UNIVERSITY OF THE WESTERN CAPE

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A human resource strategy to facilitate competencies of assistant nurse managers in the public health facilities in the Western Cape

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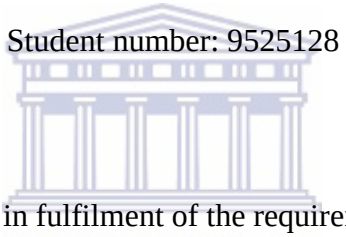

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DECLARATION

I, Vatiswa Veronica Makie, declare that this research study titled 'A human resource strategy to facilitate competencies of assistant nurse managers in the public health facilities in the Western Cape' is my own original work. It has not been submitted before for any degree or examination at any other university and all the sources that I have used or quoted are indicated and acknowledged as complete references.

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Student number: 9525128

Signature ……V V Makie……
Date ……15 March 2017……

This thesis has been read and approved for submission by:
Prof Karien Jooste
Supervisor

Signature …… K Jooste ……
Date ……15 March 2017……

DEDICATION

This dissertation is dedicated to the memory of my late grandmother Nomvula Angelina, who wanted me to be a nurse. I started nursing on 1 August 1985 and she died on 17 November 1985.

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ABSTRACT

The health workforce provides the most important input to any health system. There are estimated to be 59.2 million full-time paid health workers worldwide. The workforce has a strong comprehensive impact on the performance of the health system. Competent nurse managers are needed, particularly in countries such as South Africa, which places nurses at the epicentre of the health delivery system. During the implementation of the Occupational Specific Dispensation in 2007, the post of Assistant Director of Nursing was amended to Assistant Nurse Manager on a higher managerial level and newly appointed ANMs were expected to be competent. A generic human resources strategy was initiated in 2010 because of complaints about the competencies of nurse managers in the South African public health sector. This attempt excluded assistant nurse managers. The aim of this study was to develop a human resources strategy for facilitating the competencies of ANMs at the public health facilities in the Western Cape.

A sequential exploratory mixed method design was implemented. A qualitative phase was undertaken, followed by a quantitative phase. Phase 1 of the study focused on the exploration and description of the expectations of the nurse managers about the competencies of ANMs in the health facilities in the Western Cape. This phase followed a qualitative, exploratory, descriptive and contextual approach. The study population was selected by means of a purposive sampling technique. A total of eight focus group discussions were conducted with operational nurse managers (n = 48) and assistant nurse managers (n = 12). Each focus group consisted of between 6 and 8 participants and the interviews did not last more than an hour per session. A total of 15 unstructured individual interviews were conducted with Senior Nurse Managers (n = 2), a Nurse Manager (n = 1), Deputy Nurse Managers (n = 7) and Assistant Nurse Managers (n = 5). The number of interviews conducted in this study was determined by data saturation. Analysis of the data involved transcription of the voice recordings of all the interviews and writing up field notes. Open coding was conducted and an independent coder and the researcher reached consensus around the categories. Six categories and seventeen sub-categories emerged from the data of operational nurse managers (Phase 1). These main categories related to knowledge of the healthcare environment, technical skills, managerial skills, inter-personal skills, professionalism and leadership and support. Seven categories and twenty sub-categories emerged from the data analysis of the individual interviews (Phase 1). Similar main categories were found in the analysis of the data of the focus group discussions, that referred to interpersonal competencies, professional competencies, technical skills, leadership skills knowledge of the

care environment and its processes, guidance and support. To ensure trustworthiness of the collected data, Guba and Lincoln's strategies of credibility, transferability, dependability, confirmability and authenticity were applied.

The results of Phase 1 informed the development of an instrument that was distributed in Phase 2. Phase 2 of the study was a survey, that explored and described the perceptions of ANMs of their expected and their existing competencies for effective nursing management in public health facilities in the Western Cape. The instrument (questionnaire) used a 4-point scale for measuring the 'expected competencies' of participants on the left hand side and their 'current competencies' on the right hand side. Questionnaires were distributed to ANMs (n = 156) in the six districts in the Western Cape, that is Metro District and the five rural districts (Central Karoo, Cape Winelands, Eden, Overberg and West Coast). Pretesting of the instrument was conducted with five ANMs of the psychiatric hospitals determine the clarity of questions, effectiveness of instructions, completeness of response sets, and time required to complete the questionnaire. The data were analysed using the SPSS Version 20 software program and descriptive and inferential statistics were conducted. Descriptive statistics was described in terms of frequencies, mean values and standard deviations and were presented in the format of tables. The Spearman Correlation test was used to determine the relationship between the expected and the existing competencies of the ANMs. Reliability and validity of the research process during the quantitative phase was indicated by Cronbach's alpha (α). The findings from Phase 2 informed the development of a strategy to facilitate competencies of assistant nurse manager in the public health facilities in the Western Cape, described in Phase 3. The survey list of *Practice oriented theory* of Dickhoff, James and Wiedenbach (1968:434) was adapted as a reasoning map for the framework of the strategy on competencies of assistant nurse nursing in the public health facilities in the Western Cape. Finally, recommendations to implement the strategy and recommendations for nursing practice, nursing education and nursing research were suggested, based on the findings from the study. Ethical principles were followed during the study. Ethical considerations were ensured by obtaining written, informed consent from participants before they took part in the study, and for voice recording of the interviews. Participants could withdraw at any stage of the study. Confidentiality was explained to participants.

Key words: mixed method, assistant manager nurse, competencies, expectations, competency framework, perceptions, human resources strategy, nursing management, interviews, questionnaires

LIST OF ABBREVIATIONS

ANA	American Nursing Association
ANC	African National Congress
ANCC	American Nurse Credential Centre
ANM	Assistant Nurse Manager
ANMFG	Assistant Nurse Manager Focus Group
ANA	American Nurses Association
AONE	American Organisation of Nurse Executives
APP	Annual Performance Plan
CCL	Center for Creative Leadership
CEDEFOP	European Centre for the Development of Vocational Training
CFCD	Canadian Framework for Career Development
CFCDPSA	Competency Framework for Career Development Practitioners in South Africa
CFGP	Competency Framework for Guidance Practitioners
CICA	Career Industry Council of Australia
CSP	Comprehensive Service Plan
DHET	Department of Higher Education and Training
DNM	Deputy Nurse Manager
DOE	Department of Education
DPSA	Department of Public Service Administration
IAEVG	International Association for Educational and Vocational Guidance
ICN	International Council of Nurses
INT	Individual Interviews
FGD	Focus Group Discussions
GDP	Gross Domestic Product
HLA	Healthcare Leadership Alliance
HR	Human Resources
HRD	Human Resource Development
HRH	Human Resources for Health
HRHSA	Human Resource for Health South Africa
HRM	Human Resource Management
MTEF	Medium Term Expenditure Framework

MTSF	Medium Term Strategic Framework
NM	Nurse Manager
NCHL	National Center for Healthcare Leadership
NHS	National Health Sector
NOS	National Occupational Standards
NWC	National Workforce Competencies
NCDA	National Career Development Association
NEHAWU	National Education Health & Allied Workers' Union
NUPSAW	National Union of Public Service & Allied Workers
OECD	Organisation for Economic Cooperation and Development
ONM	Operational Nurse Manager
ONMFG	Operational Nurse Manager Focus Group
OSD	Occupational Specific Dispensation
NCHL	National Center of Healthcare Leadership
NDoH	National Department of Health
NHS	National Health Sector
NOS	National Occupational Standards
PHC	Primary Healthcare
PHSDSBC	Public Health and Social Development Sectoral Bargaining Council
SANC	South African Nursing Council
SNM	Senior Nurse Manager
TB	Tuberculosis
UK	United Kingdom
UNIDO	United Nations Industrial Development Organisation
USA	United States of America
WCDoH	Western Cape Department of Health
WCGH	Western Cape Government Health
WHO	World Health Organisation
WHPA	World Health Professional Alliance

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CHAPTER 1
ORIENTATION TO THE STUDY

1.1 INTRODUCTION

Fritzen (2007:4) states that the health workforce provides the most important input to any health system. The WHO (2006) estimates that there are 59.2 million full-time paid health workers worldwide. The workforce has a strong and comprehensive impact on health system performance, since all healthcare is ultimately delivered by people. Therefore, effective human resource management plays a crucial role in maintaining an effective healthcare system (Kabene, Orchard, Howard, Soriano & Leduc, 2006:20). Competent nurse managers are needed, particularly in countries such as South Africa that have embraced the primary healthcare approach which places nurses at the epicentre of health delivery. Competent nurse managers should have the ability to provide effective nursing management, to improve the responsiveness and to strengthen interventions with the purpose of meeting health goals, such as the Millennium Development Goals (South Africa, 2007).

Competencies have been considered the single biggest contributor to the difference between effective and ineffective managers. Delargy and Leteney (2005:12) define competencies as clusters of skills, behavioural attributes and personal attitudes that contribute more to the effectiveness of managers than either formal qualifications or number of years of experience. Competencies are the standardised requirement for an individual to properly perform a specific job (Delargy & Leteney, 2005:12-13). Competencies are necessary for daily practice or job performance and contribute to the achievement of target outcomes (Delargy & Leteney, 2005:13). The International Council of Nursing (ICN) defines competence as 'the effective application of a combination of knowledge, skill and judgement demonstrated by an individual in daily practice or job performance' (ICN, 2009:6). In the performance of nursing roles, it is agreed that, competence reflects the following attributes: knowledge; understanding and judgement of a range of cognitive, technical or psychomotor and interpersonal skills; and a range of personal attributes and attitudes (ICN, 2009:6). However, competencies vary according to the level of the managers, with top and middle managers who focus more generally on human resources management (HRM) and planning, while functional level managers focus more specifically on human resources management (Lin, Wu, Huang & Tseng, 2007:156). Middle-level managers, such as assistant nurse managers (ANMs), make decisions that affect the entire organisation. Instead of directing day-to-day activities, they set goals for the organisation that need to be achieved by their direct followers. Middle-level managers are ultimately responsible for the performance of followers and the organisation, and often these managers have highly

visible jobs that require specific competencies. In the Western Cape Department of Health, these competencies of ANMs are indeterminate and their job descriptions only mention certain expected skills, knowledge and attitudes (Annexures O, P, Q, R). Furthermore, strategies should be implemented to address shortcomings in the competencies that are expected of them.

The competencies of some categories of nurses have been defined in international competency frameworks. A competency framework or a competency-based approach is not a new strategy for dealing with the challenges that healthcare institutions are faced with. Different competency frameworks and models provide information that assists the understanding of the nurse manager's roles and functions for all levels (Lin et al., 2007:156). The American Organisation of Nurse Executives (AONE) (1992:36) provides a framework with only four functions of a nurse manager namely: management of clinical nursing practice and patient care delivery; management of human, fiscal and other resources; development of personnel; and interdisciplinary, collaborative relationships within a unit or area. The American Nurse Association (ANA) reveals five areas of competence of a nurse manager related to organisation and structure, economics, human resources, and ethics and legal regulatory compliance (Calhoun, Davidson, Sinioris, Vincent & Griffith, 2002). The Healthcare Leadership Alliance (HLA) has developed a model that includes 300 competencies that are clustered in five areas. These areas are communication and relationship management, leadership, professionalism, knowledge of the healthcare environment and business knowledge and skills (Stefl, 2008:360). These frameworks do not specifically address the competencies of ANMs. On the other hand, literature that provides information about nurse management competencies in South Africa, is limited.

1.1.1 Management competencies

The literature about nurse manager's competencies is globally relatively limited and primarily published in developed countries. A competency is a measurable human capability that is expected for effective performance. It may comprise knowledge, a single skill or ability, a personal characteristic, or a cluster of two or more of these attributes. According to Wright (2005), competency is the minimum set of criteria somebody needs to meet for performing a job. Competencies are viewed as the building blocks of work performance.

The performance of most tasks requires the simultaneous or sequenced demonstration of several competencies (Marrelli, Janis & Hoge, 2005:534). Shewchuk, O'Connor, Fine and Tyler (2005:32) define competencies as 'a cluster of related knowledge, skills and attitudes that affect a major part of one's job (role or responsibility) and can be improved by training and

development. A study conducted by the Regional Council in the State of Sao Paulo, Brazil in 2011, included technical nurses who were responsible for health services and established the need for the following competencies: leadership, communication, decision-making, negotiation, teamwork, interpersonal relationships, flexibility, entrepreneurship, creativity, systematic perspective planning and organisation (Furukawa & Cunha, 2011:108).

Some nurse managers consider leadership as the most important competency and the job market is demanding nurses who have and apply knowledge of leadership. On the other hand, teamwork is an important competency that is essential for achieving organisational objectives. A strategic perspective on process and resource management is also identified as a competency needed by nurse managers for the delivery of effective healthcare (Furukawa & Cunha, 2011:108). Nishiyama and Partskhladze (2008:179) have assessed the level of competency among nurse administrators in the Republic of Georgia. The results of the study proved that there are no organised procedures for regularly evaluating competencies of nurse managers. While basic clinical practice guidelines exist, nurse managers do not fully utilise them for either mentoring or assuring adequate quality of nursing care (Nishiyama & Partskhladze, 2008:179).

According to the ICN (2009), the advantages of a competency framework are the provision of clear roles and responsibilities for the nurse, the promotion of professional accountability, the assistance of professional expectations that are associated with nursing roles and the provision of a foundation for setting job-specific performance criteria.

1.2 BACKGROUND TO THE SOUTH AFRICAN CONTEXT

In South Africa, the importance of the nurse managers' competencies for effective nursing management has been identified by various national documents. In the South African context, Pillay (2010:547) alludes to hospital managers who need people management and self-management competencies. These two seems to be the most valuable competencies for the efficient and effective management of hospitals, followed by 'hard management skills' and the ability to think strategically. According to the competency framework for nursing practice of the SANC (2004), nurses must demonstrate competencies in the three aspects of professional ethical practice, clinical practice and quality of care. The strategic goals for the Western Cape Department of Health (WCDoH) (2010) aim to address the burden of disease; improve the quality of health services and the patient experience; ensure and maintain organisational strategic management capacity and synergy; develop and maintain a capable workforce for delivering the required health service; as well as develop and maintain appropriate health technology, infrastructure and optimal financial management for maximising health outcomes. These goals

require certain competencies for effective nursing management. On the other hand, some of the priorities of the Ten Point Plan for National Health Systems (2009–2014) aim at renewing and improving the management of the healthcare systems and human resources planning development (WCGH, 2014:8-9). To this end, the South African Government mandated the commissioning of a competency framework for all the categories of staff members (WCGH, 2014:8-9).

The public health sector in South Africa has been characterised by inequity, inaccessibility to the majority of the population and an inability to respond to the health challenges that are facing the country (Pillay, 2010:134). In an attempt to address non-responsiveness to the prevailing health challenges, the post-apartheid government has adopted the primary healthcare approach (Pillay, 2010:134). However, most of the policy documents that are guiding the transformation of the health sector, have identified a lack of management capacity, particularly in the public sector, as a major stumbling block in bridging the gap between policy and implementation; especially since the primary healthcare approach emphasises increased decentralisation of power (Pillay, 2010:134). Assuming that nurses are a critical component of the health system, especially in the environment with a primary healthcare (PHC) philosophy, it is vitally important that nurse managers perform their managerial duties in such a way that ensures effective and efficient delivery of care in a sustainable manner. Pillay (2009) argues that the general negative perception of care in the public sector, in association with the fact that public sector nurses appear to be significantly more dissatisfied with their work context, raise questions about a potential lack of nursing management capacity in the public health sector. The mandate from the South Africa Government in compliance with Skills Development Statutes and Regulations, require departments to develop a Workplace Skills Plan that encompasses strategic business objectives; identify organisational training needs; develop individual personal development plans that are based on the core service delivery objectives; and the alignment of the education, training and development of their workforce (South Africa, 1998:10). The Comprehensive Service Plan (CSP) is the essential guiding document for the implementation of Healthcare 2010 (Western Cape Department of Health (WCDoH), 2007). The proposed vision statement of the Western Cape Government Health (WCGH, 2011) for 2020 is ‘creating a superior patient experience by delivering the best possible healthcare for individuals and the community, through a well-managed, modernised and balanced health service; competent, caring and committed staff work in partnership with communities, civil society and all spheres of government to help people achieve and maintain wellness’ (WCGH, 2011:15). This vision requires competent personnel to perform their jobs. The various levels of nurse managers are listed in Table 1.1.

Pillay (2010:545) states that defining a competency-based model for nursing management development will help to establish core competencies for nursing managers. This will not only strengthen their practice and provide further learning and development opportunities, but will also provide further learning and development efforts. However, contextually these competencies do not address the required competencies of an ANM for effective nursing management. This research study sought to develop strategies for facilitating the competencies of ANMs in the public health facilities in the Western Cape. The key to reducing the burden of disease and achieving these goals is partly dependent on improving the available nursing management capacity and the competencies of nurse managers (Wallick, 2002:391). Exploring and describing a strategy for facilitating the competencies of the ANMs could assist with strengthening their practice.

Table 1.1: Post levels of nurse managers according to the Department of Public Service Administration (2007)

POST	JOB PURPOSE (SHORT DESCRIPTION)	SALARY SCALE
Operational Manager Nursing (General Unit)	To ensure that a comprehensive nursing treatment and care service is delivered to patients in a cost-effective efficient and equitable manner by the unit To ensure compliance with professional and ethical practice	**PN-A5**
Operational Manager Nursing (General Unit)		**PN-A5**
Operational Manager Nursing (Speciality)		**PN-B3**
Operational Manager Nursing (Primary Healthcare)		**PN-B3**
Assistant Manager Nursing (Area: General and Speciality)		**PN-A7**
Assistant Manager Nursing (Head of Nursing/Services)		**PN-A7**
Assistant Manager Nursing (Primary Healthcare)		**PN-B4**
Deputy Manager Nursing (Level 1 & 2 Hospitals)	To give direction to and coordinate nursing services within the Department of Health and to manage and direct corporate nursing planning	**PN-A8**
Manager Nursing (Level 3 Hospitals)		**PN-A9**
Senior Manager Nursing on Nursing Services (Level 3 hospitals)		**PN-A10**
Senior Manager Nursing of Nursing Services (Provincial Head Office)		**PN--A10**

The Department of Public Service and Administration (DPSA) has determined the implementation of the Occupational Specific Dispensation (OSD) (post and salary structures) in terms of Section 3 (3) (c), in conjunction with Section 5 (4) of the Public Service Act, 1994 and the Public Health and Social Development Sectorial Bargaining Council (PHSDSBC) Resolution 3 of 2007, effective from 1 July 2007 (South Africa, 1994; South Africa, 2007). The OSD includes a competency mix of positions that provide health services at ward/unit/clinic level.

1.2.1 Human resources in South Africa

South Africa faces a huge shortage of highly skilled personnel (Jinabhai, 2005:85). The World Competitive Report (2007/2008) ranked South Africa 44th out of 131 countries for lacking skilled staff (World Economic Forum, 2007). The report confirmed that participants were asked to select the five most problematic factors that hampered business in their country. An inadequately educated workforce was ranked highest in a list of 14 factors in South Africa (World Economic Forum, 2007). In 2001, the Department of Labour launched the human resources (HR) strategy, which emphasises the need for knowledge and training. At the heart of the proposed human resources development (HRD) strategy is the belief that enhancing the abilities and skills of people is an essential response to current low skills levels and unemployment. The Department of Labour argues that people require knowledge, skills and democratic values and, more importantly, opportunities to apply them (National Department of Labour, 2001:5).

1.2.2 Human resources in health

Fritzen (2007) and WHO (2006:XV) state that the health workforce is the most important input in any health system. The WHO (2006: XV) estimates that there are 59.2 million full-time paid health workers worldwide. The workforce has a strong impact on overall health system performance as all healthcare is ultimately delivered by people. Hence effective HRM plays a crucial role in maintaining an effective healthcare system (Kabene et al., 2006). According to Kabene et al. (2006), proper management of human resources is critical to providing a high quality of healthcare. South Africa faces a crisis of human resources for health since there is a shortage of workers (Wadee & Khan, 2007:141).

1.2.3 Human resources in the Western Cape

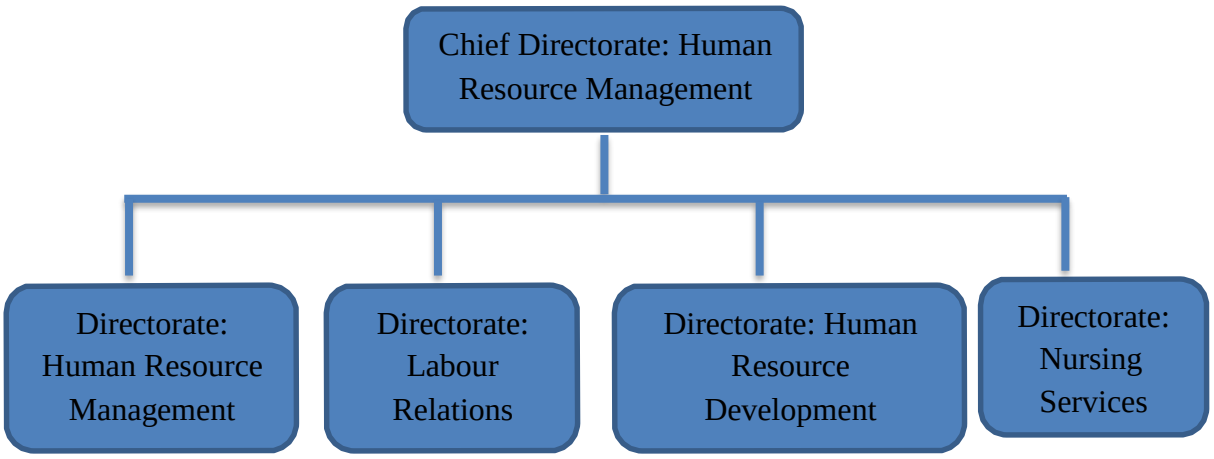

Figure 1.1: Organisational chart Chief Directorate: HR Management (WCDoH, 2011)

Figure 1.1 highlights the organisational chart for the Chief Directorate: Human Resource Management in the Western Cape. As part of the Western Cape Provincial Head Office structure, the divisional head office is dependent on the Chief Directorate: HRM and the Directorate: HRD (based off-site) for these services as seen in Figure 1.1 (WCDoH, 2011). According to the Public Service Regulations (Chapter 1 Part III/D of 2001), the Chief Directorate: HRM was tasked to establish a human resource planning process. Human resource planning is defined as: 'an ongoing process of determining and satisfying an organisation's human resource needs as derived from its statutory mandates, strategic objectives and available financial resources. Through this process human resource strategies can be developed to assist the organisation to deliver in all areas – not just areas related to human resources' (WCDoH, 2011).

1.3 PARADIGMATIC PERSPECTIVE

A paradigm may be described as a way of looking at a natural phenomenon, representing a world view that encompasses a set of philosophical assumptions that guides one's approach to inquiry (Polit & Beck, 2012:736). Denzin and Lincoln (2008:31) define a paradigm as 'a net that contains the researchers' epistemological, ontological and methodological premises'. In other words, paradigms are ways in which a researcher looks at reality. A paradigm is a frame of reference through which to observe and understand' (Babbie, 2010:33). The paradigmatic perspective of this study referred to meta-theoretical, theoretical and methodological assumptions.

1.3.1 Meta-theoretical assumptions

Meta-theory refers to the analysis of the theoretical underpinnings on which the study is grounded. It is used to describe and deconstruct theories that shape a body of enquiry (Polit & Beck, 2008:671). Henning (2005:14) describes meta-theory as the philosophical foundations, nature and structure of scientific theories. Issues that are considered at meta-theoretical level include the nature of scientific development and the meaning of truth (Henning, 2005:14). A pragmatic approach was followed in this study. This paradigm is most often associated with mixed method research and provides a basis for a stance that has been stated as the 'dictatorship of the research question' (Polit & Beck, 2012:604). The assumptions of pragmatism are:

- The use of a mix of research methods and modes of analysis is part of a research approach.
- The research questions drive the inquiry.
- A continuous cycle of inductive and deductive reasoning is followed, while being guided primarily by the researcher's desire to produce socially useful knowledge.

In this study the strategy is practice oriented as it focuses on facilitating the competencies of ANMs.

1.3.2 Theoretical framework

Theoretical frameworks play several interrelated roles in the progress of a science. In addition, the theories often provide a basis for predicting phenomena (Polit & Beck, 2012:131). Theories are an essential resource for the development of nursing interventions and help to stimulate research and the extension of knowledge by providing direction and impetus (Polit & Beck, 2010:131). The theoretical assumptions of this study were adapted from the Competency Framework for Career Development Practitioners in South Africa (CFCDPSA), developed by the Department of Higher Education and Training (DHET) (2015) in South Africa, and the levels of competency of the United Nations Industrial Development Organisation (UNIDO, 2002:8).

1.3.2.1 Competency Framework for Career Development Practitioners in South Africa

Competencies stem from the knowledge, skills, abilities, attitudes and personality traits of nurses (Jooste, 2010:55). The literature shows a debate around the meaning of competencies. Debate about and controversy over the concept of competence in nursing practice has existed for well over two decades, with inconsistencies and a lack of clarity over its definition (Garside & Nhemachena, 2013:542; Smith, 2012:176). Cowan, Norman and Coopamah (2007:22) argue that a holistic definition needs to be agreed on, whereas in their analysis, Garside and Nhemachena (2013:542) emphasise the importance of context in any specific definition. In her concept analysis, Smith (2012:176) observes that a benefit of the ongoing debate has been that multiple perspectives around competencies are explored and that becoming competent is a journey and levels of competence develop over time. On the other hand, there is little difference between core competencies and the specialised competencies described in many competency frameworks. The

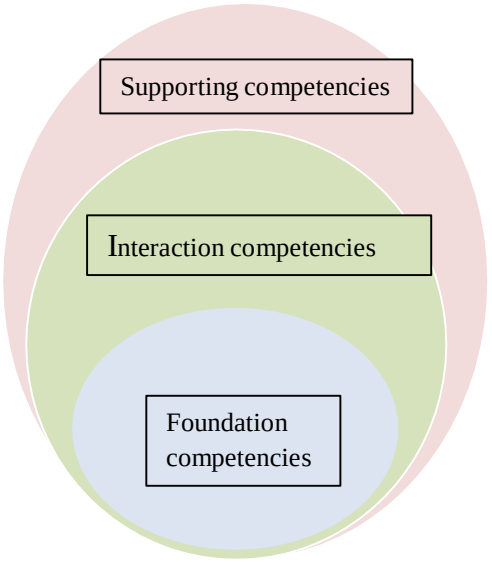

Figure 1.2: Competency framework, adapted from the Department of Education and Training (DHET) (2015)

Competency Framework for Career Development Practitioners in South Africa (DHET, 2015) describes three broad areas of competencies that refer to foundation competencies client interaction competencies, and supporting competencies (Figure 1.2). First, *foundation or transversal competencies* relate primarily to personal competence, namely knowing how to conduct oneself in a specific situation (skills), and ethical competence (the possession of certain personal and professional values). The foundation competencies apply to all professional, clinical, educational and administrative activities. Secondly, *interaction competencies* are interpersonal relationships that apply to working with clients or staff members that relate to the facilities. Thirdly, *supporting competencies* are less visible but fundamental to the work of career practitioners and entails networks and resources required for service delivery. Within these three broad areas of competencies, there are various levels of competencies. UNIDO (2002:11) maintains that any function in an organisation requires a set of essential managerial/generic and technical/functional competencies to be performed effectively, and mentions:

Advanced level

Demonstrate a high level of understanding of the particular competency to perform fully and independently related tasks. Frequently demonstrates application that indicates profound level of expertise. Can perform adviser or trainer roles. Work activities are carried out consistently with high quality standards (UNIDO, 2002:11).

Proficient level

Demonstrate a sound level of understanding of the particular competency to adequately perform related tasks, practically without guidance. Work activities are performed effectively within quality standards (UNIDO, 2002:11).

Knowledgeable level

Demonstrate a sufficient understanding of the particular competency to be used in the work place, but requires guidance. Tasks or work activities are generally carried out under direction (UNIDO, 2002:11).

1.3.2.2 Other definitions of other concepts

Management

Hewison (2007:697) indicates that it has not been possible to arrive at a universally agreed definition of management, despite many years of research and theoretical development. According to the Business Dictionary (2008:1), management is the 'organisation and coordination of the activities of an enterprise in accordance with certain policies and in achievement of clearly defined objectives'. Management usually takes place at three levels in an organisation. At the executive level, we find person(s) in charge of an organisation referred to as top management which focuses on conceptualising aspects and processes such as planning and

strategy (Jooste, 2010:78). At the second level we find middle management with e.g. the ANMs. Departmental managers operate at the middle management and they spend most of their time working with people, resolving conflict, understanding people's behaviour, motivating them, communicating and giving feedback to staff (Jooste, 2010:78). The first or lowest level is usually known as the operational, ground level, unit level where services are rendered. Jooste and Sibiya (2015:18) define nurse management functions as including management of care delivery, personnel development, management of human, fiscal and other resources, strategic planning, compliance with regulatory and professional standards and fostering of interdisciplinary and collaborative relationships. In this study, as alluded to by Jooste (2010:78), management is defined as the process of planning, organising, staffing, leading and controlling the resources of a healthcare organisation to predetermined stated organisation goals, as productively as possible and to the highest standards.

Nurse manager

The South African Nursing Council defines a nurse as a person registered in a category under Section 31 (1) in order to practice nursing or midwifery (South Africa, 2005:6). Front-line nursing positions are characterised by line responsibility for staff nurses who report directly to them and ensuring day-to-day operations with adequate staffing as one of the major responsibilities for this leadership position (MacPhee & Suryaprakash, 2012:254). In this study the front line positions are referred to as nursing unit managers who operate at unit level and need a high standard of technical skills and knowledge related to a specific unit or nursing speciality. Nursing unit managers play a key role in coordinating patient care activities and in ensuring safety and quality and quality care in hospital wards (Armstrong, Rispel & Penn-Kekana, 2015:2). Additionally the nursing unit manager (sometimes referred to as 'charge nurse' or 'operational nurse manager') is responsible for the management of nursing care to patients, all nursing staff in the unit, and the resources associated with healthcare delivery in the unit. These unit managers are held accountable for the quality of patient care in their units or wards, and enter into performance management agreements that outline their operational management responsibilities (Armstrong et al., 2015:2).

According to MacPhee and Suryaprakash (2012:254), mid-level nurses also have line authority and are generally responsible for human resource decisions and financial management. Planning organisational change is one of the most important responsibilities at the more senior ranks (Havaei, Dahinten & MacPhee, 2015:309). At higher levels, individuals are granted more authority and power in the formal chain of command, and their positions require higher levels of cognitive, interpersonal, business and strategic skills (Mumford, Campion & Morgeson,

2007:160). A study by MacPhee, Skelton-Green, Bouthillette and Suryaprakash (2012:163) note a difference between front-line and more senior leaders whereas front-line leaders were highly task focused in their approach, higher ranked individuals showed more insight into their work roles and had a broader understanding of issues influencing staff and work environment. In this study the ANM is a manager in middle management level. A middle manager is defined as a manager who reports to the Chief Executive Officer or to a manager who reports to the chief executive officer (Carney, 2004:14). The middle level manager is a nurse reporting to a Chief Executive Officer in a district hospital, reporting to a Deputy Nurse Manager (DNM) in a 90 and more beds district hospital, regional hospital, psychiatric hospital, tertiary hospital and academic hospital.

Strategy

According to Lawson (2013:14), strategy is the long-term direction and scope of an organisation. It aims at achieving benefits for the organisation by its configuration of resources in a challenging environment with the purpose of meeting the needs of markets and to fulfil stakeholder expectations. Ehlers and Lazenby (2010:214) state that a strategy is used to create an action plan. In the current study a strategy is developed with an action plan to facilitate competencies of ANMs in the public health facilities in the Western Cape. The aim of the strategy in this research study was to facilitate competencies of assistant nurse managers to deliver effective nursing management. These competencies were identified based on the findings from the current and the expected competencies of ANMs.

Facilitation

Facilitation implies actions or results. Facilitation is a process of enabling things to happen more easily in order to move forward (Hattingh, Dreyer & Roos, 2006:176). In this study facilitation refers to the role of different nurses who should perform activities in the strategy to guide ANMs towards accomplishment, in their workplace.

Gap

A gap is a space between two people or things. In this study it refers to the shortcomings between the existing and expected competencies of an ANM.

1.4 PROBLEM STATEMENT

Pillay (2010:552) conducted a survey on the skill gap in nursing management in the South African public health sector. The results demonstrated a lack of management capacity in the public health sector in South Africa. Because nurse managers in this sector rate themselves as at

least ‘reasonably competent, but not good’ in most competencies, this suggests that they lacked confidence in their ability, because they did not possess the requisite management skills or because they lacked self-belief. Either source has the potential to impede service delivery and the transformation of the public sector into a more efficient and effective service (Pillay, 2010:552). The main reason for the lack of nurse managers’ competencies is believed to be due to the OSD (2007). During the implementation of the OSD in 2007, the post of Assistant Director of Nursing was translated to Assistant Manager Nursing at a higher managerial level and newly appointed ANMs were assumed to be competent. Subsequently, a human resources plan was initiated in 2010 because of complaints about the competencies of nurse managers in the South Africa public health sector. The first step in developing a human resources strategy was commissioning a competency framework. A survey of competencies of all categories of staff members in the WCDoH was conducted in 2010 by Decipher Research Services and Software, which led to the development of a competency framework for all categories of staff members in nursing, excluding the assistant nurse managers (ANMs) in the South African context.

As a result, the ANMs started to complain that they were uncertain about which competency framework determined their functions. Also, it was unclear to them what the stakeholders’ expectations were about their competencies at the public health facilities. On the other hand, it was unclear whether the ANMs were competent to perform their expected duties of effective nursing management. If the expectations of stakeholders of ANMs competencies and the gap between their expected and current competencies was known, a human resources strategy could be developed to facilitate their competencies.

Therefore, the following research questions were posed:

- What are the expectations of the stakeholders, namely senior nurse managers, deputy nurse managers, operational nurse managers and assistant nurse managers about the competencies of assistant nurse managers, in public health facilities in the Western Cape?
- What are the perceptions of assistant nurse managers about their expected and existing competencies?
- How should the gap between the current and expected competencies of assistant nurse managers be addressed?

1.5 PURPOSE OF THE STUDY

The purpose of the research study was to develop a human resources strategy to facilitate the competencies of assistant nursing managers at the public health facilities in the Western Cape.

1.6 OBJECTIVES OF THE STUDY

The objectives of the study were to:

- explore the expectations of stakeholders Senior Nurse Managers (SNMs), Nurse Managers (NMs), Deputy Nurse Managers (DNMs), Operational Nurse Managers (ONMs) and the ANMs about the competencies of ANMs in public health facilities in the Western Cape;
- explore and describe the perceptions of ANMs about the expected and their existing competencies for effective nursing management in public health facilities in the Western Cape; and
- develop a human resources strategy for addressing the gap between the existing and expected competencies of ANMs in public health facilities in the Western Cape.

1.7 RESEARCH SETTING

The public health facilities in the Western Cape are divided into seven areas; namely academic, regional, psychiatric, infectious and district hospitals and maternity obstetrics units and community health centres and clinics in the Western Cape metro and rural districts. In the Western Cape public health sector, there are currently 53 hospitals, 74 community health centres, 13 maternity obstetric units and 135 clinics. Furthermore, the public hospitals are classified according to five categories; namely central hospitals, regional hospitals, district hospitals, psychiatric hospitals; and specialised hospitals (WCDoH, 2007)

1.8 RESEARCH DESIGN

In this study a sequential mixed method design was used that encompassed a qualitative phase followed by a quantitative phase (Figure 1.3). The design intended that the results of the first (qualitative) phase should inform the second (quantitative) phase of the study.

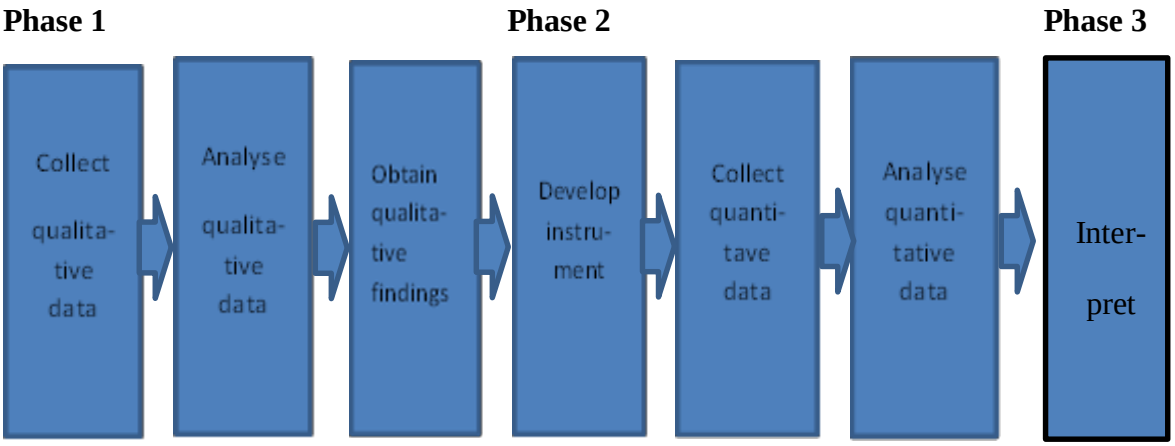

Figure 1.3: Visual diagram of a mixed method instrument development study (sequential exploratory design)

The mixed method design is based on the premise that an exploration is undertaken during the qualitative phase in the absence of a guiding framework for the development of an instrument (Creswell, Plano Clark, Gutmann & Hanson, 2003:222). In other words, the qualitative findings guided the development of items for a quantitative survey instrument (second data collection phase). During the qualitative phase, the researcher explored the expectations of stakeholders and ANMs about the competencies of the ANMs, followed by the quantitative phase to explore and describe the perceptions of ANMs about their expected and existing competencies (See Table 1.2).

Table 1.2: Phases in the research

Phase 1: Qualitative exploratory design		
Objective 1: Situation analysis To explore the expectations of Nursing Service Managers about the competencies of Assistant Nurse Managers		
Population	**Sampling and sample**	**Method**
Senior Nurse Managers (n = 3) Nurse Managers (n = 3) Deputy Nurse Managers (n = 32)	Purposive sampling (n = 1) Purposive sampling (n = 1) Purposive sampling (n = 7)	Individual interviews
Assistant Nurse Managers (n = 156) Operational Nurse Managers (n = 639)	Purposive sampling (n = 5 groups)	Focus group discussions
Phase 2: Quantitative exploratory and descriptive design		
Objective 2: Gap analysis in expected and current competencies To explore and describe the perceptions of Assistant Nurse Managers about the expected and their existing competencies to perform their job.		
Population	**Sample**	**Method**
Assistant Nurse Managers (N = 156)	Total sample n = 156	Questionnaires
Phase 3: Development of strategy		
Objective 3: Development of a human resources strategy for addressing competencies of ANMs		

1.8.1 Phase 1: Qualitative phase

This phase addresses Objective 1 (Situation analysis):

To explore the expectations of stakeholders and ANMs about *the competencies of ANMs in public health facilities in the Western Cape.*

A qualitative, exploratory and contextual design was followed. Qualitative research involves an interpretive, naturalistic approach to the world. Qualitative researchers study things in their natural settings, while attempting to make sense of, or interpret phenomena in terms of meanings people bring to them by means of field notes, interviews and conversations (Creswell, 2009:36).

Polit and Beck (2012:612-613) indicate that exploratory designs are part of sequential designs with qualitative data that are collected during the first phase. In this study, the exploratory design was used to gain insight into and an understanding of the phenomenon of the ANMs competencies. Context implies the conditions and situations of an event. This study is contextual because it focused on the competencies of ANMs.

1.8.1.1 Population

Polit and Beck (2012:33) state that the target population includes all the members who are under study and who conform to a designated set of specifications. In this study, in Phase 1 (also see Table 1.2) the population (N = 833) constituted of Senior Nurse Managers (N = 3), Nurse Managers (N = 3) and Deputy Managers Nursing (N = 32) who are the seniors of the 156 Assistant Nurse Managers and the experts in the field of nursing management. Operational Nurse Managers (n = 639) are under the direct supervision of the ANM. In Phase 2, the population constitutes of ANMs (N = 156) that is, the Head of Nursing (N = 23), ANMs general and speciality stream (N = 113) and ANMs of the primary healthcare stream (N = 20). The entire population served as the sample in this study.

1.8.1.2 Sample

A purposive, non-probability sampling method was used to select the participants at the respective healthcare facilities. There are no fixed rules that apply to sample size in qualitative studies. Gerrish and Lacey (2006:180) agree that purposive sampling is based on the judgment of the researcher by choosing the sample that contains elements that are of interest to the study. Participants were approached and requested to participate with the purpose of exploring their expectations about the competencies of ANMs. Professional Nurses (PNs) were excluded in the study, because the researcher held the opinion that they do not have direct access to the ANMs since they are reporting to the operational nurse managers. Fifteen individual, unstructured interviews were conducted with SNMs, NMs and DNMs (included 2 pilot interviews) while eight focus group discussions were held with ANMs and ONMs of the seven areas of the public facilities in the Western Cape (included 1 pilot focus group). The researcher continued until data saturation was reached. Polit and Beck (2012:521) define data saturation as sampling to the point at which no new information is obtained and redundancy starts occurring.

1.8.1.3 Data collection

The researcher conducted *individual, unstructured individual interviews* with SNMs, NMs, DNMs and ANMs; these interviews did not last longer than 45 minutes. Unstructured interviews are conversational and interactive and are the mode of choice when researchers do not have a

clear idea of what it is that they do not know (Polit & Beck, 2012:536). Researchers who are using *unstructured interviews* do not prepare a set of questions because they do not yet know what to ask or even where to start (Polit & Beck, 2012:536).

Focus group discussions are valuable for obtaining an in-depth understanding of the rich and detailed own words of the participants, since experiences are described in the own words of participants (Liamputtong, 2011:6). Henning (2005:6) recommends focus groups that consist of eight participants, and in this study between six to eight participants took part in a group discussion. The proposed research question and possible probing questions that the researcher would pose, during the interviewing, were stipulated on an interview schedule. Langer (2006:35) indicates that a focus group interview should not last longer than two hours and that most focus group discussions should be conducted within one and a half hours. The focus group discussions did not last longer than 60 minutes. For the purpose of data gathering of all interviews, voice recordings were used and supported by field notes. This procedure enabled data triangulation, that is, data from voice recordings were corroborated with the field notes (Tobin & Begley, 2004:393). The researcher ensured that the voice recorder was in working order at the commencement of the interviews. Interviews were conducted in a well-prepared private room. In preparation for the study, the researcher conducted two pilot unstructured individual interviews and one pilot focus group interview at a public health facility to detect possible flaws that could occur during the data collection process. Because the interviewees answered the research questions, the findings of the pilot interviews formed part of the main study.

1.8.1.4 Qualitative data analysis

Data analysis involved the collection of data, based on asking questions and developing an analysis from the information that is supplied by participants (Creswell, 2009:178-182). Polit and Beck (2012:569) indicate that open coding is used in the first stage of a constant comparative analysis by capturing the data. Data analysis was conducted separately for the individual interviews and focus group discussions, revealed the same categories. The researcher began with organising, classifying and indexing the data. Data were converted to smaller, more manageable units that was retrieved and reviewed. This conversion involved a search for patterns and emerging categories and sub-categories. Polit and Beck (2012:569) state that a code book must be kept. Categories were gradually modified and replaced during the subsequent stages of analysis. The discrete categories that were identified during the initial coding process were compared and combined in new ways while the researcher / coder started assembling a comprehensive picture of the phenomenon. Developing a high quality category scheme involved a careful reading of the data, with an eye to identify underlying concepts and clusters of concepts

(Polit & Beck, 2012:558). An independent coder and the researcher reached consensus about the categories and sub-categories of the analysis. Data that were obtained in this phase, were supported by a literature control with a view to developing the questionnaire, which was used to conduct the survey in Phase 2.

1.8.1.5 Trustworthiness

The major criteria of trustworthiness are credibility, dependability, confirmability and transferability (Polit & Beck, 2012:585). Trustworthiness is discussed more extensively in Chapter 2. Credibility refers to confidence in the truth of the data and interpretations thereof (Polit & Beck, 2012:585). The researcher ensured credibility by revisiting the participants to verify the information. Feedback was also sought from them after completion of the strategy. Dependability, according to Polit and Beck (2012:585), refers to the stability (reliability) of data over time and conditions. Dependability was enhanced by the researcher by means of a thick description of the research method that was followed in the study. Confirmability refers to objectivity, that is, the potential for congruence between two or more independent people about the accuracy, relevance, or meaning of the data (Polit & Beck, 2012:585). The researcher documented the procedures for continual scrutiny of the data during the study. The researcher provided an audit trail that comprised of raw data, and analysis notes. Transferability, according to Polit and Beck (2012:585), refers to the potential for extrapolation, that is, the extent to which findings can be transferred to or have applicability in other settings or groups. The study findings will not be generalised to all health facilities in the Western Cape Province, and will remain limited to public facilities only. Transferability was however enhanced by the researcher who described the research context thoroughly, for the findings to be evaluated in other settings at a later stage. The concept consensus discussion between the researcher and the independent coder was held to determine whether there was an agreement with regard to the categories that have emerged.

1.8.2 Phase 2: Quantitative phase

This phase addresses Objective 2:

To explore and describe the ANM of the expected and their existing competencies to perform the job.

1.8.2.1 Research design

An exploratory descriptive design was followed that explored and described the perceptions of ANMs about their expected and existing competencies to provide an effective health service.

1.8.2.2 Population and sample

In this study, the accessible population and sample of ANMs (N = 156) constituted the ANMs Head of Nursing (N = 23), ANMs General and Speciality Stream (N = 113) and ANMs Primary Healthcare Stream (N = 20). The entire population served as the sample in this study (Table 1.2). *For purposes of this study the word participant was also used in the quantitative phase of the study instead of the word respondent.*

1.8.2.3 Data gathering

The identification of participants and the defined systematic gathering of information relevant to the research purpose, objectives and questions of the study are termed data gathering (Dawson, 2010:98). A structured questionnaire with a 4-point scale was used. The information from the qualitative descriptive research suggested variables for inclusion in the questionnaire. Instruments were coded beforehand that ensured anonymity of the participants. The questionnaires were distributed by the researcher to the participants who completed it in their own time. It took about 30 minutes to complete the questionnaire and all were returned in enclosed sealed envelopes, at a time prearranged with the researcher. De Vos, Strydom, Fouche and Delport (2009:168) recommend that instruments should be collected within 48 hours, and the researcher collected the instruments on the same day after handing out.

1.8.2.4 Quantitative data analysis

The Statistical Package for the Social Sciences (SPSS) Version 20.0 software program, was used as a tool to facilitate the statistical analysis. Descriptive and inferential statistics were used to make sense of the data. Variables were described in summary tables in terms of frequencies (f), relative frequency distribution and mean values ($\bar{x}$), percentages (%) and standard deviations (SD). The Spearman Correlation method was used to determine the relationship between the expected and the existing competencies of the ANMs.

1.8.2.5 Quantitative rigor

Validity

'Validity' means the degree to which an instrument measures what it is supposed to measure (Polit & Beck, 2012:236-237). The instrument was assessed for face and content validity. 'Face validity' refers to whether the instrument appears to be measuring the appropriate construct (Brink, 2008:160; Polit & Beck, 2008:458). Face validity was established through consultation with experts in nursing management who scrutinised the questionnaire to establish the appropriateness of questions and whether the questions corresponded with the objectives of the study (Salkind, 2017:114). 'Content validity' concerns the degree to which an instrument has an

appropriate sample of items for the construct to be measured (Polit & Beck, 2008:458). To assess for appropriateness, accuracy and representation of the items, the instrument was reviewed by senior nursing managers and nursing managers to provide input about face and content validity study. Pretesting of the instrument was conducted before the main study with five ANMs in a psychiatric hospital to determine the clarity of questions, effectiveness of instructions, completeness of response sets, time required to complete the questionnaire, and the success of the data collection technique. Participants were requested to comment on the applicability and appropriateness of the questionnaire. Validity is further discussed in Chapter 3.

Reliability

'Reliability', according to Polit and Beck (2012:331), means the degree of consistency or accuracy with which an instrument measures the attribute it is designed to measure. The reliability of the measurement was enhanced by questions in the instrument that were relevant to participants and by ensuring that the questions were clear and unambiguous. Reliability is further discussed in Chapter 3.

1.9 PHASE 3: DEVELOPMENT OF THE STRATEGY

This phase addresses Objective 3:

To develop a human resources strategy for addressing the gap between expected and existing competencies of Assistant Nurse Managers in public health facilities in the Western Cape.

The findings of Phase 2, was incorporated in the survey list of *Practice oriented theory* by Dickhoff, James and Wiedenbach (1968:434) that was adapted to form a framework for the strategy on competencies of ANMs in the public health facilities in the Western Cape. In Chapter 3, the development of the strategy is described.

1.10 ETHICAL CONSIDERATIONS

One has to maintain the highest ethical standards when including people in research (Jooste, 2017:479). To protect the rights of the participants, certain ethical considerations were implemented. Ethical clearance was requested from the Higher Degrees Committee of the Faculty of Community and Health Sciences (CHS) at the University of the Western Cape (Ethical clearance number 13/4/23, Annexure A). Permission was also requested from the Western Cape Department of Health (WCDoH) Head of Health, where the research was conducted (Annexure B). Participants were informed of the nature and intent of the study. Informed consent was requested from the participants (Annexure F) and they were informed that any information that was obtained could be used exclusively for the purposes of the study and that their names could not be disclosed. Interviews were conducted in a private room and participants completed questionnaires in their own lunch time and in private settings. All information was treated with

strict confidentiality and used for research purposes only. The confidentiality of the data were maintained by using codes on questionnaires and other techniques, such as disguising the tone of the recorded voice to avoid any identifying information. Participants in the focus group discussions were requested to keep all information shared during the group discussions confidential (Annexure D). The participants were informed that their reports could not harm the person(s) reported on in any way. Participation was free and voluntary; the participants were informed of their right to withdraw from the process at any stage of the project, without prejudice. The researcher was available for consultation by the participants for the duration of the study. Feedback of the findings was shared with the participants who were involved in this study prior to dissemination. Data will be kept under lock and key for two years after publication of the results and then it will be destroyed. Ethical considerations are discussed in more detail in Chapter 3.

1.11 RATIONALE AND CONTRIBUTION OF THE STUDY

Muller, Bezuidenhout and Jooste (2011:3) are of the opinion that successful management of a healthcare organisation is dependent on the competence of individuals and team/corporate managers, clinical practitioners and all non-clinical practitioners. This study added to the Human Resources Plan (2010) of the National Department of Health specifically through a nursing perspective. During Phase 1 of the study, data were gathered from which an original questionnaire was developed. The questionnaire explored expected and existing competencies of ANMs. An original HR strategy was developed to facilitate the competencies of ANMs in public facilities in the Western Cape, the first on the African continent. The strategy can be evaluated in other provinces of South Africa. The unique contribution of this study is that unique data were obtained as no previous formal nursing research on the expectations of the nurse expects about the competencies of the ANMs in the Western Cape and in South Africa as a whole, was conducted. There was no coherent formal strategy at the time of the study to address the ANMs competencies in South Africa and the Western Cape health sector. Provincially, this strategy will be piloted and implemented in academic hospitals, regional hospitals, psychiatric hospitals, district hospitals and primary healthcare centres that will enhance the assistant nurse managers' knowledge and skill needed for nursing management functions needed in hospitals. Nationally, the findings of this study could affect the fulfilment of Healthcare 2030 and the National Nursing Strategy 2012. The Healthcare 2030 framework does not detail competencies required for every level of care. However, this strategy could develop knowledge and skilled nurse managers required to address the burden of disease, achieve the desired health outcomes, and manage the implementation of complex healthcare reforms (WCGH:2014).

1.12 LAYOUT OF THE THESIS

This thesis is presented as follows:

Chapter 1:	Orientation of the study	Chapter 5:	Presentation of results of Phase 2
Chapter 2:	Overview of competency concepts and frameworks	Chapter 6:	Human resource strategy
Chapter 3:	Research methodology	Chapter 7:	Conclusion, limitations and recommendations
Chapter 4:	Findings from Phase 1		

1.13 SUMMARY

Chapter 1 presents the rationale and overview of this research project. Articulation of the research questions and objectives assists in focusing the scope of the research. The context of the research study was identified, that guided the identification of the research method for the study. The literature presented in this chapter incorporated references to empirical studies and to policy documents nationwide and globally. The researcher illustrated the importance of the research problem and provided a motivation for the significance of the study with regard to the research questions, which assisted with focusing on the scope of the research topic. The researcher was committed to conducting the research study because of her understanding and training in nursing management. The researcher was an integral part of developing the strategy based on the phenomenon of the research project. Therefore, she became more knowledgeable in the field of interest related to competencies of nurse managers. The point of departure and suppositions for the strategy were based on meta-theoretical and theoretical assumptions. These assumptions were described in relation to pragmatism. From the researcher's point of view, it was important to outline those assumptions early because they resonated with the researcher's principles and could later be reflected in the description of the development of the strategy in Chapter 6. These assumptions facilitated the research approach and purpose of the study (Knight & Cross, 2012). To align with the pragmatic paradigm, the researcher used a mixed method design by subscribing to a qualitative approach in Phase 1 and a survey in Phase 2. The research methods were described briefly and presented logically, starting with the manner in which the study could be conducted in two phases and the methods of data collection and analysis, to lead to finalising a strategy. The researcher used the survey list of *Practice-oriented theor*y (Dickhoff, et al., 1968:434) for the framework of the strategy. Also, the researcher described how the developed strategy could be validated. Ethical considerations and rigour were followed during the research process.

During the writing of this chapter, the researcher reflected on the impact of the study. These reflections emphasised the unique contribution of this research project to knowledge in nursing management.

CHAPTER 2
OVERVIEW OF COMPETENCY CONCEPTS, NEED FOR HUMAN RESOURCES, AND COMPETENCY FRAMEWORKS

2.1 INTRODUCTION

The main purpose of a literature review is to recognise and incorporate the known and unknown of a research area to provide the reader with an understanding of the body of research in a specified area (Polit & Beck, 2012:116). However, there are diverse points of view among researchers with regard to the purpose of a literature review and under what circumstances it should be conducted (Burns & Grove, 2011:192). In quantitative studies, the study starts with a clear theoretical framework. However, Holloway and Wheeler (2010:37) suggest that for qualitative studies, the literature review should be carried out at the beginning of the study with the aim of providing a simple overview of the knowledge base in the area of study. On the other hand, some qualitative researchers believe that data should be collected before reviewing literature when the theory has been sufficiently developed. The purpose of a literature review is to examine how prior studies fits or extends the emerging theory (Polit & Beck, 2012:94). The researcher was of the opinion that it was important to comprehend the context of the phenomenon of the proposed study. This chapter provided an overview in the field of study, in a healthcare management environment with reference to competency concepts and frameworks.

2.2 OVERVIEW OF CONCEPTS

Several studies on clinical competencies in nursing were published in the last two decades of the twentieth century (Watson, Stimpson, Topping & Porock, 2002:425). These studies indicate diffuse definitions of concepts such as competency and competent. A decade later, there are still uncertainties around the definitions of these terms (Yanhua & Watson, 2011:834). The terms 'competent', 'competence', 'competency' and 'competencies' are in exacted and not interchangeable (Donaher, Russell, Scoble & Chen, 2007:277). A competent nurse manager is legally qualified and has the capacity to perform certain specified duties (Donaher et al., 2007:277). Competence refers to the individual's capacity to perform job responsibilities or his or her ability to perform skills-based activities to a prescribed standard, including the capacity to transfer skills and knowledge to new situations (Donaher et al., 2007:277). Jooste (2010:55) maintains that to meet the standards set for nursing care delivery, professional nurses need certain competencies. Competencies are a repertoire of competence and are inferred by an individual's actual performance in a given situation (Donaher et al., 2007:277). Competencies offer a way of binding and integrating the elements of a progressive human resources strategy (Khan, 2003:63).

Pijl-Zieber, Barton, Konkin, Awosoga and Caine (2013:677) and Yanhua and Watson (2011:834) argue that measuring clinical competence, for example of nursing students, is problematic because of the heterogeneity in the concept of competency. Furthermore, these authors are of the opinion that there is extensive use of the term by different agents and contexts (education, employment, organisational, professional, etcetera) with blurred boundaries between the terms of capacity, performance and competence. 'Competency' as defined by Chase (2010:4) refers to the global ability to be effective in work activities. A historical definition of competency includes knowledge and psychomotor abilities, attitudes and cognitive skills such as problem-solving. Other definitions, as indicated by Chase (2010:4), include fundamental abilities and capabilities to do the job well and use descriptive language such as traits, capabilities, intelligence and human abilities to describe competence. Actual competencies are skills and behaviours that are essential to the role (McCarthy & Fitzpatrick, 2009:346).

The American Nurses Association (ANA) (2013:3) defines 'competency' as an expected level of performance that integrates knowledge, skills, abilities, and judgement. This integration occurs in formal, informal and reflective learning experiences. In addition, this competency model states that knowledge encompasses thinking, understanding of theories, professional standards of practice, and insights gained from context, practical experiences, personal capabilities and leadership performance (ANA, 2013:3). In addition, according to this competency model, skills include communication, interpersonal and problem-solving skills, and ability or capacity to act effectively. It requires listening, integrity, self-awareness, emotional intelligence and openness to feedback (ANA, 2013:3). Judgement includes critical thinking, problem-solving, and ethical reasoning and decision-making (ANA, 2013:3).

Competency frameworks identify 'the minimum competencies necessary to perform a particular occupation or job effectively within a particular field' (National Career Development Association (NCDA), 2009 cited in the Department of Higher Education and Training (DHET), 2015:5). These frameworks describe the knowledge and skills needed by all levels of practitioners who work in diverse roles in diverse settings with diverse client groups. Moreover, competency frameworks can foster professional identity for those working in a specific field and provide a structure for qualifications and training (DHET, 2015:5). Certain international, general and nursing competency frameworks are noteworthy.

2.3 BRIEF OVERVIEW OF THE CONCEPTS OF MANAGEMENT, LEADERSHIP AND HUMAN RESOURCES MANAGEMENT

Management is defined in various ways. Khadka, Gurung and Chaulagain (2014:63) define 'management' as 'the art of getting things done by people', and identified five general functions of management: planning, organising, leading, coordinating and controlling. Management is a fine blend of many subjects and disciplines that can be hard to define and even harder to learn (Khadka et al., 2014:63). Furthermore, managers are not confined to walls of the industry. This is crucial whether it be a hospital, an educational institution, or department in government administration. Management is 'what managers do' (Khadka et al., 2014:63). Managers are expected to possess several competencies that will allow them to perform managerial functions effectively and efficiently. Hospital-specific management practices are related to a hospital's quality of patient care and productivity outcomes.

Booyens, Jooste and Sibiya (2015:18) define nursing management functions as management of care delivery, personnel development, management of human, fiscal and other resources, strategic planning, compliance with regulatory and professional standards, and fostering of interdisciplinary and collaborative relationships. There is general agreement that the competencies and skills of nurse managers affect every aspect of patient care and staff wellbeing, because nurse managers are basically responsible for creating environments in which clinical nurses are able to provide high-quality patient-centred holistic care (Van Dyk, Siedlecki & Fitzpatrick, 2016; Peñarrieta-de Cordova, Castañeda-Hidalgo, Acevedo-Porras, Rangel-Torres, González-Salinas & Garza- Hernández, 2014:92). On the other hand, 'leadership' is defined as a process of influence in which the leader uses power, authority and influence to realise mutual goals (Jooste, 2009, in Booyens et al., 2015:206). These authors describe leadership as inspiring and influencing a group of people to achieve shared goals by using a set of activities such as attentiveness, good interpersonal connections and decision-making (Booyens et al., 2015:206). Similarly, Hersey, Blanchard and Johnson (2013) in Booyens et al. (2015:206) posit that good leadership is a function of the leader and followers and facilitating dynamics that are present in the environment in which the leadership is taking place. Jooste (2017) found that the role of nurse leaders in South Africa and the global healthcare environment is continuously moving to new dimensions. The role of leaders is to act as visionaries rather than control the employees. They have to act as prophets, who assist employees to plan, organise, lead and control their activities, to develop and to emphasise self-management and entrepreneurial behaviour (Jooste, 2017). Likewise, among nursing leadership, in Chase's (2010:2) view, the nurse manager's role has been identified as crucial to the provision of high performing, effective and efficient care in the care delivery setting.

2.3.1 Nursing management competencies – Moving from the past to the future

To understand competencies in nursing, it is necessary to know where nursing management originated. In former times, a matron was an autocratic figure rather than a leader or manager in contemporary terms. Nightingale, who lived in the second half of the nineteenth century, called her nursing managers 'specials'. They were drawn from the higher social classes of the time and treated differently from their counterparts in the military, in terms of education and reward systems (Woodham-Smith, in Girvin, 1998:42-43). Fraser-Gamble in Girvin (1998:43) claims that the autocratic matron led nursing services clearly and unambiguously until the 1960s. The Griffiths Report (1983) in Girvin (1998:43), addresses the same issue by expressing concerns over the perceived lack of management accountability in the service in general. Due to political and organisational changes and influences, that have affected nurses and nursing management over the past 30 years, the roles and responsibilities of nurse managers have changed enormously and the interest in this and subsequent publications about it could be increasing. Since the 1980s there have been considerate debate and discussions about nurse management (Girvin, 1998:40).

Nurse managers play a critical role in effective functioning in hospitals (AONE, 1992:36; Mathena, 2002), because they greatly influenced nurses, who constituted the major staff group in hospitals. However, Oroviogoicoechea (1996:1274) found a lack of clarity in the definition of nurse managers' functions, skills and characteristics because of logical problems and the changing needs for those in the position. Some literature about nurse managers emphasises the importance of Fayol's (1949) five managerial skills of planning, organising, staffing, leading and controlling (Loo & Thorpe, 2004). Sherman (1980) cited in Loo and Thorpe (2004:91) find managers perform weekly managerial skills tasks such as planning, organising, staffing, communicating, decision-making and controlling. Loo and Thorpe (2004:91) find that traditional management roles such as planning, budgeting and staffing were the duties performed by nurse managers that were referred to most often. HRM is managing an organisation's employees to achieve the objectives of the business (Armstrong, 2000:6; Meyer, Mabaso, Lancaster & Nenugwi, 2004:2). These authors say that the role of HRM has changed in the last decades. Previously, HRM was concerned primarily with the administration of the employees, but currently is seen as a proactive strategy among business partners (Grobler, Warnich, Carrell, Elbert & Hatfield, 2002:9; Meyer et al., 2004:3).

Various nursing management competency models provide information that assists in understanding the nurse manager's roles and functions. Lin et al. (2007) find that four main functions needed for managers were HRM, operation management, goal setting and planning and material environment. The ANA cited in Calhoun et al. (2002) who reveal five areas of

competence, these being in organisation and structure, economics, HR, ethics and the legal regulatory framework. The HLA developed a model that includes 300 competencies, which are clustered in five areas (Stefl, 2008:360). These areas are communication and relationship management, leadership, professionalism, knowledge of the healthcare environment and business knowledge and skills (Stefl, 2008:360).

Literature identifies human resource management, as well as leadership and decision-making as the most important managerial skills (Mathena, 2002; Loo & Thorpe, 2004:91). Chase (2010:176) identifies human and leadership competencies as the most important competencies of nurse managers and effective communication and decision-making as the most significant skills. Other important competencies are effective staffing strategies, counselling strategies, performance evaluation, team-building strategies, delegation, change process, conflict resolution and problem-solving (Chase, 2010:177-180). Human and leadership skills and decision-making are the most important management skills for nurse managers, and according to Mathena (2002) communication, negotiation, critical thinking, the balance between work and home and conflict management are the most important skills needed to be successful as a nurse manager.

Taylor, Roberts, Smyth and Tulloch (2015:881) suggest that nurse managers need an armoury of clinical and management skills and knowledge, underscored by a high level of emotional intelligence, not only to 'survive' regular working days, but to develop sufficient expertise to begin to personally enjoy and feel empowered by their work. Given the specificity and complexity of the role, Shirey, Elbright and McDaniel (2013:22) outline that nurse managers need a combination of strategies when they deal with personal and organisational factors. The issues created by the fast-paced complexity of nurse managers' work have been explored in various ways, such as through research, focusing on their decision-making processes (Shirey et al., 2013), the work strategies nurse managers could use to improve their practices (Johansen, 2012; Matsuo, 2012; Udod & Care, 2013) and the need for their work roles (Horton-Deutsch & Sherwood, 2008; Lucas, Laschinger & Wong, 2008; Morrison, 2008). Very little South African literature could be found about managerial skills of assistant nurse managers in South Africa, hence the need to develop strategies to facilitate competencies of assistant nurse managers in the public health facilities in the Western Cape.

2.4 THE NEED FOR HUMAN RESOURCES

The workforce has a strong impact on overall health system performance because all healthcare is ultimately delivered by people. Hence effective HRM plays a crucial role in maintaining effective healthcare systems (Kabene et al., 2006). South Africa faces a huge shortage of highly

skilled personnel (Jinabhai, 2005:85). The World Competitive Report 2007/2008 ranks South Africa in the 44th place of 131 countries for skilled staff (World Economic Forum, 2007). South Africa is also ranked in 56th place for higher education and training, referring to acquired competencies of the workforce. The report confirms that participants were asked to select the five most problematic factors that hamper business in their country. An inadequately educated workforce was ranked highest in a list of 14 factors in South Africa (World Economic Forum, 2007). The process of planning improvements in Human Resources for Health is guided by the National Department of Health (NDoH)'s 10 Point Plan (Human Resource for Health South Africa (HRHSA) (NDoH, 2011:16), which incorporates human resource planning, development and management. There are six documented strategic priorities in the Medium Term Strategic Framework (MTSF) for 2009–2014. One of these is refinement of the Human Resource Plan for Health (NDoH, 2011:16). The assumption has to be made in planning for HRHSA, that spending could be aligned to growth in Gross Domestic Product (GDP) (NDoH, 2011:19). Furthermore, the percentage of GDP spent on human resources for health may be increased in one or more of the following components: a rise in health workforce financing as a share of GDP; revenue generation by the public sector; a shift in public spending towards HRHSA; and additional private sector financing towards HRHSA (NDoH, 2011:19). Provincial human resources plans are developed by the provincial departments of health in a template format prescribed by the Department of Public Service Administration (DPSA) (NDoH, 2011:58). The provincial departments of health produce human resource plans to comply with Public Service Regulations (2001) and the Public Finance Management Act (1999) (NDoH, 2011:58). Human resource plans are required to support the Medium Term Expenditure Framework (MTEF) strategic plan for each provincial department of health. Furthermore, human resource plans should detail the human resource requirements to address the gaps that inhibit service delivery (NDoH, 2011:58).

The Annual report of the Western Cape Government Health (2016:2) indicates that human resources have a pivotal role in ensuring the success of the Healthcare 2030 strategies to address the requirements for a person-centred quality health service because staff are the most critical enablers (WCGH, 2014). Furthermore, HR through the HSHSA strategy (NDoH, 2011), in terms of the public service legislative framework, could significantly influences the strengthening of health systems towards an effective and person-centred health service, that could contribute to population outcomes and the achievement of these principles: person-centred quality care; an outcomes-based approach; primary healthcare (PHC) philosophy; strengthening the district health services model; equity and cost-effective and sustainable health service (WCGH Report, 2016:2).

2.5 INTERNATIONAL COMPETENCY FRAMEWORKS

2.5.1 Canadian Framework for Career Development

The Canadian Framework for Career Development (CFCD) was developed in Canada and launched in 2001, after a three-phase consultation and development process. The main goal of this framework was to spell out the competencies that service providers need in order to deliver comprehensive career services to clients across the lifespan (Canadian National Steering Committee for Career Development Guidelines and Standards, 2004 cited in DHET, 2015:73). A basic framework was developed and subsequent consultation with the career development community determined that there was strong support for the project to continue. Consultation was conducted with career practitioners and stakeholders of organisations for the development and validation of the content of the standards and guidelines. The CFCD is a generic HR framework, which includes core competencies, areas of specialisation and a code of ethics, which emphasises the knowledge, skills, attitudes and values required by all career development practitioners in Canada, regardless of their client group or the nature of their work. The four core competencies are the categories of professional behaviour, interpersonal competence, career development knowledge, and needs assessment and referral. This framework seems to focus on interaction competencies rather than support and foundation competencies, and addresses all healthcare professionals, not only professional nurses.

2.5.2 Professional Standards for Australian Career Development Practitioners

The Professional Standards for Australian Career Development Practitioners were developed on the initiative of the Australian Government to address inadequacies in the training and qualifications of career general practitioners in Australia (CICA, 2011 cited in DHET, 2015:72). The Australian Government funded the project, which was commissioned through the Career Industry Council of Australia (CICA) in 2006 cited in DHET, 2015:72). These standards contain competency guidelines (CICA, 2011) cited in DHET, 2015:72). In them, core competencies and areas of specialisation in general management practice, are identified. These areas of specialisation are regarded as 'additional knowledge, skills, attitudes and values that may be required to undertake specialised tasks and work with specialised populations, depending on the type of work setting and the client groups that are being served' (CICA, 2011 cited in DHET, 2015:72). The core competencies address seven broad categories of career development theory, labour market, advanced communication skills, ethical practice, diversity, information and resource management, and professional practice. This framework of professional standards was successfully implemented after extensive consultation with stakeholders, developing a communication strategy, and collaborative implementation processes in reasonable timeframes that allow for practitioners to prepare effectively. It appears that this framework emphasises

foundation or transversal competencies rather than support and interaction competencies and it addresses general practitioners, and not only for nurses.

2.5.3 European Centre for the Development of the Vocational Training Competency Framework

The European Centre for the Development of Vocational Training (CEDEFOP) investigated general practitioner competencies and qualification routes, and proposed a competency framework. The motivation for the work undertaken by CEDEFOP was recognition that the training of career development general practitioners is highly variable across countries and that their mobility between workforce sectors and from paraprofessional to professional roles is limited. Drawing on a definition of competence adopted by the European Qualifications Framework, CEDEDFOP regarded competence as being underpinned by propositional knowledge (knowing what), practical knowledge (knowing how) and procedural knowledge (knowing how to be) (DHET, 2015:65). This framework focuses on three broad areas of competencies: foundation competencies, interaction competencies and supporting competencies. Foundation competences entail practitioner skills and values; client interaction competences working with clients; and supporting competencies involving systems and networks (DHET, 2015:65). The framework focuses on the competencies of individuals that are required to carry out functions delivered by the career development workforce, mostly medical practitioners.

2.5.4 A Competency Framework for Guiding Practitioners

In Ireland, the Competency Framework for Guidance was developed by a subcommittee of the National Guidance Forum, a joint initiative of the Minister for Education and Science and the Minister for Enterprise, Trade and Employment, which was formed in 2006. The purpose of this competency framework was to 'influence the future professional education and training of practitioners who will provide guidance across the life cycle and in a range of different contexts' (National Guidance Forum (NGF), 2007 cited in DHET, 2015:71). The framework focuses on the theory and practice of vocational, educational, and personal/social guidance across the lifespan, the labour market, educational and training, counselling, information and resource management and professional practice. It seems that this framework focuses on the foundation or transversal competencies of health practitioners rather than support and interaction competencies, and addresses all professional practitioners, not with a specific focus on professional nurses.

2.6 INTERNATIONAL FRAMEWORKS FOR HEALTHCARE PROFESSIONALS

2.6.1 Competency Framework for Guidance Practitioners

The Competency Framework for Guidance Practitioners (CFGP) was developed in the Republic of Ireland by a subcommittee of the (NGF, 2006 cited in DHET, 2015:71). It was a joint initiative of the Minister for Education and Science and the Minister for Enterprise, Trade and Employment, which was formed in April 2004. The purpose of this framework was to 'influence the future professional education and training of healthcare practitioners who should provide guidance across the life cycle and in a range of contexts' (NGF, 2007 cited in DHET, 2015:71). This framework focuses on five general competencies of practitioners. The first addresses the theory and practice of vocational, educational and personal/social guidance throughout the lifespan. This included facilitating educational choices and making educational choices (NGF, 2007 cited in (DHET, 2015:71),

The second competency in this framework refers to adequate labour market education and training. The focus is on up-to-date information on educational and training opportunities, using information technology and other resources as appropriate to assist individuals in their career development; self-management, self-promotion and networking, and to establish linkages with other specialist services (NGF, 2007 cited in DHET, 2015:71). Counselling is the third competency, which refers to engaging people in personal counselling individually or in groups; clarifying the professional and ethical issues in group counselling and group guidance; helping individuals to develop a personal life plan; engaging in appropriate supervision to develop counselling skills and seeking support of other professionals in the counselling role (NGF, 2007 cited in DHET, 2015:71). The fourth competency is around information and resource management. Aspects that are addressed include information management strategies; personal and social, educational, and vocational/ career information; information technology to support practice; case and project management procedures and records, confidentiality guidelines (NGF, 2007 cited in DHET, 2015:71).

Professional practice is the fifth competency with reference to engaging in consultation, working collaboratively, continuing professional development, supervision and research to improve and develop professional practice; evaluating the service provided to individuals; practising in accordance with ethical guidelines; organising and managing a service and supervising personnel as appropriate, and developing and implementing strategic and operational plans for lifelong guidance services as appropriate (NGF, 2007 cited in DHET, 2015:71). This framework therefore includes general competencies that were developed for all categories of practitioners (not only nurses), for their professional education and training as healthcare practitioners.

2.6.2 International Association for Educational and Vocational Guidance Competency Framework

The International Association for Educational and Vocational Guidance (IAEVG) is the only international professional association that focuses on the career and educational guidance of healthcare practitioners and practitioner associations with over 16,000 members from 53 countries on the six continents (IAEVG, 2014 cited in DHET, 2015:64). IAEVG advocates for educational and vocational guidance for all communities and supports the provision of quality services by recommending minimum qualifications for educational and vocational guidance practitioners. A framework of international competencies for educational and vocational guidance practitioners was published by the IAEVG (2003). It was developed to guide practitioners and to enhance the quality of guidance services. It identified the knowledge, skills, and attitudes needed by healthcare practitioners to provide healthcare quality services (Repetto, Malik, Ferrer, Manzano & Hiebert, 2003 cited in DHET, 2015:64). The competencies were developed after an extensive international consultation process in nine world regions, including Africa. Responses from 41 countries informed the development of the competency framework. The identification of competencies contributes to defining the field of career development of healthcare professionals by distinguishing them from other professions. The IAEVG competency framework focuses on the general core competencies that all healthcare practitioners need, regardless of their job setting, and specialised competencies, which are additional skills, knowledge, and attitudes that may be required, depending on the type of work setting and the client groups that were being served (DHET, 2015:64)

2.6.3 Competency Framework for International Health Consultants

The competency framework of the International Council of Nurses (ICN) was developed in 2003 on the initiative of World Health Professions Alliance (WHPA) project, which was sponsored by Burdett Trust for Nursing, in the United Kingdom. The WHPA brings together dentistry, medicine, nursing and pharmacy through their representative international organisations: ICN, International Pharmaceutical Federation, World Dental Federation and World Medical Association. The alliance, speaking for more than 23 million healthcare professionals worldwide, assembles essential knowledge and experience from key healthcare professions. The WHPA aims to facilitate collaboration among key health professionals and major international stakeholders such as governments, policy makers and WHO. By working in collaboration, instead of along parallel tracks, the patient and healthcare system benefit (WHPA, 2007:3). The core competencies of the framework for international healthcare consultants are grouped under seven domains: client context, accountability, ethical practice, legal practice, service provision, communication and continuing competence. The client context competency entails demonstrating sound understanding of the cultural, social, economic and political environments

within the client operates (WHPA, 2007:10). The accountability competency focuses on the accountability to the client for the services rendered (WHPA, 2007:11). Acting in an ethical manner in all interactions with, and on behalf of the client is proven to be ethical practice competency (WHPA, 2007:12). Legal practice competency refers to understanding and working within legal and ethical parameters (WHPA, 2007:12). Service provision entails rendering services that reflect client needs and capacity (WHPA, 2007:13). Communication involves communicating effectively and building positive relationships with and on behalf of the client (WHPA, 2007:13). Continuing competence entails assuming responsibility for lifelong learning and continuing competence (WHPA, 2007:15).

The competencies focus on clusters of behaviours, skills and knowledge of health practitioners that are identified as essential to high performance and quality consultancy. They are proposed to be broad enough to be applied, regardless of profession, yet specific enough to serve as a useful guide to those who wish to use healthcare consultation. These competencies serve to guide the individual, client and contractor (WHPA, 2007:15). It appears that this framework place more emphasis on the foundation or transversal competencies and interaction competencies than the supporting competencies, and also addressed all healthcare professionals not only professional nurses.

2.6.4 International Council for Nurses: Framework of Competencies

This framework was developed to identify competencies expected of a generalist at the point of entry into professional practice (professional nurse) in 2003. ICN applied it successfully to identify core competencies for the emerging specialty of the family nurse. The purpose of the ICN Competency Framework is to clarify the role of nurses, and provide guidance on nursing's role and scope of practice in relation to healthcare. The framework focuses on nursing competencies that address concepts. The first competency addresses professional, ethical and legal practice. The second refers to care provision and management. Professional development is the third competency. These competencies apply to a nurse who has completed the educational requirements for the full scope of practice as defined in that country (Guest editorial, 2004:119). The use of ICN frameworks, policies and positions can strengthen nursing's voice in international and regional negotiations to establish mechanisms to recognise education,

Table 2.1: Summary of competency frameworks						
Frameworks	**Where developed**	**Who developed**	**When**	**For who**	**Main goal**	**How was developed**
Competency framework for Guidance Practitioners	Republic of Ireland	National Guidance Forum	2004	Healthcare practitioners	To influence the future professional education and training of practitioners who will provide guidance across the life cycle and in a range of different contexts	A Competency Framework for Guidance Practitioners was developed in the Republic of Ireland by a subcommittee of the National Guidance Forum. It focuses on general competencies that provide guidance in the future professional education and training of practitioners.
International Association for Educational and Vocational Guidance	Internationally	International Association for Educational and Vocational Guidance	2003	General practitioners	To guide practitioners and to enhance the quality of guidance services	The competencies were developed after an extensive international consultation process in nine identified world regions including Africa. Responses from 41 countries informed the development of the competency framework.
Canadian Standards and Guidelines for Career Development	Canada	National Steering Committee for Career Development Guidelines and Standards	2001	Career development practitioners	To spell out the competencies that service providers need in order to deliver comprehensive career services to clients across the lifespan	Phase 1: A framework was developed and subsequent consultation with the career development. Phase 2: Further consultation with career practitioners and stakeholders and development and validation of the content of standards and guidelines. Phase 3: Implementation of the standards and guidelines.
Professional Standards for Australian Career Development Practitioners	Australia	Australian Government	2011	Career practitioners	To address the inadequacies in the training and qualifications of career practitioners in Australia	The Professional Standards for Australian Career Development Practitioners were developed on the initiative of the Australian Government.
Competency Framework for International Health Consultants	Internationally	World Health Professions Alliance	2007	Health consultants	To guide the individual, client and contractor	The validation panel members and the working group contributed to the development of the competency framework.
European Centre for the Development of Vocational Training (CEDEFOP)	Europe	European Centre for the Development of Vocational Training (CEDEFOP)	2011	General career development practitioners	To investigate general practitioners and qualifications routes and propose a competency framework	After reviewing existing competency frameworks, Cedefop concluded that there was little difference between the core competencies and specialised competencies described in some competency frameworks.
ICN Framework of Competencies	Internationally	ICN	2003	Nurses	To identify competencies expected of a generalist at the point of entry into professional practice	The European Parkinson's Disease Association funded and facilitated access to specialist expertise and commentary throughout the development of ICN Competency Framework paper.
The South African Competency Framework for Career Development Practitioners	South Africa	Organisation for Economic Cooperation and Development	2011	SA career development practitioners	Provide information to employers, practitioners, qualification developers, professional bodies, service beneficiaries as to the knowledge, skills, attitude and values that can be expected of CDPs	Extensive research into international career development frameworks and national career development context. Framework has undergone consultative process with industry experts, stakeholders and public participation. Career development services can assist individuals to develop career management skills that include decision-making, transition, and career planning skills.
SANC Competency Framework	South Africa	SANC	2004	Nurses	The purpose of the nursing competency framework is to identify competencies expected of a generalist nurse and a specialist nurse at the point of entry into professional practice	SANC, as a regulatory body, is authorised by the Nursing Act (Act No. 33 of 2005) to develop and maintain the Scope of Practice, Professional Standards and Competencies through Section 3(e) which stipulates that the objects of the Council are, amongst others, to maintain professional conduct and practice standards for practitioners and to uphold and maintain professional and ethical standards within nursing (SANC, 2005:8). Sections 4(1)(l)(i) and (iv) of the act maintain that the council must determine the scope of practice of nurses and the requirements for any nurse to remain competent in the manner prescribed (SANC, 2005:9).

experience, licensing or certification obtained by nurses in other countries (Guest editorial, 2004:119). This framework does not address nursing management competencies particularly.

2.7 NATIONAL FRAMEWORKS

2.7.1 The South African Competency Framework for Career Development Practitioners

The South African Competency Framework for Career Development Practitioners was developed by the Organisation for Economic Cooperation and Development (OECD) in 2011, in the context of a growing awareness in South Africa and internationally, that career development services have a positive impact on the economic development of a country (DHET, 2015:9). Career development services can assist individuals to develop career management competencies that include decision-making, transition, and career planning. Career development services in South Africa are mostly unregulated and the competency level of those offering such services ranges between highly qualified and highly experienced to unqualified persons (DHET, 2015:9).

The purpose and rationale of the proposed competency framework are to establish the minimum competencies which individuals must possess in order to enhance career development. This could result in formalised educational and career progression routes that individuals in this field of work could enter into. This framework was designed to provide information to employers, practitioners, qualification developers, professional bodies and service beneficiaries as to the knowledge, skills, attitudes and values that can be expected of career development practitioners. The competency frameworks of several countries have been extensively researched and analysed. This has resulted in these competencies being identified as either core or specialised in the South African context (DHET, 2015:12). Core competencies are effective communication; managing stakeholder relationships; demonstrating ethical behaviour; demonstrating professional behaviour; managing diversity; using career information effectively; delivering an effective career development service; advancing employability of clients; understanding career development and conducting career assessments. Specialised competencies entail career counselling, psychometric assessment, research, career development education and recruitment, selection and placement (DHET, 2015:12). It appears that this framework emphasises foundation or transversal, support and interaction managerial competencies for general practitioners, not specifically professional nurses.

2.7.2 South African Nursing Council Competency Framework

The South African Nursing Council (SANC), as a regulatory body, is authorised by the Nursing Act (Act No. 33 of 2005) to develop and maintain the scope of practice, professional standards and competencies through Section 3(e) which stipulates that the objects of the council are, among others, to maintain professional conduct and practice standards for practitioners and to uphold and maintain professional and ethical standards within nursing (SANC, 2005:8). Sections 4(1)(l)(i) and (iv) of the Nursing Act maintain that the council must determine the scope of practice of nurses and the requirements for any nurse to remain competent in the manner prescribed (SANC, 2005:9). The purpose of a nursing competency framework is to identify competencies expected of a generalist nurse and a specialist nurse at the point of entry into professional practice. This framework focuses on nursing competencies that address three concepts. The first concept addresses professional ethical practice, which contains the legal framework, ethical practice and accountability. The second concept refers to clinical practice. This concept consists of competencies for care provision and for care management. Quality of practice is the third concept. This concept encompasses quality improvement, continuing education, professional enhancement and research (SANC, 2004:30). It seems that this framework emphasises foundation or transversal, interaction and support competencies, that addresses all categories of nurses, not only nurse managers.

2.8 SPECIFIC COMPETENCIES IN HEALTHCARE MANAGEMENT FRAMEWORKS

Protagonists for a specific health management model as reflected by Pillay (2010:546), believe that healthcare managers require additional competencies owing to the uniqueness of the health environment. The Skills for Health, as a Sector Skills Council for the United Kingdom (UK) health sector, developed National Occupational Standards (NOS) and National Workforce Competences (NWC) in 2010, to 'describe what individuals need to do, what they need to know and which skills they need in order to carry out an activity' (Green & Thorogood, 2009:1293). These competences, according to these authors, can be used in individual and team development; role design and re-design; service design; education programme and curriculum design; and collecting evidence for the National Health Sector (NHS) Knowledge and Skills Framework post outlines. The National Center for Healthcare Leadership (NCHL) in the USA developed an approach for healthcare managers that includes three main domains of competencies and 26 various competencies. The domains are transformation (strategic), execution (organising and controlling) and people (leadership). Transformation includes competencies which envisage, energise and stimulate a change process that merges communities, patients and professionals around the model of healthcare and wellness. Execution includes skills that translate vision and strategy into optimal organisational

performance and the people domain includes HRM, leadership, ethical and self-management skills (National Center for Healthcare Leadership, 2006).

However, Pillay (2010:546) identifies healthcare operations, patient focus, financial/economic, legal/ethical and medical relationships as domains that are important for competent healthcare executives. This was preceded by the American College of Preventive Medicine, which defines a list of health management competencies and performance indicators related to the delivery of healthcare, financial management, organisational management, and legal and ethical considerations to assist in the development of training programmes in medical management (Pillay, 2010:546). Pillay (2010) states that studies in the UK have identified financial, medical and people related skills as important for inclusion in management development programmes for hospital managers. Hospital managers in South Africa felt that people management and self-management skills were the most valuable for the efficient and effective management of hospitals, followed by 'hard management skills' and skills related to the ability to think strategically. Specific skills or knowledge related to healthcare delivery were perceived to be least important (Pillay, 2010:547). Rao (2010:68) puts together a comprehensive framework for building the competencies of healthcare providers to improve the quality of care, with the focus on primary care. This author states that this framework is reliable as the quality imperative is well recognised in India (Rao, 2010:68). The competency building process entails a competency need assessment of knowledge, skills and attitude set for each category of healthcare professional. The skills and knowledge required for the job are facilitated by the provision of in-service training, learning on the job and enabling conditions such as support from other members, supplies and infrastructure, supporting supervision and guidance and mentoring. This process, as claimed by Rao (2010:87), could result in the delivery of best quality of care, ensuring attainment of healthcare objectives. From the general competencies framework previously developed, it seems that they focus on specific individual competencies rather than giving a holistic list of competencies needed in a management position.

2.9 RATIONALE FOR A COMPETENCY-BASED STRATEGY

According to Khan (2003:63), a competency-based strategy offers one set of criteria that can be applied across the full range of human resource processes. Khan (2003:63) posits that if competencies are defined with reference to the needs of the business, then a competency-based system could reinforce particular approaches to work, for example continuous improvement. Khadka et al. (2014:63) believe that the lack of competencies and skills of managers in hospitals is related to inefficient allocation of resources, quality and outcomes of healthcare services. Furthermore, roles, competencies and skills of hospital nurse managers have an

impact on the efficient management of the hospital and help to sustain services. Meeker and Byers (2003) state that solutions that are proposed to meet the demand for competent nurse managers are strategies that outline curriculum redesign, innovative teaching methods that reflect workplace realities and portfolios that illustrate competency.

2.10 SUMMARY

This chapter has drawn on an overview of the phenomenon in the field of study. The researcher outlined related concepts and frameworks in the field of study as well as reasoning for the importance of a competency-based strategy. The literature indicates lack of insight into the role of the assistant nurse manager specifically in the SA context. It was therefore a decision of the research to start with an inductive approach, thus first following a qualitative phase in a mixed method design. The overview of literature indicated that a competency framework for ANMs is needed as not yet developed. Chapter 3 describes the research methodology followed in the study.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

Research methodology is the theory of correct scientific conclusions and the quality of research is reliant directly on the accountability of the research methodology. It is necessary to follow a specific research methodology to exclude apparent incorrect decisions and to enhance the validity of research findings (Polit & Beck, 2012:12). The main purpose of this chapter is to describe the research design and methods that led to fulfilling the purpose of the study, namely to develop a strategy to facilitate competencies of ANMs in the public health facilities in the Western Cape.

3.2 PRAGMATISM AS THE PARADIGM

Pragmatic inquiry 'is primarily concerned with transforming and evaluating the features of situations in which we find ourselves' (Biesta & Burbules, 2003, cited in Hannes & Lockwood, 2011:1636). The foundation of pragmatism, according to Hannes and Lockwood (2011:1636), 'is that the meaning and truth of any thought or idea are determined in some way by criteria of practical usefulness, meaning that the value of an idea or proposition is to be found in the practical consequences of accepting it'. From a mixed method design with two phases, direction was given to important ideas to be included in the strategy for ANMs. Pragmatism provides a philosophical basis for research, and is not committed to one system of philosophy and reality. This applies to mixed methods research in that inquirers draw liberally from quantitative and qualitative assumptions when they engage in their research (Creswell, 2014:11). Furthermore, pragmatist researchers look to the 'what' and 'how' of research based on the intended consequences, that is, where they want to go with it. In this study, the outcome was a human resources strategy to be used in the context of nursing management. Mixed method researchers need to establish a purpose for their mixing, a rationale for their reasons that quantitative and qualitative data need to be mixed (Creswell, 2014:11). Thus, for the mixed methods researcher, pragmatism opens the door to multiple methods, different worldviews, and different assumptions, and different forms of data collection and analysis (Creswell, 2014:11). This study followed an exploratory sequential mixed method.

3.3. GEOGRAPHICAL BOUNDARIES AND RESEARCH SETTING

3.3.1 Geographical area

South Africa is positioned at the southern tip of the continent of Africa. The total land boundaries are 5244 km, with a coastline of 2798 km. Countries neighbouring South Africa

include Botswana (1969 km), Lesotho (1106 km), Mozambique (496 km), Namibia (1005 km), Swaziland (438 km) and Zimbabwe (230 km). South Africa is divided into nine provinces: Eastern Cape, Free State, Gauteng, KwaZulu-Natal, Limpopo, Mpumalanga, Northern Cape, North West and Western Cape (South Africa, 2015). This study was conducted in the Western Cape of South Africa (Figure 3.1). Government is based in three capitals, namely the administrative capital, which is situated in Pretoria, the legislative capital in Cape Town, and the judicial capital in Bloemfontein (South Africa, 2015). The total population of South Africa is estimated at 54 002 000 million people (Statistics SA, 2015) with various cultural populations. The official languages include English, Afrikaans, IsiXhosa isiZulu, Sepedi, Setswana, Sesotho, Xitsonga, siSwati, Tshivenda and IsiNdebele.

Figure 3.1: Map of South Africa (Source: www.southafrica.info/about/ geography/ htm/provinces.htm

3.3.2 Study setting

The study was conducted in the public health facilities in the Western Cape, South Africa. The Western Cape is a province of South Africa, situated in the south-western part of the country. It is roughly L shaped, extending north and east from the Cape of Good Hope. It is bordered on the north by the Northern Cape and on the east by the Eastern Cape. It is the fourth largest of the nine provinces in terms of both area and population, with an area of 129,462 square kilometres, about 10.6% of the country's total, and 5.8 million inhabitants. About two thirds of these inhabitants live in the metropolitan area of Cape Town. Western Cape is divided into five rural district municipalities, that are, Eden, Cape Winelands, Central Karoo, Overberg and West Coast, as well as one metropolitan district, Cape Town Metro (Figure 3.2). Central Karoo

covers the largest surface area (38 873 km^2) and Cape Town Metro District covers the smallest surface area (2 502 km^2) (Western Cape Government Health, (WCGH), 2014:3). Cape Town Metro District accommodates approximately 64 per cent of the population and displays higher density ratios than rural district, which is significant for planning. The remainder of the population are distributed more sparsely in approximately equal proportions among the other rural districts, that is, Cape Winelands, Overberg, Eden, and West Coast, with the exception of the Central Karoo, which is sparsely populated (WCGH, 2014:3).

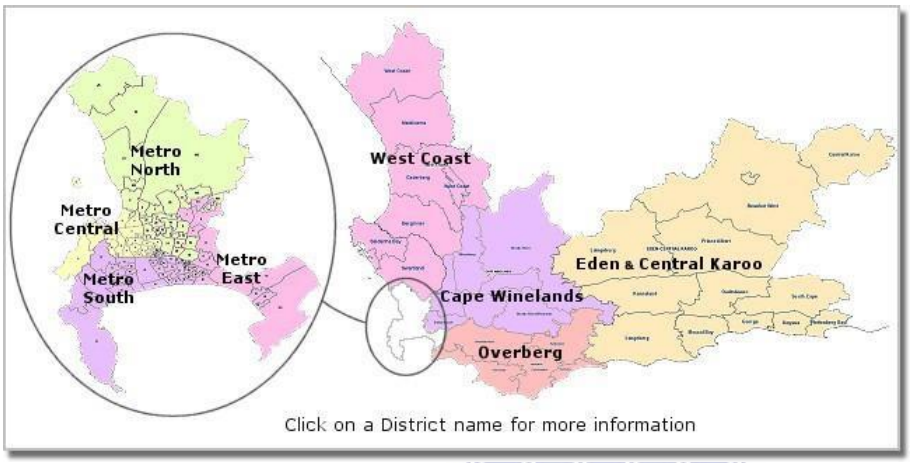

Figure 3.2: City of Cape Town Metropole and its sub-districts (Source: The Local Government Handbook (2012-2016)

Western Cape districts

A central tenet of the Comprehensive Service Plan (CSP) of the WCDoH is management of the patient at the appropriate level of care. For this reason, defining the packages of care and the competencies and resources required for each level of care is a key enabler for implementing the CSP. The package of care defines the services that will be provided at all levels by identifying the clinical conditions and procedures that are appropriate for each level of care. The lists of conditions are not exhaustive. The defining requirement for the provision of Level 1 services is the availability of a family physician or medical officer; that of Level 2 services is the availability of a general specialist; and that of Level 3 is the availability of a sub specialist with specific skills (WCDoH, 2007:3). ANMs run these services and must be up to date with new developments in health in the Western Cape. The WCDoH public sector has two academic hospitals and one tertiary hospital health facility, which are led by Level 3 sub-specialists, and provides a Level 2 general specialist service to the population in their immediate vicinity. There are five regional hospitals that are general-specialist-led services, which also provide a district hospital service to the population in the immediate vicinity (Table 3.1).

The introduction of the Mental Healthcare Act (Act no 17) (South Africa, 2002) created a statutory obligation on ANMs to assist in improving access to mental healthcare by mainstreaming and integrating mental health services in the general health services. In addition the NDoH believes that the majority of people living with intellectual disabilities require supported living arrangements, and not medical institutionalisation (South Africa, 2002). Hence these patients are managed in the four psychiatric hospitals in the Western Cape. In addition, there is one rehabilitation centre, which provides high-intensity specialised comprehensive and multi- disciplinary inpatient and outpatient rehabilitation services (see Table 3.1).

ANMs play a crucial role in PHC services. Ninety per cent of patients with tuberculosis (TB) are currently managed within the PHC platform, and strengthening community-based services (CBS) and PHC services improve efficiencies in TB hospitals. Six TB hospitals provide acute, sub-acute and chronic care beds for the proportion of patients who are transferred from acute hospitals. Five district hospitals provide a family-physician-driven service. The larger district hospitals provide a varying quantum of general specialist services, depending on, among other things, the burden of disease and available infrastructure (see Table 3.1). A comprehensive range of curative and preventive services are provided, with complementary capacity for rehabilitative and palliative care at primary healthcare facilities.

Table 3.1: Western Cape public health facilities

Public Health Facilities											
DISTRICT	**Rehabilitation**	**Psychiatric**	**Tuberculosis**	**Central**	**Tertiary**	**Regional**	**District**	**MOU's**	**Clinic's**	**CHC's**	**CDC's**
Metro	1	4	2	2	1	2	9	11	88	9	38
Cape Winelands	0	0	1	0	0	2	4	0	44	0	5
Central Karoo	0	0	0	0	0	0	4	0	8	0	1
Eden	0	0	1	0	0	1	6	0	35	0	5
Overberg	0	0	0	0	0	0	4	0	23	0	1
West Coast	0	0	2	0	0	0	7	0	27	0	0
Total facilities	1	4	6	2	1	5	34	11	225	9	50

Maternity Obstetric Units (MOU), Clinics, Community Health Centres (CHCs) and Community Day Centres (CDCs)

A clinical nurse practitioner, supported by a medical officer, provide the core of this frontline service. These clinical nurse practitioners report to the ANM. In the district health services model that is applied in the Western Cape, each clinic is linked to a community day centre (CDC) or community health centre (CHC). These centres provide clinical and administrative support to clinics. In the City of Cape Town, all the clinics are well within 2.5 km walking distance for the population they serve (Western Cape Government Health (WCGH, 2014:45). There are 34 district hospitals, 11 maternity obstetrics units, 225 clinics, 9 Community Health

Centres and 50 Community Day Centres (see Table 3.1). Participants in the study were allocated to these facilities.

3.4 RESEARCH DESIGN

The purpose of a research design is to improve the validity of the study in examining the research problem (Burns & Grove, 2011). A research design outlines the plan used in examining a research problem and can be regarded as the blueprint for conducting a research study (Christensen, Johnson & Turner, 2011:507). It may be categorised as a qualitative, quantitative or mixed methods research approach. Qualitative research methods centre around exploring and describing the views, opinions or experiences of research participants in a real-life setting with the purpose of comprehending the meaning that the participants ascribe to reality (Harwell, 2011:148). They use textual data (the words of the research participants), and typically research participants are selected purposefully (Hennink, Hutter & Bailey, 2011:16). On the other hand, quantitative research methods involve the creation of a hypothesis and testing relationships and associations with mathematical or statistical tests. Mixed methods design combines qualitative and quantitative research methods in a way that balance the differences between the two research methods (Harwell, 2011:148; Punch, 2014:201). Mixed methods can be used in various situations such as for hypothesis generation; explication and theory building; testing and refinement of instruments and, in this study, developing a strategy. Polit and Beck (2012:608) argue that in designing a mixed method study, researchers make several important decisions. One is whether to have a fixed design at the outset. Other key design decisions concern sequencing, prioritisation and integration (Polit & Beck, 2012:608).

Burns and Grove (2011) maintain that the research design selected for a research study must adequately address the research question(s). It was decided to follow a mixed method design because it was most suitable to address the research problem.

3.4.1 Mixed method design

Mixed methods in research that involves the collection of qualitative (open-ended) and quantitative (closed-ended) data in response to research questions or hypotheses. It includes the analysis of both forms of data. The procedures for qualitative and quantitative data collection and analysis need to be conducted rigorously (for example adequate sampling, sources of information, data analysis steps) (Creswell, 2014:217). The researcher assumed that collecting diverse types of data could provide a more complete understanding of the research problem than quantitative or qualitative data alone (Creswell, 2014:19). According to Creswell and Plano Clark (2011:5), mixed method research is a research design with philosophical

assumptions as well as methods of inquiry. As a methodology, mixed methods research involves philosophical assumptions that guide the direction of the collection and analysis and the mixture of qualitative and quantitative approaches in many phases of the research process (Creswell & Plano Clark, 2011:5). The mixed method approach is universally applicable and is not necessarily superior to mono-method research and the outcomes of combining quantitative and qualitative research can be planned or unplanned (Bryman, 2012:651). Mixed method research focuses on collecting, analysing and mixing quantitative and qualitative data in a single study (Creswell & Plano Clark, 2011:5). Mixed-method designs do not attempt to reconcile different epistemological orientations, but emphasise the complementarity of qualitative and quantitative methods and their practical application for joint research objectives (Kroll, Neri & Miller, 2005:107).

A sequential exploratory mixed method design was chosen for this study. The exploratory sequential approach is best suited to research questions in areas for which there is little prior knowledge (Kroll, Neri & Miller, 2005:107). This design has its central premise as the need for initial in-depth exploration of the phenomenon, in this instance the competencies of the ANMs. According to Polit and Beck (2012:608), the central question posed by the sequential exploratory mixed method design is: 'What are the characteristics of the phenomenon?' In sequential exploratory research, the study begins with a qualitative research phase and explores the views of participants (Creswell, 2014:16). In this study the question was posed: *What are the expectations about the competencies of assistant nurse managers in public health facilities in the Western Cape?* The data of Phase 1 were then analysed, and the information used to inform the second, quantitative phase, constructing an instrument (Creswell, 2014:16). In this study the quantitative question of the second phase was: *What are the perceptions of assistant nurse managers about their expected and their existing competencies?* The first phase thus focused on the detailed exploration of the phenomena, and the second phase on measuring it (Polit & Beck, 2012:612). See Table 3.2, which outlines the phases of the study.

3.4.1.1 Exploratory design

An exploratory research design was used to search for answers to unclear research questions in a relatively unknown area of scientific enquiry (Streb, 2010:372). Babbie (2013:91) maintains that exploratory studies aim at establishing new facts through the collection of new information, ideas or the existence of new patterns. They are used to explore research questions about which little is known. Furthermore, in his explanation of an exploratory design in research, Streb (2010:372) posits that an exploratory design 'investigates distinct phenomena

Table 3.2: Summary of the phases of the study

Phases according to the objectives	Objectives	Population and sampling	Data collection	Data analysis	Reasoning strategy
Phase 1 Qualitative phase	To explore the expectations of stakeholders, namely senior nurse managers (SNMs), nurse managers (NM), deputy nurse managers (DNMs), operational nurse managers (ONMs) and assistant nurse managers (ANMs) about the competencies of ANMs at the public health facilities in the Western Cape	**Population** SNMs, NMs, DNMs, ANMs, ONMs **Sampling method** Purposive	Unstructured individual interviews Focus group discussions	Open coding	Inductive
Phase 2 Quantitative phase	To explore and describe the perceptions of ANMs about the expected and their existing competencies for effective nursing management in public health facilities in the Western Cape	**Population** SNMs, NMs, DNMs, ANMs, ONMs **Sampling method** Total sampling	Survey 4-point scale structured questionnaire	Statistical Package for the Social Sciences (SPSS) Version 20.0 Descriptive and inferential statistics	Deductive
Phase 3 Strategy development	To develop an human resources strategy to address the gap between existing and expected competencies of ANMs in public health facilities in the Western Cape	Results from phases 2 and 3		Survey list of Dickhoff et al. (1968)	Synthesis

characterised by a lack of detailed preliminary research'. This study explored the expectations of stakeholders (SNMs, NMs, DNMs, ONMs and the ANMs) about the competencies of ANMs in public health facilities in the Western Cape (Phase 1). The exploratory design also aided the researcher to understand the perceptions of ANMs of the phenomenon (Phase 2) in order to develop a strategy, which was the purpose of the study.

3.4.1.2 Descriptive research

In Human Sciences, descriptive research is the most commonly used approach, since it permits researchers to examine situations that occur naturally. Descriptive research is viewed in human sciences as a form of naturalistic investigation because it describes situations and events as they occur naturally (Babbie, 2013:93; Given, 2007:251). A descriptive design was used to gather qualitative data that gave a voice to the expectations of the SNMs, NMs, DNMs, ANMs and ONMs about the competencies of ANMs in the public health facilities in the Western Cape (Phase 1). A descriptive design provides an accurate portrayal or account of characteristics of a particular group, for example nurse managers, for the purpose of discovering new meaning, describing what exists, determining the frequency with which something occurs, and categorising information (Burns & Grove, 2009:30, 52). To ensure that the study was truly descriptive in nature, focus group and unstructured individual interviews were employed as data collection methods (Phase 1). At those meetings and interviews, participants were allowed to describe their experiences on their expectations around the phenomenon. In quantitative research, a descriptive design involves the researcher observing, documenting and describing in detail the phenomenon under study to the point that the findings can be transferred to another social setting (Babbie, 2013:91). In Phase 2, the study described the perceptions of ANMs about the expected and their existing competencies to act in their position (Phase 2).

3.4.1.3 Contextual

The understanding and interpretation of findings in Phase 1 took into consideration the context or setting in which the research study was carried out. According to Henning, Van Rensburg and Smit (2007:62), the interpretation of findings should take into account the context of a research study and the interaction between the research participants and the setting in which they live or function. The research context focused on the phenomenon of competencies being investigated, while keeping in mind the background related to the research phenomenon (Chapter 2). This study was contextual in nature and started with a focus on the expectations of nurse managers about the competencies of ANMs in the specific public health facilities in the Western Cape in South Africa (Phase 1).

3.4.2 Reasoning strategies

Burns and Grove (2011:56) describe reasoning as processing and organising ideas to reach conclusions. The types of reasoning employed in this study were inductive reasoning, deductive reasoning and synthesis.

3.4.2.1 Inductive reasoning

Inductive reasoning is the process of developing generalisations from specific observations to more general rules (Polit & Beck, 2012:11). With a view to supporting the argument, De Vos et al. (2009:49) suggest that the researcher should observe a sample and then draw conclusions about the population from which the sample comes. On the other hand, Babbie (2010:22) points out that inductive reasoning usually does not provide reasons for the inference that has been drawn. The researcher applied inductive reasoning in Phase 1 of this study through using focus group discussions, unstructured individual interviews and field notes, to draw conclusions from the data.

3.4.2.2 Deductive reasoning

Deductive reasoning or deduction is the process of moving from general to specific evidence (Polit & Beck, 2012:11). It moves from a pattern that logically or theoretically might be expected to testing whether the pattern actually occurs (Babbie, 2010:2). Deductive reasoning was used in Phase 2 of this study. Thus, inductive and deductive reasoning processes were used to create an understanding of the phenomenon.

3.4.2.3 Synthesis

Burns and Grove (2011:550) describe synthesis as a process of clustering or grouping and interrelating ideas from diverse sources (Phases 1 and 2) to form a completely new picture of what is known or not known in an area, in this study, a strategy to facilitate competencies of ANMs nursing in the public health facilities in the Western Cape.

3.5 PHASE 1

QUALITATIVE PHASE

Objective 1: To explore the expectations of stakeholders senior nurse managers, nurse managers, deputy nurse managers, assistant nurse managers and operational nurse managers about the competencies of assistant nurse managers in public health facilities in the Western Cape.

3.5.1 Population

A research population is a group of people in whom you are interested, and from whom the sample is selected (Christensen et al., 2011:505). The target population of this study for Phase 1, included all SNMs, NMs, DNMs, ANMs and ONMs employed in the public health facilities in the Western Cape (N = 833).

Table 3.3: Target population

POSITION	POPULATION N	FACILITIES
Senior nurse managers (SNMs)	3	Central hospitals, Directorate Nursing Service Head Office
Nurse managers (NMs)	3	Tertiary hospital & Directorate Nursing Service Head Office
Deputy nurse managers (DNMs)	32	Central, tertiary, regional, psychiatric, district, tuberculosis hospitals and rehabilitation centre
Assistant nurse managers (ANMs)	156	Central, tertiary, regional, psychiatric, district, tuberculosis hospitals; rehabilitation centre, community district centre
Operational nurse managers (ONMs)	639	Central, tertiary, regional, psychiatric, district, tuberculosis hospitals; rehabilitation centre, community health centre, community district centre and clinics
TOTAL	833	

3.5.2 Sampling technique

Sampling is a process of selecting a portion of the population to represent the entire population (Polit & Beck, 2012:742). The researcher used a purposive sampling technique to solicit participation from the sample who met the inclusion criteria. Polit and Beck (2012:739) define purposive sampling as a 'method in which the researcher selects participants based on personal judgement about which ones will be most informative'. Johnson and Christensen (2012:231) and Polit and Beck (2012:517), maintain that homogenous purposive sampling is a type of non-random sampling technique in which a researcher specifies certain characteristics that research participants must have and then chooses only participants who meet such characteristics to participate in the research study. The researcher decided to use this sampling method because the goal was to include eligible participants who could make useful contributions to the discussions and interviews, and whose participation could be of benefit to the study (Johnson & Christensen, 2012:231; Polit & Beck, 2012:517). SNMs, NMs and DNMs are the seniors of the ANMs and are the experts in the field of nursing management while ONMs are under the direct supervision of the ANMs.

3.5.2.1 Sampling criteria

The participants who were selected to take part in the FGDs and interviews in Phase 1, were nurse experts in the positions of SNMs, NMs, DNMs, ONMs and ANMs employed in the eight public health facilities in the Western Cape. Eligibility criteria are the conditions that all potential participants must meet to be included in the study (Johnson & Christensen, 2012:92;

Polit & Beck, 2012:274). The researcher considered the criteria that the participants had to meet to be part of individual interviews and focus group discussions. The participants had to be:

- Registered with the South African Nursing Council as a professional nurse (SANC, 1980:1)
- Permanently employed at a public health facility in the Western Cape
- In a senior or junior position in relation to an ANM or in an assistant manager nursing post

3.5.2.2 Sample

A sample had to be drawn for conducting focus group discussions and individual interviews.

Focus group discussions

The researcher conducted eight FGDs with 60 (2 males and 58 females) ONMs, and ANMs employed in public health facilities in the Western Cape (Table 3.4).

Table 3.4: Focus group discussions conducted in Phase 1

Position	Number of focus group discussions	Males	Females
Assistant nurse manager	2	2	14
Operational nurse manager	6	0	44
TOTAL	8	2	58

Table 3.5: Composition of focus group discussions conducted in Phase 1

Focus groups discussions	Composition	Institutions
1	8 female operational nurse manager	Institution A
2	7 female and 1 male assistant nurse manager	Institution B
3	8 female operational nurse manager	Institution B
4	6 female operational nurse manager	Institution B
5	8 operational nurse manager	Institution D
6	6 operational nurse manager	Institution D
7	7 female and 1 male assistant nurse manager	Institution D
8	8 female operational nurse manager	Institution F

Individual interviews

In Phase 1 the researcher conducted fifteen unstructured individual interviews (Table 3.6). During the individual interviews, more in-depth data were obtain around expectations mentioned in the focus groups. The sample sizes of focus group discussions and individual interviews were determined by reaching data saturation. In Phase 1, no new information was generated after the eighth focus group discussion and the fifteenth unstructured individual

interview. Data saturation was detected during the interviewing process at the point that no new information was provided by participants (Burns & Grove, 2011:317). Samples in qualitative studies are small and investigate each participant intensively to obtain a wealth of data. Furthermore, naturally qualitative studies involve fewer (and sometimes much fewer)

Table 3.6: Unstructured individual interviews conducted in Phase 1

Post	Number of unstructured interviews
Senior nurse manager	2
Nurse Manager	1
Deputy nurse manager	7
Assistant nurse manager	5
Operational nurse manager	0
TOTAL	15

50 participants. These authors state that sample selection is driven to a great extent by conceptual requirements rather than by a desire for representativeness (Polit & Beck, 2012:516).

3.5.3 Research method: Phase 1

A research method denotes the ways or strategies for collecting, organising, and analysing data (Polit & Beck, 2006:504).

3.5.3.1 Preparation for the study field

After ethical clearance for this study had been received from the Higher Degrees Committee of the Faculty of Community and Health Sciences (CHS) and the Senate Research Committee of a university in the Western Cape, South Africa (Ethical clearance number 13/4/23, Annexure A), approval was received from the WCDoH where the FGDs and structured interviews were conducted. The researcher contacted the nurse managers to secure appointments for the focus group discussions and individual interviews. All interviews were scheduled at a time and place convenient for them. The researcher was assisted by personal assistants to the head of nursing in the various health facilities, who helped with identifying and contacting nurse managers who met the eligibility criteria for the study. Those nurse managers were invited to participate in the research by providing an information sheet (Annexure F) containing the objectives and purpose of the study and a consent form. The information sheet sought their support for the study. The researcher requested that they should bring along a signed copy of the permission letter when attending a focus group discussion or individual interview. A large private quiet room was selected by the personal assistant to the head of nursing in the health facilities for

conducting focus group discussions and individual interviews. The environment fostered psychological freedom and augmented participation. The researcher ensured that the room was free of noise, was unlikely to have distractions, that the temperature was fairly constant, and that air-conditioning units were in working condition. Fans were provided because it was a hot season. Participants were requested to switch off their cell phones, and all other phones were taken off the hook. The chairs were organised in a circle to facilitate eye contact for focus group discussion. Before data collection, the researcher ensured that the voice recorder was in good condition and that an extra recorder with batteries were available.

3.5.3.2 Pilot interviews

Pilot interviews are done to assess the adequacy of the questions that are to be asked in the interviewing or data collection process and to discover and correct possible errors (Hennink et al., 2011:120). In this study, three pilot interviews (two unstructured individual interviews and one focus group discussion) were conducted to assess whether the questions that were put to the participants were clear and well understood and generated the information that was required to obtain the purpose of the study. Participants confirmed that the questions and process followed were clear and required no changes, and he researcher obtained the desired information. Since no changes were made, the data from the pilot interviews were included in the main study.

3.5.3.3 Data collection

The methods used for data collection in Phase 1 were focus group discussions, unstructured individual interviews through interview guides (Annexures H and I) and field notes. The researcher introduced herself and made the participants feel at ease and comfortable. She provided an explanation of the study objectives and gave the participants an opportunity to read the information letter. The participants were encouraged to ask questions to which the researcher provided answers. They were reminded of their right to withdraw from the study at any stage. The researcher thanked the participants for taking time to participate in the study.

3.5.3.3.1 Focus group discussions

Focus group discussions are valuable for obtaining an in-depth understanding of the rich detailed own words of the participants (Liamputtong, 2011:6). Focus group discussions produce qualitative data that provides insight into the attitudes, perceptions and opinions of participants (Burns & Grove, 2009:81). A focus group discussion is an interactive discussion between six to eight preselected participants that focuses on a delineated set of issues and is

controlled by a facilitator. A focus group should be homogenous; that participants should share similar characteristics to encourage positive group dynamics and feel comfortable in one another's presence and at ease with their views in the company of their peers (Polit & Beck, 2012:537). The aim of focus group discussions was to enable the researcher to obtain a broad range of views about a topic in a comfortable, accommodating, non-judgemental and non-threatening way. In addition, it allowed participants to express themselves freely and to clarify their own views. Focus group discussions should not last more than 60 to 90 minutes (Hennink et al., 2011:136). Discussions in this study lasted for not longer than an hour. The researcher acted as a facilitator for the focus group discussions. The participants (ONMs) were asked: 'What are your expectations about competencies of assistant nurse managers in public health facilities? The ANMs were asked: 'Tell me about your competencies in being an assistant nurse manager? Probing questions, based on their answers, were asked to explore their perceptions and to yield a wealth of responses (also see Section 3.5.3.3.3). Probing means eliciting more useful or detailed information from a participant in an interview than was volunteered in the first reply. Probing questions gave the participants an opportunity to provide rich detailed information about the phenomenon under study. The researcher built rapport with the participants and used facilitative skills and techniques to incite responses from them. She made an effort to ensure that the discussions remained focused on the central objectives of the study. Field notes were taken during the sessions to record the nonverbal cues of the participants and the highlights of the discussions.

3.5.3.3.2 Unstructured individual interviews

An interview is a process of obtaining information in which the interviewer meets in person with participants (Polit & Beck, 2012:265). Unstructured interviews are discussions between a researcher, who is the interviewer, and an interviewee, who is the research participant. Typically, unstructured interviews are conversational and interactive, and are the mode of choice when researchers do not have a clear idea of what it is that they do not know (Polit & Beck, 2012:536). They usually begin with the interviewer asking an introductory question, followed by questions that are based on the responses of the participant. Every unstructured interview session was recorded and the researcher wrote down field notes. The researcher posed a central question to each of the participants (SNMs, NMs, and DNMs): 'Tell about your expectations about competencies of assistant nurse managers in the public health facilities.' The ANMs were asked: 'Tell me about your competencies in being assistant nurse manager.' The core question was followed by probing questions based on their responses. The participants were allowed to express themselves freely. The interview sessions lasted around forty-five

minutes. The unstructured interviews proved valuable because the participants provided rich in-depth descriptions of their experiences.

3.5.3.3.3 Field notes

Field notes represent the participant researcher's effort to record information and to synthesise and understand the data (Polit & Beck, 2012:548). Field notes consist of in-depth written accounts of the details, happenings and experiences of a researcher during the research process. They are used to assist a qualitative researcher to recall and explore an interview more systematically (Given, 2008:341). Field notes can include information, such as the number of participants, their demographic characteristics, the research setting, participants' behaviour and the thoughts and feelings of the researcher (Myers, 2013:144; Sharan, 2009:130). Polit and Beck (2012:549) claim that field notes can encompass the summary or highlights of the conversation between the researcher and a participant during the interview process. In this study the researcher wrote notes about what she observed during the interviews and the participants' verbal and nonverbal gestures, such as tone of voice, facial expressions, eye contact and body language. Additionally, the researcher noted the location, date and time at which the observations were made during the focus group discussions and unstructured individual interviews. The researcher also wrote down her personal experiences, thoughts, feelings and reflections about the study. The voice recordings were transcribed and the field notes were incorporated into the transcribed data to record the data as completely as possible.

3.5.3.3.4 The skills of the researcher

During data collection, the researcher used various communication techniques and skills for effective communication between herself and the participants, as expounded by (Okun, 2002:81). These techniques were used to stimulate the participants to be open and talk freely. They are discussed in more detail below.

Minimal verbal response

Okun (2002:81) contends that a verbal response includes occasional interjections, for example 'Mm, Eh, Irm, Yes,' which show participants that the researcher was listening. Kadushin and Kadushin (2013:158) suggest that an interviewer should make minimal verbal responses during an interview to avoid distracting and interrupting the interviewee. They add that the interviewer can use minimal non-verbal encouragers such as nodding and verbal responses such as 'Hmm', 'Uh-huh'; preferably at the end of a sentence to avoid interruption (Kadushin & Kadushin, 2013: 158). The researcher ensured that the participants did the most of the talking during the

interviews and discussions. She provided the participants with enough time to respond to the questions and avoided interrupting them while they were talking.

Active listening

Active listening is described as displaying interest and proving attention to what the person says (Okun, 2002:81). Miller and Meinzinger (2014:330) posit that active listening is the key to productive and effective interaction, because it enables the interviewer to understand and clarify what is being said and to provide feedback. The researcher ensured that she listened attentively to the participants while they were providing information. This was done by having a friendly demeanour, maintaining constant eye contact and intermittently nodding her head.

Clarifying

Clarifying is an attempt to focus on or understand nature of each participant's statement (Okun, 2002:81). The Oxford Learners Dictionary (2014) defines clarifying as making something clearer or easier to understand. The researcher sought clarification from the participants when a statement was unclear and aimed to understand the ideas, thoughts and feelings of the participants.

Probing

Probing is described as eliciting more useful or detailed information from a participant in an interview than was volunteered in the first reply (Polit & Beck, 2012:310). According to Hennink et al. (2011:161), probing is an essential technique in the collection of qualitative data because it supports the discussion process and assists the researcher in clarifying issues and obtaining more details about the matter from the participants (Hennink et al., 2011:161). The researcher probed using statements such as 'Is that so?', 'Is it?', 'to stimulate and encourage the participants to say more. Moreover, explanatory probing statement were utilised to obtain more information, such as 'What do you mean by…?' ('Can you please explain?', 'Tell me more').

Silence

Keeping quiet for short periods could be an effective technique that promotes effective communication because it gives a participant time to think about the answer. Hennink et al. (2011:163) propose that a researcher should remain silent for five seconds after a participant has made a contribution. The researcher used the silence technique during focus group discussions and interviews to encourage the participants to contribute freely.

Paraphrasing

Paraphrasing is a verbal statement that is interchangeable with the interviewee's statement (Okun, 2002:81). The words may be synonyms for those that the interviewee has utilised. Paraphrasing is a verbal response in which a researcher states what the participant has said in another form or in different words, without compromising the meaning with the aim of

increasing understanding and clarity (De Vos et al., 2009:345). The researcher stated what the participants had indicated in her own words when it was necessary to search clarification.

Summarising

Summarising involves the interviewer integrating what was communicated during the interview and highlighting the major themes or categories. Summarising provides an opportunity for the interviewer to persuade each participant to share his or her feelings about the situation. It gives the interviewees a sense of progress and creates an opportunity for them to focus on what they have already stated with the purpose of adding new ideas that the participants might think about (Ivey, Ivey & Zalaquette, 2010:152). The researcher summarised the key concepts mentioned by the participants, thus giving them an opportunity to reflect on important issues and confirm whether the researcher had grasped their information accurately.

3.5.3.4 Data analysis of Phase 1

Data analysis involves collecting open-ended data, based on asking questions and developing an analysis from the information that is supplied by participants (Creswell, 2009:178). Burns and Grove (2009:479) define data analysis as the technique used to reduce, organise and give meaning to the data. Polit and Beck (2012:556-560) describe the process of data analysis as an assignment of the researcher to reduce a huge amount of information to certain patterns, themes and categories and interpret it with certain schema. The focus is on gaining an understanding of the phenomenon and conceptualising valid meanings from it, instead of giving general explanations or predictions (Babbie & Mouton, 2011). These strategies were followed in this study.

Transcribing

The audio recordings of the individual interviews and focus group discussions were transcribed verbatim (Hennink et al., 2011:211). The researcher read through the field notes several times. The process of verbatim transcription included writing down the details of the interviews word for word without leaving out information. The researcher used the method of Polit and Beck (2012:556-560) as a point of reference. Polit and Beck (2012:733) define method triangulation as the use of data collection about the same phenomenon to enhance rigor and validity. The data of the focus groups with field notes, and individual interviews with field notes were analysed separately and then merged (Table 4.5). These were the steps for data analysis followed:

- The text was transcribed from raw data that were supplied by participants (individual interviews or focus group discussions) with field notes.
- Data were converted to smaller, manageable units that were retrieved and reviewed. This conversion involved searching for patterns and emerging categories.
- Units were labelled according to their meaning.
- The researcher kept a code book. The codes were grouped together.

The categories were identified during the coding process. They were compared and combined, while the researcher was starting to assemble a comprehensive picture of the phenomenon. A list of categories was arranged and the texts were read again to see whether they made sense and there was consistency. All the transcripts and field notes were analysed. An experienced qualitative researcher specialist was requested to conduct the independent coding. The same transcripts, field notes and research protocol were sent to the co-coder. To ensure the credibility of the researcher data interpretations, an independent coder, who was an experienced qualitative researcher and university lecturer with a doctoral degree in nursing, analysed and interpreted the collected data. The researcher and the co-coder reached consensus on the codes, categories and sub-categories (Annexure U). Similar categories were obtained for focus groups and individual interviews and data merged when developing the strategy.

Use of thick descriptions

Hennink et al. (2011:239) posit that a vital part of qualitative data analysis is the provision of a thick description of a phenomenon by exploring its deep meaning and particularities. The thick description initiated from the information provided by the participants and the context in which the study was conducted (Chapter 4). In this study, the researcher supported qualitative data with literature. This was done by confirming the findings with knowledge from the literature about the competencies of nurse managers (Babbie & Mouton, 2011)

3.5.4 Trustworthiness

Guba and Lincoln (1985:290-331) identify criteria and strategies for establishing trustworthiness. These authors states that there are four criteria for establishing the trustworthiness of qualitative data, namely credibility, transferability, dependability and confirmability. These four criteria were followed in this study.

Table 3.7: Trustworthiness

Credibility	Prolonged engagement Persistent observation Triangulation Peer debriefing Member checking Negative case analysis Referential adequacy
Transferability	Saturation of data Thick description Purposive sampling
Dependability	Prolonged engagement

	Triangulation Member checking Data separately analysed by the researcher and the independent coder
Confirmability	Inquiry audit Triangulation

3.5.4.1 Credibility

Credibility refers to confidence in the truth of the data and their interpretations (Polit & Beck, 2012:585). When participants are involved, the researcher needs to ascertain that the results are believable from the perspective of the participant as the participant is the only one who can justifiably judge the integrity of the results (Polit & Beck, 2012:585). Credibility was achieved in this study through the use of data triangulation. Triangulation is defined as the use of multiple methods to collect and interpret data about a phenomenon, so as to converge on an accurate representation of reality (Polit & Beck, 2012:744). Qualitative researchers employ triangulation in their studies to reach sound interpretations of the real world and increase the validity of their findings (Guion, Diehl & McDonald, 2013:1). Furthermore, it assists with capturing a broad picture of the issue under investigation (Polit & Beck, 2012:590). The researcher used different methods of data collection: focus group discussions, unstructured individual interviews and field notes. The researcher also ensured credibility by revisiting the participants to verify the information. Patton in Polit and Beck (2012:583) postulates another indicator of integrity, which is the faith that can be put in the researcher who conducts the study. The researcher is a professional nurse and midwife with a master's degree in nursing, and has 17 years' of experience in nursing management. She was supervised by a senior academic, who holds a PhD degree with vast knowledge and experience in nursing management and leadership studies. The independent coder, who also holds a PhD degree with years of experience in qualitative research, assisted with the coding of the collected data, after which a consensus meeting was held.

3.5.4.2 Transferability

Transferability refers to the potential for extrapolation, that is, the extent to which findings can be transferred to or have applicability in other settings or groups (Polit & Beck, 2012:585). A complete research design, method and literature support of the findings were provided, to support transferability of the information (Guba & Lincoln, 1985:331). The researcher also ensured a thick description of the research data, the context and setting of the research study and the findings of the study. The study findings will not be generalised to all health facilities in the Western Cape, but can be evaluated in similar settings to be used.

3.5.4.3 Dependability

Dependability, according to Polit and Beck (2012:585), refers to the stability (reliability) of data over time and conditions. First, purposive sampling was conducted that maximised the range of data that could be obtained from and about the context by deliberately participants from different hospitals. Dependability was enhanced by the researcher by a thick description of the research method that was followed in the study. To enhance reliability of a research project, Creswell (2014:253) postulates voice recording and verbatim transcription of the interviews, writing detailed field notes and meticulously cross-checking the transcripts to ensure that there are no errors (Creswell, 2009:121). The enquiry audit also ensured dependability as relevant supporting documents were analysed by the researcher. The researcher provided a thorough description of the research methodology of the study and the interviews were transcribed verbatim and transcripts were cross-checked for errors to achieve dependability. The data collected were separately analysed by the researcher and the independent coder.

3.5.4.4 Confirmability

Confirmability refers to objectivity, that is, the potential for congruence between two or more independent people about the accuracy, relevance, or meaning of the data (Polit & Beck, 2012:585). The researcher documented the procedures for continual scrutiny of the data during the study with the help of the independent coder. The researcher provided an audit trail that comprised, for example raw data, analysis notes, process notes, personal notes and preliminary developmental information.

3.6 PHASE 2

QUANTITATIVE PHASE

Objective 2: To explore and describe the perceptions of Assistant Nurse Managers about the expected and their existing competencies for effective nursing management in public health facilities in the Western Cape.

3.6.1 Population and sampling

Population refers to individuals who have specific characteristics in common that are of interest to a researcher (De Vos et al., 2009:193). In Phase 2, the researcher conducted a survey. The population was ANMs (N=156) who were employed in the public health facilities in the

Western Cape. The population served as the total sample that were requested to participate in the study. The total number of assistant nurse managers per district is specified in Table 3.8.

Table 3.8: Population of Assistant Nurse Managers (N = 156)

DISTRICTS	ASSISTANT NURSE MANAGERS
District 1: Metro (central, tertiary, regional, psychiatric, rehabilitation and TB, district hospitals and community district centre)	114
District 2: Central Karoo (district hospitals and sub district)	4
District 3: Cape Winelands (regional, TB & district hospitals and sub district)	10
District 4: Eden (regional, TB & district hospitals and sub district)	9
District 5: Overberg (district hospitals and sub district)	5
District 6: West Coast (TB and district hospitals and sub district)	14
TOTAL	156

3.6.2 Research method

In this study, a survey was conducted. Polit and Beck (2012:736) define survey research as non-experimental research that obtains information about people's activities, beliefs, preferences and attitudes via direct questioning. A survey is a group of methods that apply to quantitative analysis (Grove, Burns & Gray, 2013:224). According to Grove et al. (2013:224), a survey is a technique of data collection in which questionnaires, collected by mail or in person, are used to gather information about a population. Data were collected through self-report and a self-developed instrument was developed from the findings of Phase 1. Polit and Beck (2012:353) state that in-depth qualitative research (Phase 1 in this study), which is an in-depth enquiry relating to a phenomenon, is a particularly rich source of scale items (instrument in Phase 2 of this study). Polit and Beck (2012:265) state that in a survey, standardised information is collected from individuals from a larger population of more than one hundred. The benefits of surveys are that they can accurately document outcomes and define associations among variables in a sample. With survey data, a researcher is able to draw reasonable conclusions about the situation in an effort to reduce bias (Polit & Beck, 2012:265). In addition, the researcher was able to obtain information from a sample that could be generalised to the population (Scott & Mazhindu, 2011:28).

3.6.2.1 Research instrument: questionnaire

In this study, a self-administered structured instrument was developed (Annexure J) for Phase 2. 'Self-administered' means that a researcher delivers an instrument to participants to complete on their own and in their own time, with the aim of returning it to the researcher

(Head, Stansfeld, Ebmeier, Geddes, Allan, Lewis & Kivimaki, 2013:2649). A self-administered instrument was considered cost-effective to administer and convenient, since participants completed their questionnaires individually without supervision. Five dimensions of competencies were addressed with 100 items (regarding competencies) in the questionnaire:

Legal and professional framework domain: (Items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 and 11).
Interpersonal domain: (Items 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35 and 36).
Evidence based domain: (Items 41, 42, 43, 44, 45, 46, 47, 48 and 49).
Strategic resource management domain: (Items 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73 and 74).
Leadership domain: (Items 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95 and 96).

Items 12 to 15, 37 to 40, 50 to 53, 75 to 78 and 97 to 100 were open-ended questions. The questionnaire contained items that focused on data that emerged from Phase 1. Each questionnaire had two sections. The first section required anonymous demographic data and the second required responses on the phenomenon of competencies of the ANMs, that is, questions on items 1 to 100 as highlighted above. The instrument had a left and right 4-point scale next to the items. The instrument measured 'expected competencies' on the left side and 'existing competencies' on the right with this scale:

To no extent
To a small extent
To a moderate extent
To a large extent

The participants were instructed to mark a block on each side of a statement.

Table 3.9: Example of scale

I have the following competencies: I am expected to have the following competencies

Item no	EXISTING 1	2	3	4	ITEM	EXPECTED 1	2	3	4
1		X			I communicate with my peers on the processes of problem-solving issues			X	

3.6.2.2 Data collection

Pretesting the instrument

Instrument pretesting is an evaluation process that seeks to establish whether there are ambiguities in the construction of an instrument before a main study (Dawson, 2010:100). According to Bezuidenhout (2011:55), the essence of the process is to comment on the structure and reveal whether participants could understand the instructions and whether confusing questions might affect the response rate from participants (Polit & Beck, 2012:296). Pretesting was conducted with five ANMs in a psychiatric hospital as experts to determine the clarity of questions, effectiveness of instructions, completeness of response sets, time required to complete the questionnaire, and the success of the data collection technique. The reason for choosing these ANMs was that they were in a similar working situation to the ANMs that took part in the study. Participants were requested to comment on the applicability and appropriateness of the questionnaire. All questions were answered, and corrections to the items were not required. The researcher determined that it could take thirty minutes to complete the questionnaire.

Permission and preparation of the field

Access to the ANMs was gained after ethical clearance had been received from the Higher Degrees Committee of the Faculty of Community and Health Sciences (CHS) and the Senate Research Committee of a university in the Western Cape. Approval was also received from the Western Cape Department of Health (Annexure K), where the research survey conducted. Preparation of the field meant that the researcher had to plan the collection of data carefully in the setting to ensure a high response rate (Hertel, Singer & Van Cott, 2009:305). The researcher had to answer questions such as:

- Where the data could be gathered?
- How could it be possible for all the participants to get the instrument in the same way?
- Was confidentiality ensured?
- Whom should participants contact when they need to have a question clarified?

Appointments were made at the health facilities to meet the ANMs to discuss issues pertaining to voluntary participation, consent (Annexure F) and confidentiality, the purpose of the research study, the importance of completing the questionnaire, and the date of handing out questionnaires in closed envelopes, and time for collection of questionnaires. The questionnaires were distributed to the participants by the researcher with the support of other nurse managers, and could be completed in their own time. It took about 30 minutes to complete the questionnaire, which was returned in a sealed envelope, at a time prearranged with the researcher, which was fortunate the same day.

3.6.2.3 Quantitative data analysis

Data analysis is the systematic organisation and synthesis of research data (Polit & Beck, 2012:725). Grove et al. (2013:45) indicate that quantitative data analysis is a way of working with lots of figures by putting them into rows and columns to make them practicable for the statistician or researcher. According to Speziale and Carpenter (2003:218) quantitative data analysis relies on the research questions, purpose and conceptual framework of the study. With the assistance of a statistician, the instrument items were analysed with the SPSS version 20.0 software program. Descriptive and inferential statistics were used to make sense of the data. Descriptive statistics were used to describe and synthesise data (Polit & Beck, 2012:379). In this study data were reported as frequencies (f), mean values ($\bar{x}$), percentages (%) and standard deviation (SD) Brink et al., 2012:172).

Frequency distribution is a systematic arrangement of values from lowest to highest, together with a count of the times that each value was obtained (Polit & Beck, 2012:382). Frequency distributions are used to organise numeric data. The mean value is a measure of central value for a continuous variable given for a sample of observations, from the sum of the observations divided by the number of observations (Bauer, 2009:88). In this study, mean values provided the mathematical basis for comparing two distributions: one for existing competencies and another for expected competencies. A standard deviation (SD) according to Bauer (2009:88) is a statistical measure of accuracy for a series of repetitive measurements. It indicates the average amount of deviation of values from the mean and is calculated with every score (Polit & Beck, 2012:387). A higher value of the SD showed that the data points were spread out over a large range of values, and thus with a lower precision. The lower value of the SD, the higher the precision, since data are more densely concentrated around the mean value.

Inferential statistics are statistics that permit conclusion about whether results observed in a sample are likely to be found in the largest population (Polit & Beck, 2012:379). Sha (2007:81) states that they are used to draw conclusions about the reliability and generalisability of the findings and allow the researcher to gather from the data by analysing the relationship between two variables. In this study, the inference also focused on whether there was a relationship between the existing and the expected level of competence and the significant difference between expected and existing competencies of ANMs.

Wilcoxon signed-rank test according to Polit and Beck (2012:743) was used to compare the mean ranks of existing and expected scores of each of the sub-scales. The mean difference is the difference between the average score of existing level of competence and the average score of the expected level of competence for each scale. A significance level of less than

0.05 meant that there was a significance difference between existing and expected scores (under the paired t- test) or that there was a relationship between existing and expected competencies (under Spearman correlation).

Spearman correlation is a correlation coefficient that indicates the magnitude of a relationship between variables measured on an ordinal scale (Polit & Beck, 2012:743). The Spearman correlation method was used to determine the relationship between the existing and expected levels of competence. The significant differences between expected and existing competencies of the ANMs using paired t-test were determined. With regard to the interpretation of correlation coefficient (ρ), there is:

No relationship between two variables if $\rho = 0$

A weak and positive relationship between two variables if ρ is positive and between 0.1 to 0.49

A moderate and positive relationship between two variables if ρ is positive and between 0.5 to 0.69

A strong and positive relationship between two variables if ρ is positive and between 0.7 to 0.79

A very strong and positive relationship between two variables if ρ is positive and between 0.8 and 0.9.

When the p-value is less than 0.05, then the interpretation is made that there is a statistically significant moderate and positive correlation between variable X and variable Y.

3.7 QUANTITATIVE RIGOR

3.7.1 Validity

The notion of measurement in research and standards demonstrated by a researcher create confidence in the reliability and validity of the findings (Grove et al., 2013:45). In this study, validity was the extent to which the developed instrument assessed the existing and the expected competencies of ANMs. The instrument was developed from the findings of Phase 1 with the guidance of the supervisor and statistician. Whether the instrument measured what it was supposed to measure was evaluated on a 4-point scale.

The instrument was assessed for *face and content validity*. Face validity refers to whether the instrument appears to be measuring the appropriate construct (Brink, 2008:160; Polit & Beck, 2008:458). Face validity was established through consultation with experts, who scrutinised

the questionnaire to establish the appropriateness of the questions and whether they corresponded with the objectives of the study (Polit & Beck, 2008:458).

Content validity concerns the degree to which an instrument has an appropriate sample of items for the construct to be measured (Polit & Beck, 2008:458). Content validity was achieved because the items were compiled from the data analysis in Phase 1. To assess for appropriateness, accuracy and representation of the specifications in relation to the topic, the instrument was reviewed by eight experts in the field of nursing management and health service management in the educational and Nursing Directorate. The pretesting was conducted with five ANMs from a psychiatric hospital to determine the clarity of questions, effectiveness of instructions, completeness of response sets, time required to complete the questionnaire, and the success of the data collection technique. Participants were requested to comment on the applicability and appropriateness of the questionnaire (Annexure J).

3.7.2 Reliability

Reliability was ensured by pretesting the instrument with five participants from a psychiatric hospital who were not part of the main study. The reliability of the measurement was enhanced by asking questions in the instrument that were relevant to participants and by ensuring that the questions were clear and unambiguous. There was limited scope for random error by the researcher because the questionnaire was self-administered. Completion did not require direct researcher involvement. The instrument was internally consistent to the extent that the items in the five domains –that is, legal and professional framework, interpersonal, evidence based, strategic resource management and leadership – measured the same trait, with Cronbach's Alpha coefficient (α) higher than 0.70. All five domains of the instrument obtained a value higher than 0.83.

Table 3.10: Level of reliability of each of the five domains

Domain	Scale Cronbach's alpha (α)	Number of items
Legal and professional framework	0.88	11
Interpersonal	0.93	20
Evidence-based Practice	0.83	9
Strategic resources management	0.94	21
Leadership	0.92	18

Chapter 4 describes the results in detail.

3.8 ETHICAL CONSIDERATIONS

Babbie (2010:64) defines ethical as 'conforming to the standards of conduct of a given profession or group'. The research proposal, which included the problem statement, purpose, design and methodology of the research, was first presented to a panel of academics and postgraduate students at the School of Nursing, University of the Western Cape, for critical review. After the proposal presentation, corrections were made before it was submitted to an ethics review committee at a university. Ethical approval for conducting the study was received from the Higher Degrees Committee of the Faculty of Community and Health Sciences (CHS) at the University of the Western Cape, South Africa. The registered ethical clearance number 13/4/23 was allocated to this research project. The Research Ethics Committee conducted a formal assessment of the research protocol adopted in this study and ensured that the research process to be executed ethically in a manner that protected the rights of the participants. Permission to conduct the study was also requested from the Western Cape Department of Health (Annexure K), and Heads of 3 public hospitals (Annexures L, M, N) where the research was conducted.

The ethical principles of the Belmont Report (National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, 1978) and the International Council of Nurses Code of Ethics for Nurses (ICN, 2012) directed the ethical approach of this research study. These are based on the three fundamental ethical principles of respect for persons, beneficence and justice.

The principle of respect for persons implies that individuals are autonomous and have the right to decide whether they want to participate in a study, to withdraw from a study at any stage, to refuse to provide information, and to ask questions relating to the study (Brink et al., 2012:35). Beneficence refers to the rights of participants to be protected from every form of physical, psychological, emotional, spiritual, economic, social and legal discomfort or harm (Brink et al., 2012:35). The principle of justice encompasses the participants' rights to fair selection and treatment. These three principles are anchored in the human rights perspective that acknowledges the protection of all human research participants' rights (Brink et al., 2012:35). These rights are discussed in more detail below.

3.8.1 Respect for informed consent

Informed consent is based on the principle that individuals should not be coerced, persuaded, or induced into participating in a research study against their will (Green & Thorogood, 2009:68), but in this study participated voluntarily with a complete understanding of the

implications of participation. The researcher provided all the potential participants verbally with an adequate explanation of the aims and objectives, risks and benefits of the study and the assurance of anonymity and confidentiality and an option to withdraw at any stage, and answered their questions. Information sheets with the same information were distributed to all the potential participants. The participants were told that they were welcome to contact the researcher or the research supervisor at any time if they had further questions about the study. Written informed consent forms (Annexures D, E and G) were distributed and permission obtained from the participants after they agreed to be interviewed (Phase 1) and the participants that had completed the instrument (Phase 2). All were informed that the information that was obtained was used for the purposes of the study and that their names could not be disclosed.

3.8.2 Right to privacy

Privacy is the freedom people have to determine the time, extent and general circumstances of sharing or withholding their private information from other people (Burns & Grove, 2011:114). Frequently, social research requires that participants reveal private information about themselves. It was important that their privacy should be respected and that they were not forced to participate in the research study (Babbie, 2010:64). The participants' privacy was regarded as being protected when they were informed about the study and when they gave their consent to participate in the study voluntarily and share private information with the researcher during interviews (Burns & Grove, 2011:114). They were not forced into disclosing information to the researcher. Interviews were conducted in a private room and participants completed questionnaires in their own time and returned them in sealed envelopes.

3.8.3 Right to anonymity and confidentiality

Anonymity requires the removal of all information that identifies or traces the research participants. A researcher has to exclude information that could identify a participant from the interview transcripts, questionnaires and research report (Hennink et al., 2011: 71). Confidentiality is assured when a researcher who could identify the participants' responses chooses not to disclose such information (Babbie, 2010:67). In this, all information was treated with strict confidentiality and used for research purposes only. The confidentiality of the data were maintained by using codes on questionnaires and disguising the tone of the recorded voice to avoid identifying information. Participants in the focus group discussions were requested to keep all information shared during the group interviews confidential. Only the researcher, supervisor, data capturer and independent coder had access to the data. Data will to be kept under lock and key for two years after publication of the results and then it will be destroyed by shredding. The findings will be disseminated to the university community and the wider academic community in presentations at the university and at conferences and in an article in a peer-reviewed journal.

3.8.4 Right to fair treatment

This right is based on the ethical principle of justice. According to this principle, research participants must be treated fairly (Burns & Grove, 2011:114). In this study, the research participants were selected fairly and they were all treated with utmost dignity and respect. The findings will also be shared with the participants in an article in an accredited peer reviewed journal.

3.8.5 Right to protection from discomfort or harm

The right to protection from discomfort or harm in a research study is based on the ethical principle of beneficence, which states that no participant should be harmed. Human research should never injure or cause damage in any form to the study participants, although they volunteered to participate (Babbie, 2010:65; Burns & Grove, 2011:114). The participants were informed that their participation could not harm them in any way. No sensitive questions were asked.

3.8.6 Right to withdraw from the study

Participation was free and voluntary. The participants were informed of their right to withdraw from the process at any stage, without prejudice. The researcher was available for consultation by the participants throughout the duration of the study.

3.9 PHASE 3

Development of a strategy

The objective was to develop a human resources strategy for addressing the gap between expected and existing competencies of Assistant Nurse Managers in public health facilities in the Western Cape.

From the findings of Phase 2, a strategic plan was developed. The survey list of Dickhoff, et al. (1968:434) was adapted as a reasoning map to serve as a framework for the strategy on competencies of assistant nurse managers in the public health facilities in the Western Cape. These questions were answered in developing a human resource strategy to facilitate competencies of assistant nurse managers in the public health facilities in the Western Cape:

- In what context is the (strategy) performed?
- Who or what performs the (strategy)? (Agent)
- Who or what is the recipient of the (strategy)? (Recipient)
- What is the guiding processes of the strategy? (Procedure)
- What is the energy source for the activity, whether physical, biological, or psychological? (Dynamics)
- What is the end point of the activity? (Terminus)

The objectives of the strategy (procedure) followed the adapted principles of SMART (Quirk & Fandt, 2000:89) and incorporated the theoretical assumptions as outlined in Chapter 1. The strategy had a plan that was set out with clear objectives, priority goals related to the gaps identified in the findings, and actions for each goal. Chapter 6 describes the process in full detail.

3.10 SUMMARY

In Chapter 3 the research methodology was discussed with reference to the research approach, population and sampling, research design, data collection and data analysis, that addressed the purpose of the study. Steps to ensure rigor and ethical considerations were discussed. The results of the data analysis are discussed in Chapter 4 and Chapter 5.

CHAPTER 4
FINDINGS FROM PHASE 1

4.1 INTRODUCTION

This chapter discusses the findings from the individual interviews and focus group discussions with nurse managers (Phase 1). The objective in Phase 1 was to explore the expectations of the SNM, DNM, ONM and the ANMs about the competencies of the ANMs in public health facilities in the Western Cape. The researcher briefly elaborates on the data collection and data analysis, followed by the findings (including the field notes). Literature supported the findings of the research.

4.2 BRIEF OVERVIEW OF THE FIELDWORK ACTIVITIES

The eight FGDs with ONMs and ANMs and fifteen unstructured individual interviews with SNMs, DNMs and ANMs were conducted over six weeks, from October 2013 to November 2013. The health facilities were visited by the researcher after requesting permission to conduct the study by email and telephone follow-ups. After permission had been granted, the researcher called the health facilities to confirm the interview dates and times. The researcher visited the participants, gave a briefing session, and those interested were given letters and written consent forms, which were collected at the interviews. The FGDs and unstructured individual interviews were held at pre- arranged venues, as described in Chapter 3. This room was conducive to data gathering because it was free from noise and distractions, and could accommodate the participants. After the participants had been settled, the researcher repeated the purpose of the meeting briefly, as stated in the letter (see Annexure C). They were informed that the research had received ethical clearance and were given information sheets containing the details of the study. All participants were encouraged to ask questions, which were answered appropriately, and they were reminded of their right to withdraw at any stage. The researcher facilitated all the sessions. The participants could speak and understand English, therefore the discussions were facilitated in English. Facilitative communication techniques (Chapter 3) were used. Likewise, the researcher practised bracketing to consciously recognise and avoid personal bias, which could have influenced the information. The discussions were voice recorded. The researcher wrote field notes to record nonverbal cues and the highlights of the discussions. These recordings were transcribed and the field notes were incorporated into the transcribed data to record the data as completely as possible. The FGDs and unstructured individual interviews were conducted to the point of data saturation.

4.3 COMPOSITION OF THE FOCUS GROUP DISCUSSIONS, UNSTRUCTURED INDIVIDUAL INTERVIEWS AND DEMOGRAPHIC PROFILE OF THE PARTICIPANTS

The **focus group discussions** in this study were conducted with ONMs (n = 44) and ANMs (n = 16) from the public health facilities in the Western Cape (Table 4.1).

Table 4.1: Composition of the eight focus group discussions and demographic profile

Focus group	Participants	Description of participants		Number of participants per FGD
		Participants' code	Gender	
* FG 1	Operational Nurse Managers	P1	Female	8
		P2	Female	
		P3	Female	
		P4	Female	
		P5	Female	
		P6	Female	
		P7	Female	
		P8	Female	
FG 2	Assistant Nurse Managers	P1	Female	8
		P2	Female	
		P3	Male	
		P4	Female	
		P5	Female	
		P6	Female	
		P7	Female	
		P8	Female	
FG 3	Operational Nurse Managers	P1	Female	8
		P2	Female	
		P3	Female	
		P4	Female	
		P5	Female	
		P6	Female	
		P7	Female	
		P8	Female	

FG 4	Operational Nurse Managers	P1	Female	6
		P2	Female	
		P3	Female	
		P4	Female	
		P5	Female	
		P6	Female	
FG 5	Operational Nurse Managers	P1	Female	8
		P2	Female	
		P3	Female	
		P4	Female	
		P5	Female	
		P6	Female	
		P7	Female	
		P8	Female	
FG 6	Operational Nurse Managers	P1	Female	6
		P2	Female	
		P3	Female	
		P4	Female	
		P5	Female	
		P6	Female	
FG 7	Operational Nurse Managers	P1	Male	8
		P2	Female	
		P3	Female	
		P4	Female	
		P5	Female	
		P6	Female	
		P7	Female	
		P8	Female	
FG 8	Assistant Nurse Managers	P1	Female	8
		P2	Female	
		P3	Male	
		P4	Female	
		P5	Female	
		P6	Female	
		P7	Female	
		P8	Female	

* Pilot

Fifteen **unstructured individual interviews** were conducted among participants employed at the public health facilities in the Western Cape. These interviews were conducted with ANMs (n = 5), DNMs (n = 7), NMs (n = 1) and SNMs (n = 2). Table 4.2 shows the composition of each of the unstructured individual interviews.

The results of the focus group are addressed first under Point4.4, and the results of the individual interviews under Point 4.5.

Table 4.2: Composition of the unstructured individual interviews and the demographic profile (n = 13)

Interview	Participants	Description of participants	
		Participants' code	Gender
1 *	Deputy nurse manager	P1	Female
2 *	Nurse Manager	P2	Female
3	Deputy nurse manager	P3	Female
4	Deputy nurse manager	P4	Female
5	Deputy nurse manager	P5	Female
6	Assistant nurse manager	P6	Female
7	Assistant nurse manager	P7	Female
8	Assistant nurse manager	P8	Male
9	Deputy nurse manager	P9	Male
10	Senior nurse manager	P10	Female
11	Senior nurse manager	P11	Female
12	Deputy nurse manager	P12	Female
13	Assistant nurse manager	P13	Female
14	Assistant nurse manager	P14	Female
15	Deputy nurse manager	P15	Female

*Pilot

4.4 EXPECTATIONS OF OPERATIONAL NURSE MANAGERS ABOUT COMPETENCIES OF ASSISTANT NURSE MANAGERS

The data collected during the FGD of the ONMs were analysed and six categories and seventeen sub-categories emerged. The summary of the findings is presented in Table 4.3. Each of the categories was discussed with supporting quotes from the results, for example ONMFG6, P3 refers to Operational Nurse Manager 3 in Focus Group 6.

4.4.1 Categories and sub-categories

The six categories were; i) knowledge of healthcare environment and its process; ii) technical skills; iii) managerial skills; iv) interpersonal skills; v) professionalism and leadership; and vi) support.

Table 4.3: Categories and sub-categories identified from data analysis in relation to the expectations of the operational nurse managers

CATEGORIES	SUB-CATEGORIES
Knowledge of healthcare environment and its process	Operational Nurse Manager expects Assistant Nurse Manager to know the following:
	Legislation
	Clinic monitoring/ Job Description/ Clinical experience
Technical skills	Operational Nurse Manager expects Assistant Nurse Manager to be skilled in the following:
	Writing reports
	Acting as a resource
Managerial skills	Operational Nurse Manager expects Assistant Nurse Manager to manage resources:
	Staff allocation
	Training of staff
	Strategic planning
Interpersonal skills	Operational Nurse Manager expects Assistant Nurse Manager to have the following:
	Effective communication
	Managing conflict
	Provision of feedback
	Openness/honesty/trust
Professionalism and leadership	Operational Nurse Manager expects Assistant Nurse Manager to have the following competencies:
	Up skilling of staff members
	Orientation for OPS managers
	Succession planning/teaching
	Engaging with OPS manager
Support	Operational Nurse Manager expects Assistant Nurse Manager to be there for them:
	Mentoring
	Guidance and support

4.4.2 Category 1: Knowledge of healthcare environment and its process

Findings from the FGDs showed that ONMs expect ANMs to have knowledge of the healthcare environment. This refers to demonstrating understanding of the healthcare system and the environment in which healthcare managers and providers function (Stefl, 2008:364).

4.4.2.1 Sub-category: Legislation

Legislation is the act or process of making or enacting laws. Because nursing care poses a risk of harm to the public if practised by professionals, who are unprepared or incompetent, the state, through its police powers, is required to protect its citizens. SANC was established in terms of the Nursing Act (Act 33 of 2005) to protect the public and uphold and maintain professional nursing standards; promote the provisioning of nursing service; and establish, improve, control conditions, standards and quality of nursing education and training. The mentioned Act prohibits anyone from practising as a nurse practitioner if he or she is not

registered with the SANC. The ONMs expressed their views of the role and responsibility of the ANMs in terms of legislation. It was specified that managers are expected to know the acts and circulars and provide guidance to the ONM when needed. One participant expressed her dissatisfaction with the lack of guidance in legislation:

> '*You also expect the managers to know the acts varied from they should know it more, they can know it word for word but also the education of it. You should know your circulars, what's new, what's old, what needs to be updated because when I come to you and say: 'I have this dilemma, I need to move A to B, can I? is the hospital allowing me in a memo to move A to B, no she said I must go find out. But you actually should have'* (ONMFG3, P4).

ANMs as heads of nursing services or heads of nursing components should have knowledge of labour relations. They are professional nurses with human resources management as one of their most important functions. A nurse manager has dual accountability, namely to ensure the quality of nursing care in his or her service and to provide quality management of that service. It was found that ANMs were expected to manage labour relations matters well. Local labour stability could be vital to the effectual delivery of health services. One participant expressed her experience around the delegation of labour relation duties to the ONM and said:

> *'Nurse manager also needs to have a very strong labour relations background, so they need to be able to know how to manage any labour relation queries and then should not expect an operational manager to do that, eh right to the, so that when you encounter problem on the ground floor at operational level and cannot deal with it any longer'* (ONMFG5, P1).

According to the participants, one of the roles and functions of the ANMs was to participate in the analysis, formulation and implementation of nursing policies, guidelines, practices, standards and procedures. ANMs are required to implement policy changes that are often driven by regulatory agencies, such as state health departments and the joint commission (Regan & Rodriguez, 2011:101). Furthermore, they should review and revise policies and circulars and not expect the ANMs to remind them and they should ensure execution of nursing policies. This was evident from what an ONM participant said ('was adamant', according to field notes), that the ANM should review policies regularly:

> *'And if there is any shift in how we used to do things, they should take part in policy changes, they should be reviewing policies on a regular basis, issues arising on a regular basis about certain things not going well, then surely it's not up to the OPM to say this policy needs to be reviewed'* (ONMFG5, P5).

Policies and procedures have been suggested as one possible strategy for moving research evidence into practice among nursing staff in hospitals. Squires, Mordejo and Le Fort (2007:13) suggest that nurses use policies and procedures to guide their practice. However, the mere existence of policies and procedures is not sufficient to translate research into nursing practice. Stefl (2008:364) asserts that newly appointed managers, for example should consult a policy manual to deal with distraught and angry patients and family members. A mid-level manager, however, should already be familiar with the protocols governing the situation and could

employ strategies and responses that have effectively diffused similar situations. A senior-level executive could respond more intuitively, recognising patterns in the situation and knowing implicitly when to apply rules and when to be more creative (Stefl, 2008:366).

Concluding statements

It appears that the ANM is expected to have the foundation competencies of:

- Knowing the acts and circulars and providing guidance to ONMs when they are in a dilemma;
- Creating a setting for review and updating of patient-care policies and procedures;
- Having a background knowledge of labour relations;
- Participating in the analysis, formulation and implementation of nursing policies; and
- Reviewing and revising policies when requested is needed.

4.4.2.2 Sub-category: Clinical experience

Clinical experience involves the care and treatment of patients. ANMs are nurse leaders in their area of experience. ANMs are required to have educational qualifications and experience according to the National Department of Public Service and Administration (2007:21). These posts differ in title and years of experience, (see Annexures O, P, Q, R), as it is important to understand the context of the various posts, that is Assistant Manager Nursing (Area), Assistant Manager Nursing (Head of Nursing), Assistant Manager Nursing (Specialty) and Assistant Manager Nursing (Primary Healthcare).

There is a considerable gap in the articulation of 'what should be done' by way of generic and specific competencies at national level and 'what is done' to translate these into everyday working lives of clinical nurse/midwife managers at regional and hospital level in particular (Milner, 2005:761). Furthermore, there is a need to develop management skills of clinical nurse/midwife managers to ensure effective nursing management of the unit (Milner, 2005:761). It is expected of an ANM to possess clinical competence and management skills to function in the role. An ONM referred to speciality training as an essential requirement for an ANM:

> *'They should be trained in which ever field that they are going to work in, like if they are coming in to paediatric or orthopaedic or theatre or psychiatry, they should have that, they must be a paediatric or psychiatric trained'* (ONMFG1, P6).

Some researchers have established the need for certain clinical competencies and skills (Lindholm, Sivberg & Uden, 2000:330; Boucher, 2005:220) and the ability to implement evidence-based care initiatives (Dopson & Fitzgerald, 2006: 47). One participant stated that in her understanding, clinical experience is essential for speciality nursing:

> *'They must be experienced in that clinical field, they must be a specialist'* (ONMFG1,

P3).

The nurse's clinical role is a complex process of interaction between the nurse and the client, who requires knowledge of the guiding partner (Mendes, Cruz & Angelo, 2015:329). This point of view was shared by a participant:

> *'What I am thinking about is that a manager should have experience in how to manage the client so that she can guide me in how to manage mine, often it's not what you do'* (ONMFG1, P7).

Participants expected the ANM to have the knowledge, skills and competencies to fill the post. In addition, the ANM should be up to date with current trends in nursing. Protagonists for a specific health management model believe that health managers require additional competencies owing to uniqueness of the health environment (Pillay, 2010:546). A statement expressing this view included:

> *'My expectation is for a manager is to have the necessary knowledge, skills and competencies in order to fill the post'* (ONMFG1, P2).

Clinical skills are considered important in middle management. Hence skill development training should be aimed at enhancing this skill (Meissner & Radford, 2015:788) as a participant pointed out:

> *'It exceptionally valuable when your nurse manager is experienced, she's got skills and competencies herself because then they can identify what are the shortcomings in their assistant nurse manager'* (ONMFG1, P16).

The need for partnerships between healthcare professionals continues to increase as new healthcare needs, trends, and issues arises (Klein, 2011:17), and it was mentioned:

> *'I think a person should also be up to date with current trends in nursing'* (ONMFG5, P5).

Providing middle managers with a more formalised process could enable the organisation to provide guidelines around the required skills and knowledge (Meissner & Radford, 2015:290). Another participant revealed:

> *'My labour ward, it's for her to have knowledge skills or insight of a labour ward and how to treat the patient and care'* (ONMFG7, P2).

The perception that clinical experience, knowledge, skills and competencies are required for effective nursing management is shared by Chase (2010:2), who asserts that among nursing leadership, the nurse manager's role has been identified as critical in the provision of effective and efficient care.

Concluding statements

It seems that the ANM is expected to have the foundation competencies of:

- Having a speciality training qualification;
- Implementing knowledge management;
- Having clinical competence, experience, knowledge and skills to fill the post and function in the role; and

- Being abreast of current trends in nursing.

4.4.3 Category 2: Technical skills

Technical skills involve knowledge of process and technique and proficiency in certain specialised fields, such as computers, engineering, accounting or manufacturing. These skills are more important at the lower level of management since these managers are dealing with employees who do the organisation's work at operational level. Chase (2010:29) views technical skills operationally as an understanding of and proficiency in a specific kind of activity, particularly one involving methods, processes, procedures or techniques. Technical skills involve the manager's understanding of the nature of the job that people under him or her have to perform. The participants indicated that the ANM should display technical skills, which include computer literacy and acting as a resource for the ONM.

4.4.3.1 Sub-category: Computer literacy

Computer skills are defined in this study as proficiency in the use of computer hardware and software (Staggers, Gassert & Curran, 2002:384). The nature of healthcare is being transformed in response to environmental drivers such as the demand for cost–effective delivery of high-quality services and enhanced patient safety. It is evident that the nurse manager should be computer literate to provide computer technical support:

> *'You expect some technical support, with computer, information management'* (ONMFG5, P11).

Changes have occurred in nursing, including computer skills courses, digital library workshops, establishing websites in hospitals, and developing information technology (IT) training in the curriculum of nursing students to increase accessibility to best practice information and provide an opportunity for nurses and students to use research-based information in their clinical decision-making (Mehdi, Hassan, Soheila & Jamilei, 2013:369). However, a participant indicated that nurse managers lack computer skills:

> *'There is an expectation that you need to be computer literate, even that is a struggle for nurse manager'* (ONMFG5, P11).

It is vital that nurses should have the ability to use selected applications in a comfortable and knowledgeable way. It is essential that nurses should feel confident in their use of computers and software in the practice and management setting. Staggers et al. (2002:383) assert that healthcare professionals need to be computer literate and have informatics knowledge and skills. These can range from using a clinical application and knowing basic technology terms to more advanced concepts of nursing structured languages and evaluating the impact of e.g. a clinical information system on (Staggers et al., 2002:383). McNeil, Elfrink, Beyea, Pierce and Bickford (2006:53) concur, stating that to meet the demands for change, healthcare providers

need the knowledge, skills, and resources to communicate and manage information effectively and efficiently in an electronic environment.

Concluding statements

It appears that the ANM is expected to have the supporting competencies of:

- Being computer literate to provide computer technical support;
- Being confident in his or her use of computers and software in the practice and management setting.

4.4.3.2 Sub-category: Act as a resource for Operational Nurse Manager

Being resourceful is not having all the answers, but knowing where to find answers. Researchers describe five effective decision-making behaviours for staffing: resourcefulness, tactful communication, flexibility, decisiveness, and awareness of the big picture (Wilson, Talsma & Martyn, 2011:805). One participant mentioned that the ANM should provide help when needed:

> *'She actually needs to be a resource for us so that when we don't know, especially when we don't go for updates, because it's a struggle to go'* (ONMFG1, P4).

Another participant shared the opinion that an ANM is expected to have knowledge and skills and should provide an opportunity for exposure:

> *'The person should have that knowledge and skills to know what to do and also expose us to the opportunities and it must be somebody that is proactive, not reactive in the way that he or she handles situations'* (ONMFG1, P8).

Policies promote and protect the health of communities by integrating public health actions with a primary care approach across all necessary sectors (WHO, 2011:5). It is evident that it is the responsibility of the ONM to know the policies, but corporate and provincial policies must be provided by the ANM. One participant stated:

> *'You know it's also our responsibility to know our policies, but corporate or provincial policies they must provide'* (ONMFG, P7).

Wickramasinghe (2003:298) argues around the dissemination of knowledge and information being vital to successful management of an organisation. One participant stated:

> *'They should be reading articles and disseminating that information to the operational managers'* (ONMFG5, P5).

It is apparent that the ANM is expected to act as a resource for members of the health team and policy makers. With everything that is expected of a nurse manager in this role, many hospitals have dedicated resources to help them succeed, going well beyond traditional manager orientation (Hudson-Thrall, 2006:71). This author further states that some organisations provide special on-site training, some send nurses to programmes offered by universities and professional groups, and some link nurses with mentors and support groups (Hudson-Thrall, 2006:71).

Concluding statements

It seems that the ANM is expected to have the competencies of:

- Supporter by being resourceful and instrumental to the ONM to provide help when needed;
- Having foundation competencies regarding knowing the policies and disseminating corporate and provincial policies.

4.4.4 Category 3: Managerial skills

The findings indicated that staff allocation, training and strategic planning were the managerial skills that were essential for the ANM. Well-developed managerial skills and experience should be acquired to organise and direct assigned areas of responsibility (NDoH, 2012:103).

4.4.4.1 Sub-category: Staff allocation

Nurse managers take full responsibility for ensuring that processes are in place to enable staffing establishments to be met on a shift-to-shift basis. Furthermore, nurse manages should allocate staff, and routinely monitor shift-to-shift staffing levels, including the use of temporary staffing solutions, seeking to manage the immediate implications and identify trends. The current statistics in South Africa, as reported in the Health Affairs Act, No 3 of 2004, indicate that there should be 472 professional nurses per 100 000 of the population (Jooste, 2010:96). This author recommends that staffing for any unit must have adequate professional skills and competencies (Jooste, 2010:96). While referring to staff allocation one participant commented:

> *'She can help find staff for an example find staff in the entrant for the next shift so that the work can continue'* (ONMFG1, P5).

Hennerby and Joyce (2011:239) suggest that it the responsibility of the middle manager to allocate staff and recruit agency nurses as needed to address staffing for the duty roster. This is supported by Jooste (2010:96), who stated that the planning of staffing is a major task of the nurse manager. Consideration must therefore be given to the type of client care, the education and the level of knowledge required of the nurse, the budget constraints of the organisation, and the historical background of staffing needs.

Concluding statements

It appears that the ANM is expected to have the interaction competencies of:

- Assuming responsibility for staffing and scheduling personnel and recruit nurses as needed; and
- Allocating staff members to units in new and creative ways.

4.4.4.2 Sub-category: Training of staff

Staff development is an important function in ensuring optimal utilisation of healthcare professionals in an organisation and is key to quality healthcare (Jooste, 2010:249). Staff development refers to a well-planned, comprehensive system of continuing professional growth activities carried out over time to achieve specific institutional goals and objectives (Jooste, 2010:249). Participants highlighted the value of staff training. They said that the ANM is responsible for ensuring appropriate training for personnel:

> *'This person must be in that way and also identify your needs while we are working with you because often we see what our needs are and they should have the ability to see other needs are that we maybe cannot see and guide me towards those fulfilling those'* (ONMFG1, P 8).

Although the ward manager is likely to be extremely clinically competent, he or she often lacks the skills to achieve the organisation's HRM objectives effectively (Townsend, Wilkinson & Kellner, 2015:213). A participant mentioned that people development was important amongst supervisors:

> *'To identify the gaps in the skills of those people that they are working with and also be keen to develop those people'* (ONMFG7, P8).

A hospital should identify what training and other resources are required and how it should be addressed (WCDoH, 2010:26). The in-service training programme must be structured in such a way that there are internal training and external training courses:

> *'You should have regular updates, regular training sessions, whether it can be internal or external'* (ONMFG5, P4).

The findings in this study as reflected by the participants suggest that the ANM should assume responsibility for identifying skills gaps, professional development and maintenance of competence in staff. These findings are supported by Chase's report (2010:2), which indicated that because of everything that is expected of nurse managers in the role, some organisations provide special on-site training, some send nurses to programmes offered by universities or professional groups; and some link nurses with mentors and support groups. On the other hand, Luo, Shen, Lou, He and Sun (2016:87) argue the it is essential to understand what competencies should nurse managers have in order to establish suitable training programmes and improve the management skills.

Concluding statements

It seems that the ANM is expected to have the supporting competencies of:

- Ensuring appropriate training for personnel;
- Identifying the personnel's skills gaps, needed training areas, and address the skills gaps; and
- Providing regular updates and training sessions.

4.4.4.3 Sub-category: Strategic planning

Strategic planning as defined by Kotler and Armstrong (2012), cited in Booyens et al. (2015:73) involves a process of developing and maintaining a strategic fit that is aligned with the organisation's goals and capabilities and its changing marketing opportunities. According to these authors, a strategic plan involves adapting the organisation to take advantage of all opportunities in its ever-changing environment (Booyens et al., 2015:73). Pillay (2011:177) defines strategic planning as an organisation's or institution's process of defining its strategy or direction, and making decisions on allocating its resources to pursue this strategy. It may extend to control mechanisms for guiding the implementation of the strategy. Strategy involves setting goals, determining actions to achieve these goals, and mobilising resources to execute the actions (Pillay, 2011:177).

It is essential to implement effective performance management systems for all categories of staff and set norms for all categories and clinical areas based on best care practices, staff satisfaction and quality of services (National Department of Health, 2012:47). There was a general agreement among the participants that nurse managers should engage in strategic planning:

> *'They should start doing strategic planning and assist us with policies and provide structure'* (ONMFG7, P7).

Another participant reflected the nurse manager's need to be part of strategic planning:

> *'Your manager needs to part with you in that vision and goal, needs to give you tools to achieve those goals, and needs to be an on-going dialogue between the operational manager and the nurse manager about where you* go, *so periodically how are you getting with your goals, what strategies have you employed'* (ONMFG5, P1).

The latter is supported by Carney (2004:14), who states that involvement of middle managers in strategy development is an important stimulus to strategic thinking and therefore the strategies formulated with middle management are likely to be superior to those designed solely by top managers.

Concluding statement

It appears that the ANM is expected to have the foundation competency of:

- Engaging in strategic planning, which entails formulation of a vision and goals, achievement and strategies employed in achieving these goals.

4.4.5 Category 4: Interpersonal skills

The first important skills that a job may require are interpersonal affective emotional skills that allow working with other people (Slipicevic & Masic, 2012:106). Findings from the FGD reflected that the ONM expects the ANM to have good interpersonal skills. These are the life

skills we use every day to communicate and interact with other people, individually and in groups. People who have developed strong interpersonal skills are usually more successful in their professional and personal lives. Leaders can benefit from further development of the interpersonal and leadership skills that are needed to create direction, alignment, and commitment in the organisation (Center for Creative Leadership (CCL), 2016:13).

4.4.5.1 Sub-category: Effective communication

Communication refers to interaction between employees and management. Communication is seen as the link between management, peers, colleagues and the entire institution. Effective communication between professionals is critical to information transfer and patient safety (Koivunen, Niemi & Hupli, 2015:621). However, Jooste (2010:205) concurs that during communication, conflict is an unavoidable part of life because health professionals have different perceptions of the goals, values, priorities and methods of operation in any institution. Participants reflected on several issues that affect communication, indicating that it is expected of the ANM to have good listening skills. Participative management involves using effective listening skills and communication to involve others, build consensus and influence others in decision-making (CCL, 2016:6). One participant said:

> *'They must just have a listening ear and if u listen then maybe you'll have an understanding why the person is performing the way they are'* (ONMFG3, P3).

The literature reveals that the aim of listening is to form or address a question to which one does not know to which one does not know (Bunkers, 2015:105). Listening is important in communication. It is responsible nursing practice and requires concentration of attention and mobilisation of all the senses for the perception of verbal and non-verbal messages emitted by each patient (Kourkouta & Papathanasiou, 2014:66). It was also specified that a manager must show interest in people that might have problems that could affect their work performance. In addition, it is necessary to acknowledge workers for the work that they do:

> *'To be a manager you must really be interested in people and not think the people are just workers and I mean like we all have problems and sometimes affects your work performance that you must give'* (ONMFG3, P3).

Another participant stated that it is expected of the nurse manager to communicate and engage with the ONM constantly especially if the ONM is a new employee:

> *'And then the other thing is communication also, effective communication and especially when they know you just started they should maybe try to engage with you on a regular basis'* (ONMFG7, P6).

It became evident that effective communication was needed, with the ability to communicate clearly and concisely with employees. When reflecting in greater detail on these participants'experiences, it was clear that the ANM should be closer to all employees, and engage with them regularly.

The quality of interactions between managers and nurses was viewed as essential to effective communication (Marx, 2014:965). Effective communication in the organisation is characterised by the free flow of information, active participation of employees in organisational activities, good interpersonal relationships, team spirit and high productivity (Regan & Rodriguez, 2011:101). Support for effective communication was stated:

> *'They should be competent in communication'* (ONMFG7, P4).

It is reasoned that nurse managers' unique position in the structure has given them special insights into operational problems, where they can make valuable contributions to change initiatives (Marx, 2014:965). On the other hand, Lanning and Doyle (2010:158) state that the appropriateness of the message is critical for effective communication. The message needs to be delivered in such a way that it promotes an increase in functional health literacy of the receiver, and it should be clear, unambiguous and linguistically appropriate for the intended receiver (Lanning & Doyle, 2010:158). A participant mentioned that messages should be clear and unambiguous:

> *'That messages are relayed in a clear concise manner that is not ambiguous, that is the same message being given consistently, as supposed to two different messages, that is written, documented, via email or memo style'* (ONMFG5, P2).

Good communication is an essential ingredient of a vibrant, well-performing organisation that has a shared vision, is focused on its goals, and is committed to person-centred care (Western Cape Department of Health, 2010:128). Effective communication remains an important goal for bureaucracies as it is the cement that bonds the organisation's functions, and failure to communicate has resulted in effective and inefficient operations (Marx, 2014:965). Nonetheless, a participant verbalised that communication should be a top-down approach, emphasising transparency:

> *'I could say open communication, from top to bottom, filter down and to be transparent, eh, all that goes with that, like the verbal, the written, the emails'* (ONMFG6, P2).

De Oliveira and Tuohy (2015:1081) agree with the participants' notions, that effective communication could improve institutional relationships and build trust between employees and management. It is obvious that participants agree that ANM' role in communication is to improve management-employee relationships, peer relationships, trust, guidance and providing support.

Concluding statements

It seems that the ANM is expected to have the interaction competencies of:

- Having good listening skills;
- Showing an interest to people who might have problems in the workplace and acknowledge them for work done;
- Communicating and engaging the ONM constantly especially if the ONM is a new

employee;

- Being able to communicate clear guidelines, for example the procedure to move equipment
- from one unit to another
- Being competent in communication;
- Sharing a common vision through ongoing dialogue with all stakeholders; and
- Encouraging the free flow of information in a top-down approach ensuring transparency

4.4.5.2 Sub-category: Managing conflict

Daft (2005:410) defines conflict as a hostile or antagonistic interaction in which one party attempts to thwart the intentions or goals of another. A conflict exists when two or more parties (individuals, groups or organisations) differ over facts, opinions, beliefs, feelings, drives, needs, desires, goals, methods and values (Bach & Ellis, 2011:57). Participants verbalised that management of conflict is essential:

> '*Management of conflict is another thing that they need to'* (ONMFG7, P11).
> *'I expect my manager to manage conflict'* (ONMFG1, P3).

While conflict in the nursing profession has traditionally been reported as generating negative emotions, it can have positive effects, such as creating new policy, increasing competition and improving the quality of nursing care, assuming that the conflict could be managed productively (Al-Hamdan, Norrie & Anthony, 2014:41).

Hendel, Fish and Galon (2005:137) state that nurse managers deal with conflicts daily. The choice of conflict management mode is associated with managerial effectiveness, and the ability to creatively manage conflict situations towards constructive outcomes is becoming a standard requirement' (Hendel et al., 2005:135). Conflict management is the process of planning to avoid conflict where possible and organising to resolve conflict when it does happen as rapidly and smoothly as possible (Bach & Ellis, 2011:57).

Concluding statement

It appears that the ANM is expected to have the interaction competency of conflict management.

4.4.5.3 Sub-category: Feedback

Muller, Bezuidenhout and Jooste (2011:325) describe feedback as the perceptions of the receivers of a message determine the effectiveness of communication. Feedback is more effective if the nurse manager focuses on the values and needs of the receiver when conveying a message, rather than concentrating solely on what he or she wants to get across. These authors further state that having received feedback, the receiver should be able to fully understand the situation and what he or she is expected to do about it (Muller et al., 2011:325). In this study

the participants complained that the ANMs were not providing feedback in terms of staff performance management system (SPMS) appraisals. The ANM should play an essential role in creating an empowering work environment for their staff. For the ANM to be able to empower others, management must provide access to resources (Regan & Rodriguez, 2011:101). The ONMs indicated that they had to write their own SPMS appraisals and then took it to the manager to sign. It seems that their performance was never discussed with them to improve their behaviour.

One participant ('appeared to be frustrated with the problem of not getting feedback with regard to strategic planning' (field notes)) verbalised her dissatisfaction at never getting feedback, only hearing about strategic planning, and not knowing what was involved, while some of her colleagues laughed in the background:

> *'You hear about strategic planning, you never hear the feedback, you hear about strategic planning, and you don't know what it entails'* (ONMFG2, P7).

Feedback from meetings involves letting others know in a straightforward manner what you think of them, how well they have performed, and whether they have met your needs and expectations (Gerstberger & Gromala, 2010:48). The same point of view was shared by a participant, who specified that the ANM should report about the meetings they attend:

> *'Giving the feedback of the meetings'* (ONMFG6, P2).

Constructive feedback is linked to the situation in which output from, or information about the result of an event in the past could influence the same event in the present or the future (Duffy, 2013:51). Duffy (2013:51) states that students want feedback that addresses positive and negative aspects of their practice so that they can identify progress and areas that require development. A benefit of constructive feedback is that it aims to promote improvement or development of the person (Duffy, 2013:51-52). Similarly, a participant verbalised that she expected the ANM to give constructive feedback when she does something wrong:

> *'If I have done something wrong here I need a constructive feedback'* (ONMFG7, P4).

Performance management is the process of defining clear objectives and targets for individuals and teams, and includes a regular review of achievement and eventual rewarding for target achievement (Hennerby & Joyce, 2011:241). The findings in this study that nurse managers managed performance management effectively, supported the reports of Tulgan (2007:20), who suggested that new nurse managers receive little management support. Most managers do not spend the time with new appointees in order to set expectations, track performance and offer feedback. One participant said:

> *'You need feedback from your nurse managers because I don't know about everybody else but in the past when it comes to SPMS time I normally have to write my own SPMS and then take it up to my manager to sign, but my performance is never discussed with*

me to say you good in this, you good in this, you need to improve on this, you need to improve on that' (ONMFG5, P3).

Likewise, a participant reflected on the experience ('smiling and making gestures with hands and laughing' (field notes)):

'We experience the same … hahahaha ' (ONMFG5, P3).

It is evident that from the findings of the study that nurse managers are not giving feedback to their staff. Hence a feedback-rich working environment is essential for effective nursing management. Muller et al. (2011:325) suggest that feedback should be a planned endeavour, identifying the topic on which feedback should be given, and contemplating what it is about the topic to be conveyed. Having received feedback, the receiver should be able to fully understand the situation and what he or she is expected to do about it (Muller et al., 2011:325).

Concluding statements

It seems that the ANM is expected to have the interaction competencies of:

- Providing feedback meetings to the staff;
- Discussing and providing feedback in terms of their SPMS appraisals;
- Providing constructive feedback to staff members and expecting them to respond promptly to issues that need attention; and
- Providing feedback to the ONM on recent developments in the service.

4.4.5.4 Sub-category: Openness, honesty and trust

Managers who establish and maintain solid relationships are respectful, diplomatic, and fair. They are able to relate to all kinds of people and easily gain the support and trust of peers, higher management, and customers (CCL, 2016:15). Senior leadership should support a culture of honesty and openness (Rhoads & Kuhn, 2014:3). These authors state that the crucial quality of trust is that the individual's words and actions should be seen by others to coincide and express a consistent set of values (Muller et al., 2011:391). The future success of managers and leaders centres on their ability to develop and sustain the levels of trust in an organisation and its leadership. Nurse managers have a responsibility to adhere to ethical conduct, which includes maintenance of confidentiality when dealing with staffing matters:

'We need an advocate for us as well, someone you can go to that's trustworthy or when you have personal issues then they don't have to hear by this one and that one' (ONMFG3, P3).

Confidentiality means not disclosing information about a person without his or her consent or permission, while trust has to do with the feelings or assurance that one can rely on another person (ICN, 2012). A participant viewed the ANMs as managers that should be respectful, trustworthy and maintain confidentiality:

'Respect, they must show respect and confidentiality and they must show trust' (ONMFG28, P8).

Another participant iterated that an ANM needed to maintain confidentiality:

'I just wanted to touch on the confidentiality, whatever you tell her must just stay in confidence' (ONMFG3, P3).

The role of an ANM involves communication with staff, patients, and members of the interdisciplinary healthcare team (Regan & Rodriguez, 2011:101). Lack of honesty and transparency could lead to absence of trust, which can result in disloyalty. Effective communication plays a major role in ensuring honesty and transparency. This view is emphasised by one participant:

'Openness and transparency that includes communication, effective communication. Eh, honesty, empowerment' (ONMFG5, P1).

It appeared that the ANM lacked confidence in certain areas. Hence, one participant raised the view that she expected the ANM to inform her that she was uncertain:

'She must also have that confidence to tell me that she doesn't know and refer me to someone that knows' (ONMFG3, P3).

It became evident from the findings that the level of trust is maintained by ensuring constant transparency, openness and honesty in every respect. This is supported by Chase (2010:39, 47), who stated that the nurse manager is expected to treat others with respect, trust employees to do their work and have self-trust.

Concluding statements

It appears the ANM is expected to have the interaction competencies of:

- Maintaining trust through talking openly about challenges that need to be addressed in the workplace; and
- Adhering to work ethics, which includes maintenance of confidentiality when dealing with staffing matters.

4.4.6 Category 5: Professionalism and leadership

Professionalism is defined as a skill, competence, expertise, know-how, efficiency (Muller et al., 2011:415). Leadership is defined as a complex process by which a person influences others to accomplish a mission, task or objective and directs the organisation in a way that makes it more cohesive and coherent (Muller et al., 2011:415). This competency involves cultivating an environment in which all employees can contribute to their full potential in support of the organisation's structure.

4.4.6.1 Sub-category: Upskilling of staff

Organisational training and development, succession planning and individual feedback, coaching, and development efforts should address healthcare gaps (CCL, 2016:4). To enhance

nursing management capacity, appropriate training and development programmes to upskill nurse managers must be established. The necessity of empowering the ONM was stressed:

> *'And the empowerment of all the Operational Nurse Managers in your area not certain alone the ONM you see like in the office, so all the ONM must get a chance to work'* (ONMFG5, P3).

All nursing staff in each role are expected to share their expertise informally and through formal avenues, such as the roles of preceptor, coach, and mentor, as well as programmes that prepare one for these roles (McCallin & Frankson, 2010:320). The importance of mentoring and teaching the ONM by the ANM was emphasised:

> *'They must mentor me, teach me how to balance my work, how to do my admin'* (ONMFG1, P7).

Community health workers are an important component of the South African healthcare system, who should be accredited and undergo training in line with the NDoH (2012:45). The nurse managers raised the need for training in management skills and financial management in an established institution:

> 'We need more *courses that will upskill us'* (Int 13).

The same participant elaborated that in terms of enabling the managers to gain managerial skills, there was a need for a management course:

> *'We need eh some courses, I will say at established institutions'* (Int 13).

Similarly, Morley, Gunnicle, O'Sullivan and Collins (2006:615) note that organisations struggle with the question of whether human resource activities (training and development) should be provided in-house or outsourced:

> *'You should have regular updates regular training sessions, whether it can be internal or external, you'* (ONMFG5, P2).

The literature on employee training supports the view on managers and employees' development needs that must be addressed continuously (Plakoyiannaki, Tzokas, Dimitratos & Saren, 2008:274).

Concluding statements

It seems that the ANM is expected to have the supporting competencies of:

- Enhancing nursing management capacity for nurses. Appropriate training and development programme to upskill the operational nurse managers should be established; and
- Offering training in management skills and financial management in an established institution.

4.4.6.2 Sub-category: Orientation for operational nurse managers

Induction is the first step towards gaining an employee's commitment. It involves orientation and training of the employee in the organisational culture and guiding the ways in which he or she is linked to the departments of the institution. (Cloete & Allen-Payne, 2009:50). The induction and orientation programme are intended to enable the new employee to become a

useful member of the team (Palma, 2009:10). The operational nurse managers nursing expressed the need to be oriented in operating a unit:

> *'I think it must be part of the orientation so that you can have a little knowledge in how to operate in a unit'* (ONMFG7, P9).

Likewise, another participant commented that there is a necessity for orientation for new employees:

> *'They must also have orientation for new people because I'm coming from private not that we don't know what to do'* (ONMFG7, P4).

To have a functional health system, there is need to orient the management and select a proportional structural model because the organisational structure in the dynamic healthcare environment is important. Participants believed that there should be an orientation place for the newly appointed ONM designed by the ANM:

> *'I mentioned that I could've loved them to have an orientation plan in place for the new operational manage'* (ONMFG7, P5).

Similarly, a participant verbalised the need for orientation and provision of support in a new position:

> *'Orientation and support is really important when you come into this position really'* (ONMFG7, P5).

A designated clinical teaching unit or clinical teaching department could be established at each clinical facility and district office. Such units could be responsible for the clinical training of student nurses, staff development, in-service training of qualified nursing staff, and induction and orientation of new nursing staff and community service nurses (NDoH, 2012:88). The participants stated that the ANM must have an orientation programme or plan in place for the ONM, which could guide them in adjusting to new surroundings and circumstances. It was clear that operational nurse managers expect the assistant nurse managers to have an orientation programme for them. One participant stated:

> *'So we are saying that the assistant nurse managers should have a programme orientation for the operational nurse managers'* (ONMFG7, P5).

One participant (appeared to be irritated with the problem of absence of an orientation plan (field notes)) complained that there was no orientation plan for operational nurse managers, but that they were expected to perform the duties delegated to them although they are not oriented:

> *'But there was no orientation, but then they expect when they want something, it must be this way and that way'* (ONMFG7, P5).

Induction checklists are designed to give employees and their line managers a guide to a logical and comprehensive procedure and provide the employer with a record of the employee's induction (Health Service Executive, 2014:8). A participant mentioned:

> *'We are doing this roll call, we are not orientated to do this and I ask her what you are doing'* (ONMFG7, P5).

Induction and orientation are essential to gain the employee's commitment. The process should cover the employer and employee's rights and the terms and conditions of employment. The programme, according to Palma (2009:10) and Allen-Payne (2009:69), is part of an organisation's knowledge management process and is intended to enable the new starter to become a useful, integrated member of the team.

Concluding statements

It appears that the ANM is expected to have the supporting competencies of:

- Ensuring the ONM are oriented on how to operate a unit; and
- Conducting updated orientation sessions for new employees.

4.4.6.3 Sub-category: Succession planning

Succession planning is a process for identifying and developing internal people with the potential to fill leadership positions in an organisation (Booyens et al., 2015:157). Marquis and Hudson (2011:243) define succession planning as a designed system of training and developing people so that they acquire the skills, insights, attitudes and values to manage people and their work effectively. Some ONMs showed resentment towards standing in for ANMs having lack of knowledge of what is expected of her to do:

> *'We spoke about the assistant manager and the dual role that affect you and the nursing component I felt often decisions within an FBU and you stand in and its way over your head and I have been in those meetings maybe for months, two months in a time, because she finds herself sick and then I am supposed to stand in for her, I have no clue because a lot of the FBU stuff don't filter it down to the ground level what is expected and what I also felt that the things that are being discussed at that level at such an extent that they sometimes think they have filtered it, but it hasn't, and so you feel humiliated, I felt humiliated and to be told ' oh, let's wait for so-and-so because she'll know'* (ONMFG3, P5).

Succession planning ensures a well-prepared nursing workforce. A formalised, effective succession plan for recruiting and preparing potential leaders must be developed, implemented, and maintained (Griffith, 2012:901). Through the succession planning process, employees with potential are identified and their knowledge, skills and abilities are developed (Griffith, 2012:901). It is evident that the ONM should have a succession plan in which every ONM has the opportunity to fulfil some of the duties of the ANM. One participant said:

> *'I think for the managers coming should have an succession plan, a succession plan where every operational nurse manager has the opportunity to fulfil some of those duties or be exposed to that and that must happen over the year and for every year, maybe if we have a 3 or 5 year plan, then we can work towards that'* (ONMFG1, P14).

Succession planning is a strategic process involving identification, development and evaluation of intellectual capital, ensuring leadership continuity within an organisation (Titzer, Phillips, Tooley, Hall & Shirey, 2013:972). Succession planning increases the availability of experienced and capable employees that are prepared to assume these roles as they become

available (Palma, 2009:10). Sherman, Bishop, Eggenberger and Karden (2007:87) argue that nurses in middle and senior leadership positions have a responsibility to assess current leadership talent, define the needs for the future, and develop strategies for succession planning.

Concluding statements

It seems that the ANM is expected to have the supporting competencies of:

- Having leadership succession planning that prepares employees to assume management roles in the absence of their managers; and
- Ensuring that succession plan employees are exposed to peer teaching.

4.4.6.4 Sub-category: Engaging with Operational Nurse Managers

It is vital that the ANMs should constantly engage with ONMs, communicating the organisational purpose, vision, mission and goals and outlining key opportunities, building relationships and facilitating interaction, which could result in outstanding performance (Murphy & Cooper, 2000:231). One participant articulated the need for the ANM to share institutional goals with the ONM:

> *'Your manager needs to part with you in that vision and goal, needs to give you tools to achieve those goals and needs to be an on-going dialogue between the operational nurse manager and the nurse manager about where you, so periodically how are you getting with your goals, what strategies have you employed'* (ONMFG5, P1).

One participant expressed the view that the ANM should set goals and guidelines that focus on the role of an ONM:

> *'You need to have clear goals and guidelines from them'* (ONMFG5, P1).

The current role of the ANM as a middle level nurse manager is not only to supervise the smooth day-to-day running of the unit and ensure quality care, but to manage staff and administer organisational policy and budget (Ganz, Wagner & Toren, 2015:45). A participant indicated that the ANM should involve the ONM in e.g. budgetary planning:

> *'To involve the operational managers in budgetary planning, keep on being told the budget, the budget, the budget'* (ONMFG5, P6).

Concluding statements

It appears that the ANM is expected to have the interaction competencies of:

- Engaging with the ONMs, communicating the organisational vision and goals, building relationships and facilitating interaction that effect outstanding performance and produces results with assistant nurse managers;

- Use authority in assisting the ONM in the development of the departmental strategic plan;
- Collaborating with members of the health and social care teams;
- Participating in decision-making pertaining to healthcare delivery by attending external meetings; and
- Involving the ONM in budgetary planning.

4.4.7 Category: Support

Findings from the FGDs reflected that the ANM is expected to provide support to nurses. The objectives of the national nursing strategy are to ensure strong leadership that provides appropriate support, guidance and direction to nurses and ensures that adequate resources and support systems are available for nursing services (NDoH, 2012:16).

4.4.7.1 Sub-category: Mentoring

Mentoring future leaders is a critical succession planning element and must be a deliberate and strategic action (Laframboise, 2011:70). Furthermore, mentoring future leaders provides a nurturing 'learning environment' (Swearingen, 2011:1). The participants thought that nurse managers have responsibility to guide and mentor personnel who are accountable to them. One participant stated that the ANM as a supervisor has the responsibility to guide and mentor:

> *'My indication of a supervisor is to guide and to mentor'* (ONMFG3, P2).

Current nurse leaders acting as mentors transfer key organisational knowledge to potential successors (Swearingen, 2011:1). Mentorship is an interpersonal process that is engaged between an experienced healthcare provider and a less experienced healthcare provider (Jooste, 2017:254). Hence the ONM expects the ANMs to provide support and mentor them. Marshburn, Crickmore, Rose, Dutton and Hudson (2012:28) state that nurse managers spent time mentoring charge nurses, providing indirect patient care, doing rounds in the unit, talking to patients and families, and attending meetings with senior executives and nursing leaders. One participant expressed her view that the ANM should provide guidance and mentoring to ONM:

> *'They must be able to guide us and mentor us because we have to stand in for them most of the time'* (ONMFG4, P1).

Mentoring should be seen as part of continuous professional programme. It is suggested that managers should designate a recognised leader to mentor future leaders. This has been recognised as an effective practice to stimulate aspiring leaders and engage new nurses in leadership positions (Trepanier & Crenshaw, 2013:982). One participant outlined the role of the mentor:

> *'They must mentor me, teach me how to balance my work, how to do my admin, how to teach, you know how to make sure everything is in there, its running smoothly'….* (ONMFG1, P7).

Similarly, another participant verbalised the need for the ANM to mentor the ONM to demonstrate how they interact at various levels and with multidisciplinary teams:

> *'They must mentor us to model how he/she interact between the different levels, how she interacts between the doctors and the professors but still remains as a nursing manager'* (ONMFG1, P14).

The perception that nurse managers are expected to mentor nurses is shared by McCallin and Frankson (2010:320), who indicate that mentoring is fundamental to the nurse manager's role, as is the need for continuing professional development. One participant emphasised the need for the ANM to mentor ONMs:

> *'They are there to support but they should get mentors from some of the old managers to mentoring us, is the thing that they are neglecting because there is nothing in place'* (ONMFG7, P5).

Griffiths (2012:907) emphasises the importance of mentoring at every stage in the development of a nurse's leadership and managerial competency.

Concluding statements

It seems that the ANM is expected to have the supporting competencies of:

- Guiding and mentoring personnel accountable to her or him;
- Having power to mentor followers by planning their career paths;
- Providing mentorship programmes to influence healthcare providers to obtain competencies for delivery of quality care; and
- Being assertive, exercise his or her rights while recognising those of fellow members of staff.

4.4.7.2 Sub-category: Guidance and support

Jooste (2017:141) defines support as being available and approachable. Nurse managers have a responsibility to provide support and guidance to personnel accountable to them (Stefl, 2008:366). It is reported that middle managers have limited opportunities to prepare for their new roles (Jeon, Glasgow, Merlyn & Sansoni, 2010:194). This leads to role ambiguity and ultimately poor management and leadership (Jeon et al., 2010:194). It is crucial that senior managers provide guidance and support to middle managers during role transition, navigating the complexity and tensions of the role (Meissner & Radford, 2015:790). A participant commented:

> *'Able to guide me as an operational manager in order to provide better supervision and also support the team'* (ONMFG1, P3).
>
> *'Is expected of the nurse managers to guide the operational managers and support, they should be risk taken as well'* (ONMFG1, P3).

An excerpt from another participant supported the view that the assistant nurse manager should provide guidance to operational nurse manager nursing so that that the ONM can come to them for guidance:

> *'I can just run to them and expect them to guide me and what they were saying that this is a tertiary hospital'* (ONMFG1, P4).

Another participant reflected that a manager must guide her, raising the importance of having management experience to do so:

> *The thing I am thinking about is that a manager should have experience in how to manage the client so that she can guide me in how to manage mine, often it's not what you do'* (ONMFG1, P7).

A participant revealed that the ONM should feel confident to approach the ANM, and the ANM should provide answers to questions posed by ONM:

> *'I should be confident to go to her and she should provide me with the answers that I do not have because you encounter problems in your unit'* (ONMFG3, P2).

This point of view was shared by another participant, who claimed that there is uncertainty about dealing with disciplinary cases, and the ANM is expected to provide guidance:

> *'Especially in disciplinary cases, we don't know how and where and what and she is supposed to guide you or contact that person and tell us to ask that person or something like that and confirm how to do it'* (ONMFG3, P3).

Access to support refers to the availability of guidance from the supervisor, for example, receiving helpful advice (Spence Laschingera, Noskob, Wilkc & Finegand, 2014:1618). A participant mentioned:

> *'But at least my senior will take me through the journey to at least to show me and not assume that I know everything because you are a new OPM and you've never been an OPM before so at least you need a guidance before you start to do anything'* (ONMFG28, P2).

Another participant iterated her expectation that the ANM should guide and support her and not assume that she knows everything:

> *'You expect your assistant manager to guide you and support you and not to assume that you know everything and if like you don't know how to do whatever'* (ONMFG7, P2).

A supportive supervisor works with all elements of the healthcare delivery system to create an environment in which high-quality health services can be provided (WHO, 2010). It is evident from the findings of the study that the ONMs expect the ANM to guide and support them in the performance of their duty.

Concluding statements

The ANM is expected to have the supporting competencies of:

- Providing support to personnel accountable to nurse manager; and
- Acting as a role model by guiding operational nurse managers in supervisory skills to promote team work.

4.5 EXPECTATIONS OF THE SENIOR NURSE MANAGERS, NURSE MANAGERS, DEPUTY NURSE MANAGER AND ASSISTANT NURSE MANAGER ABOUT COMPETENCIES OF ASSISTANT NURSE MANAGER

The data collected during the unstructured individual interviews of the senior nurse managers, nurse managers, deputy nurse managers and assistant nurse managers and focus group discussions of assistant nurse managers were analysed together and seven categories and twenty sub-categories emerged. A summary of the findings is presented in Table 4.4.

4.5.1 Categories and sub-categories

The data analysis showed that the senior nurse managers, nurse managers, deputy nurse managers and assistant nurse managers expect the assistant nurse managers to have certain competencies to fulfil their role. Seven categories and twenty sub-categories emerged. The categories were i) interpersonal competencies; ii) personal mastery; iii) professional competencies; iv) technical skills; v) leadership skills; vi) knowledge of healthcare environment and its process and vii) support.

Table 4.4: Categories and sub-categories from individual interviews and focus group discussions

CATEGORY	SUB-CATEGORIES
Interpersonal competencies	Self-confidence & assertiveness
	Communication skills
	Conflict management skills
	Relationship building
Personal mastery	Self-development/self-motivation
Professional competencies	Human resource management
	Financial resource management
	Strategic planning
Technical skills	Technology and computers
	Research activities
Leadership skills	Feedback
	Education and training and upskilling
	Innovative
	Responsibility towards ONM
Knowledge of the healthcare environment and its processes	Patient care
	Clinical skills and activities
	Legislation
	Scope of practices
	Healthcare system outcome
Support	Support and guidance

Each of the categories was discussed with supporting quotes from the results. For example, *Int 3* refers to Participant 3 in the individual interviews.

4.5.2 Category 1: Interpersonal competencies

Findings from the interviews reflected that the ANM is expected to have interpersonal competencies. There is a popular view in the project management community that project

managers are managers of change or change agents, according to Crawford and Nahmias (2010:405), but others (Partington, Pellegrinelli & Young, 2005:87) consider that projects or programmes that require major behavioural and organisational change, particularly those that might be characterised as second-order change (Gareis, 2010:315), demand high levels of interpersonal skills.

4.5.2.1 Sub-category: Self-confidence and assertiveness

According to Van Dyk et al. (2016:536), self-confidence is a glorious feature of an effective nurse manager. Self-confidence is strengthened by quality and performance. Experience as a nurse is an important component of confidence and self-efficacy. There is a need to develop educational programmes for nurse managers to enhance their self-confidence and self-efficacy, and to maintain experienced nurse managers in the role (Van Dyk et al., 2016:536). When people are performing well, they become more confident. Individuals who are confident speak up when they are wronged, challenge unfairness, strive for positive change, work well with others and bring energy and enthusiasm to their work. Managers and executives who are effective in leading employees invest in others and push decision-making to the lowest appropriate level, developing employees' confidence in their ability to take action (CCL, 2016:15). The ANMs are expected to be confident and assertive: A participant indicated:

> *'A sense of self confidence and who they are of course a sense of responsibility and accountability'* (Int 3).

Another participant emphasised the need for assertiveness and self-assurance:

> *'To have been assertive, be self-assured'* (Int 3).

Competence and confidence are the essential structures of empowerment (Ahn & Choi, 2015:1303). A participant accentuating the significance of competence and confidence:

> '*You must be competent and confident … to relate with your staff members that have been assigned to you'* (Int 14).

The importance of a manager being confident in a broader sense than nursing was expressed:

> *'Nurse manager needs to be confident in different fields'* (Int 7).

Jooste (2010:201) states that self-confidence entails awareness of one's self (assurance, confidence) and becoming assertive.

Concluding statements

It seems that the ANM is expected to have the foundation competencies of:

- Being confident, competent, self-assured and assertive in their work area;
- Taking initiative by proposing suggestions with confidence in an open arena; and
- Taking a risk confidently about a specific solution.

4.5.2.2 Sub-category: Communication skills

Communication refers to the process of interaction between employees and the managers, and can be verbal or written. Nurse managers are the conduit of communication between upper management and the bedside staff, providing key messages and setting the culture for their units and organisation (Chase, 2010:4). The participants mentioned the factors that could enhance communication skills, and build a trusting relationship between employees and managers. A participant stated the importance of integrity:

> *'Integrity, it's loyalty, it's listening skills, it's being impartial, it's being objective and you know, but again it's easy for me just to spit that out but you must be able in every situation that you are faced, you must be able to first and foremost be able to sit down if you feel that you are a manager'* (Int 11).

Nurses communicate with patients, their families and other health professionals in a wide range of circumstances for which they need appropriate communication skills (Philip, Manias & Woodward-Kron, 2015:2627). Furthermore, listening is placed at the centre of human communication, and Bunkers (2015:104) posited that listening involves a place from which human beings can both be and become. A participant revealed that the ANM should be respectful, honest, and communicate effectively with good listening skills:

> *'You actually respect people, you are able to communicate, you are able to be truthful, you are able to be a good listener'* (Int 11).

Mentors are required to assess and provide feedback on such aspects as the students' applied knowledge base, interpersonal skills, attitude, psychomotor skills, professionalism, safety and motivation for professional development (Duffy, 2013:51). Similarly, a participant stated that managers should have good interpersonal skills and communicate effectively:

> *'They need to have good interpersonal skills, they need to communicate effectively'* (Int 4).

Likewise a participant verbalised that the ANM should communicate effectively and build trusting relationship with personnel:

> *'I should be competent to effectively communicate and relate with them and build a trust relationship'* (Int 14).

It is essential to revive and coordinate the professional associations which give the nursing profession a sense of belonging and enhance professionalism (NDoH, 2012:44). An ANM is expected to have positive characteristics:

> *'I expect that person to be a good communicator, a motivator'* (Int 9).

Communication is a vehicle that can drive and build trusting relationship between employees and management. Jooste (2015:196) states that the purpose of communication is to enquire, inform, persuade, entertain, request and investigate.

Concluding statements

The ANM is expected to have the interaction competencies of:

- Being respectful, honest, communicate effectively and build trusting relationship with personnel;
- Being a good communicator and motivator;
- Having effective communication; and
- Maintaining professional working relationships based on sound work ethics.

4.5.2.3 Sub-category: Conflict management skills

Brinkert (2011:80) defines conflict as involving two or more people in perceived opposition. A review of conflict in nursing demonstrated the importance of its causes, costs and benefits (Brinkert, 2010:148). Conflict management refers to the modes used by either or both parties to cope with a conflict (Hendel et al., 2005:139). Conflict resolution is prescribed 'not simply as a mechanism for dealing with difficult differences within an existing social system, but also as an approach that can facilitate constructive social change towards a responsive and equitable system (Fisher, 2000:176). Conflict management style refers to the individual's characteristic modes of managing disputes in interaction episodes (Al-Hamdan et al., 2014:42). A participant stressed uncertainty in managing conflict:

> *'How do we manage difficult conversations, somebody is intoxicated on duty or drunk, how are we going to manage difficult conversations'* (Int 11).

Managers must manage conflict during difficult conversations in order to provide an environment that stimulates personal growth and ensures quality patient care (Al-Hamdan et al., 2014:42). A participant stated that it is essential to manage difficult conversation:

> *'They need to be able to manage difficult conversations'* (Int 4).

The proposed Office of Health Standards Compliance (OHSC) could perform functions that include investigating complaints relating to the national health system (South Africa, 2012:337). A participant emphasised ('was adamant' (field notes)) that the ANM should be able to deal with public and patients' complaints:

> '*They should be able, to be able to deal effectively with the public and patients, you know with, with complaints, deal effectively with complaints within distributed timeframe'* (Int 4).
>
> *'You must be able to manage conflict'* (Int 3).

The need for the ANM to manage conflict is supported by literature, which demonstrates the need to develop the conflict communication competencies of nurse managers and frontline nurses and to extend organisational dispute resolution processes to individual level (Brinkert, 2011:90).

Concluding statements

The ANM is expected to have the interaction competencies of:

- Managing conflict on the basis that parties indicate their commitment to finding an amicable solution;

- Dealing with public and patients' complaints;
- Using various strategies to resolve conflict in the workplace;
- Addressing patients and the public complaints satisfactorily within an appropriate timeframe; and
- Solving problems by using a specific framework.

4.5.2.4 Sub-category: Relationship building

Relationship building is defined as an influence on behaviours, ability to work with diversity, and shared decision-making. According to AONE (2005:16), 'relationship comprises shared decision-making, multi-disciplinary and academic relationship and influence'. It was reported that middle-level managers and leaders should focus more on team building in every aspect of management and leadership (MacPhee, Skelton-Green, Bouthillette & Suryaprakash, 2012:166). One participant expressed her view on team building:

> *'Know that they should have team building, they should set an example and I'm not going to go into the detail of that its part of the core'* (Int 10).

This point of view was shared by another participant, who emphasised the need for a team-building session and complimenting staff for good work:

> *'... and we have a system that starts at modular level, teambuilding session ... look at what they do right and complimenting staff for good works done'* (Int 4).

Acknowledging your co-workers and praising them for the job well done is one of the principles in achieving positive relationships between healthcare professionals (Jooste, 2010:141). One participant claimed that the ANM should develop and acknowledge healthcare professionals:

> *'Awarding and acknowledgement of them. We do not only develop people, we also acknowledge'* (Int 10).

Strategic Objective number 3, to ensure nurses' expertise is relevant to the context in which nursing care is provided – emphasises the need to develop workplace systems that support common professional ethical values and behaviour (NDoH, 2012:65). The need for the ANM to have a good relationship with the multidisciplinary team was emphasised by one participant:

> *'They need to be able to have collegial relationship with the whole multidisciplinary team, to the doctors whatever and be able to put nursing's point across and they understand that we are, we are not the support system, we are professionals'* (Int 13).

One participant stated that as an ANM she is expected to be competent and confident to relate with her team:

> *'Competent and confident to relate with your team, and also with multidisciplinary team and role players of your component and also be able to see outside of the boundaries of the hospital, the wards, also to communicate with other, with your other colleagues in the institution and then be part of the bigger team'* (Int 14).

Team building includes rewarding and acknowledging good work. Managers who are effective team leaders set clear goals and expectations and are able to resolve conflict, motivate team members, and help individuals to understand how their work fits into the goals of the organisation (CCL, 2016:15).

Concluding statements

It appears that the ANM is expected to have the interaction competencies of:

- Providing team building and feeling competent and confident to relate with the team;
- Focusing on diversity in the workplace and building trust among the employees with the aim of ensuring productivity;
- Promoting shared decision-making;
- Providing team building opportunities;
- Acknowledging outstanding professional work; and
- Having people management skills.

4.5.3 Category 2: Personal mastery

Findings from the interviews reflected that the ANM is expected to have personal mastery competencies.

4.5.3.1 Sub-category: Self-development and self-motivation

Self-development is defined as committing to lifelong learning and personal mastery (Russell & Scoble, 2004). Similarly, Jooste (2010:201) believes that it is worthwhile to become more positive, to feel that it is possible to achieve personal growth and bring about change in how you feel and work. Personal development includes improving self-awareness, self-knowledge and learning new skills. Providing tailored opportunities for personal and professional development that is mindful of the individual's core self-evaluation is important, particularly in terms of appraisals of self-efficacy, which are amenable to change with practice opportunities, verbal encouragement, and exposure to successful role models (Spence Laschingera et al., 2014:1620). One participant emphasised the necessity for nurse managers to be abreast of developments in healthcare:

> *'So you have to keep yourself abreast as a competent nurse manager'* (Int 11).

Likewise, another participant verbalised the need to be updated by buying books about new developments:

> *'So in order to gain that especially to refresh and also to, eh, get myself updated, maar this is not about women and child health anymore; this is our component so I had to buy books, get myself going so that I can be aware when the nurses are talking about things I need to know what they talking about'* (Int 14).

Students should maintain and increase their motivation, boost their confidence and self-esteem, improve interpersonal relationships, promote personal development, develop teamwork and build competence, thereby enhancing the quality of care delivered to patients (Duffy, 2013:52). Another participant shared this view:

> *'Your own development, what do you want to achieve and then also training in your department because development of your staff is very important'* (Int 7).

A male participant verbalised the necessity for enthusiasm for developing themselves:

> *'Assistant Nurse Manager needs to be eager to develop her or himself to further her studies'* (Int 19).

A participant emphasised the need to develop herself, and spoke of the rewards of self-development and of developing the staff that she supervises:

> *'How necessary it is to develop yourself and to… how good it is actually to develop yourself, how rewarding it is to develop yourself, not only for yourself but for your staff and the people you come into contact with, the people you supervise'* (Int 3).

It is evident that it is essential for the ANM to develop themselves to become skilful and knowledgeable in nursing management. Personal development includes improving self-awareness, self-knowledge and learning new skills. Jooste (2010:201) confirms this view, stating that self-development entails an awareness of one's self (one's own abilities, tasks, and leadership role) and becoming assertive.

Concluding statements

It seems that the ANM is expected to have these supporting competencies:

- Having appropriate self-awareness to satisfactorily address own limitations and strengths;
- Having knowledge to identify needs that require learning new skills and staff development; and
- Initiate activities to develop fellow workers.

4.5.4 Category 3: Professional competencies

Empowered staff are more likely than un-empowered employees to start to behave in ways that maintain professionalism, even in challenging environments. This increases work effectiveness (Regan & Rodriguez, 2011:103). The category of professional competencies is supported by the sub-categories of human resource management, financial resource management and strategic planning, which are discussed below.

4.5.4.1 Sub-category: Human resource management

Human resource management (HRM) is understood in the broadest sense of the term as encompassing all decisions and actions that affect the nature of the relationship between the organisation and employees, its human resources (Muller et al., 2011:240). The purpose of HRM is to enable integrated decisions about the employment relationship that will influence

the effectiveness of the employees and the organisation, ensuring organisational growth, employee productivity and stronger financial performance (Muller et al., 2011:240). The HRM discipline offers a wide range of strategies to assist managers at all levels when dealing with the complexity and challenges of managing people effectively (O'Donnell, Livingston & Bartram, 2012:199). A male participant stated that HRM, the disciplinary code and procedures are mainly the manager's job:

> *'Human resource management is a very big concern because this is mainly your job, human resource, disciplinary code and procedures, recruitment'* (Int 6).

'Faced with the need to deliver world-class standards of healthcare by highly trained and motivated professional staff, there is an emerging awareness that more HRM strategies could improve performance both in terms of staff satisfaction, staff retention, positive patient outcomes and cost effectiveness' (O'Donnell et al., 2012:198). A participant stressed the need for nurse managers to be knowledgeable in HRM, that is, disciplinary procedures and management of leave:

> *'For starters you the person must know the human resource management skills, it's not just the matter where you just know how to discipline somebody, you know how to fill in a leave form, it's not just that, human resource management is a wide component'* (Int 11).

Similarly, a different participant stated that a manager should be knowledgeable in HRM:

> *'A manager to be able broadly to know the aspect of human resources management'* (Int 3).

Armstrong (2000:6) and Meyer et al. (2004:2) refer to HRM as the management of an organisation's employees to achieve the objectives of the business.

Concluding statements

It appears that the ANM is expected to have the foundation competency of:

- Possess human resource skills to perform the function of ANM effectively; and
- Implementing staffing and staff development, recruitment and retention, management of absenteeism and disciplinary measures.

Staffing

According to Muller et al. (2011:326-327), staffing is one of the major problems of most healthcare organisations. Nurse staffing methodology should be an orderly systematic process, based on sound rationale, and applied to determine the number and kind of personnel required to provide the nursing care according to the standards of nursing practice. This view is shared by Jooste (2010:96), who indicated that staffing means determining how many people of what skills are needed and making them available. One participant commented:

> *'How to handle the situation and you have everyday problems and complaints that you have to staff distribution during the night'* (Int 6).

In South African private hospitals, nurse managers use patient profiles, not budget indicators, as the driving force for a safe skills mix. That is, staffing norms are not calculated only in terms of paid patient days or occupancy levels (Jooste & Jasper, 2012: 59). Patient acuity, based on professional and functional dependencies, is the departure point for general and specialised units. An optimal skills mix is totally dependent on the utilisation of the right numbers for the right reasons at the right service levels with the right skills, in all situations (Jooste & Jasper, 2012:59). Similarly, another participant said that it is expected of an assistant nurse manager to analyse staffing needs and develop a plan to meet them:

> *'They must be able to analyse staffing needs, day to day or in advance what sort of staff do they need or specific particular service'* (Int 10).

Given the unpredictability inherent in hospital care, hospitals can staff according to peak demand or the average patient census and add nursing staff when needed (Shindul-Rothschild & Gregas, 2014:158). A participant shared this view, indicating that a manager must take charge and calculate staff:

> *'You are going to take charge in, how much staff must you have and how do you calculate that staff, if you calculate that staff you must know what package each staff'* (Int 10).

A participant described the implications of staffing as part of the functional business unit:

> *'The cost of staffing forms part of the functional business unit and also you know we look at attendance, eh, you know the attendance profile of staff because that all affects our budget, the use of consumables items'* (Int 4).

According to Tierney (2010:21), consideration must be given to the type of client care required, the education and the level of knowledge required of the nurse, the budget constraints of the organisation, and the historical background of staffing needs (Tierney, 2010:21). Reasonable nurse staffing and proper nursing care assignment are required to secure patient safety and provide high-quality nursing care (Tierney, 2010:73). There is a delicate balance between the increased nursing care needs for patients and cost containment requirements of hospitals. Therefore healthcare delivery systems must examine nurse staffing and nursing care delivery. Nursing staffing levels are reported to be a determinant of nursing care quality and patient outcomes. It has been demonstrated that higher nurse staffing levels are associated with better outcomes, including lower mortality rates, lower failure to secure rates, and shorter hospital stays (Jianga, Lib, Gua, Lua & Yec, 2015:106). Another participant supported the view of allocation of appropriate staff:

> *'Allocate certain number of the nursing staff to a certain area, you must recognise what's the qualifications and what's the experience, you must work out rosters for leave you must be able to, that is all sorts of leaves, you must manage absenteeism' (*Int 3).

According to Muller et al. (2011:327), the issue of staffing and scheduling is complex because healthcare service managers are responsible for providing sufficient numbers of qualified nursing personnel to ensure adequate safe nursing care for all patients. In South Africa, the

training of nurses and the quality of care provided are regulated by the SANC. The scope of practice regulations for the various categories of nursing personnel stipulate the types and levels of tasks that nurses are allowed to perform, depending on their qualifications, and whether they form part of the registered or enrolled categories of nursing staff with SANC (Muller et al., 2011:329).

Concluding statements

It seems that the ANM is expected to have the foundation competencies of:

- Analysing staffing needs with the aim of ensuring cost effectiveness;
- Developing a plan to meet the staffing needs in the workplace;
- Monitoring duty register/ attendance to ensure fair staff allocation

Absenteeism

Absenteeism is defined as not coming to work when scheduled, and is measured by frequency or duration of work days missed (Davey, Cummings, Newburn-Cook & Lo, 2009:313). The responsibility of an ANM is to know the staffing process:

> *'You must know what are the HR prescripts for your staff, how do you manage absenteeism, how do you manage appointments, how and what is your selection and recruitment policy, how do you retain your staff, what is your interaction as manager with your staff'* (Int 10).

According to the NDoH (2013:114), the key performance indicator of the critical success factor of efficiency management states the emphasis to monitor the management of absenteeism within the hospital by ensuring that sick leave is within the required norms, and that deviations are managed according to the 'policy guidelines for absenteeism management'. Similarly a participant shared the view that a manager should know how to manage sick leave and absenteeism:

> *'How are you going to manage your sick and absenteeism'* (Int 5).

If an institution intends to reduce the cost of unscheduled absences of its workers, ANMs should recognise that absenteeism is a problem, develop an absenteeism management plan, train supervisors in how to monitor absenteeism, and develop corrective action. Johnson, Croghan and Crawford (2003:336) agree that employee absenteeism is an expensive and difficult problem. These authors argue that nurse managers need to assess the extent and characteristics of absenteeism, be aware of their organisation's sickness policies, evaluate the effectiveness of these policies, and contribute to the development of initiatives to ensure prudent management of sickness absence.

Concluding statements

The ANM is expected to have the foundation competencies of:

- Determining the staff absenteeism rate monthly to advise senior management on solutions and
- Training supervisors on management of absenteeism.

Disciplinary procedure

Discipline means guiding followers to act and grow in the way the leader prescribes or determines (Jooste, 2010:174). This author describes disciplinary action as an action initiated by management in response to an employee's unacceptable work performance or behaviour (Jooste, 2010:174). In support of this view, Chase (2010:116) suggest that there is an increasing need for nurse managers to assess and monitor performance of staff and the complexity of human resource issues related to disciplinary standards, especially in unionised environments. Senior nurse managers concur with the operational nurse managers that assistant nurse managers are expected to have strong labour relations backgrounds, and know the disciplinary and grievance handling processes. One participant verbalised that managers need to deal with grievances:

> *'They need to know the disciplinary processes, they need to manage grievances'* (Int 10)
>
> .

Similarly, a participant indicated the importance of having knowledge of the disciplinary and grievance procedure in line with legislation:

> *'So disciplinary measures apart from the just the corrective measures according to the Labour Relations Act, you must know how a person can set a grievance you must know your grievance procedures. It is important that you as a nurse manager ofay yourself with the control measures from a staffing point of view'* (Int 2).

The purpose of discipline (Muller et al., 2011:402) is to serve as a deterrent for unacceptable behaviour, to bring about improvement, and to act as punishment. Disciplinary action taken against taken against employees must be for justifiable reasons, and there must be effective policies and procedures to govern its use (Muller et al., 2011:402).

Concluding statements

It seems that the ANM is expected to have the foundation competencies of:

- Applying knowledge of grievance handling processes;
- Implementing workplace discipline

Recruitment and retention

Recruitment and retention strategies emphasise the importance of positive work environments that support professional nursing practice for sustaining the nursing workforce (Spence Laschingera et al., 2014:1615). McCallin and Frankson (2010:324) maintain that healthcare organisations need competent healthcare leaders. These authors suggest that because nurse manager is an organisational management role, it is essential that organisations should offer an

in-house training programme, which includes managing the recruitment process (McCallin & Frankson, 2010:324). One male participant spelled out the processes around posts:

> *'Recruitment, selection processes, how to retain staff within that eh, within that area, how to handle resignations, how to handle appointments, how to handle transfers eh, how to motivate for specific post eh how to deal with agency staff'* (Int 9).

It is important that managers should identify differences in the core values and personality traits of different generations because of the current situation in healthcare, where effort needs to be made to retain nurses (Mokoka, 2015:45). Within these differences, strengths need to be identified and implemented, thus benefiting the organisation and employees, who will stay, thus enhancing retention (Mokoka, 2015:45).

Concluding statements

It seems that the ANM is expected to have the foundation competencies of:

- Being knowledgeable and understanding the recruitment process to ensure the invitation of suitable candidates;
- Selecting the best candidate to fill an advertised post, irrespective of race, religion, gender and sexual orientation;
- Knowing how to deal with agency staff; and
- Implementing strategies to retain staff members.

Performance management

Performance management is described as a technology or science embedded in application methods for managing behaviour and results, which are two critical elements of what is known as performance (Armstrong & Baron, 2005). Marguis and Hudson (2011:585) define performance as an ongoing process by employing strategies such as ongoing coaching, setting goals with employees, and providing them with leadership training. The NDoH (2011:60) pointed out that the implementation of performance management in the health workforce is essential to improving efficiency, productivity and quality of care (NDoH, 2011:60). Participants said that to ensure performance management, assessment and evaluation of performance is essential:

> *'To ensure performance management, we call it the SPMS also the assessment and evaluation'* (Int 10).
>
> *'You must know the process, how do you go about, what is the bell curve, all about the SPMS, so how could you implement'* (Int 11).

A successful performance management system is aligned the existing systems and strategies of the organisation, leadership commitment, a culture in which it is seen as a way of improving and identifying good performance; stakeholder involvement and continuous monitoring, feedback, dissemination and learning from results (Fryer, Antony & Ogden, 2009:480).

Concluding statements

It seems that the ANM is expected to have the foundation competencies of:

- Being knowledgeable about the performance management process and monitoring the implementation of staff performance agreements; and
- Assessing the performance of members quarterly with the aim of identifying limitations in terms of behaviour.

4.5.4.2 Sub-category: Financial resource management

Financial management is described as a process of budgeting, expenditure control and financial risk management (Muller et al., 2011:445). According to Chase (2010:69), financial resource management is the management that is related to the financial structure of the company and therefore to decisions of source and use of financial resources, which are is reflected in the size of the financial income and charges. The allocation of budgets, financial management and the procurement of supplies are major support functions that are central to the effective and efficient functioning of the department and the achievement of the objectives of Healthcare 2030 (WCGH, 2014:30). A participant verbalised the importance of financial management:

> *'Finance is for me a very important thing'* (Int 8).

The findings in this study supported the view of Pillay (2011:178) that nurse managers are responsible for controlling and allocating financial resources in the institution. A participant ('pointing to her head' (field notes) stated that a manager is responsible for managing financial resources within the directives of the province, which have an impact on patient services:

> *'The financial resources, manage financial resources. Within the legislation or directives of the province, this expectation they should have knowledge of whatever findings directives have an impact on patient services'* (Int 10).

Chase (2010:26) is of the opinion that a nurse manages is expected to develop, implement, monitor and be accountable for the budget for the defined area(s) of responsibility. A participant explained types of budgets:

> *'... must be able to plan a budget, consumable budget, as well as an agency budget, as well as they must be able to plan a staffing budget you know. So they must be able to plan a budget'* (Int 10).

A participant ('with concern on her face' (field notes), proclaimed that an ANM must manage a budget within a budget:

> *'Manage the budget, manage within the budget'* (Int 3).

A male participant, stated that an ANM must manage a budget within her specific work area:

> *'To manage budget within that area'* (Int 9).

Budget allocation is a powerful form of strategic decision-making (WCGH, 2014:88). It was indicated to be important of being able to draw up the budget, and stay within the budget:

> *'You need to be able to read the budget, to draw up the budget, to come up with ways and means of staying within the budget, to look outside the box and looking at savings measures not just, eh, what I mean, finance it's not just only rands and cents, it's how to use the resources most effectively'* (Int 5).

A participant state the necessity for financial training to enhance effective management of the centres:

> *'We need more financial courses so that we can be able to manage our own components because we are we have moved to cost centre management'* (Int 13).

From the arguments of Chase (2010) and Pillay (2011) and the findings of this study, it is evident that the ANM is expected to control and allocate financial resources. Assistant nurse managers should develop business plans in line with the strategic plan and ensure that spending is maximised in line with strategic objectives. They must be able to read and draw up the budget and ensure ways of cost containment.

Concluding statements

It seems that the ANM is expected to have the foundation competencies of:

- Planning a budget, consumable budget, staffing budget as well as an agency budget;
- Monitoring financial resources with emphasis on cost containment;
- Participating in the development of the business plan of the institution;
- Identifying ways of containing healthcare costs without compromising standards;
- Ensuring implementation of the budget by monitoring the expenditure report; and
- Knowing and understanding the operational principles of functional business units.

4.5.4.3 Sub-category: Strategic planning

According to Kotler and Armstrong (2012), cited in Booyens et al. (2015:73) strategic planning involves a process of developing and maintaining a strategic fit that is aligned to the organisation's goals and capabilities and its changing marketing opportunities. Strategic planning practices improve their management in the long term, to guide public institutions and to improve their performance in an increasingly turbulent context' (Lega, Longo & Rotolo, 2013:1). A participant stated:

> '*Develop or implement and maintain a strategic plan in their areas or nursing in their areas'* (Int 10).

The findings of a FGD suggested that at their level they are expected to know the strategic plan of the department and the operational plan of the institution:

> *'Strategic planning at this level you already have to have knowledge of what is the strategic plan of the department, the annual operational plan, what is the strategic plan of your institution'* (ANMFG2, P6).

A participant stated that the ANM should develop an annual operational plan with short-term and long term goals:

> *'So you develop an annual operational plan where you have your short-term goals and your long-term goals'* (Int 7).

Nursing strategic plans complement, augment, and supplement the organisation's broader strategic plan, how the organisation will achieve the mission and vision, and defines the goals of the nursing division and the steps for achieving these goals (Conway-Morana, 2009:25). The nursing strategic plan also defines the priorities by which resources – human and capital – are allocated (Conway-Morana, 2009:25). Similarly, a participant indicated the importance of looking ahead and doing a SWOT analysis when undertaking strategic planning:

> *'There, you could look at your department and you look ahead, what are you planning for next year, what are you planning for next five years what is your, be able to do a SWOT analysis, what is your strengths and weakness … opportunities, threats and be able to look strategically, not micro manage your wards because you do have your operational managers'* (Int 7).

A male participant stressed that the ANM should think quickly, and plan strategically:

> *'The ANM needs to be a quick thinker, needs to be able to plan strategically within a unit, short-term and long-term goals'* (Int 9).

Chase (2010:52) supported the views of the participant that a nurse manager has a role in strategic planning in the institution in which she or works.

Concluding statements

It seems that the ANM is expected to have the foundation competencies of:

- Developing a strategic plan in the workplace that aligns with the vision of the institution;
- Setting priorities to ensure that employees are working towards common goals; and
- Developing an annual operational plan with emphasis on short- and long-term goals.

4.5.5 Category 4: Technical skills

The category of technical skills is supported by the sub-categories of technology and computers, and research activities.

4.5.5.1 Sub-category: Technology, computers and writing reports

Information technology is an integral part of life encompasses communication, documentation and consumerism. Today the terms 'information technology' and 'informatics' are interchangeable and the primary goal of information technology is simply information management, always having the right information always available at the right time (Rundio & Wilson, 2013:61). Computer skills are defined as the proficiency in the use of computer hardware and software (Staggers et al., 2002:385). Nursing professionals increasingly use mobile phones, laptop computers, handheld tablets and other electronic devices for

communication with healthcare team members (Koivunen et al., 2015:621), and clients (Weaver, Lindsay & Gitelman, 2012). A participant said that a certain level of computer literacy is anticipated, namely to be able to create, format and edit documents:

> *'Firstly there is a computer literacy level that is required, in terms of creating documents, formatting and then editing, editing here your own documents'* (Int 3).

In addition, nurse managers are expected to know how to draw up a memorandum and know computer programs such as e-mail programs, use of the intranet and Internet. A participant commented:

> *'I say, communication, they need to, they need to, they need to know how to draw up a memo'* (Int 4).

The utilisation of technologies allows workplaces to advance efficiency by improving access to information and reducing the amount of time to complete activities. A participant stated:

> *'They generally only communicate to verbal communication, they forget everything that goes with communication, start with the non-verbal communication, goes with your email to Googling, thinks, to use the internet, to use the intranet, to use nowadays the cell phone and Whatsapp, eh, eh, having, having a group of operational managers where you can get a message out quickly to looking at how to actually write memorandums'* (Int 5).

Nurse managers need to be computer literate, to meet the demands for change, healthcare providers must have knowledge, skills and resources to communicate and manage information effectively and efficiently in an electronic environment (McNeil et al., 2006:53). This view is shared by Williams and Zippener (2003), who state that nurse managers are expected to make decisions based on the most current and best evidence accessible via electronically stored bibliographic databases and the Internet. Furthermore, the nursing data aggregated from documentation in computerised records across healthcare systems and settings are essential to build large databases to support knowledge discovery (Jennings & McClure, 2004). In addition McNeil et al. (2006:58) assert that information management provides a critical pathway to ensuring that reliable and valid clinical data are collected in such a way that they can be analysed to guide clinical practice.

Concluding statements

It seems that the ANM is expected to have the supporting competencies of:

- Reaching a certain level of computer literacy to be able to create, format and edit documents;
- Applying knowledge of computer programs in the workplace;
- Using computer software confidently;
- Knowing how to draw up a memorandum; and
- Having the ability to write according to formal formats.

4.5.5.2 Sub-category: Research activities

Nurse managers face continuous challenges related to the advancement of medicine, technology, nursing practice and scarce resources (Carney, 2010:510). In addition, there is a constant challenge for the profession to underpin nursing practice on the best available evidence (Bradshaw, 2010:118). This author further stresses that positive attitudes towards research are a key factor in use of research. Internationally nurses' attitudes to using research in practice are regarded as positive (Bradshaw, 2010:118). One participant stated:

> *'In the taking part in research we group research under KRA training and development and we, eh, do not only participate in research, we assist others and then we also work through protocols'* (Int 10).

It is suggested that 'nurse managers who show a positive regard for research, who demonstrate good role modelling by actively engaging with and using research activity, who allow time and resources for their nurses to read and understand research, and who provide strong leadership and encouragement, are more likely to encourage their nurses to follow suit' (Timmins, McCabe & McSherry, 2012:226). A participant shared a positive view towards research:

> *'We have to get our nurse managers to buy in research'* (Int 11).

Nurse managers are key personnel in the drive to encourage nurses to use and engage in research, through creating the right atmosphere and conditions for research and ensuring nurses that have the required skills (Timmins et al., 2012:226). A participant indicated the importance of the ANM participating in research:

> *'Okay, and you also need to participate in research because research at the end will eh bring out our strong points and it will also highlight the shortcomings and so that we can evaluate and improve and put measures in place to address those shortcomings'* (Int 7).

Nurse managers and leaders should remember that evidence-based nursing is an integral part of everyone's role and responsibility in ensuring safe, quality and compassionate care (Timmins et al., 2012:232). It is apparent that nurse managers are expected to initiate and conduct research to inform nursing management and practice.

Concluding statements

It appears that the ANM is expected to have the supporting competences of:

- Identifying trends when conducting audit;
- Participating in research projects;
- Involving nursing staff in conducting research activities; and
- Promoting research in current trends of nursing to maintain professional growth of staff.

4.5.6 Category 5: Leadership skills

Leadership is increasingly seen as a skill that should not be confined to senior managers at the apex of organisations, but something to be embraced by staff at all levels (Martin & Waring, 2012:359). In this understanding, leadership is less about formal position or role, and more a situated activity where a diversity of actors can 'do leadership'. 'A leader develops and uses effective strategies, change management and interpersonal skills to influence others towards accomplishment of identified objectives' (Martin & Waring, 2012:360).

4.5.6.1 Sub-category: Feedback

It is evident that an ANM should provide feedback to her operational nurse managers. One participant stated that as middle managers the ANM should guide, interpret and provide feedback between the Executive Committee and operational nurse managers:

> *'At this level to interpret, to guide and to feedback and once again as middle managers having you know to feed between the EXCOs and the Operational Managers'* (ANMFG2, P6).

Giving feedback to followers is one of the core functions of nurse managers in the district health system: he or she needs to provide effective, positive feedback to followers to enable the team to grow and develop (Jooste, 2017:405).

Concluding statements

It seems that the ANM is expected to have the supporting competency of:

- Providing feedback to his or her operational nurse managers.

4.5.6.2 Sub-category: Education and training

Professional development is necessary for nursing quality. Nurse managers play an important role as facilitators for nurses who want to grow and develop excellence in nursing practice (Torstad & Bjork, 2007:819). They are also responsible for providing or facilitating educational experiences for nursing and students. One participant verbalised:

> *'The nurse manager when she goes around she goes to teach, when she walks in she must be quite sure that the person that is in charge of that ward that she's supervising and is aware of the basic principles of management'* (Int 11).

The literature on employee training supports the views of managers that employees' development needs must be addressed continuously (Plakoyiannaki et al., 2008:274). It was stated:

> *'Same way the staff component, like, you know, they have been not, the staff of this institution, but I've got a responsibility towards them to make sure that they develop and that they know how to relate to patients'* (Int 11).

Staff development is the process that provides employees with planned specialised skills and wide knowledge. It is vital that the managers should assess all employees to identify any skills

gap in their sphere of operation. The planning of a staff development programme should be based on identified needs, which will guide and provide direction to the planners (Plakoyiannaki et al., 2008:274). One manager emphasised the importance of ensuring availability of equipment and a proper venue for development sessions:

> *'You should have regular updates regular training sessions, whether it can be internal or external … and of course your equipment if you want to give, provide training you should have proper venue, you should have proper equipment, your facility, you're how can I use an example your projector, you should have those kinds of things you should have, tools, those kind of things'* (Int 2).

The manager's role includes training employees, ensuring the availability of resources in provision of training. For any training to be successful, a situational analysis must be done to establish the needs of the institution versus the employees' needs. The purpose of a training programme is to provide employees with specialised skills and extensive skills (Meyer et al. 2004:76).

Concluding statements

It seems that the ANM is expected to have the supporting competencies of:

- Playing a role in training employees;
- Identifying skills gaps in personnel;
- Addressing employees' development needs continuously;
- Addressing the skills gap by ensuring that all staff members attend professional training;
- Conducting a situational analysis to identify the needs of the institution and employees; and
- Creating an empowering environment by providing support and opportunities to junior members of staff.

4.5.6.3 Sub-category: Innovation and initiation

'Leading in the 21st century requires innovation and adaptation to the environment. Innovation may involve a simple change or a radical redesign of the system, but using something different seems to be the answer' (Warner & Burton, 2009:331). Innovation is defined as creativity that is characterised by originality and expressiveness and creativity is enhanced with intrinsic motivation, a nurturing environment, an ability to function independently and a willingness to take risks' (Fasnacht, 2003). Initiative is defined as an evaluation, selection and acting on various methods and strategies for solving problems and meeting objectives before being asked or required to do so (Fasnacht, 2003).

One participant stated the need for the ANM to be innovative and create initiatives to address unforeseen circumstances:

'They need to adapt to come up with initiatives how to adapt as an example I can just say whenever there is an outbreak of Gastro whatever Meningitis you know you cannot budget for that and then you need more staff, you need more resources so they need to come up with initiatives' (Int 10).

Another participant stressed that the ANM should look at new ways of staffing and rescheduling shifts:

'Look at some more innovative ways of staffing, eh, rescheduling of shifts' (Int 5).

A participant shared the view that the ANM must produce initiatives of skills update or programmes:

'They must come up with initiatives of skills update, upskilling programme' (Int 10).

A climate is needed that emulates innovativeness (creative work climate) that support new ideas, open relationships, mutual trust and confidence; while being committed to the goals and operations of the organisation; and having an open exchange of opinions and ideas' (Sellgren, Ekvall & Tomson, 2008:580).

Concluding statement

It appears that the ANM is expected to have the supporting competency:

- Being innovative by adapting procedures to suit a changing environment

4.5.6.4 Sub-category: Responsibility towards operational nurse manager

The assistant nurse manager has certain responsibilities towards an operational nurse manager. Nursing management and education in South Africa are tasked with translating new policies and legislation into actions to improve the provision of nursing services and deliver on the health outcomes envisaged in the Millennium Development Goals (Jooste & Jasper, 2012:63). One participant suggested that the ANM should provide guidance in terms of the implementation of policies and guidelines and ensure consistent communication of accurate comprehensive information on healthcare.

'Bedside nursing by managing or giving guidance to your supervisor use of policies, guidelines, giving assistance to those sort of you know work in order to deliver patient care' (ANMFG2, P 1).

The ANM should assist operational nurse managers in the development of the departmental strategic plan, which will feed to the hospital strategic plan and then to the nursing strategic plan. A participant stated:

'So you should be enabling your operational managers to do almost a mini strategic plan for their department which then feeds in to, if I talk surgery or clinic, feeds in to that surgical strategic plan, which then will feed to nursing strategic plan, then to the hospital strategic plan' (Int 5).

It was mentioned that a nurse manager should identify a senior professional nurse that could mentor junior staff:

'Then I need the OPMs or assistant managers to be able to look and see here is a senior sister who knows and you need to have her as a mentor for the junior' (Int 5).

The roles of the nurse manager (Chase, 2010:32) include the ability to delegate, coordinate, supervise and provide support and teach.

Concluding statements

It appears that the ANM is expected to have the supporting competencies of:

- Delegating, supervising and coordinating the provision of effective and efficient patient care through adequate nursing;
- Providing guidance in the policy implementation and guidelines and ensure consistent communication of relevant, accurate comprehensive information on healthcare; and
- Assisting the operational nurse managers in the development of the departmental strategic plan.

4.5.7 Category 6: Knowledge of the healthcare environment and its process

According to UNIDO (2002:8), the concept 'competency' refers to a set of skills, related knowledge and attributes that allow an individual to perform a task or an activity in a specific function or job. Knowledge is an awareness or understanding of, or information about facts, rules, principles, guidelines, concepts, theories, or processes that is needed to successfully perform a task. Knowledge is acquired by learning and experience (Marrelli et al., 2005: 534).

4.5.7.1 Sub-category: Legislation

Senior nurse managers, nurse managers, deputy nurse managers and ANMs support the view that as heads of services, heads of components, ANMs should have knowledge of labour relations. This was evident from what a participant said:

> *'Labour issues also plays a big role so they also need to give labour induction to address labour problems'* (Int 8).

Another participant shared this view:

> *'They need to know labour relations issues'* (Int 10).

According to the participants, one of the roles and functions of the ANM is to take part in the analysis, formulation and implementation of nursing policies, guidelines, practices, standards and procedures. They should review and revise policies and ensure their execution. A participant stated:

> *'Coordinate the execution of nursing policies, maybe it's for their section but they also participate in the execution, also the implementation and the development of policies for the whole hospital'* (Int 10).

Similarly, a participant indicated the importance of knowing the national core standards for health establishments:

> *'The assistant nurse managers must know the national core standards. They are coming from national, also they should know the standards of the hospital, the province, in order to accredit'* (Int 10).

Managers need to recognise the limits of their current practice in terms of knowledge generation and management and assess whether they pay enough attention to issues related to policies and their implementation (Meesen, Kouanda, Musango, Richard, Ridde & Soucat, 2011:1011). Participants indicated that the ANM need to know the relevant acts and legislation documents, and policies:

> *'How to, to interpret and implement policies, eh, procedures, protocols, directives within that specific area and of the hospital … they need to know, eh, they need to know the acts, Labour Relations Acts, eh, Basic Conditions of Employment Acts'* (Int 9).
>
> *'The most important thing in management is control, what are your control methods, do you know your labour relations act, do you know your disciplinary, do you know the rights, do you know the Batho Pele principles, you know your patience rights charter, what governing body governs you, do you know what council expects of you, do you know what your employer expects of you'* (Int 11).
>
> *'Your IPC, you need to be knowledgeable with regard to infection prevention and control things'* (Int 13).

Understanding the legal requirements for public sector funds is vital:

> *'They must firstly have an understanding of the legal requirements that, eh there's an act that stipulate the manager of the public funds, public sector funds'* (Int 3).

Knowledge of the regulatory body is of paramount importance:

> *'Then also we need to know everything about the professional body the Nursing Council. They must be able to assist the Nursing Council when investigation takes place, they need to get the reports, liaise with registration or other details'* (Int 10).

The Nursing Act 2005 (Act No 33 of 2005) regulated the scope of practice of nurses and midwives. Scope of practice means the parameters within which a category of nurse who has met the prescribed qualifications and registration requirements may prescribe (South Africa, 2005:1). The act defines nursing as a regulated profession comprising scientific knowledge and skills practised by the professional nurse and other categories (South Africa, 2005:25). The act, regulations, rules and codes in terms of the act provide the legal and ethical framework for the practice of nursing. The nurse manager has a responsibility to ensure that the Nursing Act regulations in terms of scope of practice are adhered to. One participant said:

> *'Where you as a manager you must be able to take eh responsibility, there is a lot of accountability also, you must ensure that decisions that you make is within your scope of practice also and you know things that we do to render quality patient care you just ensure that everybody is on the same line'* (ANMFG2, P4).

The act stipulates that no person may practise as a practitioner unless he or she is registered to practice in the following capacities; professional nurse, midwife, staff nurse or auxiliary nurse or auxiliary midwife (South Africa, 2005:25). The act specifies that a receipt issued by or on behalf of the council for payment of registration fees will be proof that such person is registered. The statement expressing the view:

> *'That area manager could be expected to inform the staff of that all, … South African Nursing Council annually receipt payments is received by her office at a certain time'* (Int 3).

According to the Constitution of the Republic of South Africa, 'every South African is entitled to respect for human dignity and every employee deserves to be treated as an individual in his or her own right and should enjoy the right to fair labour practice' (South Africa, 1996). Human resource-related legislation protects staff against discrimination, unfair labour practices and occupational health and safety standards, namely Employment Equity Act (South Africa, 1998) Labour Relations Act (South Africa, 1995), Basic Conditions of Employment Act (South Africa, 1997), and other related legislation/regulations (Muller et al., 2011:225).

Concluding statements

It seems that the ANM is expected to have the foundation competencies of:

- Knowing about labour relations and provide labour induction to address labour issues;
- Coordinating holistic nursing care according to the set standards of a professional and legal framework;
- Ensuring adherence to the relevant acts and prescripts; and
- Participating in the analysis, formulating and implementation of nursing policies, guidelines, practices, standards and procedures.

4.5.7.2 Sub-category: Patient care

The role of the nurse manager has been identified as critical to the provision of high-performing, effective and efficient care in the patient care delivery setting (Chase 2010:2). Similarly, Thrall (2006:72) explains that the nurse manager not only provides administrative and clinical leadership, but also has 24-hour accountability for all patient-care activities in the unit.

ANMs could be expected to initiate, direct and participate in the provision of nursing care to

One participant stated:

> *'So for me as an assistant manager I have got firstly the biggest key performance area that I need to be on par with and updated and perform my quality patient care'* (Int 25).

The same participant indicated the importance of the provision of quality improvement, quality assurance, leading to best quality of care, with the focus on patient-centred experience:

> *'Quality, the patient care with the focus on providing more of quality improvement., quality assurance, under the heading of quality patient care ... currently the focus emphasis is on patient centred experience'* (Int 14).

In support of the provision of quality care, another participant stated:

> *'I actually wrote here to perform efficient and effectively in the service area with the available resources to render quality care to your patients and also to take care of your own staff in the framework of policies and procedures guiding you as a manager'* (ANMFG2, P4).

The role of the ANM could be to participate in the analysis, formulation and implementation of nursing guidelines, practices, standards and procedures and to develop a plan regarding

prescribing treatment for health conditions presented at healthcare facilities in accordance with prescribed norms and standards (NDoH, 2015). A female patient stated:

> *'It's a nursing norm and it's based on clinical needs and your patient acuity, your area you serve, the total number of patients, if one looks at how the environment change outside in terms of the burden of disease and you now have to struggle with, not struggle'* (ANMFG5, P6).

Nurse managers are expected to audit clinical records by analysing data, identifying health indicators and risk factors and coordinating the conduct of client satisfaction surveys. One participant indicated:

> *'And then the complaints and the compliments and then also it not only the trends that you identify that will tell about you where are we lacking. The patients keep on complaining about nurses attitudes, it gives you direction of that is what we need to work on because we need to, we shouldn't be at the bottom or getting the same complaints over and over again and not doing something. Because everything that we do, we must not just do it'* (Int 14).

Managers in healthcare have a legal and moral obligation to ensure a high quality of patient care and to strive to improve care (Parand, Dopson, Renz & Vincent, 2014:1). These managers are in a prime position to mandate policy, systems, procedures and organisational climates. Parand et al. (2014:1) argue that it is evident those healthcare managers possess an important and obvious role in quality of care and patient safety and that it is one of the highest priorities of healthcare managers.

Concluding statements

It seems that the ANM is expected to have the interaction competejncies of:

- Providing high-performing, effective and efficient care in the patient care delivery setting;
- Updating and performing quality patient care, and create a setting for review or update of patient care policies and procedures;
- Initiating, directing and participating in the provision of nursing care to patients with emphasis on a patient-centred experience;
- Reviewing the developed nursing care plan for effectiveness of use;
- Monitoring nursing care management activities according to the standards of practice and scope of practice; and
- Identifying health indicators and risk factors.

4.5.7.3 Sub-category: Clinical activities

The main competencies of nurse managers in their role are clinical care, care coordination, operational unit functions, leading staff and personnel management and quality improvement (Drach-Zahavy & Dagan, 2002: 20-21). There was general agreement among the participants

that they should be competent in the clinical field in which they specialise. One participant expressed her view:

> *'And then also the competencies in my field of expertise, my clinical competencies, that is very important as the leader in this specialty, certain areas you know, as I experience it'* (Int 14).

One participant specified that although she is performing clinical duties it is expected of her to keep abreast of the developments:

> *'I might not work clinically anymore, you know, but I still need to read up so that I don't get left behind in the knowledge'* (Int 5).

A participant stated that she could be familiar with the clinical activities in the area:

> *'To be familiar with the clinical activities within that area'* (Int 5).

Nurse managers are responsible for management of clinical nursing practice and patient care delivery. One participant said:

> *'Clinical activities, what I mean is, the assistant nurse manager for a specific area needs to know exactly what is the needs of the patient within the area, she needs to know what is the practices for nursing staff within that area, needs to know what is the specific diseases or the illnesses she is working with, she needs to give guidance, give guidance to junior staff, even to senior staff within that area'* (Int 5).

It is evident that the ANM should be competent in the clinical field in which they are specialising to perform the functions assigned to them effectively to and meet nurses' and patients' needs (Morash, Brintnell & Rodger, 2005:84).

Concluding statements

It appears that the ANM is expected to have the interaction competencies of:

- Being responsible for management of clinical nursing practice and patient care delivery;
- Implementing knowledge management; and
- Initiating, directing and actively participating in the provision of nursing care to patients and ensure the formulation of accurate nursing and healthcare diagnosis to clarify clients' needs

4.5.7.4 Sub-category: Healthcare systems outcome

The NDoH's vision, as stated in the NDoH (2012), is to ensure 'an accessible, caring and high-quality health system', aligned to the objectives of the 10-Point Plan and the strategic outputs of the Negotiated Service Delivery Agreement (NSDA), with the emphasis on strengthening health system effectiveness through improved healthcare and patient satisfaction and the accreditation of health establishments (Jooste, 2016:164). Patient experience has been recognised as a cornerstone of improved healthcare, and measures of patient experience are related to health outcomes (Schlesinger, Grob & Shaller, 2015:2123). Booyens et al. (2015:26) define the healthcare system as an open system that strongly influenced by the environment in which it functions. An outcome refers to the results expected after good healthcare has been rendered (Booyens et al., 2015:308).

The ANM are expected to ensure dissemination of clinical practice guidelines and information to enhance patient outcomes, and maintain the quality of nursing data and information and utilise it to advise, advance and evaluate the quality and cost-effectiveness of nursing care.

A participant stated:

> *'Part of the quality, they must ensure effective quality in their levels, in the modules and that's up to the standard set in the hospital to know policies of the province, of the national department'* (Int 10).

Policies are needed to guide the provision of care as suggested by Parand et al. (2014:1). Policies provide direction for decision-making, so that action can be taken within the framework of the organisation's principles, therefore ensuring provision of good quality of care to patients. One participant stated the reason for providing quality care:

> *'First of all is quality care and the reason that we ask for quality care is because there will be no nursing posts'* (Int 10).

The assistant nurse manager is expected to delegate, supervise and coordinate the provision of effective and efficient patient care through adequate nursing care.

One nurse manager said:

> *'You are expect to deliver proper nursing care at the end of the day to see everything runs according to what is expected, what is expected of us, you know in our* workplace' (ANMFG, P1).

In the literature quality care experiences that are essential include assessing, seeking information, diagnosis, planning and intervening (Mendes, Cruz & Angelo, 2015:324). Care outcome improvement strategies and practice characterise the clinical role (Mendes et al., 2015:324). It can be difficult to know whether organisations have the leadership talent they need to set direction, create alignment, and gain commitment among employees, partners, and stakeholders as they seek to provide safe high-quality patient care (CCL, 2016:1). The aim of primary healthcare (PHC) is to ensure that all people are able to access the services necessary for realising the highest level of health (WHO, 2011: VII). It includes organising the health system to provide quality and comprehensive healthcare for all people, and ensuring that the poor and disadvantaged people have fair access to essential health services (WHO, 2011: VII). The National Health Act provides the overarching legislative framework for health services (WCGH, 2014:34). The District Health Council Act and the Health Facility Boards Act provide the legislative framework for governance structures in the Western Cape health system.

Concluding statements

It seems that the ANM is expected to have the interaction competencies of:

- Maintaining the quality of nursing data and information and utilise it to advise, advance and evaluate the quality and cost-effectiveness of nursing care;
- Knowing the policies of the province to ensure adherence to their application;
- Having knowledge of health systems and its processes to achieve good patient health

outcomes; and

- Ensuring dissemination of information to enhance patient outcomes.

4.5.8 Category 7: Support

Nurse managers have a responsibility to provide support and guidance to personnel accountable to nurse manager (Stefl, 2008:366). One participant commented that guidance is essential in preparation for a deputy manager post:

> *' To guide us with interviews like you said earlier to me that we haven't got that, eh, guidance, now I fall out my deputy post here because my CV was not right for the panel'* (Int 8).

A participant stated that the Head of Nursing or the Deputy Nurse Manager should provide the ANM with guidance and support, especially when the ANM is newly appointed in the post:

> *'Head of nursing or the deputy manager to give me guidance and especially I was put in night duty and I was only in the post for about 10 months'* (Int 6).

A participant stressed that that ANMs must be mentored and guided in terms of what is expected of them to do in the public sector:

> *'I think it's also important mentorship in terms of, like, guiding us on what are we expected to do in the public sector'* (Int 13).

The literature revealed that nurse managers could benefit from early guidance on how to work more effectively (Luo et al., 2016:93).

Concluding statement

It appears that the ANM is expected to have the supporting competency:

- Being guided and supported for their role by their supervisor and to know what is expected of them to perform in the workplace.

4.6 CONCLUSION

Table 4.5 provides the summary of merging the main categories and sub-categories as discussed in Chapter 4, which outlined the competencies needed of an ANM. The literature confirmed the findings and authors agreed with the participants' expectations of these competencies. The findings and literature confirmed that the scope of the role of the charge nurse manager is wide ranging. Certain competencies came to the fore from the findings from which the instrument was developed for Phase 2. It was expected of ANMs to perform in a legal and professional framework in their scope of practice with regard to patient care and involvement in clinical activities to obtain the outcomes of the healthcare system. Interpersonal relationships are core dimensions in their role. Through self-confidence, effective communication can be promoted for building relations and enhancing development. In

challenging circumstances, certain problem-solving and conflict management skills are needed, while building trust and providing feedback. In the current healthcare environment, evidence-based practice is needed that requires effective report writing, computer literacy, resourcefulness and active involvement in the research processes. Strategic HRM is crucial, and requires effective staffing strategies. This entails staff recruitment, allocation, retention, discipline, monitoring performance and discipline, within the scope of a strategic plan in a cost-effective environment.

As leaders they should be innovative in planning orientation, staff development sessions, and leadership succession, working with other departments and acting as mentors.

Table 4.5: Categories and sub-categories, concluding statements of the findings from Operational Nurse Managers focus group discussions, Assistant Nurse Managers focus group discussions and Assistant Nurse Managers, Deputy Nurse Managers, Managers Nursing and unstructured individual interviews

Expectations of Operational Nurse Managers			Expectations of Senior Nurse Managers, Nurse Manager, Assistant Nurse Managers, Deputy Nurse Managers & Assistant Nurse Manager		
Categories	**Sub-categories**	**Summary of concluding statement**	**Categories**	**Sub-categories**	**Summary of concluding statement**
Interpersonal skills as interaction competencies	Effective communication as interaction competencies	-The ANM is expected to have good listening skills.	Personal competencies as interaction competencies	Communication skills as interaction competencies	The ANM are expected to be respectful, honest, communicate effectively and build trusting relationship with personnel
		- Showing interest to people that might have problems in the workplace and acknowledge them for the work done is essential.			- To be a good communicator and motivator
		Engage the ONM constantly especially in the event that the ONM is a new employee		Self-confidence & assertiveness	The ANM to be confident, competent, self-assured and assertive in their work area.
	Conflict management as interaction competencies	The ANM is expected to manage conflict.		Conflict management skills as interaction competencies	The ANM must be able to manage conflict and difficult conversations.
	Feedback as interaction competencies	Feedback of meetings attended by the ANM is not provided to the staff	Leadership skills as interaction competencies	Feedback as interaction competencies	Provide feedback to her ONM
	Openness/honesty/ trust as interaction competencies	The levels of trust are maintained by ensuring constant transparency, openness and honesty in every respect			

Expectations of ONM			Expectations of SNM, NM, DNM & ANM		
Categories	**Sub-categories**	**Summary of concluding statement**	**Categories**	**Sub-categories**	**Summary of concluding statement**
		Effective communication plays a major role in ensuring honesty and transparency			
				Relationship building as interaction competencies	-The ANM should provide team building.
					The ANM should be competent and confident to relate with the team.
					Team building includes awarding and acknowledgement of good work
				Self-development/self-motivation	.Personal development includes improving self-awareness, self-knowledge and learning new skills.
				Human resources	Knowledge of human resource management to perform the function effectively
Managerial skills as a foundation competency	Staff allocation as an interaction competency	The ANM to assume responsibility for staffing and scheduling personnel and recruit nurses as needed to address staffing needs.	Professional competencies	Staffing as an interaction competency	-The ANM is expected to develop a staffing plan to meet the needs. The ANM is responsible to compile and control duty register as cost of staffing forms part of Functional Business Unit Assignments, should reflect appropriate -utilisation of personnel, considering scope of practice, competencies, patient needs and -complexity of care -The ANM must be able to analyse staffing needs on daily basis or in advance

Expectations of ONM			Expectations of SNM, NM, DNM & ANM		
Categories	**Sub-categories**	**Summary of concluding statement**	**Categories**	**Sub-categories**	**Summary of concluding statement**
	Training of staff as the supporting competencies	The ANM to identify the personnel's skills gap, needed training areas, address the skills gap.			
		- The ANM are responsible for ensuring appropriate training for personnel - The ANM should identify the personnel's skills gap, needed training areas, address the skills gap, - The ANM should provide regular updates and training sessions			
				Absenteeism	Responsibility of the ANM is to determine manage absenteeism
				Disciplinary measures	The ANM to have knowledge of the disciplinary and grievance handling processes.
				Recruitment & Retention	It is expected of an ANM to be knowledgeable of the recruitment and selection process & retention of staff
					They should know how to deal with agency staff
				Performance management	Knowledgeable in performance management process and manage the staff performance effectively
				Financial resources	Plan a budget, consumable budget, staffing budget as well as an agency budget

Expectations of ONM			Expectations of SNM, NM, DNM & ANM		
Categories	**Sub-categories**	**Summary of concluding statement**	**Categories**	**Sub-categories**	**Summary of concluding statement**
	Strategic planning as the foundation competencies	ANM should engage in strategic planning which entail formulation of a vision and goals, achievement and strategies employed in achieving the aforesaid goals.		Strategic planning as the foundation competencies	Develop, implement and maintain a strategic plan in their areas. Establishing strengths, weaknesses, opportunities and threats are vital during strategic planning process
Technical skills as part of supporting competencies	Computer literacy as part of supporting competencies	Should be computer literate in order to provide computer technical support	-Technical skills as part of supporting competencies	Technology, computers & writing reports	Computer literate to create, format and edit documents.
		Nurse manager lacks the computer skills			Know how to draw up a memorandum
	To act as a resource Operational Nurse Managers as part of supporting competencies	The responsibility to know their policies, but the corporate and provincial policies must be provided by the assistant nurse managers			
				Research activities	-Expected to participant research -Conduct research and involve nursing staff in research activities

Expectations of ONM			Expectations of SNM, NM, DNM & ANM		
Categories	**Sub-categories**	**Summary of concluding statement**	**Categories**	**Sub-categories**	**Summary of concluding statement**
Professionalism & leadership as interaction competencies	Upskilling of staff members as supporting competencies	Training and development programme to upskill the operational nurse managers	Leadership skills	Education & training as supporting competencies	Role to play in the training of employees. Employees' development needs must be addressed continuously
	Orientation for Operational Nurse Managers as supporting competencies	The ANM should conduct update orientation sessions for new employees for example orientation plan that includes professional behaviour of staff members			
		The ANM should provide an orientation plan for operational nurse managers			
	Succession planning as supporting competencies	The ANM should have a leadership succession planning that prepares employees to assume management roles in the absence of their managers			
		ANM should ensure that succession planning employees are exposed to peer teaching e.g attend specific meetings			

Expectations of ONM			Expectations of SNM, NM, DNM & ANM		
Categories	**Sub-categories**	**Summary of concluding statement**	**Categories**	**Sub-categories**	**Summary of concluding statement**
		that develop professional competencies			
				Innovative/ initiative	Leading requires innovation and adaptation to the environment. Nurse managers needs to come up with initiatives on how to adapt to the environment
	Engaging with OPS Managers as supporting competencies	The ANM should engage with ONM managers, communicate the organisational, vision and goals, building relationship and facilitating interaction Collaborate with members of the health and social care teams.		Responsibility towards the ONMs as supporting competencies	Assist the ONM in the development of a strategic plan Provide guidance in the implementation of policies and guidance
Knowledge of healthcare environment and its processes as foundation competencies	Legislation as foundation competencies	The ANM to know the acts and circulars and provide guidance to ONM when they are in a dilemma	Knowledge of healthcare environment and its processes as foundation competencies	Legislation as foundation competencies	Have knowledge of labour relations, disciplinary procedures, Batho Pele Principles, Infection Prevention & Control
		The ANM should have a strong labour relations to manage labour effectively and efficiently			Knowledge of regulatory body SANC
		The ANM to participate in the analysis, formulation and implementation of nursing policies			

Expectations of ONM			Expectations of SNM, NM, DNM & ANM		
Categories	**Sub-categories**	**Summary of concluding statement**	**Categories**	**Sub-categories**	**Summary of concluding statement**
		The ANM should involve the ONM in budgetary planning			
				Patient care as interaction competencies	The biggest key performance is to be updated and perform quality patient care - The ANM is expected to initiate, direct and actively participate in the provision of nursing care to patients and ensure the formulation of accurate nursing and healthcare diagnosis to clarify clients' needs
	Clinical experience as a foundation competence	Possess clinical competence, experience, knowledge and skills to fill the post & function in the role		Healthcare systems outcome	Knowledge of the health systems and its processes
		Keep abreast of trends in nursing			
Support as supporting competencies	Guidance and support Mentor as supporting competencies	Responsibility to guide and mentor personnel accountable to her or him.	Support as supporting competencies	Support and guidance as supporting competencies	The ANM expect to be guided and supported by their nurse managers in terms of their role what is expected of them to do
		Provide support and guidance to personnel accountable to nurse manager Guide operational nurse managers in order to provide better supervision and also support the team			

CHAPTER 5
PRESENTATION OF RESULTS OF PHASE 2

5.1 INTRODUCTION

This chapter discusses the results of the analyses of the data that were collected in the survey. The objective in Phase 2 was to explore and describe the perceptions of ANMs of expected and existing competencies for effective nursing management in public health facilities in the Western Cape. This chapter sought to answer the following question:

What are the perceptions of assistant nurse managers about their expected and existing competencies?

5.2 BACKGROUND TO DATA COLLECTION

A response rate is the percentage of questionnaires that participants return to the researcher (Creswell, 2014:390). Research on acceptable response rates uncovers a wide range of percentages. Many survey studies in leading educational journals report a response rate of 50% and better (Creswell, 2014:390). However, this rate fluctuates, depending on proper notification, adequate follow-up procedures, participant interest in the study, the quality of the instrument and the use of incentives (Creswell, 2014:390). This argument is supported by Babbie and Mouton (2011:71), who claim that there is consensus that a response rate of a postal questionnaire of 50% or above is adequate for analysis. A response rate of 60% is generally seen as good and 70% as very good. The researcher used a hand-delivered self-report questionnaire to obtain information about the existing and expected competencies of ANM in the public health facilities in the Western Cape. A structured questionnaire was used with a 4-point scale (Annexure J). A total of 156 (100.0%) questionnaires were distributed by the researcher to the participants, that is, all the ANMs in the public health facilities in the Western Cape. In total, 110 questionnaires were received back. The response rate, including additional efforts to encourage potential participants to return their questionnaires, was 70.5% (Figure 5.1). However, 94 (60.0%) fully completed questionnaires were used for data analysis.

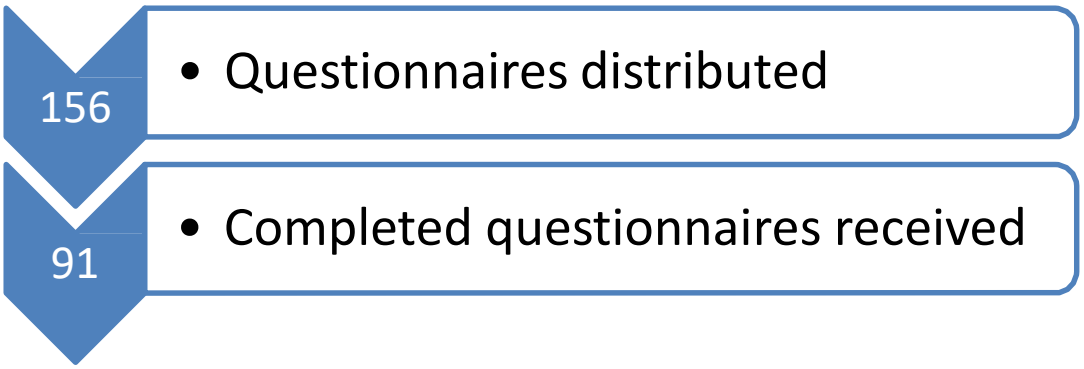

Figure 5.1: Survey response rate

The results of Chapter 5 are presented in two sections:

Section A: Biographical and demographic information of the participants

Section B: Competencies of ANMs.

The results of the survey are discussed according to the sequence of the headings in the questionnaire. The number of respondents varied in answering the different items.

5.3 SECTION A: BIOGRAPHICAL AND DEMOGRAPHIC INFORMATION

Demographic data help to give an accurate picture of the group of professional nurses who participated in the survey. This section includes findings on gender, age distribution, highest level of education, years practising as professional nurse, years working as an ANM in a health facility, and area of work.

5.3.1 Gender distribution

Historically, before the twentieth century, men dominated the nursing profession, particularly in providing medical care to South African miners and military personnel. However, female nurses became more dominant after Florence Nightingale encouraged women to take up nursing as a profession when she started to train female nurses in 1894 (Adamson, Muula, Nyasula & Msiska, 2004:75). Ozdemir, Akansel and Tunk (2008:153) concur, stating that nursing is a female-dominated profession.

In South Africa the gender picture has changed dramatically. The current survey showed that of the 94 (100.0%) questionnaires received, only 7 (7.0%) were from men and 87 (93.0%) were from the female gender.

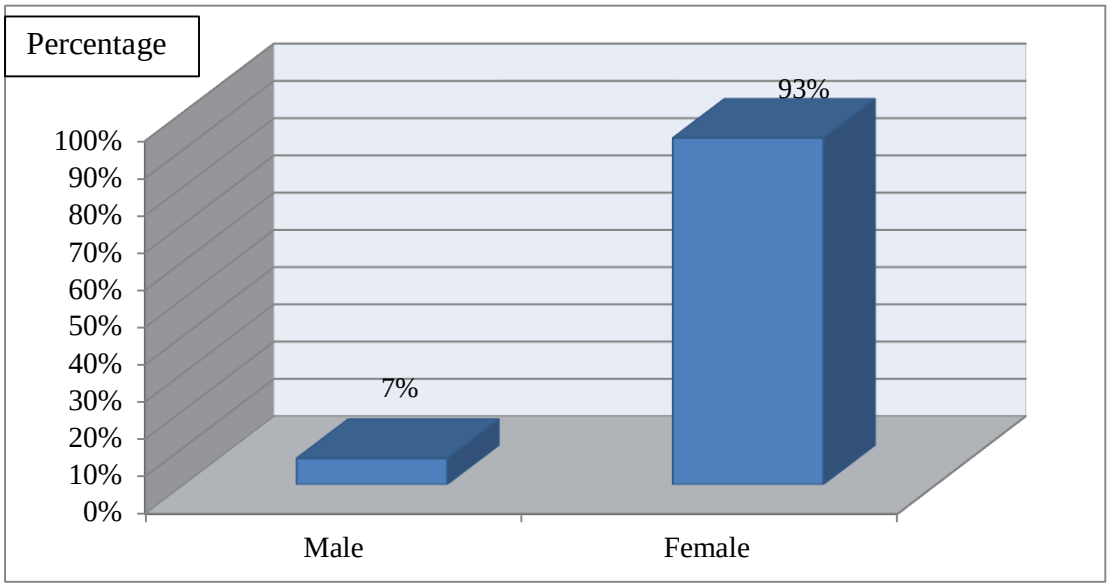

Figure 5.2: Gender of participants (n = 94)

There has been a natural growth in the number of men entering the profession. For instance, in Austria, Tanzania, Italy, Spain and Chile, men make up more than 20% of the nursing population (Pearson & Peels, 2001:7). In the last few years, Malawi has reported an increase in male students (Adamson et al., 2004:75). Men have nearly levelled the equilibrium in the Democratic of Congo (DRC), where 45% of the total nurse population are male (Pearson & Peels, 2001:7).

5.3.2 Age distribution

The age distribution of participants was grouped into four categories. All participants (n = 94) volunteered their age. The results showed that the majority of the participants, namely 47 (50.0%) of the 94 (100.0%), were in the 50–59 age group, and 31 (33.0%) in the 40–49 age group (Figure 5.3 and Table 5.1). The median age of the participants was 51.0 years. Participants ranged in age between 35 to 64 years, with an interquartile range of 10 years. This means that half of the participants were 51 and younger. The data also show that 80 (75.0%) of the 94 (100.0%) participants were 56 years and younger. Statistics from SANC showed that the nursing population of South Africa is mostly middle aged, with a mean age of 40 and a range from less than 25 years to more than 69. In 2013 only 113 professional nurses were younger than 25 years (SANC, 2014).

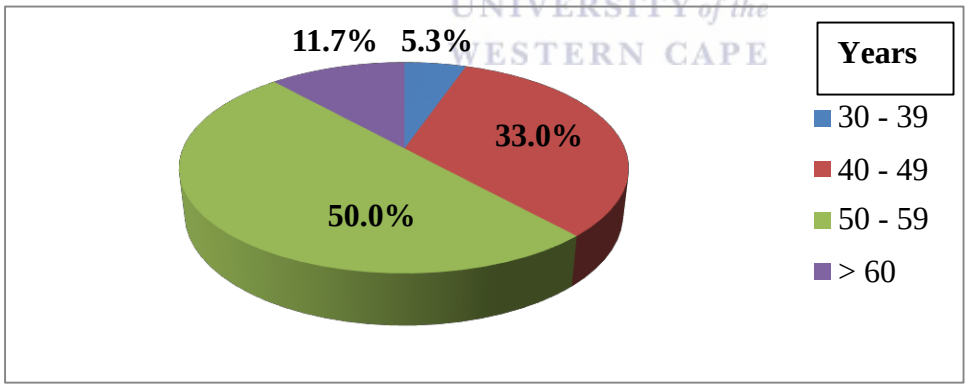

Figure 5.3: Age distribution (n = 94)

The majority of professional nurses in South Africa are over the age of 40. Close to two thirds of the nursing profession will retire in the previous 10 years (Govender & Appel, 2006:1).

Table 5.1: Age of participants (n = 94)

Age of respondents									
30 - 39		40 - 49		50 - 59		> 60		Total	
n	%	n	%	n	%	n	%	n	%
5	5.3	31	33.0	47	50.0	11	11.7	94	100.0

George, Quinlan and Reardon (2009:31) confirm that the nursing profession is slowly becoming an ageing population, with low numbers of young nurses entering the ranks. The findings indicate that the ageing pool of ANMs could warrant the Human Resources Plan of the NDoH to make provision for the supply of professional nurses and for mentoring young professional nurses to prepare them for future management positions (DPSA, 2009).

5.3.3 Level of education

The qualifications of the participants were grouped into diploma, bachelor degree, master's degree and doctorate. Figure 5.4 reveals that the ANMs had diplomas and degrees. Two thirds, namely 66 (70.0%) of the 94 (100.0%) participants, had a diploma as their highest academic qualification, while 28 (30.0%) had a degree in nursing (Figure 5.4). Surprisingly, no participants had master's or doctoral degrees. This is a concern and a reflection that nurse managers are not taking responsibility for advancing their career paths, particularly in research.

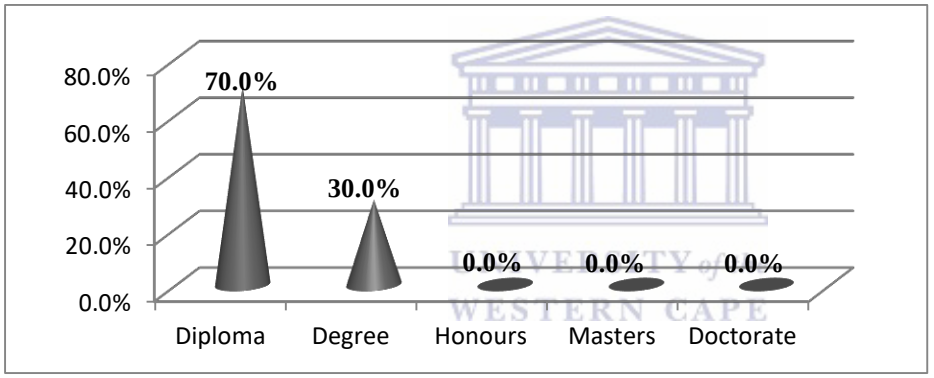

Figure 5.4: Highest level of education (n = 94)

It is evident that there is a lack of master's and doctoral nurses in the clinical setting, where their skills are needed. Redman (2007:64) states that there is a growing need for expanding the numbers of doctoral programmes and having more nurses qualified at doctoral level. Redman (2007:64) adds that doctoral nurses are able to address the pressing health problems faced globally and translate the findings of their research into practice and health policy.

5.3.4 Time spent in practice as a professional nurse

The participants' years of experience may indicate how long they have been working in certain clinical areas. The majority, namely 37 (45.7%) of 81 (100.0%), had 20–29 years' experience as professional nurses, and 26 (32.1%) had 30–39 years' experience (see Figure 5.5). The least number of participants, namely 18 (22.2%), had 11–19 years of experience. The median of the number of years the participants had been practising as professional nurses was 24 years,

ranging from 2 to 38 years, with an interquartile range of 10 years. It was also noted that 55 (68.0%) of the participants had worked as professional nurses for 29 years and less.

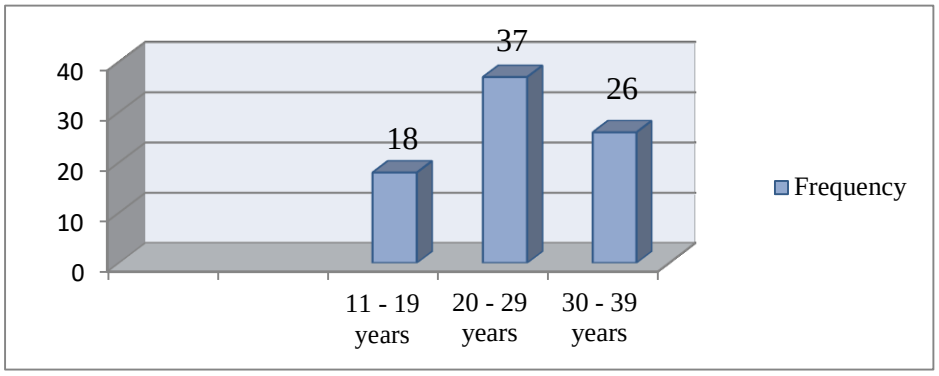

Figure 5.5: Experience as a professional nurse (n = 81)

5.3.5 Length of time in the current position

Approximately 48 (48.9%) of 91 (100.0%) participants had been in their current nurse manager position for five years and less. One third (33.0%) had been in a nurse manager position for 6 to 10 years (Table 5.2).

Table 5.2: Length of time in current position (n = 91)

How long have you been practising as an assistant nurse manager	(n)	%
0–5 years	46	50.5
6–10 years	31	34.1
11–15 years	9	9.9
16 years and above	5	5.5

The participants have been working in their posts for a median time of 5 years, ranging from less than 1 year to 21 years, with an interquartile range of 4 years, and 77 (84.6%) have worked in the post for less than 11 years. It is confirmed by Mokoka, Oosthuizen and Ehlers (2010:3) that managerial positions require experience.

5.3.6 Work setting

The responses to the setting in which work are illustrated in Figure 5.6. Ninety three (100.0%) participants were drawn from various levels of care, including district health services (n=41, 43.6%) (that is, community health centres, community day centres and clinics), specialised hospitals, namely 22 (23.4%) (that is, psychiatric and TB hospitals), academic hospitals and regional hospitals (n=11, 11.7%). The largest population (43.6%) in the survey stated that they

worked in district health services. Only 22 (23.4%) worked in specialised hospitals and 19 (20.2%) in academic hospitals.

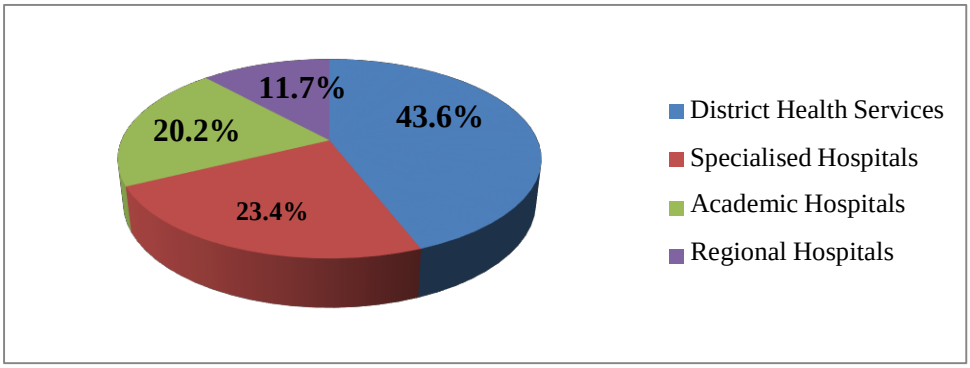

Figure 5.6: Work setting (n = 93)

5.3.7 Area of speciality

The areas of speciality of 94 (100.0%) participants are shown in Table 5.3 below.

Table 5.3: Area of speciality (n = 94)

Area of speciality	n	%
Surgical	31	33.0
Gynaecology	17	18.1
Medical	34	36.2
Trauma	22	23.4
Intensive care	12	12.8
Paediatrics	21	22.3
Theatre	15	16.0
Oncology	6	6.4
Ophthalmology	5	5.3
Obstetrics	23	24.5
Orthopaedics	12	12.8
Primary healthcare	6	6.4
Psychiatry	36	38.3
Neonatal	11	11.7
Burns unit	3	3.2

The most common nursing specialities were psychiatry (n=36, 38.0%), medical (n=34, 36.2%) and surgical (n=31, 33.0%). The least number of participants was in the burns unit (n=3, 3.2%).

5.4 SECTION B: COMPETENCIES OF ASSISTANT NURSE MANAGERS

The findings address these five domains on the perceptions of ANMs of their existing and expected competencies:

Legal and professional framework domain: (Items 1, 2, 3, 4, 5, 6, 7, 8, 9, 10 and 11).

Interpersonal domain: (Items 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35 and 36).

Evidence-based domain: (Items 41, 42, 43, 44, 45, 46, 47, 48 and 49).

Strategic resource management domain: (Items 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73 and 74).
Leadership domain: (Items 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95 and 96).
Items 12 to 15, 37 to 40, 50 to 53, 75 to 78 and 97 to 100 were open-ended questions, and responses were integrated in the findings.

Descriptive statistics were conducted on the responses of 94 (100.0%) participants. The descriptive statistics refer to the number of responses (n), and the standard deviation on the items in section B in the questionnaire. For the purposes of the discussion n refers to the number of responses to an item. Nurse managers were asked to rate their existing (current) and expected (future) competencies as they perceive them as necessary to carry out their jobs effectively. The nurse managers rated each competency statement with this scale:
1 = To no extent
2 = To a small extent
3 = To a moderate extent
4 = To a large extent

The competency ratings assigned to each item by participants were totalled and mean values and standard deviations were calculated. Higher scores on a competency statement meant that the nurse manager was competent in that item. Thus, the higher the mean value for an item, the higher it was valued as having the competency. For purposes of this study, the findings in each of the sub-headings are presented with reference to responses:

- A total of 15.0% or more of the participants indicated to no extent and to a small extent in their responses to the items in a sub-domain;
- Responses in which 45.0% and higher of the participants indicated that they agreed to a moderate extent on the items in a sub-domain;
- Items in which 80.0% and a higher percentage of responses indicated to a large extent for existing and expected responses in a sub-domain;
- Highest two mean values regarding existing or expected responses in each sub-domain;

The highest mean value of a sub-domain in a domain;
The three items with the highest corrected item-total correlation and squared multiple correlation the mean value for each domain for the existing and expected scores;
The strongest item in each of the sub-domains of a domain;
A significant difference between the existing and expected scores of a sub-domain;
The level of reliability of the sub-domains in each of the five domains.

Overall, the mean values were lower for existing competencies than for expected competencies.

Tables 5.4, 5.9, 5.14, 5.19 and 5.24 indicate into which competency category the items fall:

Foundation or transversal competencies
Supporting competencies
Interaction competencies

5.4.1 Legal and professional framework domain

The legal and professional framework comprises four sub-domains:

Legislation (Items 1, 2, 3, 4 and 5)

Patient care (Items 6, 7 and 8)

Clinical activities (Items 9 and 10)

Health systems outcomes (Item 11) (Table 5.4)

Items 12 to 15 were open-ended questions, and the responses were integrated in the findings.

5.4.1.1 Legislation

The Western Cape Government Health Strategic 2015-2019 highlights national and provincial legislation that prescribes the services to be rendered by the DoH (WCGH, 2015:7). The Nursing Act, No 33 of 2005, regulates the profession, promotes the provision of nursing services to the citizens, and serves and protects the public in matters involving health services in the Health Plan (WCGH, 2015:10). Nursing is a regulated profession, comprising a body of scientific knowledge and skills practised by persons who are registered in terms of Section 31 of the Nursing Act, No 33 of 2005. In this sub-domain the items were negatively skewed, with a narrow distribution of .25 to .76 around the mean values (Table 5.4) of existing and expected responses.

In Item 2, 14 (15.1%) of 93 (100.0%) participants indicated that they to no and to a small extent currently ensured adherence to the acts and prescripts. It was noted that similarly, 14 (15.2%) of the 92 (100.0%) participants indicated that they to no and to a small extent currently created a setting for reviewing or updating patient care policies and procedures (Item 3). Nurse managers are central to the process of implementing policies and procedures (Townsend et al., 2015:213). In addition, nurse managers interpret policy from human resource departments and senior managers, and deliver it to ward staff. Hence, the introduction of managerial skill training to potential and existing nurse managers is critical (Townsend et al., 2015:211).

Table 5.4: Mean values and percentage of the rating of items measuring existing and expected legal and professional framework															
Item	**Competency items**		**Responses of assistant nurse managers**												
	Foundation or transversal competencies **Supporting competencies** **Interaction competencies**		**Total**		**To no extent**		**To a small extent**		**To a moderate extent**		**To a large extent**		$\bar{x}$	**SD**
			n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**		
	Legislation													
1	Coordinate optimal, holistic nursing care according to professional/legal framework	Existing/ Current	93	100.0	0	0.0	0	0.0	28	30.1	65	69.9	3.70	0.46
		Expecting	89	100.0	0	0.0	0	0.0	6	6.7	83	93.3	3.93	0.25
2	Ensure adherence to the acts/prescripts	Existing	93	100.0	2	2.2	12	12.9	40	43.0	39	41.9	3.25	0.76
		Expecting	88	100.0	0	0.0	1	1.1	15	17.5	72	81.8	3.81	0.43
3	Create a setting for review or update of patient-care policies	Existing	92	100.0	0	0.0	14	15.2	48	52.2	30	32.6	3.17	0.67
		Expecting	86	100.0	0	0.0	3	3.5	19	22.1	64	74.4	3.71	0.53
4	Monitor nursing care management activities according to the standards or scope of practice	Existing	92	100.0	0	0.0	1	1.1	36	39.1	55	59.8	3.59	0.52
		Expecting	87	100.0	0	0.0	1	1.1	9	10.3	77	88.5	3.87	0.37
5	Have background or current knowledge on labour relations	Existing	91	100.0	0	0.0	7	7.7	42	46.2	42	46.2	3.38	0.63
		Expecting	87	100.0	0	0.0	2	2.3	16	18.4	69	79.3	3.77	0.48
	Patient care													
6	Provide quality care with emphasis on patient-centred experience	Existing	92	100.0	0	0.0	3	3.3	26	28.3	63	68.5	3.65	0.54
		Expecting	86	100.0	0	0.0	0	0.0	8	9.3	78	90.7	3.91	0.29
7	Review the nursing care plan	Existing	93	100.0	0	0.0	15	16.1	36	38.7	42	45.2	3.29	0.73
		Expecting	87	100.0	1	1.1	5	5.7	19	21.8	63	72.4	3.71	0.63
8	Identify health indicators and risk factors	Existing	93	100.0	2	2.2	13	14.0	36	38.7	42	45.2	3.27	0.78
		Expecting	87	100.0	0	0.0	5	5.7	19	21.8	63	72.4	3.67	0.58

SD = standard deviation, $\bar{x}$ = mean value

Table 5.4: Mean values and percentage of the rating of items measuring existing and expected legal and professional framework														
Item	**Competency items**		**Responses of assistant nurse managers**											
			Total		**To no extent**		**To a small extent**		**To a moderate extent**		**To a large extent**		$\bar{x}$	**SD**
			n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**		
	Clinical activities													
9	Participate in the provision of nursing care to patients to ensure the formulation of accurate nursing diagnoses to address clients needs	Existing	92	100.0	1	1.1	17	18.5	40	43.5	34	37.0	3.16	0.76
		Expecting	88	100.0	2	2.3	7	8.0	20	22.7	59	67.0	3.55	0.74
10	Implement knowledge management	Existing	93	100.0	0	0.0	8	8.6	43	46.2	42	45.2	3.37	0.64
		Expecting	87	100.0	1	1.1	2	2.3	20	23.0	64	73.6	3.69	0.58
	Healthcare systems outcomes													
11	Ensure dissemination of information to enhance patient outcomes	Existing	92	100.0	0	0.0	10	10.9	33	35.9	49	53.3	3.42	0.68
		Expecting	86	100.0	0	0.0	2	2.3	13	15.1	71	82.6	3.80	0.46

SD = standard deviation, $\bar{x}$ = mean value

In Item 5, 42 (46.2%) of 91 (100.0%) participants indicated that to a moderate extent they had background or current knowledge of labour relations. More than two thirds, 65 (69.9%) of 93 (100.0%) participants, specified that to a large extent they agreed on currently coordinating nursing care according to the set standards of a framework (Item 1), versus the majority of 83 (93.3%) of 89 (100.0%) participants who expected it.

It is therefore essential that nurse managers should be expected to coordinate optimal holistic nursing care according to a professional, legal framework and monitor nursing care management activities according to the standards and scope of practice (WCGH, 2015). Fewer than half, namely 39 (41.9%) of 93 (100.0%) participants, versus three quarters namely 72 (81.8%) of 88 (100.0%) responses respectively indicated that they to a large extent agreed on their existing and expected competency regarding coordination of nursing care according to set standards of a framework (Item 2). For existing and expected competencies, respectively, 55 (59.8%) of 92 (100.0%) and 77 (88.5%) of 87 (100.0%) participants to a large extent monitored nursing care management activities according to the standards of practice / scope of practice (Item 4).

The highest mean values were indicated by the participants on respectively their existing and expected competency in coordinating optimal, holistic nursing care according to the set standards of a professional and legal framework (Item 1, $\bar{x}$ 3.70, SD 0.46; $\bar{x}$ 3.93, SD 0.25). The second highest mean values for respectively existing and expected competencies were for monitoring nursing care management activities according to the standards of practice (Item 4, $\bar{x}$ 3.59, SD 0.52; $\bar{x}$ 3.87, SD 0.37). The scope of practice addresses the role and boundaries of practice describe what is considered best practice by the profession. Hence an ANM is expected to monitor nursing care management activities according to the standards of practice (SANC, 2005:4).

5.4.1.2 Patient care

Epstein and Street (2011:100) define patient-centred care as a quality of personal, professional and organisational relationship. The efforts to promote patient-centred care should consider patient-centeredness of patients (and their families), clinicians and health systems (Epstein & Street, 2011:100). In this sub-domain all the items were negatively skewed, with a narrow distribution of .29 to .78 around the mean values (Table 5.4). The mean values were mostly lower for existing competencies than for expected competencies.

In Item 7, 15 (16.1%) of 93 (100.0%) participants indicated that they to no and a small extent

currently reviewed the developed nursing plan. It was noted that 15 (16.2%) of 93 (100.0%) participants to no and a small extent identified health indicators or risk factors currently (Item 8). More than two thirds, 63 (68.5%) of 92 (100.0%) participants, indicated that they to a large extent agreed on currently providing quality care, with the emphasis on patient-centred experience (Item 6), as opposed to 78 (90.7%) of 86 (100.0%) participants who were expected to do it. Chase (2010:4) agrees that the nurse manager's role has been identified as being critical in the provision of patient care.

The highest mean value was shown by participants on their expected competency in providing quality care with the emphasis on patient-centred experience (Item 6) ($\bar{x}$ 3.91, SD 0.29). The second highest mean value for expected competencies was for review of the developed nursing care plan (Item 7) ($\bar{x}$ 3.71, SD 0.29). The nurse manager is responsible for quality, safety, satisfaction and financial performance in alignment with regulatory and accrediting body requirements. In addition, the nurse manager represents the direct caregiver voice at nursing leadership decision-making (Chase, 2010:16).

5.4.1.3 Clinical activities

The nurse manager not only provides administrative and clinical leadership, but has a 24-hour accountability for all patient-care activities in the unit (Chase, 2010:18). Managing clinical excellence includes maintaining a safe, caring environment for patients, developing methods to assess the patient's and family's responses to nursing care, validating consistent medical regimes, and evaluating the effectiveness of unit-based clinical programmes (Chase, 2010:52). In this sub-domain the items were negatively skewed, with a narrow distribution of .58 to .76 around the mean values (Table 5.4). The mean values were mostly lower for existing competencies than those for expected competencies. A total of 18 (19.6%) of 92 (100.0%) participants indicated that they to no and a small extent, currently participated in the provision of nursing care to patients to ensure the formulation of accurate nursing diagnoses to address client's needs (Item 9). In Item 10, 43 (46.2%) of 93 (100.0%) participants indicated that they were expected to a moderate extent to implement knowledge management. The highest mean values for existing and expected competencies were on implementing knowledge management (Item 10) ($\bar{x}$ 3.37, SD 0.64, $\bar{x}$ 3.69, SD 0.58). Nurse managers communicate information to staff, coordinate activities, implement strategies formulated in the environment, act as agents of change, and oversee the day-to-day running of the business (Meissner & Radford, 2015:786).

5.4.1.4 Healthcare systems outcomes

In South Africa there is a new approach to healthcare system reform, with a shift from curative services to PHC. Tulchinsky and Varavikova (2010) state that this approach is a trend in the USA and UK. In addition, South Africa's healthcare system, which is predominantly run by nurses, requires more and more that nurses have the competence and expertise to manage the country's burden of disease and to meet its healthcare needs (NDoH, 2012:5). In this sub-domain the item was negatively skewed, with a narrow distribution of .46 to .68 around the mean values (Table 5.4). The mean value was lower for the existing competency as opposed to the expected competency. A majority of 71 (82.6%) of 86 (100.0%) participants indicated that to a large extent they agreed that they were expected to ensure dissemination of information to enhance patient outcomes (Item 11). The mean values on existing and expected competencies were on ensuring dissemination of information to enhance patient outcomes ($\bar{x}$ 3.42, SD 0.68; $\bar{x}$ 3.80, SD 0.46). Chase (2010:7) stresses that knowledge of healthcare environment and systems encompasses clinical practice knowledge, an understanding of evidence-based practices and outcome measurements. The importance of this role cannot be underestimated in successful healthcare organisation (Chase, 2010:7).

5.4.1.5 Overall findings on the legal and professional framework domain

Overall, in the legal and professional framework domain, the mean values for expected and existing competencies were lowest in the clinical activities ($\bar{x}$3.61, $\bar{x}$3.24) (Figure 5.7).

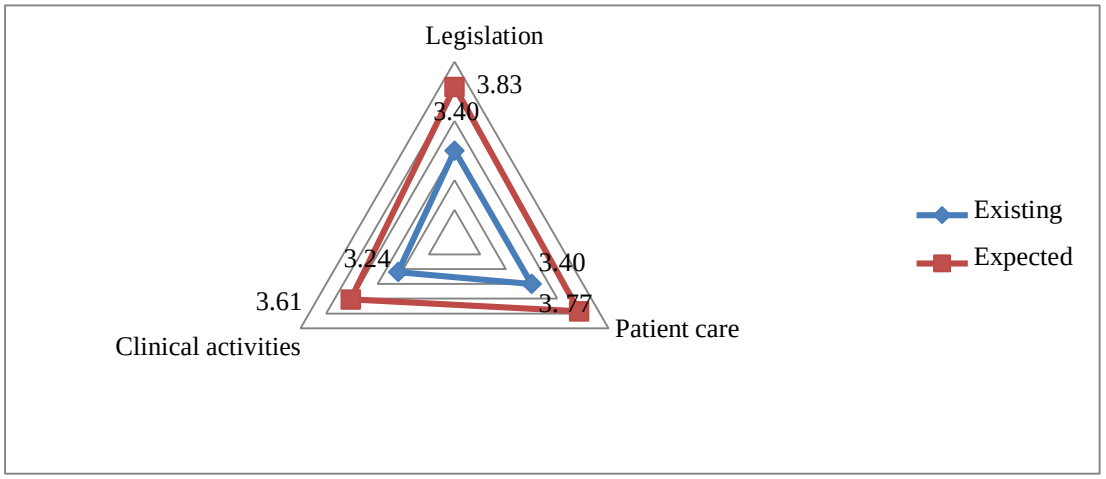

Figure 5.7: Mean values of the *legal and professional framework* domain

The mean values of the *existing* competencies of the ANM in the legal and professional framework domain sub-scales were lower than *expected* competencies, that is, Legislation (Item 1, 2, 3, 4 & 5 $\bar{x}$ 3.40; $\bar{x}$ 3.83); Patient care (Item 6, 7, & 8 $\bar{x}$ 3.24; $\bar{x}$ 3.61); and Clinical activities (Item 35 & 36 $\bar{x}$ 3.61; $\bar{x}$ 3.82) Figure 5.7.

Table 5.5 shows the level of reliability of each of the 4 sub-domains in the legal and professional domain. Scales with Cronbach's Alpha(α) higher than 0.70 are considered as reliable. Cronbach's alpha was lowest in the sub-domain of clinical activities (α 0.57) (Table 5.5).

Table 5.5: Reliability of the legal and professional framework domain

Scale	Scale Cronbach's alpha (α)	Number of items
Legislation	0.83	5
Patient care	0.68	3
Clinical activities	0.57	2
Healthcare systems outcomes	Only one item in scale	1

Table 5.6 shows the relationship between the existing and the expected level of competencies of the ANM in the legal and professional domain. The findings showed the average scores of the participants for each of the sub-scales of competence. Each item was measured on a scale with a minimum score of 1 and a maximum of 4. The scores below are the average scores for the sub-scale regarding the legal and professional domain. This means that the total score of the sub-scale was calculated by adding the score of each item (question) that made up the sub-scale, and dividing by the number of items. The mean difference between existing and expected level of competence is also presented.

Table 5.6: Comparison of average sub-scale items for existing and expected scores in the legal and professional framework domain

SD: Standard deviation, Sig: Significance difference

Scale	Number of participants that answered all the questions	Average score	SD	Paired t-test			Spearman correlation	
				Mean difference (existing minus expected)	SD	Sig	Correlation coefficient	Sig
Legislation								
Existing	81	3.40	0.47	-0.44	0.50	0.00	0.19	0.09
Expected	81	3.83	0.28					
Patient care								
Existing	84	3.40	0.52	-0.37	0.50	0.00	0.40	0.00
Expected	84	3.77	0.37					
Clinical activities								
Existing	85	3.24	0.59	-0.37	0.63	0.00	0.41	0.00
Expected	85	3.61	0.57					

The findings suggested that there is a significance difference between the existing and the expected scores of all the sub-scales with significance level 0.00 (Table 5.6). The mean differences mostly had negative values, which meant that the participants rating of existing competences was lower that their rating of expected competences. The highest average score was for the expected competencies under legislation ($\bar{x}$ 3.83) with a narrow distribution around the mean value of 0.28. This was followed by the sub-domains of Patient care ($\bar{x}$ 3.77, SD 0.37) and Clinical activities ($\bar{x}$ 3.61, SD 0.57) (Table 5.6). In the legal and professional framework domain, the three strongest items were those with the 'highest corrected item-total correlation' and 'squared multiple correlation'. The items have been arranged in descending order, based on their squared multiple correlation, then on their corrected item-total correlation (Table 5.7). The three strongest items with the highest corrected item-total correlation and squared multiple correlation in the legal and professional domain were; Item 11: Ensure dissemination to enhance patient outcome; Item 4: Monitor nursing care management activities according to the standards of practice / scope of practice) and Item 10: Implement knowledge management.

The level of reliability of the domain of legal and professional framework was Cronbach's alpha (α) 0.88 (Table 5.8). The instrument was internally consistent to the extent that the items in the legal and professional framework domain measured the same trait.

5.4.1.6 Summary of the legal and professional framework domain

The findings indicated that according to the criteria, certain items were identified as being important in a strategy for ANMs in the three broad areas of competencies. From these items, the levels of competencies were identified in sequence of priority, namely advanced (the first item under the broad area ○), proficient (second item under the broad area ◉) and knowledgeable (other items under the broad area ⊙).

Interaction (green)

- ○ Providing quality care with emphasis on patient-centred experience (Item 6) in the sub-domain of patient care.
- ◉ Ensuring dissemination of information to enhance patient outcomes (Item 11) in the sub-domain of health systems outcomes.

Foundation competencies (blue)

- ○ Coordinating optimal, holistic nursing care according to the set standards of a professional/legal framework (Item 1) in the sub-domain of legislation.
- ◉ Ensuring adherence to the acts/prescripts (Item 2) in the sub-domain of legislation.
- ⊙ Monitoring nursing management activities according to the standards of practice / scope of practice (Item 4) in the sub-domain of legislation.

Table 5.7: Total statistics of the legal and professional framework domain

Item no	Competency items	Scale mean if item deleted	Scale variance if item deleted	Corrected item-total correlation	Squared multiple correlation	Cronbach's alpha if item deleted
11	Ensure dissemination of information to enhance patient outcomes	33.90	19.11	0.69	0.60	0.861
4	Monitor nursing care management activities according to standards of practice / scope of practice	33.76	20.33	0.65	0.60	0.866
10	Implement knowledge management	33.95	19.74	0.64	0.54	0.865
1	Coordinate optimal, holistic nursing care according to the set standards of a professional/legal framework	33.63	20.90	0.61	0.52	0.869
3	Create a setting for review or update of patient care policies/procedures	34.14	19.84	0.57	0.51	0.870
2	Ensure adherence to the acts/prescripts	34.07	19.05	0.62	0.50	0.866
8	Identify health indicators or risk factors	34.06	18.67	0.65	0.49	0.864
5	Have background or current knowledge on labour relations	33.95	20.12	0.55	0.49	0.871
6	Provide quality care with emphasis on patient-centred experience	33.67	20.46	0.59	0.48	0.869
9	Participate in the provision of nursing care to patients in order to ensure the formulation of accurate nursing diagnoses to address clients' needs	34.17	19.42	0.54	0.46	0.873
7	Review the developed nursing care plan	34.07	19.88	0.48	0.41	0.876

Table 5.8: Level of reliability of legal and professional framework and two strongest items

Domain	Scale Cronbach's alpha (α)	Number of items	Strongest items
Legal and professional framework	0.88	11	Ensure dissemination of information to enhance patient outcomes
			Monitor nursing care management activities according to the standards of practice / scope of practice

Supporting competencies (pink)

- Participating in the provision of nursing care to patients to ensure the formulation of accurate nursing diagnoses to address client needs (Item 9) in the sub-domain clinical activities.
- Addressing clinical activities, identify health indicators or risk factors (Item 8) in the subdomain on patient care.
- Addressing patient care and create a setting for review or update of patient care policies (Item 3) in the sub-domain on legislation.
- Implementing knowledge management (Item 10) in the sub-domain on clinical activities.

The highest mean value ($\bar{x}$ 3.83) was the sub-domain of legislation, followed by the sub-domains of patient care, clinical activities and healthcare systems.

5.4.2 Interpersonal domain

Eight sub-domains are discussed under the interpersonal domain:

Effective communication (Items 16, 17, 18 and 19)

Self-confidence (Items 20 and 21)

Self-development (Items 22, 23 and 24)

Relationship building (Items 25, 26, 27 and 28)

Conflict management (Items 29 and 30)

Problem-solving (Item 31 and 32)

Providing feedback (Items 33 and 34)

Openness, honesty and trust (Items 35 and 36) (see Table 5.9).

Items 37 to 40 were open-ended questions, and the responses were integrated in the findings.

5.4.2.1 Effective communication

Effective communication is the key to organisational success. It is a strategic tool that can build or break organisational functioning. Achieving organisational goals is about communicating, clarifying, motivating, team dynamics, sense-making, negotiating, presenting, influencing and building feedback loops (Chase, 2010:138).

In this sub-domain the items were negatively skewed, with a narrow distribution of .25 to .65 around the mean values (Table 5.9). The mean values were typically lower for existing competencies as opposed to those of the expected competencies.

More than two thirds, namely 66 (71.0%) of 93 (100.0%) of the participants, agreed to a large extent that they had the ability to currently communicate clear guidelines (Item 16), as opposed to 76 (86.4%) of 88 (100.0%) participants who expected it. More than two thirds, namely 69 (74.2%) of 93 (100.0%) participants, stated that they agreed that they to a large extent currently maintained professional working relationships based on ethics, as opposed to the majority of 82 (93.2%) of 88 (100.0%) participants who were expected to do it. Building interpersonal relationships is basic to the success of nurse managers. Chase (2010:7) stresses that communication and relationship building comprise shared decision-making, multidisciplinary and academic relationships and influence. Additionally, nurse managers are the conduit of communication between upper management and the bedside staff, providing key messages and setting the culture for their units and organisation (Chase, 2010:4).

Less than two thirds of participants, that is, 59 (63.4%) of 93 (100.0%), as opposed to three quarters, namely 71 (82.6%) of the 86 (100.0%) responses, respectively, agreed to a large extent on their existing and expected competencies regarding sharing a common vision through ongoing dialogue with all stakeholders (Item 18). The majority of 82 (93.2%) of 88 (100.0%), 76 (86.4%) of 87 (100.0%) and 71 (81.6%) of 86 (100.0%) participants indicated that they to a large extent were expected to have the competencies of maintaining professional working relationships based on ethics (Item 17), being able to communicate clear guidelines (Item 16) and sharing a common vision through ongoing dialogue with all stakeholders (Item 18). Nurses communicate with patients, their families and other health professionals in a wide range of circumstances for which they need appropriate communication skills. Despite technological advancements and increasing complexities of the healthcare environment, the holistic nature of care requires the ability to engage with patients and colleagues using effective communication strategies (Philip et al., 2015:2629).

The highest mean values for existing and expected competencies were on maintaining professional working relationships based on ethics (Item 17) ($\bar{x}$ 3.72, SD 0.50; $\bar{x}$ 3.93, SD 0.25) The second highest mean values for existing and expected competencies were on the ability to communicate clear guidelines (Item 16) ($\bar{x}$ 3.69, SD 0.51; $\bar{x}$ 3.85, SD 0.39). In promoting institutional governance and leadership, the National Nursing Strategy 2012-2017.

Table 5.9: Mean values and percentage of the rating of items measuring existing and expected interpersonal category															
Item	**Competency items**		**Responses of assistant nurse managers**												
	Foundation or transversal competencies Supporting competencies Interaction competencies		**Total**		**To no extent**		**To a small extent**		**to a moderate extent**		**To a large extent**		$\bar{x}$	**SD**
			n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**		
	Effective communication													
16	Have ability to communicate clear guidelines	Existing	93	100.0	0	0.0	2	2.2	25	26.9	66	71.0	3.69	0.51
		Expecting	88	100.0	0	0.0	1	1.1	11	12.5	76	86.4	3.85	0.39
17	Maintain professional working relationship based on ethics	Existing	93	100.0	0	0.0	2	2.2	22	23.7	69	74.2	3.72	0.50
		Expecting	88	100.0	0	0.0	0	0.0	6	6.8	82	93.2	3.93	0.25
18	Share a common vision through ongoing dialogue with all stakeholders	Existing	93	100.0	0	0.0	8	8.6	26	28.0	59	63.4	3.55	0.65
		Expecting	86	100.0	0	0.0	2	2.3	13	15.1	71	82.6	3.8	0.46
19	Follow a top-bottom or bottom-top approach for ensuring transparency	Existing	93	100.0	0	0.0	5	5.4	36	38.7	52	55.9	3.51	0.60
		Expecting	89	100.0	1	1.1	1	1.1	17	19.1	70	78.7	3.75	0.53
	Self-confidence													
20	Take initiative by proposing suggestions in an open arena	Existing	89	100.0	1	1.1	9	10.1	25	28.1	54	60.7	3.48	0.73
		Expecting	89	100.0	1	1.1	0	0.0	13	14.6	75	84.3	3.82	0.47
21	Take a risk confidently about a specific solution	Existing	93	100.0	1	1.1	8	8.6	44	47.3	40	43.0	3.32	0.68
		Expecting	87	100.0	2	2.3	5	5.7	17	19.5	63	72.4	3.62	0.70
	Self-development													
22	Have appropriate self-awareness to address own limitations	Existing	93	100.0	0	0.0	4	4.3	38	40.9	51	54.9	3.51	0.58
		Expecting	89	100.0	2	2.2	2	2.2	19	21.3	66	74.2	3.67	0.64
23	Have self-knowledge to identify need that requires learning new skills	Existing	93	100.0	0	0.0	2	2.2	37	39.8	54	58.1	3.56	0.54
		Expecting	89	100.0	2	2.2	2	2.2	15	16.9	70	78.7	3.72	0.62
24	Initiate activities to develop fellow workers	Existing	92	100.0	0	0.0	9	9.8	37	40.2	46	50.0	3.40	0.66
		Expecting	89	100.0	1	1.1	6	6.7	18	20.2	64	71.9	3.63	0.66
25	Focus on diversity in the workplace	Existing	92	100.0	0	0.0	5	5.4	26	28.3	61	66.3	3.61	0.59
		Expecting	89	100.0	1	1.1	2	2.2	12	13.5	74	83.1	3.79	0.53

SD = standard deviation, $\bar{x}$ = mean value

Table 5.9: (cont.) Mean values and percentage of the rating of items measuring existing and expected <u>interpersonal</u> category														
Item	**Competency items**		**Responses of assistant nurse managers**											
	Foundation or transversal competencies Supporting competencies Interaction competencies		**Total**		**To no extent**		**To a small extent**		**To a moderate extent**		**To a large extent**		$\bar{x}$	**SD**
			n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**		
	Relationship building													
26	Build trust among the employees ensuring productivity	Existing	92	100.0	0	0.0	5	5.4	23	25.1	64	69.6	3.64	0.59
		Expecting	89	100.0	1	1.1	0	0.0	10	11.2	78	87.6	3.85	0.44
27	Promote shared decision-making	Existing	93	100.0	1	1.1	12	12.9	42	45.2	38	40.9	3.26	0.72
		Expecting	88	100.0	1	1.1	8	9.1	17	19.3	62	70.5	3.59	0.71
28	Have people management skills	Existing	91	100.0	0	0.0	1	1.1	23	25.3	67	73.6	3.73	0.47
		Expecting	89	100.0	1	1.1	0	0.0	11	12.4	77	86.5	3.84	0.45
	Conflict management													
29	Manage conflict commitment to finding amicable solution	Existing	93	100.0	0	0.0	3	3.2	23	24.7	67	72.0	3.69	0.53
		Expecting	89	100.0	1	1.1	0	0.0	10	11.2	78	87.6	3.85	0.44
30	Use various strategies to resolve conflict in the workplace	Existing	92	100.0	0	0.0	5	5.4	34	37.0	53	57.6	3.52	0.60
		Expecting	88	100.0	3	3.4	1	1.1	11	12.5	73	83.0	3.75	0.65
	Problem-solving													
31	Address patient and public complaints	Existing	93	100.0	1	1.1	2	2.2	27	29.0	63	67.7	3.63	0.59
		Expecting	89	100.0	0	0.0	1	1.1	8	9.0	80	89.9	3.89	0.35
32	Solve problems by using a specific framework	Existing	91	100.0	0	0.0	6	6.6	43	47.3	42	46.2	3.40	0.61
		Expecting	87	100.0	1	1.1	2	2.3	13	14.9	71	81.6	3.77	0.54
	Providing feedback													
33	Provide constructive feedback to staff	Existing	93	100.0	0	0.0	1	1.1	28	30.1	64	68.8	3.68	0.49
		Expecting	87	100.0	1	1.1	2	2.3	7	8.0	77	88.5	3.84	0.50
34	Provide feedback to operational nurse managers on recent developments	Existing	91	100.0	1	1.1	10	11.0	33	36.3	47	51.6	3.38	0.73
		Expecting	86	100.0	1	1.1	2	2.3	17	19.8	66	76.6	3.72	0.57

SD = standard deviation, $\bar{x}$ = mean value

Table 5.9: (cont.) Mean values and percentage of the rating of items measuring existing and expected interpersonal category														
Item	**Competency items**		**Responses of assistant nurse managers**											
			Total		**To no extent**		**To a small extent**		**To a moderate extent**		**To a large extent**		$\bar{x}$	**SD**
			n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**		
	Openness, honesty and trust													
35	Maintain trust through talking openly about challenges that need to be addressed	Existing	93	100.0	0	0.0	1	1.1	33	35.5	59	63.4	3.62	0.51
		Expecting	89	100.0	1	1.1	2	2.2	10	11.2	76	85.4	3.81	0.52
36	Adhere to work ethics	Existing	93	100.0	0	0.0	0	0.0	14	15.1	79	84.9	3.85	0.36
		Expecting	89	100.0	1	1.1	1	1.1	7	7.9	80	89.9	3.87	0.46

SD = standard deviation, $\bar{x}$ = mean value

(NDoH, 2012:45) maintains that communication strategies must be implemented to facilitate open channels of communication. The NDoH (2012:28) is in agreement, stating that nursing leaders must develop collaborative relationships with stakeholders, as well as support to garner the cooperation required to achieve the goals.

5.4.2.2 Self-confidence

Meissner and Radford (2015:785) emphasise the significance of confidence of middle managers because they are an essential element of healthcare organisations. In the self-confidence sub-domain, the items were negatively skewed, with a narrow distribution of .47 to .73 around the mean values (Table 5.9). The mean values were typically lower for existing competencies as opposed to those of the expected competencies. In Item 21, 44 (47.3%) of 93 (100.0%) participants indicated that to a moderate extent were currently taking a risk confidently about a specific solution. Less than two thirds, namely 54 (60.7%) of 89 (100.0%) participants indicated that they agreed to a large extent on currently taking the initiative by proposing suggestions in an open arena, versus the majority of 75 (84.3%) of 89 (100.0%) participants that were expected to do it. The majority of 75 (84.3%) of 89 (100.0%) participants indicated that to a large extent they were expected to take the initiative by proposing suggestions in an open arena (Item 20). The highest mean values for both existing and expected competencies were for taking the initiative by proposing suggestions in an open arena (Item 20, $\bar{x}$ 3.48, SD 0.73; $\bar{x}$ 3.82, SD 0.47). Managerial activities performed by middle managers require self-confidence. Furthermore, while technical skills are important, a broader skill set is needed to be effective as a middle manager, which includes taking a risk about a specific solution and proposing suggestions (Meissner & Radford, 2015:785).

5.4.2.3 Self-development

Self-development is a key in nursing management. Individualised training and development plans are critical to developing effective middle managers (Meissner & Radford, 2015:791). In this sub-domain the items were negatively skewed, with a narrow distribution of .54 to .66 around the mean values (Table 5.9). The mean values were typically lower for existing competencies as opposed to those of the expected competencies. More than half, namely 51 (54.9%) of 93 (100.0%) of the participants, agreed to a large extent on their existing appropriate self-awareness to address their own limitations (Item 22), as opposed to the majority of 66 (74.2%) of 89 (100.0%) participants, who were expected to do it. Self-awareness skills are important to being an effective middle manager. Additionally, provision of training in self-awareness skills was needed to improve the performance of middle managers (Meissner & Radford, 2015:291). More than half, namely 54 (58.1%) of 93 (100.0%), as opposed to three

quarters, namely 70 (78.7%) of 89 (100.0%) responses, indicated that to a large extent participants agreed on their existing and expected competencies regarding having self-knowledge to identify needs that require learning new skills (Item 23). Half, namely 46 (50%) of 92 participants indicated that to a large extent they agreed on currently initiating activities to develop fellow workers (Item 24), as opposed to the 64 (71.9%) of 89 (100.0%) that were expected to do it. To achieve considerable changes in the nursing workforce, the director of nursing may believe that nurses need to know what they are responsible for and to whom they are accountable; and the leaders of the nursing workforce need to know what they are leading and why (Graham & Jack, 2008:956). Therefore, a Director of Nursing could approach a university to lead a development programme to improve leadership skills; develop a team of leading nurses to enhance personal insights and abilities (Graham & Jack, 2008:956).

The highest mean values on existing and expected competencies were on having self-knowledge to identify needs that require learning new skills (Item 23, $\bar{x}$ 3.56, SD 0.54; $\bar{x}$ 3.72, SD 0.62). The second highest mean values for both existing and expected competencies were for having appropriate self-awareness to address own limitations (Item 22, $\bar{x}$ 3.51, SD 0.58; $\bar{x}$ 3.67, SD 0.64). An ANM should identify needs that require new skills. In addition, the provision of effective training and development opportunities to assist middle managers to address the demands of the role is essential (Meissner & Radford, 2015:786)

5.4.2.4 Relationship building

Al-Hamdan et al. (2014:42) declared that the nurse manager has a role in building relationships among employees and can use conflict management to solve problems and strengthen relationships. In this sub-domain the items were negatively skewed, with a narrow distribution of .45 to .72 around the mean values (Table 5.9). The mean values were typically lower for existing competencies as opposed to those of the expected competencies. In Item 27, 42 (45.2%) of 93 (100.0%) participants indicated that to a moderate extent they currently promoted shared decision-making. In Item 25, 74 (83.1%) of 89 (100.0%) participants indicated that to a large extent they were expected to focus on diversity in the workplace. A total of 78 (87.6) of 89 (100.0%) participants specified that to a large extent they were expected to build trust among employees, ensuring productivity (Item 25). A total of 77 (86.5%) of 89 (100.0%) indicated that to a large extent they were expected to have people management skills (Item 28).

The highest mean values on the existing and expected competencies were on building trust among the employees, ensuring productivity (Item 25, $\bar{x}$ 3.64, SD 0.59; $\bar{x}$ 3.85, SD 0.44). The second highest mean values for both existing and expected competencies were on having people management skills (Item 28, $\bar{x}$ 3.73, SD 0.47; $\bar{x}$ 3.84, SD 0.45). Provision of additional training in managerial and people management skills, could better equip them to be more productive, efficient and effective in providing quality care to clients (Meissner & Radford, 2015:791).

5.4.2.5 Conflict management

ANMs are expected to commit to managing conflict amicably. Nurse managers must manage conflict in order to provide an environment that stimulates growth and ensures quality patient care (Al-Hamdan et al., 2014:42). Bousari, Ebrahimi, Ahmadi, Abedi and Kennedy (2009:239) state that conflict can help nurse managers to achieve their goals. In this sub-domain the items were negatively skewed, with a narrow distribution of .44 to .65 around the mean values (Table 5.9). The mean values were classically lower for existing competencies than expected competencies.

More than two thirds, namely 67 (72.0%) of 93 (100.0%) participants, versus more than three quarters, namely 78 (87.6%) of 89 (100.0%) responses, indicated that they to a large extent agreed on their existing and expected competencies regarding managing conflict commitment to finding amicable solutions (Item 29). As a positive force, conflict can help maintain an optimum level of stimulation and activation among organisational members, and properly managed conflict can facilitate organisational growth (Al-Hamdam et al., 2014:41). More than half, 53 (57.6%) of 92 (100.0%) of the participants indicated that to a large extent they agreed on currently using different strategies to resolve conflict in the workplace (Item 30), as opposed to more than three quarters, namely 73 (83.0%) of 88 (100.0%) participants that were expected to do it. The highest mean values on the existing and expected competencies were around managing conflict commitment by finding amicable solutions (Item 29) ($\bar{x}$ 3.69, SD 0.53; $\bar{x}$ 3.85, SD 0.44). Conflict can be valuable to an organisation since it promotes innovative and creative problem-solving, clarifies issues, and allows underlying problems to rise to the surface, again assuming it can be managed effectively (Al-Hamdam et al., 2014:41).

5.4.2.6 Problem-solving

Problem-solving is one of the functions of a nurse manager in a healthcare environment. In this sub-domain the items were negatively skewed, with a narrow distribution of .35 to .61 around the mean values (Table 5.9). The mean values were typically lower for existing competencies

oppose to those of the expected competencies. In Items 32, 43 (47.3) of 91 (100.0%) participants indicated that to a moderate extent they currently solved problems by using a specific framework. In Item 31, 80 (89.9%) of 89 (100.0%) participants indicated that to a large extent they were expected to address complaints from patients and the public. It was also found that 71 (81.6%) of 87 (100.0%) participants to a large extent expected to solve problems by using a specific framework. (Item 32). The highest mean values on the existing and expected competencies were on addressing complaints from patients and public (Item 31, $\bar{x}$ 3.63, SD 0.59; $\bar{x}$ 3.89, SD 0.35).

5.4.2.7 Providing feedback

Provision of feedback to staff is critical in the current healthcare system to bridge the gap between staff and management (Chase, 2010:113). In this sub-domain, the items were negatively skewed, with a narrow distribution of .49 to .73 around the mean values (Table 5.9). The mean values were classically lower for existing competencies oppose to those of the expected competencies. More than two thirds, namely 64 (68.8%) of 93 (100.0%) participants, indicated that they to a large extent agreed on currently providing constructive feedback to staff (Item 33), versus more than three quarters, namely 77 (88.5%) of 87 (100.0%), that were expected to do it. More than half, namely 47 (51.6%) of 91 (100.0%) versus more than three quarters, namely 66 (76.6%) of 86 (100.0%) participants indicated that they to a large extent agreed on their existing and expected feedback provided to the ONM on recent developments (Item 34). The highest mean values on the existing and expected competencies were on providing constructive feedback to staff (Item 33, $\bar{x}$ 3.68, SD 0.49; $\bar{x}$ 3.84, SD 0.50).

5.4.2.8 Openness, honesty and trust

It has been suggested that teams are most productive where there is openness and trust, and members can work to their own strengths. Hence, nurse managers should be open, honest and trustworthy (Craig & McKeown, 2015:14). In this sub-domain the items were negatively skewed, with a narrow distribution of .36 to .52 around the mean values (Table 5.9). The mean values were typically lower for existing competencies as opposed to those of the expected competencies. In Item 35, 76 (85.4%) of 89 (100.0%) participants to a large extent indicated that they were expected to maintain trust through talking openly about challenges that need to be addressed. More than three quarters, namely 79 (84.9%) of 93 (100.0%) participants, versus more than three quarters, namely 80 (89.9 %) of the 89 (100.0%) responses, respectively, to a large extent agreed on their existing and expected adherence to work ethics. The highest mean values on the existing and expected competencies were around adherence to work ethics e.g. maintenance of confidentiality (Item 36, $\bar{x}$ 3.85, SD 0.36; $\bar{x}$ 3.87, SD 0.46). There is a loyalty

inherent to the role of the nurse manager that is work ethics, related to ethical principles of practice, which include openness, honesty and trust (Ganz et al., 2015:44)

5.4.2.9 Overall findings on the interpersonal domain

Overall in the interpersonal findings domain, the mean values for the expected competencies were lowest in the sub-domain self-development ($\bar{x}$ 3.67) and the mean values for the existing competencies were the lowest in the sub-domain self-confidence ($\bar{x}$ 3.40) (Figure 5.8).

The mean values of the existing competencies of the ANM in the interpersonal domain sub-scales were lower than expected competencies, that is, Effective communication (Items 16, 17, 18 & 19 $\bar{x}$ 3.59; $\bar{x}$ 3.84); Self-confidence (Items 20 & 21 $\bar{x}$ 3.40; $\bar{x}$ 3.73); Self-development (Item 22, 23, 24 & 25 $\bar{x}$ 3.48; $\bar{x}$ 3.67); Relationship building (Items 26, 27 & 28 $\bar{x}$ 3.54; $\bar{x}$ 3.79); Conflict management (Items 29 & 30 $\bar{x}$ 3.61; $\bar{x}$ 3.81); Problem solving (Items 31 & 32 $\bar{x}$ 3.63; $\bar{x}$ 3.89); Providing feedback (Items 33, & 34 $\bar{x}$ 3.51; $\bar{x}$ 3.77) and Openness, honesty and trust (Items 35 & 36 $\bar{x}$ 3.61; $\bar{x}$ 3.82) Figure 5.8.

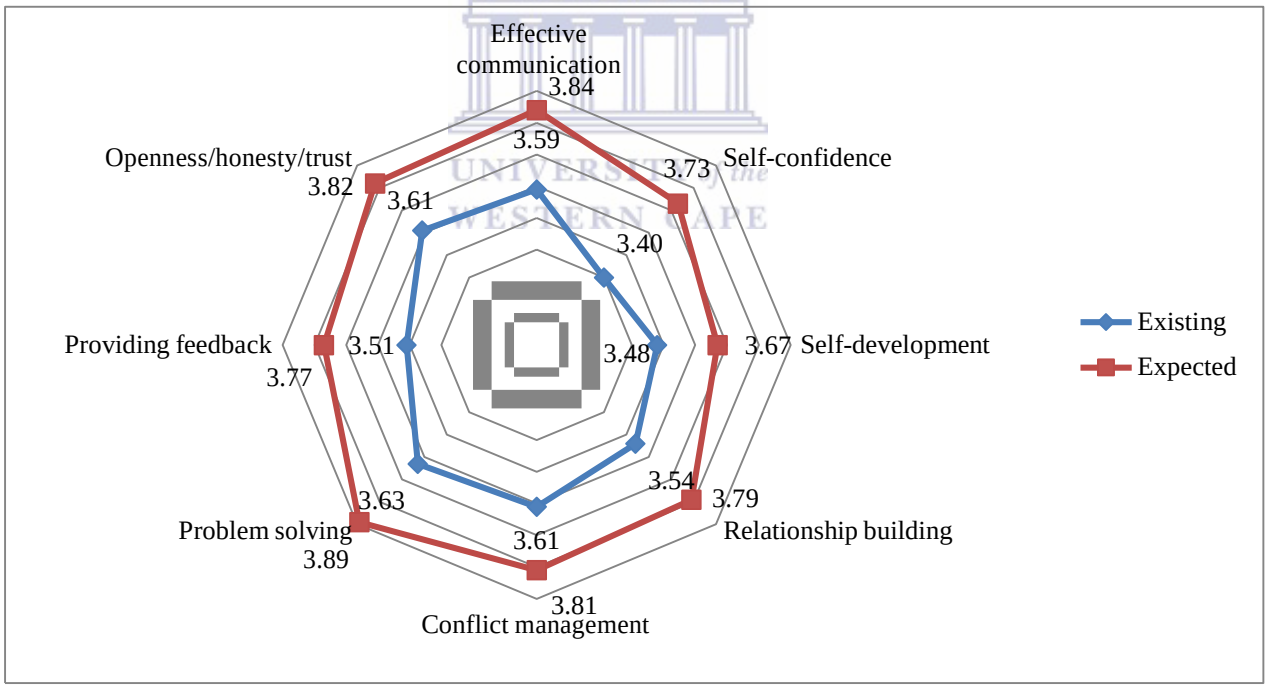

Figure 5.8: Mean values of *interpersonal* domain sub-scales

Table 5.10 shows the level of reliability of each of the 8 sub-domains. Scales with Cronbach's Alpha higher than 0.70 are considered as reliable. The highest Similarly, Cronbach's alpha (α) was the lowest in the sub-domain of openness, honesty and trust (α 0.61).

Table 5.10: Reliability of interpersonal domain

Scale	Scale Cronbach's alpha (α)	Number of items
Effective communication	0.80	4
Self-confidence	0.78	2
Self-development	0.76	3
Relationship building	0.82	4
Conflicts management	0.64	2
Problem-solving	Only one item in scale	
Providing feedback	0.65	2
Openness/ honesty/ trust	0.61	3

Table 5.11 shows a relationship between the existing and the expected level of competencies of the ANM in the interpersonal domain. The findings showed the average scores of the participants for each of the sub-scales regarding the interpersonal domain of competence consisting of individual questions (items). Each item was measured on a scale with minimum score of 1 and a maximum score of 4. The scores are the average scores for the interpersonal domain. The findings suggested that there is a significance difference between the existing and the expected scores of all the sub-scales with significance level 0.00 (Table 5.11). The mean differences mostly had negative values, which meant that the participants' rating of existing competence was lower than their rating of expected competence. The highest average score was for the expected competencies under problem-solving ($\bar{x}$ 3.89) with a narrow distribution around the mean value of 0.35. This was followed by the sub-domains of effective communication ($\bar{x}$ 3.84, SD 0.33); openness, honesty and trust ($\bar{x}$ 3.82, SD 0.48) and conflict management ($\bar{x}$ 3.81, SD 0.51) (Table 5.11).

In the interpersonal domain the four strongest items were identified as those with the highest corrected item-total correlation. The items have been arranged in descending order based on their corrected item-total correlation (Table 5.12). The four strongest items with the highest corrected item-total correlation in the interpersonal domain were Item 26 building trust among the employees ensuring productivity; Item 18, sharing a common vision through ongoing dialogue with all stakeholders; Item 25, focusing on diversity in the workplace and Item 27, promoting shared decision-making. The level of reliability of the domain of interpersonal was Cronbach's alpha (α) 0.93 (Table 5.13). It is reflected in Table 5.13 that the instrument is internally consistent to the extent that the items in the Interpersonal domain measure the same trait. The coefficient alpha scale is 0.93, with 20 items.

Table 5.11: Comparison of the average sub-scale items for existing and expected scores in the interpersonal domain

Scale	Number of participants that answered all the questions	Average score	SD	Paired t-test			Spearman correlation	
				Mean differences	SD	Sig	Correlation coefficient	Sig
Effective communication								
Existing	85	3.59	0.46	-0.24	0.52	0.00	0.16	0.14
Expected	85	3.84	0.33					
Self-confidence								
Existing	84	3.40	0.63	-0.33	0.64	0.00	0.39	0.00
Expected	84	3.73	0.52					
Self-development								
Existing	88	3.48	0.49	-0.19	0.65	0.01	0.15	0.18
Expected	88	3.67	0.56					
Relationship building								
Existing	85	3.54	0.49	-0.25	0.53	0.00	0.29	0.01
Expected	85	3.79	0.40					
Conflicts management								
Existing	87	3.61	0.48	-0.20	0.65	0.01	0.15	0.18
Expected	87	3.81	0.51					
Problem-solving								
Existing	88	3.63	0.59	-0.26	0.58	0.00	0.34	0.00
Expected	88	3.89	0.35					
Providing feedback								
Existing	83	3.51	0.54	-0.26	0.57	0.00	0.41	0.00
Expected	83	3.77	0.49					
Openness, honesty and trust								
Existing	86	3.61	0.38	-0.21	0.51	0.00	0.31	0.00
Expected	86	3.82	0.48					

5.4.2.10 Summary of the interpersonal domain

The findings indicated that according to the criteria set for this study certain items were identified as important to be addressed in a strategy for ANMs, in the three broad areas of competencies. From these items, the levels of competencies were identified in sequence of

priority, namely advanced (the first item under the broad area ○), proficient (second item under the broad area ⦿) and knowledgeable (other items under the broad area ⊙):

Interaction (green)

⦿ Share a common vision with stakeholders (Item 18)

⦿ Focus on diversity in the workplace (Item 25)

⊙ Build trust among the employees to ensure productivity (Item 26)

⊙ Address complaints of patients and public (Item 31)

⊙ Manage conflict effectively (Item 29)

Foundation competencies (blue)

○ Have ability to communicate clear guidelines (Item 16)

⦿ Maintain professional working relationship based on ethics (Item 17)

⦿ Adhere to work ethics (Item 36)

⊙ Use various strategies to resolve conflict in the workplace (Item 30)

⊙ Take initiative by proposing suggestions in an open arena (Item 20)

Supporting competencies (pink)

⦿ Have people management skills (Item 28)

⊙ Maintain trust through openly talking about challenges that needs to be addressed (Item 35)

⊙ Provide constructive feedback to staff (Item 33)

⊙ Provide feedback to ONMs on recent developments (Item 34)

The highest mean value ($\bar{x}$ 3.89) was found to be in the sub-domain problem-solving in the interpersonal domain, followed by the sub-domains of effective communication, and openness, honesty and trust.

Table 5.12: Total statistics of the interpersonal domain

Item no	Competency items	Scale mean if item deleted	Scale variance if item deleted	Corrected item-total correlation	Squared multiple correlation	Cronbach's alpha if item deleted
26	Building trust among the ensuring productivity	68.05	50.57	0.69	.	0.921
18	Share a common vision through ongoing dialogue with all stakeholders	68.16	49.78	0.69	.	0.921
25	Focus on diversity in the workplace	68.07	50.90	0.67	.	0.921
27	Promote shared decision-making	68.44	49.34	0.67	.	0.922
23	Have self-knowledge to identify need that requires learning new skills	68.13	51.33	0.65	.	0.922
17	Maintain professional working relationship based on ethics	67.98	51.83	0.65	.	0.922
33	Provide constructive feedback to staff	68.01	51.94	0.64	.	0.922
21	Take a risk confidently with a specific solution	68.34	50.58	0.64	.	0.922
24	Initiate activities to develop fellow workers	68.31	50.26	0.62	.	0.922
20	Take initiative by proposing suggestions in an open arena	68.19	50.37	0.62	.	0.922
19	Follow a top-to-bottom or bottom-top approach to ensure transparency	68.19	50.96	0.62	.	0.923
31	Address complaints by patients and public	68.06	51.15	0.62	.	0.923
22	Have appropriate self-awareness to address own limitations	68.19	51.32	0.60	.	0.923
29	Manage conflict commitment to finding amicable solution	68.00	52.07	0.57	.	0.924
35	Maintain trust through talking openly about challenges that need to be addressed	68.07	52.28	0.57	.	0.924
30	Use different strategies to resolve conflict in the workplace	68.16	51.69	0.55	.	0.924
16	Have ability to communicate clear guidelines	68.00	52.40	0.55	.	0.924
34	Provide feedback to operational nurse managers on recent developments	68.29	50.52	0.55	.	0.925
28	Have people management skills	67.95	53.00	0.52	.	0.924
36	Adhere to work ethics	67.82	55.27	0.28	.	0.928

Table 5.13: Level of reliability of the interpersonal domain and two strongest items

Domain	Scale Cronbach's alpha (α)	Number of items	Strongest items
Interpersonal	0.93	20	Building trust among the employees ensuring productivity
			Share a common vision through ongoing dialogue with all stakeholders

5.4.3 Evidence-based domain

The evidence-based domain comprises of four sub-domains:

Writing reports (Items 41 and 42)

Computer literacy (Items 43 and 44)

Acting as a resource for operational nurse managers (Item 45)

Research activities (Items 46, 47, 48 and 49) (Table 5.14)

Items 50 to 53 were open-ended questions, and responses were integrated in the findings.

5.4.3.1 Writing reports

It is essential that nurse managers should have the knowledge and ability to write reports and job descriptions (Stefl, 2008:370). In this sub-domain the items were negatively skewed, with a narrow distribution of .55 to .88 around the mean values (Table 5.14). In Item 41, 31 (34.4%) of 90 (100.0%) participants indicated to *no extent and to a small extent* they currently had the knowledge to draft a memorandum. For the existing and expected competencies, 50 (54.9%) of 91 (100.0%) and 71 (80.7%) of 88 (100.0%) participants, respectively, to a *large extent* indicated that they currently had the ability to write according to formal formats (Item 42). The highest mean values for both existing and expected competencies were for ability to write according to formal formats (Item 42, $\bar{x}$ 3.48, SD 0.62, $\bar{x}$ 3.76, SD 0.55).

5.4.3.2 Computer literacy

Within healthcare environments, computerised information systems underpin work activities, including the throughput of clients, allocation of workloads, cost assignment and recovery, clinical care, diagnostic testing, communication between service providers, and administration and funding sources. So all professionals must be computer literate with the capacity to harness

Table 5.14: Mean values and percentage of the rating of items measuring existing and expected responses in the evidence-based domain														
Item	**Competency items**		**Responses of assistant nurse managers**											
	Foundation competencies Supporting competencies Interaction competencies		**Total**		**To no extent**		**To a small extent**		**To a moderate extent**		**To a large extent**		$\bar{x}$	**SD**
			n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**		
	Writing reports													
41	Have the knowledge to draft a memorandum	Existing	90	100.0	4	4.4	27	30.0	33	36.7	26	28.9	2.9	0.88
		Expecting	87	100.0	4	4.6	6	6.9	23	26.4	54	62.1	3.46	0.82
42	Ability to write accord-ing to formal formats	Existing	91	100.0	0	0.0	6	6.6	35	38.5	50	54.9	3.48	0.62
		Expecting	88	100.0	1	1.1	2	2.3	14	15.9	71	80.7	3.76	0.55
	Computer literacy													
43	Apply knowledge of computer programs in the workplace	Existing	93	100.0	0	0.0	9	9.7	35	37.6	49	52.7	3.43	0.67
		Expecting	89	100.0	2	2.2	2	2.2	14	15.7	71	79.8	3.73	0.62
44	Use basic computer software programs confidently	Existing	91	100.0	0	0.0	7	7.7	28	30.8	56	61.5	3.54	0.64
		Expecting	86	100.0	1	1.2	1	1.2	12	14.0	72	83.7	3.8	0.51
	Act as a resource for operational nurse managers													
45	Act as a resource for operational nurse managers	Existing	89	100.0	0	0.0	1	1.1	21	23.6	67	75.3	3.74	0.47
		Expecting	85	100.0	2	2.4	1	1.2	9	10.6	73	85.9	3.8	0.57
	Research activities													
46	Identify nursing trends when conducting audits	Existing	92	100.0	1	1.1	9	9.8	36	39.1	46	50.0	3.38	0.71
		Expecting	89	100.0	2	2.2	3	3.4	13	14.6	71	79.8	3.72	0.64
47	Participate in research projects	Existing	92	100.0	5	5.4	19	20.7	47	51.1	21	22.8	2.91	0.81
		Expecting	90	100.0	0	0.0	5	5.6	25	27.8	60	66.7	3.61	0.59

SD = standard deviation, $\bar{x}$ = mean value

Table 5.14: Mean values and percentage of the rating of items measuring existing and expected *evidence-based* category														
Item	**Competency items**		**Responses of assistant nurse managers**											
	Foundation competencies **Supporting competencies** **Interaction competencies**		**Total**		**To no extent**		**To a small extent**		**To a moderate extent**		**To a large extent**		$\bar{x}$	**SD**
			n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**		
48	Involve nursing staff in conducting research activities	Existing	92	100.0	9	9.8	32	34.8	38	41.3	13	1.1	2.6	0.86
		Expecting	90	100.0	1	1.1	23	25.6	21	23.3	45	50.0	3.22	0.87
49	Promote research in current trends to maintain professional growth	Existing	90	100.0	6	6.7	30	33.3	42	46.7	12	13.3	2.67	0.79
		Expecting	88	100.0	2	2.3	14	15.9	26	29.5	46	52.3	3.32	0.82

SD = standard deviation, $\bar{x}$ = mean value

the advantage that computers in the workplace provide (Mills, Francis, McLeod & Al-Motlaq, 2015:284). In this sub-domain the items were negatively skewed, with a narrow distribution of .51-.67 around the mean values (Table 5.14). More than half, 49 (52.7%) of 93 (100.0%) participants indicated that to a *large extent* they agreed on currently applying knowledge of computer programs in the workplace (Item 43), versus more than three quarters 71 (79.8%) of 89 (100.0%) participants that were expected to do it. Provision of training and allowing time to adjust nurses' practice to accommodate acquired knowledge on the use of computer and computer systems, improve the uptake of these technologies and ultimately improves workplace efficiencies (Mills et al., 2015:288). More than half, namely 47 (51.6%) of 91 (100.0%), versus more than three quarters, namely 72 (83.7%) of 86 (100.0%) participants, to a *large extent* agreed on their existing and expected actions in using basic computer software programs confidently (Item 44). The highest mean values on the existing and expected competencies were in using basic computer software programs confidently (Item 44, $\bar{x}$ 3.54, SD 0.64; $\bar{x}$ 3.80, SD 0.51). Nurse managers should be computer literate, that is, use a computer and basic software, such as word-processing and spreadsheet programs (Dowding, 2013:36).

5.4.3.3 Acting as a resource for operational nurse manager

'Research across industries internationally (including healthcare) has demonstrated that there is a risk for organisations in focusing on technical skills, such as high-performing nurses into middle management, rather than considering career motivation and management potential' (Meissner & Radford, 2015:790). In addition, nurses are encouraged to move into administrative management roles, organisations do not support or resource them in their role. Hence it is essential for ANM to act as resources for ONM (Meissner & Radford, 2015:790). In this sub-domain the item was negatively skewed, with a narrow distribution of .47–.57 around the mean values (Table 5.14).

For the existing and expected competencies, 67 (75.3%) of 89 (100.0%) and 73 (85.9%) of 85 (100.0%) participants, respectively, to a *large extent* indicated that they act as a resource for the ONM (Item 45). The highest mean values for both existing and expected competencies were acting as a resource person for operational nurse manager (Item 46, $\bar{x}$ 3.74, SD 0.47, $\bar{x}$ 3.80, SD 0.57). Middle managers are an essential element of any healthcare organisation as they perform important duties that make contributions, acting as a resource for operational nurse managers (Meissner & Radford, 2015:785).

5.4.3.4 Research activities

Nurse managers have a vital role in the use and dissemination of research among staff. Nurse

managers must have clinical expertise and research awareness training, promote research-based practice and attempt to provide positive role modelling, in addition to having protected time for research efforts (Timmins et al., 2012:224). In this sub-domain the items were negatively skewed, with a narrow distribution of .59 - .87 around the mean values (Table 5.14).

In Item 47, 24 (26.1%) of 92 (100.0%) participants indicated that they to *no extent* and *to a small extent* currently participated in research projects. On the one hand nearly half, namely 41 (44.6%) of 92 (100.0%) participants indicated that currently they to *no extent and to a small extent* were involved in research activities. On the other hand, 24 (26.7%) of 90 (100.0%) participants were expected to involve nursing staff in research activities (Item 48). It was also noted that 36 (40.0%) of 90 (100.0%) participants indicated that they to *no extent and to a small extent* and 16 (18.2%) of 88 (100.0%) participants currently to no extent and to a small extent promoted research in current trends to maintain professional growth (Item 49).

In Item 49, 42 (46.7%) of 90 (100.0%) participants indicated that they to a *moderate extent* currently promoted research in current trends to maintain professional growth. Half, 46 (50.0%) of 92 (100.0%) participants indicated that they to a *large extent* agreed on currently identifying nursing trends when conducting audits (Item 46), versus more than three quarters 71 (79.8%) of 88 (100.0%) participants that were expected to do it. The highest mean values on the existing and expected competencies were on identifying nursing trends when conducting audits (Item 46, $\bar{x}$ 3.38, SD 0.71; $\bar{x}$ 3.72, SD 0.64). The second highest mean values on the existing and expected competencies were on participating in research projects (Item 47, $\bar{x}$ 2.91, SD 0.81; $\bar{x}$ 3.61, SD 0.59). Integration of research evidence in clinical nursing care is essential for the delivery of quality nursing care. Furthermore, the leadership behaviours of nurse managers and administrators are important in supporting research use and evidence-based practice (Gifford, Davies, Edwards, Griffin & Lybanon, 2007:126).

5.4.3.5 Overall findings on the evidence-based domain

Overall in the evidence-based domain, the mean values for the expected and existing competencies were the lowest in research activities. The mean values of the existing competencies of the ANM in the Evidence-based practice domain sub-scales were lower than expected competencies, that is, Writing reports (Items 41 & 42 $\bar{x}$ 3.17; $\bar{x}$ 3.62); Computer literacy (Items 43 & 44 $\bar{x}$ 3.47; $\bar{x}$ 3.77); Act as a resource for operational nurse managers (Item 45 $\bar{x}$ 3.73; $\bar{x}$ 3.80) and Research activities (Items 46 & 47 $\bar{x}$ 2.89; $\bar{x}$ 3.47) Figure 5.7.

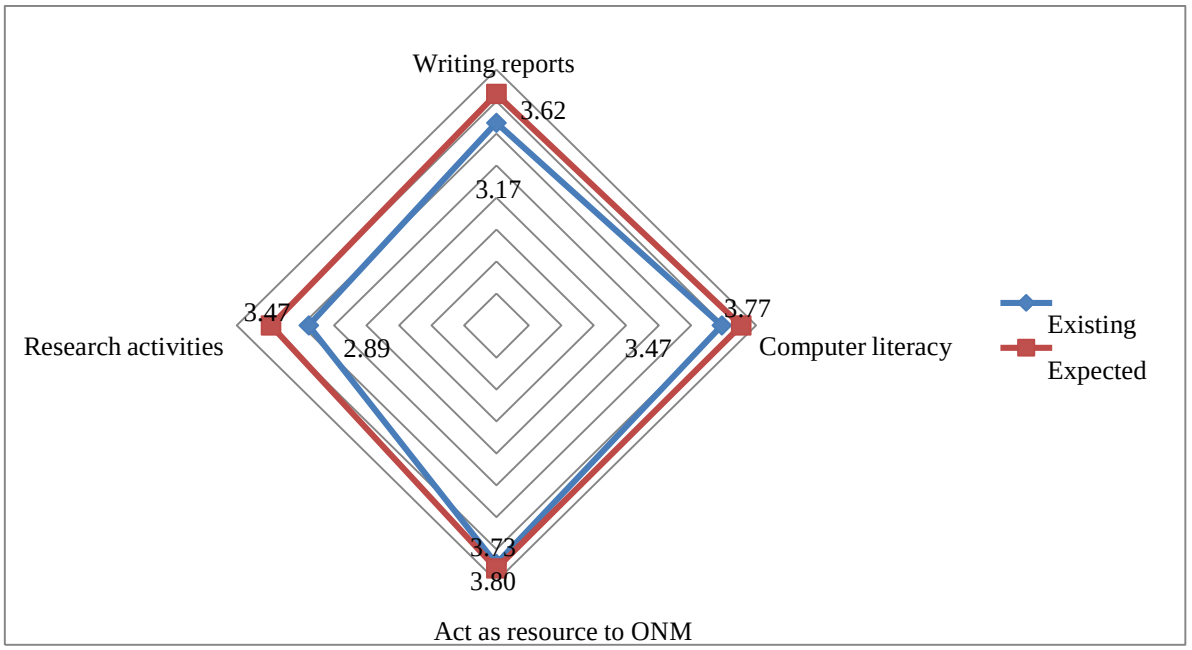

Figure 5.9: Mean values of *evidence-based practice* domain

Table 5.15 shows the level of reliability of each of the 4 sub-domains. Scales with Cronbach's Alphas (α) higher than 0.70 are considered as reliable. The Cronbach's alpha was lowest in the sub-domain of writing reports (α 0.03).

Table 5.15: Reliability of evidence-based practice sub-scales

Scale	Scale Cronbach's alpha (α)	Number of items
Writing reports	**0.03**	2
Computer literacy	0.76	2
Acting as a resource to ONM	Only one item in scale	
Research activities	0.82	4

Table 5.16 shows a relationship between the existing and the expected level of competencies of the ANMs in the evidence-based domain. The findings show the average scores of the participants for the sub-scale of the evidence-based practice domain of competence, consisting of individual questions. Wilcoxon signed-rank test was used to compare the mean rank of the existing and expected scores of the sub-scales. The findings suggested that there is a significance difference between the existing and the expected scores of all the sub-scales with significance level (sig) 0.00 (Table 5.16). The mean differences mostly had negative values, which meant that the participants' rating of an existing competence was lower than their rating of the expected competence. The highest average score was for the expected competencies under the sub-domain, Acting as a resource to the ONM ($\bar{x}$ 3.80), with a narrow distribution around the mean of 0.58. This was followed by the sub-domains of Computer literacy ($\bar{x}$ 3.77, SD 0.52); Writing reports ($\bar{x}$ 3.62, SD 0.64); and Research activities ($\bar{x}$ 3.47, SD 0.61) (Table 5.16).

Table 5.16: Comparison of the average sub-scale items for existing and expected scores in the evidence-based practice domain

Scale	Number of participants that answered all the questions	Average score	SD	Paired t-test			Spearman Correlation	
				Mean difference (existing minus expected)	SD	Sig	Correlation Coefficient	Sig
Writing reports								
Existing	83	3.17	0.65	-0.45	0.83	0.00	0.16	0.16
Expected	83	3.62	0.64					
Computer literacy								
Existing	84	3.47	0.60	-0.30	0.74	0.00	0.13	0.23
Expected	84	3.77	0.52					
Act as resource to ONM								
Existing	83	3.73	0.47	-0.06	0.67	**0.41**	0.20	0.07
Expected	83	3.80	0.58					
Research activities								
Existing	85	2.89	0.63	-0.59	0.74	0.00	0.29	0.01
Expected	85	3.47	0.61					

In the evidence-based practice domain the four strongest items were identified as those with the highest corrected item-total correlation and squared multiple correlation. The items have been arranged in descending order based on their corrected item-total correlation (Table 5.17). The four strongest items with the highest corrected item-total correlation in the *evidence-based* domain were Item 48 involve nursing staff in conducting research activities; Item 49 promote research in current trends to maintain professional growth; Item 42 ability to write according to formal formats and Item 47 participate in research projects. The level of reliability of the evidence domain was the Cronbach's alpha (α) of 0.83 (Table 5.18). It is reflected that the instrument is internally consistent to the extent that the items in the evidence-based domain measure the same trait, with 9 items.

Table 5.17: Total statistics of the evidence-based practice domain

Item No	Competency Items	Scale mean if item deleted	Scale variance if item deleted	Corrected item-total correlation	Squared multiple correlation	Cronbach's alpha if item deleted
48	Involve nursing staff in conducting research activities	26.25	14.06	0.58	0.63	0.813
49	Promote research in current trends to maintain professional growth	26.18	14.30	0.60	0.62	0.811
42	Ability to write according to formal formats	25.34	15.19	0.65	0.56	0.808
47	Participate in research projects	25.94	14.03	0.65	0.51	0.804
44	Use basic computer software programs confidently	25.31	15.96	0.43	0.49	0.828
43	Apply knowledge of computer programs in the workplace	25.41	15.69	0.45	0.49	0.826
46	Identify nursing trends when conducting audits	25.48	14.58	0.63	0.47	0.808
41	Have the knowledge of drafting a memorandum	25.98	14.38	0.49	0.38	0.827
45	Act as a resource for operational nurse manager	25.13	16.57	0.47	0.36	0.827

Table 5.18: Level of reliability of evidence-based domain and the two strongest items in the evidence-based practice domain

Domain	Scale Cronbach's alpha (α)	Number of items	Strongest item
Evidence-based practice	0.83	9	Involve nursing staff in conducting research activities
			Promote research in current trends to maintain professional growth

5.4.3.6 Summary of the evidence-based domain

The findings indicated that according to the criteria set for this study certain items were identified as important to be addressed in a strategy for ANMs, within the three broad areas of competencies. From these items, the levels of competencies were identified in sequence of priority, namely advanced (the first item under the broad area ○), proficient (second item under the broad area ⓿) and knowledgeable (other items under the broad area ⊙):

Interaction (green)

○ Act as a resource for operational nurse managers (Item 37)

Foundation competencies (blue)

⊙Have the knowledge to draft a memorandum (Item 33)

⊙Be able to write according to formal formats (Item 34)

Supporting competencies (pink)

⓿ Use basic computer software programs confidently (Item 36)

⓿ Identify nursing trends when conducting audits (Item 38)

⓿ Participate in research projects (Item 39)

⓿ Involve nursing staff in conducting research activities (Item 40)

⓿ Promote research in to maintain professional growth (Item 41)

⊙ Apply knowledge of computer programs in the workplace (Item 35)

5.4.4 Strategic resource management domain

Strategic resource management comprised nine sub-domains:

Effective staffing strategies (Items 54 and 55)

Staff allocation (Items 56 and 57)

Recruitment strategies (Items 58 and 59)

Retention strategies (Item 60)

Management of absenteeism (Items 61 and 62)

Effective discipline (Items 63 and 64)

Performance evaluation (Items 65 and 66)

Strategic planning (Items 67, 68, and 69)

Financial management (Items 70, 71, 72, 73 and 74) (Table 5.19).
Items 75 to 78 were open-ended questions, and responses were integrated in the findings.

5.4.4.1 Effective staffing strategies

Appropriate staffing is a match of professional nurse expertise with the needs of the recipient of nursing care services in the context of the practice setting and situation (Mensik, 2014:2) Traditionally, staffing plans have been developed through the use of historical averages of fulltime equivalents. The importance of using an empirically-based method for creating staffing plans is emphasized (Tierney, 2010:2) and the provision of appropriate nurse staffing is necessary to reach safe, quality outcomes (Mensik, 2014:2). In this sub-domain the items were negatively skewed, with a narrow distribution of .45 to.70 around the mean values (Table 5.19). More than half, namely 48 (52.7%) of 91 (100.0%), versus more than three quarters, namely 80 (90.9%) of 88 (100.0%) participants, respectively indicated that they to a *large extent agreed* on their existing and expected competencies in Item 54 regarding analysing staffing needs to ensure cost effectiveness. Nurse managers should develop an empirical method for building nursing unit staffing plans through the incorporation of patient acuity and patient turnover as an adjustment to hours per patient day to ensure cost effectiveness (Mensik, 2014:2).

More than half, 49 (53.8%) of 91 (100.0%) participants indicated that they to a *large extent agreed* on currently developing a plan to meet the staffing needs (Item 55), versus the majority of 74 (84.1%) of 88 (100.0%) participants that were expected to do it. Nurse managers must be able to utilize and translate staffing data into appropriate staffing plans (Tierney, 2010:1). Furthermore, the development of a staff planning model that incorporates adjustments to planned hours per patient day by incorporating patient acuity and patient turnover may reduce the variation between planned and actual hours per patient per day (Tierney, 2010:2). The highest mean values for both existing and expected competencies were for analysing staffing needs to ensure cost effectiveness (Item 54, $\bar{x}$ 3.88, SD 0.45, $\bar{x}$ 3.46, SD 0.62). Adequate nurse staffing is essential in a healthcare environment for provision of quality patient care (Jooste & Prinsloo, 2013:115). Furthermore, it is extremely important to appoint a person in the right post to facilitate high-quality nursing care (Jooste & Prinsloo, 2013:115).

Table 5.19: Mean values and percentage of the rating of items measuring existing and expected S*trategic resource management* domain														
Item	**Competency items**		**Responses of assistant nurse managers**											
	Foundation/transversal competencies Supporting competencies Interaction competencies		**Total**		**To no extent**		**To a small extent**		**To a moderate extent**		**To a large extent**		$\bar{x}$	**SD**
			n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**		
	Effective staffing strategies													
54	Analyse staffing needs ensuring cost effectiveness	Existing	91	100.0	0	0.0	6	6.6	37	40.7	48	52.7	3.46	0.62
		Expecting	88	100.0	1	1.1	1	1.1	6	6.8	80	90.9	3.88	0.45
55	Develop a plan to meet the staffing needs	Existing	91	100.0	2	2.2	5	5.5	35	38.5	49	53.8	3.44	0.70
		Expecting	88	100.0	1	1.1	1	1.1	12	13.6	74	84.1	3.81	0.5
	Staff allocation													
56	Allocate staff members to the different units	Existing	92	100.0	0	0.0	4	4.3	18	19.6	70	76.1	3.72	0.54
		Expecting	88	100.0	2	2.3	1	1.1	8	9.1	77	87.5	3.82	0.56
57	Monitor the duty roster/ attendance register	Existing	92	100.0	1	1.1	1	1.1	13	14.1	77	83.7	3.8	0.50
		Expecting	89	100.0	1	1.1	2	2.2	5	5.6	81	91.0	3.87	0.48
	Recruitment strategies													
58	Know and understand the recruitment process	Existing	90	100.0	0	0.0	7	7.8	29	32.2	54	60.0	3.52	0.64
		Expecting	86	100.0	2	2.3	6	7.0	9	10.5	71	80.2	3.69	0.71
59	Select the best suitable candidate to fill post	Existing	90	100.0	2	2.2	6	6.7	20	22.2	62	68.9	3.58	0.72
		Expecting	85	100.0	0	0.0	3	3.5	10	11.8	75	84.7	3.81	0.48
	Retention strategies													
60	Implement strategies to retain staff members	Existing	91	100.0	5	5.5	12	13.2	50	54.9	24	26.4	3.02	0.79
		Expecting	87	100.0	0	0.0	6	6.9	19	21.8	63	71.3	3.64	0.61
	Management of absenteeism													
61	Determine the monthly staff absenteeism rate	Existing	90	100.0	2	2.2	4	4.4	37	41.1	47	52.2	3.43	0.69
		Expecting	87	100.0	1	1.1	2	2.3	11	12.6	74	83.9	3.79	0.53
62	Train supervisors on management of absenteeism	Existing	90	100.0	2	2.2	11	12.2	32	35.6	45	50.0	3.33	0.78
		Expecting	85	100.0	2	2.4	5	5.9	15	17.6	65	74.1	3.64	0.71
	Effective discipline													
63	Implement workplace discipline	Existing	90	100.0	1	1.1	4	4.4	36	40.0	49	54.4	3.48	0.64

SD = standard deviation, $\bar{x}$ = mean value

Table 5.19: (cont.) Mean values and percentage of the rating of items measuring existing and expected *strategic resource management* domain														
Item	**Competency items**		**Responses of assistant nurse managers**											
	Foundation/transversal competencies Supporting Competencies Interaction competencies		**Total**		**To no extent**		**To a small extent**		**To a moderate extent**		**To a large extent**		$\bar{x}$	**SD**
			n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**		
		Expecting	87	100.0	0	0.0	1	1.1	14	16.1	73	82.8	3.82	0.42
64	Apply knowledge of grievance handling process	Existing	90	100.0	2	2.2	4	4.4	44	48.9	40	44.4	3.36	0.68
		Expecting	86	100.0	1	1.2	4	4.7	11	12.8	72	81.4	3.74	0.60
	Performance evaluation													
65	Monitor the implementation of staff performance agreements	Existing	90	100.0	0	0.0	2	2.2	28	31.1	60	66.7	3.64	0.53
		Expecting	87	100.0	0	0.0	1	1.1	9	10.3	79	88.5	3.87	0.37
66	Quarterly assess the performance of staff members	Existing	91	100.0	0	0.0	2	2.2	30	33.0	59	64.8	3.63	0.53
		Expecting	87	100.0	0	0.0	0	0.0	13	14.9	76	85.1	3.85	0.36
	Strategic planning													
67	Develop a strategic plan in the workplace that aligns with the vision of the institution	Existing	90	100.0	1	1.1	10	11.1	39	43.3	40	44.4	3.31	0.71
		Expecting	86	100.0	0	0.0	3	3.5	18	20.9	67	75.6	3.72	0.52
68	Set priorities to ensure that employees are working towards common goals	Existing	88	100.0	1	1.1	7	8.0	42	47.7	38	43.2	3.33	0.67
		Expecting	85	100.0	1	1.2	3	3.5	19	21.2	65	74.1	3.68	0.60
69	Develop an annual operational plan with emphasis on short term goals	Existing	90	100.0	1	1.1	18	20.0	32	35.6	39	43.3	3.21	0.80
		Expecting	87	100.0	1	1.1	4	4.6	17	19.5	66	74.7	3.68	0.62
	Financial management													
70	Monitor financial resources with emphasis on cost containment	Existing	91	100.0	2	2.2	11	12.1	36	39.6	42	46.2	3.3	0.77
		Expecting	88	100.0	2	2.3	3	3.4	13	14.8	70	79.5	3.72	0.64
71	Participate in the development of a business plan	Existing	90	100.0	7	7.8	22	24.4	39	43.3	22	24.4	2.84	0.89
		Expecting	86	100.0	3	3.5	9	10.5	17	19.8	58	66.3	3.49	0.82
72	Identify ways of containing healthcare costs without compromising standards	Existing	89	100.0	6	6.7	9	10.1	38	42.7	36	40.4	3.17	0.87
		Expecting	85	100.0	3	3.5	3	3.5	16	18.8	64	74.1	3.64	0.72
73	Ensure implementation of the budget by monitoring the expenditure report	Existing	89	100.0	2	2.2	12	13.5	25	28.1	50	56.2	3.38	0.81
		Expecting	87	100.0	2	2.3	1	1.1	14	16.1	70	80.5	3.75	0.60
74	Know and understand the operational principles of functional business unit	Existing	91	100.0	1	1.1	17	18.7	30	33.0	43	47.3	3.26	0.80
		Expecting	88	100.0	3	3.4	7	8.0	10	11.4	68	77.3	3.63	0.78

5.4.4.2 Staff allocation

ANMs are expected to allocate staff in the various units. The main models of nurse staffing are budget based, in which nursing staff is allocated according to nursing hours per patient day; nurse-patient ratio, in which the number of nurses per number of patients or patient days determines staffing levels; and patient acuity, in which patient characteristics are used to determine a shift's staffing needs (Mensik, 2014:1). In this sub-domain the items were negatively skewed, with a narrow distribution of .48 to .56 around the mean values (Table 5.19). More than three quarters, 70 (76.1%) of 92 (100.0%) participants, indicated that they to a *large extent agreed* on currently allocating staff members to the various units (Item 56), versus the majority of 77 (87.5%) of 88 (100.0%) participants that were expected to do it. Nurse managers may be accountable to their organisation for nurse staffing and all nurses are accountable to their patients and the profession. Furthermore, the nurse manager assesses and determines the shift-to-shift ratio of nurses to ensure adequate staffing on each shift and unit (Mensik, 2014:1).

More than three quarters, namely 77 (83.7%) of 92 (100.0%), versus the majority of 81 (91.0%) of 89 (100.0%) participants, respectively, indicated that they to a *large extent agreed* on their existing and expected competency regarding monitoring the duty roster attendance (Item 57). In Item 56, 77 (87.5%) of 88 (100.0%) participants indicated they *to a large extent* were expected to allocate staff members to the different units. For the existing and expected competencies, 77 (83.7%) of 92 (100.0%) and 81 (91.0%) of 89 (100.0%) participants, respectively, to a *large extent* indicated that they currently monitored the duty roster attendance (Item 57). The highest mean value was indicated by the participants on their expected competency around allocating staff members to the different units (Item 56, $\bar{x}$ 3.82, SD 0.56). The second highest mean values for both existing and expected competencies were for monitored the duty roster attendance (Item 57, $\bar{x}$ 3.80, SD 0.50; $\bar{x}$ 3.87, SD 0.48).

5.4.4.3 Recruitment strategies

Recruitment and retention strategies emphasise the importance of positive work environments that support professional nursing practice for sustaining the nursing workforce. Nurse managers that recruit and select the best candidates and display leadership, create an empowering workplace and play a key role in establishing supportive practice environments that increase work effectiveness, and, ultimately, improve job satisfaction (Spence Laschingera,2014:1615). In this sub-domain the items were negatively skewed, with a narrow distribution of .48 to .72 around the mean values (Table 5.19). Two thirds, namely 54 (60.0%) of 90 (100.0%) participants, versus more than three quarters (n=71, 80.2%) of 86 (100.0%)

participants, respectively, to a *large extent agreed* on their existing and expected competency in knowing and understanding the recruitment process (Item 58). More than two thirds, 62 (68.9%) of 90 (100.0%) participants, indicated that they to a *large extent agreed* on currently selecting the best suitable candidate to fill the post (Item 59), versus the majority of 75 (84.7%) of 85 (100.0%) participants that were expected to do it. In Item 58, 71 (80.2%) of 86 (100.0%) participants indicated they *to a large extent* expected to know and understand the recruitment process. For expected competencies, respectively, 75 (84.7%) of 85 (100.0%) participants to a *large extent* expected to select the best suitable candidate to fill the post (Item 59). The highest mean value was indicated by the participants on their expected competency around selecting the best suitable candidate to fill post (Item 59, $\bar{x}$ 3.81, SD 0.48). The second highest mean value was for knowing and understanding the recruitment process (Item 58) ($\bar{x}$ 3.69, SD 0.71). Nursing managers must develop a recruitment process that addresses all hiring stages, including identifying open positions, finding and attracting candidates, interviewing and selecting candidates and making job offers (Daley, 2013:1).

5.4.4.4 Retention strategies

Continuing education opportunities, flexible schedules, mentoring programs and recognition programs are all excellent ways that a nurse manager could implement to improve retention of nursing staff (Daley, 2013:1). Ritten (2010:31) iterates that nurse managers are a fundamental link to the retention of nurses. They are in the key position to promote change and ensure a positive work environment therefore enhancing retention. Ritten (2010:31) adds that nurse managers reported that staffing, retention, staff happiness and ensuring good patient outcomes were key roles in their position. In this sub-domain the items were negatively skewed, with a narrow distribution of .61 to .79 around the mean values (Table 5.19).

In Item 60, 17 (18.7%) of 91 (100.0%) participants indicated that they to *no extent* and to *a small extent* currently implemented strategies to retain staff members. Nearly half, 50 (54.9%) of 91 (100.0%) participants indicated that they to a moderate extent currently implemented strategies to retain staff members. More than one quarter, 26 (26.4%) of 91 (100.0%) participants indicated that they to a large extent agreed on currently implemented strategies to retain staff members (Item 60), versus less than three quarters, 63 (71.3%) of 87 (100.0%) participants, that were expected to do it. The highest mean value was indicated by the participants on their expected competency around implement strategies to retain staff members (Item 60, $\bar{x}$ 3.64, SD 0.61). Nurses who expressed that their practice environment met their expectations also reported higher appreciation of job characteristics and management style, greater emphasis on quality of customer service,

higher satisfaction with benefits, higher organisational commitment and increased job satisfaction. Those nurses whose expectations were not met in the practice environment reported higher job tension. Involving staff in changing the practice environment can lead to favourable results (Ritten, 2010:31).

5.4.4.5 Management of absenteeism

Absenteeism and turnover among healthcare workers have a big impact on quality outcomes in hospital settings and on overall healthcare system performance (Daouk-Oyry, Anouze, Otaki, Dumit & Osman, 2014:93). Therefore, the nurse managers should take a lead role in recruitment, selection, management of absenteeism to reduce the costs effectively, performance management and appraisal (O'Donnell et al., 2012:199). In this sub-domain the items were negatively skewed, with a narrow distribution of .53 to .78 around the mean values (Table 5.19). More than half, 47 (52.2%) of 90 (100.0%) participants indicated that they to a *large extent agreed* on currently determining the monthly staff absenteeism rate (Item 61), versus the majority of 74 (83.9%) of 87 (100.0%) participants that were expected to do it. Half, namely 45 (50.0%) of 90 (100.0%), versus more than three quarters, namely 65 (74.1%) of 85 (100.0%) participants, indicated that they respectively to a *large extent agreed* on their existing and expected competencies regarding training supervisors on management of absenteeism (Item 62). In Item 61, 74 (83.9%) of 87 (100.0%) participants indicated they *to a large extent* were expected to determine the monthly staff absenteeism rate. The highest mean values for both existing and expected competencies were for determining the monthly staff absenteeism rate (Item 61, $\bar{x}$ 3.43, SD 0.69; $\bar{x}$ 3.79, SD 0.53). It is essential for nurse managers to screen prior absence behaviour of potential employees and monitor attendance behaviour of current employees for patterns in absenteeism. Finding such attendance patterns could allow nurse managers to implement interventions in collaboration with individuals or groups to improve absenteeism rates. (Davey et al., 2009:326).

5.4.4.6 Effective discipline

The practice of discipline is needed to deal with problems that arise from the failings of employees, deficiencies of character or attitude, lack of self-control and disobedience (O'Donnell et al., 2012:203). In this sub-domain the items were negatively skewed, with a narrow distribution of .42 to .68 around the mean values (Table 5.19). In Item 64, 44 (48.9) of 90 (100.0%) participants indicated that they to a *moderate extent* currently applied their knowledge of grievance handling process. More than half, namely 49 (54.4%) of 90 (100.0%), versus more than three quarters, namely 73 (82.8%) of 87 (100.0%) participants, indicated that they respectively to a *large extent agreed* on their existing and expected competency regarding implementing workplace discipline (Item 63). Less than half, 40 (44.4%) of 90 (100.0%)

participants indicated that they to a *large extent agreed* on currently applying knowledge of grievance handling process (Item 64), versus the majority of 79 (88.5%) of 87 (100.0%) participants that were expected to do it. In Item 63, 73 (82.8%) of 87 (100.0%) participants indicated they were to *a large extent* expected to implement work discipline. It was noted that 72 (81.4%) of the 86 (100.0%) participants indicated that they to *a large extent* were expected to apply knowledge of grievance handling process (Item 64). The highest mean values for both existing and expected competencies were on implementing workplace discipline (Item 63, $\bar{x}$ 3.48, SD 0.64; $\bar{x}$ 3.82, SD 0.42). Every nurse manager has to deal with an employee who is insubordinate, steals property, arrives consistently late for work and engages in other problem behaviours (O'Donnell et al., 2012:203).

5.4.4.7 Performance evaluation

The outcomes of nursing performance mean the level of the achievement of healthcare organisational goals, and the outcomes of nursing performance are determined by the quality of nursing care for patients, which is measured mainly according to patient outcomes and the achievement of organisational goals (Lee, Kim & Kim, 2014:3515). The nurse manager is instrumental in facilitating the performance of employees (Townsend et al., 2015:215). In this sub-domain the items were negatively skewed, with a narrow distribution of .36 to .53 around the mean values (Table 5.19). Two thirds, namely 60 (66.7%) of 90 (100.0%) participants indicated that they to a *large extent* agreed on currently monitoring the implementation of staff performance agreements (Item 65), versus the majority of 79 (88.5%) of 87 (100.0%) participants that were expected to do it. Less than two thirds, 59 (64.8%) of 93 (100.0%), versus more than three quarters, namely 72 (85.1%) of 87 (100.0%) participants, respectively, indicated that to a *large extent* they agreed on their existing and expected competencies in assessing the performance of staff members quarterly (Item 66). In Item 65, 79 (88.5%) of 87 (100.0%) participants indicated that to *a large extent* were expected to monitor the implementation of staff performance agreements. It was noted that 76 (85.1%) of 87 (100.0%) participants indicated that they to *a large extent* were also expected to assess the performance of staff members quarterly (Item 66). The highest mean values for both existing and expected competencies were on monitoring the implementation of staff performance agreements (Item 65, $\bar{x}$ 3.64, SD 0.53; $\bar{x}$ 3.87, SD 0.37). The features of a successful performance management system are leadership commitment and continuous monitoring, feedback, dissemination and learning results (Fryer et al., 2009:480).

5.4.4.8 Strategic planning

The formulation of a strategic plan in the public sector is the responsibility of a nurse manager.

It requires disciplined effort to take the fundamental decisions and actions that shape and guide what an organisation is, what it does, and why it does it, all within a legal framework (Lega et al., 2013:2). In this sub-domain the items were negatively skewed, with a narrow distribution of .52 to .80 around the mean values (Table 5.19). The mean values were typically lower for existing competencies oppose to those of the expected competencies. It was noted that 19 (21.1 8%) of 90 (100.0%) participants specified that they to *no extent* and *to a small extent* currently developed an annual operational plan with the emphasis on short-term goals (Item 69). In Item 68, 42 (47.7) of 88 (100.0%) participants indicated that they to a *moderate extent* currently set priorities to ensure that employees are working towards common goals. Less than half, namely 40 (44.4%) of 90 (100.0%), versus more than three quarters, namely 67 (75.6%) of 86 (100.0%) participants, indicated that they respectively to a *large extent agreed* on their existing and expected competency, regarding developing a strategic plan in the workplace that aligns with the vision of the institution (Item 67).

Less than half, 38 (43.2%) of 88 (100.0%) participants indicated that they to a *large extent* agreed on currently setting priorities to ensure that employees are working towards common goals (Item 68), versus less than three quarters, 65 (74.1%) of 85 (100.0%) participants, that were expected to do it. For existing and expected competencies, respectively, 39 (43.3%) of 92 (100.0%) and 66 (74.7%) of 87 (100.0%) participants to a *large extent* agreed that they expected to develop an annual operational plan in the workplace with the emphasis on short-term goals (Item 69).

The highest mean value on the existing competencies of ANMs was on setting priorities to ensure that employees are working towards common goals (Item 68, $\bar{x}$ 3.33, SD 0.67). For existing competencies, the lowest mean value was on developing an annual operational plan with the emphasis on short-term goals (Item 69, $\bar{x}$ 3.21, SD 0.80). The highest mean value for expected competencies was on developing a strategic plan in the workplace that aligns with the vision of the institution (Item 67, $\bar{x}$ 3.33, SD 0.67). Nurse managers should be trained on ways in which to develop a strategic plan in the workplace (Terzic-Supic, Bjegovic-Mikanovic, Vukovic, Santric-Milicevic, Marinkovic, Vasic & Laaser, 2015:1). In addition, training for strategic planning and management enhanced the strategic decision-making of hospital management teams, which is a requirement for hospitals in an increasingly competitive, complex and challenging context (Terzic-Supic et al., 2015:1).

5.4.4.9 Financial management

That every management decision has financial and budgetary implications, and every financial

decision has management implications, is a living and working reality for nurse managers (Dunham-Taylor & Pinczuk, 2010:618). In this sub-domain the items were negatively skewed, with a narrow distribution of .60-.89 around the mean values (Table 5.19). In Item 71, 29 (32.2%) of 90 (100.0%) participants indicated that they to *no extent* and *to a small extent* currently participated in the development of business plan. It was noted that 15 (16.8%) of 89 (100.0%) participants specified that they to *no extent* and *to a small extent* currently identified ways of containing healthcare costs without compromising standards (Item 72). It was found that 14 (15.7%) of 89 (100.0%) participants indicated that they to *no extent* and *to a small extent* currently ensured implementation of the budget by monitoring the expenditure report (Item 73). It was also noted that 18 (19.8%) of 91 (100.0%) participants indicated they to *no extent* and to *a small extent* currently knew and understood the operational principles of functional business unit (Item 74). Less than half, 42 (46.2%) of 91 (100.0%) participants indicated that they currently to a *large extent* agreed on monitoring financial resources with emphasis on cost containment (Item 70), versus more than three quarters, 70 (79.5%) of 88 (100.0%) participants that were expected to do it.

Less than a quarter, namely 22 (24.4%) of 90 (100.0%), versus more than three quarters, 58 (66.3%) of 86 (100.0%) participants indicated respectively that they to a *large extent agreed* on their existing and expected competencies regarding participating in the development of business plans (Item 71). Less than half, 36 (40.4%) of 89 (100.0%) participants indicated that they to a *large extent* agreed on currently identifying ways of containing healthcare costs without compromising standards (Item 72), versus three quarters 64 (74.1%) of 85 (100.0%) participants that were expected to do it. More than half, namely 50 (56.2%) of 89 (100.0%), versus more than three quarters, 70 (80.5%) of 87 (100.0%) participants, indicated that they to a *large extent agreed* on their existing and expected competencies regarding ensuring implementation of the budget by monitoring the expenditure report (Item 73).

Less than half, 43 (47.3%) of 91 (100.0%) participants indicated that they to a large extent agreed on currently knowing and understanding the operational principles of functional business unit (Item 74), versus three quarters, 68 (77.3%) of 88 (100.0%) participants that were expected to do it. The highest mean values on the existing and expected competencies were around ensuring implementation of the budget by monitoring the expenditure report (Item 73, $\bar{x}$ 3.38, SD 0.81; $\bar{x}$ 3.38, SD 0.81). The second highest mean value on the expected competency was on identifying ways of compromising standards (Item 72, $\bar{x}$ 3.64, SD 0.72). It is suggested that to be effective in financial management, it is necessary for nurse managers to be effective leaders, to have an organisational/systems perspective, understand patients' values, be

conversant in financial practices and techniques and understand how this all fits in the community and society (Dunham-Taylor & Pinczuk, 2010:618).

5.4.4.10 Overall findings on the strategic resource management domain

Overall in the strategic resource management domain, the mean values for the expected competencies were lowest in the sub-domain financial management ($\bar{x}$ 3.65) and the mean values for the existing competencies were the lowest in the sub-domain retention strategy ($\bar{x}$ 2.98) (Figure 5.10). The mean values of the existing competencies of the ANM in the strategic resource management sub-scales were lower than expected competencies, that is, Effective staffing strategies (Items 54 & 55 $\bar{x}$ 3.43; $\bar{x}$ 3.84); Staff allocation (Items 56 & 57 $\bar{x}$ 3.76; $\bar{x}$ 3.84); Recruitment strategy (Items 58 & 59 $\bar{x}$ 3.52; $\bar{x}$ 3.75); Retention strategy (Item 60 $\bar{x}$ 2.98; $\bar{x}$ 3.66); Managing absenteeism (Items 61 & 62 $\bar{x}$ 3.36; $\bar{x}$ 3.72); Effective discipline (Items 63 & 64 $\bar{x}$ 3.41; $\bar{x}$ 3.79); Performance evaluation (Items 65 & 66 $\bar{x}$ 3.63; $\bar{x}$ 3.86); Strategic planning (Items 67, 68 & 69 $\bar{x}$ 3.26; $\bar{x}$ 3.70) and Financial management (Items 70, 71, 72, 73 & 74 $\bar{x}$ 3.16; $\bar{x}$ 3.65) Figure 5.10.

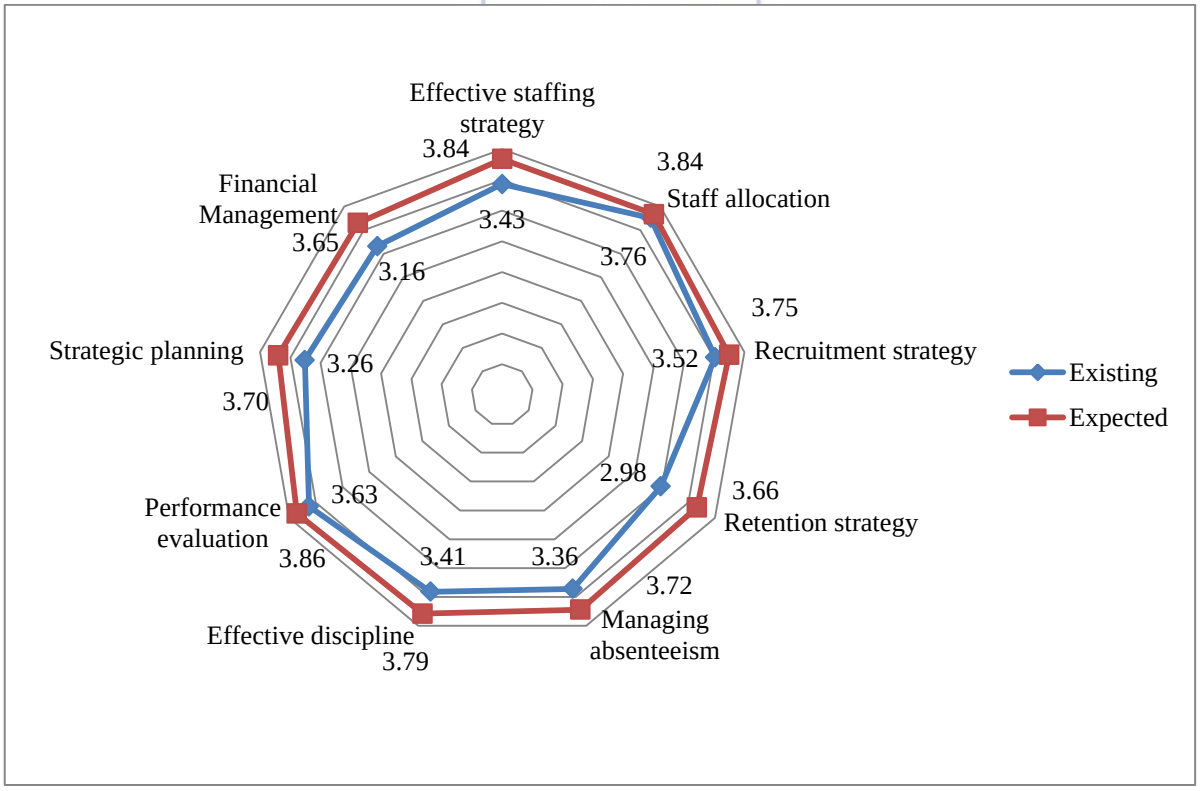

Figure 5.10: Mean values of the strategic resource management domain

Table 5.20 shows the level of reliability of each of the 9 sub-domains in strategic resource management. Scales with Cronbach's Alpha (α) higher than 0.70 are considered as reliable. Similarly, Cronbach's alpha was lowest in the sub-domain of staff allocation (α 0.62).

Table 5.20: Reliability of the strategic resource management domain sub-scales

Scale	Cronbach's alpha (α)	Number of items
Effective staffing strategy	0.88	2
Staff allocation	0.62	2
Recruitment strategies	Only one item in scale	
Managing absenteeism	0.72	2
Effective discipline	0.72	2
Performance evaluation	0.86	2
Strategic planning	0.84	3
Financial management	0.85	5

Table 5.21 shows the relationship between the existing and the expected level of competence of the ANMs in the strategic resource management domain, using Spearman correlation and the mean values regarding the difference between existing and expected competence using the paired t-test.

Table 5.21: Comparison of average sub-scale items for existing and expected scores in the Strategic resource management domain

Scale	Number of participants that answered questions	Average score	SD	Paired t-test			Spearman Correlation	
				Mean difference	SD	Sig	Correlation coefficient	Sig
Effective staff-ing strategy								
Existing	86	3.43	0.63	-0.41	0.73	0.00	0.12	0.26
Expected	86	3.84	0.46					
Staff allocation								
Existing	87	3.76	0.45	-0.08	0.53	**0.16**	0.37	0.00
Expected	87	3.84	0.49					
Recruitment strategies								
Existing	84	3.52	0.61	-0.23	0.58	0.00	0.48	0.00
Expected	84	3.75	0.51					
Retention strategies								
Existing	86	2.98	0.78	**-0.69**	0.80	0.00	0.34	0.00
Expected	86	3.66	0.59					
Managing absenteeism								
Existing	84	3.36	0.66	-0.36	0.60	0.00	0.54	0.00
Expected	84	3.72	0.58					
Effective discipline								

Existing	84	3.41	0.59	-0.38	0.57	0.00	0.44	0.00
Expected	84	3.79	0.46					
Performance evaluation								
Existing	85	3.63	0.50	-0.23	0.45	0.00	0.47	0.00
Expected	85	3.86	0.34					
Strategic planning								
Existing	82	3.26	0.64	-0.44	0.68	0.00	0.34	0.00
Expected	82	3.70	0.53					
Financial management								
Existing	82	3.16	0.67	-0.50	0.68	0.00	0.43	0.00
Expected	82	3.65	0.60					

The findings suggest that there is a significance difference between existing and expected scores of all the sub-scales with significance level (sig) 0.00 (Table 5.21). The mean differences mostly had negative values. The highest average score was for the expected competencies under Performance evaluation ($\bar{x}$ 3.86) with a narrow distribution around the mean of 0.34. This was followed by the sub-domains of Effective strategy ($\bar{x}$ 3.84, SD 0.46); Staff allocation ($\bar{x}$ 3.84, SD 0.49); Effective discipline ($\bar{x}$ 3.79, SD 0.46); Recruitment strategies ($\bar{x}$ 3.75, SD 0.51); Managing absenteeism ($\bar{x}$ 3.72, SD 0.58), Strategic planning ($\bar{x}$ 3.70, SD 0.53) and Financial management ($\bar{x}$ 3.65, SD 0.60) (Table 5.21).

In the strategic resource management domain, the four strongest items were identified as the items with the highest corrected item-total correlation and squared multiple correlation. The items have been arranged in descending order based on their corrected item-total correlation (Table 5.22). The three strongest items with the highest corrected item-total correlation in the Strategic resources management domain were Item 64 (Apply knowledge of grievance handling process); Item 63 (Implement strategies to retain staff members) and Item 65 (Monitor the implementation of staff performance agreements).

Table 5.22: Total statistics of the Strategic resources management domain

Item no	Competency Items	Scale mean if item deleted	Scale variance if item deleted	Corrected item-total correlation	Squared multiple correlation [a]	Cronbach's alpha if item deleted
64	Apply knowledge of grievance handling process	67.74	90.17	0.72	.	0.933
63	Implement strategies to retain staff members	68.04	88.53	0.72	.	0.932
65	Monitor the implementation of staff performance agreements	67.41	92.62	0.70	.	0.934
67	Develop a strategic plan in the workplace that aligns with the vision of the institution	67.77	90.16	0.69	.	0.933
73	Ensure implementation of the budget by monitoring the expenditure report	67.68	88.89	0.69	.	0.933
71	Participate in the development of business plan	68.23	87.88	0.68	.	0.933
68	Set priorities to ensure that employees are working towards common goals	67.76	90.90	0.67	.	0.933
55	Develop a plan to meet the staffing needs	67.63	90.36	0.67	.	0.933
54	Analyse staffing needs ensuring cost effectiveness	67.60	91.55	0.67	.	0.934
69	Develop an annual operational plan with emphasis on short term goals	67.83	89.11	0.66	.	0.934
63	Implement workplace discipline	67.56	91.76	0.65	.	0.934
62	Train supervisors on management of absenteeism	67.77	89.83	0.64	.	0.934
72	Identify ways of containing costs without compromising standards	67.88	89.05	0.63	.	0.934
66	Quarterly assess the performance of staff members	67.44	93.34	0.62	.	0.935
61	Determine the monthly staff absenteeism rate	67.63	91.37	0.61	.	0.934
74	Know and understand the operational principles of functional business unit	67.79	90.34	0.58	.	0.935
70	Monitor financial resources with emphasis on cost containment	67.77	91.17	0.56	.	0.935
57	Monitor the duty roster/ attendance register exist	67.27	94.30	0.55	.	0.936
58	Know and understand the recruitment process	67.54	93.07	0.54	.	0.936
59	Select the best suitable candidate to fill post	67.50	92.30	0.51	.	0.936
56	Allocate staff members to the different units	67.38	94.71	0.46	.	0.937

a: The determinant of the covariance matrix is zero or approximately zero. Statistics based on its inverse matrix cannot be computed and they are displayed as system missing values.

Table 5.23: Mean values and percentage of rating of items measuring existing and expected leadership domain															
Item	**Competency items**		**Responses of Assistant Nurse Managers**												
	Foundation/transversal competencies Supporting competencies Interaction competencies		**Total**		**To no extent**		**To a small extent**		**To a moderate extent**		**To a large extent**		$\bar{x}$	**SD**
			n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**		
	Innovation/initiation													
79	Innovate by adapting procedures to suit a changing environment	Existing	86	100.0	2	2.3	11	12.8	30	33.7	43	50.0	3.56	2.26
		Expecting	84	100.0	0	0.0	3	3.6	20	23.8	61	72.6	3.69	0.54
	Upskilling of staff/training needs													
80	Identify personnel skills gaps	Existing	90	100.0	5	5.6	16	17.8	39	43.3	30	33.3	3.04	0.86
		Expecting	85	100.0	2	2.4	6	7.1	17	20.0	60	70.6	3.59	0.73
81	Address skills gaps by ensuring staff attend professional training	Existing	90	100.0	2	2.2	12	13.3	39	43.3	37	41.1	3.23	0.77
		Expecting	87	100.0	1	1.1	5	5.7	15	17.2	66	75.9	3.68	0.64
82	Create an empowering environment by providing support	Existing	91	100.0	1	1.1	5	5.5	38	41.8	47	51.6	3.44	0.65
		Expecting	87	100.0	2	2.3	3	3.4	18	20.7	64	73.6	3.66	0.66
	Proper orientation plan													
83	Update orientation sessions for new employees	Existing	91	100.0	2	2.2	10	11.0	32	35.2	47	51.6	3.36	0.77
		Expecting	86	100.0	1	1.2	3	3.5	17	19.8	65	75.6	3.70	0.60
	Succession planning													
84	Have a leadership succession planning	Existing	90	100.0	1	1.1	14	15.6	31	34.4	44	48.9	3.31	0.77
		Expecting	85	100.0	3	3.5	6	7.1	11	12.9	65	76.5	3.62	0.77
85	Ensure that succession plan employees are exposed to peer teaching	Existing	91	100.0	1	1.1	15	16.5	29	31.9	46	50.5	3.32	0.79
		Expecting	85	100.0	3	3.5	5	5.9	15	17.6	62	72.9	3.60	0.76
	Collaborate with other departments/ hospitals													
86	Collaborate with members of the health and social care teams	Existing	89	100.0	1	1.1	9	10.9	28	31.5	51	57.3	3.45	0.72
		Expecting	83	100.0	0	0.0	2	2.4	16	19.3	65	78.3	3.76	0.48
87	Participate in decision-making pertaining to healthcare delivery	Existing	88	100.0	2	2.3	25	28.4	29	33.0	32	36.4	3.03	0.86
		Expecting	85	100.0	1	1.2	8	9.4	20	23.5	56	65.9	3.54	0.72
	Relationship building													
88	Provide team-building opportunities	Existing	86	100.0	4	4.7	24	27.9	36	41.9	22	25.6	2.88	0.85
		Expecting	82	100.0	4	4.9	6	7.3	20	24.4	52	63.4	3.46	0.84
89	Acknowledge outstanding professional work	Existing	88	100.0	13	14.8	29	33.0	22	25.0	24	27.3	2.65	1.04
		Expecting	85	100.0	11	12.9	6	7.1	20	23.5	48	56.5	3.24	1.54

SD = standard deviation, $\bar{x}$ = mean value

Table 5.23 cont. Mean values and percentage of the rating of items measuring existing and expected leadership domain														
Item	**Competency items**		**Responses of assistant nurse managers**											
	Foundation/transversal competencies Supporting competencies Interaction competencies		**Total**		**To no extent**		**To a small extent**		**To a moderate extent**		**To a large extent**		$\bar{x}$	**SD**
			n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**		
	Engaging with ONM / responsibility towards ONM													
90	Use authority to assist the operational nurse manager in the development of strategic plan	Existing	90	100.0	1	1.1	22	24.4	32	35.6	35	38.9	3.12	0.82
		Expecting	85	100.0	2	2.4	8	9.4	17	20.0	58	68.2	3.54	0.77
91	Involve operational nurse managers in budgetary planning	Existing	89	100.0	6	6.7	23	25.8	29	32.6	31	34.8	2.96	0.94
		Expecting	82	100.0	5	6.1	6	7.3	19	23.2	52	63.4	3.44	0.88
	Mentoring													
92	Have power to mentor followers by planning their career paths	Existing	91	100.0	2	2.2	10	11.0	44	48.4	35	38.5	3.23	0.73
		Expecting	87	100.0	4	4.6	3	3.4	19	21.8	61	70.1	3.57	0.77
93	Provide mentorship programmes to influence healthcare providers to obtain competencies	Existing	91	100.0	1	1.1	19	20.9	42	46.2	29	31.9	3.09	0.76
		Expecting	87	100.0	1	1.1	8	9.2	20	23.0	58	66.7	3.55	0.71
94	Be assertive, exercise one's rights while recognising the rights of fellow members	Existing	92	100.0	0	0.0	3	3.3	31	33.7	58	63.0	3.60	0.56
		Expecting	86	100.0	1	1.2	4	4.7	14	16.3	67	77.9	3.71	0.61
	Support													
95	Provide support to personnel accountable to nurse manager	Existing	89	100.0	1	1.1	5	5.6	31	34.8	52	58.4	3.51	0.66
		Expecting	84	100.0	1	1.2	5	6.0	16	19.0	62	73.8	3.65	0.65
96	Act as role model by guiding operational nurse managers in supervisory skills to promote team	Existing	88	100.0	0	0.0	4	4.5	22	25.0	62	70.5	3.66	0.57
		Expecting	84	100.0	1	1.1	3	3.2	21	24.9	59	70.2	3.73	0.59

SD = standard deviation, $\bar{x}$ = mean value

It is reflected in Table 5.23 that the instrument is internally consistent to the extent that the items in the Strategic resource management domain measure the same trait. The coefficient alpha scale is 0.94, with 21 items. The two strongest items are Item 64 (Apply knowledge of grievance handling process) and Item 63 (Implement strategies to retain staff members).

Table 5.24: Level of reliability of Strategic management domain and the two strongest items in the Strategic management domain

Domain	Scale Cronbach's alpha (α)	Number of items	Strongest item
Strategic resources management	0.94	21	Apply knowledge of grievance handling process
			Implement strategies to retain staff members

5.4.4.11 Summary of the strategic resource management domain

The findings indicated that according to the criteria, certain items were identified as important to be addressed in a strategy for ANMs, within the three broad areas of competencies. From these items, the levels of competencies were identified in sequence of priority, namely advanced (the first item under the broad area ○), proficient (second item under the broad area ◉) and knowledgeable (other items under the broad area ⊙):

Foundation competencies (blue)

○ Analyse staffing needs ensuring cost effectiveness (Item 54)
○ Develop a plan to meet the staffing needs (Item 55)
○ Develop a strategic plan in the workplace that aligns with the vision of the institution (Item 67)
○ Develop an annual operational plan with emphasis on short term goals (Item 69)
○ Monitor financial resources with emphasis on cost containment (Item 70)
○ Participate in the development of business plan (Item 71)
◉ Allocate staff members to the different units (Item 56)
◉ Monitor the duty roster/ attendance register (Item 57)
◉ Determine the monthly staff absenteeism rate (Item 61)
◉ Implement workplace discipline (Item 63)
◉ Apply knowledge of grievance handling process (Item 64)
◉ Monitor the implementation of staff performance agreements (Item 65)
◉ Quarterly assess the performance of staff members (Item 66)
◉ Set priorities to ensure that employees are working towards common goals (Item 68)

- ⭘ Identify ways of containing costs without compromising standards (Item 72)
- ⭘ Ensure implementation of the budget by monitoring the expenditure report (Item 73)
- ⭘ Know and understand the operational principles of functional business unit (Item 74)
- ⊙ Select the best suitable candidate to fill post (Item 59)
- ⊙ Implement strategies to retain staff members (Item 60)

Supporting competencies (pink)

- ○ Train supervisors on management of absenteeism (Item 62)

5.4.5 Leadership domain

Nine sub-domains of 18 are discussed under the leadership domain:

Innovation and initiation (Item 79)

Upskilling of staff/training needs (Items 80, 81, 82)

Proper orientation plan (Item 83)

Succession planning (Items 84, 85)

Collaborate with other departments/hospitals (Items 86 and 87),

Relationship building (Items 88, 89)

Engaging with operational nurse managers / responsibility towards operational nurse managers (Items 90 and 91)

Mentoring (Items 92, 93, 94)

Support (Items 95, 96) (Table 5.24)

Items 97 to 100 were open-ended questions, and responses were integrated in the findings.

5.4.5.1 Innovation and initiation

Literature suggests that middle managers influence innovation implementation by bridging informational gaps between top managers and frontline employees (Birken, DiMartino, Kirk, Lee, McClelland & Albert, 2015:1). Nurse managers who provided innovative work environments helped nurses to develop and integrate their new roles (Torstad & Bjork, 2007:819). In this sub-domain the items were negatively skewed, with a narrow distribution of .54 to 2.26 around the mean values (Table 5.24). In Item 79, 17 (15.1%) of 86 (100.0%) participants indicated they to *no extent and to a small extent* were currently innovated by adapting procedures to suit a changing environment. The mean values on the existing and expected competencies were on innovate by adapting procedures to suit a changing environment (Item 79, $\bar{x}$ 3.56, SD 2.26; $\bar{x}$ 3.69, SD 0.54). Half, 43 (50.0%) of 86 (100.0%) participants indicated that they to a *large extent agreed* that they currently used innovating by adapting procedures to suit a changing environment (Item 79), versus less than three quarters 61 (72.6%) of 84 (100.0%) participants that were expected to do it.

5.4.5.2 Upskilling of staff / training needs

Upskilling of staff is supported by Jooste and Jasper (2012:62-63), who claim that nurse managers can play a major role in maintaining an adequate supply of nursing professionals by providing supervision and adequate clinical facilities for students and implementing the principles of the National Human Resources Plan (2009). These authors add that opportunities need to be created for nurse managers to influence the SANC and deans of nursing schools, to encourage the development of work-based (portfolio-based) part-time programmes for CPD that accommodate the duty rosters of nurses, and incorporate principles of the recognition and accreditation of prior learning (Jooste & Jasper,2012:63). In this sub-domain the items were negatively skewed, with a narrow distribution of .64 to .86 around the mean values (Table 5.24).

In Item 80, 21 (23.4%) of 90 (100.0%) participants indicated they to no extent and to a small *extent* currently identified personnel skills gaps. It was noted that 14 (15.5) of 90 (100.0%) participants specified that they to no extent and to a small extent currently addressed the skills gap by ensuring staff attend professional training (Item 81). One third, 30 (30.0%) of 90 (100.0%) participants indicated that they to *a large* extent agreed on currently identifying the personnel skills gaps (Item 80), as opposed to less than three quarters, 60 (70.6%) of 85 (100.0%) participants that were expected to do it. Less than half of 37 (41.1%) of 90 (100.0%) participants, versus more than three quarters, namely 66 (75.9%) of the 87 (100.0%) responses, respectively, indicated that to a large extent they agreed on their existing and expected competency regarding addressing the skills gap by ensuring that staff attend professional training (Item 81). For the existing and expected competencies, 47 (51.6%) of 91 (100.0%) and 64 (73.6%) of 87 (100.0%) participants, respectively, to a large extent indicated that they currently created an empowering environment by providing support (Item 82). The highest mean value for existing competencies was on creating an empowering environment by providing support (Item 82, $\bar{x}$ 3.44, SD 0.65). For expected competencies the highest mean value was on addressing the skills gap by ensuring staff attended professional training (Item 81, $\bar{x}$ 3.68, SD 0.64). Lin et al. (2007:157) presented an exploratory study that used an activity competency model to investigate the perceived importance of managerial activities for nurse manager. These authors found that nurse training, regardless of hospital size, was perceived to be one of the essential competencies of managers (Lin et al., 2007:157).

5.4.5.3 Proper orientation plan

In this sub-domain the items were negatively skewed, with a narrow distribution of .60 to .77 around the mean values (Table 5.24). The mean values on the existing and expected competencies were on update orientation sessions for new employees (Item 83, $\bar{x}$ 3.36, SD

0.77; $\bar{x}$ 3.70, SD 0.60). More than one quarter, 47 (51.6%) of 91 (100.0%) participants indicated that they to a large extent agreed on currently updating orientation sessions for new employees (Item 83), versus three quarters, 66 (75.6%) of 86 (100.0%) participants that were expected to do it. It was believed that retention was associated with selection and fit. That is, if suited nurses could be found, and were correctly oriented to their jobs, then retention could improve. There is a need to expand the orientation programme for newly hired nurses and nurse managers to enhance self-confidence (Wallis & Kennedy, 2013:628).

5.4.5.4 Succession planning

There is an indication that there is a current leadership crisis in healthcare, which warrants deliberate succession planning efforts (Titzer & Shirey, 2013:155). In this sub-domain the items were negatively skewed, with a narrow distribution of .76 to .79 around the mean values (Table 5.24). In Item 84, 15 (16.7%) of 90 (100.0%) participants indicated they to *no extent and to a small extent* currently had leadership succession planning. It was noted that 16 (17.6%) of the 91 (100.0%) participants indicated that they to *no extent and to a small extent* currently ensured that succession plan employees were exposed to peer teaching (Item 85). The lowest mean value for existing competencies was on having a leadership succession planning (Item 84, $\bar{x}$ 3.31, SD 0.77). Integrating succession planning in an organisation's mission, vision and strategic plan is the first element. In addition, determining short- and long-term succession planning goals is essential and helps to identify who fits and enhances the organisation's culture (Titzer & Shirey, 2013:974).

Fewer than half, 44 (48.9%) of 90 (100.0%) participants indicated that they to a *large extent agreed* on currently having a leadership succession planning (Item 84), versus more than three quarters, 65 (76.5%) of 85 (100.0%) participants that were expected to do it. More than half, namely 46 (50.5%) of 91 (100.0%), versus less than three quarters, namely 62 (72.9%) of the 85 (100.0%) participants, respectively, indicated that they to a large extent agreed on their existing and expected competency regarding ensuring that employees were exposed to peer teaching (Item 85). The highest mean value on the expected competencies was on having leadership succession planning (Item 68, $\bar{x}$ 3.62, SD 0.77). It is evident in this study that succession planning is needed for the ANM. This is supported by Titzer and Shirey (2013:156), who state that succession planning prepares future leaders, ensuring effective and competent nurse managers to improve environments, increase nurse retention, and decrease staff (Titzer & Shirey, 2013:156).

5.4.5.5 Collaborate with other departments/hospitals

Jooste and Japer (2012:59) maintain that that collaboration of nurse managers with various role

players is essential. In achieving Health for All, nurse managers are expected to collaborate with partners and key role players in the healthcare context (Jooste & Jasper, 2012:59). These role players include NDoH, SANC, Democratic Organisation for Nurses in South Africa (DENOSA) and unions such as the National Education, Health & Allied Workers' Union (NEHAWU), National Union of Public Service & Allied Workers (NUPSAW), Forum of University Nursing Deans in South Africa (FUNDISA), government committees, South African Qualifications Authority (SAQA 2007) and the Department of Education (DoE) (Jooste & Jasper, 2012:59).

In this sub-domain, the items were negatively skewed, with a narrow distribution of .48 to .86 around the mean values (Table 5.24). It was noted that 27 (30.7%) of the 88 (100.0%) participants currently to *no extent and to a small extent* participated in decision-making pertaining to healthcare delivery (Item 87). The lowest mean value for *existing* and *expected* competencies was on participating in decision-making pertaining to healthcare delivery (Item 87, $\bar{x}$ 3.03, SD 0.86; $\bar{x}$ 3.54, SD 0.72). Less than two thirds, namely 51 (57.3%) of 89 (100.0%), versus more than three quarters, namely 65 (78.3%) of 83 (100.0%) participants, indicated that they respectively to a *large extent agreed* on their existing and expected competencies regarding collaborating with members of the health and social care teams (Item 86). Fewer than half, 32 (36.4%) of 88 (100.0%) participants indicated that they to a large extent agreed on currently participating in decision-making pertaining to healthcare delivery (Item 87), versus two thirds, 56 (65.9%) of 85 (100.0%) participants that were expected to do it. The highest mean values on the existing and expected competencies were on collaborating with members of the health and social care teams (Item 86, $\bar{x}$ 3.45, SD 0.72; $\bar{x}$ 3.76, SD 0.48).

5.4.5.6 Relationship building

Among the challenges for nurse managers when new professional roles are introduced are clarifying the reallocation of tasks and managing altered working relationships in the nursing team (Torstad & Bjork, 2007:823). This needs the nurse manager's attention. Hence, it could be expected of ANMs to provide team-building opportunities and acknowledge outstanding professional work. In this sub-domain the items were negatively skewed, with a narrow distribution of .84 to 1.54 around the mean values (Table 5.24). In Item 88, 28 (32.6%) of 86 (100.0%) participants indicated that they to no extent and to a small extent currently provided team building opportunities. It was noted that 42 (47.8%) of 88 (100.0%) participants indicated that they to no extent and to a small extent currently acknowledged outstanding professional

work (Item 89). It was also found in Item 89, that 17(20.0%) of 85 (100.0%) participants specified that they to no extent and to a small extent were expected to acknowledged outstanding professional work.

One quarter, 22 (25.6%) of 86 (100.0%) participants indicated that they to a *large extent agreed* on currently providing team-building opportunities (Item 88), as opposed to less than two thirds, 52 (63.4%) of 82 (100.0%) participants that were expected to do it. In healthcare, good team building is when all team members understand, believe in and work towards the shared purpose of caring and working for patients. Nurse managers should develop a teaming strategy to plan how people act and work together, including effective use of communication technology to help them make better use of face-to-face time (Craig & Mckeown, 2015:16)

More than half, namely 24 (27.3%) of 88 (100.0%), versus more than two thirds, namely 48 (56.5%) of 85 (100.0%) participants, respectively, indicated that they to a *large extent agreed* on their existing and expected competencies in acknowledging outstanding professional work (Item 89). The highest mean value on the existing and expected competencies was on providing team-building opportunities (Item 88, $\bar{x}$ 2.88, SD 0.85; $\bar{x}$ 3.46, SD 0.84). Team leaders should provide team-building opportunities, and talk about sense of common purpose at every opportunity in workshops to ensure all team members are working towards it in their day-to-day work (Craig & McKeown, 2015:14)

5.4.5.7 Engaging with operational nurse manager / responsibility towards operational nurse manager

Changes in the external environment (e.g. demographic and epidemiological transitions, economic fluctuations, public and political expectations) and within the system (e.g. the health market, demands, costs, new technologies, regulations) have put pressure on hospital managers to implement strategic management programmes to respond to environmental challenges. Hence the ANM should involve the ONM in budgetary and strategic planning (Terzic-Supic et al., 2015:2). In this sub-domain the items were negatively skewed, with a narrow distribution of .77 to .94 around the mean values (Table 5.24). In Item 90, 22 (25.5%) of 86 (100.0%) participants indicated that they to *no extent and to a small extent* currently used authority to assist the ONM in the development of strategic plan. It was noted that 29 (32.5%) of 89 (100.0%) participants indicated that they to *no extent and to a small extent* were currently involved with the ONM in budgetary planning (Item 91).

Fewer than half, namely 35 (38.9%) of 90 (100.0%), versus more than two thirds, 58 (68.2%) of 85 (100.0%) participants, respectively, to a *large extent agreed* on their existing and expected competencies regarding the use of authority to assist the ONM in the development of strategic plan (Item 90). More than one quarter, 31 (34.8%) of 89 (100.0%) participants indicated that they to a *large extent agreed* that they currently involved the ONM in budgetary planning (Item 91), versus more less than three quarters, 52 (63.4%) of 82 (100.0%) participants that were expected to do it. The highest mean values for both existing and expected competencies of the ANM was on using authority to assist the ONM in the development of strategic plan (Item 90, $\bar{x}$ 3.12, SD 0.82; $\bar{x}$ 3.54, SD 0.77).

5.4.5.8 Mentoring

There is evidence that new managers often do not receive the support they need to succeed. Hence, a mentor relationship offers them a nurturing and protective environment in which they are supported as they encounter management challenges and can flourish as managers who make significant contributions to patient care (Grindel, 2003:517). Furthermore, mentors encourage their protégés' growth by challenging them to move beyond their comfort zones to master communication and problem-solving skills in various roles and contexts (Jakubik, Eliades, Weese & Huth, 2016:252). In this sub-domain the items were negatively skewed, with a narrow distribution .56 to .77 around the mean values (Table 5.24). In Item 93, 20 (22.0%) of 91 (100.0%) participants indicated they to *no extent and to a small extent* currently provided mentorship programmes to influence healthcare providers to obtain competencies. In Item 92, 44 (48.4) of 91 (100.0%) participants indicated that they to a *moderate extent* currently had power to mentor followers by planning their career paths. It was noted that 42 (46.2%) of 91 (100.0%) participants indicated that they to a moderate extent currently provided mentorship programmes to influence healthcare providers to obtain competencies (Item 93).

Less than half, 35 (38.5%) of 91 (100.0%) participants indicated that they to a *large extent agreed* about currently having power to mentor followers by planning their career paths (Item 92), versus more than two thirds 61 (70.1%) of 87 (100.0%) participants that were expected to do it. More than a quarter, namely 29 (31.9%) of 91 (100.0%), as opposed to two thirds, 58 (66.7%) of 87 (100.0%) participants, respectively, indicated that to they a *large extent agreed* on their existing and expected competencies in providing mentorship programmes to influence healthcare providers to obtain competencies (Item 93). For the existing and expected competencies, 58 (63.0%) of 92 (100.0%) and 67 (77.9%) of 86 (100.0%) participants respectively, to a *large extent*, indicated that they are assertive, and exercise their rights, while recognising the rights of fellow members (Item 94). The highest mean values for both existing and expected competencies were on being assertive, exercising their rights, while recognising

the rights of fellow members (Item 94, $\bar{x}$ 3.60, SD 0.56; $\bar{x}$ 3.71, SD 0.61).

5.4.5.9 Support

The National Nursing Strategy 2012–2017 iterates that middle management is an important source of support, mentorship and role modelling of excellence in nursing care for entrance into the profession (NDoH, 2012). The National Nursing Strategy 2012–2017 (2013) adds that nurse managers are expected to develop positive relationships in a culture of accountability and excellence (NDoH, 2012). In this sub-domain the items were negatively skewed, with a narrow distribution of .57 to .66 around the mean values (Table 5.24). Less than two thirds, 52 (58.4%) of 89 (100.0%) participants indicated that they to a *large extent agreed* that they currently provided support to personnel who are accountable to nurse manager (Item, 95) versus less than three quarters, 62 (73.8%) participants that were expected to do it. More than two thirds, 62 (70.5%) of 88 (100.0%), versus more than two thirds, 59 (70.2%) of 84 (100.0%) participants, respectively, indicated that they to a *large extent agreed* on their existing and expected competencies in acting as role models by guiding operational nurse managers in supervisory skills to promote team work (Item 96).

The highest mean values for both existing and expected competencies were on acting as role models by guiding operational nurse managers in supervisory skills to promote a team approach (Item 96, $\bar{x}$ 3.66, SD 0.57, $\bar{x}$ 3.73, SD 0.59). Nurse managers should serve as role models in a people-centred management style, which promotes the professional development and mentoring of personnel (NDoH, 2007). Among nursing leaders, according to Chase (2010:4), the nurse manager should provide a structured orientation and development programme, which includes 30/60/90 day checkpoints and establishes long-term mentorship building on the key ingredients of inspiration and role modelling.

5.4.5.10 Overall findings on the leadership management domain

Overall in the leadership management domain, the mean values for the *expected* and *existing* competencies were lowest in the sub-domain relationship building ($\bar{x}$ 2.72; $\bar{x}$ 3.35); (Figure 5.11).

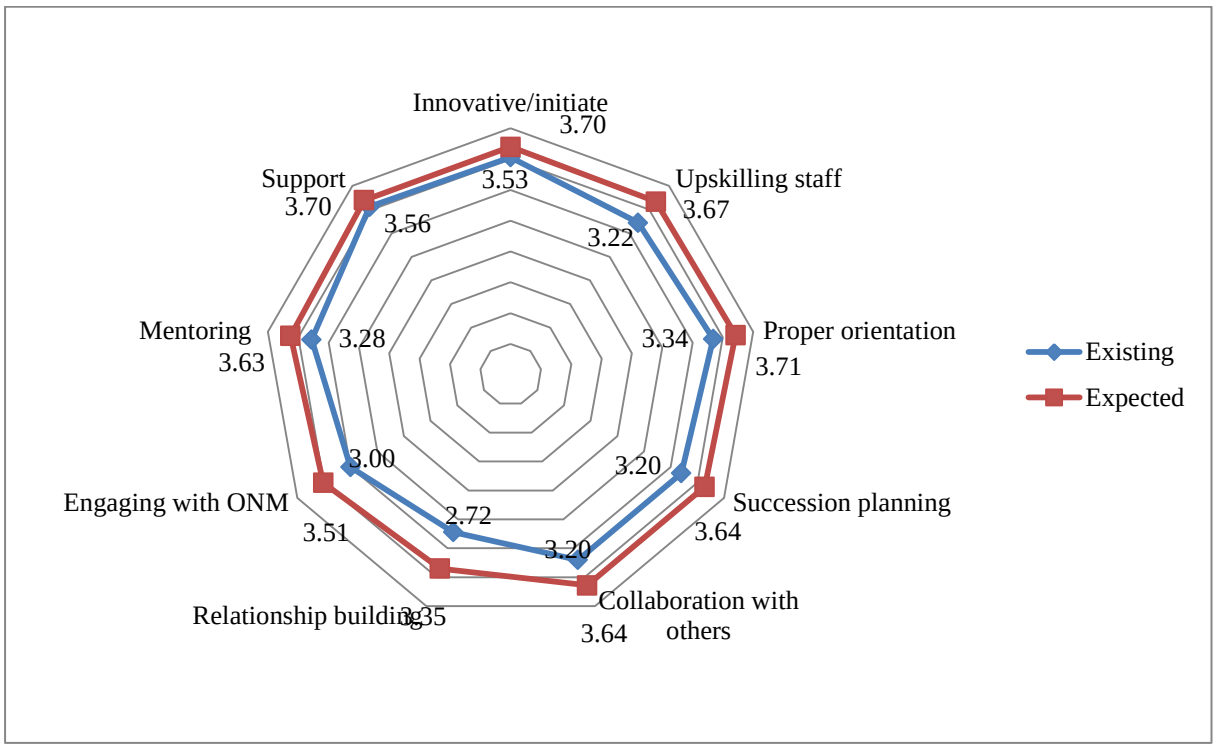

Figure 5.11: Mean values of *leadership* domain

The mean values of the existing competencies of the ANM in the leadership sub-scales were lower than the expected competencies, that is, Innovation/initiation (Item 79 $\bar{x}$ 3.53; $\bar{x}$ 3.70); Upskilling of staff (Items 80, 81 and 82 $\bar{x}$ 3.22; $\bar{x}$ 3.67); Proper orientation plan (Items 83 $\bar{x}$ 3.34; $\bar{x}$ 3.71); Succession planning (Items 84 and 85 $\bar{x}$ 3.20; $\bar{x}$ 3.64); Collaborating with other department/hospitals (Items 86 and 87 $\bar{x}$ 3.20; $\bar{x}$ 3.64); Relationship building (Items 88 and 89 $\bar{x}$ 2.72; $\bar{x}$ 3.35); Engaging with ONM/ responsibility towards ONM (Items 90 and 91 $\bar{x}$ 3.00; $\bar{x}$ 3.51); Mentoring (Items 92, 93 and 94 $\bar{x}$ 3.28; $\bar{x}$ 3.63) and Support (Items 95 and 96 $\bar{x}$ 3.56; $\bar{x}$ 3.70) (Figure 5.21).

Table 5.25: Reliability of the leadership domain sub-scales

Scale	Scale Cronbach's alpha (α)	Number of items
Innovation/Initiation	Only 1 item in scale	
Upskilling staff/ training needs	0.85	3
Proper orientation	Only 1 item in scale	
Succession planning	0.89	2
Collaboration with other departments/ hospitals	0.70	2
Relationship building	**0.66**	2
Engaging with Operational Nurse Managers	0.79	2
Mentoring	**0.60**	3
Support	**0.20**	2

Table 5.25 shows the level of reliability of each of the 9 sub-domains. Scales with Cronbach's

Alpha (α) higher than 0.70 are considered as reliable. Similarly, Cronbach's alpha was lowest in the sub-domain of support (α 0.20). Table 5.26 shows the relationship between the existing and the expected level of competence of the ANM in the leadership domain using Spearman correlation and the mean difference between existing and expected competence using paired t-test. The findings suggest that there is a significance difference between the existing and the expected scores of all the sub-scales with significance level 0.00 (Table 5.26). The mean differences mostly had negative values. The highest average score was for the expected competencies under proper orientation ($\bar{x}$ 3.71) with a narrow distribution around the mean of 0.59. This was followed by the sub-domains of Innovation/initiation ($\bar{x}$ 3.70, SD 0.51); Support ($\bar{x}$ 3.70, SD 0.53); Upskilling staff/ training needs ($\bar{x}$ 3.67, SD 0.55); Succession planning ($\bar{x}$ 3.64, SD 0.52); Collaboration with other departments/hospitals ($\bar{x}$ 3.64, SD 0.52); Mentoring ($\bar{x}$ 3.63, SD 0.59); Engaging with operational nurse managers ($\bar{x}$ 3.51, SD 0.77) and Relationship building ($\bar{x}$ 3.35, SD 0.86) (Table 5.18).

Table 5.26: Comparison of the average sub-scale for items existing and expected in the leadership domain

***Leadership* domain Scale**	**Number of partici-pants**	**Average score**	**SD**	**Paired t-test**			**Correlation**	
				Mean difference (existing minus expected)	**SD**	**Sig**	**Correlation coefficient**	**Sig**
Innovation/ Initiatiation								
Existing	81	3.53	2.33	-0.17	2.37	**0.51**	0.04	0.73
Expected	81	3.70	0.51					
Upskilling staff/training needs								
Existing	83	3.22	0.64	-0.45	0.61	0.00	0.48	0.00
Expected	83	3.67	0.55					
Proper orientation								
Existing	85	3.34	0.78	-0.36	0.84	0.00	0.27	0.01
Expected	85	3.71	0.59					
Succession planning								
Existing	80	3.20	0.71	-0.44	0.72	0.00	0.36	0.00
Expected	80	3.64	0.52					
Collaboration with other departments/ hospitals								

Existing	80	3.20	0.71	-0.44	0.72	0.00	0.36	0.00
Expected	80	3.64	0.52					
Relationship building								
Existing	78	2.72	0.81	**-0.63**	0.93	0.00	0.38	0.00
Expected	78	3.35	0.86					
Engaging with ONM								
Existing	80	3.00	0.80	-0.51	0.82	0.00	0.46	0.00
Expected	80	3.51	0.77					
Mentoring								
Existing	84	3.28	0.51	-0.35	0.65	0.00	0.32	0.00
Expected	84	3.63	0.59					
Support								
Existing	81	3.56	0.51	-0.15	0.06	0.01	0.54	0.00
Expected	81	3.70	0.53					

In the leadership domain the five strongest items were identified as the items with the highest corrected item-total correlation and squared multiple correlation. The items have been arranged in descending order based on their squared multiple correlation, then on their corrected item-total correlation (Table 5.27). The five strongest items with the highest corrected item-total correlation and squared multiple correlation in the Leadership domain were Item 61 (Ensure that succession plan employees are exposed to peer teaching); Item 68 (Have leadership succession planning); Item 66 (Create an empowering environment by providing support); Item 65 (Address the skills gap by ensuring staff attend professional training) and Item 75 (Involve operational nurse managers in budgetary planning) (Table 5.27).

Table 5.27: Total statistics of the leadership domain

Item no	Competency items	Scale mean if item deleted	Scale variance if item deleted	Corrected item-total correlation	Squared Multiple Correlation	Cronbach's alpha if item deleted
85	Ensure that succession plan employees are exposed to peer teaching	55.05	77.27	0.64	0.77	0.919
84	Have a leadership succession planning	55.04	77.29	0.67	0.77	0.918
82	Create an empowering environment by providing support	54.92	78.08	0.77	0.75	0.917
81	Address the skills gap by ensuring staff attend professional training	55.15	77.41	0.69	0.75	0.918
91	Involve operational nurse managers in budgetary planning	55.48	74.39	0.70	0.72	0.917
86	Collaborate with members of the health and social care teams	54.95	78.66	0.57	0.71	0.921
90	Use authority to assist the operational nurse managers in the development of strategic plan	55.29	76.26	0.70	0.69	0.917
95	Provide support to personnel accountable to nurse manager	54.84	79.61	0.66	0.68	0.919
80	Identify personnel skills gap	55.40	76.83	0.62	0.67	0.919
96	Act as role model by guiding operational nurse managers in supervisory skills to promote team work	54.74	80.03	0.64	0.63	0.920
87	Participate in decision-making pertaining to healthcare delivery	55.29	77.74	0.55	0.63	0.921
78	Be assertive, exercise your rights while recognising the rights of fellow members	54.77	80.74	0.58	0.61	0.921
77	Provide mentorship programmes to influence healthcare providers to obtain competencies	55.32	77.00	0.67	0.59	0.918
89	Acknowledge outstanding professional work	55.74	75.42	0.58	0.55	0.922
83	Update orientation sessions for new employees	55.01	78.82	0.57	0.55	0.921
88	Provide team-building opportunities	55.45	78.83	0.51	0.53	0.922
92	Have power to mentor followers by planning their career paths	55.23	78.65	0.57	0.49	0.921
79	Innovate by adapting procedures to suit a changing environment	55.10	79.95	0.46	0.46	0.923

It is reflected in Table 4.20 that the instrument is internally consistent to the extent that the items in the leadership domain measure the same trait. The coefficient alpha scale is 0.92, with 18 items. The two strongest items were Item 69 (Ensure that succession plan employees are exposed to peer teaching) and Item 68 (Have leadership succession planning).

Table 5.28: Level of reliability and the two strongest items in the leadership domain

Domain	Scale Cronbach's alpha (α)	Number of items	Strongest item
Leadership	0.92	18	Ensure that succession plan employees are exposed to peer teaching
			Have leadership succession planning

5.4.5.11 Summary of the leadership management domain

The findings indicated that according to the criteria set for this study certain items were identified as being important to be addressed in a strategy for ANMs, within the three broad areas of competencies. From these items, the levels of competencies were identified in sequence of priority, namely advanced (the first item under the broad area ○), proficient (second item under the broad area ◉) and knowledgeable (other items under the broad area ⊙):

Interaction (green)

◉ Provide team building opportunities (Item 88)

◉ Be assertive, exercise your rights while recognising the rights of fellow members (Item 94)

⊙ Collaborate with members of the health and social care teams (Item 86)

⊙ Acknowledge outstanding professional work (Item 89)

Foundation competencies (blue)

○ Use authority to assist the operational nurse manager in the development of strategic plan (Item 90)

◉ Involve operational nurse manager in budgetary planning (Item 91)

⊙ Participate in decision-making pertaining to delivery (Item 87)

Supporting competencies

○ Update and implement orientation sessions for new employees (Item 83)

○ Have a leadership succession planning (Item 84)

○ Have power to mentor followers (Item 92)

○ Provide support to personnel accountable to nurse manager (Item 95)

○ Act as role model by guiding operational nurse managers in supervisory skills to promote team work (Item 96)

◉ Identify personnel skills gaps (Item 80)

- ❶ Address skills gaps by ensuring staff attend professional training (Item 81)
- ❶ Create an empowering environment by providing support (Item 82)
- ❶ Ensure that succession plan employees are exposed to peer teaching (Item 85)
- ⊙ Innovate by adapting procedures to suit a changing environment (Item 79)

5.5 ALL DOMAINS

Of the 80 existing competencies rated by participants, 72 had mean ratings that were greater than or equal to 3.0, defined as contributing largely to the effectiveness for nurse manager competence. Only eight competencies had a mean rating less than 3.0, which was considered contributing moderately to effectiveness for nurse manager competence. In the legal and professional domain, the range of mean values was 3.16–3.70. In the interpersonal domain, it was 3.32–3.85, the evidence-based domain it was 2.6–3.74, in the strategic resource management domain 2.84–3.84, and in the leadership domain 2.65– .66. The top rated competencies on the questionnaire were maintenance of confidentiality (Item 36), monitoring of the duty roster (Item 57), identifying nursing trends (Item 46), people management (Item 28), professional working relationship (Item 17), staff allocation (Item 56) and practice standards (Item 1).

All 80 expected competencies rated by participants had mean values greater than or equal to 3.0, defined as contributing largely to the effectiveness of nurse manager competence. In the legal and professional domain, the range of mean values was 3.55–3.93. In the interpersonal category it was 3.59–3.93, in the evidence-based domain 3.22–3.76, the strategic resource management domain 3.49–3.88 and in the leadership domain 3.24–3.76. The top rated expected competencies on the questionnaire were holistic nursing care according to set standards (Item 1), maintenance of professional working relationship (Item 13), provision of quality care with emphasis on patient-centred experience (Item 2), analysing staffing needs ensuring cost effectiveness (Item #41) and addressing complaints of patients and public (Item 27). Figure 5.12 shows the average score under each domain for existing and expected scores. The closer it is to the centre, the lower it is. For example, the existing leadership domain score is the lowest at $\bar{x}$ 3.25. Hence it is closest to the centre. The interpersonal domain expected score is the highest. Hence it is furthest from the centre at $\bar{x}$ 3.79 and the difference (gap) between its existing and expected competencies is also the least ($\bar{x}$ 3.59 and $\bar{x}$ 3.79) when compared with the others. The blue line is for existing competencies while the red is for expected competencies. In addition, the existing and expected scores under each of the domains were compared using the Spearman correlation and they were all significantly different (p>0.000).

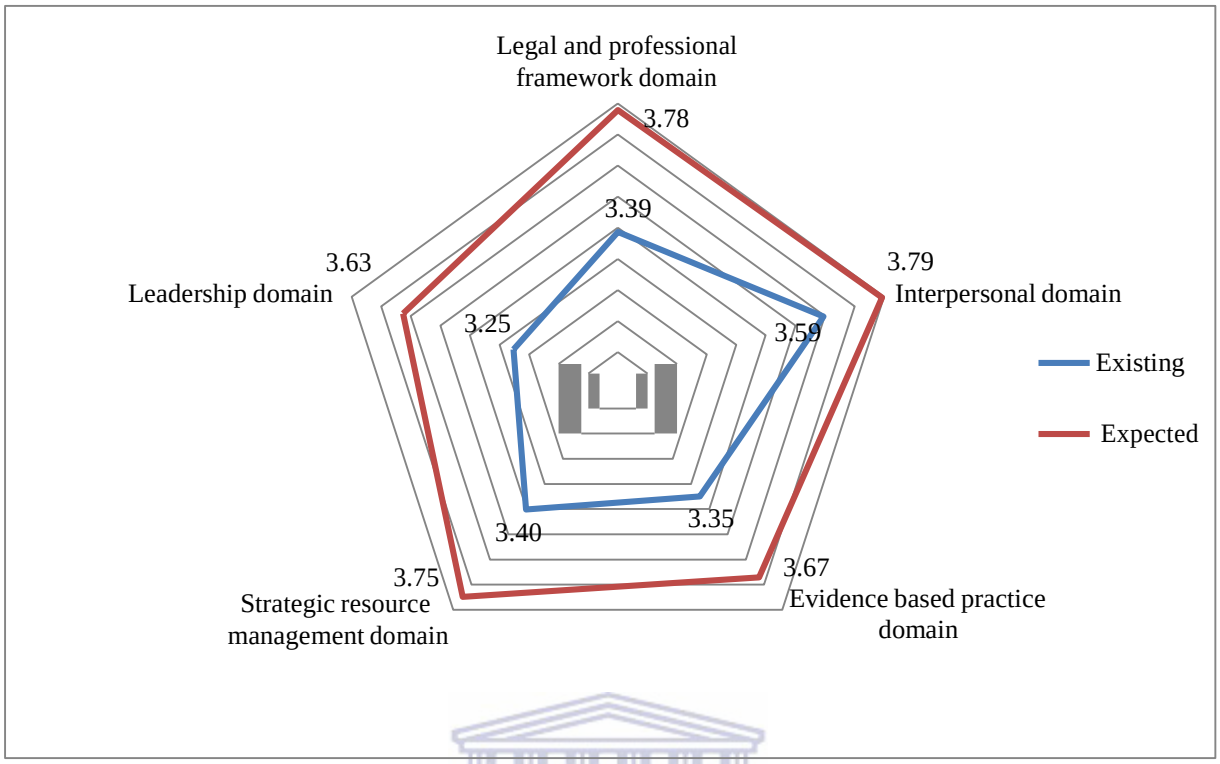

Figure 5.12: Mean values of all domains

5.6 RELIABILITY OF ALL DOMAINS

In the review of Cronbach's alpha analysis, it is important that in all the domains the overall ratings were as follows: Legal and professional framework domain = α 0.88; Interpersonal domain = α 0.93; Evidence-based practice domain = α 0.83; Strategic resources management domain = α 0.94; and Leadership domain = α 0.92.

In order of priority, it seems that a strategy in Phase 3 should address the domains of strategic resources management, interpersonal relations, leadership, resource management, a legal and professional framework and evidence-based practice. Table 5.30 presents the level of reliability of each of the 34 scales and the strongest item under each scale. The strongest items in scales with more than two items were identified as the items with the highest corrected item-total correlation and squared multiple correlation, while the strongest items in scales with only two items were identified as the item with the lowest scale variance if item deleted. Single item scales were taken as they are. Scales with Cronbach's alpha (α) higher than 0.70 were considered reliable, while those below 0.70 were considered unreliable. If a scale is unreliable the questions cannot be combined to measure the scale that it aims to measure. Scales that were unreliable are highlighted in red. For scales that are unreliable, one may choose to rephrase the questions or choose one question that best describes the scale as the measure for the scale, and

it possibly becomes a single-item scale. This highlights the importance of piloting testing tools.

Table 5:29: Level of reliability of each of the five domains and the two strongest items in each domain

Domain	Scale Cronbach's alpha (α)	Num-ber of items	Strongest items
Legal and professional framework	0.88	11	Ensure dissemination of information to enhance patient outcomes
			Monitor nursing care management activities according to the standards of practice / scope of practice
Interpersonal	0.93	20	Building trust among the employees ensuring productivity
			Share a common vision through ongoing dialogue with all stakeholders
Evidence-based Practice	0.83	9	Involve nursing staff in conducting research activities
			Promote research in current trends to maintain professional growth
Strategic resources management	0.94	21	Apply knowledge of grievance handling process
			Implement strategies to retain staff members
Leadership	0.92	18	Ensure that succession plan employees are exposed to peer teaching
			Have a leadership succession planning

before the actual study to avoid having scales with low reliability in the final results. Table 5.30 shows the nine ways (factors) in which the strongest items from the 34 scales can be combined to measure different concepts. The items with the highest loading under each factor are highlighted in red for the reader's convenience. Each factor potentially measures a concept similar to what the highest loading item is measuring. The first factor may have to do with planning as the first three highest items seem to relate to planning matters. The combination of items listed in Factor 2 may have to do with acknowledgment and recognition and so on.

Table 5.30: Level of reliability of each of the 34 scales and the strongest item under each scale

Scale	Scale Cronbach's alpha (α)	No of items	Strongest item	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's alpha if Item Deleted
Legislation	0.83	5	Monitor nursing care management activities according to the standards of practice / scope of practice	13.51	3.87	0.69	0.56	0.76
Patient care	**0.68**	3	Review the developed nursing care plan	6.93	1.20	0.52	0.28	0.51
Clinical activities	**0.57**	2	Participate in the provision of nursing care to patients in order to ensure the formulation of accurate nursing diagnoses to address clients needs	3.36	0.41	0.40	0.16	
Healthcare systems outcomes	Only one item in scale		Ensure dissemination of information to enhance patient outcome					
Effective communication	0.80	4	Share a common vision through ongoing dialogue with all stakeholders	10.91	1.60	0.72	0.59	0.69
Self-confidence	0.78	2	Take initiative by proposing suggestions in an open arena	3.33	0.47	0.64	0.41	
Self-development	0.76	3	Have self-knowledge to identify need that requires learning new skills	6.91	1.09	0.67	0.46	0.57
Relationship building	0.82	4	Focus on diversity in the workplace	10.62	2.13	0.71	0.54	0.72
Conflict management	**0.64**	2	Use different strategies to resolve conflict in the workplace	3.70	0.28	0.47	0.22	
Problem-solving	Only one item in scale		Address patients' and public's complaints satisfactorily within an appropriate timeframe					
Providing feedback	**0.65**	2	Provide feedback to operational nurse managers on recent developments	3.67	0.25	0.48	0.23	
Openness/honesty/ trust	**0.61**	3	Solve problems by using a specific framework	7.47	0.50	0.46	0.22	0.43
Writing reports	**0.03**	2	Have the knowledge to draft a memorandum	3.76	0.30	0.02		
Computer literate	0.76	2	Apply knowledge of computer programs in the workplace	3.54	0.41	0.61	0.37	
Act as resource to Operational Nurse Manager	Only one item in scale		Act as a resource to operational nurse manager					
Research activities	0.82	4	Involve nursing staff in conducting research activities	8.93	3.50	0.73	0.60	0.73

Scale	Scale Cronbach's alpha (α)	Number of items	Strongest item	Scale mean if item deleted	Scale variance if item deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's alpha if Item Deleted
Recruitment strategies	0.72	2	Select the most suitable candidate to fill post	3.53	0.41	0.57	0.32	
Effective staffing strategy	0.88	2	Develop a plan to meet the staffing needs	3.46	0.39	0.78	0.60	
Staff allocation	**0.62**	2	Allocate staff members to the different units	3.80	0.25	0.45	0.20	
Effective discipline	0.72	2	Apply knowledge of grievance handling process	3.48	0.41	0.56	0.32	
Performance evaluation	0.86	2	Quarterly assess the performance of staff members	3.64	0.28	0.76	0.58	
Strategic planning	0.84	3	Develop a strategic plan in the workplace that aligns with the vision of the institution	6.55	1.74	0.74	0.56	0.74
Financial management	0.85	5	Ensure implementation of the budget by monitoring the expenditure report	12.56	7.18	0.73	0.55	0.80
Innovation/ Initiative	Only one item in scale		Innovate by adapting procedures to suit a changing environment					
Upskilling staff/training needs	0.85	3	Address skills gaps by ensuring staff attend professional training	6.52	1.71	0.79	0.62	0.70
Proper orientation	Only one item in scale		Update orientation sessions for new employees					
Succession planning	0.89	2	Ensure that succession plan employees are exposed to peer teaching	3.31	0.60	0.81	0.65	
Collaboration with other hospitals	0.70	2	Participate in decision-making pertaining to healthcare delivery	3.44	0.53	0.54	0.29	
Relationship building	**0.66**	2	Acknowledge outstanding professional work	2.88	0.71	0.49	0.24	
Engaging with Operational Nurse Manager	0.79	2	Involve operational nurse managers in budgetary planning	3.14	0.67	0.65	0.42	
Mentoring	**0.60**	3	Provide mentorship programmes to influence healthcare providers to obtain competencies	6.84	1.05	0.48	0.24	0.39
Support	**0.20**	2	Provide support to personnel accountable to nurse manager	3.73	0.35	0.11	0.01	

Table 5.31: Strongest item under each scale

Strongest item under each scale	Factors								
	1	2	3	4	5	6	7	8	9
Develop strategic plan in workplace that aligns with vision of institution	**0.76**								
Implement strategies to retain staff members	0.69								
assess the performance of staff members quarterly	0.68								-0.31
Ensure implementation of the budget by monitoring the expenditure report	0.67		**0.49**						
Monitor nursing care management activities according to standards of practice / scope of practice	0.66								
Develop a plan to meet staffing needs	0.65		-0.34			-0.38			
Address complaints by patients and public	0.64				-0.38				
Solve problems by using a framework	0.64								
Share a common vision through ongoing dialogue with all stakeholders	0.63		0.30						
Focus on diversity in the workplace	0.62				-0.31				
Provide feedback to operational nurse managers on recent developments	0.62								
Ensure dissemination of information to enhance patient outcomes	0.62		-0.33			0.40			
Have self-knowledge to identify needs that require learning new skills	0.61								
Involve operational nurse managers in budgetary planning	0.59	0.44	0.35						
Apply knowledge of grievance-handling process	0.58				0.32				
Provide support to personnel accountable to nurse manager	0.58			0.41			-0.34		
Provide mentorship programmes to influence providers to obtain competencies	0.57	0.38							
Ensure that succession plan employees are exposed to peer teaching	0.54						-0.36		
Involve nursing staff in conducting research activities	0.54							**-0.48**	
Participate in decision-making pertaining to delivery	0.53								
Address the skills gap by ensuring staff attend professional training	0.53	0.47						0.36	
Use different strategies to resolve conflict in the workplace	0.53					-0.32	**-0.36**		
Take initiative by proposing suggestions in an open arena	0.51	-0.45		-0.30					
Participate in the provision of nursing care to patients in order to ensure the formulation of accurate nursing diagnoses to address client needs	0.50		-0.31	-0.36	-0.31				
Update orientation sessions for new employees	0.47	0.35							
Select the most suitable candidate to fill post	0.42								
Allocate staff members to the different units	0.40								**0.34**
Review the developed nursing care plan	0.40			-0.34					
Act as a resource for operational nurse managers	0.40								
Acknowledge outstanding professional work	0.44	**0.53**							
Apply knowledge of computer programs in the workplace	0.42			**0.46**					
Innovate by adapting procedures to suit a changing environment			0.32	0.34					
Train supervisors on management of absenteeism	0.50				**0.56**				
Know how to draft a memorandum	0.43	-0.32				**0.54**			

5.7 CONCLUSION

The findings of the study indicate that in the legal and professional framework domain, the mean values for expected and existing competencies were the highest, followed by patient care, while the lowest results were in clinical activities. In the interpersonal domain, the mean values for expected and existing competencies were the highest in problem-solving, followed by effective communication, openness, honesty and trust, and conflict management, however the lowest results were found in self-development.

Overall in the evidence-based domain, the mean values for the expected and existing competencies were the highest in acting as a resource to the ONM and computer literacy, while the lowest was in research activities. In the strategic resource management domain, the mean values for the expected and existing competencies were the highest in performance evaluation, effective staffing strategy, and the staff allocation sub-domains and the lowest in the retention strategy sub-domain. Overall in the leadership domain, the mean values for the expected and existing competencies were the highest in the proper orientation, innovative and support sub-domains and lowest in the relationship building.

A human resource strategy to facilitate the competencies of the ANM is developed in Chapter 6.

CHAPTER 6

HUMAN RESOURCE STRATEGY

6.1 INTRODUCTION

The previous two chapters (Chapters 4 and 5) described the findings on Objectives 1 and 2, namely to explore their expectations of competencies of ANMs in public health facilities in the Western Cape; and to explore and describe the perceptions of ANMs about their expected and existing competencies for effective nursing management in public health facilities in the Western Cape. In this chapter the researcher provides a description of the strategy and its sub-strategies for addressing Objective 3 of the study, namely to develop a human resource strategy for addressing the gap between existing and expected competencies of ANMs in public health facilities in the Western Cape.

The categories and sub-categories identified in Chapter 4 reflected on the competencies required of ANMs through focus group discussions and individual interviews. This led to the development of an instrument that were used to gather data that indicated gaps between the existing and the expected competencies of the ANMs (Chapter 5). These gaps are addressed by a strategy in this chapter to address the competencies required of ANMs to deliver effective service. South Africa's healthcare system, which is predominantly nurse based, requires nurses to have the competence and expertise to manage the country's burden of disease and to meet its healthcare needs (NDoH, 2012:5). Given that nurses are a critical component of health systems, especially in the PHC philosophy, the nurse manager's role has been identified as vital to the provision of high-performing, effective and efficient care in the patient care delivery setting, hence the need for development of a human resource strategy to address the competencies of ANMs.

6.2 BACKGROUND TO THE PROPOSED STRATEGY

According to Ehlers and Lazenby (2010:214), a strategy is used that includes creating an action plan. The strategy, with its five sub-strategies, was constructed by the researcher in such a manner that the agent had clear guidance for implementing it. A strategy was developed that represented the expectations of stakeholders of competencies needed from ANMs in public health facilities in the Western Cape (Figure 6.1). During the analysis of the qualitative data, certain categories and subcategories emerged. With confirmation from a survey and substantiation from the literature, the researcher interpretated the expected competencies of nurse managers. The researcher combined the findings in an overarching strategy, namely a human resource strategy, to address the competencies of ANMs.

6.2.1 Purpose of the strategy

The purpose of the strategy was to set goals for sub-strategies containing each a proposed action plan. It was aimed at facilitating the competencies of ANMs, who should portray the values of the WCGH and who should possess the competencies essential to effectively managing and therefore improving the health outcomes of the people in the community of the Western Cape. The strategy sets a clear direction and highlights the shared responsibility and accountability of the ANM and other roleplayers in public health facilities.

6.2.2 Overview of the components of the strategy

The main strategy relates to five sub-strategies (processes/procedure):

Legal and professional framework

Interpersonal relationships

Evidence-based practice

Effective management of human resources

Leadership.

The findings indicated that in this study certain items were identified with set criteria (see Point 5.4), the as being important to be addressed in a strategy for ANMs, within the three broad areas of competencies. From these items, the various levels of competencies were further outlined with regard to the advanced, proficient and knowledgeable competency levels of (see Point 1.3.2.1).

6.2.3 The goals for the sub-strategies

The goals of the strategy relate to the five main sub-strategies (processes/procedure):

- To facilitate quality patient care by partaking in effective clinical activities within a legal and professional framework that promotes healthcare systems outcomes.
- To promote good interpersonal relationships between the ANMs and stakeholders, through effective communication and feedback, by showing self-confidence, honesty and trust, problem-solving skills and conflict management skills, with the focus on relationship building and self-development opportunities.
- To write complete reports on evidence-based and research activities, which need computer literacy, while acting as a resource for ONMs.
- To recruit, place, retain, monitor, and evaluate staff members in healthcare units through appropriate motivational, training and corrective actions, within financial resources and the strategic plan of the facility.
- To mentor and support through innovative actions and relationship building the up-scaling of staff through orientation and succession planning while engaging with ONMs and collaborating with other departments.

Each of the sub-strategies has an action plan. The goal of each sub-strategy has objectives, included in the action plan. The action plan aimed to set out objectives according to principles adapted from Quirk and Fandt (2000:89):

1. Create SMART objectives identified from the gaps in the data and articulate them with the purpose of the strategy. Brooker, Waugh, Van Rooyen and Jordan (2009:325) are in agreement, explaining the acronym SMART as follows:

- **S**pecific: There should be a clear statement of what to be achieved.
- **M**easurable: Goals should be quantifiable.
- **A**chievable: It must be possible for ANMs to attain the goals.
- **R**ealistic: The goals should be accurate and results focused.
- **T**ime oriented: It must be specified when a goal is to be achieved.

2. Prioritise the goals relating to the gaps, and explain or rank their importance for practice.
3. Leverage actions for each goal. Identify and be explicit about actions to address the gaps.
4. Draw up a schedule for activities and outline the steps by answering the 'how' to clarify the way in which gaps should be addressed.
5. Establish objective, quantifiable standards, measures for the actions.
6. Establish realistic time lines for accomplishing the goals and sustaining them.

6.2.4 What is the strategy about?

The concept 'human' is interpreted as 'belonging to a person or people' (*Concise Oxford English dictionary*, 2008). 'Resource' is described as 'a person, book, etc, that helps or information (*Concise Oxford English dictionary*, 2008). Competence is a multi-faceted and dynamic concept, which refers to the understanding of knowledge, clinical skills, interpersonal skills, problem-solving, clinical judgement, and technical skills by the various professions (Verma, Paterson & Medves, 2006:109). 'Competencies' are specific skills, traits, capabilities and behaviours (Chase, 2010:28).

6.3 THE REASONING MAP FOR THE STRATEGY

The survey list of practice-oriented theory (Dickhoff et al., 1968:434) was used in this study as the reasoning map (Figure 6.1) for the human resource strategy to facilitate the competencies of ANMs. These questions answered in the human resource strategy addressed the competencies of ANMs:

- In what context is the activity/strategy performed?
- Who or what performs the strategy? (Agent)
- Who or what is the recipient of the strategy?

- What are the guiding processes of the strategy? (Procedure)
- What is the energy source for the strategy, whether physical, biological, or psychological? (Dynamics)
- What is the end-point of the strategy? (Terminus)

6.3.1 In what context is the strategy performed?

The context of the strategy to facilitate competencies of ANMs in the public health facilities in the Western Cape is in a legal and professional framework, with different public facility levels in the Western Cape Province and these facilities have different hierarchical structures (Figure 6.2). To deliver quality care in these public health facilities certain international, national and provincial legislation and other legal documents should be taken into consideration. The WCGH (2014) is the current strategic approach that the WCDoH recognises. It requires a strong transformational leadership in light of its strict hierarchical nature with its intention to develop nurse managers. The key is to create a work environment that harnesses the relationships, skills and capabilities of individuals in the system. Managers at all levels need to be visible at the coalface to support the frontline staff, listening to their issues and needs to address problems with creative solutions. The context requires important relevant legislative frameworks and policies such as the global strategic directions that addresses the nursing and midwifery workforce management, education, regulation, practice and research as a cross-cutting issue (WHO, 2016:7). The National Development Plan (NDP) (2011:28) proposes to strengthen primary health-care services and broaden district-based health programmes such as midwife programmes and health education.

Healthcare 2010 and the Comprehensive Service Plan for health services in the WCDoH (2007) signal a change in the way the health services in the province should be dealt with towards re-engineering of PHC. One of the underlying principles of Healthcare 2010 is the primary healthcare approach which led to the strengthening of district health services. This improved access to services without compromising the quality and access to care. The plan led to the strengthening of district health services which would result in better quality and more accessible care for many people in the communities where they live. In addition, it allowed the development of more specialised health services in the regional and central hospitals in support of district-based services (WCDoH, 2010:3). In the Provincial Strategic Plan of the Western Cape (2011), the NDoH Strategic plan for nursing education, training and practice (2012) it is stated nurse managers should be developed and be reoriented with the requisite management competencies. The WHO Global strategic provides directions for strengthening nursing and midwifery 2016-2030 (2016) that requires competent nurse managers.

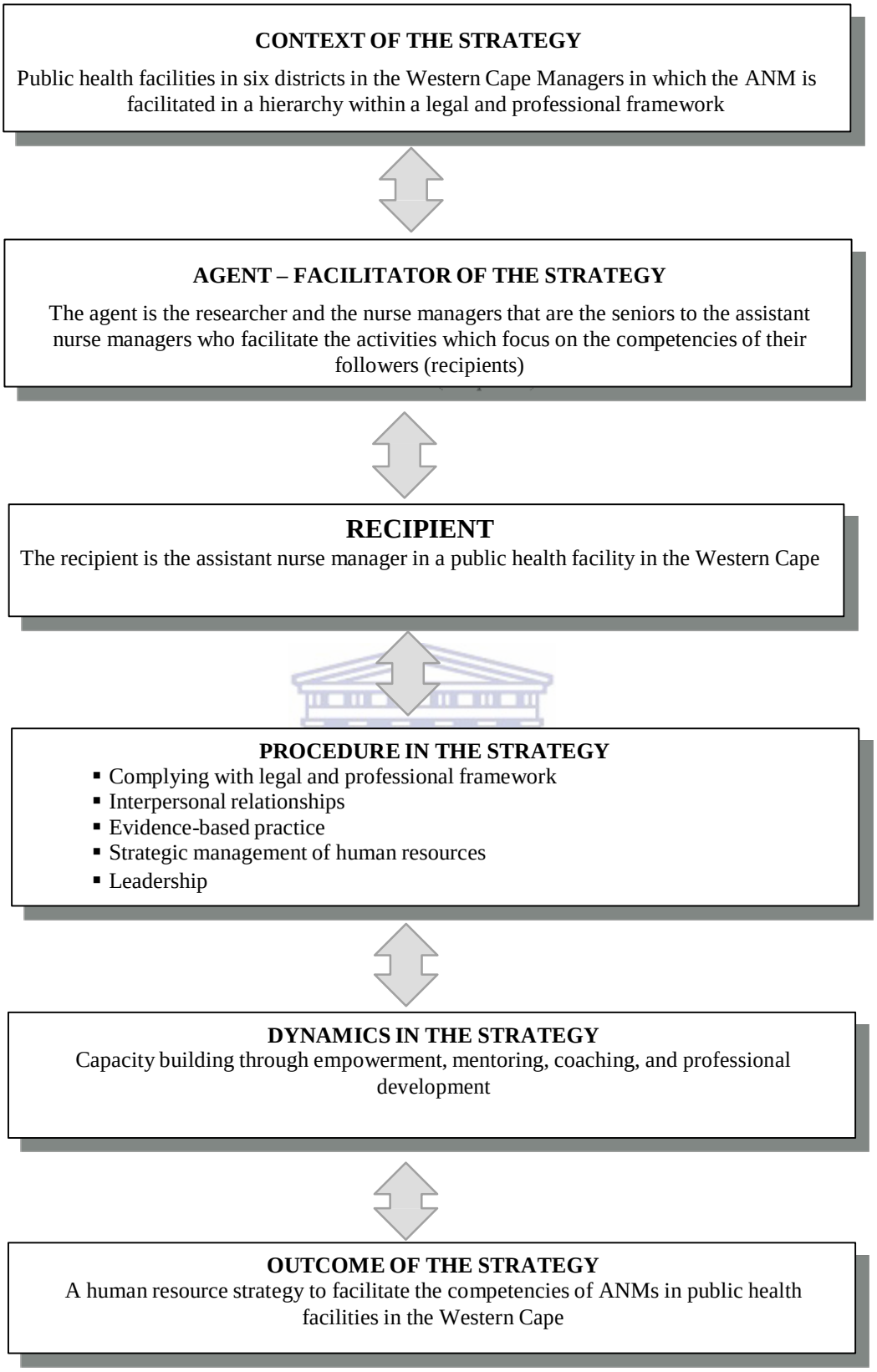

Figure 6.1: Framework to address competencies of assistant nurse managers

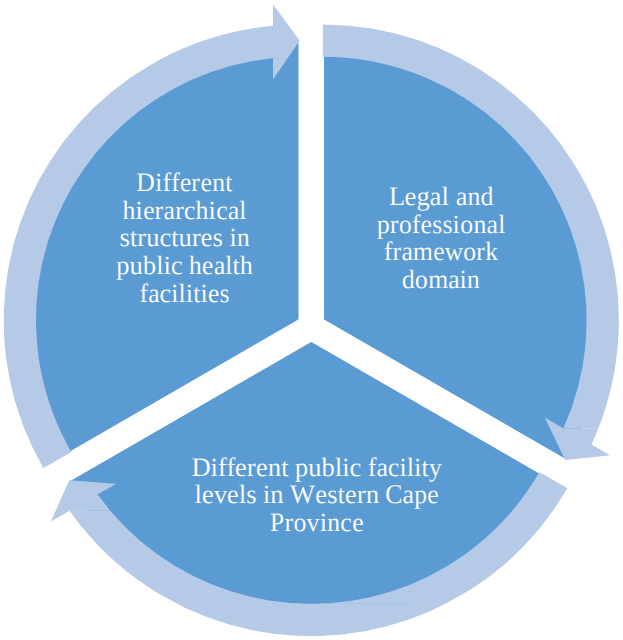

Figure 6.2: Context

Furthermore, the professional framework of nurse managers is guided by the SANC Code of Ethics for Nursing Practitioners in South Africa (2013), the ICN Code of Ethics (2000), the Nursing Act No 33 of 2005 (SANC, 2005) and the document on the Scope of Practice, Practice Standards and Competencies of SANC (2005) (Jooste, 2010:91). The latter are social instruments that have been designed to guide and control the members of the nursing profession (Jooste, 2010:91).

There has to be a clear vision and mission which form the basis for unit and organisational plans. The vision provides a sustainable competitive advantage to the organisation; it is fundamental for leadership and strategy implementation, and forms an important tool for decision making during periods of change or transformation. The vision is an important strategic element when building the brand or reputation for the organization (Kukkurainen, Suominen, Rankinen, Harkonen & Kuokkanen, 2012:869). The vision statement should be established first to provide the foundation for developing a comprehensive mission statement that answers the question 'What is our business'. Furthermore, the vision describes the desired identity answering the question 'What do we want to become? The vision gives strategic direction to the organisation and also serves as the basis for decision-making (Kukkurainen et al., 2012:869). The strategy to facilitate competencies of ANMs in for the public health facilities in the Western Cape, in the geographical context of six districts, namely the Metro (central hospitals, regional hospitals, psychiatric and specialised hospitals, district hospitals, community health centres, community district centres, maternity obstetric units and clinics) and Rural Districts (Cape Winelands; Central Karoo; Eden; Overberg and West Coast) with

regional, specialised hospitals, district hospitals, community health centres and clinics. Healthcare units in Level 1, 2, and 3 facilities in these districts exist to provide essential services as defined in the National Health Act No 61 of 2003 and they operate within authorised institutions according to the relevant acts.

District health services include; community-based services, primary healthcare provided at clinics and community health centres, and district hospitals or Level 1 services. An efficiently functioning district health system facilitates prompt diagnosis and treatment of patients and reduces the need for unnecessary and expensive hospital care. Regional hospitals provide general specialist care or Level 2 services which have strengthened outreach and support to the District health services. Central hospitals primarily provide highly specialised tertiary healthcare or Level 3 services within the allocated conditional grant as well provide support to general specialist services in regional hospitals. Specialised hospitals provide general specialist services such as TB hospitals, psychiatric, rehabilitation and dental hospital services (WCGH, 2011:21,23).

The strategy could be instituted in public health facilities with different hierarchical structures. The ANM could be the head of nursing in a district hospital with 90 or less beds who reports to the Chief executive officer of the institution, who is similar to the position of a SNM. In a district hospital with 91 beds or more the ANM reports to a DNM. On the other hand, the ANM in a primary health facility, reports to a primary healthcare manager who is similar to the position of a DNM. The ANM in a clinical area in a regional or central hospital reports to a DNM, and the DNM reports to the NM. In a tertiary hospital the report line is to a NM. In this context, direct interaction therefore takes place between the SNMs, NMs and DNMs (agents) with the ANMs (recipients).

6.3.2 Who or what performs the strategy? (Agent)

In the context of the study, the agent will initially be the researcher, and thereafter it will be the SNMs, NMs or DNMs (agents) (Figure 6.3). These agents may be supported by staff development nursing officers and trainers where needed. The agent is a professional nurse, who works as a strategic partner in the nursing management team in a public health facility in the Western Cape, to facilitate the competencies of an ANM. A facilitator, enables others to effect changes in practice for the benefit of patients (Lansdell, 2016:6). The role of a facilitator has been to enable staff to make explicit their values and beliefs about holistic nursing assessment and consequently to support them to review their current practice critically, challenging the 'norms' and exploring alternatives (Dewing, McCormack & Titchen, 2014). Facilitation is

about enabling others to reach a goal while optimising their learning (Shaw, 2013), that could include critical reflection to stimulate self-awareness and therefore change amongst others.

Figure 6.3: The agent

The agent (SNMs, or NMs, DNMs) operates in an interactive manner with the ANM in the professional, legal environment of healthcare units as discussed under point (Point 6.3.1). These agents are diverse in background, being males and females, usually selected from the age of 40 and can serve till retirement (age 65), from different cultures and ethnical groups. They are positioned on Levels 11 to 13 of the OSD HR structure of the Western Cape Province.

The agent plays a major role in capacity building through empowering the ANM (recipient) to be competent in nursing management. For her role she needs good interpersonal characteristics such as e.g. conflict management and problem-solving skills to build a relationship that enhances the ANM to acts competent in the work situation. The agent acts as a problem solver, who should be able to effectively analyse problems and make the best decisions for each situation (Kocoglu, Duygulu, Abaan & Akin, 2016:956). This means that nurses working in managerial positions must develop their problem solving skills and nurse manager candidates should receive training in several areas to include problem solving skills (Kocoglu et al., 2016:956). An agent, as a good problem solver, help the recipient to find solutions to problems that are particular troublesome. Conflict management is a key role of managers and a skill which every nurse manager needs to possess to retain staff. Studies about the effectiveness of educational and mediation training programs in conflict management in the workplace for nurse managers revealed the positive correlation with the acquisition of skills and competencies as important means for handling conflict (Moisoglou, Panagiotis, Galanis, Siskou, Maniadakis

& Kaitelidou, 2014:80). The agent as a good conflict manager assists the recipient to implement the best strategy to resolve a conflict. Moreover, modern management considers that constructive conflict management helps improve decision quality, stimulates creativity and encourages interest (Moisoglou et al., 2014:76).

The agent also acts as a leader who influences the ANM through her authority, towards being competent. A leader influences the ANM to set a clear vision for the organisation, motivates and guides the ANM through the work process and builds morale (Thompson & Hyrkas, 2014:1). The leader motivates and bring others and makes the vision become strategic; the leader's voice is persuasive and results become more tangible (Dolamo, 2015:489). Highly successful leaders project the ability to think and act strategically. They influence, motivate and inspire, thereby enabling others to realise their potential. These leaders lead by example, possess the talents of a superb communicator, reflect selflessness, and are perceived as making a large difference to an organisation (Slavkin, 2010:36). Leadership behaviour that facilitate learning and individual development in the workplace is essential (Matsuo, 2012:610).

The agent should use external resources and strategic partners that could assist to facilitate the competencies of ANMs. External resources can be to involve the advice of experts that have already been identified by the Western Cape Government as training providers and amongst other include the Department of the Premier, that is, Kromme Rhee Academy Centre in Stellenbosch, Western Cape, the People Development Centre, and the Directorate People Development. Therefore the agent has a specific role to play in implementing the human resource strategy for the ANM.

6.3.3 Who or what is the recipient of the strategy?

A recipient is an individual who receives information from a sender (Basavanthappa, 2009:931). In this study the primary recipients were ANMs who are employed by the Western Cape Government: Health (WCG: H): in the posts of Assistant Nurse Managers General Wards/Units, Assistant Nurse Managers Speciality Units, Assistant Nurse Managers Primary Healthcare or Assistant Nurse Managers Head of Nursing/Services (Figure 6.4). In a district hospital with 90 beds and less, the ANM report to the Chief Executive Officer, in a district hospital with more than 90 beds, regional, specialised and tertiary and academic hospital the ANM report to a Deputy Nurse Manager. In a community district centre the ANM report to the Primary Healthcare Manager.

Becoming a nurse leader is essential for ANMs as they are in the fore front of communities and increasingly face the need to understand and take initiatives in responding to this rapidly

changing world (Thompson & Hyrkas, 2014:1). There is a need to ensure that the global nurse leader have a good understanding of the health care system, social and political context, purposes of health reform, a vision of how health and nursing services may be developed in their countries, the ability to plan strategically for and manage change, and the strength and confidence to be proactive in a challenging and often stressful change environment (Thompson & Hyrkas, 2014:1)

Figure 6.4: The recipient

As recipients, ANMs should possess certain characteristics to enhance optimum learning and to accomplish during the facilitation of their competencies. Good interpersonal skills are needed by e.g. good listening, willingness to receive knowledge, eagerness to learn, self-confidence, motivation and preparedness to assume responsibilities and being courageous and persevering in the facilitation of their competencies are indispensable. It is essential that the recipients in this study, namely the ANMs, should be receptive to and responsible for acquired knowledge and skills, as this could enable them to manage effectively. Paterson, Henderson and Burmeister (2015:1086) support the need for self-development that lead to effective leadership in such environments because leadership has been shown to be important in establishing and maintaining team relationships that foster high- quality and safe environments conducive to nurses voicing concerns and asking for help, attracting and retaining staff and improving staff satisfaction, providing patient-centred, evidence based and outcome oriented and managing change. It is vital that the ANMs should be developed by the agent or develop themselves by either attending leadership courses or being mentored or coached by an agent in

order to challenge themselves and improve what they do which would enable them to feel safe in their working environment (Fenton, 2005:3).

The ANMs as recipients should enhance communication, problem-solving and participatory decision-making (MacPhee et al., 2012:160). Empowerment structures should be implemented which includes advancement opportunities and access to information, supports and resources. Furthermore, access to organizational empowerment structures results in organizational commitment, trust and self-motivation and confidence (MacPhee et al., 2012:160).

6.3.4 What is the guiding procedure of the strategy?

The processes (sub-strategy) in the strategy included complying with the legal and professional framework, having interpersonal competencies, implementing evidence-based practice, development of leadership and strategic management of human resources (see Figure 6.5).

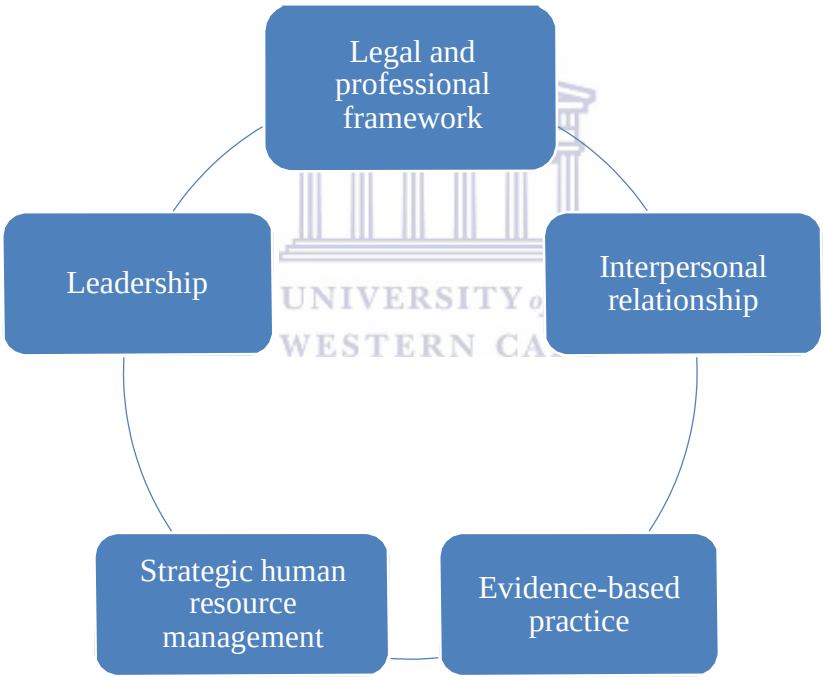

Figure 6.5: Processes (sub-strategies) that address the strategic goals

Each of the five sub-strategies needed a clear action plan for implementation. Each sub-strategy has important aspects (as outlined at the end of Chapter 5), which are addressed in the plans. The following symbols and colours are used in the plans of the sub-strategies to demonstrate the competency frameworks, adapted from the Department of Education (2015) and UNIDO (2002) as the starting point of this study (Chapter 1):

Green: Client interaction competencies
Blue: Foundation competencies

Pink: Supporting competencies

The plan will also refer to the competency levels of;

Advanced competency: ○

Proficient competency: ◘

Knowledgeable⊙

The action plan of each of the sub-strategies includes the strategic objective, strategic priorities, activities responsible persons, time frames and resource requirements.

6.3.4.1 Plan for the sub-strategy on the legal and professional framework

Introduction and rationale

'Legal' is construed as being based on law, allowed or recognised by law (*Concise Oxford English dictionary* 2008). Framework is defined as an essential supporting structure or a basic system (*Concise Oxford English dictionary*, 2008). Nursing is a regulated profession, consisting a body of scientific knowledge and skills practised by persons that are registered in terms of Section 31 of Act Nursing Act No 33 of 2005 The act, and regulations, rules and codes made in terms of the act, provides the legal and professional framework for the practice of nursing (See Point 6.3.1). It is therefore essential that nurse managers should be expected to coordinate optimal holistic nursing care according to the standards of a legal and professional framework, and monitor nursing care management activities according to the standards and scope of practice. Competencies needed in complying with knowledge of legislation are to coordinate optimal, holistic nursing care according to the standards of a professional/legal framework; to monitor nursing care management according to the standards of practice and to ensure adherence to the acts/prescripts. According to Gillies (1994:561) cited in Jooste (2010:67), laws governing nursing may be classified as follows:

Laws affecting the nurse as an employee

Laws that specify the nurse's responsibilities towards healthcare users

Laws that regulate the nurse's relationship with physicians

Laws that specify a nurse's duty to protect the public

Laws that specify the nurse's duty for record keeping and reporting.

The above confirms that the ANM should comply with knowledge of legislation to render effective nursing management. This argument is supported by Carvallo, Reeves and Orford (2011:14), who state that the public sees the nurse in full bloom, yet nurses have their clinical practice firmly rooted in the legal, ethical and professional foundations of their education and training.

Competencies needed in the provision of quality patient include the emphasis on patient-centred experience. Chase (2010:4) states that the nurse manager's role has been identified as

being critical to the provision of high-performing, effective and efficient care in the patient care delivery setting. The nurse manager is responsible for quality, safety, satisfaction and financial performance in alignment with regulatory and accrediting body requirements. In addition, the nurse manager represents the direct caregiver voice at nursing leadership decision-making tables (Chase, 2010:16). Nurse managers ensure that care delivery aligns with the highest quality to understand key quality and safe improvement measures, and to lead staff training to ensure the safety care for patients. Management of clinical activities and information was identified as a competency needed for ANMs in order to render effective nursing management.

To perform the clinical activities in practice within the legal and professional framework knowledge management is essential. Jooste (2010:152) argues that knowledge management is about people who have and can indicate the location of knowledge in a healthcare organisation and aims at making employees 'all knowing'. The value of knowledge management relates to directly to the effectiveness with which the managed knowledge enables the members of the healthcare organisation to deal with today's situation, and envision and create their future effectively (Jooste, 2010:152). This author states that knowledge management is the acquisition and use of resources to create an environment in which information is accessible to individuals and in which individuals acquire, share and use that information to develop their own knowledge and are encouraged and enabled to apply their knowledge for the benefit of the organisation.

Competencies needed by the ANM in the effective implementation of healthcare systems include dissemination of information to enhance patient outcomes, for example clinical practice guidelines and circulars. This is supported by Chase (2010:7), who accentuates that knowledge of healthcare environment and systems encompasses clinical practice knowledge, an understanding of evidence-based practices and outcomes measurement. The importance of this role cannot be underestimated in successful healthcare organisation (Chase, 2010:7). Jooste (2012:58) argues that the new healthcare system approach in South Africa, which is a district-based system, requires orientation and reorganisation of the healthcare workforce.

Objectives

The objectives for the sub-strategy on the legal and professional framework is:

To facilitate quality patient care by partaking in effective clinical activities within a legal and professional framework, which promotes healthcare systems outcomes.

To facilitate competent, knowledgeable and skilful ANMs, who could meet the functions, responsibilities and accountabilities of the role effectively in the legal framework.

Table 6.1 Plan for legal and professional framework

STRATEGIC OBJECTIVE	STRATEGIC PRIORITIES	ACTIVITIES	RESPONSIBLE PERSON/S	TIMEFRAME	RESOURCE REQUIREMENTS
The ANM should fulfil his or her role effectively within the professional and legal framework of nursing	○ Coordinate optimal, holistic nursing care according to the standards of a professional or legal framework	Involve the ANM as part of a team in developing a quality nursing care monitoring tool for his or her division	SNM; NM; DNM ANM	By 2017	Support from internal and external stakeholders
		Serve on a rotationary basis on quality assurance committee	SNM; NM; DNM	By 2017	Quality assurance committee established
		Identify gaps in and motivate revisions to direct supervisors on changes needed in patient care standards, policies and procedures to stay in line with the nursing statutory body		By 2017	Patient care standards, policies and procedures
		Attend management meetings on laws and legislation promptly	SNM; NM & DNM	Promptly	Laws and legislation meeting attendance
		Have a chat room to discuss the implementation of norms and standards	SNM; NM; DNM	By 2018	Implementation of norms and standards guidelines
	⊙Ensure adherence to the relevant acts / prescripts for example by attending educational sessions on new legislation	Ensure compliance with acts/prescripts by taking responsibility for being updated on latest legislation and reading circulars from SANC	SNM; NM; DNM	Annually	Adherence to acts and prescripts
	⊙Monitor nursing management activities according to the standards of practice / scope of practice	Review nursing care plans frequently to include latest developments	ANM	Quarterly	Nursing care plan reviewed
		Update and review patient care standards by being involved in the quality assurance committee	ANM	Quarterly	Patient care standards updated and reviewed

		Audit client records to assess the quality of care rendered, and keep record of improvements Ensure nursing care management plan is implemented, through for example a quality assurance instrument that can serve as a teaching moment	ANM ANM	Quarterly Quarterly	Client records audited and assessed for quality of care Nursing care management plan implemented
	⊙Address patient care and create a setting for review or update of patient care policies	Review nursing care plans frequently to identify if latest technologies are incorporated in care Update and review patient care policies	ANM SNM; NM; DNM; ANM	Quarterly	Nursing care plan reviewed Patient care standards updated and reviewed
The ANM should demonstrate competency in delivering safe patient care in his or her service	○Provide quality care with emphasis on patient-centred experience	Provide guidance to followers to improve patient experiences	SNM; NM; DNM; ANM	Quarterly	Patient-centred experience
	◘Address clinical activities, identify health indicators or risk factors	Encourage use of mobile technology at relevant places to point out risks and complications	SNM; NM; DNM; ANM	Quarterly	Mobile technology
The ANM should demonstrate competencies in clinical activities	○ Participate in the provision of nursing care to patients to ensure the formulation of accurate nursing diagnoses to address clients' needs	Collaborate in research projects with other members of the multi-disciplinary team	SNM; NM; DNM; ANM;	Annually	Collaboration with multidisciplinary team in research projects
	⊙Implement knowledge management for example by updating staff	Attend computer literacy courses by external providers	ANM; HRD / people development	Quarterly	Computer training

		Demonstrate willingness to use computerised client records Create an environment that is accessible to individuals, in which they acquire, share and use mobile information to develop their own knowledge, and are enabled to apply the knowledge for the benefit of the organisation	ANM SNM; NM; DNM & ANM	By 2017 In one year	Computerised client records Accessible environment for use of mobile technology
The ANM should disseminate information to enhance patient outcomes	⓿Ensure dissemination of information to enhance patient outcomes systems	Distribute clinical practice guidelines and circulars to followers to enhance patient outcomes	SNM; NM; DNM & ANM	Quarterly	Clinical practice guidelines and circulars
		Create a daily information reporting system for decision-making and risk management	SNM; NM; DNM & ANM	In one year	Information reporting system created

Key: Green: client interaction competencies; Blue: foundation competencies; Pink: supporting competencies

Key: advanced competency: ○; proficient competency: ⓿; knowledgeable⊙

6.3.4.2 Plan for the sub-strategy on interpersonal relationships

Introduction and rationale

An effective interpersonal relationship is a strong, deep, or close association or acquaintance between two or more people that may range in length from brief to lasting (de Oliviera & Tuohy, 2015:1082). Communication is essential in nursing because it facilitates the establishment of relationships of trust, respect and mutual help (de Oliviera & Tuohy, 2015:1082). Effective communication is the cornerstone of the development of students' professional and therapeutic relationships with patients, their families, the public and with other health professionals (de Oliviera & Tuohy, 2015:1081).

In this sub-strategy seven strategic goals are addressed, that is, effective problem-solving, effective communication; effective management of conflict; ensure openness, honesty and trust; establishment of a constructive relationship building; provision of constructive feedback and self-confidence. Chase (2010:51) states that the nurse manager should have the competencies of, decision-making, communication, problem-solving, conflict management and group processes. These include addressing patient and public complaints and solving problems within a specific framework. Addressing problem solving as the first strategic goal of this sub-strategy, is also mentioned by Kocoglu et al. (2016:955) who maintains that all healthcare units should have a strategy to enhance managers as problem solvers. Furthermore, top management needs to be supportive to e.g. he ANM and willing to take part in problem-solving without taking the problem entirely into their own hands. In addition, Kocoglu et al. (2016:955) stresses that the process of problem solving should be part of professional development for every team member, from the lowest to the highest level, and that the participation of all members should be encouraged in this regard.

Effective communication was identified as the second strategic goal of the sub-strategy, as a competency needed by the ANM. This strategic goal is addressed by maintaining professional working relationships based on ethics, communicating clear guidelines, and constantly sharing a common vision with stakeholders. Communication is essential in nursing because it facilitates the establishment of relationships of trust, respect and mutual help (Kourkouta & Papathanasiou, 2014:65) essential aspects of professional practice. Various literature studies produced similar results and concluded that one cannot perform the role of a competent manager without mastering important human relations skills of communication, listening and conflict management (Chase, 2010:289).

This study also identified effective management of conflict. Nurse managers deal with conflict daily and the choice of conflict management mode is associated with managerial effectiveness

(Hendel et al., 2005:137). These authors maintain that the ability to creatively manage conflict situations towards constructive outcomes is becoming a standard requirement (Hendel et al., 2005:137). Effective conflict management healthcare implemented by the ANM as a key part of the nurse manager role to influence patient outcomes and staff satisfaction. Conflict management is addressed by creating a work environment in which conflict may be used as a conduit to growth, innovation and productivity.

The fourth strategic goal focuses on ensuring openness, honesty and trust as competencies needed by ANMs to maintain trust and adhering to work ethics. Building a bond of honesty and trust requires good communication, personal approach, motivation and expertise that would result to providing good and comfortable care to the patients (Wassenaar, Van den Boogaard, Van der Hooft, Pickkers & Schoonhoven, 2015:3239). In addition, trust has proven essential in team-building; trust appears to relate to honesty, integrity and benevolence in communication, and affirms positive relationships between communicating parties (Hofhuis, Van der Rijt & Vlug, 2016:714).

Establishing constructive relationship building was identified as a fifth strategic area needed in interpersonal matters. This could be addressed by building trust among employees to ensure productivity, having people management skills, and focusing on diversity in the workplace. Nurse manager's ability to identify leadership work related to promoting good work related to promoting good working conditions and maintaining awareness of the mission is highly important in their management duty. Furthermore, managing successfully does not only require empowered nurse managers and support from other managers and employees and well co-operation with other professions group for the benefit of the patients (Saarnio, Suhonen & Isola, 2016:7).

This study also identified the provision of feedback to staff as a competency needed for ANM and this is addressed by providing feedback to staff and ONMs on recent developments. Feedback should be a planned endeavour, identifying the topic on which feedback should be given, and in addition, contemplating what is about the topic that is to be conveyed (Muller et al., 2011:325).

Table 6.2 Plan for interpersonal matters

STRATEGIC OBJECTIVE	STRATEGIC PRIORITIES	ACTIVITIES	RESPONSIBLE PERSON/S	TIMEFRAME	RESOURCES
The ANM should maintain relationship, communicate vision and clear guidelines	⦿Maintain professional working relationship based on ethics	Maintain relationships among colleagues by building trust and respect among followers and becoming involved in an ethical or research committee at a facility	SNM, DNM, NM, ANM	Regularly	Relationship maintained
	○Have ability to communicate clear guidelines	Communicate clear guidelines in various manners to accommodate different generations that should implement the guidelines	SNM, DNM, NM, ANM	Monthly	Clear guidelines communicated and implemented
	⦿Share a common vision with stakeholders	Communicate the importance of a shared vision of the work setting to promote employee commitment towards organisational goals	SNM; NM; DNM; ANM	Quarterly	Vision communicated
The ANM should address complaints and solve problems effectively	⊙Address patients and public's complaints	Be involved in appropriate settings to address patient and public complaints Undertake training in problem-solving with the emphasis on staffing	SNM; NM; DNM; People Development	Monthly By 2017	Patient and public complaints addressed in a workshop
	⦿Solve problems by using specific framework	Have a special climate meeting with ANM to identify problems and find appropriate ways to assist them to solve them.	SNM, DNM, NM	Quarterly	Meetings scheduled and agenda determined

The ANM should be open, honest and maintain trust	⊙Maintain trust through talking openly about challenges that needs to be addressed	Encourage open and honest debate among employees about contemporary issues Include a facilitator in climate meetings to address challenging situations while building report with stakeholders	SNM; NM; DNM; ANM	2017	Open debate among employees
		Create a climate of trust, in which followers design their tasks in such a way that they promote independent empowered behaviour	SNM; NM; DNM ANM;	Quarterly	Climate of trust created
	⊙Adhere to work ethics	Demonstrate respect for and understanding of diverse points of views in daily work and decision-making by undertaking online ethics courses	SNM; NM; DNM; ANM	Annually	Respect demonstrated
The ANM should resolve conflict effective by using various strategies	⊙Manage conflict effectively	Create a work environment where effective conflict management techniques may be used as conduits for growth, innovation and productivity	SNM; NM; DNM; ANM	Quarterly	Conflict resolution training
	⊙Use various strategies to resolve conflict in the workplace	Train in conflict resolution	People development department	Quarterly	Conflict resolution training
The ANM should manage people, establish a constructive relationship, and focus on workplace	⊙Build trust among the employees ensuring productivity	Treat members as having unique attributes that should be seen as important to the success of the team	SNM, DNM, NM; ANM;	Frequently	Building trust
	⊙Have people management skills	Be instrumental in developing the full potential of employees through planning, empowering,	SNM, DNM, NM, ANM	Annually	Developing potential of employees

		recognition and development programmes			
	⓿Focus on diversity in the workplace	Promote diversity awareness training to understand the core dimensions of diversity among generations	People Development Department	Quarterly	Diversity awareness training
The ANM should provide constructive feedback to staff on recent developments	⊙Provide constructive feedback to staff	Have meetings to provide the opportunity for open climate discussions and joint decision-making and individual discussions	ANMs, ONMs	Regularly	Meetings scheduled and agenda determined
	⊙Provide feedback to ONMs on recent developments	Establish a computer information network so that ONMs have daily access to information	Information Technology Department	By 2017	Computer information network established
The ANM should ensure self confidence	⊙Take initiative by proposing suggestions in an open arena	Provide guidance in public speaking to build confidence of ANM	SNM; NM; DNM	Regularly	Self-confidence

Key: Green: client interaction competencies; Blue: foundation competencies; Pink: supporting competencies

Key: advanced competency: ○; proficient competency: ⓿; knowledgeable⊙

Lastly, ensuring self-confidence was identified as a competency needed for ANMs. This is addressed by providing guidance in public speaking to build confidence. Self-confidence has been reported as a key component for effective clinical and management performance (Porter, Morphet & Raymond, 2013:83). Sources of self-confidence is identified by Bandura's social learning theory as performance accomplishment, vicarious experience, verbal persuasion and emotional arousal (Porter et al., 2013:83).

Objective

The overall objective for the sub-strategy on interpersonal relationships is:

To promote good interpersonal relationships between the ANMs and stakeholders, through effective communication and feedback, by showing self-confidence, honesty and trust, problem-solving skills and conflict management skills, with the focus on relationship building and self-development.

6.3.4.3 Plan for the sub-strategy for evidence-based practice

Introduction and rationale

Leadership is essential for successful implementation of evidence-based practice. Line managers, that is, the managerial level directly above employees, are crucial in this process (Mosson, Hasson, Wallin & Von Thiele Schwarz, 2014:82). Line managers consider themselves as central in the implementation of evidence based practice and are often responsible for the translation of evidence into practice (Mosson et al., 2014:82).

Four strategic goals are addressed in this sub-strategy, namely effective report writing with specific reference to memoranda; effective application of computer software; acting as a resource person for ONMs; and participating in research projects and promoting research.

Effective report writing was identified as a competency that was necessary for ANMs to manage effectively. Nursing records remain one of the most important communication tools for multi-professional healthcare team. These records must provide an accurate and comprehensive report of the care planned and decisions made, as well as the treatment and care delivered to the patient (Geyer, 2015:14). This skills gap is addressed by having the knowledge to draft a memorandum and ability to write according to formal formats. Jooste (2010:100) stresses that memoranda have a twofold purpose: they draw attention to problems; and they solve them. They accomplish goals by informing the readers about new information or by persuading them to take action. The writing style should demonstrate evidence of clear thinking and logical presentation (Jooste, 2010:100). Memos have different formats, depending on the institution. Some organisations provide standardised pads, usually interspaced with carbon

paper, so that the writer retains a copy for filing. The use of memo templates in computers and emailing is time saving (Jooste, 2010:100). A memorandum should be simple, unambiguous, clear and brief, yet use complete sentences, be readable and grammatically correct (Jooste, 2010:100-101).

Effective application of computer software is another competency. ANMs have to apply knowledge of computer programs in the workplace and use basic computer software programs confidently. McNeil et al. (2006:52) concur, claiming that computer literacy and information literacy are critical to the future of nursing. These authors maintain that facilitating the quality transformation depends on strategic changes such as implementing evidence-based practice, promoting outcome research, and initiating interdisciplinary care coordination (McNeil et al., 2006:52). In addition, McNeil et al. (2005:1022) state that computer literacy skills include the use of word processors, database and spreadsheet software, hardware applications, software applications, email and other informatics applications for document care.

Acting as a resource for ONMs was identified as a competency needed for ANM to successful and effectively manage nursing. To be resourceful in guiding others is essential. This links to participating in research projects and promoting research. It is addressed by identifying nursing trends when conducting audits, participating in research projects, involving nursing staff in conducting research and promoting research in health with the purpose of maintaining professional growth. Research contribution refers to the organisation's ability to make a meaningful contribution to knowledge generation and service improvement through research participation and subsequent outputs (Muller et al., 2011:55)

Objective for the evidence-based sub-strategy

The overall objective for the evidence-based sub-strategy is:
To write complete reports on evidence-based and research activities, which needs computer literacy, while acting as a resource for ONMs.

Table 6.3: Plan for evidence-based practice

STRATEGIC OBJECTIVES	STRATEGIC PRIORITIES	ACTIVITIES	RESPONSIBLE PERSON/S	TIMEFRAME	RESOURCE REQUIREMENTS
The ANM should write reports effectively	⊙Have the knowledge to draft a memorandum	Provide guidance on drafting a memorandum according to new formats Conduct a workshop on writing memoranda and other reports	SNM; NM; DNM SNM; NM; DNM	Quarterly Biannually	Memorandum Workshop on memorandum writing
	⊙Ability to write according to formal formats	Assist ANM with writing according to department/institutional formats	SNM; NM; DNM	Quarterly	Writing according to formats
The ANM should apply knowledge of computer software	⊙Apply knowledge of computer programs in the workplace	Train in computer programs, which encourages research	Trainers, skilled computer personnel	In 1 year	External training providers
		Coach on how to apply knowledge of computer programs	Computer skilled personnel	Quarterly	Computer programs
	⊙Use basic computer software programs Confidently	Train in computer programs to be creative in development of new ideas	Staff development trainers;	Quarterly	External training providers
		Coaching on use of basic computer software programs, and ethical principles	Computer skilled personnel	Quarterly	Computer software programmes
The ANM should act as a resource for operational nurse managers	○Act as a resource for ONMs	Have meetings to provide opportunity for open questions, which could include a facilitator, with an open door policy Provide guidance to ANM in being resourceful to ONMs	SNM; DNM; NM; ANM SNM; NM; DNM	Monthly	Meetings scheduled and agenda determined

The ANM should participate in research projects and promote research	⓿Identify nursing trends when conducting audits	Create a platform to discuss trends identified in the audits in a creative manner	SNM; NM; DNM; ANM	Quarterly	Trend identified and discussed
	⓿Participate in research projects	Encourage ANMs to partake in research projects in their field of interest	SNM; NM; DNM	In 1 year	Participation in research projects
	⓿Involve nursing staff in conducting research activities	Create an opportunity for nursing staff to conduct research activities with guidance and support to strengthen their scope of practice	SNM; NM; DNM; ANM	In 1 year	Research activities
	⓿Promote research in nursing to maintain professional growth	Promote extensive training in research Encourage ANMs to attend research conferences and forums to gain insight into methodologies	SNM; NM; DNM SNM; NM; DNM; ANM	In 1 year In 1 year	Research training Research conference

Key: Green: client interaction competencies; Blue: foundation competencies; Pink: supporting competencies

Key: advanced competency: ○; proficient competency: ⓿; knowledgeable⊙

6.3.4.4 Plan for strategic human resource management

Introduction and rationale

A strategic priority in the National Strategic Plan (2012) is planning for Human Resources for Health which requires a refined understanding of needs at service level, the gap between ideal and actual staffing, ensuring supply through training and education, training and development of appropriate categories of nurses.

Sherman, et al. (2007:323) state that human resource management is crucial to effective nursing management and is even more critical in an environment where staff retention is crucial in a scenario of scarce resources. In this sub-strategy, nine goals are addressed, that is, effective staffing; effective allocation of staff; application of recruitment strategies; application of retention strategies; management of absenteeism; knowledge and ability to carry effective discipline; effective evaluation of staff performance; effective strategic planning; and effective financial planning. Implementation of effective staffing strategies was identified as a competency needed for nurse managers to render effective nursing management.

O'Donnell et al. (2012:199) maintains that planning for human resources is a major task of the nurse manager. This author contends that when planning for human resources, consideration must be given to the type of client care, the education and level of knowledge required of the nurse, the budget constraints of the organisation and the historical background of staffing needs (O'Donnell et al., 2012:196). This is supported by Chase (2010:11), who claims that the nurse manager assumes responsibility for staffing and scheduling personnel. This author states that assignment reflects appropriate utilisation of personnel, considering scope of practice, competencies, patients, needs and complexity of care (Chase, 2010:11).

Nurse managers should ensure effective allocation of staff with professional skills and competencies required to carry nursing care regularly. Muller et al. (2011:326-327) maintain that the issue of staffing and scheduling is complex, as healthcare service managers are responsible for providing sufficient numbers of qualified nursing personnel to ensure adequate, safe nursing care for all patients 24 hours a day. According to Tappen (2001:253-266), the major factors that should be considered in making staffing decisions are patient census, patient acuity classification systems, skills mix, non-productive time and the adequacy of the budget.

Knowledge and application of the recruitment and retention strategies were identified as necessary for effective management. Training on recruitment processes and encouraging the participation of the ANM in the recruitment and selection of staff are vital to address this skills gap. Chase (2010:9) confirmed that knowledge of and ability to carry out effective staffing

strategies, retention strategies and effective discipline are the most important skills for the nurse manager. The ability of nurse managers to enhance positive practice environment is critical to the recruitment and the retention of professional nurses with diverse backgrounds and appropriate education and experience (Chase, 2010:9-10).

The retention of skilled staff is dependent on the opportunities offered by an organisation. ANMs should be assisted to implement retention strategies and promote staff retention. Sherman et al. (2007:92) support the idea that retention begins with a sound selection and orientation process. The needs and desires of nursing staff in different age groups are often very different. Identifying what motivates staff and keeps them is an important part of their job. It is important for nurse managers to keep open minds about scheduling, how to best develop staff and what might work as a reward system (Sherman et al., 2007:92).

Management of absenteeism was also identified as a competency. The approach to this skills gap is to provide guidance in analysing the causes of absence and assisting in the control of staff absenteeism and training ANMs on management of absenteeism. Johnson et al. concur (2003:337), stating that absenteeism of nurses is an important phenomenon, not only for the nurses themselves, but also because of its adverse effect on healthcare. These authors state that absence attributed to sickness cannot be wholly eradicated because of the inevitability of disease and ill health. The management of attendance is essential not only to its financial costs and service effects, but also to the health and well-being of employees (Johnson et al., 2003:337).

Interventions aimed at reducing sickness absence (Grundemann & Vuuren, 1997, in Johnson et al., 2003:341) can be categorised as a) procedural measures (monitoring absenteeism, absenteeism procedures and policies); b) preventative work-oriented measures (for example health and safety initiatives, management training, better organisation of work, flexible working hours, job enrichment); c) preventative person-orientated measures (counselling, information on bullying, stress management, manual handling training); and d) reintegration measures (for example rehabilitation procedures, phased re-integration, reduction of working hours, return to work interviews, and physiotherapy).

Knowledge of and ability to carry out effective discipline is a competency that is needed by ANMs. ANMs should be assisted and guided in the execution of the disciplinary and grievance handling procedure. Jooste (2010:183) supports the argument, claiming that grievances fall under the authority of management. The grievance procedure requires top management support and action from all levels of management (Jooste, 2010:183). Effective evaluation of staff

performance was identified by ANMs as being necessary for effective management. Performance appraisal is a formal system of periodic review of an employee's current or past performance relative to set performance standards (Jooste, 2017:319). This skills gap is addressed by monitoring the implementation of staff performance agreements and assessing staff performance quarterly.

Effective strategic planning was identified as a competency needed for s for successful management. This skills gap is addressed by developing a strategic plan in the workplace that aligns with the vision of the institution, setting priorities to ensure that employees are working towards common goals, and developing an annual operational plan with the emphasis on short-term goals. Strategic planning efforts need to be achieved through people. The organisational mission should be to translate the service vision into key performance objectives, and budget allocations are necessary. Strategic annual plans must describe the action needed for achievement, which should then be operationalised into the annual plan of individual work plan objectives and into performance measurement indicators for each follower in the health services (Terzic-Supic et al., 2015:2).

This study identified effective financial management as a competency needed for effective management. This goal is addressed by monitoring financial resources with the emphasis on cost containment, participating in the development of business plan, identifying ways of containing healthcare costs without compromising standards, ensuring implementation of the budget by monitoring the expenditure report, and understanding the functional business unit. Financial management means controlling costs for profit and ensuring that value is added to products and services in the primary customer areas that matter to consumers (Dunham-Taylor & Pinczuk, 2010:618). Dunham-Taylor & Pinczuk (2010:618) believes that the containment of costs should be a continuous process with the aim of rendering effective quality care while containing the costs. Chase (2010:54) stresses that nurse managers have to deal with finance and budgeting, implement and manage financial control systems, collect financial data, analyse financial reports and make sound financial decisions based on these analyses. Effective financial management competency is addressed by monitoring resources with the emphasis on cost containment; participating in the development of business plan; identifying ways of containing healthcare costs without compromising standards; ensuring implementation of the budget by monitoring the expenditure report and knowing and understanding the operational principles of the business plan.

Table 6.4: Plan for strategic resource management

STRATEGIC GOALS	STRATEGIC PRIORITIES	ACTIVITIES	RESPONSIBLE PERSON/S	TIMEFRAME	RESOURCE REQUIREMENTS
The ANM should implement effective staffing strategies to meet staffing needs	○ Analyse staffing needs ensuring cost effectiveness	Assist in determining the number and types of personnel needed to fulfil the philosophy of the organisation, meet the fiscal responsibilities and carry out the chosen client care management	SNM; NM; DNM	Monthly	Staffing needs analysed
	○ Develop a plan to meet the staffing needs	Provide guidance in the planning of allocation of staff to ensure provision of adequate nursing coverage	SNM; NM; DNM; ANM	Monthly	Staffing plan developed
The ANM should ensure effective allocation of staff	⊙Allocate staff members to the various units	Ensure allocation of staff with professional skills and competencies to carry out nursing care	SNM; NM; DNM; ANM	Monthly	Allocation of staff
	⊙Monitor the duty roster/ attendance register	Constantly monitor the duty roster / attendance register and adjust as required on the shift to provide adequate nursing cover	SNM; NM; DNM; ANM	Monthly	Duty roster monitored
The ANM should apply recruitment strategies	⊙Know and understand the recruitment process	Training on the recruitment process followed by involvement of the ANM Provide guidance on the recruitment process	Trainers SNM; NM; DNM	Biannually	Recruitment training
	⊙Select the best suitable candidate to fill post	Participate in recruitment and selection of staff in various forums	ANM	Biannually	Recruitment prescripts/policy
The ANM should apply retention strategies effectively	⊙ Implement strategies to retain staff members	Provide guidance in the implementation strategies to retain staff members	SNM; NM; DNM; ANM	In 1 year	Retention strategy in place

The ANM should manage absenteeism	❶Determine the monthly staff absenteeism rate	Assist in control of staff absenteeism rate	SNM; NM; DNM; ANM	Monthly	Control of staff absenteeism
	○Train supervisors on management of absenteeism	Undergo training on management of absenteeism Provide guidance on management of absenteeism	SNM; NM; DNM SNM; NM; DNM	In 1 year In 1 year	Management of absenteeism training Guidance on management of absenteeism
The ANM should apply knowledge to carry out effective discipline	❶Implement workplace discipline	Assist and provide guidance in the execution of disciplinary code	SNM; NM; DNM;	Quarterly	Disciplinary policies and procedures
	❶Apply knowledge of grievance handling process	Assist and provide guidance in the execution of grievance handling procedure	SNM; NM; DNM	Quarterly	Grievance handling policy
		Training in grievance handling procedure	Labour relations manager	Biannually	Grievance handling training
The ANM should manage staff performance effectively	❶Monitor the implementation of staff performance agreements	Training in performance staff performance management system	Human resource manager	Biannually	Performance management
		Carry our regular reviews to ensure understanding of the priorities and consequences for performance	SNM; NM; DNM; ANM	Quarterly	Performance reviews
	❶Assess the performance of staff members quarterly	Offer coaching and support in the performance of staff members	SNM; NM; DNM; ANM	Quarterly	Performance assessments
The ANM should develop a strategic plan and an operational plan with the emphasis	○Develop a strategic plan in the workplace that aligns with the vision of the institution	Workshop on the development of a strategic plan in the workplace	SNM; NM; DNM; ANM	Annually	Strategic plan
	❶Set priorities to ensure that employees are	Provide guidance on setting of priorities towards common goals	SNM; NM; DNM; ANM	Annually	Setting priorities

on short-term goals	working towards common goals				
	○Develop an annual operational plan with emphasis on short term goals	Assist in the development of an annual operational plan with emphasis on short term goals	SNM; NM; DNM; ANM	Annually	Operational plan developed
The ANM should monitor financial resources, develop a business plan and ensure implementation of the budget	○Monitor financial resources with emphasis on cost containment	Provide guidance on monitoring of financial resources with emphasis on cost containment	SNM; NM; DNM; ANM	Quarterly	Monitored financial resources
	○Participate in the development of business plan	Provide guidance and support in the development of business plan	SNM; NM; DNM	Annually	Business plan developed
	⊙Identify ways of containing healthcare costs without compromising standards	Assist in the identification of ways of containing healthcare without compromising standards	SNM; NM; DNM	Quarterly	Cost containment
	⊙Ensure implementation of the budget by monitoring the expenditure report	Have meetings to discuss proper implementation of the budget by monitoring, projecting and reporting expenditure	SNM; NM; DNM; ANM	Monthly	Meetings scheduled and agenda determined
	⊙Know and understand the operational principles of functional business unit	Participate in the development of the business plan	SNM; NM; DNM; ANM	Annually	Developed business plan

Key: Green: client interaction competencies; Blue: foundation competencies; Pink: supporting competencies

Key: advanced competency: ○; proficient competency: ⊙; knowledgeable⊙

Objective for the strategic resource management sub-strategy

The overall objective for the sub-strategy on strategic resource management is:

To recruit, place, retain, monitor, and evaluate staff members in healthcare units through appropriate motivational, training and corrective actions, within financial resources and the strategic plan of the facility

6.3.4.5 Plan for taking leadership

Introduction and rationale

In this sub-strategy nine strategic goals are addressed, namely being innovative; upskilling staff; implementing a proper orientation plan; executing, an effective succession planning; collaborating with other departments; establishing an effective relationship building; engaging with ONMs; provision of effective mentorship and provision of effective support.

Being innovative as a competency for ANMs refers to adapting procedures to suit a changing environment. In this study, upskilling of staff was also identified as important. This is addressed by identifying skills gaps and conducting staff skills audits; addressing skills gaps by ensuring staff attend professional training; and creating an empowering environment by providing support. Staff development is a field of practice that helps shape the future of healthcare professions and services. In addition, staff development is a key to quality healthcare and is an important function in ensuring optimal utilisation of healthcare professionals in an organisation (Jooste, 2010:249).

Implementation of a proper orientation plan was identified as a competency needed for ANMs to ensure effective nursing management. The goal of nursing orientation is to ensure that orienteers receive consistent information about policies, procedures, standards and documentation to support practice and familiarise them with the organisational vision, mission, values, goals and structure**.** The nurse manager should ensure appropriate orientation, education, credentialing and continuing professional development for personnel (Chase, 2010:11).

Implementation of an effective succession planning means having leadership succession planning in place, and ensuring that employees are exposed to peer teaching. The purpose of succession planning is to assist in the development of knowledge and skills to support career progression in nursing management. Effective collaboration with other stakeholders, department and hospitals was identified as a competency needed by ANMs. This is addressed by collaborating with members of the healthcare and social care teams, and participating in decision-making pertaining to healthcare delivery. This is supported by the scope and standards

for nurse managers (Chase, 2010:10), which state that to fulfil the responsibilities, the nurse manager, in collaboration with nursing personnel and members of other disciplines, should participate in nursing organisational policy formulation and decision-making involving staff, coordinating nursing care with other healthcare disciplines, and assisting in integrating services across the continuum of healthcare.

In this study, effective relationship building was identified as another competency. Relationship building comprises shared decision-making, multidisciplinary and academic relationships and influence (Chase, 2010:7). Jooste (2017:246) stresses that leaders have the ability to build relationships. Relationship building is enhanced by providing team-building opportunities and acknowledging outstanding professional work.

Provision of effective mentorship was also identified. Mentoring is a critical part of leadership development. Effective mentoring depends heavily on the motivation and commitment of both parties and on the time available, which is probably the biggest challenge to successful mentoring in healthcare. Mentors cultivate talent, take an interest in the person, facilitate mentees' personal and professional growth, and guide them into appropriate networks (Jakubik et al., 2016:253). In terms of this study, this competency is addressed by providing mentorship programmes to influence healthcare providers to obtain competencies. Lastly, provision of effective support was identified. It is addressed by providing support to personnel accountable to nurse managers and acting as role models by guiding operational nurse managers in supervisory skills to promote teamwork. This argument is supported by Chase (2010:11), who claims that to fulfil the responsibilities, the nurse manager should provide guidance for and supervision of personnel accountable to him or her.

Objective for the sub-strategy on leadership

The overall objective for the sub-strategy on leadership is:

To mentor and support through innovative actions and relationship building, and upscaling staff through orientation and succession planning, while engaging with operational nurse managers and collaborating with other departments

Table 6.5: Plan for leadership

STRATEGIC GOALS	STRATEGIC PRIORITIES	ACTIVITIES	RESPONSIBLE PERSON/S	TIMEFRAME	RESOURCE REQUIREMENTS
The ANM should be innovative by adapting procedures that suit a changing environment	⊙Innovate by adapting procedures to suit a changing environment	Have meetings to provide opportunities for innovation and talks on types of power	SNM; NM; DNM; ANM	Monthly	Meetings scheduled and agenda determined
The ANM should identify and personnel's skills gap	⊙Identify personnel skills gaps	Assess the need for training and areas where improvement is needed in using authority	SNM; NM; DNM; ANM	Annually	Skills audit conducted
	⊙Address skills gap by ensuring staff attend professional training	Create and implement learning opportunities on using influence	SNM; NM; DNM; ANM	Annually	Learning opportunities implemented
	⊙Create an empowering environment by providing support	Assess the need for training and areas where improvement is needed in leadership succession	SNM; NM; DNM; ANM	Quarterly	Empowering environment created
The ANM should implement a proper orientation plan	○ Update and implement orientation sessions for new employees	Get to know one another, developing expectations of each employee	SNM; NM; DNM; ANM	Annually	Orientation programme
The ANM should implement leadership succession planning	○Have leadership succession planning	Provide guidance in designing developmental activities to ensure the right people are available with the right skills at the right time	SNM; NM; DNM; ANM	Annually	Succession planning programme
	⊙Ensure that succession plan employees are exposed to peer teaching	Provide opportunities for employees to be exposed to peer teaching and mindfulness	SNM; NM; DNM; ANM	Biannually	Succession planning programme
The ANM should collaborate with other stakeholders/ departments/ hospitals	⊙Collaborate with members of the health and social care teams	Promote collaborative partnership with members of the health and social care teams	SNM; NM; DNM; ANM	In 1 year	Stakeholder collaboration
	⊙Participate in decision-	Conduct meetings to	SNM; NM; DNM; ANM	Quarterly	Meetings scheduled and agenda determined

	making pertaining to healthcare delivery	provide opportunity for open discussions and joint decision-making in new developments			
		Conduct meetings and help team members to focus and allow everyone to participate in discussions	SNM; NM; DNM; ANM	Monthly	Meetings scheduled and agenda determined
The ANM should establish an effective relationship building	⊙Provide team building opportunities for example by arranging workshop ONM	Conduct workshop ONM and provide team building opportunities	SNM; NM; DNM	Annually	Workshop conducted
	⊙Acknowledge outstanding professional work	Create a platform to recognise outstanding professional work	SNM; NM; DNM; ANM	Quarterly	Outstanding professional work acknowledged
The ANM should engage with ONM, assist and provide guidance	○Use authority to assist the ONMs in the development of strategic plan	Assist the ONM in the development of strategic plans for leadership development	SNM; NM; DNM	Annually	Strategic plan
	⊙Involve ONMs in budgetary planning	Provide guidance and be involved in budgetary planning to influence the nursing budget	SNM; NM; DNM	Annually	Budget planning
The ANM should provide mentorship to followers	○Have power to mentor followers	Have a sustained relationship through a continued involvement and provide support and guidance to followers	SNM; NM; DNM; ANM	Monthly	Sustained relationship
	○Provide mentorship programmes to influence healthcare providers to obtain competencies	Provide one-on-one support and guidance to empower followers to develop people skills	SNM; NM; DNM; ANM	Quarterly	Mentoring programme
	⊙Be assertive, exercise your rights while recognising the rights of fellow members	Create an open friendly climate and recognise the rights of fellow members	SNM; NM; DNM; ANM	In 1 year	Recognised fellow members' rights
The ANM should provide support to personnel, be	○Provide support to personnel accountable to nurse manager	Create an open friendly climate and provide support to staff	SNM; NM; DNM ;ANM	In 1 year	Provision of support

accountable, and act as a role model	○Act as role model by guiding ONMs in supervisory skills to promote team work	Have regular meetings and empower ONMs to ensure that their supervisory skills are fulfilled Conduct workshop ONM that address the theme of role-modelling and supervision	SNM; NM; DNM; ANM SNM; NM; DNM; ANM	Monthly Biannually	Meetings scheduled and agenda determined Workshop ONM

Key: Green: client interaction competencies; Blue: foundation competencies; Pink: supporting competencies

Key: advanced competency: ○; proficient competency: ⊙; knowledgeable⊙

6.3.5 What is the energy source for the strategy (dynamics)?

In this study, 'dynamics' refers to underlying factors that could facilitate the competencies of ANMs. Overall the findings indicated that capacity building could enhance the competencies of the ANM. Building capacity is a dynamic process, which entails empowerment, mentoring, coaching, and professional development through guidance and support.

Empowerment is about involvement and starts with truly believing that everyone counts (Jooste, 2010:198). The key concepts that constitute the concept of empowerment may be applied to ANM as empowering management structures. power sharing, participative decision-making, empowering skills and responsibilities, motivation and reward strategies, and empowering characteristics of the manager (Jooste, 2010:198). Mentoring in healthcare (Jooste, 2010:253) has been identified as a critical part of leadership development. Effective mentoring depends heavily on the motivation and commitment of both parties and on the time available, which is probably the biggest challenge to successful mentoring in healthcare. 'Coaching' refers to educating and developing the skills of healthcare professionals. Coaching is a powerful tool for novice leaders who want to develop into expert leaders (Jooste, 2017:240). To establish a successful coaching relationship for novices, these factors should be taken into consideration:

Clear guidelines should be established for the relationship and coaching process.

Feedback should be shared between the novice and the expert leader.

Motivational aspects should be part of the process: the development of the novice should be acknowledged and successes praised along the way (Jooste, 2017:241).

'Professional development' in a healthcare environment should be observed as a number of processes that improve the job-related dimensions of knowledge, skills, values and attitudes of healthcare professionals (Jooste, 2017:251-252).

6.3.6 What is the end point of the activity? (Terminus)

The last aspect of activity of the framework is the terminus. 'Terminus' is the accomplishment of the activity or end results. In this study, the terminus refers to competent ANMs, who deliver effective nursing management, which is the core outcome. The activity is considered in terms of its final point of the processes. In relation to the title of the study, the attainment of the

terminus suggests facilitating competencies of ANMs, which culminates in competent ANMs who manage effectively. In other words, competent, knowledgeable and skilled ANMs meet the functions, responsibilities and accountabilities of the role effectively (Chase, 2010:37).

The strategy developed addresses the outcomes of:

- Compliance with legal and professional framework within his or her scope of nursing practice, with regard to patient care, and involvement in clinical activities to obtain the outcomes of the healthcare system.
- Through self-confidence, to promote effective communication for building relations and enhancing development. In challenging circumstances certain problem-solving and conflict management skills are needed, while building trust and providing feedback.
- To focus on evidence-based practice, which is desirable in the current healthcare environment, which requires effective report writing, being computer literate, being resourceful, and being actively involved in research processes.
- To implement strategic human resource management, which is critical, and requires effective staffing strategies. This involves staff recruitment, allocation, retention, discipline, performance monitoring and discipline, within the scope of a strategic plan in a cost-effective environment.
- As a leader should be innovative in planning orientation, staff development sessions, leadership succession, working with other departments, and acting as a mentor.
- The terminus through the strategy is more than just providing training to ANMs. It seeks to build capacity among ANMs, which entails empowerment, mentoring, coaching, professional development, guidance and support.

6.4 CONCLUSION

The survey list of Dickoff et al. (1968:423), which comprised six components (agent, recipient, framework, dynamics, procedure and terminus) served as the reasoning map for the strategy on required competencies of ANMs The list described the relationships between the aspects of the strategy for ANMs. The agent, that is the researcher, staff development office trainers, SNMs, NMs, and DNMs, who are professional nurses and direct supervisors working as members of management team were identified as organisers with the roles of leadership, empowerment, mentoring, coaching, provision of guidance and support, role modelling and collaboration. In addition, the agent should possess internal resources that encompass

capability, skills, education, experience, attributes, and values to be able to develop skills of ANMs through mentoring, coaching, and empowerment. The agent coordinates and monitors all key tasks for their effects, outcomes and achievement within set timeframes. Similarly, in the agent-recipient relationship, the recipient should possess certain characteristics in order to enhance optimum learning in practice. The characteristics of good listening, willingness to receive information, eagerness to learn, self-confidence and motivation and preparedness to assume responsibilities and to be courageous and persevering in the facilitation of their competencies are indispensable. The researcher discussed the context of the study, reflecting on the geographical context of the six districts in the Western Cape in which the strategy will take place. Also, she described it in relation to where the strategy could be instituted at the healthcare institutions where the ANM is the head of nursing in the district hospital, primary healthcare facility, manager of a clinical area in the regional, tertiary and central hospitals. The underlying dynamic for building capacity of the ANMs entails empowerment, mentoring, coaching, and professional development through guidance and support. The procedure to be used by the agents included compliance with the legal and professional framework within his or her scope of nursing practice, with regard to patient care, involvement in clinical activities to obtain the outcomes of the healthcare system, through self-confidence, promoting effective communication for building relations and enhancing development. In challenging circumstances, certain problem-solving and conflict management skills are needed, while building trust and providing feedback; focusing on evidence-based practice that is desirable in the current healthcare environment that requires effective report writing, being computer literate, being resourceful and actively involved in research processes; implementing strategic human resource management, which is critical, and requires effective staffing strategies. This involves staff recruitment, allocation, retention, discipline, monitoring performance and discipline, within the scope of a strategic plan in a cost-effective environment, and nurse managers should be innovative in planning orientation, staff development sessions, leadership succession, working with other departments and acting as a mentor. The terminus (competent ANM) was described as being characterised by knowledge and skills that could meet the functions, responsibilities and accountabilities of the role effectively.

In Chapter 7, the researcher concludes the study by discussing limitations and recommendations for nursing practice, nursing education and nursing research. A summary of the study and its outcome, namely the strategy and its sub-strategies, is included.

CHAPTER 7

OVERVIEW AND CONCLUSIONS, GUIDELINES FOR IMPLEMENTATION OF THE STRATEGY, LIMITATIONS OF AND RECOMMENDATIONS FROM THE STUDY

7.1 INTRODUCTION

In the previous chapter, the development of a human resource strategy to address the competencies of ANMs was described using the survey list of Dickoff et al. (1968:423). In this chapter, the overview of the research process, conclusions of the study, dissemination plan, guidelines for the implementation of the strategy, limitations of the research, and recommendations of the study are presented.

7.2 OVERVIEW OF THE RESEARCH PROCESS AND CONCLUSIONS

The purpose of this mixed method study was to develop a strategy to facilitate the competencies of ANMs in the public health facilities in the Western Cape. Three objectives were set, namely to explore and describe the expectations of nursing service managers about the competencies of ANMs (Phase 1 of the study); to explore and describe the perceptions of ANMs of their expected and existing competencies to perform their job (Phase 2); and to develop a human resource strategy for addressing competencies of ANMs (Phase 3). The first objective was achieved through eight focus group discussions between 60 (two male and 58 female) professional nurses (ANMs and ONMs) and 15 unstructured individual interviews with two SNMs, one NM, seven DNMs and five ANMs, who were employed at the study sites. After data had been collected and analysed, it was clear from the findings that certain main competencies had come to the fore, from which an instrument was developed for Phase 2. It was expected of an ANM to perform in a legal and professional framework within his or her scope of practice, with regard to patient care, and involvement in clinical activities to obtain the outcomes of the healthcare system. Interpersonal relationships are a core dimension in the role of an ANM. Through self-confidence, effective communication can be promoted for building relationships and enhancing development. In challenging circumstances, certain problem-solving and conflict management skills are needed, while building trust and providing feedback. In the current healthcare environment, evidence-based practice requires effective report writing, computer literacy, resourcefulness and active involvement in research processes. Strategic human resource management is crucial, and requires effective staffing strategies. This entails staff recruitment, allocation, retention, discipline, monitoring

performance and discipline, within the scope of a strategic plan in a cost-effective environment. As a leader, the ANM should be innovative in planning orientation, staff development sessions, leadership succession, working with other departments and acting as a mentor.

Equally, the second objective was realised because the findings from the survey conducted with 94 ANMs (7 males and 87 females) with a median age of 51.0 years, ranging from 35 years to 64 years, with an interquartile range of 10 years. The findings indicated that in the legal and professional framework domain, the mean values for expected and existing competencies were highest in legislation, followed by patient care, and lowest in clinical activities. In the interpersonal domain, the mean values for expected and existing competencies were the highest in problem-solving, followed by effective communication, openness/honesty/trust, and conflict management, and lowest in self-development. Overall, in the evidence-based domain, the mean values for expected and existing competencies were highest in acting as a resource to the ONM and computer literacy, and lowest in research activities. In the strategic resource management domain, the mean values for expected and existing competencies were highest in performance evaluation, effective staffing strategy and staff allocation, and lowest in retention strategy. Overall, in the leadership domain, the mean values for expected and existing competencies were the highest in the proper orientation, innovative and support sub-domains and lowest in relationship building.

The findings from Objectives 1 and 2 were synthesised to answer the third objective, which was to develop a human resource strategy to address the gap between existing and expected competencies of ANM in public health facilities in the Western Cape. The survey list of Dickoff et al. (1968), which comprised six components (agent, recipient, framework, dynamics, procedure and terminus) was utilised as the reasoning map for the strategy. The survey list described the relationships among the aspects of the strategy for ANM.

The SNM, NM, DNM were identified nurse managers as the leaders with the roles of leadership, empowerment, mentoring, coaching, provision of guidance and support, role modelling and collaboration. In addition, the agent should possess internal resources, which encompassed capability, skills, education, experience, attributes, and values to be able to develop skills of the ANMs by mentoring, coaching, and empowerment. The ANM should possess the characteristics of good listening, willingness to receive, an eagerness to learn, self-

confidence in order to enhance optimum learning and to accomplish knowledge in the facilitation of his or her competencies.

The researcher discussed the context of the study, reflecting on the geographical context of the six districts in the Western Cape in which the strategy will take place. The procedures to be used by the agents were compliance with the legal and professional framework within their scope of nursing practice, with regard to patient care, and involvement in clinical activities to obtain the outcomes of the healthcare system, through self-confidence, and to promote effective communication for building relations and enhancing development. In challenging circumstances certain problem-solving and conflict management skills are needed, while building trust and providing feedback, focus on evidence based practice that is desirable in the current healthcare environment that requires effective report writing, being computer literate, being resourceful and active involvement in research processes; implement strategic human resource management that is critical, and requires effective staffing strategies. This involves staff recruitment, allocation, retention, discipline, monitoring performance, within the scope of a strategic plan in a cost-effective environment. SNMs, NMs and DNMs should be innovative in planning orientation, staff development sessions, leadership succession, working with other departments and acting as a mentor.

Building capacity of the ANMs was identified as crucial, and should entail empowerment, mentoring, coaching, and professional development through guidance and support of SNM, NM, DNM. ANMs should meet regularly to evaluate their vision of capacitating themselves. Finally, it is necessary that ANMs should receive sufficient mentoring and coaching, guidance and support to assist them to become knowledgeable and skilled to meet the functions, responsibilities and accountabilities of the role effectively.

7.3 RECOMMENDATIONS FROM THE FINDINGS

These recommendations are suggested as a result of the findings of the study. They are discussed under the subsections of dissemination plan, nursing practice, nursing education, and nursing research.

7.3.1 Dissemination plan

The strategy that was developed is the first of its kind to be used by SNMs, NMs, and DNMs

in building the capacity of ANMs, which entails empowerment, mentoring, coaching, and professional development through guidance and support. Though developed to be used in the public context, it can be useful in contexts with similar realities.

The researcher, supported by her research supervisor, will disseminate the strategy in these ways:

It will be communicated to the Western Cape Department of Health in writing for endorsement. This will be done to engender support and to encourage successful implementation.

It will be made accessible to the target population of SNMs, NMs, DNMs, ANMs and ONMs. For instance, it will be printed out and circulated to them.

The strategy will be used in facilitating training programmes for ANMs.

It will be presented at seminars and workshop ONM arranged by institutions and organisations in leadership development.

It will be shared with managers and academic peers through presentations at scientific research conferences organised nationally and internationally.

The findings will be published in a peer-reviewed journal, which is available online, to increase accessibility.

The strategy should become part of the People Management Leadership Strategy at the Western Cape Government Health and will be used as a document for strategic planning.

The strategy is expected to form part of the service learning component for nurse managers at the universities and training providers.

7.3.2 Nursing practice

There is a need for strong partnerships and collaboration between nursing management and stakeholders, who are expected to be involved in putting into practice programmes aimed at capacitating ANMs to become knowledgeable and skilled and to meet the functions, responsibilities and accountabilities of the role effectively. There is need for increased commitment among SNMs, NMs, and DNMs that provide leadership roles in building the capacity of ANMs by empowering, mentoring, coaching, and developing them professionally through guidance and support. ANMs should update their knowledge regularly of current management issues. This will enhance their competence and confidence. On the governmental front, it is crucial that the Western Cape Department of Health should invest in the professional development of ANMs by providing them with educational support. They should make

funding available for ANMs to attend training programmes.

The agent should utilise a participative approach by involving ANMs in the implementation and evaluation process of the strategy. The recipient should be actively involved in the programmes established to build capacity among the ANMs. The recipient should accept responsibility for own professional development.

7.3.3 Nursing education

Nursing managers have been identified as being pivotal to overcoming the health challenges that South Africa faces. It is crucial that that they should be endowed with appropriate and relevant skills to enable them to meet these challenges. This research confirms the lack of management capacity, and identifies the areas in which a dearth of knowledge and skills is most needed.

This research provides valuable information and challenges for those responsible for the education and training of ANMs. It provides the evidence of the need for a paradigm shift from predominantly formal approaches to management development to more informal approaches. Coaching and empowering programmes should be established to assist the ANMs to acquire the knowledge and skills to meet the functions, responsibilities and accountabilities of the role effectively

7.3.4 Nursing research

Given that the study was conducted only in the Western Cape it could be interesting to duplicate this study in the entire South Africa to confirm whether similar findings could emerge. The population in the other provinces could yield similar results to those reported by participants interviewed in this study or could be different. Further research can be conducted after implantation of this strategy to evaluate it.

7.4 LIMITATIONS OF THE RESEARCH

The limitation of this current study is that the findings are not generalizable to all public hospitals in South Africa. The study was conducted only in the province of the Western Cape, which of course is not representative of the entire population of ANMs. However, despite these

limitations, the study has important theoretical and practical relevance for the improvement of nursing management training in South Africa because programmes can be designed, based on the perceived gaps in competencies of ANM. The qualitative phase is contextual however the whole thesis were described densely and richly. The depth of this study is of great value and the results are transferable to similar contents.

7.5 CONTRIBUTION OF THE STUDY

In Chapter 1 the significant and contribution of the study was written. The strengths of this study is definitely the use of mixed methods design, the inclusion of various levels of managers, the use of pilots and the graphic depiction of the perceived versus actual competence. The strategy is user-friendly with semantic clarity and can be operational as it was clear that there was an absence of strategy amongst participants. There is a strong link to create and strengthen competencies to reach strategies especially when considering the vastness of a public health facility as an enterprise. This study can address the challenges around firstly, the disconnection within the public health system whereby operations management jargon is used in job titles of which nurse managers are more and more exposed to, and in which it seems as if it hasn't dawned on the nurse managers yet. The strategy secondly focuses on better integration of nurse management with operations management that is an opportunity for the future. The strategy further focuses on the awareness and insight of nurse managers in general of health information systems and their critical role within these systems.

7.6 CONCLUSION

This chapter concludes the research report of the study. An overview of the research process and the conclusions of the study were presented. To enable the researcher to describe these competently, she adapted and refined her theoretical lens continually (Knight & Cross, 2012) and described the conclusions logically in relation to the main objectives that were set out to be achieved in the study. The researcher maintained her commitment to the administration of the research study as she reflected on its importance and impact.

Finally, in concluding the chapter, she made recommendations for the dissemination plan to ensure implementation of the strategy and for nursing practice, nursing education and nursing research. These recommendations were made in such a way that they resonated with the findings of the study and the researcher's insight. The researcher remained transparent and

presented the limitations that were encountered in the conduct of the research as clearly as possible.

LIST OF REFERENCES

Adamson, S., Muula, A. S., Nyasula, Y. & Msiska. G. (2004). Gender distribution of teaching staff and students at the Kamuzu College of Nursing, Malawi 1979-2001. *African Journal of Health Science*, 11(1), 74-76.

Ahn, Y.H. & Choi, J. Factors affecting Korean nursing student empowerment in clinical practice. *Nurse Education Today*, 35(12), 1301-1306.

Al-Hamdan, Z., Norrie, P. & Anthony, D. (2014). Conflict management st**y**les used by nurses in Jordan. *Journal of Research in Nursing*, 19(1), 40-53.

American Nurses Association. (2013). Competency Model. *ANA Leadership Institute*, 1-11. Retrieved 10 October 2014 from www.ana.leadershipinstitute.org.

American Organization of Nurse Executives. (1992). The Role and Function of the Hospital Nurse Manager. *Nursing Management*, 23, 9-36.

American Organization of Nurse Executives. (2005). Nurse executive competencies. *Nurse Leader*, 3(1), 15-21.

Armstrong, M. (2000). *Strategic Human Resource Management. A guide to action.* (2nd ed.). London: Kogan Page.

Armstrong, M. & Baron, A. (2005). *Managing Performance: Performance Management in Action.* London: CIPD.

Armstrong, S.J., Rispel. L.C. & Penn-Kekana. L. (2015). The activities of hospital nursing unit managers and quality of patient care in South African Hospitals: a paradox? Transforming nursing in South Africa. *Global Health Action*, 8, 1-9.

Babbie, E. (2010). *The practice of social research.* (12th ed.). Belmont, California: Wadsworth.

Babbie, E. & Mouton, J. (2011). *The practice of social Research.* Cape Town: Oxford South African.

Babbie, E. (2013). *The practice of social research.* (13th ed.). Belmont, CA: Wadsworth. Bach,

S. & Ellis, P. (2011). *Leadership, Management and Team Working in Nursing*. Exeter: Learning Matters Ltd.

Bahadori, M., Yaghoubi, M., Javadi, M. & Rahim, Z.A. (2015). Study of relationship between the organizational structure and market orientation from the viewpoint of nurse managers. *Journal of Education and Health Promotion*, 4(1), 15.

Basavanthappa, B.T. (2009). *Nursing Administration.* New Dehli:Jaypee

Bauer, J. C. (2009). *Statistical analysis for decision makers in healthcare: understanding and evaluating critical information in changing times*. London: Taylor & Francis Group.

Becker, B., Huselid, M. & Ulrich, D. (2001). *The HR Scorecard Linking people, strategy and performance.* Boston. MA: Harvard Business School Press.

Bezuidenhout, S. (2011). The guidelines for the implementation of performance appraisal in clinics in the Dr Kenneth Kaunda District. Unpublished Dissertation. Potchefstroom: North West University.

Birken, S.A., DiMartino, L.D., Kirk, M.A., Lee, S-Y.D., McClelland, M. & Albert, N.M. (2015). Elaborating on theory with middle manager's experience implementing healthcare innovations in practice. *Implementation Science,* 11(2). Retrieved 14 November 2016. doi:10.1186/s13012-015-0362-6.

Booyens, S., Jooste, K. & Sibiya, N. (2015). *Introduction to Health Services Management for the Unit Managers.* (4th ed.). Cape Town: Juta & Company Ltd.

Boucher, C.J. (2005). To be or not to be a manager: the career choices of health professionals. *Australian Health Review*, 29(2), 218–225.

Bousari, M.P., Ebhahimi, H., Ahmadi, F., Abedi, H.A. & Kennedy, N. (2009). The process of nurses interpersonal conflict: Qualitative study. *Research Journal of Biological Science,* 4(2), 236-243.

Bradshaw, W.G. (2010). Importance of nursing leadership in advancing evidence-based nursing practice. *Neonatal Network*, 29(2), 117–122.

Brink, H. I. L. (2008). *Fundamentals of research methodology for healthcare professionals*. Cape Town: Juta & Company Ltd.

Brink, H.I.L., Van der Walt, C. & Van Rensburg, G. (2012). *Fundamentals of research methodology for healthcare professionals.* (3rd ed.). Cape Town: Juta & Company Ltd.

Brinkert, R. (2010). A literature review of conflict communicate, causes, costs, benefits and intervention in nursing. *Journal of Nursing Management*, 18, 145-156.

Brinkert, R. (2011). Conflict coaching training for nurse managers: a case study of a two-hospital health system. *Journal of Nursing Management*, 19, 80-91.

Bryman, A. (2012). *Social research methods.* (4th ed.). New York: Oxford University Press Inc.

Bunkers, S.S. (2015). Listening: Important to the Stuff of a Life. *Nursing Science Quarterly,* 28(2), 103-106.

Burns, N. & Grove, S. (2009). *The Practice of Nursing Research: appraisal, synthesis, and generation of evidence.* (6th ed.). St. Louis: Saunders.

Burns, N. & Grove, S. (2011). *Understanding nursing research: building an evidence-based practice*. (5th ed.). Maryland Heights: Elsevier Saunders.

Business dictionary. (2008). Definition of management. Retrieved 10 May 2013, from http://www.businessdictionary .com/definition/management.html

Calhoun, J. G., Davidson, P. L., Sinioris, M.E., Vincent, E. T. & Griffith, J. R. (2002). Towards Understanding and Assessment in Healthcare Management. *Quality Management in Healthcare*, 11(1), 14-19.

Carney, M. (2004). Middle manager involvement in strategy development in not for profit organisations: the director of nursing perspective – how organisational structure impacts on the role. *Journal of Nursing Management*, 12, 13-21.

Carney, M. (2010). Challenges in healthcare delivery in an economic downturn, in the Republic of Ireland. *Journal of Nursing Management*, 18(5), 509–514.

Carvallo, S., Reeves, M. & Orford, J. (2011). *Fundamental aspects of legal, ethical and professional issues in nursing.* (2nd ed.). MA Healthcare Ltd, London.

Center for Creative Leadership. (2016). *Addressing the Leadership Gap in Healthcare. What's Needed when It Comes to Leader Talent?* White Paper. Retrieved 16 November 2016, from www.ccl.org.

Chase, L.K. (2010). *Nurse manager competencies*. Unpublished PhD Thesis. University of Iowa. Iowa City. Retrieved June 2013, from http://ir.uiowa.edu/etd/2681.

Christensen, L., Johnson, R. & Turner, L. (2011). *Research methods, design and analysis.* (11th ed.). New York: Pearson.

Cloete, E. & Allen-Payne, C. (2009). *Human Resource Management: Induction and Employment Equity*. South Africa: Van Schaik Publisher.

Concise Oxford Dictionary. (2008). Oxford. Oxford University Press.

Conway-Morana, P.L. (2009). Nursing strategy: What's your plan? *Nursing Management*, 40(3), 25-29.

Cowan, D.T., Norman, I. & Coopamah, V.P. (2007). Competence in nursing practice: a controversial concept – a focused review of literature. *Accident and Emergency Nursing*, 15(1), 20-26.

Craig, M. & McKeown, D. (2015). How to build effective teams in healthcare. *Nursing Times*, 111(14), 16-18.

Crawford, L. & Nahmias, A.H. (2010). Competencies for managing change. *International Journal of Project Management*, 28(4), 405-412.vanced mixed methods research designs.

Creswell, J.W., Plano Clark, V.L., Gutmann, M.L. & Hanson, W.E. (2003). Advanced mixed methods research designs In A. Tashakkori and C Teddlie (Eds), Handbook on mixed methods in the behavioural and social sciences, 209-240. Thousand Oaks, California: Sage Publications.

Creswell, J.W. & Plano Clark, V. L. (2007). *Designing and conducting mixed methods research*. (1st ed.). Thousand Oaks, California: Sage Publications.

Creswell, J.W. & Plano Clark, V.L. (2011). *Conducting and Designing Mixed Methods Research.* (2nd ed.). Thousand Oaks, California: Sage Publications.

Creswell, J.W. (2009). *Research design: qualitative and mixed methods approaches.* (3th ed.). Thousand Oaks: Sage Publications.

Creswell, J.W. (2014). *Research design: qualitative, Quantitative and Mixed Methods Approaches.* (4th ed.). Thousand Oaks: Sage Publications.

Daft, R.L. (2005). *The Leadership.* (3th ed). Thompson: South-Western.

Daley, T. (2013). Human Resource Strategies for Nurse Managers. *Emerging RN Leader,* Online. Retrieved 14 October 2014 from: http://www.emergingrnleader.com.

Daouk-Oyry, L., Anouze, A.L., Otaki, F., Dumit, N.Y. & Osman, I. (2014). The JOINT model of nurse absenteeism and turnover. *International Journal of Nursing Studies,* 51(1), 93-110.

Davey, M.M., Cummings, G., Newburn-Cook, C.V. & Lo, E.A. (2009). Predictors of nurse absenteeism in hospitals: a systemic review. *Journal of Nursing Management,* 17(3), 312-330.

Dawson, C. (2010). *Introduction to research methods: A practical guide for any one undertaking a research project*. (4th ed.). London: How to books Ltd.

De Oliviera, A.K.M. & Tuohy, D. (2015). Communication and nursing: a study-abroad student's reflections. *British Journal of Nursing*, 24(21), 1080-1084.

De Vos, A., Strydom. H., Fouché, C. & Delport, C. (2009). *Research at grassroots. For the social sciences and human service professional.* (5th ed.). Pretoria: Van Schaik Publishers.

Delargy, K. & Leteney, F. (2005). Managing competencies during times of change. *Knowledge Management Review*, 8(1), 12-15.

Denzin, N.K. & Lincoln, Y.S. (2008). *Strategies of Qualitative Inquiry.* (3rd ed.). Thousand Oaks, California: Sage Publications.

Department of Public Service and Administration. (2001). *Public Service Regulation, Government Notice No. R.1 of 5 January 2001.* Pretoria, South Africa: Department of Public Service and Administration. Retrieved 13 August 2013, from http://www.dpsa.gov.za.

Department of Public Service and Administration. (2007). *Occupational Specific Dispensation*. Pretoria, South Africa: Department of Public Service and Administration.

Department of Public Service and Administration. (2009). *Human Resource Planning for the Public Service Strategic Framework Vision.* Pretoria: Department of Public Service and Administration.

Department of Higher Education and Training (DHET). (2015). *Competency framework for career development practitioners in South Africa.* Pretoria, South Africa: Department of Higher Education and Training. Retrieved October 2015, from http://www.dhet.gov.za.

Dewing, J., McCormack, B. and Titchen, A. (2014) *Practice Development Workbook for Nursing, Health and Social Care Teams*. Chichester: Wiley-Blackwell.

Dickoff, J., James, P. & Wiedenbach, E. (1968). Theory in a practice discipline: part 1. Practice oriented discipline. *Nursing Research*, 17(5), 415–435.

Dolamo, B.L. (2015). Preparing the new nurse leader for health care delivery in South Africa in the twenty-first century. *African Journal for Physical, Health Education, Recreation and Dance*, 1-2, 485-497.

Donaher, K., Russell, G., Scoble K.B. & Chen, J. (2007). The Human Capital Competencies Inventory for Developing Nurse Managers. *The Journal of Continuing Education in Nursing*, 38(6), 277-283.

Dopson S. & Fitzgerald L. (2006). The role of middle manager in the implementation of evidence-based healthcare. *Journal of Nursing Management*, 14(4), 43–51.

Dowding, D. (2013). Are nurses expected to have information technology skills. *Nursing Management*, 20(5), 31-37.

Drach-Zahavy, A. & Dagan, E. (2002). From caring to managing and beyond: an examination of the head nurse's role. *Journal of Advanced Nursing*, 38(1), 19-28.

Duffy, K. (2013). Providing constructive feedback to students during mentoring. *Nursing Standard*, 27(31), 50-56.

Dunham-Taylor, J. & Pinczuk, J.Z. (2010). Financial Management for Nurse Managers: Merging the Heart with the Dollar. *Journal of Nursing Management*, 18, 618. Retrieved 14 October 2015 https://www.amazon.com. doi:10.1111/j.1365-2834.2010.01099.x

Ehlers, T. & Lazenby, K. (2010). *Strategic management: Southern African concepts and cases.* (3rd ed.). Pretoria: Van Schaik.

Epstein, R.M. & Street, R.L. (2011). The Values and Value of Patient-Centered Care. *Annals of Family Medicine*, 9(2), 100-103.

Fasnacht, P. H. (2003). Creativity: A refinement of the concept for nursing practice. *Journal of Advanced Nursing*, 41(2), 195-202.

Fenton, K. (2005). Self- development. *Nursing Management*, 12(1), 3.

Fisher, R.J. (2000). *Comparing three different approaches to graduate training in international conflict resolution*. Victoria, BC: Peace and Conflict Studies Division, Royal Roads University.

Fritzen, S. (2007). Strategic Management of the Health Workforce in Developing Countries: What have we learned? *Human Resources for Health*, 5(4). Retrieved 15 January 2012 from http://www.human-resources-health.com/content/5/1/4 (15 January 2012).

Fryer, K., Antony, J. & Ogden, S. (2009). Performance management in the public sector. *International Journal of Public Sector Management*, 22(6), 478-498.

Furukawa, P.O. & Cunha, I.C.K.O. (2011). Profile and Competencies of Nurse Managers at Accredited Hospitals. *Rev. Latino-Am.Enfermagem*, 19(1), 106-114.

Ganz, F.D., Wagner, N. & Toren, O. (2015). Nurse middle manager ethical dilemmas and moral distress. *Nursing Ethics*, 22(1), 43-51.

Gareis, R. (2010). Designing changes of permanent organisations by processes and projects. *International Journal of Project Management*, 28(4), 314-327.

Garside, K. & Nhemachena, J. (2013). A concept analysis of competence and its transition in nursing. *Nurse Education Today*, 33(5), 541-545.

George, G., Quinlan, T. & Reardon, C. (2009). *Human Resources for Health in South Africa*. Retrieved October 2012 from: http://www.rhap.org.za/wpcontent/uploads/2010/06/.

Gerrish, K. & Lacey, A. (2006). *The research process in nursing*. London: Blackwell Publishing Company.

Gerstberger, R.L. & Gromala, K.A. (2010). How effective is utility leadeship? *American Water Works Association*, 102(1), 46-55. Retrieved 06 April 2016 from www.jstor.org/stable.

Geyer, N. (2015). How important are nursing records?: legal and ethical column. *Professional Nursing Today*, 19(1), 14,16.

Gifford, W., Davies, B., Griffin, P. & Lybanon, V. (2007). Managerial leadership for nurses' use of research evidence: an integrative review of the literature, *Worldviews Evidence-Based Nursing*, 4(3), 126-145.

Girvin, J. (1998). Leadership in Nursing. Basingstoke: Macmillan

Given, L. (2007). Descriptive research. In N. Salkind & K. Rasmussen (Eds.), *Encyclopedia of Measurement and Statistics*, 251–254. Thousand Oaks, CA: Sage Publications Inc.

Given, L. (Ed.). (2008). *The SAGE Encyclopedia of Qualitative Research Methods* edited by *Lisa M*. Thousand Oaks, California: Sage Publications.

Govender, S. & Appel, M. (2006). Nursing profession faces numerous challenges. Pretoria News, 12 May:12.

Graham, I.W. & Jack, E. (2008). Promoting leadership: the development of a nurse executive team in an acute hospital trust, *Journal of Nursing Management*, 16(8), 955-963.

Green, J. & Thorogood, N. (2009). *Qualitative methods for health research.* (2nd ed.). London: Sage Publications Ltd.

Green, T., Dickerson, C. & Blass, E. (2010). Using competences and competence tools in workforce development. *British Journal of Nursing*, 19(20), 1293-1298.

Griffith, M.B. (2012). Effective succession planning in nursing: a review of the literature. *Journal of Nursing Management*. 20(7), 900-911.

Grindel, C.G. (2003). Mentoring Managers, *Nephrology Nursing Journal*, 30(5), 517-522.

Grobler, P., Warnich, S., Carrell. M., Elbert, N. & Hatfield, R. (2002). *Human Resource Management in South Africa*. (2nd ed.). London: Thompson Learning.

Grové, S. K., Burns, N. & Gray, J. R. (2013). *The practice of nursing research: Appraisal, synthesis, and generation of evidence*. Missouri: Elsevier.

Guba, E.G. & Lincoln, Y. (1985). Criteria for assessing trustworthiness of naturalistic inquiry. Thousand Oaks: Sage.

Guest Editorial. (2004). Unity with diversity: ICN's Framework of Competencies. *Journal of Advanced Nursing*, 47(2), 119.

Guion, L., Diehl, C. & McDonald, D. (2013). Triangulation: establishing the validity of qualitative studies. Retrieved October 10, 2014, from http://edis.ifas.ufl.edu/fy394

Hannes, K. & Lockwood, C. (2011). Pragmatism as the philosophical foundation for the Joanna Briggs meta-aggregative approach to qualitative evidence synthesis. *Journal of Advanced Nursing*. 67(7), 1632–1642.

Harwell, M. (2011). *Research design: qualitative, quantitative and mixed methods*. In C. Conrad & R. Serlin (Eds.), The Sage handbook for research in education: Pursuing ideas as the keystone of exemplary inquiry (2nd ed.). Thousand Oaks, California: Sage Publications Inc.

Hattingh, S. P.; Dreyer, M. & Roos, S. (2006). *Aspects of Community Health.* (3rd ed.). South Africa: Oxford Tertiary Institution Press.

Havaei, F., Dahinten. V.S. & MacPhee. M. (2015). The effects of perceived organisational support and span of control on the organisational commitment of novice leaders. *Journal of Nursing Management,* 23(3), 307-314.

Head, J., Stansfeld, S. A., Ebmeier, K. P., Geddes, J. R., Allan, C. L., Lewis, G. & Kivimaki, M. (2013). Use of self-administered instruments to assess psychiatric disorders in old people: validity of the general health questionnaire, the centre for epidemiologic studies depression scale and the self-completion version of the revised clinical interview schedule. *Psychological Medicine*, 43(12), 2649–2656.

Health Service Executive. (2014). *Induction Guidelines & Checklists*. Retrieved 10 November 2016 from: http://www.hse.ie.

Hendel, T., Fish, M. & Galon, V. (2005). Leadership style and choice of strategy in conflict management among Israel nurse managers in general hospitals. *Journal of Nursing Management*, 13(2), 137-146.

Hennerby, C. & Joyce, P. (2011). Implementation of a competency assessment tool for agency nurses working in an acute paediatric setting. *Journal of Nursing Management*, 19(2), 237-245.

Henning, E. (2005). *Finding your way in qualitative research* (3rd ed.). Pretoria: Van Schaik Publishers.

Henning, E., Van Rensburg, W. & Smit, B. (2007). *Finding your way in qualitative research*. Pretoria: Van Schaik Publishers.

Hennink, M., Hutter, I. & Bailey, A. (2011). *Qualitative research methods*. London: Sage Publications Ltd.

Hertel, S., Singer, M. M. & Van Cott, D. L. (2009). Symphosium: field research in developing countries: Hitting the road running. PS: *Political Science & Politics*, 42(2), 305-309.

Hewison, A. (2007). Policy analysis: a framework for nurse managers. *Journal of Nursing Management*, 15(7), 693-699.

Hofhuis, J., Van der Rijt, P.G.A. & Vlug, M. (2016). Diversity climate enhances work outcomes through trust and openness in workgroup communication. *Springerplus*, 5(1), 714. Published on line, doi:10.1186/s40064-016-2499-4. Retrieved 4th 2017 from https://sprigerplus.sringeropen.com/articles/1.

Holloway, I. & Wheeler, S. (2010). *Qualitative research in nursing and healthcare* (3rd ed.). West Sussex: John Wiley and Sons Limited.

Horton-Deutsch, S. & Sherwood, G. (2008). Reflection: an educational strategy to develop emotionally-competent nurse leaders, *Journal of Nursing Management*, 16(8), 946-954.

Hudson-Thrall, T. (2006). Nurturing your nurse managers. *H&HN*: *Hospitals & Health Networks*, 80(40), 71-74.

International Council of Nurses. (2009). *ICN Framework of Competencies for the Nurse Specialist.* Geneva: ICN

International Council of Nurses (ICN). (2012). *The ICN code of ethics for nurses*. Geneva: ICN.

Ivey, A., Ivey, M. & Zalaquett, C. (2010). *Intentional interviewing and counseling: facilitating client development in a multicultural society*. (7th ed.). Belmont, CA: Brooks/Cole, Cengage Learning.

Jakubik, L.D., Eliades, A.B., Weese, M.M. & Huth, J.J. (2016). Mentoring Practice and Mentoring Benefit 4: Supporting the Transition and Professional Growth – An Overview and Application to Practice Using Mentoring Activities. *Paediatric Nursing*, 42(5), 252-253.

Jennings, B., & McClure, M. (2004). Strategies to advance healthcare quality. *Nursing Outlook*, 52(1), 17–22.

Jeon, Y-H., Glasgow, N.J., Merlyn T. & Sansoni E. (2010). Policy options to improve leadership of middle managers in the Australian residential aged care setting: a narrative synthesis. *BMC Health Services Research,* 10, 190–201.Retrieved 16 November 2015 from https://bmchealthservres.biomedcentral.com. doi:10.1186/1472-6963-10-190.

Jianga, H., Lib, C., Gua, Y., Lua, H & Yec, W. (2015). Status of nurse staffing and nursing care delivery in Pudong, Shanghai. *Contemporary Nurse*, 50(1), 104-111.

Jinabhai, D. (2005). New challenges for South African Development and Training – Linkages to Empirical Research. *Public Personnel Management*, 34(1), 85-101.

Johansen, M. (2012). Keeping the peace: Conflict management strategies for nurse managers. *Nursing Management*, 43(2), 50-54.

Johnson, B. & Christensen, L. (2012). *Educational research: quantitative, qualitative and mixed approaches.* (4th ed.). Thousand Oaks, CA: Sage Publications Inc.

Johnson, C.J., Croghan. E. & Crawford J. (2003). The problem and management of sickness absence in the NHS: considerations for nurse managers. *Journal of Nursing Management*, 11(5), 336-342.

Jooste, K. & Jasper. (2012). A South African perspective: current position and challenges in healthcare service management and education in nursing. *Journal of Nursing Management*, 20(1), 56-64.

Jooste, K. & Prinsloo, C. (2013). Factors that guide nurse managers regarding the staffing of agency nurses in intensive care units at private hospitals in Pretoria. *Curationis*, 36(1), 1-10, Retrieved from October 2014, http://dx.doi.org/10.4102/curationis.v36i1.115.

Jooste, K. (2010). *The principles and Practice of nursing and healthcare. Ethos and professional practice, management, staff development, and research.* (1st ed.). Van Schaik: Pretoria.

Jooste, K. (2017). *Leadership in Health Services Management.* (2nd ed.). Juta. Lansdowne.

Kabene, S., Orchard, C., Horward, J., Soriano, M. & Leduc, R. (2006). The Importance of Human Resources Management in Healthcare: a Global Context. *Human Resources for Health*, 4(1), 1-17. Retrieved 15 January 2012 from: http://www.human-resources-health.com/content/4/1/20.

Kadushin, A. & Kadushin, G. (2013). *The social work interview*. (5th ed.). New York: Columbia University Press.

Khadka, D.K., Gurung, M. & Chaulagain, N. (2014). Managerial competencies – A survey of hospital managers' working in Kathmandu valley, Nepal. *Journal of Hospital Administration*, 3(1), 62-72.

Khan, B. (2003). *Exploring the factors that impact on the validity of competency profile development: a case study*. Unpublished MA Dissertation. University of the Western Cape. Cape Town.

Klein, S. (2011). The Veterans Health Administration: Implementing Patient-Centered Medical Homes in the Nation's Largest Integrated Delivery System, *Commonwealth Fund*, 16,1-24.

Knight, S. & Cross, D. (2012). Using Contextual Constructs Model to frame doctoral research methodology. *International Journal of Doctoral Studies*, *7*, 39–62.

Kocoglu, D., Duygulu, S., Abaan, E.S. & Akin, B.A. (2016). Problem Solving Training for First Line Nurse Managers. *International Journal of Caring Sciences*, 9(3), 955-965.

Koivunen, M., Niemi, A. & Hupli, M. (2015). The use of electronic device for communication with colleagues and other healthcare professionals - nursing professionals' perspectives. *Journal of Advanced Nursing*, 71(3), 620-631.

Kourkouta, L., & Papathanasiou, L.V. (2014). Communication in nursing practice. *Mater Sociomed*, 26(1): 65-7.

Kroll, T., Neri. M.T. & Miller, K. (2005). Using mixed methods in disability and rehabilitation research. *Rehabilitation*, 30(3), 106-113.

Kukkurainen, M.L., Suominen, T., Rankinen, S., Harkonen, E. & Kuokkanen, L. (2012). Organizational vision: experience at the unit level. *Journal of Nursing Management*, 20(7), 868-876.

Laframboise, L.E. (2011). Making the case for succession planning: who's on deck in your organization? *Canadian Journal of Nursing Leadership,* 24(2), 68–79.

Langer, J. (2006). *The mirrored window: focus groups from a moderator's point of view*. New York: Paramount Market Publishing Inc.

Lanning, B.A. & Doyle, E.I. (2010). Health Literacy: Developing a practical framework for effective health communication. *American Medical Writers Association*, 25(4), 155-161.

Lansdell, J. (2016). Critical reflection on practice development. Developing a holistic assessment protocol on a hospice inpatient ward: staff engagement and my role as a practice development facilitator. *International Practice Development Journal*, 6(1), 1-8.

Lawson, T. F. (2013). Strategies for curriculum mapping. *Journal for Physical & Sport Educators*, 26(1), 14-17.

Lee, E.J., Kim, H.S. & Kim, & Kim, H.Y. (2014). Relationships between core factors of knowledge management in hospital nursing organisations and outcomes of nursing performance. *Journal of Clinical Nursing*, 23(23-24), 3513-3524.

Lega, F., Longo, F. & Rotolo, A. (2013). Decoupling the use and meaning of strategic plans in public healthcare. *BMC Health Services Research,* 13(5), Retrieved from October 2012 from http://www.biomedcentral.com.

Liamputtong, P. (2011). *Focus group methodology, principles and practice*. London: Sage Publications.

Lin, L. M., Wu, J. H., Huang, I. C. & Tseng, K. H. (2007). Management Development: A Study of Nurse Managerial Activities and Skills. *Journal of Healthcare Management*, 52(3), 156-169.

Lindholm, M., Sivberg, B. & Uden G. (2000). Leadership styles among nurse managers in changing organizations. *Journal of Nursing Management*, 8(6), 327–335.

Loo, R. & Thorpe, K. (2004). Making Female First-Line Managers more Effective: a Delphi Study of Occupational Stress. *Woman in Management Review*, 19(2), 88.

Lucas, V., Laschinger, H.K. & Wong, C.A. (2008). The impact of emotional intelligent leadership on staff nurse empowerment: the moderating effect of span of control. *Journal of Nursing Management*, 16(8), 964-973.

Luo, W-Y., Shen, N-P., Lou, J-H., He, P-P. & Sun, J-W. (2016). Exploring competencies: a qualitative study of Chinese nurse managers. *Journal of Nursing Management*, 24(1), 87-94.

MacPhee, M. & Suryaprakash, N. (2012). First-line nurse leaders' health-care change management initiatives. *Journal of Nursing Management*, 20(2), 249-259.

MacPhee, M., Skelton-Green. J., Bouthilette. F. & Suryaprakash, N. (2012). An empowerment framework for nursing leadership development: supporting evidence. *Journal of Advanced Nursing*, 68(1), 159-169.

Marquis, B. & Huston, J.C. (2011). *Leadership Roles and Management Functions in Nursing: Theory and Application.* (7th ed.). Philadelphia: Lippincott, Williams & Wilkins.

Marrelli, F., Janis, T. & Hoge, M.A. (2005). Strategies for Developing Models. *Administration and Policy in Mental Health*, 32(5/6), 533-561.

Marshburn, D.M., Crickmore, K.D., Rose, S.B., Dutton, K. & Hudson, P.C. (2012). What do you do? Perceptions of nurse manager responsibilities. *Nursing Management*, 43(12), 24-29.

Martin, G.P. & Waring, J. (2012). Leading from the middle: Constrained realities of clinical leadership in healthcare organizations. *Health*, 17(4), 358-374.

Marx, M. (2014). Examining the structural challenges to communication as experienced by nurse managers in two US hospital settings. *Journal of Nursing Management*, 22(8), 964-972.

Mathena, K. (2002). Nursing Manager: Leadership Skills. *Journal of Nursing Administration*, 32(3), 136-142.

Matsuo, M. (2012). Leadership of learning and reflective practice: An exploratory study of nursing managers. *Management Learning*, 43(5), 609-623.

McCallin, A.M. & Frankson, C. (2010). The role of the charge nurse manager: a descriptive exploratory study. *Journal of Nursing Management*, 17, 319-325.

McCarthy, G. & Fitzpatrick, J.J. (2009). Development of a Competency Framework for Nurse Managers in Ireland. *The Journal of Continuing Education in Nursing*, 40(8), 346-350.

McNeil, B.J., Elfrink, V., Beyea, S.C., Pierce, S.T. & Bickford, C.J. (2005). Nursing informatics knowledge and competencies: A national survey of nursing education programs in the United States. *International Journal of Medical Informatics*, 74(11-12), 1021-1030.

McNeil, B.J., Elfrink, V., Beyea, S.C., Pierce, S.T. & Bickford, C.J. (2006). Computer Literacy Study: Report of Qualitative Findings. *Journal of Professional Nursing*, 22(1), 52-59.

Meeker, P. B. & Byers, J. F. (2003). Data-driven graduate curriculum redesign: A case study. *Journal of Nursing Education*, 42(4), 186-188.

Meesen, B., Kouanda, S., Musango, L., Richard, F., Ridde, V. & Soucat, A. (2011). Communities of practice: the missing link for knowledge management on implementation issues in low-income countries? *Tropical Medicine & International Health*, 16(8), 1007-1014.

Mehdi, K., Hassan, B., Soheila, S.G.S.P. & Jamileh, M.Z. (2013). The impact of IT infrastructures on Iranian nurses 'and students' health information-seeking strategies. *Emerald Insight*, 47(4), 369-383.

Meissner, E. & Radford, K. (2015). Importance and performance of managerial skills in the Australian aged care sector – a middle managers' perspective. *Journal of Nursing Management*, 23(6), 784-793.

Mendes, M.A., da Cruz, D. & Angelo, M. (2015). Clinical role of the nurse: concept analysis. *Journal of Clinical Nursing*, 24(3-4), 318-331.

Mensik, J. (2014). What every nurse should know about staffing. *American Nurse Today*, 9(2), 1-11. Retrieved 14 November 2016 from: http://www.healthcommedia.com.

Meyer, M., Mabaso, J., Lancaster, K. & Nenugwi, L. (2004). *ETD Practices in South Africa*. (2nd ed.). LexisNexis Butterwoths: Durban.

Miller, R. & Meinzinger, M. (2014). *Paralegal today: the legal team at work.* (6th ed.). New York: Delmar Learning.

Mills, J., Francis, K., McLeod, M. & Al-Motlaq, M. (2015). Enhancing computer literacy and information retrieval skills: A rural and remote nursing and midwifery workforce study. *Collegian*, 22(3), 283-289.

Milner, L.P.B. (2005). Management development in healthcare. *Journal of European Industrial Training*, 29(9), 751-763.

Moisoglu, I., Panagiotis, P., Galanis, P., Siskou, O., Maniadakis, N. & Kaitelidou, D. (2014). Conflict Management in a Greek Public Hospital: Collaboration or Avoidance? *International Journal of Caring Sciences,* 7(1), 75-82.

Mokoka, K.E. (2015). Managing a multigenerational nursing workforce to strengthen staff retention. *Professional Nursing Today*, 19(4), 42-45.

Mokoka, K.E., Oosthuizen, M.J. & Ehlers, V.J. (2010). Retaining professional nurses in South Africa:Nurse managers' perspectives. *Health SA Gesondheid,* 15(1), Art.#484,9.

Morash, R., Brintnell, J. & Rodger, G.L. (2005). A span of Control Tool for Clinical Managers. *Nursing Leadership,* 18 (3), 83-93.

Morley, M., Gunnicle, P., O'Sullivan, M. & Collins, D.G. (2006). New directions in the roles of the Human Resource Management fuction. *Personnel Review*, 35(6), 609-617.

Morrison, J. (2008). The relationship between emotional intelligence competencies and preferred conflict-handling styles. *Journal of Nursing Management*, 16(8), 974–983.

Mosson, R., Hasson, H., Wallin, L. & Von Thiele Schwarz, U. (2014). Towards evidence-based practice in the social services and older people care: from the line managers' perspective. *BioMed Central Health Services Research*, 14(2), 82. Retrieved 4th March 2017 from www.biomedicalcentral.com.

Muller, M., Bezuidenhout, M. & Jooste, K. (2011). *Healthcare Service Management*. (2nd ed.). Juta: Cape Town.

Mumford. T.V., Campion, M.A. & Morgeson, F.P. (2007). The leadership skills strataplex: leadership skill requirements across organisational levels. *The Leadership Quarterly*, 18(2), 154-166).

Murphy, L. & Cooper, C.L. (2000). *Healthy and productive work*. London: Taylor and Francis.

Myers, M.D. (2013). *Qualitative research in business and management* (2nd ed.). Thousand Oaks: Sage Publications Inc.

National Center of Healthcare Leadership (2006). *Competency Integration in Health Management Education - A Resource Series for Program Directors and Faculty.* Chigaco IL, USA: NCHL.

National Department of Labour. (2001). *National Skills Development Strategy Final version*. Pretoria: Department of labour. Retrieved 13 August 2013, from http://www.labour.gov.za.

National Department of Health. (2007). *Clinical Mentorship and Supportive Supervision Guidelines*. Pretoria: Government Printers.

National Department of Health. (2011). *Human Resource for Health South Africa. HRH Strategy for the Health Sector: 2012/13 – 2016/17.* Pretoria: Government Printers.

National Department of Health. (2012). *Strategic plan for nursing education, training and practice* 2012/2013-2016/2017. Pretoria: Government Printers.

National Department of Health. (2015). *Norms and Standards Regulations in terms of Section 90 (1) (b) and (c) of the National Health Act, 2003 (Act No. 61 of 2003), applicable to certain categories of health establishments*. Pretoria: Government Printers.

Nishiyama, M, Partskhladze, N. (2008). Building competencies for nurse administrators in the Republic of Georgia. *International Nursing Review*, 55(2), 179-186.

O'Donnell, D.M., Livingston, P.M. & Bartram, T. (2012). Human resource management activities on the front line: A nursing perspective. *Contemporary Nurse*, 41(2), 198-205. Journal *of Advanced Nursing*, 41(2), 195–202.

Okun, B. (2002). Effective helping interviewing and counselling techniques. Pacific Grove, California:Brookes/Cole.

Oroviogoicoechea, C. (1996). The clinical nurse manager: a literature review. *Journal of Advanced Nursing*, 24(6), 1273-1280.

Oxford Learner's Dictionary. (2014). Definition of clarifying. Retrieved June 27, 2014, from http://www.oxfordlearnersdictionaries.com/definition/english/team_1.

Ozdemir, A., Akansel, N. & Tunk, G.C. (2008). Gender and career: Female and male nursing students' pperception of male nursing role in Turkey. *Health Science Journal*, 2(3), 153-161.

Palma, M.G. (2009). Succession Planning: Solution for public managers. *America Society for Public Administration*, PA Times, 32(3), 10-11.

Parand, A., Dopson, S., Renz, A. & Vincent, C. (2014). The role of hospital managers in quality and patient safety: a systematic review. *Medical Management*, 4(9). Retrieved 15 October 2015 from, https://www.ncbi.nlm.nih.gov/pubmed. doi:10.1136/bmjopen-2014-005055.

Partington, D., Pellegrinelli, S. & Young, M. (2005). Attributes and levels of programme management competence: an interpretive study. *International Journal of Project Management,* 23(2), 87-95.

Paterson, K., Henderson, A. & Burmeister, E. (2015). The impact of a leadership development programme on nurses' self-perceived leadership capability. Journal of Nursing Management, 23(8), 1086-1093.

Pearson, A. & Peels, S. (2001). A global view of nursing in the new millennium-2: The nursing workforce. *International Journal of Nursing Practice,* 7(2), 5-10.

Peñarrieta-de Córdova, M.I., Castañeda-Hidalgo, H., Acevedo-Porras, G., Rangel-Torres, S., González-Salinas, F. & Garza-Hernández, R. (2014). Role and working conditions of hospital nurse managers: A binational study from Peru and Mexico. *Journal of Hospital Administration*, 3(3), 91-99.

Philip, S., Manias, E. & Woodward-Kron, R. (2015). Nursing educator perspectives of overseas qualified nurses' intercultural clinical comunication: barriers, enablers and engagement strategies. *Journal of Clinical Nursing*, 24(17-18), 2628-2637.

Pijl-Zieber, E.M., Barton, S., Konkin, J., Awosoga, O. & Caine, V. (2013). Competence and competence-based nursing education: finding our way through the issues. *Nurse Education Today*, 34(5), 676-678.

Pillay, R. (2009). Perceived competencies of nurse managers: A comparative analysis of the public and private sectors in South Africa. *African Journal of Business Management*, 3(9), 495-503.

Pillay, R. (2010). The skills gap in nursing management in South Africa: a sectoral analysis: research paper. *Journal of Nursing Management*, 18(2), 134-144.

Pillay, R. (2010). Towards a competency-based framework for nursing management education. *International Journal of Nursing Practice*, 16(6), 545-554.

Pillay, R. (2011). The skills gap in hospital management in South Africa Public Health Sector. *Public Health Nursing*, 28(2), 176-185.

Plakoyiannaki, E., Tzokas, E., Dimitratos, P. & Saren, M. (2008). How critical is employee orientation for customer relationship management? Insight from a case study. *Journal of Management Studies*, 45(2), 268-293.

Polit, D.F. & Beck, C.T. (2008). *Nursing Research: Generating and Assessing Evidence for Nursing Practice*. (8th ed.). Wolters Kluwer: Lippincott Williams & Wilkins.

Polit, D.F. & Beck, C.T. (2012). *Nursing Research: Generating and Assessing Evidence for Nursing Practice*. (9th ed.). Wolters Kluwer: Lippincott Williams & Wilkins.

Porter, J., Morphet, J. & Raymond, A. (2013). Preparation for high-acuity clinical placement: confidence levels of final-year nursing students. *Advanced in Medical Education and Practice*, 4(1), 83-89. Retrieved 4 March 2017 from www.ncbi.nlm.nih.gov.

Punch, K. (2014). *Introduction to social research: quantitative and qualitative approaches.* (3rd ed.). London: Sage Publications Ltd.

Quirk, M.P. & Fandt, P.M. (2000). *The 2nd Language of Leadership*. Mahwah, New Jersey: Lawrence Erlbaum.

Rao, P.H. (2010). A Framework for Building Competency: In Quality of Care at the Primary Health Level. *Journal of Management,* 39(2), 68-94.

Redman, R.W. (2007). Critical challenges in doctoral education: Highlights of the biennial meeting of the International Network for Doctoral Education in Nursing, Tokyo, Japan, 2007. *Japan Journal of Nursing Science*, 4(2), 61-65.

Regan, L.C. & Rodriguez, L. (2011). Nurse Empowerment from a Middle-Management Perspective: Nurse Managers' and Assistant Nurse Managers' Workplace Empowerment Views. *The Permanente Journal,* 15(1) e101-e107, Retrieved October 2014 from https:// www ncbi.nlm.nih.gov/pmc/articles/PMC3138177. Retrieved 25 October 2013, from www.sanc.co.za.

Rhoads, J. & Kuhn, J. (2014). When hospitals merge: turning challenges into opportunities for its excellence. *Computer Science Corporation*. Retrieved 1 December, 2016 from, www.csc.com.

Rundio, A.I. & Wilson, V. (2013). *Nurse executive: review and resource manual*. (2nd ed.). Silver Spring, MD: American Nurses Credentialing Center.

Russell, G. E. & Scoble, K. B. (2004). Mastery path for developing nurses for management: A conceptual model. *Nursing Leadership Forum,* 9(2), 41-50.

Saarnio, R., Suhonen, M. & Isola, A. (2016). Nurse managers' visions of future challenges in health care organizations. *Journal of Nursing*, 3(2), 1-8. Retrieved 4th March 2017 from http://dx.doi.org/10.7243/2056-9157-3-2.

Salkind, N.J. (2017). *Exploring research*. (9th ed.). London: Pearson.

Schlesinger, M., Grob, R. & Shaller, D. (2015). Using Patient-Reported Information to Improve Clinical Practice. *Health Services Research*, 50(2), 2116-2154.

Scott, I, & Mazhindu, D. (2011). *Statistics for healthcare professionals: An introduction*. London: SAGE Publications.

Sellgren, S. F., Ekvall, G. & Tomson, G. (2008). Leadership behaviour of nurse managers in relation to job satisfaction and work climate. *Journal of Nursing Management,* 16(5), 578–587.

Sha, N. (2007). *A study of the relationship between job satisfaction experienced by employees in a brick manufacturing company and their organizational citizenship behaviour.* Unpublished Thesis. University of the Western Cape. Cape Town.

Sharan, B. M. (2009). *Qualitative research: a guide to design and implementation*. (2nd ed.). San Francisco: John Wiley and Sons Limited.

Shaw, T. (2013). Approaches to practice development. *Practice Development in Nursing and Healthcare*. (2nd ed.). Chichester: Wiley-Blackwell.

Sherman, R.O., Bishop, M., Eggenberger, T. & Karden, R. (2007). Development of a leadership competency model. *Journal of Nursing Administration*, 37(2), 85-94.

Shewchuk, R. M., O'Connor, J., Fine, D. J. & Tyler, J. L. (2005). Building an understanding of the Competencies Needed for Health Administration. *Journal of Healthcare Management*, 50(1), 32-47.

Shindul-Rothschild, J. & Gregas, M. (2014). Patient Turnover and Nursing Employment in Massachusetts Hospitals Before and After Health Insurance Reform: Implications for the Patient Protection and Affordable Care Act. *Policy, Politics & Nursing Practice*, 14 (3-4), 151-162.

Shirey, M.M., Elbright, P.R. & McDaniel, A.M. (2013). Nurse manager cognitive decision-making amidst stress and work complexity. *Journal of Nursing Management*, 21(1), 17-30.

Slavkin, H.C. (2010). Leadership for health care in the 21st century: A personal perspective. *Journal of Healthcare Leadership*, 2, 35-41.

Slipicevic, O. & Masic, I. (2012). Management Knowledge and Skills Required in Healthcare System of the Federation Bosnia and Herzegovina. *Mater Sociomed*, 24(2), 106-111.

Smith, S. (2012). Nurse competence: a concept analysis. *International Journal of Nursing Knowledge*, 23(3), 172-182.

South Africa. (1994). *Public Service Act of 1994*. Pretoria: Government Printers.

South Africa. (1996). Department of Justice and Constitutional Development. *The South African Constitution, 1996*. Retrieved December 6, 2014, from http://www.justice.gov.za/legislation/constitution/SAConstitution-.pdf.

South Africa. (1998). *Skills development Act of 1998*. Pretoria: Government Printers.

South Africa. (2002). *Mental Healthcare Act 17 of 2002*. Pretoria: Government Printers.

South Africa. (2005*). Nursing Act, No. 33 of 2005*. Pretoria: Government Printers.

South Africa. (2007*). Millennium development mid-term country report.* Pretoria: Government Printers.

South Africa. (2007). *Public Health and Social Development Sectoral Bargaining Council Resolution 3 of 2007.* Pretoria: Government Printers.

South Africa. (2012). *National Planning Commission of the Republic of South Africa*. Pretoria: Government Printers.

South Africa. (2016). *Central Intelligence Agency, World Factbook*. Retrieved 14 September 2016, from www.theora.com/wfbcurrent/south africa/.

South African Nursing Council. (2004). *Draft Charter of Nursing Practice.* SANC: Pretoria.

South African Nursing Council. (2014). *Age Statistics*, SANC: Pretoria. Retrieved 25 October 2013, from www.sanc.co.za.

Spence Laschingera, H.K., Noskob, A., Wilkc, J. & Finegand, J. (2014). Effects of unit empowerment and perceived support for professional nursing practice on unit effectiveness and individual nurse well-being: A time-lagged study. *International Journal of Nursing Studies*, 51(12), 1615-1623.

Speziale, H. J. & Carpenter, D. R. (2003). *Qualitative research in nursing: Advancing the Humanistic imperative.* (3rd ed.). Hong Kong: Lippincott Williams & Wilkins.

Squires, J.E., Mordejo, D. & Le Fort, M. (2007). Exploring role of organizational policies and procedures in promoting research utilization in registered nurses. *Implementation Science.* Retrieved October 2015, from http://www.implementation science.com/content/2/1/17.

Staggers, N., Gassert, C.A. & Curran, C. (2002). A Delphi Study to Determine Informatics Competencies for Nurses at Four Levels of Practice. *Nursing Research*, 51(6), 383-390.

Statistics South Africa. (2015). *Mid-year population Estimates 2015*. Pretoria: Statistics South Africa.

Stefl, M.E. (2008). Common competencies for all healthcare managers: the Healthcare Leadership Alliance model. *Journal of Healthcare Management*, 53(8), 360-373.

Streb, C. (2010). Exploratory case study. In Albert J.Mills, G. Durepos & E. Wiebe (Eds.), *Encyclopedia of case study research*, 372–374. Thousand Oaks, California: Sage Publications. Retrieved October 2013, from http://dx.doi.org.

Swearingen S. (2011) Succession planning in nursing: who are tomorrow's leaders? *Nurse.com.* Available at: http://ce.nurse.com/, accessed 29 June 2011.

Tappen, R.M. (2001). *Nursing Leadership and Management: Concepts and Practice*, (4th ed.). Philadelphia: FA Davis.

Taylor B., Roberts, S., Smyth, T. & Tulloch, M. (2015). Nurse managers' strategies for feeling less drained by their work: an action research and reflection project for developing emotional intelligence. *Journal of Advanced Nursing*, 23(7), 879-887.

Terzic-Supic, Z., Bjegovic-Mikanovic, V., Vukovic, D., Santric-Milicevic, M., Marinkoviv, J., Vasic, V. & Laaser, U. (2015). Training hospital managers for strategic planning and management: a prospective study. *MBC Medical Education*, 15-25. Retrieved 15 November 2015 from http://bmcmededuc.biomedcentral.com. doi:10.1186/s12909-015-0310-9.

The International Council for Nurses (ICN). (2003). *Standards and Competencies Series: An implementation Model for the ICN Framework of Competencies for the Generalist Nurse.* The International Council for Nurses, Geneva.

Thompson, P. & Hyrkas, K. (2014). Global nursing leadership. *Journal of Nursing Management*, 22(1):1-3.

Thrall, T. (2006). Nurturing your nurse managers. *Hospitals and Health Networks*, 80(4), 71-74.

Tierney, S.J. (2010). "Nursing Unit Staffing: An Innovative Model Incorporating Patient Acuity and Patient Turnover: A Dissertation". University of Massachusetts Medical School. *Graduate School of Nursing Dissertations.* Paper 18. Retrieved 15 October 2014, from http://escholarship.umassmed.edu/gsn_diss/18.

Timmins, F., McCabe, C. & McSherry, R. (2012). Research awareness: managerial challenges for nurses in the Republic of Ireland. *Journal of Nursing Management*, 20(2), 224-235.

Titzer, J,L. & Shirey, M.R. (2013). Nurse Manager Succession Planning: A Concept Analysis, *Nursing Forum*, 48(3), 155-164.

Titzer, J.L., Phillips, T., Tooley, S., Hall, N. & Shirey, M. (2013). Nurse manager succession planning: synthesis of the evidence. *Journal of Nursing Management*, 21(7), 971-979.

Tobin, G. A. & Begley, C. M. (2004). Methodological issues in nursing: Methodological rigour within a qualitative framework. *Journal of Advanced Nursing*, 48(4), 388–396.

Torstad, S. & Bjork, I.T. (2007). Nurse leaders' views on clinical ladders as a strategy in professional development. *Journal of Nursing Management,* 15(8), 817-824.

Townsend, K., Wilkinson, A. & Kellner, A. (2015). Opening the black box in nursing work and management practice: the role of ward managers. *Journal of Nursing Management*, 23(2), 211-220.

Trepanier, S. & Crenshaw, J. (2013). Succession planning: A call to action for nurse executives. *Journal of Nursing Management*, 21(7), 980-985.

Tulchinsky, T.H. & Varavikova, E.A. (2010). What is the "New Public Health"? *Public Health Reviews*. 32(1), 25-53.

Tulgan, B. (2007). Accountability should be the standard for managers as well as employees. *Employment Relations Today.* 34(2), 21-28.

Udod, S.A. & Care, W.D. (2013). **'**Walking a tight rope': an investigation of nurse managers' work stressors and coping experiences, *Journal of Research in Nursing*, 18(1), 67-79.

United Nations Industrial Development Organisation (UNIDO). (2002). *Strengthening Organizational Core Values and Managerial Capabilities*. Human Resource Management.

Van Dyk, J., Siedlecki, S.L. & Fitzpatrick, J.J. (2016). Frontline nurse managers' confidence and self-efficacy. *Journal of Nursing Management*, 24(4), 533-539.

Verma, S., Paterson, M. & Medves, J. (2006). Core competencies for healthcare professionals: what medicine, nursing, occupational therapy, and physiotherapy share. *Journal of Allied Health*, 35(2), 109-115.

Wadee, H. & Khan, F. (2007). Human resources for health: healthcare delivery. *South African Health Review*. Durban: Health System Trust, 141.

Wallick, W. G. (2002). Healthcare Managers' Roles, Competencies, and Outputs in Organisational Performance Improvement. *Journal of Healthcare Management*, 47(6), 390-402.

Wallis, A. & Kennedy, K.I. (2013). Leadership training to improve nurse retention. *Journal of Nursing Management*, 21(4), 624-632.

Warner, J. R., & Burton, D. A. (2009). The policy and politics of emerging academic-service partnerships. *Journal of Professional Nursing*, 25(6), 329–334.

Wassenaar, A., Van den Boogaard, M., Van der Hooft, T., Pickkers, P. & Schoonhoven, L. (2015). Providing good and comfortable care by building a bond of trust': nurses views regarding their role in patients' perception of safety in the Intensive Care Unit. *Journal of Clinical Nursing*, 24(21-22) 3233-3244.

Watson, R., Stimpson A., Topping, A. & Porock, D. (2002). Clinical competence assessment in nursing: a systematic review of the literature. *Journal of Advanced Nursing*, 39(5), 421-431.

Weaver, B., Lindsay, B. & Gitelman, B. (2012). Communication technology and social media: opportunities and implications for healthcare systems. *The Online Journal of Issues in Nursing* 17(3). Retrieved 14 November 2015. doi:10.3912/OJIN.Vol17No03Man03.

Western Cape Department of Health. (2007). *Comprehensive Service Plan for the implementation of Healthcare 2010*. Cape Town.

Western Cape Department of Health. (2010). *Strategic Plan 2010-2014.* Cape Town.

Western Cape Department of Health. (2011). *Healthcare 2020. The future of healthcare in the Western Cape.* Cape Town.

Western Cape Government Health. (2011). *Annual Report 2010/2011*. Cape Town. Retrieved 12 August 2015, from http://www.westerncape.gov.za.

Western Cape Government Health. (2014). *Annual Performance Plan 2014/2015.* Cape Town.

Western Cape Government Health. (2014). *Healthcare 2030. The Road to Wellness*. Cape Town.

Western Cape Government Health. (2016). *Annual Report 2015/2016*. Cape Town.

Wickramasinghe, N. (2003). "Do we practice what we preach? Are knowledge Management systems in practice truly reflective of knowledge management systems in theory?. *Business Process Management Journal*, 9(3), 295-316.

Williams, L. & Zippener, L. (2003). Improving access to information: Librarians and nurses team up for patient safety. *Nursing Economics*, 21, 199-201.

Wilson, D.S., Talsma, A.N., & Martyn, K. (2011). Mindful staffing: a qualitative description of charge nurses' decision-making behaviours. *Western Journal of Nursing Research*, 33(6), 805-824.

World Economic Forum. (2007). *The Global Competitiveness Report 2007-2008.* World Economic Forum. Retrieved October 2015 from http://www.gcr.weforum.org/pages/analysis.aspx.

World Health Organisation. (2006). *Working together for Health*. The World Health Report 2006. WHO. Geneva.

World Health Organisation. (2016). *The Global Strategic Directions for Strengthening Nursing and Midwifery*. WHO. Geneva.

World Health Organisation. (2011). *Sexual and reproductive health. Core competencies in primary care*. WHO. Italy.

World Health Organisation. (2016). *Mentoring guidelines*. WHO. Geneva.

World Health Professions Alliance. (2007). *A Core Competency Framework for International Health Consultants.* World Health Professions Alliance, Geneva, Switzerland. Retrieved October 2015 from www.whpa.org.

Wright, D. (2005). *The Ultimate Guide to Competency Assessment in Healthcare*. (3rd ed.).: Minneapolis: Creative Healthcare Management Inc.

Yanhua, C. & Watson, R. (2011). A review of clinical competence assessment in nursing. *Nurse Education Today*, 31(8), 832-836.

ANNEXURE A: ETHICAL CLEARANCE CERTIFICATE

UNIVUIITY f'•
WISTEIN CAPI

OFFICE OF THE DEAN
DEPARTMENT OF RESEARCH DEVELOPMENT

28 May 2013

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape has approved the methodology and ethics of the following research project by:
Ms W Makie (School of Nursing)

Rcscarch Project: A human resources stnltegy to address competencies of assistant nurse managers of pubUc health facilities in the Western Cape.

Registration no: 13/4123

Any amendmerts, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be infonncd of any serious adverse event and/or termination of the study.

Ms Patricia Joslas
Research Ethics Comm/1/ce Officer
Unlwrsity of the Western Cape

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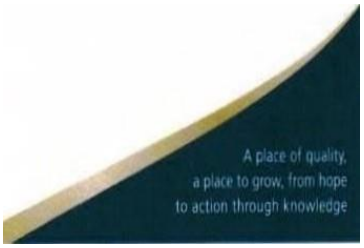

ANNEXURE B: Letter to Head of Department of Health

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9592274, Fax: 27 21-9592679

E-mail: Vatiswa.Makie@westerncape.gov.za

Letter of request to conduct the research

April 2013

Prof C Household
Head of Health
Department of Health
4 Dorp Street
Cape Town
8001

Dear Prof Household

Request for permission to conduct research investigation

I hereby request to conduct a research study in the public facilities in the Western Cape. The study is entitled: A human resources strategy to facilitate the competencies of Assistant Nurse Managers in public health facilities in the Western Cape. This study is part of the requirements for acquiring a PhD Degree in Nursing Management. The study will be done under the supervision and guidance of Professor K. Jooste of the School of Nursing, University of The Western Cape.

Data collection will be obtained in two phases:

- Individual unstructured interviews and focus group discussions will be held at the public facilities in the Western Cape. Participants invited to partake will be Senior Nurse Manager, Deputy Nurse Managers, and Operational Nurse Managers. Interviews will be held in a private room as arranged, and it will take around 45 minutes for individual interviews and 60 minutes for focus groups to conduct an interview.
- Questionnaires will be handed out to Assistant Nurse Managers Assistant Nurse Manager Assistant Nurse Manager of all the public facilities. Participants will complete it in their own time that will take about 30 minutes.

The researcher will adhere to the rights of participants to privacy and confidentiality. The identity of all participants will be protected; pseudonyms (fictitious names) will be used instead during interviews instead of their real names. The questionnaires will be allocated code numbers. The name of the public facility will not appear on the research report. All records will be kept for 5 years after publication of the results after which it will be destroyed. Only the supervisor, researcher, independent coder and statistician will have access to the data. The participants will not be coerced into participation and should they wish to withdraw at any time during the study, their wish will be respected. The researcher will ensure adherence to the highest standards of research planning, implementation and reporting.

I am also attaching the proposal, information sheet to participants as well as the informed consent sheets for your information.

If you have any questions about the research study itself, please contact:

Researcher: Vatiswa Makie

Directorate Nursing Services

10th Floor, 4 Dorp Street

Cape Town

8000.

Telephone: 021 483 3133

Cell: 083 788 2287

Email address: Vatiswa.Makie@westerncape.gov.za

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Research Supervisor/Acting Director, School of Nursing: Prof K. Jooste

University of the Western Cape

Private Bag X17, Bellville 7535

Telephone: (021) 959 2271; Email: kjooste@uwc.ac.za

This research has been approved by the Senate Research Committee and Ethics Committee of the University of the Western Cape.

ANNEXURE C: Information sheet – Individual and focus group discussions

UNIVERSITY OF THE WESTERN CAPE
Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-9592274, Fax: 27 21-9592271
E-mail: Vatiswa.Makie@westerncape.gov.za

PARTICIPANT'S INFORMATION SHEET

Project Title: A human resources strategy to facilitate the competencies of assistant nurse managers in public health facilities in the Western Cape

What is this study about?

I am Vatiswa Makie, a registered PhD student in Nursing Science at the School of Nursing at the University of the Western Cape. I hereby invite you to participate in this research project because you are a Senior Nurse Managers, Deputy Nurse Nursing, Operational Nurse Managers or Assistant Nurse Managers that have insight into the competencies of the Assistant Nurse Manager in your public health facility in the Western Cape. The purpose of this research project is to develop a human resources strategy to facilitate the competencies of Assistant Nurse Managers in public health facilities in the Western Cape

What will I be asked to do if I agree to participate?

You are asked to participate in individual interview or focus group discussions Interviews will be conducted at the public facility, in a suitable room, that ensures privacy and comfort for participants. The individual interviews and focus group discussions will last no longer than 45 and 60 minutes respectively. The main question that will be asked is ' What are your expectations about the competencies of ANM in public health facilities in the Western Cape?' Written informed consent for the interviews and to be voice recorded will be required.

Could my participation in this study be kept confidential?

We will do everything within our power to keep your personal information confidential. If partaking in a focus group you should agree not to disclose any information that was discussed during the group discussion. To help protect your confidentiality, pseudonyms (fictitious names) will be used in field notes instead of your real name. It could prevent any other person from linking specific data to you. Voice recordings of the interviews will be stored under lock

and key for five years after the results of the project have been published before it will be destroyed. Only my supervisor, an independent coder and the researcher (me) will have access to these recordings. The researcher will take written field notes during the interviews. However, your name will not be recorded in these notes. The publication of the results of the project, will not mention any names of participants.

What are the risks of this research?

The researcher is not aware of risks associated with participating in this research project.

What are the benefits of this research?

The results may assist the researcher to explore the expectations of the competencies of the assistant nurse managers in public facilities in the Western Cape. Information acquired during this research project will be shared with all participants prior to public dissemination. Results of the study will be published in an accredited journal. Stakeholders might benefit from this study by understanding the competencies of an Assistant Nurse Manager post. The research is not designed to personally benefit the researcher, but to inform the development of a human resources strategy for Assistant Nurse Managers to facilitate their competencies in public facilities in the Western Cape. This can indirectly benefit future Assistant Nurse Managers in fulfilment of their job description.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may withdraw from participating at any time. If you decide not to participate in this study, you will not be penalised or lose any benefits to which you otherwise qualify.

What if I have questions?

This research is being conducted by Vatiswa Makie of the Directorate Nursing Services of the Western Cape.

If you have any questions about the research study itself, please contact:

Researcher: Vatiswa Makie
Directorate Nursing Services
10th Floor, 4 Dorp Street
Cape Town
8000.

Telephone: 021 483 3133

Cell: 083 788 2287

Email address: Vatiswa.Makie@westerncape.gov.za

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Research Supervisor/ Director, School of Nursing: Prof K. Jooste

University of the Western Cape

Private Bag X17, Bellville 7535

Telephone: (021) 959 2271; Email: kjooste@uwc.ac.za

Dean of the Faculty of Community and Health Sciences

Prof Jose Frantz

021 9592631

Email: jfrantz@uwc.ac.za

University of the Western Cape

Private Bag X17

Bellville 7535

This research has been approved by the Senate Research Committee and Ethics Committee of the University of the Western Cape.

ANNEXURE D: Written informed focus group discussions

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-959 2274, Fax: 27 21-959 2271

e-mail: Vatiswa.Makie@westerncape.gov.za

FOCUS GROUP CONFIDENTIALITY BINDING FORM

Title of Research Project: A human resources strategy to facilitate the competencies of Assistant Nurse Managers in public health facilities in the Western Cape

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way. I agree to be audio-taped during my participation in the study. I also agree not to disclose any information that was discussed during the group discussion.

Participant's name……..

Participant's signature……..

Witness's name……..

Witness's signature……..

Date……

ANNEXURE E: Written informed individual interviews

UNIVERSITY OF THE WESTERN CAPE
Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-9592274, Fax: 27 21-9592271
E-mail: Vatiswa.Makie@westerncape.gov.za

WRITTEN INFORMED CONSENT Letter
of request to participate in the study

Title of Research Project: A human resources strategy to facilitate the competencies of Assistant Nurse Managers in public health facilities in the Western Cape

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way

Participant's name……..
Participant's signature…….

I further agree that the interview be voice recorded.
Participant's signature…….

I further agree that the researcher takes field notes.
Participant's signature…….
Witness…….

Date……

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Study Coordinator's Name: Prof Karien Jooste
University of the Western Cape
Private Bag X17, Bellville 7535
Telephone: (021)959-2274
Cell: 0828972228
Fax: (021)959-2271
Email: kjooste@uwc.ac.za

ANNEXURE F: Information sheet survey (questionnaires)

UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9592274, Fax: 27 21-9592271

E-mail: Vatiswa.Makie@westerncape.gov.za

PARTICIPANT'S INFORMATION SHEET

Project Title: A human resources strategy to facilitate the competencies of Assistant Nurse Managers in public health facilities in the Western Cape

What is this study about?

I am Vatiswa Makie, a registered PhD student in Nursing Science at the School of Nursing at the University of the Western Cape. I hereby invite you to participate in this research project because you are a Senior Nurse Manager, Deputy Nurse Manager, Operational Nurse Manager or Assistant Nurse Manager that has insight into the competencies of the assistant nurse manager in your public health facility in the Western Cape. The purpose of this research project is to develop a human resources strategy to facilitate the competencies of Assistant Nurse Managers in public health facilities in the Western Cape

What will I be asked to do if I agree to participate?

You are asked to participate in a survey. Questionnaires will be distributed at your public facility. You can complete it in a suitable place in your own time, to ensure privacy and comfort for you. The completion of the questionnaire will last no longer than 30 minutes. The items in the questionnaire will explore your perceptions of the Assistant Nurse Manager regarding the expected and your current competencies in your post. Written informed consent for the survey will be required.

Could my participation in this study be kept confidential?

We will do everything within our power to keep your personal information confidential. To help protect your confidentiality, the questionnaire will be numbered instead of revealing your

real name. Questionnaires will be returned in an enclosed envelope. It could prevent any other person from linking specific data to you. All data gathered from the survey will be stored under lock and key for five years after the results of the project have been published after which it will be destroyed. Only my supervisor, statistician and myself (the researcher) will have access to the data. The publication of the results of the project, will not mention any names of participants.

What are the risks of this research?

The researcher is not aware of risks associated with participating in this research project.

What are the benefits of this research?

The results may assist the researcher to explore and describe the perceptions of Assistant Nurse Managers on the expected and their current competencies in their position in public facilities in the Western Cape. Information acquired during this research project will be shared with all participants prior to public dissemination. Results of the study will be published in an accredited journal. Stakeholders might benefit from this study by understanding the competencies of Assistant Nurse Manager. The research is not designed to personally benefit the researcher, but to inform the development of a human resources strategy for Assistant Nurse Managers to facilitate their competencies in public facilities in the Western Cape. This can indirectly benefit future Assistant Nurse Managers in fulfilment of their job description.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may withdraw from participating at any time. If you decide not to participate in this study, you will not be penalised or lose any benefits to which you otherwise qualify.

What if I have questions?

This research is being conducted by Vatiswa Makie of the Directorate Nursing Services of the Western Cape.

If you have any questions about the research study itself, please contact:

Researcher: Vatiswa Makie

Directorate Nursing Services

10th Floor, 4 Dorp Street

Cape Town

8000.

Telephone: 021 483 3133

Cell: 083 788 2287

Email address: Vatiswa.Makie@westerncape.gov.za

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Research Supervisor/Acting Director, School of Nursing: Prof K. Jooste

University of the Western Cape

Private Bag X17, Bellville 7535

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Dean of the Faculty of Community and Health Sciences

Prof Jose Frantz

021 9592631

Email: jfrantz@uwc.ac.za

University of the Western Cape

Private Bag X17

Bellville 7535

This research has been approved by the Senate Research Committee and Ethics Committee of the University of the Western Cape.

ANNEXURE G: Written informed consent survey (questionnaires)

UNIVERSITY OF THE WESTERN CAPE
Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-9592274, Fax: 27 21-9592271
E-mail: Vatiswa.Makie@westerncape.gov.za

WRITTEN INFORMED CONSENT

Letter of request to participate in the study

Title of Research Project: A human resources strategy to facilitate the competencies of Assistant Nurse Managers in public health facilities in the Western Cape

The study has been described to me in language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way

Participant's name ……

Participant's signature ……

Date ……

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Study Coordinator's Name: Prof Karien Jooste
University of the Western Cape
Private Bag X17, Bellville 7535
Telephone: (021)959-2274
Cell: 0828972228
Fax: (021)959-2271
Email: kjooste@uwc.ac.za

ANNEXURE H: Interview guide for focus group interviews

GUIDING UNSTRUCTURED QUESTION (Operational Nurse Managers)

What are your expectations about the competencies of an Assistant Nurse Manager public health facilities?

Tell me about your expectations of the Assistant Nurse Manager?

GUIDING UNSTRUCTURED QUESTION (Assistant Nurse Managers)

Tell me about your competencies in being Assistant Nurse Manager?

Tell me about your expectations in acting as Assistant Nurse Manager?

ANNEXURE I: Interview guide for individual unstructured interviews

GUIDING UNSTRUCTURED QUESTION (Senior Nurse Managers, Deputy Nurse Managers, Operational Nurse Managers and Assistant Nurse Managers)

What are your expectations about the competencies of an Assistant Nurse Manager in public health facilities?

Tell me about your expectations of the Assistant Nurse Manager?

ANNEXURE J: QUESTIONNAIRE

	Assistant nurse manager demographic questionnaire	
		1
	Below is a demographic profile of the nurse manager. In the columns on the right-hand side, please indicate by means of an (**X**) unless otherwise required.	
	Demographic data	
	Gender	
1	Male	
2	Female	
1	**How old are you?**	
	e.g. 45 years	
	What is your highest level of education?	
1	Diploma	
2	Degree	
3	Honours	
4	Masters	
5	Doctorate	
1	**How long have you been practising as a professional nurse?**	
	e.g. 3 years	
1	**How long have you been working in the position of an assistant nurse manager?**	
	e.g. 10 years	
	What best describes the health facility where you are working?	
1	Academic hospital	
2	Regional hospital	
3	Psychiatric hospital	
4	District hospital	
5	TB hospital	
6	Community health centre	
7	Community day care centre	
8	Clinic	
	What is your speciality area? Mark all the applicable areas.	
1	Surgical	
2	Gynaecology	
3	Medical	
4	Trauma & emergency	
5	Critical care	
6	Paediatric	
7	Theatre	
8	Oncology	
9	Ophthalmology	
10	Obstetrics	
11	Orthopaedics	
12	Primary health care	
13	Psychiatry	
14	Neonatal	
15	Burns	
16	Other	

Assistant nurse manager competency questionnaire

Instructions

Below is a list of statements about the competencies of the nurse manager. In the columns on the left-hand side, please indicate by means of an (**X**) your current competencies by using the following scale:

To what extent do you have the competencies in practice?

1	To no extent
2	To a small extent
3	To a moderate extent
4	To a large extent

In the columns on the right-hand side of the statement, please indicate by means of an (x) your opinion about the extent to which you are expected to have these competencies. Use the following scale:

To what extent are you expected to have these competencies?

1	To no extent
2	To a small extent
3	To a moderate extent
4	To a large extent

Kindly note that there are no right or wrong answers to any one of the statements. We only require your **honest** opinion.

Please remember to mark two blocks – one on either side of the statement

I have the following competencies:	**Statement**	**I am expected to have the following competencies:**

No	**Existing**				**Item**	**Expected**			
	1	**2**	**3**	**4**		**1**	**2**	**3**	**4**
1					Coordinate optimal, holistic nursing care according to the set standards of a professional / legal framework.				
2					Ensure adherence to the relevant acts / prescripts by, e.g. attending educational sessions on new legislation.				
3					Create a setting for review or update of patient care policies / procedures.				
4					Monitor nursing care management activities according to the Standards of Practice / Scope of Practice.				
5					Have background or current knowledge on labour relations.				
6					Provide quality patient care to patients with the emphasis on a patient centred experience.				
7					Review the developed nursing care plan for effectiveness of use.				
8					Identify health indicators or risk factors, e.g. by coordinating the execution of client satisfaction surveys.				
9					Participate in the provision of nursing care to patients in order to ensure the formulation of accurate nursing diagnoses to address clients' needs.				
10					Implement knowledge management, e.g. by updating staff in relation to new knowledge in the field of specialisation.				
11					Ensure dissemination of information to enhance patient outcomes, e.g. clinical practice guidelines or circulars.				
					Any other competencies you want to mention with regard to having knowledge in your field:				
12									
13									
14									
15									

16					Have the ability to communicate clear guidelines, e.g. the procedure to move equipment from one unit to another.					
17					Maintain professional working relationships based on sound work ethics, e.g. engage with role players or a multidisciplinary team.					
18					Share a common vision through ongoing dialogue with all stakeholders, e.g. interaction with doctors or professors.					
19					Follow either a top to bottom or a bottom to top approach for ensuring transparency in the workplace.					
20					Take initiative by proposing suggestions with confidence in an open arena, such as at meetings.					
21					Take a risk confidently about a specific solution, e.g. initiating a new procedure.					
22					Have appropriate self-awareness to satisfactorily address own limitations /strengths.					
23					Have self-knowledge to identify any need that requires learning new skills.					
24					Initiate activities to develop fellow workers, e.g. design a schedule for in-service training.					
25					Focus on diversity in the workplace, e.g. by being culturally sensitive.					
26					Building trust among the employees with the aim of ensuring productivity.					
27					Promote shared decision making, e.g. participation in the budgeting process.					
28					Have people management skills, e.g. to listen carefully with respect for individual talents.					
29					Manage conflict on the basis that parties indicate their commitment to finding an amicable solution.					
30					Use different strategies to resolve conflict in the workplace, e.g. by addressing discrimination issues.					
31					Address patients' and the public's complaints satisfactorily within an appropriate time frame.					
32					Provide constructive feedback to staff members and expect them to respond promptly on issues that need attention.					
33					Provide feedback to operational nurse managers on recent developments in the service, e.g. exchange of information between the Executive Committee and operational nurse managers about CPD courses.					
34					Maintain trust through openly talking about challenges that need to be addressed in the work place.					
35					Adhere to work ethics, e.g. maintenance of confidentiality when dealing with staffing matters.					
36					Solve problems by using a specific framework, e.g. a stepped approach.					
					Any other competencies you want to mention with regard to interpersonal skills needed:					
37										
38										
39										
40										
41					Have the knowledge to draft a memorandum, e.g. about new equipment on the market.					
42					Have the ability to write according to formal formats, e.g. monthly reports.					
43					Apply knowledge of computer programs in the workplace, e.g. Intranet and Internet.					
44					Use basic computer software programs confidently.					
45					Act as a resource for operational nurse managers, e.g. by being approachable to share management principles needed to complete a task.					
46					Identify nursing trends when conducting audits.					
47					Participate in research projects, e.g. departmental / provincial research projects.					
48					Involve the nursing staff in conducting research activities, e.g. by discussing results of recent projects published in journals.					
49					Promote research in current trends of nursing with the purpose of maintaining professional growth of staff members.					
					Any other competencies you want to mention with regard to technical skills:					
50										
51										
52										
53										

54					Analyse staffing needs with the aim of ensuring cost effectiveness.				
55					Develop a plan to meet the staffing needs in the workplace.				
56					Allocate staff members to the different units in new or creative ways.				
57					Monitor the duty roster / attendance register to ensure fair staff allocation.				
58					Know and understand the recruitment process to ensure the invitation of suitable candidates, e.g. by motivating for a specific post.				
59					Select the best suitable candidate to fill an advertised post irrespective of race, religion, gender, or sexual orientation.				
60					Implement strategies to retain staff members, e.g. initiate interesting participatory projects.				
61					Determine the monthly staff absenteeism rate with the purpose of advising senior management on solutions.				
62					Train supervisors on management of absenteeism, e.g. in accordance with HR prescripts.				
63					Implement workplace discipline, e.g. by mitigating insubordination.				
64					Apply knowledge of grievance handling processes, e.g. study leave grievance.				
65					Monitor the implementation of staff performance agreements.				
66					Quarterly assess the performance of staff members with the aim of identifying limitations in terms of behaviour.				
67					Develop a strategic plan in the workplace that aligns with the vision of the institution.				
68					Set priorities to ensure that employees are working towards common goals, e.g. goals in the new nursing strategy.				
69					Develop an annual operational plan with an emphasis on short / long term goals.				
70					Monitor financial resources with an emphasis on cost containment, e.g. by ensuring that spending is not exceeding the provincial directive.				
71					Participate in the development of the business plan of the institution.				
72					Identify ways of containing health care costs without compromising standards, e.g. proper training plan to prevent staff shortages.				
73					Ensure implementation of the budget by monitoring the expenditure report, e.g. use of agency staff.				
74					Know and understand the operational principles of functional business units, e.g. cost of staffing.				
					Any other competencies you want to mention with regard to managerial skills:				
75									
76									
77									
78									

79					Innovate by adapting procedures to suit a changing environment, e.g. recommend an initiative to adapt in the event of a gastro outbreak.				
80					Identify the personnel's skills gap, e.g. conduct a skills audit.				
81					Address the skills gap by ensuring that all staff members attend professional training.				
82					Create an empowering environment by providing support or opportunities to junior members of staff.				
83					Update orientation sessions for new employees, e.g. the orientation plan that includes professional behaviour of staff members.				
84					Have a leadership succession plan that prepares employees to assume management roles in the absence of their managers.				
85					Ensure that succession plan employees are exposed to peer teaching, e.g. attend specific meetings that develop professional competencies.				
86					Collaborate with members of the health and social care teams.				
87					Participate in decision-making pertaining to health care delivery by attending external meetings.				
88					Provide team building opportunities, e.g. by arranging topic specific workshops.				
89					Acknowledge outstanding professional work, e.g. by announcing the best nurse of the month.				
90					Use authority to assist the operational nurse managers in the development of the departmental strategic plan.				
91					Involve operational nurse managers in budgetary planning.				
92					Have power (knowledge) to mentor followers by planning their career paths.				
93					Provide mentorship programmes to influence health care providers to obtain competencies (knowledge, skills, and attitudes) for delivery of quality care.				
94					Be assertive, exercise your rights while recognising the rights of fellow members of staff.				
95					Provide support to personnel accountable to nurse manager, e.g. counselling services.				
96					Act as role model by guiding operational managers in supervisory skills to promote team work.				
					Any other competencies you want to mention with regard to professionalism and leadership:				
97									
98									
99									
100									

ANNEXURE K: PERMISSION FROM WESTERN CAPE DoH

ANNEXURE K

Western Cape Government
Health

STRATEGY & HEALTH SUPPORT
Health.Research@westerncape.gov.za
tel: +27 21 483 6857; fax: +27 21 483 9695
5th Floor, Norton Rose House, 8 Riebeek Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: RP 095 /2013
ENQUIRIES: Ms Charlene Roderick

10th Floor
4 Dorp Street
Cape Town

For attention: **Vatiswa Makie**

Re: A human resources strategy to address competencies of Assistant Managers Nursing (AMN) of public health facilities in the Western Cape

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.
Please contact **Ms D Adams** on **021 483 3802** to assist you with any further enquiries in accessing the **Nursing Services** for **all Western Cape Facilities.**

Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final report within six months of completion of research. This can be submitted to the provincial Research Co-ordinator (Health.Research@westerncape.gov.za).
3. The reference number above should be quoted in all future correspondence.

Yours sincerely

DR NT Naledi
DIRECTOR: HEALTH IMPACT ASSESSMENT
DATE: 8/11/2012
CC **F AFRICA** **DIRECTOR: NURSING SERVICES**

ANNEXURE L: PERMISSION FROM GROOTE SCHUUR HOSPITAL

ANNEXURE L

UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee

Room E52-24 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6338 • **Facsimile** [021] 406 6411
Email: linsey.samuels@uct.ac.za
Website: www.health.uct.ac.za/research/humanethics/forms

21 October 2013

HREC REF: 546/2013

Ms V Makie
c/o Prof K Jooste
Directorate Nursing Services
University of Western Cape

Dear Ms Makie

PROJECT TITLE: A HUMAN RESOURCES STRATEGY TO FACILITATE THE COMPETENCIES OF ASSISTANT NURSE MANAGERS IN PUBLIC HEALTH FACILITIES IN THE WESTERN CAPE

Thank you for submitting your letter to the Faculty of Health Sciences Human Research Ethics Committee, dated 15th October 2013.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 30th October 2014

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.
(Forms can be found on our website: www.health.uct.ac.za/research/humanethics/forms)

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the HREC. REF in all your correspondence.

Yours sincerely

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN ETHICS
Federal Wide Assurance Number: FWA00001637.
Institutional Review Board (IRB) number: IRB00001938
This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP) and Declaration of Helsinki guidelines.
The Human Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.

ANNEXURE M

Dr TA 81ake
Manager: Medi calServices
Email: Thomos. Biake@pgwqaov .za
Tel +27 21 658 5788 fox: +27 21 658 5166

06 June 2013

Ms VV Mokle Manager
Nursi ng Directorate Nursing
Servci es
Sub-Directorate Nursing Education & Tra i ning

Dear Ms Makle

APPROVAL Of RESEARCH

PROJECT: A human resources strategy to address competenci es of Assistant Mon en Nursing (AMN) of public health facilities In the Western Cope

Il Is o pleasure to Inform that approwal hos been granted to conduct the above-mentioned reseqrch at Red Cross War Memorial Children's Hospital.

Yours faithfully.

Dr Thomas Blake
Manager: Medical Servi ces

ANNEXURE N: PERMISSION FROM TYGERBERG HOSPITAL

ANNEXURE N

Western Cape Government
Health

Tygerberg Hospital

REFERENCE: Research Projects
ENQUIRIES: Dr M A Mukosi

REGISTRATION NO.: 13/4/23 (UWC)

A human resources strategy to address competencies of assistant nurse managers of public health facilities in the Western Cape.

Dear Ms V Makie

PERMISSION TO CONDUCT YOUR RESEARCH AT TYGERBERG HOSPITAL

In accordance with the Provincial Research Policy and Tygerberg Hospital Notice No. 40/2009, permission is hereby granted for you to conduct the above-mentioned research at Tygerberg Hospital.

Yours faithfully

CHIEF EXECUTIVE OFFICER: TYGERBERG HOSPITAL

Date: 30 August 2013

Administration Building, Francie van Zijl Avenue, Parow, 7500
tel: +27 21 938-5966 fax: +27 21 938-6698

Private Bag X3, Tygerberg, 7505
www.capegateway.gov.za

ANNEXURE O: Job description of Assistant Manager Nursing (Area)

Job title of post	**Assistant Manager Nursing (Area)**
Minimum qualification required	▪ Basic R425 qualification (i.e. diploma/degree in nursing) or equivalent qualification that allows registration with the South African Nursing Council. ▪ Registration with the SANC as a Professional Nurse
Experience	▪ A minimum of 8 years appropriate/recognisable experience in nursing after registration as Professional Nurse with the SANC in General Nursing. ▪ At least 3 years of the period referred to above must be appropriate/recognisable experience at management level.

(Department of Public Service and Administration, Annexure A, 2007:21, 22, 28 & 32).

ANNEXURE P: Job Description of Assistant Manager Nursing (Head of Nursing)

Job title of post	**Assistant Manager Nursing: (Head of Nursing Services)**
Minimum qualification required	▪ Basic R425 qualification (i.e. diploma/degree in nursing) or equivalent qualification that allows registration with the South African Nursing Council. ▪ Registration with the SANC as a Professional Nurse
Experience	▪ A minimum of 8 years appropriate/recognisable experience in nursing after registration as Professional Nurse with the SANC in General Nursing. ▪ At least 3 years of the period referred to above must be appropriate/recognisable experience at management level.

Department of Public Service and Administration, Annexure A, 2007:21, 22, 28 & 32).

ANNEXURE Q: Job Description of Assistant Manager Nursing (Primary Healthcare)

Job title of post	**Assistant Manager Nursing: Primary Healthcare**
Minimum qualification required	▪ Basic R425 qualification (i.e. diploma/degree in nursing) or equivalent qualification that allows registration with the South African Nursing Council. ▪ Registration with the SANC as a Professional Nurse ▪ A post basic nursing qualification, with a duration of at least 1 year, accredited with the SANC in Clinical Nursing Science, Health Assessment, Treatment and Care
Experience	▪ A minimum of 9 years appropriate / recognisable nursing experience after registration as Professional Nurse with the SANC in General Nursing. ▪ At least 5 yrs of the period referred to above be appropriate/ recognisable experience in a relevant specialty after obtaining the 1 year post-basic qualification in the relevant speciality. ▪ At least 3 years of the period referred to above must be appropriate/recognisable experience at management level.

(Department of Public Service and Administration, Annexure A, 2007:21, 22, 28 & 32).

ANNEXURE R: Job Description of Assistant Manager Nursing (Specialty)

Job title of post	**Assistant Manager Nursing: Specialty**
Minimum qualification required	▪ Basic R425 qualification (i.e. diploma/degree in nursing) or equivalent qualification that allows registration with the South African Nursing Council. ▪ Registration with the SANC as a Professional Nurse ▪ A post basic nursing qualification, with a duration of at least 1 year, accredited with the SANC in one of the following specialties: o Advanced Midwifery and Neonatal Nursing Science o Advanced Psychiatric Nursing Science o Child Nursing Science o Medical and Surgical Nursing Science: Critical Care: Child Nursing Science. o Medical and Surgical Nursing Science: Critical Care: General. o Medical and Surgical Nursing Science: Critical Care: Trauma. o Medical and Surgical Nursing Science: Operating Theatre Nursing. o Medical and Surgical Nursing Science: Ophthalmological Nursing. o Medical and Surgical Nursing Science: Orthopaedic Nursing. o Medical and Surgical Nursing Science: Occupational Health Nursing Science. o Medical and Surgical Nursing Science: Oncology
Experience	▪ A minimum of 9 years appropriate / recognisable nursing experience after registration as Professional Nurse with the SANC in General Nursing. ▪ At least 5 yrs of the period referred to above be appropriate/ recognisable experience in a relevant specialty after obtaining the 1 year post-basic qualification in the relevant speciality. ▪ At least 3 years of the period referred to above must be appropriate/recognisable experience at management level.

Department of Public Service and Administration, Annexure A, 2007:21, 22, 28 & 32).

ANNEXURE S: INDIVIDUAL INTERVIEW SCRIPT

Individual Interview ANM

Interviewer: Good morning and let me take this opportunity to thank you very much for giving me this opportunity and for availing yourself and I know it was very difficult to schedule this meeting as you are the head of this academic hospital and you are very busy and you are really unavailable but thanks once again for giving me this opportunity. My name is Vatiswa Makie and I am a registered PHD student at the school of nursing at the University of the Western Cape and I hereby invite you to participate in this research because you are the head of this academic facility and you have the insight of the assistant nurse managers in your public health facility the purpose of this research project is to develop a Human Resource strategy of the competencies of the assistant nurse manger in the public health facilities in the western cape. The individual interview will last no longer that 45 minutes and the question that I will be asking you is ' what are your expectations about the competencies of assistant nurse manager in the public health facilities in the western cape and I have provided you with an information sheet and I will just ask you to sign the consent form and I will be voice recording you because I won't be able to write down everything that you will be telling me but I will be making some field notes and I want to inform you that the information that will be discussed will be kept confidential, no-one will have access to this information only myself who is the principal investigator or researcher or my supervisor Professor Karien Jooste and the independent coder who will analyse the data and I am not aware of any risk associated with this research task and the benefit of this task can indirectly benefit future assistant nurse managers when they are appointed in fulfilment of their job description and if you feel that you want to withdraw, you don't feel comfortable in participating in this research, feel free to withdraw, you will not be penalised or you won't lose any benefits, and if you do have any questions, you can ask me- the principal investigator, there's my contact details that I will leave the information sheets with you or you can contact my study supervisor Professor Karien Jooste or Professor Jose Franse who is the Dean of the faculty of community and health sciences. Okay now we can start, okay what are your expectations as the head which is the senior manager of this academic hospital, what are your expectations about the competencies of the assistant nurse managers in your facility?

Interviewer: What are your expectations about the competencies of Assistant Nurse Managers?

Participant: Okay eh thank you for giving me the opportunity that you have given me today. I think eh one of my expectations in regard to the competencies of Assistant Nurse Managers. Let me start administrative duties and eh I think we need more exposure with regard to the role in. Okay one of the expectations is that I think we need exposure although some of us have done nursing administration I think we need more courses in terms of eh being upskilled in what is happening in the institution because you find out that whatever we have people studying

in terms of nursing administration but when you come to the clinical setting it is totally different, so I think we need more courses that will upskill us in terms of being competent and eh in terms of being able to function very well in the hospital setting. And the other thing is that what I have noticed is that eh what some of the things that are studied in nursing administration are totally different to the clinical setting. I think we need eh some courses at a I will say at established institutions like the course that we did with the UCT School of Graduate in term of shaping the managers more to gain more managerial skills and I also think that we need platform where we can also ventilate not to say frustrations our challenges of the setting because at the moment we don't have a platform or a forum where we can voice out how we feel things can be changed. And there is a lot of things that we need exposure in because we are exposed in different manager sorry leadership styles part of change management is some upskilling or information session in regard to that. I also think that we need more exposure or more things like symposiums where we can also be upgraded because I have attended a session last year some of the private hospitals and I noticed that from the public institutions we are far behind in terms of eh, eh skills at the skills as compared to the to the private hospitals. We need more financial courses so that we can be able to manage our own components because we are we have moved to cost centre management. We are supervising operational managers that are cost centre managers and we've got challenges there in terms of eh, eh, eh financial management so I think we need more exposure in terms of financial management. And the other thing that I have also noticed is that we have a challenge because if you look at the changes like from the OSD sorry to the previous system that was used to the OSD now there is a 7 years' experience, that 7 years' experience when people come we are under the expectation that people know certain eh, eh, eh responsibilities but when they come to the institution we need to start from, from scratch. So those are the challenges that we are also facing. So I also think that we need to I don't want to say foundation or but exposure or programmes that can lead to, to effectiveness or to ask managing the system very well because the challenges that we have at the moment, manage your component and you find that people have got lesser experience. They didn't get much exposure so I think that when start in their position we need eh a programme for them so that they can be able to, to function very well. And the other thing is I don't know whether I am not

Interviewer: Okay you indicated that eh there is nursing administration courses that is expected of these Assistant Nurse Managers to do.

Participant: Yes

Interviewer: And whatever that is taught there you have indicated that is different from the clinical setting. Can you perhaps just substantiate in terms of this difference. What is different from what they are taught and the clinical setting?

Participant: Okay when you come I will say that when you come to the clinical setting nursing administration it becomes very broad. Like let me make an example of recruitment and

selection, now when you are an Assistant Manager you are expected to start from RS 1 that is filling of the post, advertising and follow that process up the end up to the RS 12 where you do the reference check. Now you find that some of us never had that exposure, never studied or it was not part, it was not in detail, and now it is in detail and now you get a challenge of getting the details. We need to start from scratch learning this RS 1 what is RS 2 up to RS 12. So those are the things that we need to start to be exposed in those issues and now when it comes to also to the financial management you know that you have got a budget for this and that now comes to the reality where you have to manage the money now you separate it, you have got your staffing, you have got budget for consumables, you have got your budget for pharmaceuticals, where you have to make a consolidation on a monthly basis and it becomes difficult because people never get an exposure in those issues. And also eh in terms of your financial planning you get your equipment you have to prioritise now. It's like managing your own budget but when you were taught it was like eh, eh combined you just get the knowledge now is the reality. And the reality I think it has let us I have to expose because we are also on the rat when it comes to budget this year because of the I won't say incompetence I think people were not aware that we have to function on a limited resources and now people ended up eh eh eh eh expanding or or or spending money on I won't say unnecessarily and the other thing you have also noted is that the packs that are in the hospital are totally different. When we start working we need to be exposed what is the package of care of the institution. Now we come we don't know the expectation and other people don't even know what is the package of care, what are we expected to do. What have we, eh what are we supposed to look as the managers because when I'm talking about the package of care that has also impacted on our budget because in my component we stating with lots of patients for CBS and these patients are blocking the beds now we have to book an extra person, extra people to look after these patients. So that has an impact on the budget, impact in our budget so if we can have sessions on, if we can have sessions, get upskilling, be knowledgeable and be mentored, that's the other thing that I think it's also important mentorship in terms of like guiding us on what are we expected to do in the public sector.

Interviewer: Okay, can you just elaborate on this package of care, what do you mean by package of care and CBS?

Participant: Oh by the package of care, each and every institution is given eh eh eh I could say a booklet on the services that are supposed to be rendered by that institution. I am working in a primary, sorry in a district hospital where there is specified period of the patient that is the average length of stay, what are we expected to do what kinds of patients, what are we supposed to do if a patient is not a level one hospital which has got an impact in the budget also on the average length of stay. Package of care it determines what level of care can we render, so now in our institution we sitting with a problem of the step down patients where the patients are coming, let say it's a CVA, the prognosis is poor we are not supposed to keep that patient we

are supposed to have a plan immediately where we can be able to transfer the patient to other institutions or step down facilities.

Interviewer: Eh CBS what does CBS stands for?

Participant: CBS is community based system services.

Interviewer: Okay, alright. You also eh indicated that you need to Assistant Nurse Managers need to have more managerial skills; eh can you elaborate on these managerial skills? What do you mean by more managerial skills?

Participant: Okay when I was eh referring to that it was an exposure to more yes. Okay what I can say is that I think working here has been an eye opener because we had a lot of people that were coming from different institutions and we had a lot of challenges where sometimes we thought a lot of people already knew some of the things manager is supposed to perform. So what we discuss what we came up with is that we need to start from the basics, that is staff performance management system, all the human resources related issues, the things that we think that people will know, because it has also impacted on the audit that was done, because you found out that the managers also are not clued up of what type of leave, how to feel the basic things we thought they know like the filling of leave forms and how to manage the Pilir system so we felt that as from next year we need to start to creating a programme for them starting from the basics that involves the management.

Interviewer: Okay, can you tell me more about your expectations of the Assistant Nurse Managers in terms of their competencies?

Participant: Okay what I can say is that since I have been appointed as an Assistant Nurse Manager I have performed lot of projects and eh from this hospital I think it is totally different to other institutions because the role that we are supposed to fulfil I feel it is not, it is not complete we are I do not want to say too dependent to too dependent on Deputy Nurse Managers to take decisions, I feel that at some point we are supposed to be given a platform where we are supposed to take decisions on our own so as to take decisions and to consult not to like finding independent because we have to report at the end of the day. There are, there's a lot of things that we are supposed to do like we are, I felt that we are supposed to manage our component, eh eh totally without having to eliminate certain responsibilities, like I make an example if maybe one of my staff members is leaving at the end of the month, I feel that it is my responsibility to feel a staff change to make an example to make sure that I feel that post I do a panel for the interviews and fulfil everything but it is not happening like that, there are certain gaps and also the financial side I am also not happy from the financial side that okay we booking agencies but we receive invoices. We used to fill the invoices, we don't fill the invoices its filled at another level at the end of the month I feel I need to compile a report for my component of which I am not able because certain information is going to different people. Of which I feel that I am supposed to compile my own report with everything that I did at the

end of the month. And I also feel that if we can be given a platform that beginning of the month we submit our monthly plans what we are supposed to do on that month including our meetings, our in-service trainings, our intervention everything then we submit but it is not happening like that. So I think if we are able to be guided and be given a platform where we can perform independently but also with the administrative support because currently we don't have administrative support we do everything on our own. We fill the books, we sent the documents human resources we do our own filing but I think we need to be given our own administrative support in order for us to function independently. Because we have gaps because when I was mentioning monthly planning that will also be able to teach our own OPMs to have monthly plans so that when we evaluate at the end of the month they can write their own reports about the issues that I have raised in terms of finance, in terms of staffing, in terms of in service training done everything that they have done we can be able to assess them every month on the basis of how far are they and their challenges, how they have overcome those challenges but at the moment is totally different.

Interviewer: Okay, all right eh I don't know whether you have touched on all the duties. You have mentioned that you did lot of duties as an Assistant Manager Nurse, I don't know whether you have covered all of them in management component.

Participant: No I did not I did not mention the quality side because we also have a role in the quality side in terms of IPC OHS auditing ensuring that SANC registrations of the staff members in terms of and also auditing of the files.

Interviewer: Okay what does IPC and OHS stands for?

Participant: IPS is Infection Prevention and Control and OHS is Occupational Health and Safety.

Interviewer: Okay, eh you have said that in appointment of these assistant nurse managers they need to have 7 years' experience and eh so when they come they do not have the experience that you are expecting the person to have and based on that you indicated that they should follow, there should be a programme which were promote the efficiency and the effectiveness. So what programmes are you referring to in terms of working towards efficiency?

Participant: Okay as I have mentioned earlier its different programmes that I was referring to like in terms of the whole human resources processes starting from leave management, up to recruitment everything, staff performance management, and also on the financial side because when people come, they become cost centre management, managers but they do not have that background of managing those cost centres. So I was referring to issues like that, I also think that if you can have information sharing sessions best care eh practices with other hospitals to find out how far are they with the summit that we have recently attended that we predominantly attended by private hospitals. I have noted that they are sharing best practices like to ask, let

me make an example Medi clinic, and like Melomed they will ask how do you manage like let say eh your infection prevention control unit and then they will share their practice. So I think we can do that as the government hospitals what I have noted is that there is no uniformity also comes to standardisation of the documents, there is also no uniformity. Maybe we canon have forums where we can share so that we can be able to be on the same platform. It will also assist and also maybe a programme that the government can initiate like the one of this place at UCT, not that one because that one is an advance one but a basic one where we can be on the same platform.

Interviewer: Okay, anything else in terms of competencies of Assistant Nurse Managers based on the leadership styles you mentioned change management right, is there anything else that you really want to add on these eh the expected leadership styles?

Participant: You know it is eh very difficult to determine how a person should manage a component but eh from my previous exposure to different nursing managers I also think that we need to, I don't want to say uniformity h I don't know whether I should elaborate more to say because I have noticed that there is no, there is no uniformity and I also think it creates a confusion from the Assistant Nurse Managers side because you get exposed to this leadership style and this way of doing thing. There is no standardised format on how certain things should be done. Let me make an example when we started we done procedure and we had a procedure manual, then one manager came, she said there is no such thing to call a procedure manual it is a policy manual. We had to change a procedure manual to a policy manual. Then another one comes I want a procedure manual, now you are this Assistant Nurse Managers we are a link between an OPM and Deputy Nurse Manager, we are conveying the message to them but at the end of the day we are caught, we are like victims expected to follow this style irrespective of whether sometimes you query if times how things are supposed to be done but we are expected to just follow. That is why I think we need our own forum. We also need to be mentored by someone by one person that will tell us how a hospital is supposed to be done how are our duties supposed to be performed, so that there can be uniformity across the board.

Interviewer: All right, anything else you want to share?

Participant: I think I have raised all my expectation's and I hope this is also going to be escalated to top management so that there can be an intervention. Sometimes we are caught in between we don't know what irrespective of Job description we have at the end of the day you find that our duty is overlapping, because you will be told that in a certain hospital this is done, and this is not done there, based on what you have.

Interviewer: Thank you for your time and your valuable input, much appreciated.

ANNEXURE T: FOCUS GROUP DISCUSSION

Focus Group Discussion OPM

Interviewer: good morning everybody, operational managers. My name is Vatiswa Makie, I'm a PHD student at the University of the Western Cape and my topic is Human Resource Strategy to facilitate the competencies of assistant nurse managers in the public health facilities in the Western Cape. I invite you operational managers to participate in this research project and if you don't feel comfortable to participate, feel free to withdraw. All the information that will be discussed in this study will be kept confidential, I am not going to mention your names, I will have access to this information and my supervisor will have access to this information as well and my independent coder. After I have collated the information I will develop a tool, an instrument, a questionnaire that I will request assistant nurse managers to complete regarding their current competencies and existing competencies. So you are going to assist me with information so that I can develop this tool. I am not aware of any risks associated with participating in this research and the only benefits will be that we can address the competencies of assistant nurse managers if there is any gap that needs to be identified and if you don't feel comfortable to participate, feel free to withdraw. if you do have any questions regarding the research you can contact me Vatiswa Makie who is the principal investigator or my supervisor who is Prof. Kariem Jooste at the University of the Western Cape or the Dean of the Faculty of Community and Health Sciences who is Prof. Frans. There is a confidentiality form that you can write your name and your signature and this is going to be unstructured, I don't have structured questions, we just need to talk, I will ask you one question and as you are giving me information, I will probe. Is everybody comfortable? Can we go ahead? Okay. I have mentioned that I will be recording you and myself, the reason for that is to enable to capture everything because I will not be able to write everything you are going to tell me.

Interviewer: what are your expectations about competencies of assistant nurse managers in the public health facility? You do have assistant nurse managers in your health facility?

Participants: yes

Participant 1: do you want us to go down the line or what?

Interviewer: Anyone that wants to start can do so, feel free to participate. What are your expectations about the competencies nurse managers in your facility? Anyone can start, you got your assistant manager, you as operational managers what are you expecting, what are your expectations in terms of the competencies of assistant nurse manager.

Participant 2: an assistant manager nurse must have management skills

Interviewer: okay

Participant: we also write it down, we like to make notes

Interviewer: okay its fine you can, you said they must have management skills, can you substantiate what you are referring to when you say management skills

Participant 2: they must have skills to operate you know to do their work, they must have certain skills because we must believe that or you can have training or you have the experience

Interviewer: Okay

Participant 2: training or years of experience of how to manage people, so ja

Interviewer: okay is there anything else, they must have management skills, they need to operate and do the work, they need to have certain skills, and I just need to know what are these skills you are referring to?

Participant 3: for instance in leadership, in their style of communicating and I think when I speak of leadership I mean that they need to identify their type of leadership style that is suited to the type of work that we do, to the sub-ordinates and also to the superiors; the employer, her supervisor or his supervisor and my indication of a supervisor is to guide and to mentor, I shouldn't be afraid to say: ' I don't know what you want from me' or ' I don't know what this means' because I have experienced people asking me: 'how and why don't you know this' and why is not he question to ask, they question is 'guide me' and I think reasonable availability and as a junior manager I need some support.

Interviewer: support, yes, you mentioned they should have a leadership style, can you substantiate on this type of leadership styles, you said they should be knowledgeable, should guide, mentor, approachable and also available, anything in terms of this leadership style

Participant 2: you get different kind of leadership styles like there's people that lead in a group or people that lead upfront and the people follow or a leader can lead from behind, you know, where the people are and you will watch them from behind so there are different ways, each one have their own leadership style.

Interviewer: okay and what are your expectations in terms of that leadership styles.

Participant 2: uhm… the way you lead it should uplift your sub-ordinates…

Interviewer: ermm…

Participant 2: but it also leaves space for you to grow

Interviewer: okay anything else? tell me about your expectations of an assistant nurse manager as an operational nurse manager reporting to this person, you are reporting to an assistant nurse manager?

Participants: yes

Interviewer: anybody else

Participant 3: can I just say

Interviewer: yes

Participant 3: I am a manager on a certain level, she's my supervisor, I should be confident to go to her and she should provide me with the answers that I do not have because you encounter problems in your unit so you can follow up on a certain extent on that problems so she should be knowledgeable especially the answers I need so that I can manage my unit further

Interviewer: okay

Participant 4: I think it's important also to look at their leadership styles is also the communication, their communication style

Interviewer: ermm…

Participant 4: as we said earlier if somebody ask you 'so why don't you know that this is not from here', the way you address me, how you address me, when you address certain issues, the relevance of the issue to what my crisis might be or what my need is will determine whether or not I have confidence in that person that leads me and do respect me as part of communication

Interviewer: okay

Participant 3: actually must be an advocate for me and my sub-ordinates whenever she differs from others when they complain about us, we need an advocate for us as well someone you can go to that's trustworthy or when you have personal issues then they don't have to hear by this one and that one.

Interviewer: okay anything else in terms of your expectations about the competencies, you wanted to say something

Participant 5: I just wanted to say I agree what you say and I just wanted to touch on the confidentiality, whatever you tell her must just stay in confidence and it will also count as her interpersonal relationships, not just only with the unit managers but also the people working on the work grounds as well

Interviewer: ermm…

Participant 5: what I also expect from my manager is that she mustn't be judgemental and like sister Williams could say 'she must give good guidance' and in a big bracket she must be accessible

Interviewer: okay

Participant 4: and she must be fair as well because there are a lot of people working under her

Participants: yes

Participant 6: but they must also bear in mind that he/she is also human

Participant 7: and to be a manager you must really be interested in people and not think the people are just workers and I mean like we all have problems and sometimes is effects your work performance that you must give, they must just have a listening ear and if u listen then maybe you'll have an understanding why the person is performing the way they are

Interviewer: okay, thank you, the element of guidance is coming out strongly, she must be able to guide

Participants: yes

Interviewer: they must be able to provide guidance; I want you to elaborate on this guidance

Participant 6: guidance for me is I see it as she…

Interviewer: be able to guide you in what way

Participant 6: yes, she must be able to guide me and it must include training as well you understand what I mean?

Interviewer: uh-ha

Participant 5: I feel as an operational manager, we don't belong in this post and there's a lot of stuff that we don't know

Participant: Ja

Participant 5: and especially in disciplinary cases, we don't know how and where and what and she is supposed to guide you or contact that person and tell us to ask that person or something like that and confirm how to do it because we don't know everything and I feel that every case is different and we don't always know and I feel that person should be able to give that guidance

Interviewer: so you mentioned disciplinary procedures

Participant: yes

Interviewer: okay anything else in terms of guidance

Participant 5: she must also have that confidence to tell me that she doesn't know and refer me to someone that knows

Participants: yes

Participant 5: because you get sometimes really confused when the manager tell you something and then you get to somebody else and you get some other feedback from them

Participant 6: I think we must look at whole aspect of FBU's and the impact it has on managers especially our seniors that are their managers and it becomes hard for them to look eye-to-eye with their assistant manager because the FBU has an expectation of this person, I have an expectation of this person and sometimes it's not the same thing. For me it was hard at first to understand why nursing issues needs to be so exposed in front of other people who don't know about the Psychologist and X, Y and Z or the social workers and nursing stuff lies right here and for me that was the problem

Participants: it's still the problem

Participant 6: there are some things that don't need to be discussed

Participant 8: we maybe hear about things that are being disciplined but nursing things they need to be open

Participant 9: I think it's the illness of the FBU's, the illness of the staff they discuss it there but you don't hear about the others, the absent problems, family problems

Interviewer: just explain to me what this FBU is

Participant 5: the Financial Business Unit and then there's the head of the FBU where they discussed patient matters and staffing matters, the area managers' responsibility is now split between the FBU's and the normal clinical nursing duties so the support must go to the FBU and the clinical nurses

Participant 6: and the area managers are part of that FBU's

Participant 5: yes

Participant 6: they are always shifting executive responsibilities *(laughing)*

(Mumbling)

Interviewer: just before we proceed, somebody mentioned the area managers, and who are they? are they the…

Participant 5: the assistant managers

Interviewer: assistant nurse managers

Participants: yes

Participant 6: assistant managers managing an area

Interviewer: okay

Participant 6: or and FBU

Interviewer: okay, and then I heard you saying shifting responsibilities, I need to know what are these responsibilities that are being shifted to the operational managers, what are these responsibilities

Participant 6: firstly the morning management meetings are for the FBU representative in the morning now...

Participant 7: just speak about those representatives, who do they comprise? its people within a working unit selected in the area to represent themselves, it's usually one member per discipline that nursing assistant manager will be part of the representatives

Interviewer: You mentioned that in the morning there is a morning FBU

Participants: yes

Interviewer: management FBU

Participant 6: they expect the representatives of the FBU to be part of

Participant 5: that meeting

Participant 6: of that meeting yes but now you are standing in for that meting then there is 4 FBU members, now they look at you…

Participant 7: don't you want to go and hand over

Participant 6: yes don't you want to go hand over and 4 of them sitting there, they part of the FBU why can't they go and take the things over because… then they always shift it over to the operational managers

Participants: yes to the operational managers

Participant 6: so then I take my book and get up and walk out

Interviewer: so one on these responsibilities is to standing in for the assistant nurse managers when not available in the FBU

Participants: yes

Interviewer: okay and then any other responsibilities?

Participant 5: it's not always in the FBU's, it's also when the assistant managers are on leave, attending a training course of having duties off-site so the assistant managers they appoint someone of the OPM's because some of the FBU's are fairly big so some people rotate regularly and this standing is for the NM and then you still have your own work to do, you have 2 wards and then you still have to do those 2 wards as well

Interviewer: okay, anything else of your expectations of the competencies of the assistant nurse managers

Participant 7: we spoke about the assistant manager and the due role that effect you and the nursing component I felt often decisions within an FBU and you stand in and its way over your head and I have been in those meetings maybe for months, 2 months in a time because finds herself sick and then I am supposed to stand in for her, I have no clue because a lot of the FBU stuff don't filter it down to the ground level what is expected and what I also felt that the things that are being discussed at that level at such an extent that they sometimes think they have filtered it but it hasn't and so you feel humiliated, I felt humiliated and to be told ' oh let's wait for so and so because she'll know'

Interviewer: so that leads to the aspect of communication that one has already mentioned because I was going to ask if you just can substantiate about this communication, so you are saying that the message does not get filtered through to the OPM's that is expected to stand in when the need arises, okay anything else in terms of the aspects of communication

Participant 7: my feeling is often on frustration and I often voice it but I have oblate to say too much and a lot of decisions are made on higher level and we are told this is how it's going to be and this what you are going to do with no clear guidelines sometimes how to do things with no compromise, no dialog, we are told and that frustrates me because I feel that I have something to say even if it is just to say 'thank you'

(Laughter)

Participant 7: but I have found like I am saying to you I have learnt to guard my tongue and I have learnt from some of my colleagues and you just accept who you… you don't want to isolate yourself as a troublemaker because you sometimes sense unspoken communication directed at you

(Laughter)

Interviewer: okay you have mentioned that decisions are made on higher levels and no clear guidelines, can you just elaborate a little bit more on those guidelines for an example what guidelines that you are referring to

Participant 6: in every other area when we sitting in those high level meetings you hear ' the SOP for this, the SOP for that and nursing has nothing to do with drawing up SOP's' and then

you sit afterhours in the manager's office and you dread the phone ringing because you yourself has no ears, some thought that a patient had died, not too long ago we weren't informed about the changes of the notifications with the death declarations and I still don't know an two weeks ago I was hoping that nobody dies, I was praying that nobody dies because I was going to snap

(Laughter)

Participant 6: and come again in two weeks' time….

(Mumbling)

Participant 6: it has become a ritual and that is what I am talking about and it's not as if did not raise it and in that meeting of the OPM that took exactly in this room it was raised but then we were silenced, 'don't' and ' why do you want to' because the decision can't be talk to Mrs Swartz that we need to have clarity, we are ill equipped even in the offices that we work in because you fall around, we don't know what's going on, there's no stationary, there's nothing, the computer didn't work for a while some of us doesn't have access but u are you expected to have things up to date

Participant 6: we don't even have proper offices

Participant 6: and we were silenced by our ANM's 'this is not the time to talk about it' so when is the time to talk about and this was raised, this platform was created for us to raise our concerns not just to use for the line function meeting that the assistant nurse managers attends to get us up to speed of the petty issues and this is real for us, we were silenced and never came up again

Interviewer: okay SOP what does that mean?

Participant 6: Standard Operator

Interviewer: so you are saying that sometimes there aren't SOP's to guide you on how to manage

Participants: yes

Interviewer: okay

Participant 6: even through it is a challenge like for instance if you work the weekend especially when it deaths, who must come fetch the body, the one time it's the ambulance and then the other it's the drivers, we don't actually know what's happening and the changes, they just need to keep up to date about the changes

Interviewer: so it stills go back to communication

Participant 7: and even that vast incident that they brought out now the other day they brought us our old forms and I said I don't know what does this mean, I don't know this form they didn't even communicate to us and say 'okay this is the new form and you must complete this for now'

Interviewer: and you people are expected to manage

Participants: yes

Participant 7: we are supposed to give guidance to our sub-ordinates because you look stupid in front of them, how don't know the things so how can you be our manager

Participant 8: I had that same experience with the LH forms…

Participant 7: what forms?

Participant 8: it's the Lentegeur Hospital insures form we refer it to the LH1 form, that is the number on the form that we order from the stores, so if order the monthly consumables, I let somebody go through the stationary form in order for us to order from our stores and then I came to the LH1 form and I said ' order 50' and I had a draft copy of the new adverse incidence form but I wasn't sure if it was in practices yet because I saw it was I draft copy and I got back from 2 days off and I got hit over the head with ' you got this forms and you people are sending these forms, just please destroy it' and I was thinking ' what is going on', I was in the ward on Friday, I didn't know we using these forms, I can't come back the Wednesday and get tracked left, right and centre, people don't communicate, people don't know how and I was thinking who was supposed to communicate these are now the forms that we are using

Interviewer: okay

Participant 8: you had the graph but you don't look at 'let's implement it'

Participant 7: the communication is very poor my dear

Interviewer: okay, you also mentioned that you as operational managers order monthly consumables so what are your expectations in terms of the assistant nurse managers, what is her responsibility in terms of the monthly consumables, you operational managers are ordering the monthly consumables?

Participants: yes

Interviewer: so what do you expect in terms of the competencies of the assistant nurse managers nursing in terms of this?

Participant 6: the assistant manager they have to authorise the order which means they have to go through and I have to motivate which we often do where it is not required in writing and if I order 60 pens instead of 10 then I can say to her we using it for our patient groups that

blows the ink out on the paper, which is not a lot of effort there and I haven't experienced any difficulty with that and sometimes when we struggle to get an order or communication from the store like I have ordered a stethoscope according to me if you haven't received it when it was delivery time they told us in a meeting that if you didn't receive it then it wasn't approved then just order again, I'm sitting with 6 now, so ja something is not lekker anymore

Participant 7: something is not lekker in the stores

(Laughter)

Interviewer: so are you saying that in terms of resources it is not managed properly that is when I am saying resources I am talking about consumables because that the mere fact is that you say you had so much instead of so much so should there be a resource financial management

Participant 7: that is the FBU supposedly but they are not yet managing their own finances, each FBU should have their own budget that they need to control and it's not controlled by the central budget

Interviewer: so the assistant manager has nothing to do with that budget they don't have a responsibility of managing that budget

(*Mumbling)*

Participant 6: the agency budget that they need to manage

Interviewer: oh so they need to manage the agency budget

Participants: and the overtime

Participant 7: only the agency budget that belongs to the FBU that we have 360 000 starting off at the end of the year so how they use their agency and the expenditure needs to reflect each time someone works overtime, we need to attach that

Participant 6: so there is a system in place

Participant 7: there is a system in place that controls the overtime and the agency but the store items there is a slight change in that when I phone and then she says there nothing ordered like that so there is also someone that is standing in for someone then they say no there no order like that please order again but in the mean time they are waiting for procurement because I'm not receiving anything definite and then the next month I order again and again and now in sitting with 6 stethoscopes

Participant 8: sometimes it's necessary for the assistant manager to gibe input because the people are complaining about the store's system management because we waiting for items,

there's a delay, we are sort, the items are not coming and all that so there is a definite need for their input

Participant 6: which could make the job easier for them because previously it has been asked that the stores please notify the wards if an order has not yet been procured but if you tell them then they tell you 'not if it has not yet been done then you must wait' and what if this happens then u didn't order it and then it becomes a nursing issue

Interviewer: anything else in terms of the competencies that you can maybe think of that you want to add

Participant 7: I thing of the issue in availability, we spoke about being available and communication, I don't think IDS has a system because we work in two different areas, IDS in connection with availabilities

Interviewer: What does IDS stand for?

Participant 7: Intellectual Disabilities Services and Psychiatric Services, and sometimes IDS will have their separate meetings to what we have here and sometimes we'll have combined meetings, they have different areas but they form of the FBU but my availability difficulty is again the after hour weekend availability, the doctors know if I am on duty today this my consultant that am going to stand in by and tomorrow that is the person I'm going to work with, we've asked for that repeatedly that we as nursing staff know who is the stand by MMA because when I am in a crisis I know who I am going to call, on a Sunday morning 9 o'clock when I am in a crisis I know who I can call not Mrs so and so is in church and that one is still sleeping because she partied last night and that one is not going to answer the phone because she's off duty then I must now search for the names of my colleagues that's not in church, that didn't party last night and still sleeping, you know, so that I dent eliminate myself in the time of need. In writing we don't have that kind of guidelines so who is the next person I can call

Interviewer: so it goes back to communication

Participant 7: and mostly we don't know each other, we know a limited amount of people

Participant 9: that is also about support, we have a lack of support

Participant 7: we don't get much support

Interviewer: okay can you elaborate on that

Participant 7: no that's what I mean; I speak for all of us

Interviewer: okay

Participant 7: we are basically supporting each other more than the support we get from the managers

Interviewer: anybody else

Participant 6: with no disrespect intended but sometimes every manager and even the 1st lady at the hospital are ruled with fear that you may make a mistake, you may look stupid so they not say what needs to be said and always intimidated and where does that come from and I this question I often ask myself and like I said to you we raised certain issues but we were silenced but we learn over a certain period, this is what is expected

Interviewer: okay anything else you want to add

Participant 7: there are times when the managers and I am referring to all of them don't talk down that are more visible, more actively involved when they profile visitor and when there are national clause standards and when there is training, then you find them very supportive and they are very organised and that is often that nursing in lower levels will bring up but where are the matrons, why aren't they here

Interviewer: you mentioned something very interesting about the national core standards, what are the national core standards?

Participant 7: it is the declaration of the orders and the national clause standards we have various people that must give us training on the spot from the QA manager to the APC manager and the directors coming in and attending our meetings and the dieticians and all those people that are not normally part of our meetings because our meetings are about ' this ward needs cutter and that was replaced etc.' the very essential stuff that falls in place, this is how we do things now, the day before the national clause standards arrive that's when we start putting all in place.

Interviewer: can somebody else add on that what does national core standards entail?

Participant 6: don't you know them (laughing)

Interviewer: no I don't know them

Participant 6: we've talking about it for a while now (laughing)

Participants: it's just procedure and stuff, things that needs to be in place, compliances, the national assurance plan

Participant 7: it's not a provincial thing it's for the national health, core standards

Interviewer: you mentioned standards, can you give me a few examples of those standards

Participants: clinical care, and how long does your patient wait…quality control…emergency disaster plan, diagrams

Interviewer: you also mentioned accreditation

Participants: that was before the ordering thing, it can be very competitive of who was the best and that, who won the prize between the OPM's

Interviewer: okay, anything else, do you want to give me more information

Participants: no that's enough (laughing)

Interviewer: thank you very much again for the valuable input that you have provided

ANNEXURE U: CERTIFICATE FROM AN INDEPENDENT CODER

Qualitative Data Analysis

PhD in Nursing

Vatiswa Makie

THIS IS TO CERTIFY THAT

Dr. Annie Temane has co-coded the following qualitative data:

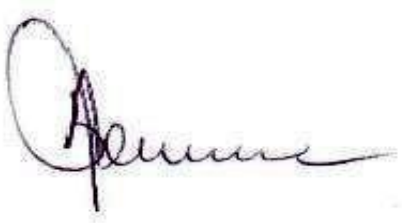
Individual Interviews and 8 Focus Groups

For the study:

A HUMAN RESOURCE STRATEGY TO FACILITATE COMPETENCIES OF ASSISTANT MANAGERS NURSING IN THE PUBLIC HEALTH FACILITIES IN THE WESTERN CAPE

I declare that the candidate and I have reached consensus on the major categories, sub-categories and codes reflected by the data during a consensus discussion. I further declare that adequate data saturation was achieved as evidenced by repeating categories.

Annie Temane



M.A.Temane (D.Cur; Research Methodology) annie.temane@gmail.com

ANNEXURE V

CONFIDENTIALITY AGREEMENT

CONFIDENTIALITY AGREEMENT WITH REGARDS TO INDEPENDENT CODING OF DATA FOR THE STUDY

A HUMAN RESOURCE STRATEGY TO FACILITATE COMPETENCIES OF ASSISTANT MANAGERS NURSING IN THE PUBLIC HEALTH FACILITIES IN THE WESTERN CAPE

I understand that identities of all participants are personal and confidential and may not be revealed to any person.

I understand that the research design and method of this study are intellectual property of the researcher(s).

I understand that all material received for coding is personal and confidential.

I understand that all material received will be deleted on completion consensus discussion with researcher(s).

I undertake herewith to treat the following information with utmost professional confidentiality:

a) The name of each participant wherein a name is indicated
b) Material received
c) Content of the information made known to me of each person
d) Content of the research design and method of this study

Independent Coder Name: Dr Annie Temane

Signature:

Date: 17 March 2014

Researcher's name: VATISWA MAKOE

Researcher's signature: .....

Date: 17/03/2014