciplinary procedures.

P01 A sensitive issue which requires knowledge and skills to implement. The procedures have to be adhered to.

P05 The disciplinary steps should be followed before the dismissal of staff.

P07 Must know mechanisms (again depends on organisational policy) and how to apply.

A01 My comments in 2 (a) relates to 44 – I think it belongs there I don't think one should group discipline with termination – it makes it very negative and it should be the opposite, remedial, not punitive. 45 would also fit better with 2(b). Does 46 imply that the disciplinary procedure has been completed and the message has now could to be conveyed?

A02 Termination is done by middle managers

A04 Q 46 She is not usually in a position to terminate employment.

A07 Don't think everything needs to be done at a clinic level.

A08 Strongly agree because it determines power levels.

A09 She/he can recommend for termination to the employers.

Round Two:

M01 A manager's right to discipline a sub-ordinate derives from the conditions of service. Most union contracts permit managers to discipline an employee for first cause.

M03 Termination is one of the sentences that the organisation may impose depending on the nature of the offence or if it is the fair and correct thing to do. It must not be seen as negative. Staff should however be made aware of disciplinary procedures within the organisation.

M04 Point 44-46 Within municipal setting there is a strong liaison between nursing managers and management services in handling disciplinary matters, correct disciplinary procedures must be followed, starting with verbal warnings at unit level.

M05 Recommend termination of service to higher level of nurse.

P02 This should fall within the policy guideline to avoid misuse of power.

P04 Q46 To be done at Regional or Provincial level.

A01 Q46: Termination is not delegated to first-line nurse managers – making sure that any reasons for possible termination is communicated to a higher level is the real responsibility.

A03 The nurse manager (first-line) must have knowledge and skills of all the above, whether it is part of her job or not. She must know how for example termination of employment works to guide her staff.

A04 Q46 She is usually not in a position to terminate employment.

A06 Q46 It is not of her scope.

A08 Knowledge of these is vital and backed by the current legislation and managers irrespective of level should know this.

A09 It needs to be remembered that he/she is also an employee. The employer is responsible for item 46.

Round Three:

M03 In terms of handling disciplinary action a first-line manager if she/he is the initiator in the case he/she may prosecute and recommend that the employee be terminated according to the seriousness of the offence, but the final decision lies with the Chairman of the inquiry.

M05 46 Recommend termination. Involvement in disciplinary hearings and counselling of staff, but does not have the power to terminate services.

P05 The manager disciplinary procedures are accurately followed up. If the subordinate continues to misbehave, the manager, management refer the matter in a written form, the signature of the person attached, then the final discussion depends on the higher authority (arbitration) or (CCMA), they'll take a decision of termination.

P07 The new act will allow termination, but what does the organisation allow.

A03 46 The first-line manager will not do the termination of staff herself, but he/she will be involved in the process!

3 PATIENT CARE MANAGEMENT

a) Standards of Care

Round one:

M01 A manager has to fill the role of a catalyst protagonist (change agent) i.e. generate ideas, develop a climate for planned change, overcome resistance and enhance care values i.e. positive attitudes, innovation and caring approach. She can ensure which a high standard of care for her patient.

M03 These are key performance areas for a first line manager.

M05 Developing nursing care plans, following up guidelines for treatment, standard treatment procedures and regimes.

P01 Most of the listed activities will rest with the line manager with the institutional manager taking accountability.

P05 Delivery of effective, efficient Primary Health Care to the community needs individual/community intervention in order to reach the goal of health for all, always.

P07 Often notes are brief and amount of clients seen does not often allow for lengthy nursing process /care plans. CHC (Community Health Centre) doctor does most of the diagnosis therefore nurse won't have time to do all the above.

A01 I am unsure of what 47 means, as all the other aspects can be included in "management". 50-54 would be limited for a nursing centre manager but she would of course have this background knowledge as part of her "hands on skills". 55 should rather be integrating research in practice. 58,61 &62 are very much the same.

A02 Direct patient care function is done by production team and not by managers.

A06 This will be with the team.

A07 Speaks for itself.

A09 Disagree elements: these competencies are too basic at this level

Round Two:

M03 Speaks for itself.

M04 Patient care management with all competencies 47-64 is the responsibility of the unit manager and Point 47 summarising all following competencies.

M05 49 & 50 Can have input into the standards developed but done participatory with the training department and management of other levels. 50 Not necessary – can be also done by all staff. 51 Have the knowledge but not functional at this level. 52 & 53 To use nursing process for any problems not necessarily with clients.

P02 The manager is not directly involved but ensures the quality of service by leading the team.

A01 A09 I agree that nearly half of these competencies are too basic for the manager – they belong to those doing the functional activities.

A03 The nurse manager must have the knowledge for effective management of the service.

A09 Stand by my decision. Concur with A02 .

Round Three:

M01 I firmly believe that a good manager needs to have a finger on the pulse of the unit she is running. It is therefore important that she has knowledge of patient care management even if most of the functions would be done by the other members in team. She after all is the leader and as such all eyes are on her guidance and support.

M02 Function of facility manager.

P05 The manager is the overall supervisor, co-ordinate from 47-64 in the primary, secondary and tertiary of the community/nurse. The manager is the advocate.

P07 55 Deadness on the research's validity/usefulness etc.

A01 Q 50 those directly in contact with patient/client should be identified, not the manager. Same applies to 51 to 55 and 58.

A08 Nurse manager is managing client care and environment, the actual tasks can be delegated. She is responsible for all that happens under her control.

b) Staffing Patterns

Round One:

M01 Through the managers knowledge and skills she must be able to co-ordinate the community medical, nursing and supportive staff activities in order to adequately provide for a wider range of health care functions.

M03 Key performance area.

M05 Utilising the staff effectively to cope with workload and protection against burnout.

P01 Planning is an essential aspect of the manager. Information on utilisation can be obtained from line managers.

P05 The unit nursing intervention is built on level of competency of staff/client/patient classification respect maintain confidence in the working situation.

P07 Again depends on the organisational views.

A01 74 & 76 must correlate, as must 72 & 73 as well. 73 would be dependent on 77, which would relate to 71. Would 74 be daily?

A06 She will delegate some of these responsibilities.

Round Two:

M01 Staff should be assigned according to the needs of the patients and also according to the skills that they bring to meet these needs. We can then be assured of not only efficient but affective nursing care would be provided.

M03 66 & 69 can be performed with the human resource personnel.

M04 In PHC services, nursing staff have own areas of responsibility for different components of care.

M05 69 Done at a higher level i.e. scheduling of staff but can have input requesting and negotiating for the correct mix. 72 & 73 Necessary to have the knowledge to motivate staff but this is done at a higher level.

P02 Staffing patterns form part of efficient utilisation of human resources.

A03 All aspects are important.

A08 Collapse Q 76 & 77.

Round Three:

M03 Staff is done at higher management level. The first-line manager may have input in point 71 & 72. Her/his key function in this will be point 73, 74, 75, 76 & 77.

M04 Daily patient staff assignments is really responsibility of immediate supervisor.

P04 Each community health centre is an independent unit. Smaller clinics or satellites of the CHC may depend on a so-called "higher level"

P05 The manager's role is to co-ordinate staffing patterns by allocating of staff (all categories) according to level of competency. In order to ensure workforce planning, alleviate workload pressure on staff..

A03 Knowledge of the implementation and management of nursing care?
64 Does it include knowledge of recording of patient care? Of not it should be included seeing that recording is so important (and poorly done in SA)
64 Rather quality improvement activities.

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c) Patient/client Care Activities

Round One:

M01 I am aware that doctors feature in the service, but our PHC Services are mostly nurse based so that the role of the manager is to ensure that PHC skills are sharpened by encouraging case conferences, review of treatments and having protocols for treatment on hand and regularly updated and organising of in-service on a regular basis for staff with medical consultants and inviting experts in certain fields to address staff.

M03 Points 83,84 & 88 can be done by other subordinate staff.

M04 Sister- in-charge is mainly involved with supervision and indirect patient care, but must provide the staff with advice, knowledge, technical skills when needed.

M05 First line managers need to have technical knowledge of the various procedures as to advise, support, evaluate staff etc.

P01 Most aspects listed are the responsibility of the line manager.

P05 The community health centre's role is performance accepted by the community/health organisation WHO. UNICEF their commitment of health implementation is monitored by the unit manager.

P07 PHC does not have some of the items listed – patients enter and leave on the same day, sometimes without the Sister- in-Charge ever having any contact with them.

P08 79. Although the first line manager may not actually be performing technical tasks any longer, one would still expect her/him to be proficient in these such that any slips in standards would be picked up in their supervisory/leadership capacity and that the necessary corrections are made. 90. One would like that the same should prevail here as for 79, but to be skilled in emergency situations the professional actually has to deal with emergencies on a continuous bases and since this would not be the case for the first line nurse manager working in a primary health care setting, it is unrealistic to expect that this manager should remain proficient in this.

A01 This overlaps too much with 50-54.58. These activities are not really managerial competencies but professional "hands on" . Is the nursing centre manager expected to do all these every day as well as all the other managerial tasks (1a,b; 2a,b,c,d,e; 3b)- or do you want to know if they know about these things.

A06 She will delegate some of these responsibilities

Round Two:

M03 Most of these activities are clinical competencies and not managerial, however any supervisor needs to know procedures in order to assess/evaluate any lack of these within the unit. Other subordinates can do points 83 to 88.

M04 In PHC services Nursing Mangers are involved to some extent with direct patient care e.g. relieving when necessary, but it is not their main duty, therefore rating is reconsidered on points 84,85,87,88,91,95,97. Very often patient management is

discussed among the staff including sister-in-charge and her input. Point 90- Involvement in disaster management in local authorities

M05 79 when necessary staff shortages and emergencies 84 & 85 Not hands on 89 If need be 83 Staff functioning should keep accurate records the managers ensure that this is done. P08 agree

P02 The first line nurse manager is the facilitator of patients but not functional on direct patient care. She sets the standard criteria, subordinates are at the delivery end.

P04 Q 84- not really clear on the meaning of this. Q85 – Manager of CHC will not be involved in actual patient care. Q88 – not clear to me Q90 – facilitate or initiate emergency procedures. Q97 – depends on size of clinic, certainly not CHC.

A03 M02 yes but the nurse manager must be competent to do so.

A06 P08 Agree with comment.

A08 Some of these activities can be delegated to other subordinates.

A09 Concur with P08 in 79

Round Three:

M01 I support A09 (Concur with P08 in 79, that even through the manager does not perform some of these functions herself she delegates and therefore needs to be knowledgeable about patient/patient care activities.

M02 It is important for the supervisors to understand these and unsure that they are done. Integration of so plans an important role.

M04 I don't think I fully understand the meaning of 88, but all applicable to patient care. 86 changing to 3- when necessary- especially when treatment guidelines for HH service are in conflict with DR's order's.

P04 83 Ensuring rather than maintaining
90 Clinical – unlikely, but organising, facilitating yes.

P05 The manager role is mostly supervision In 81,83,84,86,97, the manager stil has responsibility in obtaining daily report on patient/client all the staff in the unit including doctors.

A01 M02, M03, M04, M05, P04, A03 Agree.
Q79,81,83-88,91,95,97 are the responsibility of those directly involved, not manager.

A02 Main responsibility is to manage effectively and not direct patient care.

A03 I changed my rating to suit the in it managers' competencies. I think I rated it the previous time incorrectly thinking if the competencies of a nurse manger (CPN in charge).

A08 Client care activities are basic. Manager involved at higher level.

4 LEADERSHIP

a) Leadership Activities

Round One:

M01 I assume that leadership skills in this context refers to the manager having to be able to , through her knowledge and skills, be able to schedule and co-ordinate resources and tasks in order to ensure smooth running of the service and delivery of an efficient service.

M03 Point 111. Responsible for all staff in the centre including clerks and general workers. Point 118. This is achieved through MBO (management by objective) or/and participative management rather than power and status.

M05 Flexibility follow democratic leadership style because most staff are professional nurses.

P01 Leadership involves knowledge and skills to work with people and lead by example.

P05 Important and crucial to coach and lead to ensure decentralisation of authority which is challenging to leaders of all departments.

P06 Q 118 Using skills.

P07 110 The word control is frowned upon.111 Supervising nursing staff/staff members Again some of the items are more for a district manager than a sister-in-charge, but can be taught/given the knowledge.

P08 What power and status do we really have as health workers?

A07 Q 118 Using skills rather than power.

A06 To some extent yes and some extent no – rather motivate instead of power and status.

Round Two:

M01 Good leadership involves risk taking and an element of trust in the people with whom one is working. Power should never be used because then the element of trust is lost; instead the leadership should create a sense of purpose and hope. The social, political and economic climate also has an effect on the type of leadership displayed.

M03 Support P07.

M04 Using power and status to be “spokesperson” for the staff and the clinic, seeing that their needs and aspirations are being met, rather than exercising own wishes, needs, power over the staff. Point 106- Was not sure if there is time; from time to time articles in local newspapers are being placed, informing the public of hours of clinic, situation and services available.

M05 102 Sometimes necessary 114 Should also be the organisations responsibility in terms of having supportive structures in place. Staff support also mostly needs structures in place within the organisation for staff referral. Open door policy etc, Employee Assistance Programmes. This is becoming vital in the present daily situations of staff, increase workload and greater understaffing. We need to keep increase motivation.

P02 Leadership is about influencing people's attitudes and behaviour towards a desired objective. No coercion, manager earn and work.

P04 Q104- consultation rather than negotiation at clinic Q118 – Agree with P08. Power with rather than power over.

P08 Q118-The community should be empowered through the provision of objective information to improve conditions for themselves and the centre. The correct policies, protocols and systems should be in place to enhance goal achievement for staff, patients and the centre, so that even those without power and status can strike fair deals for themselves.

A01 Q118 Power must be seen in its broad contest e.g. expert power, connection power, information power etc. Q 110 &111 can be one with the term supervising.

A03 Q110 Control of staff sounds like policing. Rather only 111 Supervising. Guidance of staff, controlling is not a leadership skill. Q118 I am not clear on the meaning of the item.

A09 Q118: Using authority.

Round Three:

M03 A first-line manager who uses power and status to achieve goals will actually not achieve any goal. The buzzword today is that of participative decision making which improves co-operation amongst staff. Employees are very much aware of their rights and will not accept any goals imposed on them..

M04 Point 106 changing to 3 – is part of leadership competency and done periodically in various forms e.g. image building xxx of services, health education, liaison with other organisations

P04 118 Using drive, energy and commitment to achieve goals or using power with.

P05 Excellent leadership in the unit (community) is linked with risk factors. It depends according to the activity, some are role models to others and others maybe politically unacceptable. The leadership control should be firm and fair in order to create a sense of purpose

A02 Transformational leadership is necessary in an ever-changing environment.

A03 118 Rather empower patient, staff and community. I agree with P08.

b) Role Model

Round One:

M01 One has to be a good role model to all employees by being a believer in the system – everything one communicates starting from appearance would be positive – becomes easier to translate the goals, objectives etc. of the centre.

M03 Role model- one of the good attributed of a leader.

M05 Monitoring process: modelling effective leadership behaviour were both parties profit from a effective monitoring relationship

P01 Staff need to identify with a leader they respect.

P05 Copying promotes good image, which shall motivate staff to imitate good personalities in the unit.

Round Two:

M01 Being a good role model to the people one is working with plus to the organisation one is serving can never be overemphasised, especially today when the nursing profession is threatened by so many different elements.

M04 All very important, setting up the standards by own example, own image, own professionalism. For others influence people by being a good role model.

M05 128 Can be delegated

P04 Q130 – Ability to cope under stress indicates confidence, ability to priorities, delegate and focus effectively.

Round Three:

M01 It is important for the manager to be a good role model she not only is the advert for the organisation, but she is the one to give hope to the staff especially during these stressful times we all need someone or something to identify with.

M02 Role Modelling has always and must always be the xxxxx of nursing as a profession.

P04 24 Change adept

P05 The manager should be positive in her profession and believe in “GOD” the creator, that all humans beings are the same, the differences lies on behavior the respect of human life is god’s blessing.

A01 M05 This is very important aspect of planning. Co-ordination all those institutions utilising the clinical facilities for training purposes cannot be easily delegated.

c) Communication

Round One:

M01 Communication is the most essential tool a manager requires to perform all the tasks. The manager conveys the institutional image of competence and professionalism to the public. NB what we must not forget is that skills can be learned.

M03 Point 137 and staff.

P01 Every manager must be able to communicate effectively.

P05 Communication is crucially applied to maintain a successful co-operation and seminate knowledge to all sections and the community served.

A01 138 not necessarily all committees, some can be delegated.

A03 141 Counselling the staff or patients?

A04 Q146 Not clear what is mean by "dealing with..." If you mean handling it in order to achieve patient care goals then response 4.148 What do you mean by this?

A06 148 What do you mean by this? 150 To some extent she is too busy and there must be a PRO.

Round Two:

M01 As a manager one should foster a climate of supportive communication this involves the whole gambit of involving everyone in the unit in decisions to be made, encouraging employees to ask questions, regular feedback. If this method is employed one is assured of a smooth running unit.

M04 All very important.

M05 149 Can be delegated

P02 First line manager has a role of being a spokesperson and custodian of the image of the centre.

P04 Q141 Counselling both staff and patients. Q150- important for coping with community participation co- operation between staff, marketing clinic services all part of the role rather than tasks.

A01 Q148 I see it as part of information power and dissemination it.

A03 Q146 Not clear, I see it that she/he must tolerate it!

A06 Q: 149 What is this

Round Three:

M01 Good communication skills cannot be overemphasised. The whole running of the unit is based on good communication skills be they verbal or otherwise- so is the image portrayed to the community at large.

P04 Must use the system as effectively as possible to make things happen.

P05 Good communication in the unit empower a healthy environment to nurses/doctor/ community (staff). In the health situation (client/patient relatives). Decision of staff should be considered and application thereby according to relevance.

A01 M05 .The manager should be involved in the marketing aspects – this is where it happens. Cannot be delegated too often.

Q128 Manager does not have to be on all the committees, some can be delegated successfully to those with the most up to date knowledge for the specific committee.

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d) Decision-making

Round One:

M01 Nurse managers must be able to think as well as act in order to be able to solve problems and make constructive decisions which would be of benefit to the unit i.e. both employee and patient.

M03 Points 153 to 156 Not alone but with staff .Knowledge of political issues sometimes help to understand how some decisions are taken which may be political

P01 The manager's decision making will impact on the quality of the service delivery.

P05 First-line managers is to make decisions involving the unit managers and the other team members.

A01 All of these should be on a participatory level

A04 Q151 In co-operation with other members of staff, this also applies to Q152-155. Q158 Political as not in party politics, but organisational politics?

A06 This with her team.

A07 Q151 & 152 with others .Must however be done in a democratic way.

Round Two:

M01 Decision making forms the core of the management process. Very important requirement in a manager. The effectiveness of the manager is measures by the quality of her decisions.

M04 Point 157- Reconsidered rating – now 3. In organisational setting awareness of power relationships is applicable. In local authorities awareness of departmental heads, councillors, mayoral office, committees, playing a role in decision making.

M05 M05 151-156 are important but I agree with the others that there should be participate management i.e. input by the team.

P02 Decision-making is done by manager, but staff participation is essential for co-operation.

P04 Q151- in line with National, Provincial and Regional policy. Q 158 – As in political parties (have to work with all councillors). Q161 – Health and health services are a component of socio-economic upliftment. The clinic is in the health district. Health and socio-economic issue are concerns of the clinic because adverse conditions in the area affect the health of the people

A03 Decision making must always be a group effort, only in emergency situations it could be dealt by the manager only.

Round Three:

M01 N/B at local government level it is important for a manager to maintain an awareness of socio-political and economic trends it is at this level that the people and their needs are represented by the people themselves and for a manager to ignore this is a delusion.

M02 The manager must be able to take a decision, participative or co-operative decision making xxxxxxxx to times xxx wanted conflicting ideas and to personal xxxxxx priority over objectives of the institution and Health xxx.

M03 151 Could be a departmental philosophy and the manager may adapt it to the unit.
154 Could be done by higher management level.

P04 Use participative style

P05 Excellent managers decision skills maintain the high standard and acceptable, quality constructive, effective efficient skills in the unit (in every activity).

e) Research

Round One:

M01 A manager has to be familiar with and have knowledge of research principles so that she can teach her staff. It would, through findings of the research help them and the manager to plan effectively and to introduce preventative measures to avert outbreaks of certain diseases in the unit and even the community at large.

M03 This is new to nursing but important. Not a matter of must especially to older members ,but may add onto the body of knowledge of nursing. If possible, it should be encouraged. Time and finances may be a problem.

P01 Research is required to provide and improve care.

P05 Participation in research motivates the new information and its implementation on health issues in the community.

A01 overlap with 55

A07 Don't know if this can really be done on clinic level.

Round Two:

M01 Today research forms an integral part of management. A manager needs to acquire the knowledge and the skill as this could help her with planning and even forecasting trends in the district which she manages.

M04 Clinic staff often become participants in the research process, trials e.g. TB drug trials, HIV determination among antenatal patients. Point 169- Reconsider to rating 3.

M05 Research function is important even at clinic level. If they have the pre-knowledge of how to go about identifying problem areas and then develop strategies of how to overcome them which leads to improved patient care and may lead to effective utilisation of staff and resources. e.g. research: Waiting times of patients. How to reduce this etc.

P04 Participation is important. All aspects are important to the clinic manager eg environmental health, occupational health – all impact on health service demands at the clinic. There is a tendency for 'outside researchers' not to give feedback therefore all is lost to clinics, managers and clinicians.

A01 Direct research not a necessity, but facilitating important. A07 Research when there is any discrepancy.

A06 Q165: Mini research.

A09 Important to support PHC policy

Round Three:

M02 Research must start at facility level because it is where xxx sound observation is done but not validated.

M03 Research findings always seek to improve the work situation. The first-line manager may contribute by applying research findings

P05 Research is the forecast of modern technology nursing medicine. The manager should have skills of the latter in order to assist in community well being.

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4. ADDITIONAL COMPETENCIES

Round Two:

M03 Some of these are “nice to have” more of these skills can be acquired through experience.

M05 Additional competencies are very necessary for first-line nurse managers especially when dealing with nurse diversity. Communication skills and ethics in nursing are important especially today since the “caring” aspect of nursing seems to be disappearing.

P04 Q173 – Nursing services to be integrated into all other clinic and district services.
Q185 – Must be able to implement strategic plans ie convert to operational plans with measurable outcomes.

M07 CHC have clinics.

P07 There is a marked difference in the roles/functions of a district manager and that of a clinic manager.

A01 Q171 Relevant especially to research, but part of basic nursing science.

Q 173: How does this differ from all aspects being looked at?

Q 174 & 175: Difference? Does this imply that the nurse must again start taking responsibility of other services? Multi-disciplinary approach should address this. Q176: The meaning is not clear

Q177: Is covered under communication

Q178-181: Basic skills

Q182-183: Communication

Q186: Different to 171?

Q187: Can also be delegated

Q188: Relates to 170

A02 Point 179,180,181 are values.

A03 Q188 Diversity of cultures?

A04 Q174 & 175 her competency in these services is not clear, do you mean her knowledge therefor?

Q 176: Community discipline – does this imply the nurse manager making the community aware, I'm sorry but it is not clear.

A06 Q 173: What do you mean Q176: Utilising of what? Q187: If it is applicable to the clinic.

A09 Q172: Development of organisational culture? Q 173,174,175 not clear.

Round Three:

M04 187 changing to3 Health care development needs inter-sectorial co-operation and involvement in the projects with government and non-government (NGO"s) organisations.

P05 Thanks for the questionnaire it brought back the effective nursing/client managers role in my knowledge "pep" up skills, consaxxx the above knowledge gave me confidence.

A03 173 I do not understand

Rather 177 Listening to the staff

178 Empathy towards the needs of staff and patients

179 Ensuring a trusting relationship with staff and patients

181 Friendliness towards patients and staff

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ADDITIONAL COMMENTS

Round One:

M01 I have found this questionnaire very interesting but more than anything else it has brought back many principles of unit management. In the service at the moment we are very community orientated i.e. setting up committees, community involvement in decision for their own health, District Development and eventually integration of Province and Local Authority.

M05 A bit difficult to identify the level of competency of some of the questions. Some competencies are needed at a higher level and first line managers only need to have some knowledge or idea about it e.g. research

M07 Primary Health care clinics in our case first level - no doctors available.

P01 First-line nurse managers are the leaders of their service, hence their competency should be very high.

P05 This information on this questionnaire are crucial and relevant and motivation to the daily activity of the unit manager.

P06 Although this person at present functions within a management team – she is the overall co-ordinator of all disciplines. I am afraid my standards are fairly high.

P07 The Sister-in-charge should have basic knowledge of management. The district manager/ nurse-in-charge should have all the skills listed. It will be necessary to define exactly which one we are discussing as the competencies will differ in degree/level. All must have knowledge of the skills required.

A01 Supervision can be seen as “near” or “general” – the nursing centre manager will do this but it will differ in the above-named respect. In 3c where I have indicated 3 & 4 on the scale, it is because of your definition of competency, namely assessment of the knowledge needed (e.g. 80 – I don't mean that the nursing centre manager is going to report on the patient care activities as such)

A02 A very good questionnaire.

A03 Support to nurses

Round two:

M01 Congratulations on a very good questionnaire. I am really very glad to be part of the study. I can sue most of your questions as indicators to assess the quality of service we are providing in the sub-district I manage. Thank you one more.

A07 A comprehensive questionnaire

A01 . Your general indications were that it relates to nursing unit managers (first line): Comments from participants do not always reflect this.

A03 Q188 Diversity of cultures?

A04 Thank you for an interesting exercise

Round three:

M01 Thank you once more for having giving me the opportunity to be part of your study. As I mentioned previously your questionnaire has made one re-look at many of the practices of care and I have actually started some workshops with the staff to look at where we are and how we want to take the process and our work forward. Thank you once more.

M02 Very interesting questionnaire can be used for evaluation purposes.

P01 A detailed questionnaire who has helped me to look at service management in more depth.

P04 The implementation of a district system with the integration of skills and more emphasis on management abilities means that all aspects, functions will have to be considered by the clinic manager, to have an integrated whole. I guess I am trying to emphasise the changes to come.

P05 The questionnaire should be advertises or implemented in all units. Its brain teaser and storming eliminates the dying light in me. Thank you.

A03 I agree with Ao1 that the comments from participants do not always reflect the importance of the aspect to unit manager (first-line)
Maybe you could add the heading (instruction nr. 4) in bold Nursing unit..... at the top of each page , to draw the attention to the fact that it relates to the first-line manager !