Development and implementation of a staff development plan for
nurses in one district in Zambia based on a learning organization
approach

SUBMITTED BY

MIRIAM CHILEMBWE LIBETWA

In fulfilment of the requirements for the degree of Doctor of Philosophy (Nursing)

School of Nursing, Faculty of Health Sciences,

UNIVERSITY OF KWAZULU- NATAL

DURBAN

SOUTH AFRICA
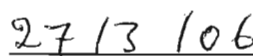
SUPERVISOR: Professor Oluyinka Adejumo

2006

DECLARATION

I, Miriam Chilembwe Libetwa, declare that this thesis titled "Development and implementation of a staff development plan for nurses in one District in Zambia based on a learning organization approach" is my original work. It has never been submitted for any other purpose, or at any University for any other degree or examination. All sources of information which I have used or quoted have been indicated and acknowledged by means of references.
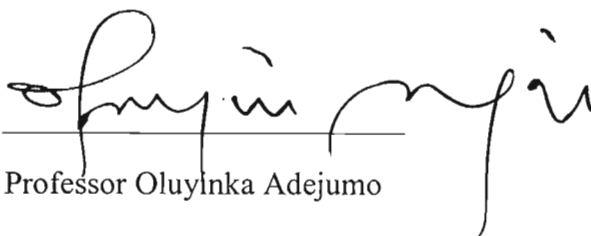
Signature: _MClbeh__

Date _27/3/06_

As the supervisor, I have approved this thesis for final submission.

Professor Oluyinka Adejumo

DEDICATION

In memory of my younger sister and brother, Phyllis Kazeu Chilembwe, Jimmy Baishi Mawala Chilembwe, and my best friend, Elizabeth Nakaumbwe Lambwe, who were laid to rest during the preparation of this thesis. Their smiles during trying moments served as an inspiration to me for continuing the struggle of education.

And

My understanding husband, Nawa Libetwa, and my four lovely children, Nalumino, Namakau, Ndyeke and Mwauluka. You have a special place in my heart. God's richest blessings to you all.

ABSTRACT

This study explored the existing planning systems that nurse managers in health institutions in the Lusaka district in Zambia used to plan staff development activities, with a view to developing a model suitable for a staff development plan for all nurses in Zambia.

The learning organization and transformational learning theory frameworks were used to guide the study. The learning organization framework was based on Senge (1990), The Fifth Discipline, which addressed five components, namely, systems thinking, personal mastery, mental models, building shared vision and team learning. The transformational learning theory framework was based on (Gravette 2000), which addressed the reflective and constructive processes that employees go through during their learning.

A survey and action research methods were used to explore the planning systems which nursing managers in the Lusaka district used to plan staff development activities. The total population of nurses designated as nursing managers, registered nurses and enrolled nurses working in the central hospital (734 nurses), in the specialized hospital (128 nurses), and in 31 health centres (980 nurses) in the Lusaka district constituted the target population.

Systematic sampling was used to select a total of 614 participants; only 368 nurses returned completely filled questionnaires. A staff development tool jointly developed with the participants also served as a means of generating data for the study. The quantitative data were analyzed according to the Statistical Package of Social Sciences (SPSS) 11.5 version, using frequencies and percentage distributions. Framework analysis was used to analyze the collected qualitative data.

The major findings of the study revealed that nursing staff in the urban district of Lusaka were not using systematic methods based on any known approach in planning staff development activities. Using a learning organization framework, a model of staff development was jointly developed with the participants, as well as a checklist for assessing staff when utilizing the model in a Zambian setting. The study concluded that the developed learning organization model was capable of facilitating the development of culture of lifelong learning among nurses and midwives in Zambia.

ACKNOWLEDGEMENTS

Table of contents

Chapter 3   Methodology

Chapter 4 Data Analysis

Chapter 5 Discussion

List of tables

List of figures

CHAPTER ONE

Introduction to the Study

1   Background to the study

Staff development is recognized as a dynamic and active concept which is a continuous activity (Joint learning strategy 2005). Staff development, according to Truelovemore (1998) is defined as the process by which individuals, organizations, and societies develop abilities (individually and collectively) to perform functions, solve problems, set and achieve objectives. Knowles (1998) defines staff development, as a process of developing and/or unleashing human expertise through organizational and staff development for the purpose of improving performance. Other authors, for example Joost (1995), point out that staff development is seen as having three cornerstones, namely, continuing learning and changing process, better use and empowerment of individuals and organizations, and required systematic approaches.

In 1992, the Government of the Republic of Zambia embarked on a radical health reform process that was aimed at providing Zambians with equity of access to cost effective quality health care as close to the family as possible. The major focus of these reforms was the development of district health systems for providing basic health services to all Zambians. To enhance implementation of the health reforms, the Ministry of Health developed a national health strategic plan which was communicated to all stakeholders (Midterm report, 2004). To facilitate the implementation of the strategic plan, staff development activities were conducted both at national and district levels. According to Ministry of Health (2004a) the staff development activities, reportedly, were mainly providing knowledge and skills in

financial management systems to three members of staff in management positions at all levels of care namely, Province, District and Hospitals. The report further stated that staff development programmes were centrally arranged and participants were doctors, clinical officers, environmental health technicians and nurses. These staff development activities were delivered in an ad hoc uncoordinated manner and were not based on assessed needs. At times participants were grouped according to their professions, and sometimes according to the positions they held.

It is common knowledge in Zambia that each tertiary health institution in the country has an in-service department responsible for staff development. Each institution conducts staff development activities. The plans developed by individual health institutions, however, including the extent to which these plans addressed the staff development needs of the nurses and midwives are either not known or unclear. This was evident because of the absence of documentation or descriptions of the staff development activities which were done. Another area that was not specified or articulated was the extent to which the individuals responsible for staff development were prepared for implementing staff development programmes.

At national level, the Ministry of Health (2004a) speculated that there was no comprehensive staff development strategy for qualified nurses and midwives. The extent to which staff development activities addressed the health service needs was also not clear. The Ministry of Health (2004a) further indicated that staff development activities were conducted on an ad-hoc basis and often under central control. Most of the staff development activities are known to be in the form of off-site training which took staff away from their posts for lengthy periods, disrupting the flow of services

(Ministry of Health 2002). The world Health Organization (WHO 2002) indicated that a well designed system of staff development was needed, as distinct from ad hoc sessions, which were not strategically linked and were therefore not particularly developmental. A developmental approach facilitated professional and personal growth in nurses and midwives, and the development of the organization in which they worked. A system of staff development was therefore part of the suite of organizational development strategies where theory, skills, knowledge, attitudes, and behaviors were strategically aligned within nursing and midwifery.

The Zambian Ministry of Health's ten year human resource plan (2001) indicated that although staff development activities were conducted every year for various cadres including nurses and midwives, the extent to which accurate records on capacity building for nurses and midwives and other staff were kept was not clear.

The Zambian education and training policy (2000) indicated that effective delivery of health services required intensive and continuous investment in staff development. This policy pointed out that when staff development was relevant, appropriately designed and organized in a cost effective manner, it was an investment that brought dividends for the individual, organization and the overall quality of service. In a study on staff performance in Zambia, Sikopo (1999) however indicated that policies and guidelines to streamline staff development activities in the health sector were lacking and needed to be strengthened if staff development was regarded as an investment. Confirming the existing situation, the Zambian hospital policy (2003) indicated that staff development workshops for nurses in the health sector were being conducted by various stakeholders without taking into consideration the national development health

priorities. WHO (2002) indicated that a strategic plan for nursing and midwifery development was required in order to provide clear direction for nursing and midwifery workforce development and the expected key result areas. It is not clear the extent to which the mentioned staff development programmes were evaluated from time to time to ascertain their usefulness.

According to the Ministry of Health (2004b), Zambia had been fortunate as it had received practical assistance from the international community through financial and technical support to increase local capacity, which included staff development. Despite this support, the Ministry of Health itself had noted that staff development was seen as a less urgent priority than other areas of expenditure (Ministry of Health, 2002).

In Zambia, the hospital policy (2003) indicated that there was no system which was in use in general handling staff development issues for nurses. For example in the institution where the researcher previously worked, the manager made a list of all the professional staff in the department. When there was a request to nominate one member of staff to attend a staff development course, the person who was next on the list was asked to attend. Upon return, there was no deliberate strategy by management through which this person could share what he/she had learnt with the rest of the workmates. In this way, only one individual had current knowledge in that area. Furthermore the utilization of the knowledge and skills gained from such a workshop might not be utilized due to the placement of the individual and the course having not been related to the job performance. According to Ministry of Health (2004a), staff development was not related to learning needs of individual staff.

Recent policy had attempted to emphasize that unless and until deliberate collective learning strategies are activated and supported by management, staff development efforts will be futile (Zambian hospital policy, 2003). The Ministry of Health (2004) pointed out that ideally, staff development programmes needed to be based on a process of matching the competency requirements of a post against an individual's current level of skills.

1.1   Statement of the problem

Despite some of the known efforts of the Ministry of Health in capacity building of staff in the health sector, there was no clarity on the type of plans that were developed for nurses and midwives to facilitate their continued acquisition of knowledge and development of the appropriate skills. WHO (1996) stated that properly designed staff development was the key to the development of excellence in nursing practice.

In Zambia there was no known staff development model for health sector staff, including nurses and midwives. Available data showed that there were models that were in use elsewhere such as the transformative model and the learning organization which were providing direction for staff development. WHO (2002) on staff development indicated that despite efforts by countries to improve the utilization of staff in the health sector towards better health outcomes, the implementation of appropriate strategies had been slow, with variable outcomes in different countries. This was partly due to the lack of consistency between countries in the development and implementation of staff development policies and strategies and also the fact that

the health sector reform programmes that countries were undertaking had inconsistent and inadequate approaches towards development of staff.

Megginson, Banfield and Mathews (1999) alluded to the need of having studies on innovative strategies or models for staff development if professionalism among staff was to be upheld. WHO (1997) pointed out that changing nursing practice required changing staff development approaches in an equally fundamental, proactive way. Other researchers (Senge, 1990; Pedler, Burgoyne and Boydell; 1996, Larsen, 1996) have described varying capacity building models among which was the learning organization model which facilitated new and open-minded ways of thinking where people were given freedom to develop their collective aspirations and individuals continually learnt how to learn together. It was the absence of such a strategy that necessitated this study which is aimed at developing a suitable staff development model for nurses and midwives in Zambia.

The absence of a model or strategy to direct staff development in Zambia in order to maintain and increase competence in nursing practice motivated the researcher in conducting this study.

1.2   **Purpose of the study**

The purpose of this study was to explore existing staff development activities among nurses in Zambia, with a view to developing and implementing a staff development plan based on learning organization approach model of staff development that could be used for all nurses in Zambia.

1.3 Objectives of the study

The following were the objectives of the study:

1 Analyze the existing planning systems for staff development among nurses in Zambia.

2 Develop a learning organization model of staff development for nurses in Zambia.

3 Develop a tool to assess implementation of this staff development model among nurses in Zambia

4 Assess the feasibility of the staff development model developed for nurses in Zambia.

1.4 Research questions

The following were the research questions for the study:

1 What is the current status of staff development in Zambia?

2 What are the essential components of a staff development model for nurses in Zambia?

3 What tool will be considered appropriate to assess staff development among nurses in Zambia?

4 What factors are essential for effective implementation of staff development in Zambia?

5 What assessment outcomes in the staff development model indicate the desired change in practice?

1.5 Significance of the Study

Heath (1998) stated that over the last decade nursing had progressed from a reliance on empirical theory applied to practice to the recognition that experience developed knowledge that could guide the actions of practitioners. Despite this, literature on studies on staff development undertaken in Africa and in particular in Zambia was not

available. An organizational approach to learning and development with a focus on innovation and activity is essential. WHO (2002) pointed out that a strategic plan for nursing and midwifery development was required in order to provide clear direction for nursing and midwifery workforce development and to define the expected key result areas. To address WHO (2002) concerns there is need to develop a staff development model to provide the framework for developing a plan for integrating a learning culture identity, developing nurse managers and staff, and maintaining focus on the values of participating organizations. The outcome of this study will also contribute significantly to the available information on staff development models in other African countries.

It was the intention of this study to explore and analyze the staff development planning systems that were in use in Lusaka district in order to provide systematic documentation on suitable strategies or models for developing nurses and midwives in Zambia. The strategy or model would be vital in building the competences of nurse managers in health institutions to plan for staff development activities systematically.

When staff development activities are systematically planned, nurses and midwives in Zambia should have a better understanding of the necessary knowledge and skills required for them to develop a culture of lifelong learning. If nurses and midwives in Zambia adopted the concept of lifelong learning while they provided the services to clients, the efficiency and effectiveness of their services would be beneficial to the community accessing health services at all levels of health care provision in the

whole country. This outcome should lead to an increase in the number of clients seeking a variety of services at all levels of service provision.

In light of the world's focus on human resource management and the concern to provide quality services to patients or clients (WHO 2002), this study could inform nurse managers and planners to enable them to plan appropriate staff development activities systematically for nurses and midwives. The systematic staff development plans would enable the nurses and midwives to acquire job related and behavioral skills to improve their potential to deal with varying client needs, personalities, and circumstances which are critical for delivering superior service. Provision of superior services by nurses and midwives could facilitate uplifting of the image of nurses within Zambia, Africa and at the international level.

The existence of this study may influence the formulation of policies which would mandate and enhance the commitment of health organizations to implement the staff development model not only in Zambia but in the whole of Africa. Existence of staff development policies would empower regulatory nursing councils in Zambia and within the African region to implement mandatory continuing education for re-licensing of nurses and midwives. Furthermore this study could serve as a bench mark for monitoring and evaluating of staff development in health institutions.

This study serves to provide documentation on the process of the implementation of the staff development model in Zambia to enable country, regional and international health authorities to replicate the study on a large scale. At the time of this study there was no documented evidence on any existing staff development model in

Zambia. This study has thus added to the current body of knowledge in the area of staff development because the study may be used as a frame of reference for staff development all over the world.

Concepts arising from this study may provide foundation for generating future research in addressing staff development. The study might stimulate others to establish how often the valuable time of nurses and midwives is wasted or misused when staff attend staff development sessions which do not meet their needs. It would be constructive to assess the staff development programme after 6 months of its implementation to establish its merits and demerits.

1.6   Operational Definitions

Learning Organization

The term learning organization refers to an institution or organization in which employees' at all levels, individually and collectively, are continually increasing their capacity to produce results according to their professional standards.

Midwives.

This term includes registered midwives who had done one year of a post basic training course at a registered midwifery school and enrolled midwives who had done one year of a post basic training course at an enrolled midwifery school.

Mental Health Nurses

This term refers to mental health nurses who had done one year of a post basic training course at a mental health nursing school.

Nurses.

This term includes registered nurses who had done a three year course at a registered nursing school and enrolled nurses who had done a two year course at an enrolled nursing school.

Nurse Managers.

This term includes senior registered nurses, sisters in charge, nursing officers and principal tutors of training institutions

Organizational Learning

This term refers to the process an institution or organization undertakes for improving individual and collective actions through better knowledge and understanding

Planning systems.

This term refers to scheduled activities/strategies, to enhance nurses' and midwives' learning.

Improved performance.

This term refers to providing quality service to clients and meeting organizational and individual targets.

Performance management.

This term refers to the development of individuals with competencies and commitment, working towards the achievement of shared meaningful objectives within an organization that supports and encourages these achievements.

Reflection

This term refers to looking back, thinking about what happened previously and, it is hoped, learning through and from those experiences.

Staff Development.

This term refers to planned activities or sequenced sets of activities aimed at developing the appropriate knowledge, attitudes, skills and competencies of nurses and midwives for improved performance in a defined area and thereby contributing to their professional growth and improving the performance of their organization.

Staff Development plan.

This term refers to a schedule of activities reflecting education and training priorities for enhancing the building of competencies for nurses and midwives in order to improve their professional growth and that of the organization.

Structure.

This term refers to the hierarchy within the profession, with the nursing officer in the topmost position for the nursing profession.

Teamwork.

This term refers to work done by a group of people who know that success or failure does not depend on individuals alone but on each and every member of the team.

Theatre Nurses

This term refers to registered and enrolled nurses who had done one year of a post basic training course at a registered or enrolled theatre nursing school

CHAPTER TWO

Literature Review

2 **Introduction to chapter two**

The literature review in this study addresses the general perspective of staff development and how it relates to the performance of any organization which includes training programmes among its employees. The literature was grouped into learning organization approach, staff development in the corporate sector and staff development in the health sector. Literature on learning organization emphasize on the five disciplines of learning as expressed by Senge (1990). Literature on staff development based on learning organizations in Africa, including Zambia, was not available. Literature on staff development in the corporate sector is used to provide a non-health sector perspective of staff development for boosting the performance of staff and organization. Non-health sector literature was used with the view of adopting some of the suitable concepts in developing a framework for staff development for nurses and midwives in Zambia. Literature on staff development in the health sector highlights the WHO concerns and efforts in strengthening human resources for health in order to ensure provision of quality services to clients in Africa and in the whole world.

2.1 General perspective of staff development

Employee training and development emerged as a major educational enterprise because of the demand in the workplace for employees at all levels to improve their performance in their jobs, to acquire skills and knowledge, to do new jobs and to continue their career progress in a changing world of work. Employer organizations

depend directly on the competence and productivity of their work forces for survival, in the fierce economic competition of the world market place. Technical change, economic change, demographic change and other forces continually create new needs for learning by the workforce.

Workers in any organization are the most important resource (David, 2000). Investment in the continual professional development of the workers through in-service training contributes to raising the quality of their work and achievement. Bagwandeen (1993) in discussing in-service education states:

> "There is no upper limit to human resource preparation. The continuum of preparation can therefore cover the individual's entire career. It has been stated repeatedly over a long time that initial training cannot provide the fuel and supplies that any worker needs for a lifelong journey" (p.26).

WHO (1998) on human resources for health indicates "In all countries of the world, human resources constitute the most valuable asset because, in addition to their economic impact, they enhance the value of all the other resources by converting them into socially useful products" (p.2). If a company is to develop its full potential, the top managerial, commercial and technical skills need to be considered as assets. This means that the company needs to assess its needs for these skills, invest in their expansion and maintenance, and allocate its limited supply of these skills to the most promising divisions and projects. No organization which handles its employees as expense items can make as wise plans or as rational allocation decisions as the one which recognizes explicitly the asset characteristics of its human resource. Robert (1995) indicates, "Talented and capable employees are the bedrock of an organization. These employees are people, who work on a daily basis to translate the firm's strategy

into tangible products or services to customers" (p.303). Equally important, employees represent much more than simply a company's head count or staff. They represent vital sources of knowledge and are the "eyes" and "ears" of the organization. Employees' close and continuing contact with customers and operational activities makes them a wellspring of knowledge and ideas for the firm. Their daily contact with customers gives them an edge over senior managers in sensing whether the firm appears to be moving in the right direction. When given the necessary knowledge and skills these employees could quickly identify potential areas of improvement among the firm's activities. They were also the same people who would be most likely to know how best to deal with the problem and suggest ways for improvement. WHO (2002) on human resources development for health indicates, "It was the health workers who, made health interventions happen. Yet very little progress had been made in tackling human resources development issues" (p.1). All these sources agree that ongoing employee development was critical to the short and long term success of every business, profit or non-profit.

2.2 Defining Staff Development

Knowles (1998) defines human resource development as:

> "a process of developing and/or unleashing human expertise through organizational development and personnel training and development, for the purpose of improving performance at the organizational, work process, and individual levels" (p.120).

The use of the term 'staff development' has become quite common in recent times. Some regard the term as being the same as in-service education, which Joost, (1995) defined as "an education programme designed to provide staff with necessary skills

and knowledge to meet the demands of their current jobs and, as such, staff development was perceived as a new term for an old activity"(p.3). Indeed in this context staff development had become a new buzzword in current educational thinking. Staff development however, needed to be seen as involving much more than in-service education. Joost (1995) argues that the development has two components:

"Firstly, it involved the development of management and leadership skills. Secondly, it included the development of those skills required by the organization. Thus staff development was the systematic process of teaching, training and growth whereby an individual acquired skills, knowledge, attitude and perceptions" (p.49).

Ortega and Molina (2003), in a study on effects of employee training on the performance of North American firms, stated that it was known that the first step to successful human capital management was to acquire the human capital necessary to support the business plan. This required that the firm had employees with the necessary skills and motivation to perform an efficient job. In this context there are two options that the firm could adopt, either to hire employees who already had the necessary skills and motivation, or to provide the training necessary to help employees, either new or current, to develop these skills. Ortega and Molina (2003) used a survey questionnaire for executives in human capital management who worked in 405 North American firms. The findings showed that there was no relationship between training and the performance of staff. The explanation given was that the responses to the survey were given during a period of financial difficulty, which reflected in the tendency to reduce training budgets as a relatively easy way to cut expenses in periods of slack demand. The other reason was that while some firms offered more training, they could have been doing so in an inadequate manner either

because they trained in the wrong areas, such as fields that were not directly related to the employee's job, or because they did not follow-up on the training to ensure good results.

Peel (2002) indicated that training was "universally agreed to be a key to success for individuals, for organizations and for the whole economy" (p.4). Training was any activity designed to improve another individual's performance in a specific area. It must be provided to enable an employee to improve his/her job performance. Training usually took the form of organized events and required pre-set objectives and programmes for acquiring certain skills. Hellriegel, Jackson and Slocum (2002) defined training for the job "as referring to improving an employee's skills to the point where he or she could do the current job more effectively" (p.250). Gerber and Lankshear (1995) define training as "referring to the use of specific means to inculcate specific learning, using techniques that could be identified and described" (p.216). Training is therefore a deliberate effort to teach specific skills, knowledge, or attitudes to serve a specific purpose.

Peel (2002) states that development and training were frequently used in double harness. People develop throughout life, slowly, well or badly as a result of their experiences. Training was one of the ways development occurred, but there were many others, and these other influences might be more powerful. Good training, for example, may be cancelled out by negative experiences. People may be trained to do a job well, and then work with a boss or others who do it badly, and pick up their bad ways. To be effective, training needed to be supported by other influences that affected their development, their own priorities, the way people were managed, the behavior of their colleagues and the reward they were given, the culture of the organization and society.

Gerber and Lankshear (1995) define education as activities aimed at developing knowledge, moral values and understanding. Its purpose is to develop the student intellectually and to provide him with a basis for further learning. Education was required in all walks of life. While management development was a process whereby managers gained experience, skills and attitudes to become or remain successful leaders in their enterprises, in other ways the term refers to the improvement of the skills of the person (manager) or it could refer to amendment of the management function within the enterprise.

From the foregoing it is clear that there is a relationship between education development and training, and that elements of each are involved whenever a specific activity is undertaken to improve an employee's performance in the enterprise.

2.3 Purpose of Development and Training

The main purpose of development and training according to Hellriegel et al (2002) "is to overcome the limitations, current or anticipated, that are causing an employee to perform at less than the desired level" (p.250). Training, according to Gerber and Lankshear (1995) served many purposes. It gave workers direction in their jobs and acquainted them with their working environment, and thereby created the opportunity for employees to become productive quickly. This increased their loyalty and raised the morale of employees. A training programme with effective feedback and evaluation techniques enabled an employee to reach the required performance level in his job in a relatively short time and helped to improve the quantity and quality of the output an enterprise. It also reduced costs incurred through wastage, and through the need to maintain inefficiently used machinery and equipment, and reduced the number and cost of

accidents. Good training can reduce labor turnover as well as absenteeism and promote job satisfaction.

Knowles (1998) argue that if human resource development were to be aligned with the goals and strategies of the organization and performance was the primary means by which the goals and strategies of organizations were realized then it followed that "human resource development should be first and foremost concerned with maintaining and/ or improving performance at the organizational, process, and individual levels" (p.117).

Indeed if human resource development is to be a value added activity of the firm (instead of a line item of cost to be controlled and minimized) then human resource development practitioners should be concerned about performance and how it enables organizations to achieve their goals.

2.4 Factors Influencing Development and Training

Peel (2002) identified several factors influencing which influence training technological development. Most jobs used to be unskilled, or needed only simple skills, such as manual work in factories, in building and on the farm. Currently these have been replaced by the use of machinery. Today in almost all jobs no sooner have staff acquired one set of skills, than technology moves on and new equipment or techniques become available. If staff do not learn the new skills these require, they will soon become out of date. Training is no longer something that staff did once for a life–time, it was something that was done continuously throughout one's life. The increasing pace of change affected those who dropped out of a career with special force. There are few jobs, which it is possible to leave for say, 10 years and then pick up again without retraining. The following are other influencing factors. "Changed systems, changes in

customers' needs, new regulation, environmental changes, new materials and products or services" (p.26).

Rapid changes in society, technology, and values cause new and different areas of learning to emerge and old ones to fade. When this occurs, it is critical to train, educate, and enhance personnel to the meeting of challenges of new areas and provide new learning experiences for staff members. This in turn aids the organization in meeting new demands and helps the professional staff member continue employment. It can be seen that no cadre in the organization was exempted from being developed. Knowles (1998) pointed out that "one important strategic role for human resource development was to build the organization's strategic capacity, the knowledge and expertise required to figure out the present and to develop rational scenarios of the future and ways to connect them" (p.119).

In a study by Griffiths (2003) in the United States (US) on meeting the needs of the health system, a refresher course for registered nurses was done in order to establish the effectiveness of nurse refresher course programs for reentry into practice. The design of this initiative entailed collaboration between nursing faculty administrators from Jefferson' baccalaureate nursing programme and clinician and administrators from the four systems that comprised the healthcare network. The four systems that comprised the healthcare network were acute, sub acute, long term institutions and community-based delivery sites. An application tool was developed to select the candidates to be enrolled. The tool was used only at the admissions interview. The methodology used included quantitative and qualitative approaches. Participants and employers had to answer a questionnaire as well as participating in focus group discussions.

Findings of the study were grouped into participant's perspectives and employer's perspectives. The participants' perspectives showed that they were able to see dramatic growth in themselves during the short term of the course. Several participants related that exposure to different attitudes and personalities of registered nurses at their employing institution were affirming and validated their decision to return to the work force. Employer perspective showed that most employers believed that the nurses were able to meet the competency level expected in medication administration and patient care. Griffiths' study demonstrates that when training is appropriately planned paid dividends for the participants and the organization.

2.5   Staff Development and Training

The first part of staff development in this study dealt with the learning organization approach. The learning organization approach mainly emphasizes on the five disciplines of learning namely, systems thinking, personal mastery, mental models, building shared vision and team learning. Emphasis is placed on organizational learning as an organizational capacity to take effective action.

2.5.1   Staff Development and Training -Learning Organizations Approach

According to Senge (1990), philosophers of science, economists and historians indicate that the world is in the midst of major transformation, a transition from one age to another. This transformation is described as the movement from the industrial age to the formation age, the capitalist to post capitalist era, the modern to the postmodern era. Jones (1999) states that "our economy was shifting. We are moving from an economy and work force based on manufacturing material products/hard goods to an economy and workforce based on the production of services using

information and knowledge" (p.3). According to Mcdermont (1995), "Knowledge work involved analyzing information and applying specialized expertise to solve problems, generate ideas, teach others, or create new products and services" (p.10).

A study by Marlo (2003) on creating a high performing leadership team was done at Lafarge NA, which is the largest diversified construction materials company and supplier of cement, aggregates and concrete, and other materials for residential, commercial, institutional and public works construction in the United States and Canada. Lafarge NA, is part of the Lafarge Group, a world leader in building materials active in 75 countries and employs more than 83,000 people. The objectives of the study were: to gain greater understanding and alignment to performance objectives, to accelerate the development of the management group into a high performing leadership team, and to reinforce cultural norms that drive business performance within the division.

The method used for collecting data was one-on-one interviews with each member of the leadership team. These interviews provided useful knowledge to determine the overall focus and scope of the intervention. After conducting these interviews, a two-day team development session was planned that brought together all members of the leadership team. The design of this session incorporated the principles and practices of Appreciative Inquiry (AI) with the team development model for high performance. Through a structured process of facilitated dialogue, inquiry, storytelling, leadership education, strategic visioning, goal setting, role playing and action planning, the team was able to gain greater understanding, alignment and commitment to what they wanted to accomplish and how they would successfully work together to lead the division. A one day follow-up session was used to update progress on four key

leadership imperatives, to reinforce desired leadership behaviour through additional inquiry and storytelling and increase individual effectiveness.

The study identified four key leadership imperatives which were subsequently implemented. These included:

Vertical Alignment–Joint customer plans and market based transfer pricing were developed in response to the cross-functional impacts caused by the re-structuring of the plans.

Communication –Organizational changes were communicated as a result of this intervention, group goals were conveyed to all employees to ensure a unified message to provide guidance and direction on key performance indicators and to re-establish credibility with employees.

Positive Stories –A process was developed to communicate positive stories of employee accomplishment to reinforce desired performance behaviours, empower ideas, gain broad based involvement and improve feedback on employee surveys.

Roles & Responsibilities –Roles and responsibilities were clarified to facilitate greater acceptance of the change, to ensure that activities were aligned with performance expectations and re-defined reporting relationships (each member of staff knew their job expectation and responsibilities.)

Bogdanowicz (2001) states that:

> "The information age of the 1990s has evolved into the knowledge age of the millennium. Knowledge has displaced traditional assets of land, labor, and capital as the principal source of industrial value. The intellectual capital, the

sum of everything everybody in a company knows, that gives it a competitive edge, is an elusive, intangible, but critical asset" (p.56).

According to Senge (1990), learning organizations are organizations in which:

"The capacity of people to create results they truly desire is continually expanding. New and open-minded ways of thinking are fostered. People are given freedom to develop their collective aspirations and individuals continually learn how to learn together" (p.90).

This set of goals may have seemed somewhat ambitious but Senge contended that they could be achieved through the gradual convergence of five 'component technologies', which were the essential disciplines. This are now discussed separately.

2.5.1.1 Systems Thinking.

According to Senge (1990):

"Systems thinking is the conceptual cornerstone ('The Fifth Discipline'). Systems thinking is a discipline which allowed the 'whole' (organization) to be greater than the 'parts' (people, departments, teams, equipment and so on). First, while the basic tools of systems theory were fairly straightforward they could build into sophisticated models. Senge argues that one of the key problems with much that was written about, and done in the name of management, was that rather simplistic frameworks were applied to what were complex systems. We tend to focus on the parts rather than seeing the whole, and to fail to see organization as a dynamic process. Thus, the argument runs, a better appreciation of systems will lead to more appropriate action. A further key

aspect of systems was the extent to which they inevitably involve delays and interruptions in the flow of influence which make the consequences of an action occur gradually" (p.91).

Senge (1990) stated that:

"The systems viewpoint was generally oriented toward the long-term view. That's why delays and feedback loops were so important. In the short term, you can often ignore them; they're inconsequential. They only come back to haunt you in the long term" (p.92).

People often have a problem seeing systems, as a whole, and it took work to acquire the basic building blocks of systems theory, and to apply them to the organization. On the other hand, failure to understand system dynamics can lead people into "cycles of blaming and self-defense: the enemy was always out there, and someone else always caused problems" (p.93).

2.5.1.2 **Personal Mastery**.

According to Senge (1990):

"The discipline of personal mastery allowed people to clarify and focus their personal visions, focus energy, develop patience and see the world as it really is. Employees who possess a high level of personal mastery can consistently generate results, which are important to them through their commitment to lifelong learning" (p.139).

Senge (1990) states that:

"Organizations learn only through individuals who learn. Individual learning does not guarantee organizational learning. But without it no organizational learning occurs. Personal mastery is the discipline of continually clarifying and deepening people's personal vision, of focusing their energies, of developing patience, and of seeing reality objectively. It goes beyond competence skills, although it involves them" (p.139).

Senge sees personal mastery as a special kind of proficiency. It is not about dominance, but rather about calling. He sees vision as vocation rather than simply just a good idea. Senge (1990) states that:

"People with a high level of personal mastery live in a continual learning mode. They never arrive. Sometimes, language, such as the term personal mastery creates a misleading sense of definiteness, of black and white. But personal mastery is not something you possess. It is a process. It is a lifelong discipline. People with a high level of personal mastery are acutely aware of their ignorance, their incompetence, and their growth areas. And they were deeply self-confident" (p.110).

2.5.1.3 **Mental Models**.

According to Senge (1990), mental models are internalised frameworks, which support people's views of the world, beliefs in why and how events happen, and understanding of how things, people and events are related. Senge (1990) states that:

"Mental models are deeply ingrained assumptions, generalizations, or even pictures and images that influence how people (staff in an organization) understand the world and how they take action. People are often not aware of

the impact of such assumptions on their behaviour – and, thus, a fundamental part of people's task is to develop the ability to reflect in and on action" (p.110).

Senge (1990) indicates that:

"The discipline of mental models started with turning the mirror inward, learning to unearth internal pictures of the world, to bring them to the surface and hold them rigorously to scrutiny. It also included the ability to carry on learningful conversations that balanced inquiry and advocacy, where people exposed their own thinking effectively and made that thinking open to the influence of others" (p.111).

Moving the organization in the right direction entails working to transcend the sorts of internal politics and game playing that dominates traditional organizations. In other words, mental model means fostering openness. Mental model also involves seeking to distribute business (job related activities) responsibly far more widely while retaining coordination and control. Learning organizations are localized organizations.

2.5.1.4 **Building Shared Vision.**

Building shared vision refers to a state where members of staff in an organization develop shared pictures of the future together so that they are genuinely committed and engaged, rather than compliant. When there are a genuine vision people excelled and learnt, not because they were told to, but because they wanted to. What was lacking among workers in an organization was a discipline for translating vision into shared vision. "Visions spread because of a reinforcing process. Increased clarity, enthusiasm and commitment rub off on others in the organization" (p.227). As people talk, the

vision grows clearer. As it gets clearer, enthusiasm for its benefits grows. There are limits to growth in building shared vision, but developing the sorts of mental models outlined above can significantly improve matters. Senge (1990) alludes to "a state where organizations can transcend linear thinking and grasp system thinking, there is the possibility of then bringing vision to fruition" (p.227).

2.5.1.5 Team Learning

Senge (1990) saw teams as a vital element of a learning organization. Team learning builds on personal mastery and shared vision. When teams learn together, not only can there be good results for the organization, members will grow (grasp ideas) more rapidly than could have occurred otherwise.

Wagner (2000) in a study on the role of patient care teams in chronic disease management states that:

> "The delivery of health care by a coordinated team of individuals had always been assumed to be a good thing. Patients reap the benefits of more eyes and ears, the insights of different bodies of knowledge, and a wider range of skills. Thus team care has generally been embraced by most as a criterion for high quality care" (p.1).

Despite its appeal, team care, especially in the primary care setting, remains a source of confusion and some skepticism. Which disciplines are essential on the team? What do the team members other than the doctor do to support patient care? With the ageing of the population and the advances in the treatment of chronic diseases, teamwork in the context of chronic diseases needs to be re-examined. Successful chronic disease

interventions usually involve a coordinated multidisciplinary care team. To provide quality services teamwork needs to be encouraged.

Pearson (1994) in a study on primary health care teams found out that teamwork was arguably difficult if not impossible to achieve. In practice, even sporting teams had captains, though if they could not keep the team together with regard to tactics spectacular failures could ensue. An imbalance of power was not in itself a contraindication to teamwork, as it might remind everyone of the need for effective leadership. When general practitioners do not agree among themselves or do not agree on who should lead, perhaps through excessive attention to democracy, a cohesive team is unlikely to develop and survive. Team building activities can help to identify problems. Pearson (1994) further established that although team building and teamwork skills were important ways of engaging isolated individuals and strengthening corporateness, teamwork took place most effectively in the functional groups that provide patient care. These groups were small (perhaps two to five people) and focused on a single task for example, care of patients with diabetes. Everyone's role should be clear, thereby encouraging team members to take on leadership positions and to be committed to the task.

Habaghery, Salsali and Ahmadi (2004) argued that nurses commonly deal with conflict by avoidance, failing to engage differences of opinion constructively. Instead, they seek to avoid the personal discomfort of conflict, which is not a positive or constructive solution, leaving the problem unresolved. Therefore, practice did not advance. Approximately 70 percent of 1000 businesses surveyed in the mid- 1990s were organizing their efforts around work teams to realize increased productivity, higher quality output, and improved employee morale. Increased diversity in the

workplace had intensified the need for workers who had the interpersonal skills that enabled them to work cooperatively and collaboratively with others to accomplish organizational goals.

2.5.2 Organizational Learning

In Senge's (1990) five-discipline approach to organizational learning, a learning organization was defined as:

> "An organization that is continually expanding its capacity to create its future. It is an organization that changes and innovates based on continuous learning. Most important, such organizations successfully translate that learning into effective action. It is this capacity to innovate and create change that is critical to competitive advantage and success in a changing environment" (p.231).

Organizational development was the mother field that encompassed interventions, such as organizational learning. Organizational development was about people and how they worked with others to achieve personal goal and organizational goals.

Nevis, Dibell and Gould (1995) commenting on organizational learning differentiate between personal knowledge, possessed by an individual by virtue of education or experience, and collective knowledge which is identified as organizational memory or a publicly documented body of knowledge. Kim (1993) defined organizational learning as an organizational capacity to take effective action. An organization cannot however develop, learn, grow or take action independently of its human capital. Until a human puts knowledge to use it is an unvalued asset. Until knowledge is shared within the firm, it was the individual's human capital not the organization's.

MacLean (2003) in a study on building capacity for health promotion used two strategies: partnership development and organizational development. Partnership development included the creation of multilevel partnerships in diverse sectors. Organizational development included the provision of technical support, action research, community activation, and organizational consultation. The study concluded that partnership and organizational development were effective mechanisms for building capacity in heart health promotion.

2.5.3 Knowledge Work Teams

Knowledge work was activity that frequently produced new knowledge. Its core task was thinking, its output was information, it was non-linear in nature and it required mental skills to perform successfully. Knowledge has become so complex and specialized that virtually no single individual can be effective alone. Specialists, who try to do it all, are not effective. They must apply their specific skills in conjunction with other professionals and employees. They can only be successful together. Drucker (1992) stated that "the only way for knowledge workers to be adequately productive was for them to work with teams" (p.95-104). According to Drucker (1992), a knowledge work team was a small number of people with complementary knowledge and skills who were committed to a common purpose, performance goals, and approaches for which they held themselves mutually accountable. They were committed to sharing information and knowledge to achieve a collective performance that was greater than any individual team member could know or accomplish alone. They recognized their interdependency. Such teams may be referred to as interdisciplinary teams or cross-functional teams, although those terms have often been used loosely and inaccurately, leading people mistakenly to believe they know

all about knowledge work teams and teamwork. Senge (1994) stated "teams, not individuals, are the fundamental learning unit of an organization" (p.15). Fisher (1998) states:

"Those organizations that master the collective intelligence of knowledge work teams will be the architects of the future. Effective knowledge work team(s) can often create a sort of synergy where the outcome of the whole is greater than the sum of its individual parts" (p.15).

Larsen (1996) stated "those who work in a learning organization are fully awakened people, they engage in their work, striving to reach their potential by sharing the vision of a worthy goal with team colleagues" (*p.2*). They have mental models to guide them in the pursuit of personal mastery, and their personal goals are in alignment with the mission of the organization. Working in a learning organization is not being a slave to a job that is unsatisfactory, but involves seeing one's work as part of a whole, a system where there are interrelationships and processes that depend on each other. Consequently, awakened workers take risks in order to learn, and they understand how to seek enduring solutions to problems instead of quick life fixes. Lifelong commitment to high quality work can result when teams work together to capitalize on the synergy of the continuous group learning for optimum performance. Those in learning organizations serve others in effective ways because they are well prepared for change and working with others.

2.5.4 Empowerment through Staff Development

Empowerment is the process of participating in the management of an organization rather than the administration of routine tasks. The purpose of empowerment is to free

people from rigorous control by instructions and orders and to give them freedom to take responsibility for their ideals and actions. This freedom is intended to release intellectual and organizational resources that would otherwise remain inaccessible. In agreement, Larsen (1996) defined a self-directed work team as a natural work group of interdependent employees who shared, most of all, the roles of a traditional supervisor. A team was a small number of people with complementary skills who were committed to a common purpose, set of performance goals and approach for which they held themselves mutually accountable. Organization development focused on the human development side of organizations. Larsen (1996) believed that individuals who had some control over how their work was done would be more satisfied and perform better. This was called empowerment in organizational development.

The times of profound change in which we live involve both changes in the nature of work and changes in the nature of organizations, including the ways in which work is managed through those new kinds of organizations. Regardless of ultimate design of health care organizations the role of a leader must evolve to support knowledge workers.

2.5.5 Knowledge Teams in Health Care Professionals

Can health care professionals come together into effective knowledge teams? Health institutions, especially hospitals, are among the most rigid bureaucratic and hierarchical organizations, fragmented by their separate disciplines. A critical barrier, which was reported, was the traditional model in which physicians were seen as irreplaceable, powerful resources, nurses as replaceable. Physicians accuse nurses of low quality care, nurses accuse physicians of arrogance. The essence of the problem

and its solution lie in the kind of relationship that professionals can and should develop. Too often relationships between professionals, like those between the physician and the nurses are competitive, where each side takes pleasure in the apparent deficiencies of the other. A study undertaken by the North Carolina division of medical assistance in an asthma learning collaborative (2002) showed that by bringing together participants from different practices, along with experts in the clinical topic and in quality improvement techniques, a collaborative provided an effective setting for practitioners to study scientific evidence, learn how to put that knowledge into practice and make lasting improvements in their practice teams. The study reiterated the importance of leadership and team participation. The teams that seemed most successful had multidisciplinary members who actively participated in all phases of the collaboration. The teams that were less successful had only one provider that participated or they had non-physician participants or did not have input from key leaders in their organization. Support from leadership was an essential ingredient for success.

A study by Horton (2001) on evaluation of training and development in various organizations was undertaken to review training activities. One on one interviews were conducted with managers. The study established that many managers have neither the skills nor the training to do much more than keep things going from day to day and so they lack the potential for mobilizing organizational learning in pursuit of institutional and performance learning.

2.5.6 Missions, Goals, Norms, Expectations and Regulations

According to Senge (1994) the role of the leaders, whether at the team or system level, is to serve as facilitators and integrators of the team initiatives. Furthermore their role,

according to Robin (2004), is to ensure that the staff are aware of the missions, goals, norms, expectations and regulations of their institutions. Knowledge of these listed factors enables management and staff to appreciate the purpose, motives and intentions of any staff development activities arranged. Much of what motivates and inspires people to make meaning and take action is contained in the listed factors for example, a mission statement is usually meant to define internal motivation. It is meant to align and engage the agents or actors in the organization. Robin (2004) points out that goals and objectives are important because a precise arrival point is not set, it is easy to wander off the point. Objectives and goals are an important part of the strategic planning process at the institutional, team and individual basis. Individual, team, and institutional objectives and goals need to be congruent. If they are not compatible, it will be difficult for any organization to achieve its mission effectively (Payne 1996).

2.6   Staff Development and Training- Individual Approach

This section of literature focuses on how to create optimum societal responsibility for the corporate sector, staff development in the heath sector, concerns of the health reforms and efforts to improve quality of service.

2.6.1 Staff Development in the Corporate Sector

The importance of training and development is recognized by most organizations, including Coca-Cola Sabco in Port Elizabeth, one of the seven anchors of Coca-Cola bottlers in the world. Sabco lists people development as one of its core values, describing it as the realization of employee potential through training and development.

Rand Merchant Bank provides for development in the form of bursaries, job specific training and skills development. Their graduate trainee programme allows a number of graduates to embark on intensive learning by doing programmes that build practical experience in all disciplines of the bank. Hellriegel et al (2002), in agreement, stated that one of the increasingly important challenges for organizations was preparing people to be expatriate employees working in a nation other than their home country. He cites Coca-Cola Sabco with its head office in Port Elizabeth, South Africa, but with plants in Ethiopia, Kenya, Uganda, Tanzania, Mozambique, Namibia and Zambia. To be able to operate in these other countries the company undertakes extensive staff development, because without any preparation such employees may not be able to take on and successfully complete an overseas assignment. He further stated :

> "Volkswagen of South Africa (VWSA) spends, on an average, R1 million a month on training. It has its own education-training institute (ETI), which was established 20 years ago to service 6,000 employees. Volkswagen of South Africa produces vehicles not only for the local market, but also for the export market and believes that the quality of the cars was greatly influenced by the quality of training given to the people who built them" (p.250).

In agreement Smith (1994) studying corporate sector activities stated:

> "The increase in management development seen in most organizations was a response to increased competition in the current economic climate and a perceived need to increase the quality of their internal management and their service to customers" (p.53).

According to Smith (1994) a customer buys a product or service when his or her expectations have been met, or exceeded. Businesses that do not meet customer expectations do not survive in the long run. Zairi and Peters (2002) found, in their study on the impact of social responsibility on business performance, that companies that have started to make real headway in the area of societal value tend to share four characteristics: They rely on value-based transformational leadership (i.e. sponsor-headed by the Chief Executive Officer and reflected in the company's vision/mission and value statements), Cross-boundary learning (a commitment to learning, innovation and through networks and global partnerships),Stakeholder linkages (mutual benefits through various modes of relationships) and Performance levers - (use of a wide range of financial and non-financial performance measures, supported by auditing, verification, reporting and recognition systems).

In a study by David (2000) on management and sustaining competitive advantages, he pointed out that Dell Computer, for example, by pursuing a strategy of mass customization, provided its customers with the satisfaction of having their computers customized to their particular liking and budget. He further indicated creating an atmosphere of innovation by customer needs and focusing on action helped employees to meet customer requests for product and service customization, and enhanced personal relationships by delivering the customer exactly what was requested, and offering inventive after sales service.

A study by Henkoff (1993) on companies that train best, points out "that Motorola calculated that for every $1 spent on training, there was a $30 productivity gain within three years" (p.3).

2.6.2 Staff Development in the Health Sector

Staff development in the health sector included concerns of the health reform, and the efforts to improve quality of service.

2.6.3 Concerns of the Health Reform

WHO (1998) concerning health reform problems stated that:

> "Among the many resources to be mobilized to this end, human resources constitute the most precious. Unfortunately, they have not always received the attention they deserve, hence the persisting significant gaps between ongoing reforms in the health sector and the management of human resources for health" (p.1).

WHO (1998) further indicated that it was therefore crucial that the changes which were taking place in the organization, functioning and financing of health care systems needed to be accompanied by appropriate measures for developing human resources both for health and supporting institutions. WHO (2002) lists the following as factors affecting the development of human resources for health: The departments responsible for human resources for health was hardly ever structured or given the tools with which to carry out the principal functions of modern day human resources management, namely, planning (qualitative and quantitative determination of staffing needs) identification projection (determining the type of staff and numbers required and programming of those needs), production (training related to needs and job profile), management (routine, forward looking and performance evaluation). The activities of departments which deal with staff planning, training and management are currently limited essentially to routine personnel management.

According to WHO (2002) initial and specialist training in the health sciences in most countries in Africa is still focused on hospitals, despite the recognized reform needs of integrating of community involvement or the reorientation of medical training and practice such that their curriculum addressed community service. Continuing training, virtually nonexistent in the private sector, was carried out almost exclusively within specific disease control programmes or for the purpose of promoting specific drugs. For example combined meetings of private sector and public health sector are held to build capacity in prescribing antimalaria drugs, similarly for antituberculosis drugs. These training efforts must be accompanied by an organizational change of the health system in order to have any chance of success. Conversely, isolated reforms without changes in the knowledge base of the personnel will stand little chance of success. For example in Zambia health centres provide 24 hour first level service to the public while complicated cases are referred to the hospital. If staff are not able to diagnose patients that need to be treated at the health centres and those to be referred unnecessary inconveniences will be caused to all stakeholders (Ministry of Health 2004a).

WHO (2002) states that training in human resources management in Africa seemed rarely to have received privileged treatment. The expertise needed for such training especially for training permanent trainers adept in human resources management, was often lacking, there was no inventory or needs assessment and partnerships between the authorities in the training institutions concerned were also practically non-existent.

According to the WHO (2002) the tools to use to influence behavior of staff or to motivate them in most African countries were generally few or non-existent, and not adapted to the sector or to ongoing reforms, be they in the area of legislation or existing regulations, including the legislation applicable to professionals' practices, living conditions, incentives or to the professional environment. Integration between human resources development and development of the health sector was lacking. There was a mismatch between training on one hand and needs and job profile on the other. The health team appropriate to each health care delivery level was not identified.

WHO (2002) indicates that investments in training at national level and within disease control programmes in most African countries have rarely produced the expected results, probably due to compartmentalized, isolated and uncoordinated approaches to implementation in all aspects of the development for human resources for health.

Baird (2003) who conducted a studying in the U.K on what being a practice nurse really means, was commissioned to review the 40 practice nurses in Sheffield south west primary care trust (PCT). There were 22 practices and 40 practice nurses, covering a population of 120,000.An in-depth questionnaire was developed and piloted on three nurses in the PCT. A number of changes as a result were made to the questionnaire. A database was set up to help with the analysis of the data. All the 40 nurses covering a population of 120,000 were interviewed face to face. The findings showed a workforce that was on the whole highly skilled and committed but received little support with professional development. In many cases regarding their salaries there was no relationship between the nurse's skill and the grade she was on. This lack

of relationship between the nurse's skill and the grade she was on demotivated the nurses.

2.7 Efforts to Improve Quality of Service

Most countries in the world are undergoing a reform process in the provision of health care services. The main thrust of health reform was for better management and improvements in quality of service. Dussault (2002) indicates that the purpose of health sector reform is to ensure equal access to all who seek health care as well as optimal protection against avoidable causes of suffering and death. To make any improvement there is need to overcome performance gaps which are often related to ineffectiveness in addressing health problems, low efficiency in the use of scarce resources, high cost of and inequities in access to health services, consequent user dissatisfaction and donor pressure.

One of the main functions of the Ministries of Health in Zambia is to provide direction for health services, to set policies and translate these into strategies. WHO (2002) indicated that health workers are vital to the health sector, as through their respective expertise, they contribute directly to saving lives and to the betterment of the general health of the population. The impact of human resources on the health sector is significant and includes the fact that health workers are the one resource that facilitates the optimal utilization of all other resources and investment made to the health sector (e.g. the consumables, the capital equipment and facilities). Inefficient deployment and management of health workers thus results in wastage, inefficiencies in costs and poor application of other resources to priority services.

Furthermore, human resource development needs to bring about greater understanding of the socioeconomic and demographic changes which must be reflected in policies and plans for the development of the health worker and be incorporated into capacity building in the region. A thorough review of and rethink on the effectiveness of existing interventions is required. New profiles for different health cadres should be implemented in order to enhance their impact on the needy populations and on the health sector as a whole. Motivation and incentives for health workers are crucial and needed to be investigated and addressed.

WHO (2002) indicates that:

> "Developing staff means attempting to provide the health personnel needed, in sufficient numbers, with the right competence, motivation and experience, in the desired institutions and at appropriate posts, at the right time, and at an affordable cost, so that users may have quality health care adapted to the state of health of the individual and the community" (p.1).

The Central Board of Health's action plan in Zambia (2002) indicated that the content of the 2002 Action Plan was built on the National Health Strategic Plan (NHSP). The National Health Strategic Plan emphasizes the need to balance necessary long-term systems development and more immediate service delivery issues with the prime objectives of attaining better effectiveness and efficiency output. The challenge for the Central Board of Health's action plan was to become better in formulating and communicating standards, expectations and goals and to strive for excellence in performance.

In support of the health reforms concept, Ennis (2002) in his study on organizational effectiveness in Irish health care organizations, found that the effective management

of health services and the delivery of quality systems in Irish health care institutions had increased in significance in recent years. Consumers (patients) were expecting more of health care providers and were demanding higher standards of care and service. Simultaneously, those paying for health care services had become more concerned about rising health costs and possible inefficiencies. As a result there was widespread interest in understanding what made for an effective health service and in developing better practices to improve existing approaches to health care management and delivery.

Humpris (2002) in a study on shaping a vision for a new generation workforce in the United Kingdom (UK) stated that putting patients /clients and carers at the heart of modernized service was the key to reforming health and social care. No profession could be viewed in isolation: each had a territory of practice that connected and often overlapped with that of other professions, managers and non-professionals. One of the most effective ways to foster an understanding about and respect for various professionals' roles and the value of multi-professional teams was to expose medical and nursing students, other health care professionals and managers, to shared education and training.

WHO (2002) study on staff development for health accelerating implementation of the regional strategy indicated that despite efforts by countries to improve the utilization of human resources for health towards better health outcomes, the implementation of appropriate strategies has been slow, with variable outcomes in countries. This was partly due to the lack of consistence, between countries in the way that human resources for health policies and strategies were developed and implemented, and also

the fact that the health sector reform programmes that countries were undertaking have had inconsistent and inadequate approaches towards human resources for health

Competency validation from initial entry through continued employment is essential to ensure human resources for health provide safe, professional practice. Rusch (2001) in her study on competency program development across a merged healthcare network stated that verification of clinical competency continues to be a major concern within the healthcare industry. The challenge became more difficult when multiple institutions integrated to become one healthcare network, especially when each institution had its own unique approach to competency verification. The nursing leaders of an evolving integrated healthcare network were challenged to restructure existing competency methodologies into a standardized, universal process. According to Alspach (1995) "performance standards may be made explicit by reference to some written document that specifies how a task or activity is to be performed" (p.171). A criterion tool identifies performance criteria essential to performing a skill or behavior safely.

2.8. Theories of Staff Development

There are theoretical orientations that contributed to staff development and training, which are used in both individual and organizational learning namely: psychological theories of human development and learning, theories from social and culture anthropology and the transformational learning perspective.

2.8.1 Psychological Theories of Human Development and Learning

Knowles's (1998) contrast of pedagogy versus andragogy (adult learning) laid a

44

social/emotional/cognitive framework for self-directed, experimental learning that staff developers have found appealing. Smith (1982) suggested that the word (learning) had been used to describe several situations and that understanding each was important. According Smith (1982)

> "When learning referred to a product, the emphasis was on the outcome of an experiment in the acquisition of a particular set of skills or knowledge. When learning described the process, the emphasis was on what happened when a learning experience took place, how learners seek to meet needs and reach goals. When learning described a function, the emphasis was on aspects believed to help produce learning: how learners were motivated, what brought about change" (p.126).

Smith (1994) further stated that effective staff development programmes addressed all three learning situations. Using knowledge about how learning was produced (function) and about what happened when people learn (process), participants in effective programs develop new knowledge and skills as teachers and administrators (product). Effective programs themselves become vehicles for learning as an active process of transmitting new knowledge, values and skills into behavior.

According to Zemke (1981) in his paper on adult learning, "No single theory seems to have an arm-lock on understanding adults or helping us work effectively and efficiently with them" (p.3). Instead, knowledge about the various theoretical approaches is useful in designing staff development that is suitable and effective for a broad variety of learners. In any learning situation, learners undergo some type of change, and understanding the nature of change is important. Effective training

programs take into account the nature of learning and the fact that learning requires change.

2.8.2 Transformational Learning Perspective

Gravett (2000) argues in favor of an academic staff development process supported by a transformational learning perspective. (Transformational learning occurs when an individual modifies old, or develops new assumptions or views whilst seeking answers to a problem.) This perspective hinged on the notion that, in the process of development, staff would be urged to reflect critically on, and articulate, their informal theories about (their) teaching practice. "Through critical reflection they would gain a deeper awareness of their current beliefs and feelings as well as the assumptions and premises on which they were based" (p.31).

2.9 Motivation

Gerber and Lankshear (1995) study on human resource management, explained that motivation was inferred from or defined by goal-directed behavior. It was anchored into two basic concepts, namely the needs that operated within the individual, and the goals in the environment toward or away from which the individual moves. In its simplest form, the process of motivation was initiated by the conscious or unconscious recognition of an unsatisfied need and a course of action was then determined that would lead towards the attainment of the goal.

According to Hellriegel et al (2002), motivation is a psychological state that is said to exist whenever internal and/or external forces trigger, direct, or maintain goal-directed behavior. He grouped the different theories of motivation into three general approaches.

2.9.1 Managerial Approach

According to this approach, the managers that employees work with on a day-to-day basis can directly motivate employees through personal, one-on-one communication. For example they can work with employees to set realistic goals and then use recognition, praise and monetary means to reward employees for achieving those goals.

2.9.2 Job and Organizational Approach

This emphasizes the design of jobs and the general organization of the environment. In particular, employees appreciate a flexible work arrangement. Human resource management policies and practices are generally an important aspect of the organizational context. The appropriate benefits (e.g. paid vacations, sick leave, insurance, child or elder care), reward structure (e.g. incentive pay) and development opportunities (for example education and mentoring) may attract new employees to the organization. Whether such policies serve to increase effort and desire to stay with the company depends partly on whether employees perceive them to be fair and equitable.

2.9.3 Individual Difference Approach

Individual differences involve the unique needs, values, competencies and other personal characteristics that employees bring to their jobs. These characteristics vary from person to person. One person may be motivated to earn more money and prefer a job that offers such an opportunity. Another may be motivated by security, preferring a job that involves less risk of unemployment. Yet another may thrive on challenges and seek a position that stretches the person's competencies to the limit and helps the person develop new ones. According to Hellriegel et al (2002) "Effective managers

understood the individual differences that shaped each employee's unique view of work and used this understanding to maximize each employee's effectiveness" (p.396).

Hellriegel et al (2002) further stated that a manager will also be responsible for helping subordinates to perform efficiently and effectively. A manager cannot however influence subordinates unless he is willing to understand what motivates them.

Rennick (1995) indicated that in this changing time, nurse managers need to create a work environment that supports and develops their staff and their organization's interdependent goals and needs. Managers must foster effective communication, accountability, and recognition to bring out the motivation that drives the profession. For nurse managers, knowledge on employee motivation and encouragement is of utmost importance.

2.10 The Trainer's Role in Developing a Learning Culture

Since the concerns for staff development activities rested with the movement of staff members towards more openness to ideas and new ways of operating as professionals, human relations were very important. According to Human (1991), the key change for trainers lay in improving the design and process of the learning situations, eliminating learning blockages in the external environment, particularly those caused by the trainers themselves, and assisting the learners to overcome their internal blockages.

2.11 Training of Managers

The needs of an organization can only be met if managers have the necessary abilities and management skills. Management development was therefore aimed at preparing managers and improving their management and public relations skills. Hellriegel et al (2002) states that "the successful manager needs to perform four basic managerial

functions: planning, organizing, leading and controlling. These functions are interrelated and most managers perform them simultaneously" (p.12). According to Gerber and Lankshear (1995),

'Supervisors control the activities of lower level employees and through those employees in their charge they were responsible for carrying out the policy and goals of management in the enterprise. The supervisor was the one member of management who really counts in the eyes of his lower level employees. The supervisor's attitude to the enterprise affected the contribution workers are prepared to make to achieve the objectives of the enterprise. The supervisor is the link between the higher levels of management and lower level employees. Because of the link they formed between management and the lower level employees, it is essential that supervisors execute their work effectively" (p. 245).

In agreement Human (1991) stated "management development had, as its objective, higher levels of productivity, which translated into greater organizational effectiveness, the key to sustainable levels of economic growth" (p.27).

Hellriegel et al (2002) indicated that in order to improve the performance of staff:

"Managers should have skills to design jobs with high motivating potential, clearly state what employees are expected to do, provide feedback as well as rewards, attend to employees' equity perceptions and engage in continuous problem diagnosing and solving. Managers also face expanding public relations duties. They should be able to respond quickly to crises that may create image problems for their organization" (p.399).

In agreement with the need for management skills, Billsberry (1996) indicated that work-based learning which managers recognize and which is taken advantage of in the course of their everyday work can be a more powerful way of developing people than formal, set-piece management development courses which are seen as being tacked on to the job of managing. Billsberry (1996) further stated that there are three main developments in the increasing provision of work- based learning for managers. Although they overlap both chronologically and in terms of content, these were action learning, the learning organization and the competence approach. These theories demanded that management needed to succeed in putting life into an old management responsibility. If it was accepted that managers have a major responsibility for developing those who work with them, all these themes demanded a major effort from those managers

2.11.1 Women Managers

Billsberry (1996) in discussing gender issues in leadership stated that women managers actually faced a different situation from male managers. The woman managers are faced with the issue of whether, and how, to adapt managerial forms of behavior, which contradicted, or conflicted with their existing style of behavior.

The real issue was how to handle the fact of being a woman within what was likely to be a majority group of male managers in an organization which had little sympathy for understanding the contribution that women might make, let alone their potentially different contribution.

Swanepoel (1998) stated that although the United States of America workforce was becoming increasingly diverse, the predominant paradigm for educating and managing this new labor force had remained rooted in an exclusively Anglo-American male mind-set. "Even management development programmes designed to focus on females had suffered from the tendency to encourage women to think (manager) think (male)" (p.360).

The think (manager) think (male) perception assumed that women succeeded if they adopted the characteristic of effective male managers but Swanepoel (1998) urged that "women could succeed if they became more assertive, competitive (dressed for success) and more politically and socially astute" (p.360).

Swanepoel (1998) pointed out that:

> "A second wave of women were making their way into top management, not by adopting the style and habits that have proved successful for men but by drawing on the skills and attitudes that were developed from their shared experience as women" (p.360).

These second generation of managerial women were drawing on what was unique to their socialization as women and creating a different path to the top. They were seeking and finding opportunities in fast changing and growing organizations to show that they could achieve results in a different way. They were succeeding because of certain characteristics generally considered to be feminine and inappropriate in leaders

This second wave of women leaders were equipped with leadership styles that were based on consensus–building, being more open and inclusive (power and information sharing), more likely to encourage participation by others, to enhance the self worth of others and to energize them and tending to be more sympathetic than the style adopted

by many of their male counterparts. Neuman (1997) also point out that women learn and express themselves differently from men.

2.12   The Conceptual Framework

The conceptual framework provided a basis for describing the process and outcome of the staff development plan among nurses and midwives in Zambia. Conceptual frameworks considered included the transformational learning perspective (Gravette 2000) and the learning organisation perspective (Senge1990).

2.12.1 Transformational Learning Perspectives

According to Imel (1998) transformational learning in adults was introduced by Jack Mezirow in 1978. Since then it has evolved into a comprehensive and complex description of how learners construe, validate, and reformulate the meaning of their experience.

According to Mezirow (1997) transformational learning occurs when individuals change their frames of reference by critically reflecting on their assumptions and beliefs and consciously making and implementing plans that bring about new ways of defining the their worlds. Mezirow (1997)   theory describes a learning process that is primarily rational, analytical, and cognitive. Apps (1994) points out that transformation can not be mandated as it involves much more than a change. Transform existing ways of thinking and doing requires people to be convinced that there is, indeed, a need for the transformation. Transformation further involves some unlearning, which implies that old knowledge must be examined in the light of the present situation or demands, and that this examination should involve both analytical reasoning and emotions.

52

Gravett and Petersen (2000) contends that developmental processes that aim at achieving substantial modification of existing ways of thinking and acting need to focus intentionally on the fostering of transformation. Furthermore the developmental processes should not merely present the new or desired way of thinking and doing, but should involve participants in examining, enhancing and converting their personal reality. Gravett (2004) contended that our meaning structures (frame of reference) consist of two dimensions, namely habits of mind and resulting points of view. Transformational learning involves individuals' gaining an awareness of their current habits of mind assumptions and premises. It also includes an assessment of alternative views and a decision to renounce an old view in favour of a new one, or to make a synthesis of old and new, resulting in more dependable knowledge and justified beliefs to guide action.

Tailor (1998) and Mezirow (2000) list the following as some of the facets of the process of transformational learning:

> "A triggering event that leads to an awareness of inconsistency amongst people's thoughts and actions, or a realization that previous views and approaches do not seem adequate any longer. A feeling of disequilibrium, a recognition and articulation of assumptions and presuppositions that are held largely unconsciously. A questioning and examining of assumptions and viewpoints, including where they came from, the consequences of holding them, and why they are important. An engagement in reflective and constructive discourse, which is a type of dialogue in which alternative view-points are discussed and assessed. Revision of assumptions and perspectives to make them more discriminating and justifiable. Action

arising from revision. A building of competence and self confidence in new

roles and relationships" (p.55).

Nurse leaders in health institutions need to utilize aspects of transformational learning

in their working environment if the goals of the organizations are to be achieved.

2.12.2 **The Learning Organization Concept**

The other framework which was considered in this study was the learning

organization. The framework was based on Senge's (1990) fig 1, The Fifth Discipline

which addressed five components namely: Systems thinking, personal mastery,

mental models, building shared vision and team learning. The concepts according to

Senge (1990) were elaborated in detail when discussing the learning organization

concept in chapter 2 (2.5.1.1-2.5.1.5)

Below is the adopted framework of a learning organization according to Senge (1990)

Fig 1A: **Learning organization Framework (Senge 1990)**
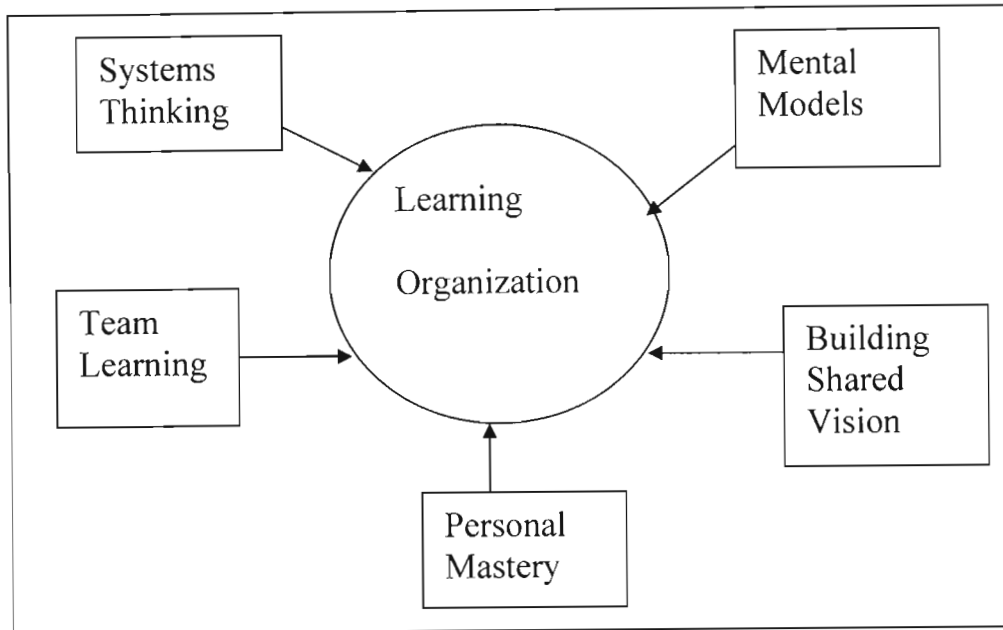
Fig1B   Transformational Learning Framework (Gravette 2000)
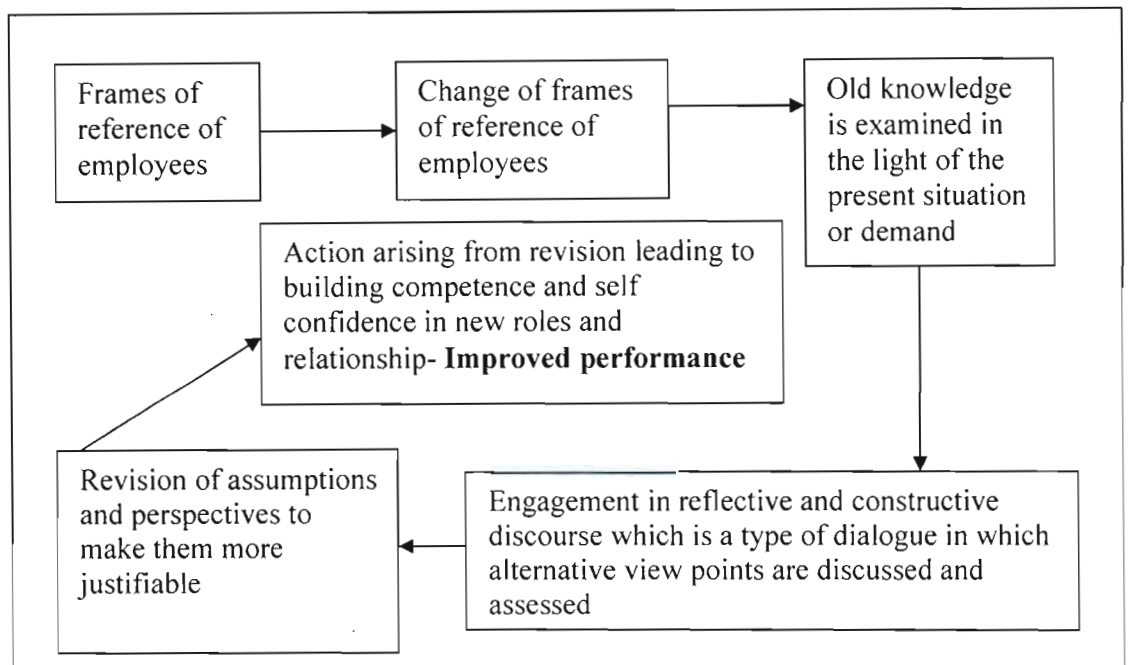
2.13 Conclusion of the literature review

There is now a shift of approach to staff development from individual staff development to organizational development. To implement this approach, managers need to be kept abreast of the new development. There is need for managers to understand other workers, accept them and release their potential by providing recognition, responsibility and opportunities for growth, learning and professional development.   Managers need to change the belief that only they can make decisions and employees, on the other hand, need to change the belief that they don't have to think on the job. Theories of learning must be applied in providing education and training for staff. Continued efforts will therefore be needed in looking for ways of turning organisations into learning organisations for the purpose of engendering the culture of staff development.

CHAPTER THREE

Research Methodology

3 **Introduction to chapter three**

This study adopted a mixed design approach, using a survey as well as action research designs. The concept of triangulating, that is using different data collection modes, is supported by Babbie and Mouton (2001) who defines triangulation as the use of multiple methodologies, methods and investigators in the same study. In this study triangulation of research designs complemented each other and made a stronger research design with more potentially valid and reliable findings.

3.1 **Research Designs**

Two research designs were used, namely the simple survey and action research designs. There were four phases in this study. In the first phase the survey design was used to collect data which served as a basis for the workshop proceedings for the human resource development plan. In the second phase the collected data was verified by the study participants as a true situation which existed in the health institutions in the Lusaka district. Using action research, the study participants and the researcher developed a joint staff development plan. In phase three the study participants constructed an assessment tool for examining the feasibility of the developed plan, through conducting workshops. In phase four the jointly constructed staff development plan was implemented and assessed, using the developed assessment tool.

3.1.1 Survey Design

A survey design was used to collect data from a large number of nurses working in the Lusaka district, in order to explore the existing planning systems that nurse managers in these health institutions used. The survey method was selected because it is particularly useful in studies that had individual people as the units of analysis (Babbie and Mouton 2001). According to Babbie and Mouton (2001), the survey method is important in collecting original data for describing the characteristics of a population too large to observe directly. In this study the respondents numbered 368. A large number of respondents was very important for an exploratory analysis (Babbie and Mouton 2001). Smith (1988) pointed out that surveys served two principal functions, namely description and explanation. Utilizing the survey method in this study was important because of its function of producing a profile of pertinent characteristics of the populations from which the sample was drawn. Babbie and Mouton (2001) indicated that careful probability sampling provides a group of respondents whose characteristics may be taken to reflect those of the larger population. The other reason for using the survey method was that the survey method generated explanations which built on descriptive data and explored the underlying theoretical reasons for the description. This study had several variables which were analyzed simultaneously. Self-administered questionnaires provided a method of collecting data from nurses.

3.1.2 Action research

According to Dick (2002) action research can also be alluded to as participatory cyclic process design. In this current study, the participatory cyclic process design was used. According to Inger (1992), the cyclic process refers to a flexible spiral process, which participants went through, which allowed action (change, improvement) and research

(understanding, knowledge) to be achieved at the same time. Dick (2002), referring to the cyclic process, indicates that it is the natural cycle which action research uses to achieve its twin outcomes of action (for example, change) and research (for example, understanding). In each cycle there was action and critical reflection. During reflection people first examined what had happened previously, and then they reviewed this material. They then decided what to do next and they then planned.

Participation by the group enabled the researcher to collect credible information. Inger (1992) stated that "the common element in participatory research approaches was that research was undertaken collaboratively with and for the individuals, groups or communities who were its subjects" (p.155). In this study, the sisters' in-charge and nursing officers were the participants. The research design was not detailed before the research started. Instead, the research design was refined as nursing sisters-in- charge and nursing officers learnt more about the situation which was being researched. The design improved and fitted the situation better, as the study proceeded. For example, after the initial meeting, the participants decided on when to meet based on the information they had gathered on the research subject. Through the cyclic process they were able to refine the activities they wanted to undertake and when they wanted to do them. Thus the cyclic processes were flexible and responsive. In this way the agenda was set by the participants and each participant was ready to present the findings in the pretest of the model and assessment instrument in their institutions. Thus the participants were involved in the data gathering, analysis and outcome. The advantage here is that the research does not have to be designed in detail before it begins. Instead, the research design can be refined as more is learnt about the situation being researched.

The nursing sisters-in-charge and nursing officers, who were the people affected by the change, were involved in the action and the critical reflection during the process of developing the plan.

According to. Inger (1992) there are three main approaches to action research technical collaborative research, mutual collaboration approach and enhancement approach.

3.1.2.1 Technical collaborative research

The underlying goal of the researcher in this approach is to test a particular intervention based on a prespecified theoretical framework. The question is to see if the intervention can be applied in a practical setting. The nature of the collaboration between the researcher and the practitioners is technical and facilitatory. The researcher enters the collaboration with an identified problem and specific intervention. The interaction is aimed at gaining the practitioners' interest in the research, and agreement to facilitate and help in its implementation. Generally this approach results in an efficient and immediate change in practice (Inger 1992).

3.1.2.2 Mutual collaboration approach

In this approach the researcher and practitioner come together to identify potential problems, their underlying causes, and possible interventions. In the action of this dialogue, the researcher and the practitioner arrive at a new common understanding of the problem and its causes, and plan for initiating a change process (Elden and Levin 1991). The practitioners involved gain new understanding of their practice and the changes implemented tend to have a more lasting character than just immediate enthusiasm caused by the change itself. The changes however, tend to be connected to

the individuals directly involved in the change process, and therefore the interventions tend to be short-lived when these individuals leave or when many new people enter the system. The type of knowledge generated from this approach is generally descriptive moves towards the development of new theory ((Elden and Levin 1991).

3.1.2.3 **Enhancement approach.**

According to Elden and Levin (1991) there are two underlying goals for the researcher using the enhancement approach. One is to increase the closeness between the actual problems encountered by practitioners in a specific setting and the kind of theory used to explain and resolve those problems. A second goal which goes beyond the other two approaches is to assist practitioners in identifying and making explicit fundamental problems, by first raising their collective consciousness. The researcher raises questions about the underlying assumptions and values, and involves the practitioners in critically reflecting on their practice and bringing to light the difference between stated practices underlying assumptions and unwritten laws, which really govern the practice. The emphasis here is on bringing to the surface the underlying value system, including norms and conflicts, which may be the core of the problems identified.

In this study the technical collaborative approach was used. The technical collaborative research approach was used to verify the extent to which an enabling working environment motivated nurses and midwives to learn continually. This approach was chosen because the researcher had data from the survey which indicated that nurse managers were not using systematic staff development plans for developing nurses and midwives. According to Inger (1992), use of technical collaborative research results in an efficient and immediate change in practice. It was anticipated by the researcher that

there would be a change in the planning systems used in Zambia. The researcher ensured that the collaboration with the nurse managers was technical and facilitatory. The researcher and the nurse managers worked together, as the researcher provided technical and facilitatory assistance to nurse managers by presenting the findings from the survey data and the concepts that supported continued learning in the health sector. The researcher, in playing the facilitatory role, planned the meetings for developing the staff development plan and the assessment tool according to when the nurse managers wanted the meetings to be. The nurse managers had control over the implementation of the plan in their institutions because they were involved from the design to the implementation in a consultative manner. This investment was to ensure that understanding was widely shared, and so was commitment to any planned change. These processes are described in detail when addressing objective two and three of this study (3.6 and 3.7). This method was selected because of the involvement of all interested parties (sister –in-charges and nursing officers who were responsible for staff development) who provided more information about the situation. The critical reflections during the discussions provided many chances to correct errors. The method enabled sisters-in- charge and nursing officers to reflect on the activities and decisions they had taken in the previous meeting before they planned for the next steps. This was especially so when there were cycles within cycles and where the critical reflection was characterised by a vigorous search for information. During the time when the staff development plan needed to be developed efforts were made to get documents which the staff had previously used in other instances, their merits and demerits were discussed and the best method was developed.

The assumptions underlying the plans were tested in action. After developing an idea on assessing staff in order to identify their training needs, the team decided on

developing a suitable method for developing staff. The concept was pre-tested for one week, after which a final staff development tool was developed.

In addition, this action research design was selected because it encouraged staff empowerment, enhanced workplace learning, and permitted staff to identify issues and make changes to achieve best practices.

Lewin (1946) outlined the process of planning action research. The process started with a general idea to reach a certain objective. The idea was then examined carefully by fact-finding about the situation. Overall plan of how to reach the objective was then formulated and a decision was taken in regard to the first step of action.

The fact-finding or reconnaissance in action research had four functions: to evaluate the action in regard to the expectations, to give planners the chance to learn and to gather new general insights, to serve as a basis of correctly planning the next step, and to serve as a basis for modifying the overall plan.

Action research proceeds in a spiral of steps. Each step is composed of a cycle of planning, action and fact-finding about the result of the action. The action research process is a problem-solving process. Lewin (1946) regards the process of research and knowledge creation as identical to the process of learning and solving in everyday situations. In this study the proceedings of spiral steps which were undertaken have been described in detail in addressing objective 2 (3.6) and 3 (3.7) when developing the staff development model and when developing the staff development assessment tool. The initial step which was taken was to utilize data from the survey for disseminating to the participants. This was followed by

identifying the problems which were highlighted by the survey data. This was followed by the participants agreeing on a model to use in constructing a staff development plan and identifying the standards which would be used to address the identified problems. There-after the model was pre-tested in the wards and health centres. The final step was to develop an assessment tool for examining the feasibility of the model and implementing and assessing the model

3.2   Population and setting

3.2.1   Target population

The target population was the aggregate of cases about which the researcher wanted to make generalizations. In this study as indicated in the Abstract on p.1v the total population of nurses designated as nursing managers, registered nurses and enrolled nurses working in the central hospital (734 nurses), in the specialized hospital (128) nurses, and 31 health centres (980 nurses) in Lusaka district constituted the target population. The participants were chosen because they were the people responsible for implementing health care services. In addition they were responsible for ensuring that the knowledge and skills of nurses and midwives were in line with the government's vision of providing health care.

3.2.2   The Setting

The setting of the study was health institutions in the Lusaka District. The Lusaka District was selected as it had various types of health institutions which provided a variety of responses from the participants. It has a specialized hospital, which offers mental health care. The hospital is a teaching hospital for paramedical officers and

mental health nurses. It has a bed capacity of 500 adult and 8 cot beds. It functions as a referral hospital for mental health care in the country.

The district also has a central hospital that is a referral and teaching hospital for medical doctors, nurses and paramedics. It has a bed capacity of 1,655 and 250 cot beds. The hospital offers specialized care in various areas such as pediatric surgery, physical handicap care, and neurosurgery and HIV laboratory services. Participation of staff from these institutions should provide in-depth information for team learning.

There are 31 urban health centres providing health services to both in-and out-patients. These health centres have between 3 and 67 beds and 1-10 cot beds. Health centres manage minor cases. All complicated cases are referred to the specialized hospital or the central hospital, including maternity cases. They all offer 24 hour services. The nursing staff working in these institutions are registered nurse-midwives, enrolled midwives, theatre nurses and mental health nurses.

3.3   Sample selection method

Participating institutions provided lists of nurses working in their institutions. The lists of nurses which were submitted were used to make a sampling frame of all nurse managers, registered nurses and enrolled nurses working in each health institution in the Lusaka urban district. Systematic sampling was used to select the participants in the study. Every third nurse was selected. The first nurse was selected randomly using a table of random numbers to pick the first name on the list. A total of 614 nurses were selected. Babbie and Mouton (2001) state that:

"Studies of organizations are often the simplest from a sampling stand point because organizations typically have membership lists. In such cases, the list of members constitutes an excellent sampling frame. If a random sample is selected from a membership list, the data collected from that sample may be taken as representative of all members, if all members are included on the list" (p.184).

In this study, the lists of nurses working in Lusaka urban health institutions which were submitted by relevant managements constituted the sampling frame.

3.3.1 Sample inclusion and exclusion criteria

The inclusion criteria for participating in the first phase of the study (survey) was being a registered nurse or enrolled nurse working in the central hospital, specialized hospital or at a health centre in Lusaka district. The inclusion criteria for participating in the second, third and fourth phase of the study was being a nurse manager working in the central hospital, specialized hospital or at a health centre in Lusaka district.

3.3.2 The sample for the second phase of the study

The selection of participants for the second phase of the study was purposive, and was based on recommendations to participate in the study by the hospital or the district management who were responsible for staff development in the respective institutions. The participants were selected because they were responsible for staff development in their wards or institutions. In addition their characteristics were similar to the population of nurses and midwives in the health institutions in Zambia, see table 2. The total number (20) of the participants was made up of 11 sisters- in-charge, 4 nursing officers(Nurse manager for a health centre or hospital department) from the

University teaching hospital and the Lusaka urban health centres, 4 tutors from the nursing schools and one officer in charge of the University teaching hospital at the in-service department. Involvement of management in the selection of the participants served as a collaboration to staff development in this study.

3.3.3 The sample for the third phase of the study

The sample for the third phase of the study comprised 3 nursing officers, 2 tutors, 4 nursing sisters-in-charge and one officer in charge of the in-service department at the University teaching hospital. The list of nurses who were recommended to participate in the second phase of the study was used to make a sampling frame of all nurse managers. Systematic sampling was used to select the participants in the third phase. Every second nurse was selected. The first nurse was selected randomly using a table of random numbers to pick the first name on the list. A total of 10 nurses were selected. Babbie and Mouton (2001) state that:

> "Studies of organizations …If a random sample is selected from a membership list, the data collected from that sample may be taken as representative of all members, if all members are included on the list" (p.184).

3.3.4 The sample for the fourth phase of the study

The sample for the fourth phase of the study comprised 7 acting sisters-in-charge, 2 teaching staff, and 2 acting nursing officers in the participating institutions. Participants for the third phase of this study made a list of all acting sisters-in- charge, and the nursing officers or tutor in charge in their institutions. Only nurse managers' sisters-in-charges of wards, health centres or departments in the participating institutions were included in this sample. The first nurse was selected randomly using

a table of random numbers to pick the first name on the list. A total of 11 nurses were eventually selected from this new group. Babbie and Mouton (2001) state that:

"Studies of organizations …If a random sample is selected from a membership list, the data collected from that sample may be taken as representative of all members, if all members are included on the list" (p.184).

3.4   Data Collection

Data collection was done in four phases. The first phase was done in a two month, period from January to February in 2004.The second phase involved the development of a staff development model and was done in 4 months between June and September 2004.The third phase was done in October 2004. The fourth phase was done in February 2005 (p.217 Annexure 5 research schedule).

3.4.1   Phase: 1 Addressed objective 1 of the study

For Objective 1, the self completion survey method was used to collect data to explore the existing planning systems that nurse managers in health institutions used. Polit and Hungler (1999) stated that a survey is designed to obtain information from populations regarding the prevalence, distribution, and interrelations of variables in those populations. Surveys obtain information from a sample of people by means of self-report. This is achieved when study participants respond to a series of questions posed by the investigator in the questionnaire. This method was selected because it collected information on the knowledge, opinions and values of a large group in a short time. As indicated on p.65, a total of 614 nurses were selected to participate in this study.

3.4.1.1 Instrument

3.4.1.2 Structured Questionnaire

In order to address objective 1 in this study the researcher developed a structured questionnaire as a method of data collection, to establish the existing systems that nursing managers used to assist them when planning for staff development. This method was selected because questionnaires were less costly and required less time to administer, especially as the sample was geographically dispersed within the district. The questionnaires offered the possibility of anonymity, which was crucial in terms of obtaining information pertaining to how nursing managers performed their work. This method was appropriate especially as the researcher worked at head office. Polit and Hungler (1999) stated that the advantage of using a questionnaire is that "the absence of an interviewer ensured that there was no bias reflecting to the interviewer...themselves" (p.269). The questions which were constructed were not complex which made analysis easier. The self-completion questionnaire annexure 2 had 6 sections with a total of 38 items to answer (The questionnaire is given as annexure 2 on pp 206-212.) The preliminary section A of the questionnaire dealt with social demographic data, section B consisted of participants' professional data, section C dealt with the activities undertaken by the human resources unit, section D covered organizational development (setting, and section E investigated the communication strategies used in the Lusaka district.All the sections of the questionnaire contained open-and closed-ended questions. Open-ended questions were included because they allowed nursing sisters- in-charge and nursing officers working in the participating institutions to provided richer information on existing staff development activities in the Lusaka district in Zambia. Collection of richer information on existing staff development activities was required in this study so that valid information on staff

development was gathered. The closed-ended questions in all the sections of the questionnaire were included to ensure comparability of responses and to facilitate analysis. The self-administered questionnaire was posted to registered nurses, enrolled nurses, sisters in charges and nursing officers. Follow- ups were done by contacting the participants by phone or radio in order to get a good response rate. The data thus collected from January to February 2004 was then analysed so that the findings could be used in the second phase of the study in June and September 2004. Detail of presentation of these results will follow in chapter 4 also see annexure 5 which is a schedule of the research.

3.5   **Phase: 2. Developing a model for staff development.**

Phase 2 addressed Objective 2

The second phase of this study dealt with the process for devising a staff development plan. After permission from the different health institutions in the Lusaka district was obtained, the researcher invited the identified participants or recommended by the district/hospital management for a meeting. The participants were selected because they were nurse managers or sisters-in-charge with vested responsibilities for staff development in their respective institutions. The positions for nurse managers and sisters-incharge were based on promotion therefore all selected participants had similar or equivalent qualifications and experience as other staff in the same categories in the whole district. The identified participants were 13 sisters-in-charge, 4 nursing officers from the University teaching hospital and the Lusaka urban health centres, two tutors from the nursing schools and one officer in charge of the University teaching hospital's in-service department for workshops. Five workshops were held

which lasted for two hours at a time convenient for the participants. In the initial workshop the researcher explained the purpose of the research.

The importance and the process of the research were discussed and explained. The researcher then disseminated the findings from the self-completion survey data to the participants to inform them and get their comments. In the second workshop the researcher presented two concepts used in developing staff namely, transformational learning perspective and the learning organization. In the third meeting the participants reflected on what was discussed in the two workshops in collaboration with the researcher decided to develop a staff development model which would assist them in developing the knowledge and skills among nurses and midwives in Zambia. In the fourth meeting participants re-examined the model and finalized it. Job training was also taken into consideration in developing the model. Mahlungulu (2001) indicated that models are structural designs consisting of organized and related concepts. Models were pictorial representations which show simplified details of concepts considered relevant to measuring specific outcomes of a discipline. Models are developed to provide some meaning to relations between concepts, enabling the user to visualize diagrammatically how one concept logically or casually influences and connects with another.

3.5.1 The purposes of the staff development model

The major purpose of a staff development model in this study was to recognize and understand the processes required in developing staff. The other purposes were to recognize the outcome of the staff development activities and to establish positive teamwork behaviors which are important in improving work effectiveness.

In ensuring technical and collaboration support the researcher maximized staff participation at every level of the model development. The technical and collaborative support facilitated effective and efficient utilization of the plan. Effective and efficient health care requires staff participation in the planning, service delivery, monitoring quality improvement and evaluation of health services. Effective participation was facilitated by the development of mutual trust, respect, integrity and good will between participants. Commitment and support were encouraged in the process of staff development for co-operation between staff hospital and health centre managers.

3.6 Phase 3 Addressed Objective 3: development of a tool for assessing staff in a learning organization

The researcher in following up participants invited the 20 selected nursing sisters-in - charge and nursing officers for the third meeting and presented to them the finalized staff development model which they had developed. This meeting (5th meeting) was held in October 2004. Through the spiral process see p.136 the participants critiqued the model and decided that they needed to implement the model and assess if it was practicable in their institutions. Inorder to assess the practicability of the developed model there was need to develop an assessment tool. During the development of the model assessment tool the participants went through flexible spiral processes. Ideas which participants volunteered were written on the flip charts, they were then examined critically one by one until the participants developed the objectives for the sister-in-charge position which is presented in chapter 4 p.136, based on the assumption that the trainees benefited by participating in the activity of being trained, they learnt by doing. In the light of this, each health centre and hospital department decided on the type of method to use for assessing the performance of their staff. They

agreed on the need to pre-test implementation of the developed model in their institutions using whatever they could use to assess staff. Each team (two or three from each participating institution) assessed selected nurses in their institutions using a check list they had developed. Having decided on what to do for the next step, what information they needed or what outcome to pursue, and what method to use lead to setting a date for the sixth meeting.

The participants during the subsequent meeting reflected on what they had done in the previous meeting and presented the proceedings for each health centre and ward in the participating institutions. After the presentations they systematically critiqued what they had done during their pre-testing of the staff development model in their institutions. It was discovered that there were discrepancies, for example some participants assessed in detail on auditing of drugs in the ward while others assessed on the type of communication which was undertaken in the participating institution. During this sixth meeting, participants reflected on what could have caused the discrepancy.

The process of reflecting on previous activity provided a chance for innovativeness in work and willingness to experiment with new approaches, communication skills, especially the ability to discuss weaknesses and strength and listen to others, flexibility and a readiness to learn from one's own and others experiences. The process of reflecting gave an opportunity for the participants to re-plan, forming a basis for the future. Dick (2002) indicates that "In each cycle there is action and critical reflection. During reflection people first examined what happened previously, they reviewed, they then decided what to do next they planned" (p. 25).

The reflective process enabled the participants to identify the need for a standard staff development tool. Having a standard staff development tool which was developed by participants was in line with Strydom and Delport (2002) who defined action research as:

> "A process in which the practitioners were included as evaluators, which featured collaborative planning and data gathering, self-reflection and responsiveness, and which embodied a substantial element of professional development. Ownership of the evaluation was vested in the practitioners" (p.7).

It was decided that only participants from selected wards and health centres needed to participate to develop the staff development tool. Ten out of the twenty participants who developed the model in phase 2 were selected to develop the tool for assessing the effectiveness of the developed model. Senge (1990) pointed out that when people worked together they "trusted each other, complemented each other's strengths and compensated for each other's weakness, aimed for goals higher than anyone might have dared individually... outcome" (p.5). According to Senge (1990), the discipline of team learning involved mastering the practices of dialogue and discussion. The purpose of dialogue was to go beyond the understanding held by each team member, and to explore complex issues creatively from many points of view. The participants decided that the position of sister-in-charge was to be used in implementing and evaluating of the effectiveness of the developed model. Hence the development of the job description of a sister in charge

3.6.1 Assessment areas of the sister-in-charge position

The same selected 10 participants from health institutions who had similar or equivalent qualifications and experiences as other staff in the same categories in the whole district in phase 3 see p.72 (those who were going to train staff in their institutions) reflected on several possible areas for assessments. The possible areas of assessment were put on flip charts, after which areas of assessment suitable for use in this study were identified. A rating scale (appendix 4) was developed for assessing the progress of the participants. The staff development assessment tool was presented to the initial 20 participants to get their input after which the tool was finalized for use.

3.7 Phase 4 addressed Objective 4: Assessment of the staff development model towards achieving a learning organization

The participants from each participating institutions assessed acting sisters-in charges and nursing officers in their area, using the assessment form which they developed. The 10 nurse managers selected from the initial group of 20 participants identified acting nurse managers in their institutions to participate in the study (table 18). These acting nurse managers were selected because they were designated as acting sisters' in charge or acting nursing officers in their institutions. Eleven participants were identified. The researcher planned a combined workshop which included the 20 initial participants and the 11 identified nursing sisters-in-charge to orient them to the developed model and to familiarise them with the developed assessment tool to get their input and commitment. The orientation was to provide them with adequate information on their expected roles and accountabilities during the implementation of the developed model. After the orientation the 10 nurse managers selected from the initial group of 20 participants assessed the eleven participants they had selected from

their institutions see tables 18-20. The researcher analysed the findings from the assessment using Statistical Package of Social Sciences (SPSS) 11.5 version.

3.8 Pilot Study

A pilot study to pre-test the questionnaire was conducted at the University of Zambia nursing department which trains nurses in the Lusaka district. The sample for the pretest was five lecturers in the nursing department who answered all the sections of the questionnaire. The responses were consistent among the five respondents except one question in section (E) question 17, which addressed the aspect of communication (Indicate how often management discussed with staff on the mission, goals, budgetary allocation for staff development, norms, expectations, regulation and direction of the organization they worked for). This comprehensive question in which many areas were investigated was split into several questions, as shown in Annexure 3. The language was checked for clarity to ensure that the respondents read the questions correctly and the clarity of instruction was also checked and was found to be correct. The estimated time allocation of 20 minutes to complete the questionnaire was checked and respondents indicated that 35 minutes were required for the completion of the instrument. Modifications were made, after which the questionnaire was finalized and was used to collect the survey data.

3.9 Validity and Reliability in Quantitative data

3.9.1 Validity

According to Babbie and Mouton (2002) validity refer to the extent to which an empirical measure adequately reflects the real meaning of the concept under consideration. Content validity was assessed using content procedure. According to

Golafshani (2003) states that:

> "Validity determines whether the research truly measured that which it was supposed to measure or how truthful the research results were. In other words, did the research instrument allow the researcher to hit the bull's eye of the research object." (p.599).

Babbie and Mouton (2002) states that content validity refers to how much a measure covers the range of meanings included within the concept. In this study, content validity was assessed using content procedure. Smith (1982) points out that content validity procedure is a measure designed to determine whether an instrument measures a representative sample of the concept under consideration. The researcher designed an instrument which measured a representative sample of staff development content. Five Nursing lecturers, two of them specialized in nursing management at the department of nursing of the University of Zambia. The lecturers were requested to judge whether the instrument content was in fact representative of staff development. The researcher then compared all individual judgments to determine the extent of inter subjective agreement. In this study there was total agreement among judges. This indicated that the instrument was measuring the essential qualities of staff development namely function of staff development unit, staff motivation and factors influencing staff development.

3.9.2 Reliability

Reliability of an instrument is the degree of consistency with which it measures the attribute it is supposed to have measured. The staff development questionnaire which was developed by the researcher was able to verify the planning systems that nurse managers used to plan staff development activities. Verification of existing planning

system In Lusaka district was facilitated by pre-testing of the questionnaire which showed consistent responses by the participants (five lecturers at the department of nursing in the school of medicine).

3.9.3 Establishing Trustworthiness in Qualitative Data

3.9.4 Credibility

The researcher carried out the inquiry in such a way that the probability that the findings were credible was enhanced, for example participants for the study were nursing officers and sisters-in-charge who were responsible for staff development and are critical in commencing in initiatives in their institutions. The findings from the survey were presented to the 20 participants recommended from the health institutions in the district. After a detailed discussion on the interpretations of the findings the sisters-in-charge and nursing officers participating in the study verified or approved them and used them as a starting point in the research proceedings. See p.81. The use of triangulation in the methods used in the collection of data also contributed to the credibility of the findings. The participants during the workshops were able to contribute to discussions freely. They were able to contribute to the discussion because the researcher and participants had worked together for a long time and had gained trust and commitment in doing the work. Due to long acquaintance between the researcher and the participants in the study in the subsequent meetings the participants freely reflected on the decisions they had taken in the previous meeting before planning for the future.

3.9.5 Consistency

This study can be replicated since procedures which were undertaken in collecting data were recorded in detail. Lincoln and Guba (1985) states that:

"There must be something tangible and unchanging out there that can serve as benchmark if the idea of replication can make sense" (p.299).

In this study if the steps which were undertaken were followed and if the human resources did not become fatigued and tend to make mistakes in conducting the workshops, findings would be similar.

3.10 Dissemination of the findings

In response to the obligation that the researcher had in informing the participants about the findings, a summary of the findings will be sent to the hospitals and health centres from which the participants were recruited. In addition the findings will be submitted to the Central Board of Health library and Institutional Collaboration library where the data will be used as resource material to enhance theory and practice in human resources management and development.

3.11 Ethical Consideration

Ethical approval was obtained from the University of KwaZulu-Natal Ethics committee and from University of Zambia Research Ethics committee (Annexure 1) Permission to conduct the study was also obtained from the Lusaka provincial health office, Chainama college hospital, University teaching hospital and the Lusaka urban district (included in annexure 1, letters of permission). Informed consent was obtained from nurse managers and principal tutors of nursing training schools. Polit and hungler (1999) state that informed consent "is a written agreement signed by a study participant and the researcher concerning the terms and conditions of a participant's voluntary participation in a study" (p.459). The informed consent is included in annexure 1, letters of permission.

Confidentiality was observed. The questionnaires which were used to collect data were given identity numbers that did not link subjects to there responses. In addition group workshops discussions were recorded in a way that individual responses could not be linked with nurse participants. The data was kept in strictest confidence. Participants were informed that they were free to withdraw at any time during the period of the study and that no cost would result from their participation. Respect and courteous treatment applied throughout the research process.

3.12 Data Analysis

3.12.1 Quantitative data

Data was analyzed using the Statistical Package of Social Sciences (SPSS) 11.5 version, which is a leading edge package in the field of data mining. It is well known for its efficiency as well as its user-friendly interface. In this study, nominal data which was categorized without an order or sequence was used. Each category was mutually exclusive; there were no limits to the number of categories. In addition there were no numerical values to the categories. The most common type of analysis techniques namely frequencies and percentage distribution, were used. Frequencies referred to the number of instances a specific response was given while percentage distribution reflected what proportion of the respondents chose a specific answer. The mode which was the most frequently occurring value was used in analyzing the data and in report writing. The statistician was consulted during the development of the quantitative instrument to get professional advice on the coding and analysis of the data.

3.12.2 **Qualitative Data.**

Data from the workshop discussions was analyzed using framework analysis. Framework analysis was explicitly developed in the context of applied policy research. Strydom and Delport (2002) indicates that applied research aimed at meeting specific information needs and provided outcomes or recommendations, often within a short timetable. The benefit of framework analysis was that it provided systematic and visible stages to the analysis process, so that the funding agency of any study and others could be clear about the stages by which the results were obtained from the data. Also, although the general approach in framework analysis was inductive, this form of analysis allowed for the inclusion of a priori (emergent concept or ideas.) in this study information from the survey findings served as a starting point in the research proceedings.

3.13   **Conclusion**

Staff development for nurses requires concerted efforts. The use of triangulation in obtaining data was necessary to achieve the required objectives. Whether the researcher relied on quantitative methods, qualitative methods, or both depended on the question the researcher was seeking to answer at the time. Credibility was maintained by involving Sisters-in-charge and nursing officers in devising the staff development plan, because they were responsible for staff development in their working environment, and knew what was necessary.

3.14 Summary of data collection

```
┌─────────────────────────────────────────────────┐
│                 First Phase                     │
│               Quantitative Data                 │
└─────────────────────────────────────────────────┘
                        │
                        ▼
┌─────────────────────────────────────────────────┐
│                 Survey Method                   │
└─────────────────────────────────────────────────┘
                        │
                        ▼
┌─────────────────────────────────────────────────┐
│  614 were selected from a population of 1,842    │
│            using systematic sampling             │
└─────────────────────────────────────────────────┘
                        │
                        ▼
┌─────────────────────────────────────────────────┐
│      368 returned the questionnaires (59.93%)    │
└─────────────────────────────────────────────────┘
                        │
                        ▼
┌─────────────────────────────────────────────────┐
│               Qualitative Data                  │
│             Framework Analysis                  │
└─────────────────────────────────────────────────┘
        │                │                │
        ▼                ▼                ▼
```

2nd Phase developing a model for staff development	3rd Phase development of a tool for assessing staff in a learning organization	4th Phase Assessment of the staff development model towards achieving a learning organization
Sample 20 Sisters in-charge, nurse managers and tutors	**Sample** 10 Sisters in-charge, nurse managers and teaching staff	**Sample** 11 Sisters in-charge, nurse managers and teaching staff.

CHAPTER FOUR

Presentation of Results

4 Introduction to chapter four

The focus of the first phase of this chapter is to present data obtained from the questionnaires used in the survey to explore the existing planning systems used by nurse managers in the Lusaka health institutions. Data from the questionnaires are represented in graphs and tables. The second phase of the study focused on data which was collected during workshop discussions with sisters-in-charge and nursing officers for developing a staff development model and assessment tool. Data obtained in the implementation phase is presented in three tables and a graph. A total of 614 questionnaires were sent out, based on the lists of names of nurses and midwives, which were provided by the hospitals and health centres. A total number of 368 (59.9%) nurses and midwives responded. Though the response rate was 59.9% of the group surveyed, this rate is well within the acceptable return rates for survey research. Keith (2002) stated that a response of 50 to 60 percent was often considered an acceptable return rate for survey research. Babbie (1990) contended that a return of 50 percent was adequate. The standards for acceptable return rates are shaped as much by how many responses a researcher can get by as by how many she should get. A number of factors influenced the rate of return. Hager (2002) stated that literature pointed to two factors that particularly influenced the expected rate of return, the type of case or subject being investigated and the method of data collection. The two most common subjects in survey research were individuals (i.e. people) and organizations (i.e. establishments or institutions). Surveys of organizations were also answered by individuals, but the questions were about the characteristics of the organization, such as the number of employees, the date of incorporation or annual budget. Surveys of

organizations typically received substantially lower return rates than surveys of individuals, with 15 percent rates sometimes reaching a level of acceptability (Hager 2002). In this study the questionnaires were delivered to workplaces, and factors such as preoccupation with work, confidentiality of information or workplace rules and policies may have contributed to the response rate. The distribution of the questionnaire and the return rate is presented in table 1

Table 1: Study sites

Institution	Distributed Questionnaires	Returned Questionnaires	Percentage Distributed	Percentage Returned
1 Hospitals				
University Teaching Hospital	300	169	48.86	27.52
Chainama Hospital	40	21	6.52	3.42
Total	**340**	**190**	**55.38**	**30.94**
2 Health Centres				
Chilenje	50	25	8.14	4.07
Chelstone	40	24	6.52	3.90
Kalingalinga	25	19	4.08	3.09
Matero Reference	25	19	4.08	3.09
Chawama	20	15	3.25	2.44
Kanyama	19	14	3.10	2.28
Zambia Air Force	19	14	3.10	2.28
Kaunda Square	18	10	2.93	1.62
Kabwata	13	9	2.11	1.46
Kamwala	12	9	1.95	1.46
Mtendere	12	8	1.95	1.30
Matero Main	12	8	1.95	1.30
Chainama	9	4	1.46	0.65
Total for Health Centres	**274**	**178**	**44.62**	**28.99**
Grand Total	**614**	**368**	**100**	**59.93**

Table 1 Shows that 30.94% of the respondents were from the hospitals while 28.99% were from health centres. The high response from the hospitals could be due to nurses

and midwives from hospitals being more familiar with responding to questionnaires, since the two institutions were teaching hospitals for nurses, doctors and paramedical officers. Staff in hospitals might have participated in various studies conducted by students as well as other stakeholders. Hager (2002) states that the reason for emphasizing an acceptable response rate is that it is not just how many subjects returned completed questionnaires that is important, but how representative the respondents were of the population being studied. The spread of the response affects how representative or valid the results are. In this study the characteristics of the respondents were similar to the population of nurses and midwives in the health institutions in Zambia. The respondents' characteristics are presented in table 2

Table 2: **Demographic characteristics of the respondents**

Characteristics	Frequency	Percentage
Age		
30-34yrs	74	20.1
35-39yrs	68	18.8
40-44yrs	62	16.8
45-55yrs	87	23.6
Total	**368**	**100.0**
Gender		
Male	30	8.2
Female	338	91.8
Total	**368**	**100.0**
Current Position		
Nursing manager	63	17.1
Registered Nurse	105	28.5
Enrolled Midwife	16	4.3
Enrolled Nurse	183	49.7
Senior Clinical Officer	1	0.3
Total	**368**	**100.0**

Table 2 shows the demographic characteristics of the respondents. Age range of the respondents was between 30 and 55 years. The range of age distribution could be attributed to the time it takes to finish the basic education of either form 2 or 5, which are the accepted entry criteria for the enrolled nursing programme and the registered nursing programme respectively in Zambia. The stipulated retirement age for civil servants in Zambia is 55 years. Table 2 also shows that enrolled nurses 183 (49.7%) outnumber the rest of the cadres who responded, although the registered nurses included the nurse tutors as well. Table 2 also shows that 338 (91.8%) of the respondents were females. This indicates until recently has recently nursing been a female dominated profession.

Table 3: **Year of appointment of the respondents**

Year	Frequency	Percentage
1965-1969	2	0.6
1970-1974	15	4.1
1975-1979	30	8.2
1980-1984	33	8.9
1985-1989	44	11.9
1990-1994	56	15.2
1995-1999	91	24.7
2000-2004	97	26.4
Total	**368**	**100.0**

Table 3 presents the number of years of the respondents have been working grouped using a 5-year class interval. The majority, 97 (26.4 %), and 91, (24.7%), of the respondents were appointed to their current position between 1995 and 2004. The range of years of appointment was between 1967 and 2004. The high number of staff appointed between 1995 and 2004

could be attributed to the period when most of the senior nurses went on voluntary separation following the public service reform programme that was launched in 1993 in Zambia. According to the structural adjustment and labour report (2000), the public service reform programme included the retrenchment of almost 20% of civil servants. In an effort to continue providing quality health service to the community, new officers had to be appointed to various positions. Vacancies might have arisen from other forms of loss. Ministry of Health Institutional Appraisal report (2001) indicated that in 1999 for all staff in the health sector, excluding casuals, the attrition rate caused by ill health and death was 2.9%. Retirement and desertion accounted for a further 3.5%, leading to an attrition rate of 6.4%, which was high.

Existing planning systems that nurse managers in health institutions use

The current status of staff development in the Lusaka district was analysed from the response to the questions that attempted to gather information on the status of staff development in the Lusaka District. Existing planning systems that nurse managers in health institutions use deal with the current status of staff development in the Lusaka district.

Table 4: **Staff responsible for training**

Staff	Frequency	Percentage
Sister in charge	104	28.26
Nursing Officer	75	20.38
Human Resources Officer	72	19.56
Medical officer	29	07.88
In service Coordinator	15	04.07
No Response	73	19.83
Total	**368**	**100.00**

Table 4 shows the frequencies and responses when asked: Who is responsible for staff development in your institution? The question was open ended and had varied responses. A list of the staff responsible for staff development was made based on the frequency. The table shows that sisters in charge, 104 (28.2%), were mostly responsible for staff development. Some of the respondents, 75 (20.3%), said nursing officers were responsible; other respondents, 72 (19.5%), indicated that the human resources officers were responsible for staff development, the remaining 29, (7.8%), indicated the medical officers and 15, (4.0%), of the respondents indicated the in-service coordinator. This question was given no response on 73 (19.8%) of the questionnaires that were returned.

Table 5: **Identification of staff training needs**

Identification of staff training needs	Frequency	Percentage
Performance needs analysis	218	59.2
No specific criteria	48	13.0
They don't identify any	37	10.1
Individual training arrangement	25	6.8
I don't know	21	5.7
By having meetings and discussing with staff	14	3.8
Through supervisors	05	1.4
Total	**368**	**100.0**

Table 5 shows the response when asked how managers identify the needs of staff for training. The question was open-ended and had varied responses. The responses were grouped according to similarities in meaning and were then coded and examples of their

statements were used in this analysis as shown in table 5. Some of the respondents, 218 (59.2%), indicated that performance needs analysis was used to identify the needs of staff for training. Other respondents, 14 (3.8%), indicated that staff training needs were identified through supervisors and another 5, (1.4%), indicated that staff training needs were identified through meetings. Table 5 also shows that some of the respondents, 48 (13%), stated that there was no specific criterion for identifying staff training needs while 37, (10.1%), said that managers did not identify staff training needs, another 25 (6.8%) indicated that staff made individual training arrangements if they wished to go for further studies. The remaining respondents, 21 (5.7%), indicated that they did not know anything about identification of staff training needs.

Table 6: **Addressing identified staff training needs**

Addressing Identified Training Needs	Frequency	Percentage
Taken for in-service training	212	57.6
Never addressed	118	32.1
Other	20	5.4
I don't know	10	2.7
Individual assessment	2	0.6
By telling nurses to teach others	1	0.3
No system in place	1	0.3
Total	**368**	**100.0**

Table 6 shows the respondents' response when asked how managers addressed the identified staff training needs. The question was open-ended and had varied responses. The responses

were grouped according to similarities in meaning and were then coded and examples of their statements used in this analysis as shown in table 6. Some respondents, 212 (57.6%), indicated that after staff training needs assessment, managers sent the nurses and midwives for training, while 118 (32.1%) said that identified needs were never addressed. Another 10 (2.7 %) said that they did not know how managers addressed the identified staff training needs.

Table 7: **Evaluation of staff development activity**

Evaluation of developmental activities	Frequency	Percentage
Through performance of those who have qualified successfully	189	51.4
Educational programmes not evaluated	105	28.5
I don't know	23	06.0
Other	17	04.6
Have no knowledge about this because it is done by Human Resource	11	3.0
By checking how many staff have gone for further studies	9	2.4
Through number of staff that are developed through in-service	8	2.2
Ask the individual to teach what she learnt to others	6	1.6
Total	**368**	**100.0**

Table 7 shows the respondents' response when asked, "How was the success of staff development evaluated?" The question was open-ended and had varied responses. The responses were grouped according to similarities in meaning and were then coded. Examples of their statements were used in this analysis as shown in table 7. Some respondents, 189 (51.4%), indicated that programme evaluation was done through the performance of those

who had qualified successfully. Other respondents, 9 (2.4%), indicated that another means of evaluating staff development activities was by checking how many staff had gone for further studies. The remaining 6, (1.6%), indicated that it was done by asking the individuals to teach others what they had learnt from having attended a workshop or training activity. Table 7 also shows that 105, (28.5%), indicated that educational programmes were never evaluated while another 11 (3%) said that they had no knowledge about evaluation because the department of human resources did it.

Fig 2: **Teamwork as a method of developing the capacities of nurses and midwives**
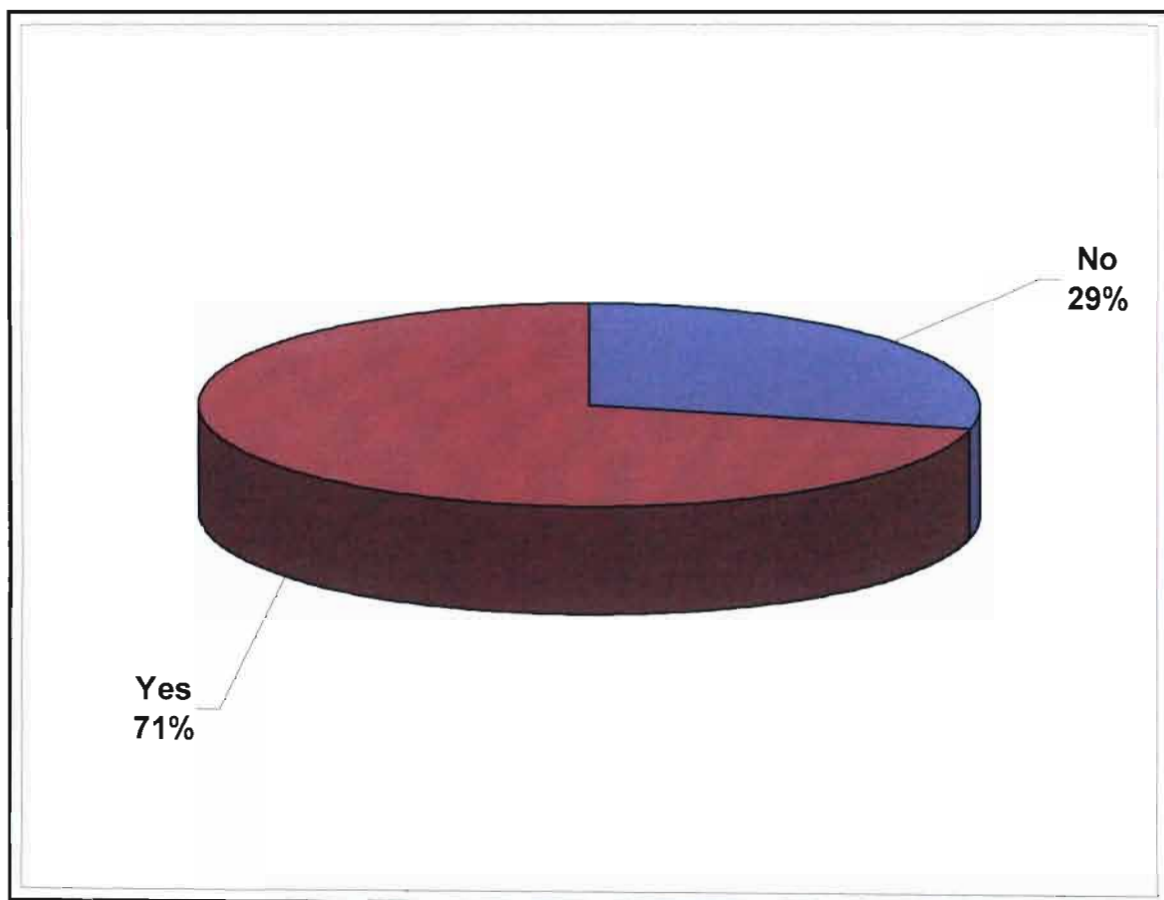
Fig 2 shows the response given by respondents when asked: was teamwork a method for developing the capacities of nurses and midwives discussed in your organization?

Fig 2 shows that the majority of the respondents, 264 (71.5%), indicated that teamwork was used as a method for developing the capacities of nurses and midwives. Some of the respondents 105 (28.5%) indicated that teamwork was not used as a method for developing the capacities of nurses and midwives.

Table 8: **Explanations given by respondents who indicated Yes when asked if teamwork was used as a method of developing the capacities of Nurses and Midwives.**

Explanations	Frequency	Percentage
Team work is encouraged as a way forward to meeting the required health care goal	209	56.8
Meetings are held once a month and every time there is new information	16	4.3
Management distributes staff equally	10	2.7
Use of teamwork among nurses else where is rare unless for nurses working in maternity wards	6	1.6
Helps in avoiding endangering the lives of clients	6	1.6
Committees are encouraged	3	0.8
Other	3	0.8
Only Sisters-in-charge and Nursing Officers use team work by attending meeting	2	0.5
Total	**255**	**69.3**

Table 8 shows the respondents' explanations for those who indicated that teamwork is used as a method of developing nurses and midwives. The responses for the explanation were open-ended. They were grouped and coded as shown in table 8. Table 8 shows that 209 (56.8%) said that teamwork was encouraged to meet the required health care goals. Some of the respondents, 16 (4.3%), said that meetings were held once a month while others, 10 (2.7%),

said that meetings were held every time there was new information, though this usually was for managers but not lower level staff. Another 6 (1.6%) indicated that use of teamwork among nurses else where is rare unless for nurses working in maternity wards. Another 6 (1.6%) said that only Sisters-in-charge and Nursing Officers use team work by attending meeting.

Table 9: **Explanations for indicating 'No'**

Explanations	Frequency	Percentage
There is nothing done to motivate nurses	55	14.9
Few workshops and the same individuals attend	19	5.2
Individual interest and development and initiative	12	3.3
I don't know	8	2.2
Working together with other cadres	2	0.5
Other	2	0.5
People liked by their heads are chosen	1	0.3
Total	99	26.9

Table 9 shows the respondents' explanation for those who indicated 'no' when asked if teamwork was used as a method of developing the capacities of Nurses and Midwives. The responses for the explanations were open ended; they were grouped and coded as shown in table 9. Table 9 shows 55 (14.9%), of the respondents said that nothing was done to motivate nurses, others, 19 (5.2%), said few workshops were arranged and the same people attended while 12 (3.3%) of the respondent said staff development was dependent on individual interest and initiative.

Team behavior among nurses and midwives in the participating institutions.

This section of the questionnaire dealt with team behavior. 'Team authority' referred to the shift of power for decision-making, allocation of roles and work from self to the group, while retaining the authority to ensure that the task was completed in accordance with the organizational needs. 'Responsibility' referred to decision-making becoming a team responsibility rather than the prerogative of the nominated leader, so that lack of success emanating from a poor decision does not result in blaming individuals. All team members fully understood and were committed to team tasks, e.g. strengthening the skills of team members necessary for success.

Fig 3: **Team authority in implementing activities.**

No
41.5%

Yes
58.5%
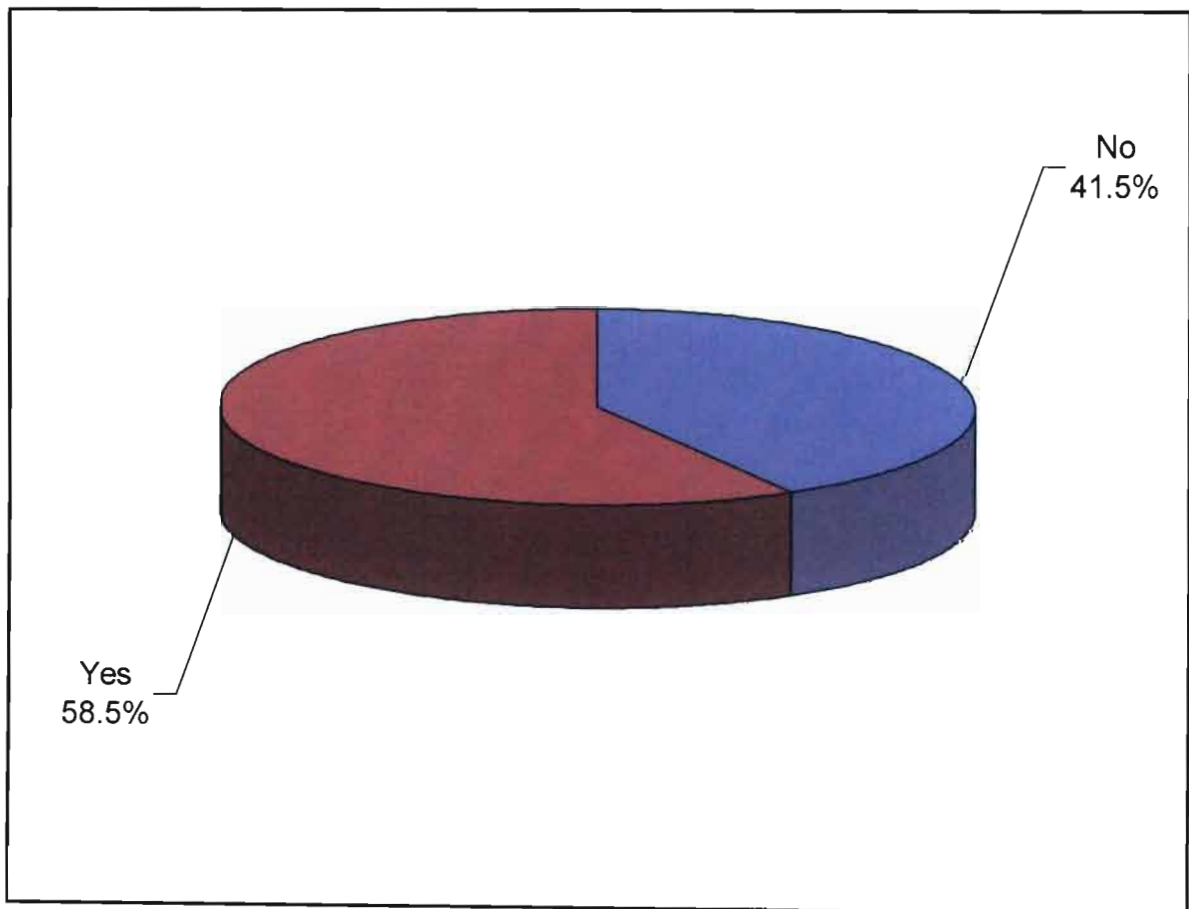
Fig 3 shows the response given by respondents' when asked whether they had any authority when the y worked in a team. The alternatives to the question were (yes) or (no). Fig 3 shows that 214 (58.2%) of the respondents indicated that teams had authority while 152 (41.3%) indicated that teams did not have authority. It is surprising that staff working in the same environment had such different opinions.

Table 10: **Reasons for saying 'Yes'**

Explanations	Frequency	Percentage
Recommendations made by team /committee are implemented.	123	33.4
Staff decide on how they should work and implement work decisions	41	11.1
No idea	15	4.1
Very minimal authority	11	3.0
Other	6	1.6
Because they were put there by management	4	1.1
Total	**200**	**54.3**

Table 10 shows the respondents' explanations for those who indicated that they thought teams had authority. The responses for the explanations were open-ended. They were grouped and coded as shown in table 10. Table 10 shows that 123 (33.4%), of the respondents said that recommendations made by the team or committee were implemented. Some of the respondents, 41 (11.1%), said that the staff decided on how they should work and implement work decisions. Others, 15 (4.1%), said that they had no idea. The range of responses might show that the respondents had varying own perceptions of teamwork.

Fig 4: **Team responsibilities in supporting members**
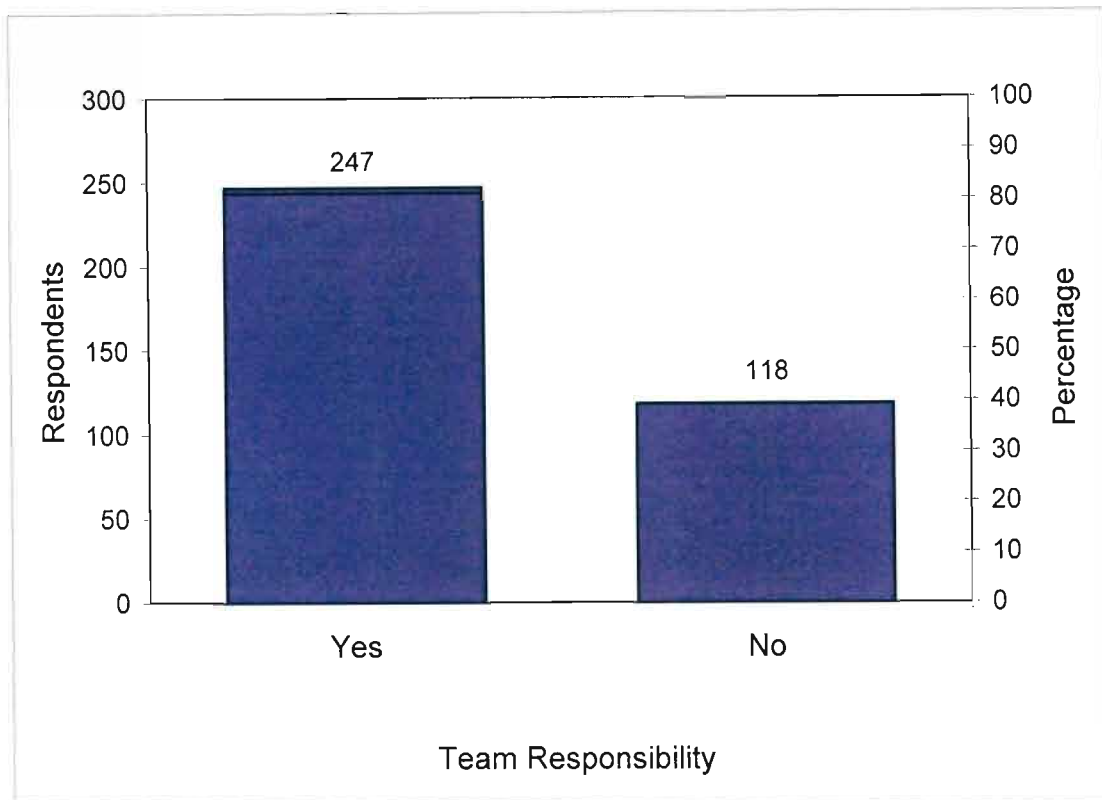
Fig 4 shows the response given by respondents when asked: If there were teams, did they have any responsibilities to support members of the team? Fig 4 shows that the majority, 247 (67.7%), of the respondents indicated that the teams did have responsibilities. Only 118, (32.3%) of the respondents said teams did not have responsibilities. The respondents' open-ended explanations for saying yes were grouped and coded as presented in table 11

Table 11: **Explanation for saying yes teams had responsibilities**

Explanation	Frequency	Percentage
The team members share knowledge and skills	194	81.5
No idea	20	8.4
Full participation by its members	10	4.2
Not effective	9	3.8
Other	5	2.1
Total	238	100

Some of the respondents, 194 (52.7%), said that the team members shared knowledge and skills. Some of the respondents, 20, (5.4%), although they had indicated yes said they did not have any idea of team responsibilities. Some of the respondents, 10 (2.7%), said that teamwork encouraged full participation of team members. The remaining 9 (2.4%) indicated that team responsibility was not effective. Nurses and midwives in spite of working in the same wards and health centres, appeared to have varied reasons.

Fig 5: **Staff involvement in developmental activities**

Fig 5 shows the response given by respondents when asked: was staff involved in the development of staff development activities? They were requested to indicate 'yes' or 'no'. Fig 5 shows that189 (51.5%) of the respondents indicated that staff were involved in staff development activities. The remaining 178(48.5%) of the respondents said that staff were not involved in developmental activities. It appears opinions were strongly divided almost 50/50

Fig 6: **How members of staff know of training activities**
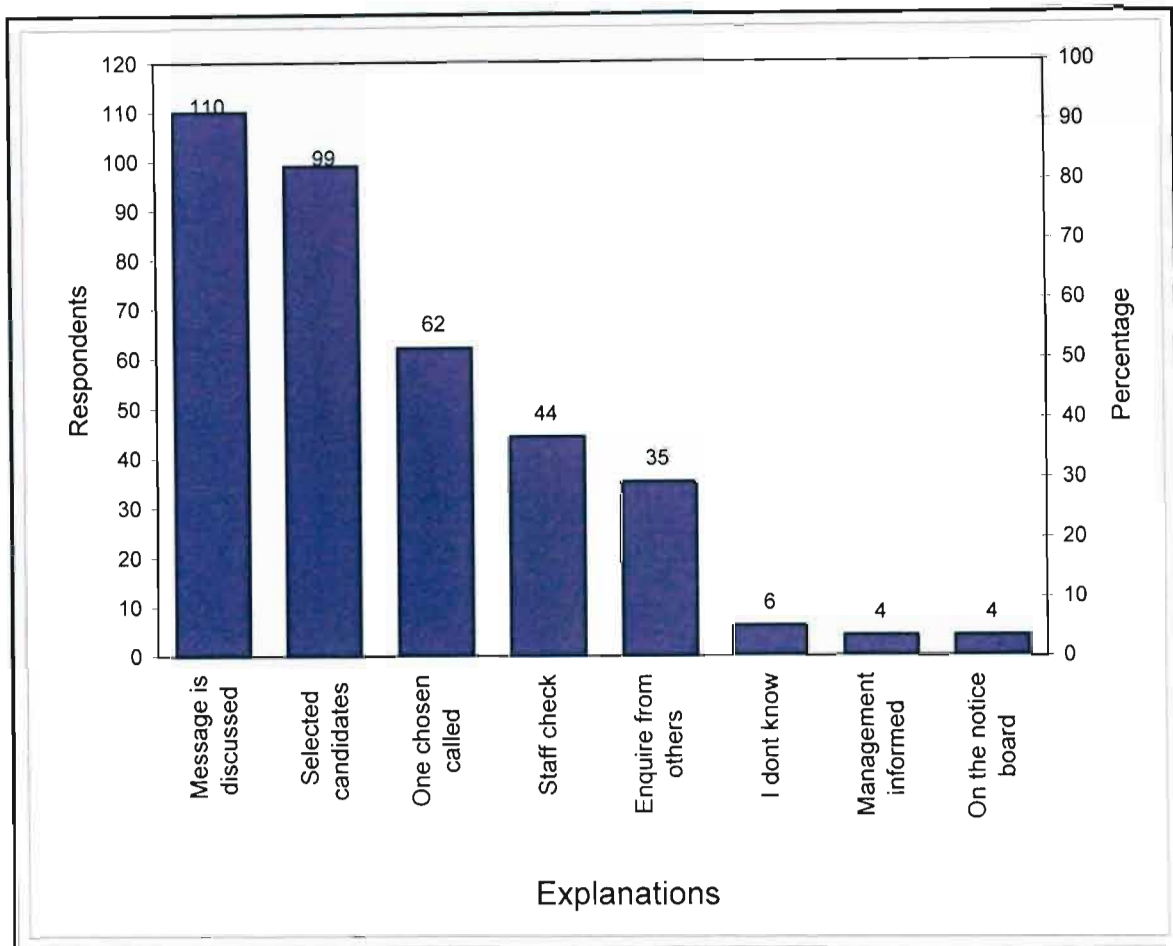
Fig 6 shows the response given by respondents when asked: how do members of staff know of the availability of training activities? Fig 6 shows that 110 (29.9%) of the respondents indicated that the opportunities for staff development were discussed at the ward or health centre staff meeting. Some of the respondents, 99 (26.9%), said that those chosen for any staff development activity were informed in writing. Other respondents, 62 (16.8%), indicated that selected members of staff were called aside and informed secretly, some of them 44 (12.0%), said in some institutions opportunities for further training were given in rotation to nurses on a list in order of seniority/service. The remaining 35 (9.5%) indicated that they got information on staff development through enquiring from other people, newspapers and

journals. It seems there was a big variation in the way respondents perceived how nurse managers communicated wit staff about availability of training opportunities

Resources in the participating institutions (Training material, budgetary allocation and staff)

The next section of the questionnaire dealt with resources, including training material, budgetary allocation and staff.

Fig 7: **Teaching materials**
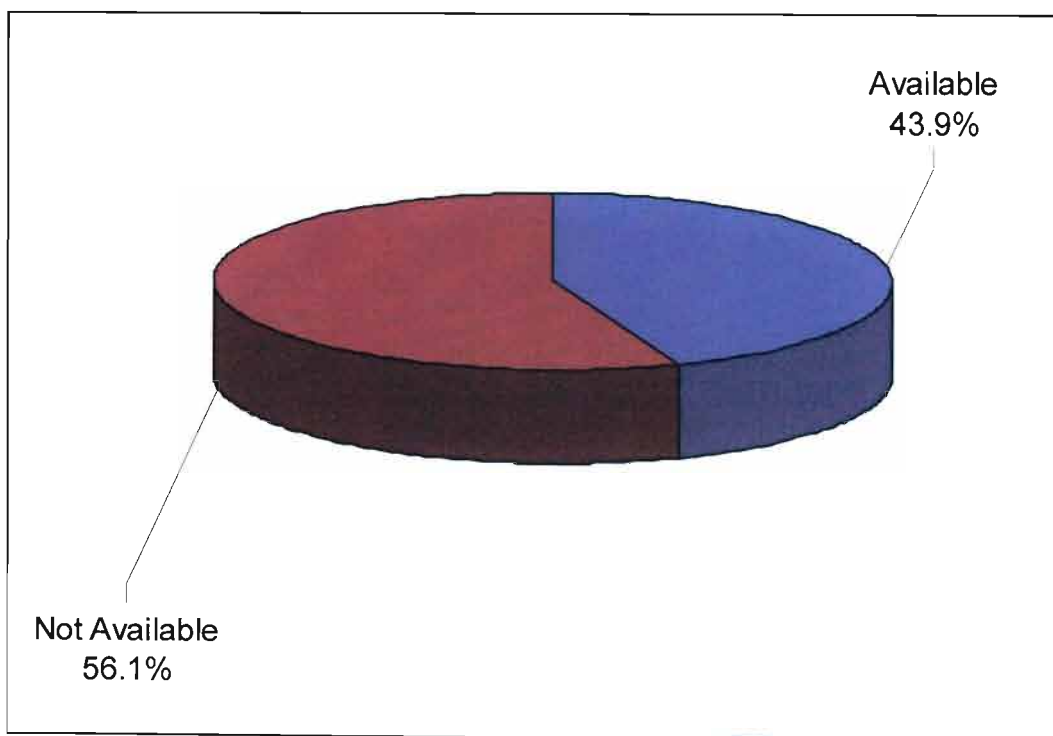
Fig 7 shows the respondents response when they were asked: Whether teaching materials were available for staff development. Respondents were asked to tick when materials were available or not available. Fig 7 shows that more than half, 206 (56.0%) indicated that teaching materials were not available. Some of the respondents, 161 (48.3%), said that the

100

teaching materials were available. These figures suggested that teachers were teaching with inadequate teaching materials. The inadequate supply of drugs and teaching materials resulting from scarce allocation of funds in the health sector had lowered health standards in hospitals (Sikopo et al 1999).

Fig 8: **Availability of staff development budget**
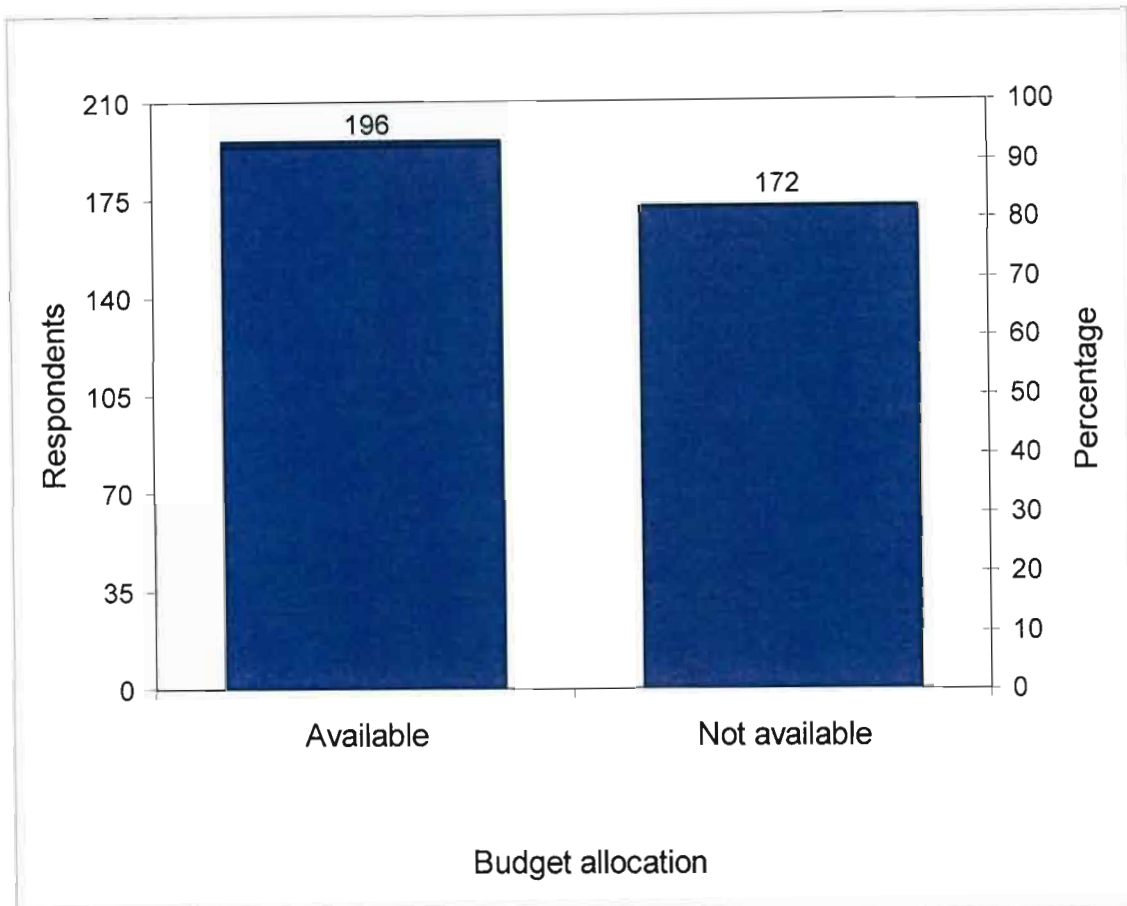
Fig 8 shows the respondents' response when they were asked whether budgetary allocations were available for staff development. The responses were predetermined the respondents were asked to tick when the funds were available or not available. Fig 8 shows that more than half 196 (53.3%) of the respondents indicated that the budget for staff development was available. One hundred and seventy (46.7%) indicated that the budget for staff development was not available. When they were asked what the budgetary allocation for staff development in their institution was, the majority, 284 (77.2%), of the respondents

indicated that they did not know the budgetary allocation for staff development while a few, 75 (20.4%), estimated ¼ of the allocation being spent for staff development in their institutions.

Fig 9: **Organizational Expenditure on Staff Development**
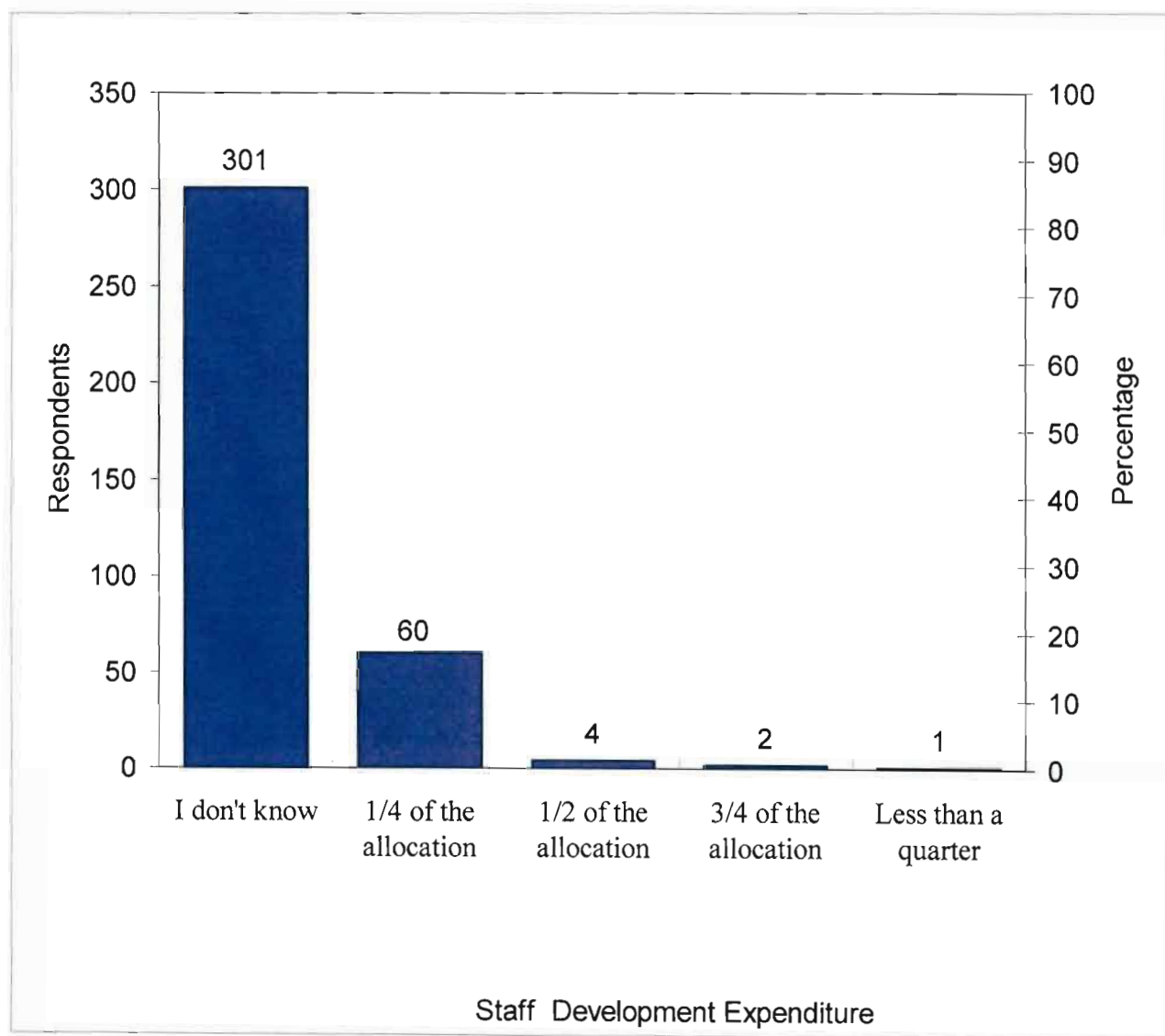
Fig 9 shows the respondents' views when they were asked how much of their total allocation their organization spent on staff development. The majority, 301(81.8%), said that they did not know how much of the budget was spent on staff development in their organization. A few, 60 (16%), of the respondents indicated that only ¼ of the institutional budget allocation

was spent on staff development. Another 4 (1.1%) of the respondents said half of the budget was spent on staff development.

Fig 10: **Availability of staff in health Institutions**
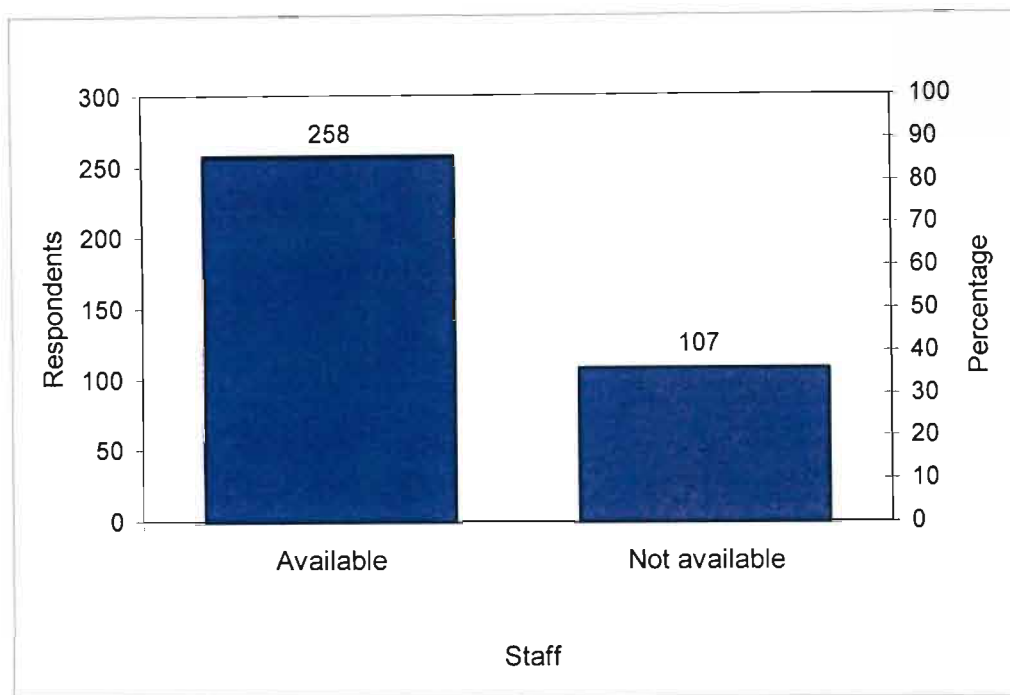
Fig 10 shows the respondents' response when they were asked if skilled human resources were available for staff development. Fig 4.4 shows that the majority, 258 (70.1%), of the respondents indicated that staff in the health institutions were available. Inspite of this positive response some of the respondents, 107 (29.1%), indicated that staff in the health institutions were not available, while 3 (.8%) did not respond to the question. The negative response agrees wit National Health Service (NHS) report (2000) which indicate that "In Zambia, the health service need, 1,500 nurses but can only find 500" (p.2).

Performance standards in the participating institutions.

The next section of the questionnaire dealt with the performance standards which provide direction for the nurses' practice. A list of what constituted performance standards was given

namely, Job descriptions, protocols and service targets. A job description in this study had been listed as one of the nursing practice standards whose purpose was to represent a criterion against which the practice of nurses and midwives would be measured by the public, clients, employers, colleagues and themselves. The following were responses that were given by the respondents. The respondents were to tick when job descriptions were available or not available.

Fig 11: **Availability of Job Descriptions**
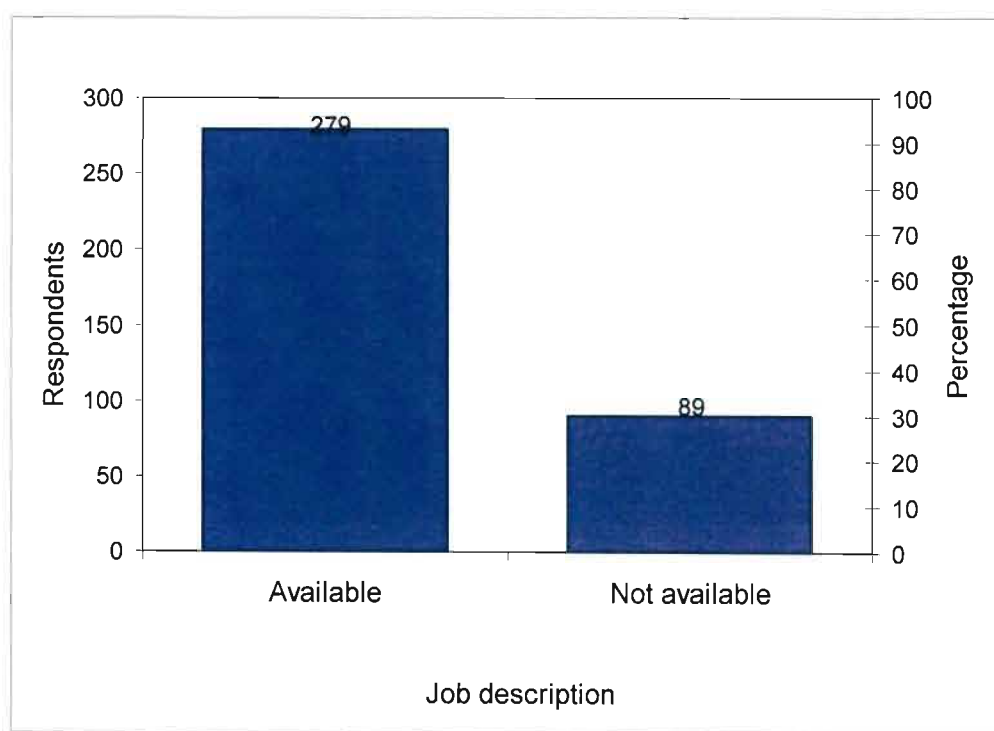
Fig 11 shows the respondents' response when they were asked if ere job descriptions were available in their institution. Fig 11 shows that the majority, 279 (75.8%), of the respondents indicated that job descriptions were available. Only 89 (24.2%) indicated that job descriptions were not available. There seems to be a consensus among respondents regarding availability of job descriptions.

Fig 12: **Availability of Protocols**
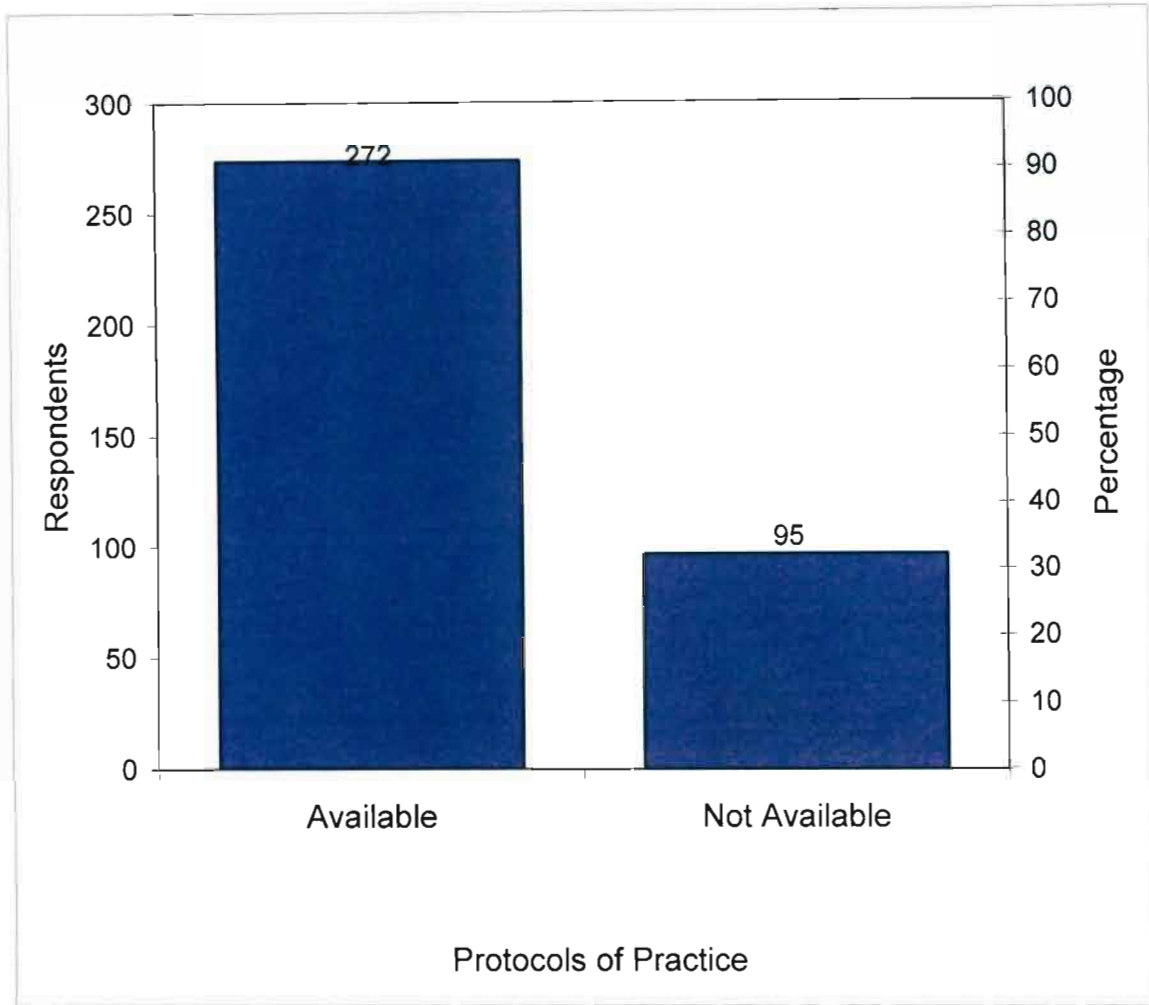
Fig 12 show the respondents' response when they were asked: Whether protocols of practice were available in your institution? Fig 12 shows that the majority 272 (73.9%) indicated that protocols of practice were available, only 95 (25.8%) indicated that they were not available. Respondents almost agree in the way they perceived availability of various protocols of practice.

Fig 13: **Service target**
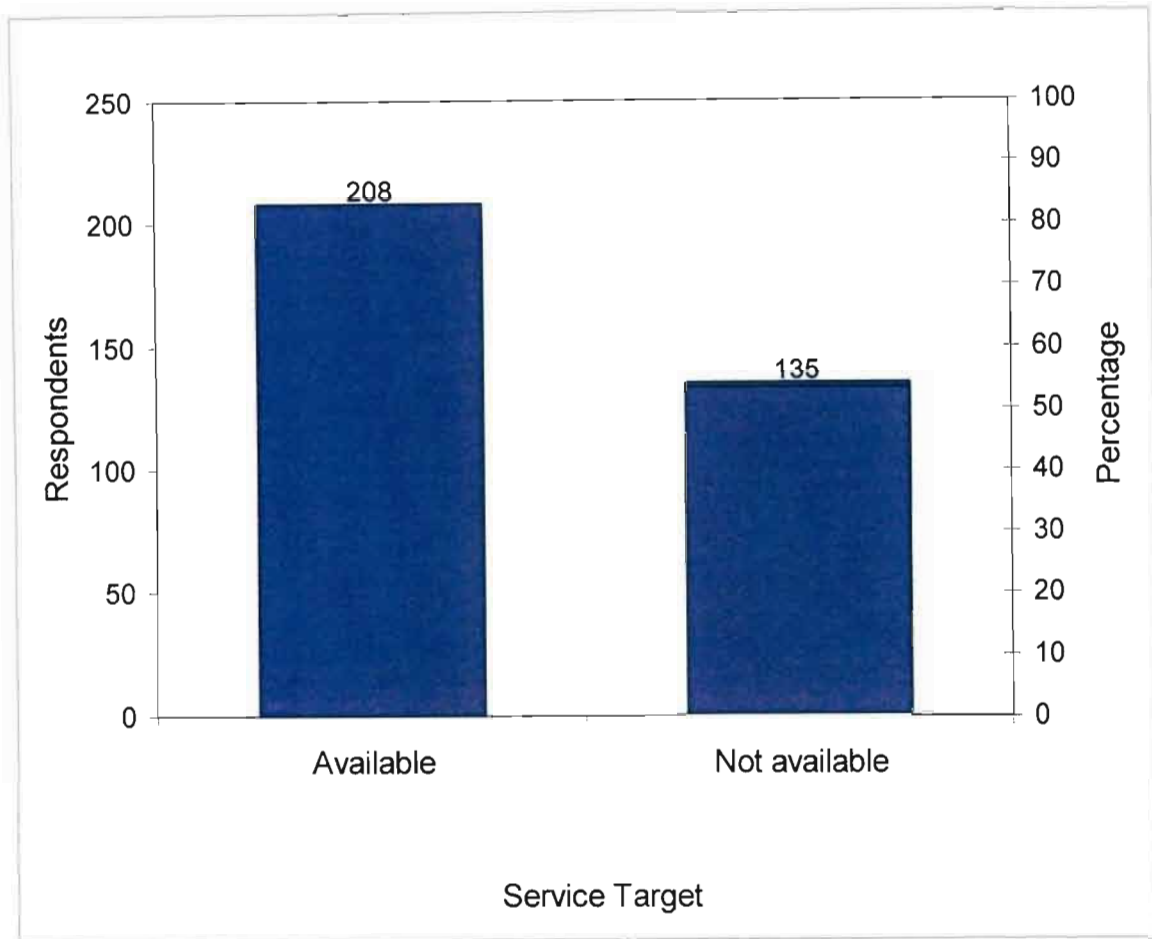
Fig 13 shows the respondents' responses when they were asked if service targets were available in their institution. Fig 13 shows that 208, (60.6%), of the respondents indicated that service targets were available in their institutions while 135, (39.4%), indicated that they were not available. Although respondents were working in hospital or heath centre it is apparent that they had divided views on service targets.

Communication between management and staff

This section of the questionnaire dealt with communication between management and staff. The areas of communication were listed as mission, goals, budget, norms, expectations and regulations of the organization as they affected staff development.

Table 12: **Management discussing mission of the organization with staff**

Explanations	Frequency	Percentage
Rarely	179	48.6
Monthly supportive meetings held by the district office	66	17.9
Three times year	33	9.0
Once a year	30	8.2
They don't and no explanation is given	30	8.2
Any time depending on the need of the staff	11	3.0
Many times	10	2.7
Twice a year	06	1.6
I don't know	03	0.8
Total	**368**	**100.0**

Table 12 shows the respondents' response when they were requested to indicate how often management discussed the mission of the organization with staff. Table 12 shows that 179 (48.6%), of the respondents said that management rarely discussed the mission of the organization with staff. Some of the respondents, 66 (17.9%), said that only monthly supportive meetings held by the district office were held. Another 33, (9.0%), said that management discussed the mission of their organization with staff three times in a year. 30 (8.2%), of respondents indicated that management discussed the mission of the organization with staff once a year.

Table 13: **Management discussing goals of the organization with staff**

Explanations	Frequency	Percent
Rarely	251	68.2
Once a year	41	11.1
Three times a year	34	9.2
More than three times a year	15	4.1
When need arises	15	4.1
Not aware of such goals	6	1.6
Twice a year	4	1.1
It is not done and there is no explanation	2	0.5
Total	**368**	**100.0**

Table 13 shows the respondents' response when they were requested to indicate how often management discussed the goals of their organization with staff. About half of the respondents, 173 (47.0%), said that management rarely discussed goals of the organization with them. Some of the respondents, 41(11.1%), said that management discussed goals with staff once a year. Other respondents, 34 (9.2%), indicated that management discussed goals with staff three times a year.

Fig 14: **Management discussing the budgetary allocation and direction of the organization with staff**
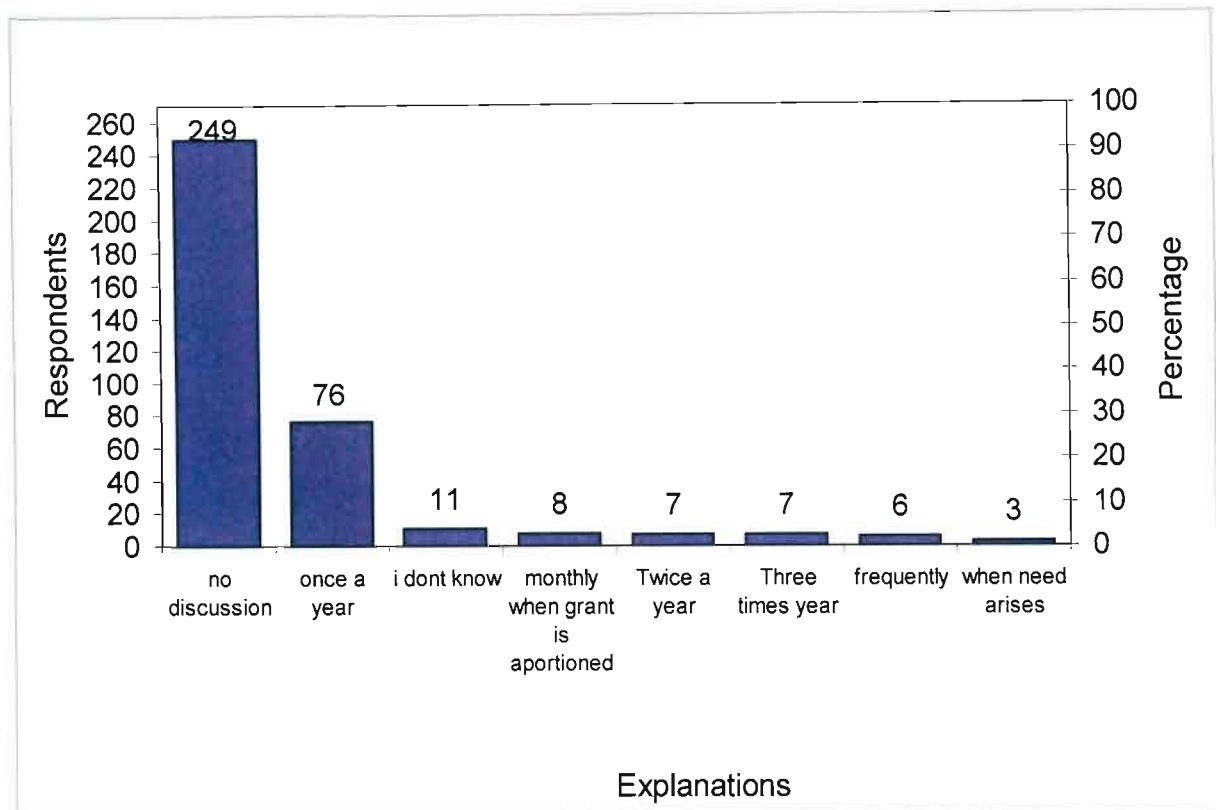
When the respondents were requested to indicate how often management discussed budgetary allocation for staff development and direction of the organization with staff, figure 14 shows that the majority, 249 (67.7%), said that management did not discuss budgetary allocation for staff development and direction of the organization with staff. Another 76 (20.7%), said management discussed budgetary allocation for staff development and direction of the organization with staff once a year. Others, 11 (3.0%), said they did not know if management ever discussed the budgetary allocation and direction of the organization with staff, 8 (2.2%), said management discussed budgetary allocation and direction of the organization with staff monthly, when the ministry of health grant was apportioned. Some of the respondents, 6 (1.6 %), said management discussed budgetary allocation and direction of the organization with staff three times a year. Six (1.6 %) respondents said such discussions took place twice a year.

Fig 15: **Management discussing the norms of the organization with staff**
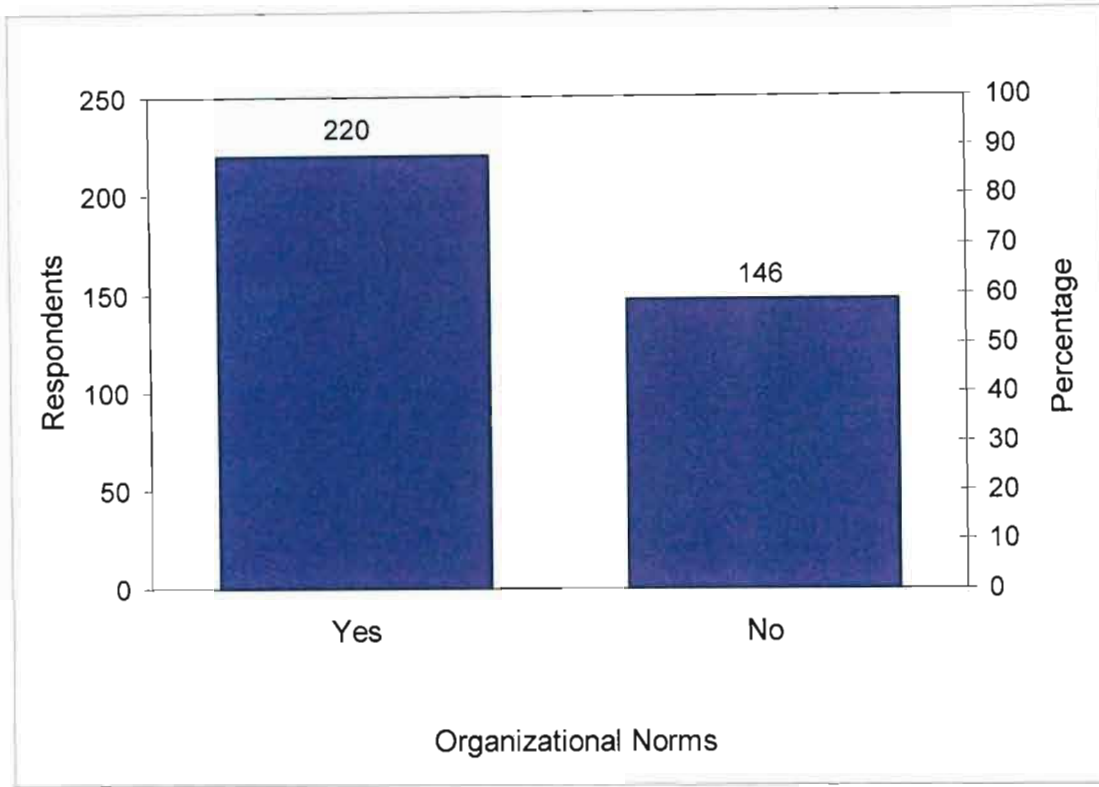
Fig 15 shows the response when asked if management discussed the norms of the organization with staff. Fig 15 shows that 220 (59.8%), indicated that management did discuss norms of the organization with staff. 146, (39.7%), said that management did not discuss the norms of the organization with staff. When they were requested to provide explanations, those respondents who had indicated yes, had to choose from alternatives that were given, except for the last one, which was open-ended. Some of the respondents, 149 (40.5%), did not give any explanations for having indicated yes. Other respondents, 136 (37 %), said that management discussed the norms of the organization with staff at the time of engagement. Another 35 (9.5%), said management discussed the norms of the organization with staff at the end of each planning year. Twenty three (6.3%) said that management discussed the norms of the organization with staff when they broke a rule or when they did not observe a norm.

Fig 16: **Management discussing the expectations of the organization with staff**
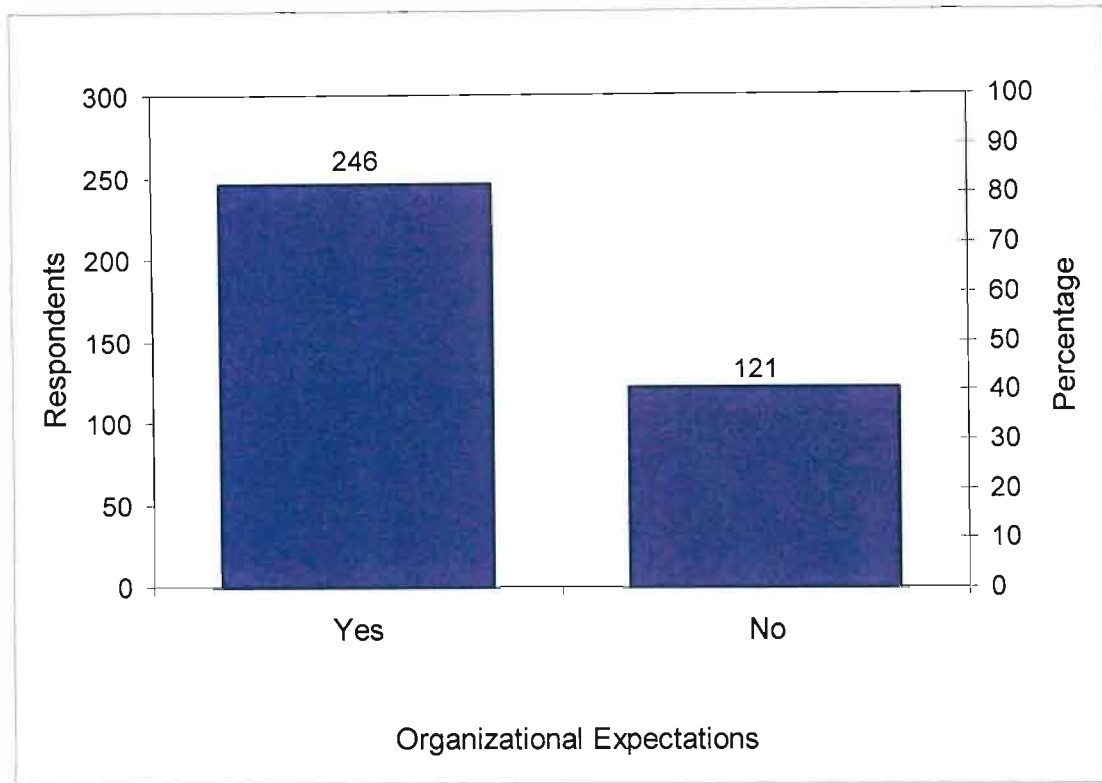
When asked if management discussed the expectations of their organization with staff, the majority, 246 (66.8%), indicated that management discussed the expectations of their organization with staff. The remaining, 121 (32.9%), said that management did not discuss the expectations of their organization with staff. When respondents were requested to provide explanations for saying 'yes', some of the respondents, 142(38.6%), indicated that management discussed the expectations of the organization with staff at the time of engagement. About a third of the respondents, 122 (33.2%), did not give any explanations. Another 51, (13.9%), said discussions were held at the end of each planning year. Other respondents, 27 (7.3%), said management did not discuss the expectations of their organization with staff. 18 (4.9%), said they did not know if management discussed the expectations of the organization with staff. This range of responses might show that nurse managers might not have made the discussion of expectations of the organization with staff as a priority.

Fig 17: **Management discussing regulations of the organization with staff**
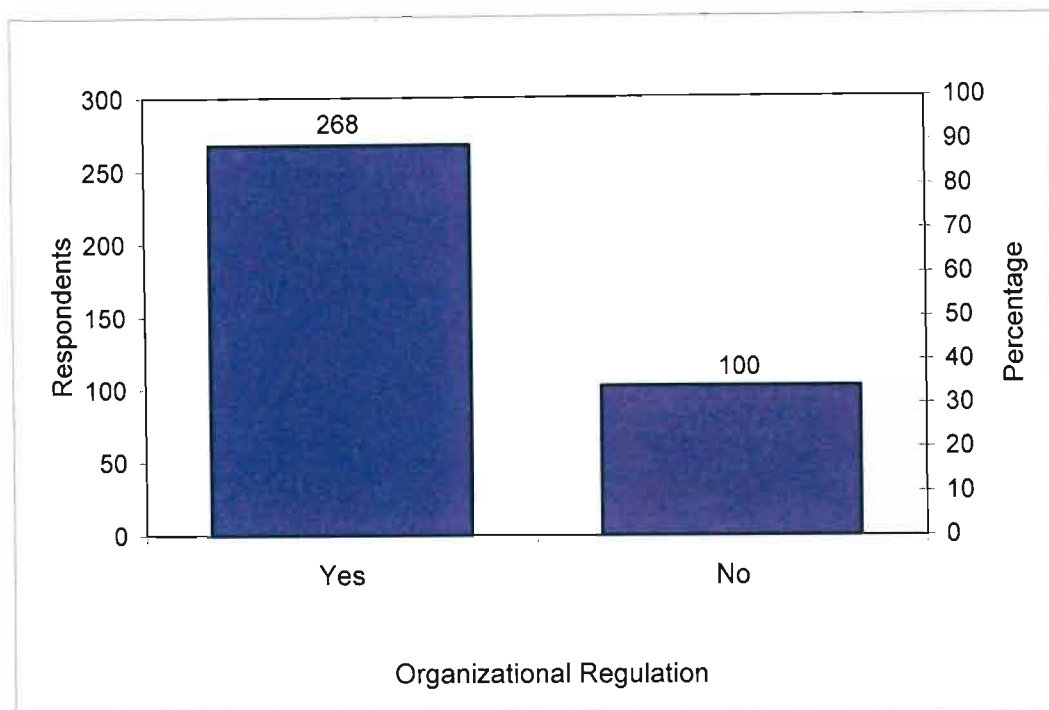
When asked if management discussed the regulations of the organization with staff, the analysis presented in Fig 17 shows that the majority, 268 (72.8%), said that management discussed the regulations of the organization with staff. The remaining 100, (27.2%), said that management did not discuss the regulations of the organization with staff. The respondents who had indicated 'yes' were requested to provide an explanation for their response. The alternative responses were given except for the last one, which was open- ended. The responses were grouped and coded and examples are used in fig 17. Some of the respondents, 178 (48.4%), indicated that management discussed the regulations of the organization with staff at the time of engagement. Thirty nine (10.6%), said management discussed the regulations of the organization with staff at the end of each planning year. Another 24, (6.5%), said that such discussions were held when need arose. This range of responses might suggest that nurse managers might not have been knowledgeable and skilled enough to handle issues regarding regulations of the organization with staff.

Processes needed to be put in place in order to develop a learning organization in selected settings

The following findings identified the processes that needed to be put in place to develop a learning organization in the selected settings.

Fig 18: **Availability of policies to support individual learning**
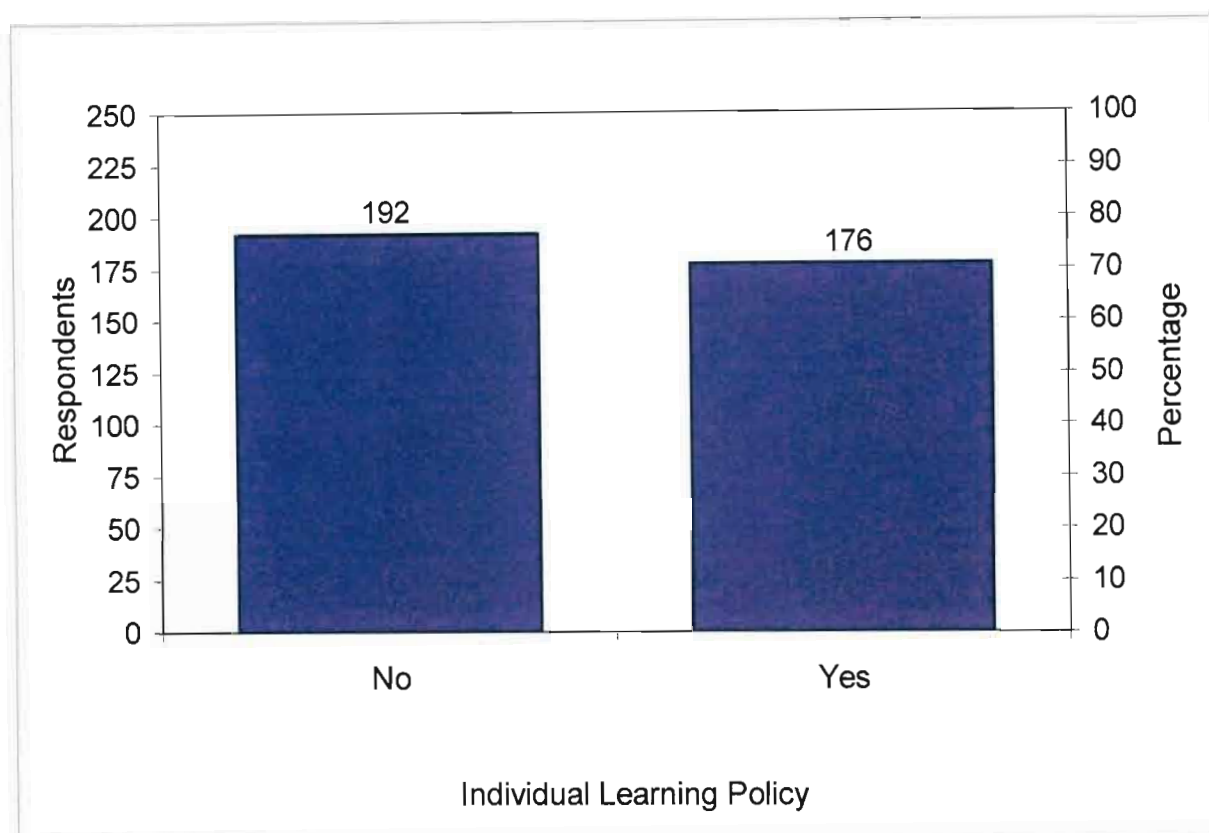
When asked if there were policies in their institutions which supported individual learning, the responses presented in Figure 18 show that 192, (52.2%), indicated that there were no policies which supported individual learning. Some of the respondents, 176 (47.8%), indicated that the policies on individual learning were available. When requested to provide an explanation for indicating 'Yes' or 'No', some of the 'no' respondents, 97 (26.4%), stated that they had never heard of any policy on individual learning since they started working in the institution. Other respondents, 85 (23.1%), said time for learning was not easily available owing to shortage of staff. Another 18, (4.9%), indicated that there was no library to make

regular reviews of conditions that one was in doubt about. Some of the respondents, 82

(22.3%), said they attended educational meetings like grand rounds.

Fig 19: **Availability of collective learning policy**
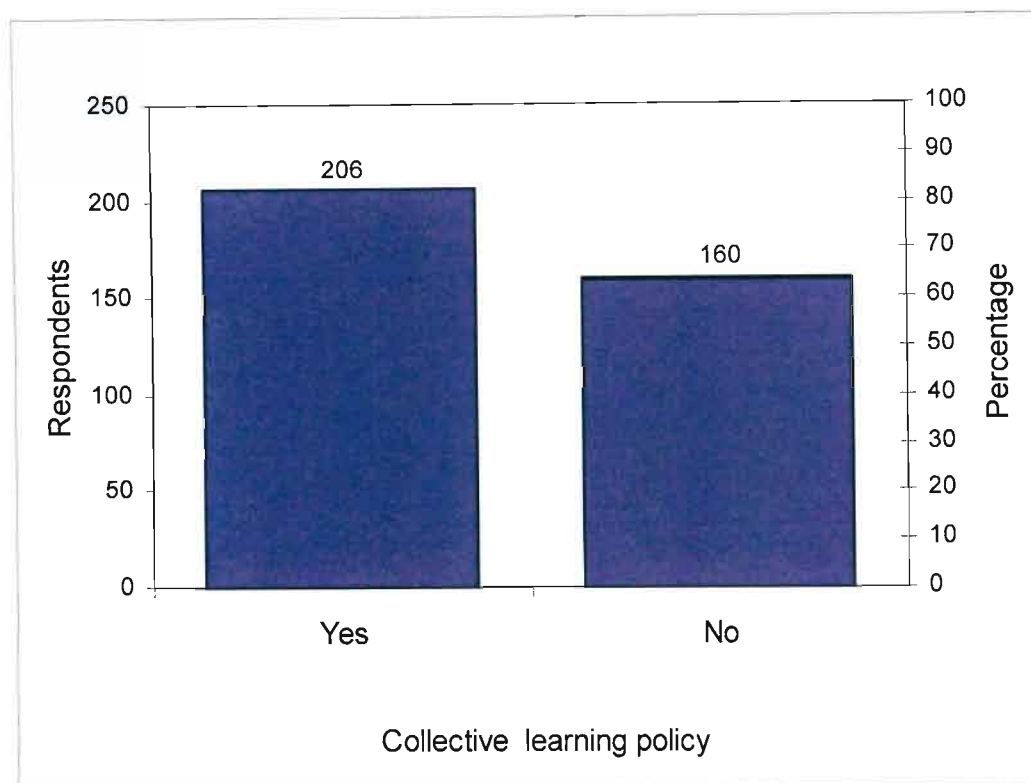
Fig 19 shows the respondents' response when they were asked: "Are there policies in your

institution which support collective learning?" Fig 19 shows that more than half, 206 (56%),

of the respondents indicated that there were policies in their institution which supported

collective learning. Some of the respondents, 160 (43.5%), indicated that there were no

policies that supported collective learning. When requested to provide an explanation for their

answer of the respondents who indicated 'yes', 85 (23.1%), said that they had clinical

meetings/grand rounds every week. Some meetings were on a monthly basis. Some of the

respondents, 52 (14.1%), indicated that they had training that was organized by the district,

Non Governmental Organization, Ministry of Health or the Central Board of Health. Of the

respondents who indicated that there was no policy on collective learning, 108 (29.3%), said

they had never heard of collective learning policy. Another 58, (15.8%), said that there were

no staff available in the wards, therefore the few nurses and midwives, dealt with the large numbers of patients. The range of responses might show that there was no systematic implementation of collective learning activities being used in the participating institutions.

Factors essential for effective implementation of staff development in Zambia

Table 14 shows the respondents' response when they were asked: what do you consider to be essential for a staff development plan in a learning organization? The question was open ended. The responses were varied; they were grouped and coded as shown in Table 14. The majority of the respondents, 231(63.5%), indicated that refresher courses, and knowledgeable people to teach them were essential for a staff development plan in a learning organization. Some of the respondents, 46 (12.6%), said the staff development plan needed to be well organized and accessible to all members of staff and should be well prepared with help from every body. Other respondents, 31 (8.4%), said that identification of training priorities and recognition of specialized training was essential. A few respondents, 28 (7.6%), said that finances and transport needed to be available for implementing staff development activities. The remaining respondents, 7 (1.9%), said it was also important to have easy access to a library and medical journals in the ward.

Table 14:   **Essential for a staff development plan**

Explanations	Frequency	Percent
Refresher courses, knowledgeable people to teach and teaching materials	231	63.5
The plan must be well organized and accessible to all members of staff and should be well prepared with help from everybody	46	12.6
Identification of training priorities and recognition of more specialized training courses	31	8.5
Finances and transport should be available for implementing planned activities	28	7.7
A system for identifying staff to be developed	14	3.8
Easy access to a library and medical journals in the wards	7	1.9
Need to have mentors	2	0.5
Other	5	1.4
Total	**364**	**100.0**

Essential factors for effective implementation of a staff development plan in a learning organization

This section of the questionnaire dealt with factors which were essential for effective implementation of a staff development plan in a learning organization. The following responses were given by the respondents.

Table 15: **Requirements in order to develop a learning organization**

Explanations	Frequency	Percent
Conducive environment, skilled manpower and budget allocation	155	42.2
All nurses should be reached and informed of all the necessary things. Departmental nursing officers should especially know what is happening.	77	21.0
Systems of identifying training needs should be in place	52	14.2
Give opportunities to each staff to attend seminars/training and report after the seminar	50	13.6
The institution needs a more developed and funded in-service course	18	4.9
Incentives for training should be provided and knowledge to be shared	4	1.1
Grand round should be held where a cross-section of doctors attend and discuss the different types of patients they come across.	4	1.1
Other	3	0.8
Right people in management who will make training opportunities available to the staff	2	0.5
I don't know	2	0.5
Total	**367**	**100.0**

Table 15 shows the respondents' response when they were asked "what was necessary to develop a learning organization. Some of the respondents, 155 (42.1%), said that having a conducive environment, skilled manpower and budget allocation were necessary for a learning organization. Seventy seven (20.9%), said that all nurses should be reached and informed of all the necessary training activities. Other respondents, 52 (14.1%), said systems of identifying training needs should be in place. Another, 50 (13.6%), said that there was need to give opportunities to each member of staff to attend seminars. Some of the respondents, 18 (4.9%), said that the institution needed a more developed and funded in- service course.

Table 16: **Factors for effective implementation of a staff development plan in a learning organization**

Factors for effective implementation of a staff development plan	Frequency	Percent
Skilled manpower, budget allocation and conducive environment	205	57.3
All nurses should be part and parcel of activities occurring in their institution	40	11.2
Dialogue	39	10.9
Development of a more elaborate training system and follow-up training	23	6.4
Training should be based on identified training needs.	13	3.6
Consider human resources needs and emolument	8	2.2
No idea	8	2.2
Need to evaluate programmes	7	2.0
Availability of modern technology and easy access	6	1.7
Putting right people in management	6	1.7
Other	3	0.8
Total	**358**	**100.0**

Factors required for effective implementation of a staff development plan were suggested by respondents as presented in table 16. More than half of the respondents, 205 (55.7%), indicated that there was need to have skilled manpower, budget allocation and conducive environment for learning to take place. Some of the respondents, 40 (10.9%), said that all nurses should be part and parcel of activities occurring in their institution. Others, 39 (10.6%), said that dialogue should be the basis for communicating all plans on staff development. The other respondents, 23 (6.3%), said that there was a need to develop a more elaborate training system and follow-up of staff. thirteen (3.5%), of the respondents said training should be based on identified training needs.

4.1 Qualitative data

4.1.1 Introduction to the qualitative data analysis

The second phase of the study focused on the group discussions during the workshops which were held with sisters-in- charge and nursing officers.

4.1.2 Framework analysis

The researcher chose to use framework analysis to analyze the group discussions during the workshops. Framework analysis was explicitly developed in the context of applied policy research. Applied research aims at meeting specific information needs and provides outcomes or recommendations, often within a short timetable. According to Ritchie and Spencer 1994, (in Lacey and Luff 2001), framework analysis shared many of the common features of qualitative analysis. The benefit of framework analysis is that it provides systematic and visible stages to the analysis process, so that funding agents and others can be clear about the stages by which the results have been obtained from the data. Also, although the general approach in framework analysis is inductive, this form of analysis allows for the inclusion of a priori as emergent concept, for example in coding. Framework analysis had 5 key stages namely:

4.1.2.1 Familiarization

This is whole or partial transcription and reading of the data. In this study data from the group discussion during the workshops was audio taped and notes were put on a flip chart. The researcher did a complete transcription and reading of the data.

4.1.2.2 **Identifying a thematic framework.**

This was the initial coding framework, which was developed both from priori issues and issues emerging from the familiarization stage. This thematic framework was developed and refined during subsequent stages. Identification of the thematic framework was done using priori issues from the survey findings and from issues emerging during the familiarization stage. The priori areas from the survey findings and emerging issues were as follows:

Knowledge and skills of nurse managers in utilizing the available staff performance appraisal system, Contributing factors to nurse managers inability to undertake capacity building activities in the wards or health centres, and current practice of building capacity of new staff at ward or health centre level. The others are Unavailability of capacity building resources. Staff development policies (individual and collective learning) and ways in which nursing managers intended to foster a learning culture in their environment in the light of team work.

4.1.2.3 **Indexing.**

This is the process of applying the thematic framework to the data, using numerical or textual codes to identify specific pieces of data, which corresponds to differing themes (this is more commonly called coding in other qualitative analysis approaches). In this study themes were organized to the emerging issues in the survey data.

4.1.2.4 **Charting.**

This uses headings from the thematic framework to create charts of the data so that the researcher can easily read across the whole database. Charts can be either

thematic for each theme across all respondent's cases or by cases for each respondent across all themes (Ritchie and Spencer, 1994 in Lacey and Luff 2001). The priori areas were used for charting the ideas.

4.1.2.5 **Mapping and interpretations**.

This means searching for patterns, associations, concepts and explanations in the data, aided by visual displays and plots. Ritchie and Spencer, (1994 cited in Lacey and Bluff 2001) suggest that at this stage, the qualitative analyst might be aiming at defining concepts, mapping the range and nature of phenomena, creating typologies, finding associations within the data, providing explanations or developing strategies. The areas the analyst chooses to focus on will depend on the research question. These stages can be undertaken in a linear fashion and therefore all data can be collected before analysis begins, although framework analysis can equally be used when data collection and analysis occur concurrently. In this study the data was collected before the analysis began.

4.2   **Knowledge and skills in staff appraisal systems in use**

Participants indicated that once in a while selected staff were requested to fill in annual confidential reports "We filled in the annual confidential report form for staff when required by the Ministry of Health." It seems annual confidential reports were done based on the staff need. The need may be education, promotion   or confirmation to the civil service establishment. Experience has shown that if an officer did not have a recent annual confidential report filled in her request on further training would not be processed. Nurse managers did not have knowledge and skill in utilizing the available appraisal system in use.

"Open appraisal system in the University Teaching Hospital was coordinated by the in-service department. The majority of us from the wards did not play a role in appraising staff. It would be useful and beneficial to the staff and the health institutions if we knew what appraisal systems were in use, and all of us were able to use them"

Verification with the hospital management indicated that an open appraisal system was commenced in 1997. In this system, a panel set by management appraised one member of staff who filled in the appraisal form prior to the assessment day. This indicated that the officer was ready for the appraisal. After the appraisal, the panel gave recommendations to the officer and management. The recommendations were in the area of staff development or practice. Most of the participants when asked about when they were last appraised indicated they had been appraised a long time ago "I was last appraised in 1997" The participants indicated that when the open appraisal system started, it was meant to appraise staff every six months.

"But the institution has many members of staff, we have pharmacists, physiotherapists, accountants and nurses in all categories. Ideally we were doing the appraisals every two to three years, even this was difficult"

In some cases these open appraisals took longer than three years.

"So for the nurses, it took six years but we were happy that at least most nurses had an appraisal. When the open appraisal system was working well it was used to identify staff training needs"

Staff training needs were identified during the appraisal.

"The appraisal panel made recommendations regarding the type of training programme the officer who was appraised needed to do and specified the time

122

within which the implementation of the training programme were required to be"

4.3 Contributing factors to nurse manager's inability to undertake capacity building activities in the wards or health centres.

Participants indicated that shortage of staff played a major role in the planning and implementation of capacity building activities in health institutions.

"Shortage of staff made planning for staff development very difficult. In a situation where you had three nurses on duty, especially in the morning shift, it became very difficult to plan and implement a training programme"

In this situation preference was given to providing a service rather than undertaking any capacity building activity. It seemed that maintaining adequate staffing levels in the health sector needed to be addressed if staff development activities were to be implemented.

4.4 Current practice of building capacity of new staff at ward or health centre level.

There was great variation in how facilities conducted orientation of new staff

The following were the few a practices that the participants highlighted

4.4.1 Internship for newly qualified staff.

This involved attachment of the new staff to a specific ward and they rotated from one ward or from one department of the health centres to another.

"At the University teaching hospital the internship in practice is designed for the newly qualified registered nurses. When the system was supported by Central Board of Health and university teaching management, the registered

nurses had to follow an internship for 6 months. During this time nurses were rotated from department to department"

This process provided the new staff with the opportunity to have an overview of what went on, in different wards or health centres. In this way staff would not be at a loss if they were requested to assist in any of the wards. In addition the rotation in general wards was done to facilitate the newly qualified nurses' to decisions on areas of interest in their career.

4.4.2 Mentorship of staff.

The participant described the existence of a mentor system in their institutions in which a senior nurse to mentor new staff was identified, in order to ensure that there was skills transfer. The following is an excerpt from one of the respondents. "Even the shift of the new staff was similar to that of the mentor, the problem was that there were very few senior staff to mentor junior staff" The attachment ranged from two weeks up to six months. The longest was the one for newly qualified staff at the University Teaching Hospital which was 6 months while at Chainama college hospital it was two weeks. "At Chainama we have post basic staff. We allocate them to all the wards (rotation). They work with senior nurses to orient them and it lasts for two weeks. "The practice seemed to have problems however. "Due to the shortage of senior staff to serve as role models the practice was not in full use"

4.4.3 Workshops or in house training.

Whenever there were new practices or new trends in the health sector. In-service training ranged from informal one-on one discussion or staff were taken for short courses ranging from one day to 6 months.

> "When the in-service training was working well we were usually called for one or two days meetings to brief us of new trends. Now'adays the in-service department organizes many commercial meetings or workshops for those who pay or their organizations pay for them, in order to be trained in any specific area"

These workshops were very rare for the nurses and midwives at the lower level "Very few of us nurses attend the organized workshops". Shortage of staff hinders the nursing managers from arranging staff development activities.

In a learning organization, the act of learning was considered a team- based, bottom-up, broad-scope process which was embedded in a continuous innovation effort.

4.5   Fostering a learning culture in the light of teamwork

The participants indicated that this was done through improving communication with staff by holding regular meetings.

> "We held sisters' meetings every week and discussed everything concerning staff development especially workshops and other issues related to practice. Grand rounds were done on a weekly basis. During these rounds, nurses and doctors discussed the management of certain clients. These rounds were used

as a teaching / learning sessions for all health providers" Others said "if we all

knew what to do, it would make teamwork in our workplaces easier"

There were different methods in use for developing staff capacity. In some health

centres or hospitals, staff were rotated from one department to another or from ward to

ward or from one health centre to another.

> "I had seven wards under my care I rotated the nurses. Where there was a
>
> problem, I sent one nurse from one ward to another ward to help. In this way
>
> they developed work relationships and at the same time developed knowledge
>
> and skills to work anywhere within surgical wards"

For staff in the registered schools of nursing, management skills were developed by

assigning the responsibility of managing a group of students for three years to one

tutor (group tutor). Three years was the duration for registered nursing training. "After

this experience the tutor developed the capacity to manage any registered nursing

school in the country"

Teamwork among tutors became easier when all tutors in the institution (School) knew

what to do at a given time. In University Teaching Hospital departments, there was a

system for building the capacity of registered nurses for senior positions. In this system

one registered nurse was made to work as the second in-charge.

> "We had a system called as 2nd in-charge but due to the shortage of staff in all
>
> the departments the practice had been stopped. These second in charge were
>
> assigned some of the responsibilities of the sister in-charge. In-order to ensure
>
> that this system worked there was need for more staff. If this system was re-
>
> activated and be supported by management it would provide an opportunity for
>
> us to build the capacity of staff in our institutions especially that there is
>
> change in disease patterns and new procedures which require that nurses and

midwives are reoriented. In this way we would maintain the staff development function in the setting of our working environment"

A registered nurse was made to understudy the sister in-charge. In this way leadership skills were built. The shortage of staff, especially senior level managers who were expected to supervise or even mentor junior staff made mentoring of staff difficult. "There were no role models in most of the health institutions to mentor staff or subordinates. They all left for other areas" Other participants indicated that the staff shortage in their work place sometimes reached some alarming levels.

"Sometimes we do experience a critical shortage of staff in the wards. When there is only one nurse for the day, I communicate to the nursing officer informing her of the existing situation. I send the available nurse home and request her to come in the afternoon. In the meantime I remained managing the ward and this solved the problem for the day"

This agrees with the results of a study by Buchan & Dovlo (2004) on recruitment of health workers to the UK which showed that between 2000 and 2001 alone, Barbados lost 10% of its nursing workforce from the health sector. The majority of them left the country for employment elsewhere. Fostering learning becomes an issue.

It was also mentioned that in some cases the shortage was created when sisters-in-charge made the time tables for the week:

"I noticed that the shortage of staff was created by how the timetables were made. When timetables were brought to me, whenever I noticed that there were no nurses on certain days I discussed with sisters-in-charge to change the timetables so that all wards were well covered. This usually had to do with off days. If given a chance I would participate as one of the members

who would be set aside to develop a model or system which would provide

directions for staff development"

One of the areas that sisters-in-charge were assessed on was their ability to make a

timetable which had a nurse on duty on every shift. Experienced staff managers were

required to strive to find solutions to the existing shortage of staff. One of the

strategies which was put in place in E department in the University Teaching Hospital

was to ensure that each ward had the beds according to the stipulated standard for the

wards. This meant that there were no extra beds. This decision was undertaken in

collaboration with the admitting unit. Patients would only be admitted if there was

confirmation of availability of an empty bed. In this way the available number of staff

was able to manage:

> "We developed a strategy – worked out the patients' turnover and the available
>
> nurse in each cubicle. There were 6 beds in each cubicle. We decided that the
>
> admitted patients would be equivalent to the number of beds in the ward. To
>
> this end a turnover chart was developed"

In support of this, other participants indicated that the system seemed to have worked

"The few available nurses were able to provide basic care" At the in-service

department of University Teaching Hospital participatory management was used to

build the capacity of staff. In this method all staff in the department were given the

opportunity to manage the department for a week. Others were observing and

providing support as the officer was managing the department. At the end of the week

staff in the department did an oral evaluation on how the officer performed, in turn the

officer was given chance to provide a feedback on his performance. In this way

capacity of staff in leadership was built. In addition to building the capacity the

officer's training needs were identified during the implementation process. "Every junior was managing the office while the rest of the staff were observing, then every week we changed and evaluated the one who had finished doing the practice" In addition there were internal memos, which were written for the information of the staff. These efforts were undertaken to improve the communication to and from management and staff regarding staff development and client care. Experience has shown that nurses and midwives did not have the habit of reading "nurses and midwives have apathy in reading"

4.6   Phase 2 constructing a staff development model

The second phase of this study dealt with the process for devising a staff development plan. Five workshops were held and each one of them lasting for two hours. The workshops were held at a time which was convenient for the participants. In the first meeting the researcher disseminated the findings from the self-completion survey data to the participants, to inform them and get their comments. In the second workshop the researcher presented two concepts used in developing staff namely, transformational learning perspective and the learning organization. In the third meeting the participants reflected on what was discussed in the two workshops in collaboration with the researcher decided to develop a staff development model which would assist them in developing the knowledge and skills among nurses and midwives in Zambia. In the fourth meeting participants re-examined the model and finalized it. In the fifth meeting participants agreed to utilize the finalized model. The areas which were considered were as follows:

4.6.1 The Setting

The participants felt that a lot which happened in their working environment had an impact on the learning of their staff.

4.6.1.1 Budget structure and policies of the organization.

Inherent in the setting is the staff development budget, participants indicated that the budget was important for developing staff.

"For example if there is no money, which is essential to have the required materials in place, it can make provision of quality service and building capacity of staff difficult"

Furthermore some of the participants said

"If the budget was not adequate and the structure and policies of the organization were not supportive of staff development they affected the performance of the organization adversely and vice versa"

4.6.1.2 Staff development unit

According to the participants in the study, a staff development unit should be responsible for staff development planning "Effective human resource development planning was a very critical function, in the achievement of organizational goals." Others pointed out that "where the staff development unit was functional staff were well informed regarding latest trends in practice"

4.6.1.3 Staff development training.

It was evident from the survey findings that staff training needed to be systematically planned. Participants and the researcher felt the need to plan for staff development.

"It was important that training for nurses and midwives was relevant, systematic and coordinated to meet the needs of the health sector and that of the staff, if organizational goals have to be achieved"

4.6.1.4 Staff development monitoring.

The survey findings showed variations of responses on the evaluation of staff development activities, which may suggest lack of knowledge and skills among nurse managers in evaluating educational programmes. The participants and the researcher felt the need to evaluate educational programmes. Some of the participants said "It was important to evaluate staff development activities in order to ensure efficient utilization of trained nurses and midwives in our institutions"

4.6.1.5 Skilled staff.

Participants felt that "There was a need to have skilled staff who would undertake human resources management, development planning and implementation of staff development activities." Other participants, in agreement with this view, said, "If the human resource unit did not have skilled and experienced staff, the objectives of the organization and that of the staff would not be achieved" It was then jointly agreed that skilled staff were necessary for any organization in order for them to mentor and coach staff.

4.6.1.6 Adequate infrastructure.

The participants and the researcher agreed on the need to have adequate infra structure, such as appropriate, adequate learning and teaching materials, make teaching and learning easier. Unavailable and inadequate infrastructure and teaching

materials affected the organizations adversely. It was agreed that priority during planning would focus on acquiring learning and teaching materials to facilitate building the capacity of nurses and midwives.

4.6.1.7 Performance standards.

These were listed as performance standards, accreditation, and regulation of practice and surveillance of practice by professional councils, to provide direction in practice. The participants felt that one critical area in the working environment was to have the standard tools to guide the performance "We need to have regulation of practice, for example job description, codes of conducts and protocols or any other policies to guide us as we work" After reflecting, it was jointly agreed that performance standards were important in building the capacity of staff.

4.6.2 Factors influencing staff development

Participants indicated that the following were factors which influenced the need to undertake activities to develop staff in their institutions. Disease patterns are changing, for example in Zambia prevalence of malaria was high during the rainy season but now it occurs throughout the year and another is HIV/AIDS. These changes require changed systems and procedures. Other factors are changes in customer needs, new regulations, environmental changes, new materials and new products. To respond to these challenges the participants said, "We need to develop relevant plans and strategies to motivate staff in our institutions to develop a culture of lifelong learning" This agrees with the WHO (2002) which pointed out that knowledge is changing at such a rate that, even with a culture of lifelong learning, keeping abreast of new knowledge is challenging for all health professionals and

health workers. The participants felt the need to develop a staff development model despite the problems which they alluded to. "Without having initiatives in our working environment how will we face the challenges of the changing disease patterns like malaria and new diseases like the HIVAIDS, and many other diseases?" Others pointed out that:

"The communities we serve are very knowledgeable. We need to be kept abreast with the latest trends in our profession if we are to meet the needs of our clients. We must uphold our professional image by the quality of services we provide to our clients. This can only be achieved if we work together and strengthen one another"

4.6.3 Communication

In reflecting on the concepts which the researcher presented with regard to communication, they said:

"We have to do something. For example we need to improve our communication, starting with developing a habit for reading. Many times messages are put on the notice board but nobody reads them. Acquiring and utilizing evidence-based knowledge and skills needs to be inculcated among nurses and midwives in our institutions. We must create an enabling environment which supports individual or collective learning"

4.6. 4 Collective and individual learning

These referred to an enabling environment which facilitated nurses and midwives to work and learn together. For example, each team member shared his or her own knowledge and skills by teaching other team members and in turn learnt from the

other team members, any skills and knowledge that she did not posses. There is need in helping others to demonstrate competencies and to learn. Sharing the learning resources. The group had to create a working dynamic such that everyone took an active part. The participants said, "For staff to reach a stage where they were able to examine their performance, identify the strengths and weakness in their performance, and adjust to meet their goals, they needed support from us supervisors". Others said "as managers we need to take a keen interest in supporting staff to learn by creating an enabling environment." This agrees with (Senge 1990) who pointed out that

> "when staff were genuinely committed to organizational activities as leading to their professional growth and that of the organization they excelled and learnt, not because they were told to, but because they wanted to" (p.90).

4.6.5 Organizational learning

The participants and the researcher agreed that improved performance was the required outcome for all the activities in a learning organization. The individual, the team and the organization improved performance if they were able to promote effective communication and leadership skills, encourage staff self-update and sharing of information and were able to identify training needs. After reflecting on the different areas which were highlighted in the workshop discussions the participants and the researcher were able to list the most important areas to address staff development. These were: the setting of the organization, the functions of a staff development unit in the organization, the factors influencing staff development and the aspects required in motivating staff to learn. Using these identified areas in a learning organization a staff development model was developed as shown in fig 20

134

Fig 20   **Staff development model**

Communication

SETTING
Budget
Structure
Policies

STAFF DEVELOPMENT UNIT
Functions
Responsible for:
Staff development planning

Staff development training
Staff development monitoring
Principles

Skilled staff

Adequate Infrastructure

Performance standards

COLLECTIVE LEARNING
Functions of staff development
Create team ⟶ Shared vision
⟶ Facilitate team reflection
⟶ Give support and feedback ⟶ Promote enabling environment

INDIVIDUAL LEARNING
Functions of staff development

Individual needs assessment ⟶
Individual plan for development
⟶ Monitor development

INFLUENCING FACTORS

Changed systems or procedures.
Changes in customer needs.
New regulations
Environmental changes
New materials
New products

Staff Development Model

IMPROVED PERFORMANCE

Promote effective communication and leadership skills

Encourage staff self-update and sharing of information

Identify training needs

Communication

135

4.6.6   **The staff development model** had six major components namely, the setting, staff development unit, influencing factors, the team and individual processes, communication and organizational learning.

4.7   **Phase 3 Development of an assessment tool**

After having developed the learning organization staff development model, the participants in collaboration with the researcher felt the need to develop an assessment tool in order to ascertain that nurse managers were effectively implementing the developed model. The participants and the researcher went through reflections of planning and identifying ideas or concepts which could facilitate in the development of an assessment tool. In view of the sister-in-charge position which had been chosen to use in implementing the model the participants and the researcher jointly decided to develop a job description of a sister in charge position which were as follows:

4.7.1   **Specific Objectives for the sister in charge position**

The specific objectives of the sister-in-charge position were to encourage self-update, sharing of information and to promote effective communication and leadership skills. Other objectives were to identify staff training needs, update staff with current trends in the provision of health services and to provide a conducive learning environment.

4.7.2   **The job purpose for position of sister-in-charge**

The job description of the sister-incharge was considered. The job purpose of the sister in-charge was to plan, organize and provide the required coordination and

instruction in all activities aimed at the provision of efficient nursing care services to restore, promote and maintain good health.

4.7.3   Principal accountabilities of the sister-in- charge position

The principal accountabilities of the sister in-charge position were to plan, efficiently to organize quality nursing care management through liaison and co-ordination with relevant departments and persons.

She would ensure availability of medical and surgical supplies, drugs, medical equipment through laid-down procedure and effectively control the usage of material resource and keep an updated inventory book at all times.

She would plan effectively for staff requirements, staff levels and identify the training needs of subordinate staff and maintain discipline in order to ensure the availability of competent and motivated staff.

She would actively teach and demonstrate procedures to subordinates, and prepare, review and display ward guidelines in order to ensure effective transfer of knowledge and skills.

She would ensure production of accurate and timely reports on patients in order to facilitate flow of information from top management to subordinates through monthly meetings or whenever necessary.

She would ensure that patients, relatives and staff were provided with quality health education so as to promote hygiene, prevent cross-infection, improve and share knowledge and prepare patients for after-care at home.

The jointly devised staff development tool had the following areas of accountabilities namely: to promote effective communication and leadership skills, encourage staff self-update and sharing of information, and the identification of training needs. The identified responsibilities were eventually used to develop a rating scale by the participants as presented in table 17 below to assess staff development activities in a given setting. A rating scale was used from 0-4. The highest score was 4, a tick was inserted if the skill was demonstrated. Successful performance was assumed if the candidate scored 50% or above

Table17: **Staff development rating scale**

Serial No	Assessment Area	0	1	2	3	4
	Promote effective communication and leadership skills.					
1	Updates staff with relevant current information					
2	Ensures effective information documentation					
3	Clarifies goals and expectations in order to update staff with current trends and practice					
4	Is systematic in planning meetings, coordinating and implementing activities					
	Encourage staff self-update and sharing of information					
5	Acknowledges the juniors knowledge, skills and experience and encourages self-update					
6	Acknowledges and values effort from junior staff					
7	Encourages staff creativity					
8	Encourages staff to participate in new projects					
	Identify training needs					
9	Spends time with juniors to build contact in order to identify their strengths and weaknesses to enable planning for their development					
10	Plans for and undertakes teaching sessions to junior					

	staff based on the identified training needs					
11	Displays ability to counsel staff					
12	Gives honest feedback to juniors in a sensitive manner					
13	Sets high standards of work by adhering to rules and regulations					
14	Keeps commitments with staff					
15	Is personally and professionally accountable					
16	Creates a user-friendly environment.					
17	Provide a conducive learning environment					
18	Maintains confidentiality					
19	Promotes teamwork among staff					
20	Inculcates team spirit					
21	Delegates responsibilities to team members					
22	Demonstrates commitment to juniors					
23	Accepts criticism					
24	Is empathetic to staff					
25	Is reliable					

4.8 Phase 4 Assessment of the implementation of the staff development plan

The participants in collaboration with the researcher decided that in order to establish the practicability of the model and the assessment tool there was need to assess the nurse managers as the model was being implemented, using the developed assessment tool. At the end of the assessment, the nurse managers discussed the assessment results with their staff in a free atmosphere. The process used was able to have a multiplier effect in building capacity for the initial participants (phase 2 and 3 participants) the new participants (phase 4 participants) and the rest of the members of staff in the participating institutions. This process is endorsed by Horton (2001) who contends that capacity development involves the acquisition of new knowledge and its application in the pursuit of individual and organizational goals. For this reason, learning by doing, or experiential learning, lies at the heart of capacity development.

4.8.1 Assessment tool pilot results

The developed tool was piloted in the participating institutions. The collected data was analyzed using SPSS, 11.5 version. Identification numbers were given to participants to ensure that they could not be recognized. The allocated numbers had no numerical value or importance.

Table 18: Promote effective communication and leadership skills

The participants were given identification numbers according to the institutions they worked. The identification numbers had no numerical values or order of importance.

ID	Respondents	Total Score	Maximum Expected Score	Percentage
1	Health institution 1	15	16	93.8
2	Health institution 2	15	16	93.8
3	Health institution 3	14	16	87.5
4	Health institution 4	14	16	87.5
5	Health institution 5	14	16	87.5
6	Health institution 6	12	16	75.0
7	Health institution 7	12	16	75.0
8	Health institution 8	11	16	68.8
9	Health institution 9	11	16	68.8
10	Health institution 10	10	16	62.5
11	Health institution 11	9	16	56.3
	Total	**137**	**176**	**77.8**

Table 18 shows the ratings for all participants in the study. The highest score was 93.8% which was scored by two participants, one who was acting nursing sister-in-charge at institution 1 the other participant who was acting nursing officer from institution 2. The lowest score was 56.3% which was scored by the participant who was acting nursing sister-in-charge from institution 3. The lowest score was above the expected successful performance see (table 17). The high rating scores could have been due to the available support from the facilitators and team members.

Table 19: **Encourage staff self-update and sharing of information**

ID	Respondents	Number	Maximum Expected Score	Percentage
1	Health institution 2	15	16	93.8
2	Health institution 9	10	12	83.3
3	Health institution 7	13	16	81.3
4	Health institution 1	13	16	81.3
5	Health institution 3	12	16	75.0
6	Health institution 4	12	16	75.0
7	Health institution 5	10	16	62.5
8	Health institution 8	10	16	62.5
9	Health institution 6	9	16	56.3
10	Health institution 10	9	16	56.3
11	Health institution 11	5	12	41.7
	Total	**118**	**168**	**70.2**

Table 19 shows the rating scores of staff in the participating institutions. The highest score was by the participant who was acting sister-in-charge from institution 2 and the lowest was 41.7 scored by the participant from institution 11 who was acting nursing sister. This score was below the expected performance.

Table 20: **Identify Training needs**

ID	Respondent	Number	Maximum Expected Score	Percentage
1	Health institution 5	61	72	84.7
2	Health institution 3	60	72	83.3
3	Health institution 1	60	72	83.3
4	Health institution 7	58	72	80.6
5	Health institution 2	56	72	77.8
6	Health institution 4	48	64	75.0
7	Health institution 6	52	72	72.2
8	Health institution 8	50	72	69.4
9	Health institution 9	47	72	65.3
10	Health institution 10	37	72	51.4
11	Health institution 11	36	72	50.0
	Total	**565**	**784**	**72.1**

Table 20 shows the rating scores for participants for identifying training needs. The highest score 84.7% was by the participant who was acting sister incharge in health institution 5

while the lowest 50% was scored by the participant who was acting sister-in-charge in health

institution 11. The lowest score was the same as the expected successful performance.

Fig 21: **Performance of participants in three areas of assessment, promote effective communication and leadership skills encourage staff self-update and sharing of information, and Identifying training needs**
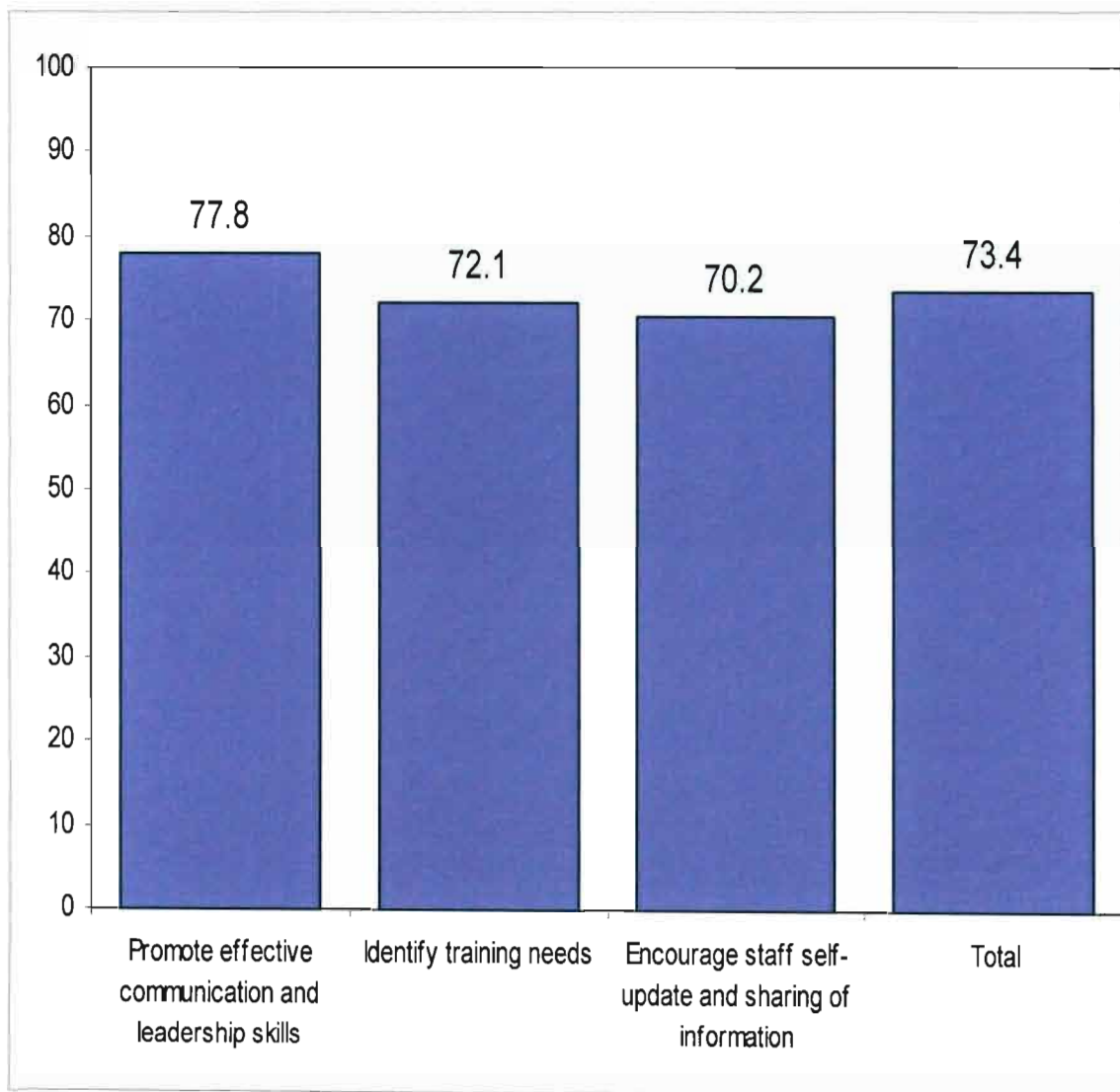
Fig 21 shows the performance of participants in three areas of assessment. It appears

there was consensus in the performance of staff in the participating institutions.

4.9   Conclusion

Data presented in this chapter has addressed identification of the planning systems which nurse managers in the Lusaka district use. The collected data provided a basis for describing the reflective processes the nurse managers went through to develop a staff development model, assessment tool and effectiveness of the implementation of the model.

CHAPTER FIVE

Discussion of results

5 **Introduction to chapter five**

Data collected and presented in the previous chapters is discussed in this chapter. The first phase of the study provides a clear cut picture of the existing planning systems that nurse managers in health institutions use. The second, third and fourth phases of the study provide an account of reflective processes which participants went through in developing a staff development model, assessment tool and implementation of the model in Lusaka district.

5.1 **Current status of staff development in Lusaka district**

The data shows that a total number of 368 (59.9%) nurses and midwives responded to the questionnaire distributed by the researcher. Though the response rate was (59.9%) of the group surveyed, this rate is well within the acceptable return rates for survey research. The data shows that sisters in-charge 104 (28.2%) nursing officers 75 (20.3%) and human resources officers 72 (19.5%) were responsible for staff development in Lusaka district. The respondents might have listed the sisters in charge and nursing officers as being responsible for staff development because these two cadres were responsible for activities in a heath centre, or hospital department.

The data indicates that the participants' range of years of appointment was between 1967 and 2004. High appointment of staff was between 1995 and 2004 which could be attributed to the period when most of the senior nurses went on voluntary separation following the public service reform programme that was launched in 1993 in Zambia. According to the structural adjustment and labour report (2000), the public

service reform programme included the retrenchment of almost 20% of civil servants. In an effort to continue providing quality health service to the community, new officers had to be appointed to various positions.

Effective management and development of human resources is, in any organization, a very critical function in the achievement of organizational goals. According to the Zambian education and training policy (2000) those entrusted with the responsibility to build the capacity of staff should be to:

> "Provide a well motivated workforce, operating in a conducisive environment in which the right skills are available in the right place, at the right time, to deliver quality health service as close to the family as possible" (p.6).

Joost (1995) pointed out that the development of staff has had two components:

> "Firstly, it involved the development of management and leadership skills. Secondly, it included the development of those skills required by the organization. Thus staff development was the systematic process of teaching, training and growth whereby an individual acquired skills, knowledge, attitude and perceptions" (p.49).

Contino (2004) states that the role of the nurse manager is an extremely important role in any organization caring for patients. Individuals who filled this role have multiple responsibilities in overseeing the coordination of care, acting as liaison between administration and their staff, insuring the quality of nursing and developing staff, and staying abreast of budgetary issues. Contino (2004) further states that:

> "An enormous part of the nurse leaders' role was the management of human resources, specifically nursing resources. Considerable attention was paid to

the complexities of understanding people, because just as with a disease, it was easier to implement interventions if the diagnosis was known" (p.54).

Kolenhmainen-Aitken (2004) indicates that local health managers have three main concerns in human resource management, regardless of their span of responsibility. They want to staff their facilities or services appropriately. They want their employees to perform well and be productive at work. They also want well functioning routine personnel administration systems in order to improve efficiency and minimize labor conflicts. The Joint learning strategy report (2005) pointed out that health care is a service that is over-whelmingly worker dependent. As a unique resource, health workers are active agents of health change.

5.1.1 Training Needs (Performance analysis, addressing of identified training needs and evaluation of staff development activities)

The positive response (Table 5), which was given by respondents on performance analysis, 218 (59.2%), indicated that managers in some sites were upholding good performance management practice. In some wards or health centres, some nurse managers were not appraising their staff and may not have been assessing staff training needs. A factor possible contributing to the lack of not identifying staff training needs might have been nurse managers were not familiar with the staff performance system in use. This view is supported by the participants' responses during the workshop discussions when they said "Open appraisal system in the University Teaching Hospital was coordinated by the in-service department, the majority of us from the wards did not play a role" The same view is supported by Martinez and Martineau (1998) who established in their study that:

146

"Effective performance management was rare in public services in developing countries, because prerequisites such as a living wage for health workers and the availability to them of drugs, equipment and transport were often missing" (p.7).

The workshop discussions on knowledge and skills for staff appraisal systems in use showed that staff did not have knowledge of and skills in utilizing the available appraisal systems. These findings were similar to the responses given in the survey and were also similar to a study by Martinez and Martineau (1998), who found that the systems used to appraise staff performance were frequently outdated or poorly understood by local staff. Despite a lack of knowledge about the type of method used for appraising staff, nursing managers were requested to fill in annual confidential reports for their subordinates based on staff need. The participants said during the workshop discussions, "We filled in the annual confidential report form for staff when required by the Ministry of Health" The need for filling in the annual confidential report form for staff may be education, promotion and confirmation to the civil service establishment. Because filling in, of annual confidential report form was on request by individual staff may have contributed to the inconsistency in appraising the staff as shown in both survey and workshop discussions. An organization needs to assess its staff training needs. Identification of staff training needs is important if capacity-building activities are to be efficiently and effectively planned and implemented (Martinez and Martineau 1998). The current practice among nurse managers in Lusaka district, according to the findings in this study, seem to indicate that they were not identifying staff training needs, which may have contributed to uncoordinated and impromptu implementation of staff development activities in the Lusaka urban district. Similar findings were cited by the WHO (2001), which pointed out that there

is a growing recognition of the need for a more strategic approach to provide on-going staff development. Initiatives are still largely delivered in an ad hoc, uncoordinated manner and are seldom based on assessed needs. Chapman (2004) pointed out that an organization needs to assess its people's training needs by a variety of methods and then structure the way that the training and development is to be delivered. Managers and supervisors play a key role in helping this process. They are also expected to 'top up' the development of their staff through their direct efforts. This type of development includes mentoring and coaching, which is very effective in producing excellent staff, and should be used as an additional training method alongside formal structured training courses.

The response (Table 6) of those who indicated that after staff training needs assessments, managers sent them for training, could have been because some staff had the opportunity to go for either short or long courses. The range of negative responses to staff training needs assessments may have been because some staff may not have had the chance to see any nursing manager assessing any staff. Another reason could be that identified staff training needs were not systematically addressed. To improve the performance and productivity of nurses and midwives, nurse managers need to assess staff performance, supervise their subordinates and respond appropriately to identifying performance gaps. According to Bond and Holland (1999):

> "Clinical supervision should be about empowerment and not control, hence emphasizing that the route to professional accountability is through building confidence and self esteem, which in turn requires careful, supportive feedback"(p.1).

Bond and Holland (1999) state that supervision aims at enabling the supervisee to achieve sustain and creatively develop a high quality of practice" (p.2).

It is important that managers realize the purpose of supervision, which is to guide, support, and assist staff to perform well in carrying out their job responsibilities. Phillips (1996) pointed out that:

"A learning organization arises from the total change of strategies that institutions of all types used to help navigate challenges. The fundamentals of the learning organization are not new. What is new was the way in which its advocates think proactively of using learning in an integrated way to support and catalyze growth for individual workers, teams and other groups, and the entire organization" (p.10).

5.1.2   Evaluation of staff development activities

Half of the participants 181 (51.4%) indicated that the success of the staff training programme evaluation was achieved through the performance of the staff who had qualified successfully. Variation of responses on evaluation of staff development activity may suggest that there's not much staff development happening. The contributing factor for not evaluating staff development programmes may have been due to lack of knowledge and skills among nurse managers to evaluate educational programmes. Rae (2000) states that:

"The evaluation cloth must be cut according to available resources, which tend to vary substantially from one organization to the other. The fact remains that good methodical evaluation produced reliable data, conversely, where little

149

evaluation was performed, little was ever known about the effectiveness of the training" (p.2).

For effective staff development and learning evaluation, monitoring should establish the extent to which the objectives of the identified training need and that of the learners' objectives were achieved by the training programme.

5.1.3 Team work as a method for developing the capacities of nurses and midwives

The response, 264 (71.5%), of respondents who answered positively that teamwork was used as a method for developing the capacities of nurses and midwives in their organization might have been attributed to the handover procedures, which staff undertook whenever they reported or went off duty because handover practice is what nurses are exposed to, in ensuring that the on-coming nurse continued the care for the patients. The subsequent responses to the question on authority and responsibility held by teams, suggest lack of understanding of the question, which might have been caused because of lack of knowledge about teamwork. Teamwork is much more than just handing over activities. Senge (1990) saw teams as a vital element of a learning organization. People needed to be able to act together.

5.1.4 Involvement of staff in developmental activities

The findings in the involvement of staff in developmental activities shows that 189 (51.4%), of the respondents indicated that staff were involved in staff development activities. The remaining 181(48.4%) of the respondents said that staff were not involved in developmental activities. Involving some and not others in staff development activities may lead to low staff morale, which may have an effect on staff productivity. Kolenhmainen-Aitken (2004) indicates, "Performance and

productivity are influenced by staff motivation" (p.7). Systematic approaches to involve all staff in developmental activities need to be developed and implemented. In addition the findings seem to suggest that staff who went on leave were not included in staff development programs to update their knowledge and skills upon their return to work. To enhance staff morale according to Kolenhmainen-Aitken (2004) nurse managers needed to institute deliberate plans to keep the staff who may have been on leave updated about developments while they were away.

Kolenhmainen-Aitken (2004) in a study on decentralization and privatization in municipal services states that decentralization brought considerable new skills needs, particularly in management competencies. Local managers' capacity to respond to these and other performance gaps through training is, however, restricted. They lack funds to pay for such training, and often have little or no capacity to plan and implement staff development activities at the local level. When respondents were asked how members of staff knew of the availability of training activities, the range of responses suggests that nurse managers were not using established communication channels. It is apparent from the finding that although staff meetings were held, mostly for managers, it appears there was no free exchange and flow of information to other members of staff. The lack of free exchange and flow of information to other members of staff could have been due to in availability of communication systems to ensure that relevant information is communicated. There is need to have scheduled meetings for the rest of the staff with a deliberate plan for staff development. Peddler, Burgoyne and Boydell (1996) lists a free –flowing information system as one of the major characteristics of a learning organization. Free flow of information is necessary

to inform and empower all members of the organization to enable them to ask questions and make decisions based on the available data.

Dhoot (2002) lists improving staff morale as one of the important aspects in achieving organization goals. Morale is a complex issue, involving things such as professional status, pay, working practices, management style and accessibility to information. The agenda for improving staff morale also includes working with stakeholders to develop effective communication strategies. Embedded in working with stakeholders is the aspect of ensuring production of accurate and timely reports on patients in order to facilitate flow of information from top management to subordinates. In the staff development model, communication cut across all activities in an organization. Employee communications and consultation were the lifeblood of the organization. Indeed whatever the size or type of organization people need to talk to each other. They need to exchange views and ideas, issue and receive instructions, discuss problems and consider developments. The Advisory, Conciliation and Arbitration services (2005) states that:

> "The benefit of employee communication includes improved organizational performance. The time spent communicating at the outset of a new project or development can minimize subsequent rumors and misunderstanding. Improved management performance and decision making allows employees to express their views, and help managers and supervisors to arrive at sound decision, which is more readily accepted by employees as a whole. This is important where new practices or procedures are introduced" (p.5).

5.1.5   Resources (Training materials, budgetary and staff)

5.1.5.1 Teaching materials

More than half, 206 (56.0%) of the respondents indicated that teaching materials were not available. William, (2001) in their study monitoring and evaluation to improve nursing performance in Zambia indicated that nursing quality is often compromised by inadequate supplies and equipment and by insufficient compliance with protocols. The inadequate supply of drugs and teaching materials resulting from scarce allocation of funds in the health sector lowered health standards in hospitals (Sikopo 1999). Nursing is a practising profession. The required and relevant teaching materials need to be available if the necessary skills are to be attained and maintained. This shortage of training material for teaching is acknowledged by the WHO (1996) which pointed out that:

> "Education is key to the development of excellence in nursing practice. However education faces tremendous challenges in keeping pace with the rate of change in nursing practice, especially in countries where financial resources for education are restricted, learning materials are few" (p.25).

5.1.5.2 Budgetary allocations

More than half, 196 (53.3%), of the respondents indicated that a budget for staff development was available. Only 172, (46.7%), indicated that a budget for staff development was not available. In order to verify the utilization of the staff development funds, a follow-up question to establish the budgetary allocation for staff development in each institution was posed. The majority, 284 (77.2%), of the respondents indicated that they did not know the budgetary allocation for staff development while a few, 75 (20.4%), estimated ¼ of the allocation as being spent for

staff development in their institutions. The high figure of those respondents, who indicated that they did not know the budgetary allocation for staff development, is suggestive of a lack of involvement of nurses and midwives in budgetary activities.

This high figure might also have been caused by lack of interest and understanding of financial arrangements by the staff. Pearson (1994) pointed out that:

> "Although there were ward sisters and charge nurses who had already been in control of their ward budgets and felt able to run them effectively, some were ill prepared to take on such a demanding role" (p.1).

Contino (2004) states that international studies indicated a global need for financial education for nurse leaders. Contino (2004) cited financial management as one of the three areas in which development is most needed. Nurse managers need to have basic knowledge of financial management, interpreting financial statements, understanding performance ratios, and recognizing the value of money is essential when financial forecasts and cost implications for business plans are being estimated. Understanding cash flow from when a patient registers to the point of collection of the patient's bill facilitates the design of effective processes. Nurse leaders need to understand how their organizations formulate budgets and how their chief financial officers prioritize capital equipment purchases and expectations for managing in accordance with the unit's budget. To compile a capital budget, managers need to understand the financial implications of leasing versus purchasing, the expected useful life of equipment, and estimated maintenance costs. According to the data in this study, financial knowledge among nurses in the participating institutions was lacking.

5.1.5.3 **Expenditure of staff development activities**

When respondents were requested to estimate how much their organization spent on staff development, the majority, 301 (81.8%), said that they did not know how much of the budget was spent on staff development in their organization. The high response of lack of knowledge might have been because nurses were not given information on expenditure.

5.1.5.4 **Skilled human resources**

When respondents were requested to indicate if staff were available for staff development, the majority, 258 (70.1%), of the respondents indicated that staff in the health institutions were available. Despite the positive response on availability of staff, Hongoro and McPake (2004) in their study on how to bridge the gap in human resources for health, established that human resources are in very short supply in health systems in low and middle income countries compared with high income countries or with the skill requirements of a minimum package of health interventions.

In support of the existing shortage among nurses and midwives, the WHO (2003) stated that the effective provision of health services was severely hampered by the lack of staff in many countries. The migration of health workers has resulted in shortages of key health personnel and has become a prominent issue on regional and international agenda. Human resources are the most critical component of health and social system for achieving improved, equitable health outcomes. Excessive losses of health workers deplete workforces and affect the capacity of health services and systems to maintain adequate coverage and access for the population. WHO (2003) projected that:

"By 2010 in the United Kingdom one in four nurses will be aged 50 years or over and more health workers will be needed to bear this extra burden. Nurses from developing countries will make up these shortages" (p.5).

Cohen Sieren and Topouzi. (2003) indicated that Zambia is not alone in the region in losing human resources through migration to other countries in the region, such as Botswana and South Africa, and overseas to the UK in particular. There are benefits from such migration but there are also severe losses for the county, since the transfers of skilled and highly professional labour represents a clear loss of human resources capacity.

In agreement with this view Parirenyatwa (2004), addressing the public at a graduation ceremony for 99 nurses in Zimbabwe, said:

"The country's health delivery system has been teetering on the verge of collapse for the past few years arising from the massive exodus of skilled manpower prompted by concerns over working and living conditions. Bonding, adopted by Zimbabwe Government last year to arrest the crippling exodus of nurses, will from next year be extended to all professionals in the health sector" (p.1).

Parirenyatwa (2004) indicated that the move was part of efforts being pursued by his ministry to improve the country's health system, which had been beset by a shortage of skilled personnel, most of whom were leaving for other countries. The bonding of health professionals trained by Government would see them being obliged to work in the country for a stipulated period before they were free to resign. Experience has shown that the Zambian on shortage of nurses and midwives in the country is similar to that of Zimbabwe. The Ministry of Health education and training policy (2000)

156

pointed out that Zambia was contemplating embarking on the bonding system for all health professionals in order to improve staffing levels in the health sector. WHO (2003) states that an absolute shortage of personnel with specific HIV/AIDS skills represented only one critical challenge to meeting the human resource needs. It is important to note that a well-trained workforce is an essential prerequisite to high quality health care, but quality is also determined by the organization of the health care system in which the workforce is operating. Harvard school of public health (2001) found a relationship between higher registered nurse staffing levels and the reduction of certain negative hospital inpatient outcomes, such as urinary tract infection and pneumonia.

5.1.6 Performance standards. (Job descriptions, protocols and service targets).

5.1.6.1 Job descriptions

The majority, 279 (75.8%), of the respondents indicated that job descriptions were available. This high proportion may have been caused because job descriptions for each category of staff were kept in each department or health centre for ease of perusal when nurse was in doubt about what should be done. Another contributing factor might have been that some of the respondents might have had personal copies of job descriptions. It is evident from the findings that nurse managers were upholding good management practice. Experience has shown that regardless of the size or complexity of an organization, good job descriptions are vital management tools and important documents for many legal reasons. Patzer (2005) in a study on job description states that while law did not require them, job descriptions are critical in supporting practically every employment action (hiring, compensating, promotion, discipline, and termination). Patzer (2005) further indicates that:

"Job description helps employees to understand exactly what their jobs require so they can focus their attention on the most important tasks first. Job descriptions give managers the guidelines to hire, promote and supervise with maximum effectiveness" (p.6-7).

Despite the reported availability of job descriptions it is not clear from the results when these job descriptions were last reviewed. Patzer (2005) argues that job duties change over time and an outdated job description is of little benefit to anyone. To guard against job descriptions becoming out-of-date there is need to include the job information fields, prepared date and approved date on all job descriptions every time the job description is revised. Each time the job descriptions are revised, all employees should be given a copy of their job description, and asked to give feedback to their managers. All these steps need to be considered if the organizational goals are to be achieved.

5.1.6.2 Protocols

When respondents were requested to indicate the existence of protocols in their institutions, the majority, 272 (73.9%), indicated that protocols of practice were available. Only 95 (25.8%) indicated that they were not available. That the proportion of respondents who replied positively was so high, indicated that various protocols of practice, were put on walls in strategic places in their working sites. Some of the respondents might have had personal copies of protocols of practice. It was clear from the findings that management and staff had made efforts to ensure that various protocols of practice were available to provide guidance in order to make work easier.

5.1.6.3 **Service targets**

When respondents were requested to indicate the existence of service targets in their institutions, more than half, 209 (56.5%), indicated that service targets were available in their institutions while 135 (36.7%), indicated that they were not available. The fairly high proportion of the respondents who said service targets were available indicates that the national service targets are set from the provincial office and each department or health centre has been informed of the targets to achieve in their working sites. The Advisory, Conciliation and Arbitration services booklet (2005) pointed out that employees performed better if they were given regular, accurate information about their jobs, such as updated technical instructions, target, deadlines and feedback. Their commitment was also likely to be enhanced if they knew what the organization was trying to achieve and how they, as individuals, could influence decisions.

5.2   **Contributing factors to nurse manager's inability to undertake capacity building activities in the wards or health centres.**

Participants in the workshop discussions indicated that shortage of staff played a major inhibiting role in the planning and implementation of capacity building activities in health institutions. One participant said

> "Shortage of staff made planning for staff development very difficult. In a situation where you had three nurses on duty especially in the morning shift, it became very difficult to plan and implement a training programme"

WHO (2003), on migration of health personnel, also states that migration of skilled health personnel has adversely affected the quality of health care offered in institutions. The heavy workload per person under very difficult conditions results in

159

long waiting time for patients. A decline in quality of health care also occurred because of unqualified staff were used to carry out specialized duties (WHO 2003). Of equal concern was the loss of experienced health managers in a context of decentralization of services. As a result, the few resources available in national health systems were not used to maximum benefit for the people (WHO 2003).

Furthermore WHO (2003) points out that the loss of mature experienced health managers, senior health personnel and professors to act as role models and mentors for the young is a major consequence of migration. In addition the increasing HIV and AIDS related capacity erosion presents a unique challenge to the operations of the public sector. A shortage of human resources can hobble a country's ability to improve the responsiveness of its health system to the population's needs and expectations. Participants during the workshop discussions highlighted shortage of staff in their working environment as follows: "Sometimes the shortage is so critical that there may be only one nurse on duty"

WHO (2003) states that the negative consequences of migration of health systems have reached a level that they threaten not only the health sector but the overall development of African states. There is need to devise ways to restrict the detrimental effects of brain drain and minimize its effects on health services. It is clear from the findings and literature that planning and the implementation of staff development activities is adversely affected by staffing levels available in the participating health institutions.

5.3 Current practice of building capacity of new staff at ward or health centre level.

The findings showed that health institutions had used different staff development methods to orient staff at one time or another on ad hoc basis.

"We had a system called as 2nd in-charge but due to the shortage of staff in all the departments the practice had been stopped. These second in charge were assigned some of the responsibilities of the sister in-charge. In-order to ensure that this system worked there was need for more staff. If this system was re-activated and be supported by management it would provide an opportunity for us to build the capacity of staff in our institutions especially that there is change in disease patterns and new procedures which require that nurses and midwives are reoriented. In this way we would maintain the staff development function in the setting of our working environment"

Another programme which the university teaching hospital used to develop staff is interns program for newly qualified registered nurses. Mentorship of staff was also being practiced in the participating institutions. A senior nurse to mentor new staff was identified in order to ensure that there was skills transfer. The following is an excerpt from one of the respondents; "Even the shift of the new staff was similar to that of the mentor. The problem was that there were very few senior staff to mentor junior staff"

Boyer (2005), in a study on a Vermont nurse internship project, indicates that there is need to create a formal nursing internship program that provides practical clinical experience for novice nurses to function at competent level when they enter the workforce. Each of these novices needs advanced support, instruction, and precepting to develop the reflecting, learning, critical thinking, and specialty practice skills that are essential to safe, effective nursing care in multiple and challenging settings.

Staff development includes attributes such as ethics and morality, behaviour leadership and determination as well as skills and knowledge. Staff development is a step-by-step process. This view is supported by Peddler, Burgoyne and Boydell (1996), in a study on personal transformation and organizational learning, who established that there could be no organizational transformation without the personal transformation of those involved. The key is in the coordination of individual and organizational learning. Watkins and Marsick (1996), in their study on framework for the learning organization, established that leaders who model learning were key to the learning organization experiments. They took human learning processes into account in the design of changes at individual, team and organizational level. The mentioned programmes namely second in-charge nurses and internship for newly qualified nurses in the participating institutions are no longer practiced due to shortage of staff.

In an effort to develop staff skills, some health centres or hospitals rotated staff from one department to another or from ward to ward or from one health centre to another, to solve existing shortage of staff but at the same time to build their skills by their exposure. Watkins and Marsick (1996) indicate that sporadic movement of staff demotivated them. Instead planned movements, with their participation, need to be encouraged if the goal is to inculcate shared vision and to develop interpersonal relations among staff.

5.4 Management discussing the mission, goals, norms, expectations and regulations of the organization with staff.

When respondents were requested to indicate how often management discussed the mission, goals norms, expectations and regulations of the organization with staff, the majority of the respondents said that management rarely did such discussion. It would seem that nurse managers were too busy to plan for such meetings or discussing with staff is not seen as a priority. It is essential that leaders disseminate and interpret information quickly and accurately. Contino (2004), in a 2-year study of Chilean nurse leaders, suggested that leadership is characterized by exerting a positive influence on others through good communications. At the root of effective communication is delivering the message in such a way as the listener will hear it. Contino (2004) indicated the concept of "seek first to understand, then to be understood" (p.54) is one of the concepts to apply in managing staff. It is very important for a leader to understand what employees need and want, as well as motivating them. The importance of communication is depicted as cutting across in fig 20 (p.135).

5.5 Processes that need to be put in place in order to develop a learning organization

These are processes that staff have to undergo in order to reach a level of contributing to their own professional growth and improving the performance of the organization. The processes referred to in this study include availability of policies to support individual and collective learning. The team and individual processes included team creation, shared vision, team reflection, and feedback support from the team. Another area which was considered by the study participants was an enabling environment for individual and collective learning. Refer to fig 20 (p.135).

When respondents were asked about the existence of individual and collective learning policies their responses showed that there are no policies which support individual and collective learning in the participating institutions (see fig.18 and fig.19,pp.113 and 114). WHO 2003), pointed out that a major drawback of health policies was their failure to make room for issues of human resources. According to WHO (2003) point out that the lack of explicit policies for human resources for health development produces in most countries. The imbalances that threaten the capacity of health care systems to attain their objectives. The absence of principles, declaration or laws that serve as a framework of reference for staff development in the participating institutions in Zambia is a major challenge. Developing explicit staff development policies is one way to clarify objectives and priorities and to promote a more comprehensive and systematic approach to human resources management.

5.6   Factors essential for a staff development plan in a learning organization

When respondents were requested to indicate factors which were essential for a staff development plan, they indicated that the mission, goals, norms, expectations and regulations were critical in planning for staff development in a learning organization. Factors which were essential for a staff development plan, is supported by the Institute for Alternative Futures report (2005), which pointed out that visions motivate high achievement, because when people are really committed to a vision, they stretch themselves and their organizations to make it happen. "Visions raise people's personal aspirations and provide a focus for collective activity" (p.4). This report (2005) further indicates that visions create a broader picture of where staff are going, which makes day to day activity more meaningful. Robin (2004) explains that:

"A vision defines a desired future and helps guide all who accept and understand it. A shared vision can be a tool for building a sense of commitment, by building shared images of the future the organization seeks to create. Within organizations, shared vision allows management to decentralise. People can be given more freedom to act independently and creatively when they have a clear sense of direction and know the importance of their role in the realization of the vision" (p.1).

According to the Institute for Alternative Futures (2005), a mission statement structures efforts to achieve vision, defining major areas of responsibility in clear, objective language. A clear mission statement defines an organization's role by listing the general types of activities that the organization will undertake to achieve its vision. Cardani (2005) defined a mission statement as an "enduring statement of purpose for an organization, that identifies the scope of its operations in product and market terms and reflects its values and priorities" (p.4). Cardani (2005) also pointed out that a good mission statement captures an organization's unique and enduring reason for being, and energizes stakeholders to pursue common goals. It also enables a focused allocation of organizational resources because it compels a firm to address some tough questions, namely what is our business? Why do we exist? What are we trying to accomplish? Cardani (2005) pointed out that a mission statement gives everyone the opportunity to know what the organization is about and what it is not about with this in mind an individual is able to decide if this mission is something to which they can commit. According to Cardani (2005) a well developed mission statement offers several potential benefits. These benefits include "Direction, focus, policy meaning, challenges and passion" (p.1).

According to the Institute for Alternative Futures report (2005) goals establish specific measures of success when they are effectively aligned with mission and vision. Goals need to be achievable within a designated period of time, and they should be well defined. When achieved, the goals provide feedback, affirming the vision, mission and strategies of an organization. In support of this view, Romig (2002) indicated that over 50 studies on goal setting proved that goals and any other direction statements must be worded as specifically as possible for them to influence improved productivity. Harder and Ward (1987, cited in Romig 2002) found that profitable companies had greater agreement on the top five priority goals. (Mission, goals, norms, expectations and regulations) In order to yield the expected outcome and benefits these goals need to be communicated to staff.

5.7 Essentials for a staff development plan

When respondents were requested to indicate what they considered to be essential for a staff development plan in a learning organization, the majority, 231(62.8%), indicated that refresher courses and, knowledgeable people to teach them were essential for a staff development plan. The fairly high proportion of responses for refresher courses and knowledgeable people to teach was suggestive that nurse managers in the wards or health centres did not conduct refresher courses. In addition, the range of responses also suggested that the staff development plans were not well-organized and accessible to staff.

5.8 Essential factors for effective implementation

In discussing essential factors for effective implementation of a staff development plan in a learning organization, the following were mentioned:

5.8.1 Requirements in order to develop a learning organization

When respondents were requested to indicate what they thought was required to develop a learning organization, less than half, 155 (42.2%), said conducisive environment, skilled manpower and budget allocation were necessary for a learning organization. This statistic suggested that these elements available for implementation of staff development activities. The range of responses seems to suggest that proper communication channels are not utilized. Staff development is intended to improve health provider practices but it depends upon many factors, such as who is to be trained and where, and how the information is taught, whether training is reinforced, and how training results are measured. Staff development needs to begin with a thorough understanding of the nurses' abilities, needs and the settings in which they work. Bradle (1998) states that staff development involves a few designated individuals, a team or an entire staff. A model used by Bradle (1998) in the United Kingdom emphasized the value of building the capacity of everyone who worked at the same location in evaluating site performance.

5.8.2 Commitment to learning and personal development.

To achieve commitment to learning and personal development by staff required support from top management. Staff at all levels of care need to be encouraged to learn regularly so that they understand their role and expectations, explore, reflect and develop. Schryer (2004), in discussing the implementing organizational redesign to

167

support practice, states that defining specific behaviors expected of staff is essential in achieving expectations. According to Senge (1990), in a learning organization leaders are designers, stewards and teachers. They are responsible for building organizations were people continually expand their capabilities to understand complexity, clarify vision and improve shared mental models. In this study, after the researcher made presentations on the findings from the survey, on transitional learning and a learning organization, the nurses and midwives felt the need to develop a model which would provide a framework for developing staff in their institutions. Strydom and Delport (2002) in support of the need of developing of a model states that "all parties involved should continue to feel that they are making a contribution that is significant both personally and to the group, while continuing to attend to their individual commitments."(p.423). According to Strydom and Delport (2002), if participants are attracted to the process of staff development they will have a desire to find solutions to the problem(s).

5.9   Components of staff development model

A flexible spiral process was used to create the staff development model with the selected nurse managers. The staff development model which was devised by the participants, in collaboration with the researcher, served as a framework reference for staff development in the participating institutions (see fig 20). The major components of the model are the setting, staff development unit, influencing factors, the team and individual, communication and organization learning. The learning organization is expressed in the form of participants' being able to promote effective communication and leadership skills. Also participants being able to encourage staff self update and sharing of information and identifying training needs. The model emphasized the

value of building the capacity of everyone who worked at the same location and training was usually done at the worksite rather than taking staff to another location (refer to team learning in fig 1A and improved performance 1B p.55). The participatory leadership method was used in implementing the model. Schryer (2004) states that a learning mindset coupled with a new skill set was essential for today's healthcare leadership team to balance quality clinical outcomes successfully with external regulatory requirements, unpredictable reimbursement, productivity demands, resource constraints, and a shrinking workforce. On-site capacity building activities, according to Horton (2001), enhances the process by which individuals, groups, and organizations improve their ability to perform their functions and achieve the desired results over time. The capacity-development efforts in this study were planned so that they improved those capacities that most severely hampered performance levels.

5.10   **Developing a tool for assessing the implementation of the staff development model**

Participants used a flexible spiral process, which allowed them to participate in developing a tool for assessing staff when implementing the staff development model. The participatory leadership method was used as a staff development initiative in building the capacity of their staff when implementing the developed model. In this method all the participants continued to feel that they were making a contribution that was significant both personally and for the other members of staff. When developing the assessment tool, participants took into consideration the existing shortage of senior nursing staff in their working environment. It was evident during the development of the tool, that the tasks of the participants were varied and that some members possessed particular skills. In view of the varied tasks of the participants in the study,

participants decided on the job description of a ward sister. A job description was used because it documented the duties and qualifications of this job.

The team developed an assessment tool to fulfill their felt need to pilot the developed model in order to ascertain the practicality of it. Advancing towards the development of an assessment tool was a result of the reflective process which the participants went through when utilizing the action research process. In this study, in order to avoid loss of interest every participant was kept functionally involved in the process. Keeping participants functionally involved was important to ensure that the training was continuous.

5.11 Implementation of the staff development model

A participatory leadership skill method was used to implement the developed staff development model. Nurses and midwives were involved in the implementation of the model. Selected participants in the participating institutions (Table 18) were assessed during the implementation. The implementation of the staff development model was done at the work site rather than taking staff to another location. Training at the site allows training of all staff in the department or health centre. Training staff at the working site enables clients not to suffer from the absence of staff. Ten of the initial participants (see p.67 sample for the third phase of the study) observed the selected 11 participants and kept anecdotal notes (see p.67 sample for the fourth phase of the study). The implementation was done in one month (February 2005) in the participating institutions and the assessment was being done simultaneously (see table 18 p.140). The final filling in of the staff development tool was done and discussed with each of the participants by the assessing nurse manager (Ten of the initial participants)

The assessment results of the implementation of the staff development model, by the initial ten participants, assessing the acting nurse nursing officers and acting sisters-in-charge in their institutions are being discussed using the theoretical framework (fig 1A Fig 1B and fig 20).

5.11.1 Systems thinking (Systems thinking in fig 1A while in fig 20 is represented by budget, structure and policies)

If top management in the organization is aware of the staff development activities in the wards and health centres and supports the activities, there is a motivational effect on the staff. Joint learning strategy (2005), points out that staff require time and investment to build their capabilities. As people, they have mixed motivations, which include dedication to service, the desire to contribute to society, or wanting to advance their own interests. Some of the nurses said

> "We were motivated especially that we were allowed to attend some of the senior nursing staff meeting. During the staff meeting we mingled freely with the senior nurses. This mingling with senior nurses made us feel recognized"

The staff motivation was shown in the positive participation of staff in the activities which were occurring in their working environment. This agrees with the findings by Martinez and Martineau (1998) in their study in which they established that "good performance requires, among other things a willingness to perform well and to do the job."(p.9). Because of being involved in the activities, there was mutual trust and commitment amongst staff as they gave feedback to each other, thus there was sharing without imposing. Inherent in this sharing among staff was the dialogue, equality and a certain level of intimacy. The participants created knowledge and learnt new behaviour to adjust to the changing circumstances for example everyone was eager to know how to perform a procedure and be able to teach others. The organization was

171

gradually propelled toward progress. In this study, the participants were motivated because "we had a good understanding of our work and how it fitted into the organization as a whole and we were actively encouraged to express our views and ideas". Others said "We became system thinkers and saw the interconnectedness of everything around us and as a result we felt more connected to the whole"

5.11.2 Personal mastery (individual learning in fig 20)

Individual staff in the participating institutions continued clarifying and deepening their personal vision of things that really mattered to them. During the implementation of the model acting sisters-in-charge were able to promote effective communication and leadership skills. They encouraged staff up-date and sharing of information and were able to identify personal as well as staff training needs. They were also able to identify the gap which existed between where they were and where they wanted to go. "Because we planned together I knew what to do next" Kienholz (1999) stated that:

> "One attained personal mastery in one's own thinking and behaviour when one was able to change at will to be situationally responsive to approach a problem or make a decision in the most intellectually...appropriate way" (p.6).

Participants provided processes that encouraged free exchange and flow of information. They ensured that expertise was available where it was needed (availability of skilled staff and availability of performance standards). Participants, in ensuring that work was done in accordance to the set guidelines and standards by the institutions where they worked, developed personal mastery in their thinking. Participants leant to use both reason and intuition. They ensured that if there were people who were incompetent in an area it became their business to bring them on board "I did not fear to ask questions. If I was not sure, everybody was willing to

assist, unlike before when everyone seemed busy and minding their own business"

Senge (1990) points that staff who are willing to assist others are needed at every level

of the organization for the organization to learn.

5.11.3 Mental models (Frame of reference fig 1B)

Larsen, (1996) states that a mental model was a framework for the cognitive processes

of the mind. An example of a mental model was given in an exercise, of pairs of

conference participants who were asked to arm wrestle. They were told that winning

in arm wrestling meant the act of lowering the partner's hard to the table. Most people

struggled against their partner to win. Their mental model was that there can be only

one winner in arm wrestling and that this was done by lowering their partners arm

more times than their partner can do the same to them. Argyris and Schon (1996)

contended that those people in the exercise had a flawed mental model. An alternative

model would present a frame work where both partners could win. If they stopped

resisting each other, they could work together, flipping their arms back and fourth. In

this current study the participants learnt to work together by supporting one another in

the acquisition of knowledge and skills which were necessary in order to achieve

individual, collective and organizational goals. The support was demonstrated in their

willingness to demonstrate procedures to each other in their health centres or wards.

The approach in the staff development model facilitated in recognizing the potential in

each and every member of staff in the participating institutions. Recognition of staff

potential had a motivational effect on the nurses and midwives, hence their

willingness to participate in the activities which were going on their institutions.

5.11.4 Building shared vision (Reflecting together fig 1B)

According to Kienholz (1999), building a shared vision involves having a vision, a set of governing values, a purpose or mission and the goals of the group. During the development of the staff development model and the assessment tool, the participants went through spiral reflections and identified an area of concern in their institutions. The identified area was the lack of leadership among nurses and midwives. "Due to the shortage of senior staff to serve as role models the practice of assigning a junior staff to a senior staff was not in full use"

To address the identified problem, they had to define the necessary objectives and accountabilities of a nursing sister-in-charge which they assessed using the assessment tool which they devised (see p.135). They also identified participatory management as a suitable method for implementing the model. A consensus had to be reached when setting objectives for and implementation of the model. The participants were oriented in the use of the assessment tool. This was done to facilitate understanding of the tool in a uniform manner thereby avoiding varying interpretations. Strydom and Delport (2002), in agreement with having a uniform manner in assessing indicated that it was important that all members were conveying content in a similar light, respecting each other's rights and gathering information in the agreed upon manner.

5.11.5 Team learning (Collective learning fig 20)

The process of developing the assessment tool the model provided for participants an opportunity to learn from their past experiences, as they reflected from transformational learning and the learning organization. "We felt motivated because our input was considered an important contribution to the decision-making process"

This experience agreed with Senge (1990) when he asserted that "In a learning organization, leaders are designers" (p.8).

The staff development model in this study is based on the job training in which staff learnt while on duty. During the implementation of the model, the concept of creating an enabling environment for both individual and collective learning was encouraged. Staff participated in ward activities and served as peer assessors for one another. A forum was deliberately arranged for nurses and midwives to provide feedback to one another, assisting one another to make informed decisions. Participants also made arrangements to demonstrate certain procedures, perform new tasks or operate new equipment, so that the skills were shared amongst the group. "We felt happy to be given a chance to demonstrate what we knew for the benefit of our friends" *Staff* took pride in demonstrating procedures to each other. They learnt on their own and mastered a skill and then wanted to share it with others.

> "We held sisters' meeting every week and discussed everything concerning staff development especially workshops and other issues related to practice. Grand rounds were being done on a weekly basis. During these rounds, nurses and doctors discussed the management of certain clients. These rounds were used a teaching / learning sessions for all health providers"

These meetings created a learning environment for nurses and midwives. "We were able to listen to each other and observed keenly how activities were implemented in our working environment" In this way learning was integrated into the doing as part and parcel of their everyday work. Inherent with integration of learning into doing, communication among the nurses and midwives was enhanced and there was a coordinated pattern of action in the participating institutions. Senge (1990) points out

that team learning starts with a dialogue. In this study the participants were able to engage themselves freely in conversations. "We were able to accept each others' point of view, especially during staff meetings and when undertaking activities" *In* agreement, Drucker (1994) indicates that:

> "Knowledge is power, which is why most people who had it in the past often tried to make a secret of it. In post capitalism, power came from transmitting information to make it productive, not from hiding it" (p.15).

Smith (2001) states that learning organizations are those that had in place systems, mechanisms and processes that are used continually to enhance the capabilities of staff and the organization. Having mechanisms and processes for enhancing capabilities of staff and the organization is an indicator that the staff development model was achieving what it was intended to achieve that of developing a system for staff to learn continually.

The nursing sisters-in-charges are responsible for planning staff development activities (staff development function).

> "Through this staff development model we were empowered to undertake staff development activities according to our job descriptions. We encouraged an enabling environment for individual and collective learning for the staff in our institutions"

The assessment of the acting sisters-in-charge in the participating institutions showed that they were able to promote effective communication and leadership skills, encouraged staff up-date and sharing of information and were able to identify training needs. This achievement is what is termed a as learning organization. "It is amazing that we are now able to do those things that we were not able to do before *"* In addition this

training (staff development function) was done in their working environment and was continuous not on ad hoc basis.

The concept of a learning organization complemented staff development because the overall out-come for the learning organization and staff development was empowering of staff. Hellriegel et al (2002) indicates that the purpose of development and training is to overcome the limitations, current or anticipated that were causing an employee to perform at less than the desired level. Knowles (1998) argued that if staff development was to be aligned with the goals and strategies of the organization and performance was the primary means by which the goals and strategies of organizations were realized, then it follows that: "staff development should be first and foremost concerned with maintaining and/ or improving performance at the organizational, process, and individual levels" (p.117).

In this study nurses grew more rapidly and were able to undertake staff development activities as stipulated by their job descriptions and other staff were able to participate effectively in the activities in their working environment. This was because staff developed the ability to think critically and creatively as shown was in the results of the staff development model assessment (Tables 18, 19 and 20)

5.12 **Limitations**

According to Burns and Grove (1997), "Limitations of a study are restrictions in a study that may decrease the generalizability of the findings" (p.49). The restrictions are either theoretical or methodological. In this study, the limitations were on generalisability, in that the study was only done in the Lusaka district, which is one of the 73 districts in Zambia. This restriction was due to financial constraints. In view of this restriction, the

177

data which was generated may apply only to the Lusaka district in Zambia. According to Babbie (2002) however careful probability sampling provides a group of respondents whose characteristics may be taken to reflect those of the larger population.

Another limitation was the fact that the researcher was known to some of the participants, which may have influenced their responses. The assumption was, however that, due to the precautions taken with the ethical requirements and the assurance of confidentiality, and the use for which the study was intended, the information which was provided by the participants was valid. To overcome these limitations this study adopted a mixed design approach using a survey as well as action research design in order for the research designs to complement each other and make a stronger research design with more valid and reliable findings.

In addition, in order to ensure validity of the data collected, content validity was assessed, using content procedure. This was done by designing an instrument which was measured a representative sample of staff development content. The response among the 5 lecturers in the Department of Nursing of the School of Medicine, who were requested to judge whether the instrument content was in fact representative of staff development, showed substantial agreement among them. This indicated that the instrument was measuring the essential qualities of staff development.

The reliability of the developed instrument was facilitated by pre-testing of the instrument, which showed consistent responses by the participants. Trustworthiness in qualitative data was maintained by carrying out the enquiry in such a way that the probability that the findings were credible was enhanced. The findings in this study of

the planning systems which were being practiced and the devised learning organization staff development can be replicated in Lusaka district.

5.13 Recommendations

This study raised many aspects in staff development that needed consideration by various stakeholders.

5.13.1 National Level

Literature review on staff development model showed that there was no known learning organization for staff development model in Zambia. The learning organization model which was developed and implemented in this study, using the participatory method, showed that staff development activities which were systematically arranged were effective in building the capacity of staff. To enhance performance resulting from learning organization for staff development activities effectively, the national level in the Ministry of Health in Zambia need to develop a staff development policy. The staff development policy should mandate health institutions in Zambia to implement learning organization for staff development model.

5.13.2 Hospital and health centre management level

The findings from the survey and workshop discussions indicated that there were no policies which supported individual or collective learning. Available data (Ministry of Health 2004a, WHO 2002) showed that staff development activities were done on an ad hoc basis and were not linked to the job descriptions of the staff. Literature has shown that training done in this way is not developmental. Hospital and health centre management needed to realize the potential that effective learning organization for

179

staff development offers. The Staff development requires the same kind of professional management and commitment that would be expected in any management function. Hospital and health centre management need to ensure that systematic in-house training courses are prioritized in their human resources plans.

The implementation of the developed learning organization for staff development model in this study showed that improved communication to and among staff was an important tool in providing staff with the information they need to do their work or acquire wider information, and provided a context for them to make decisions about their work. Hospitals and health centre managements need to strengthen and initiate communication strategies deliberately in their working environment if the institutions are to achieve the organizational goals.

5.13.3 Relevant stakeholders in the provision of health services

There were areas in the learning organization for staff development which this study could not address but which need further research. Stakeholders can either support these investigations in terms of funds or undertake further studies in order to broaden knowledge.

There is need to evaluate the learning organization for staff development model after 6 months to establish its efficiency and effectiveness in building the capacity of nurses and midwives, with a view to replicating the study on a large scale within the country and in the African region.

The learning organization for staff development model in this study established that it was possible to utilize the participatory method in developing a system to build the capacity of nurses and midwives in Zambia. Available data indicates that generally reflective analysis research is not used in staff development studies despite qualitative research paradigm having become increasingly recognized as a valuable approach to study health services improvement. Sound qualitative research was especially able to help in the understanding of people's perceptions, beliefs and culture of the setting. There was need for hospital and health centre level management to support staff in their institutions to undertake action research studies to enhance staff capacity.

5.14   Conclusion of the study

The findings showed that there were different roles which were needed to be undertaken by different stakeholders in the area of staff development, if organizational objectives in the health sector were to be achieved. Martinez and Martineau (1998) contended that healthcare reforms required fundamental changes to the ways in which the health workforce is planned, managed and developed within the national health systems. While issues involved in such transition remain complex, their importance and the need to address them in a proactive manner are vital for reforms to achieve their key policy objectives. A staff development model is an essential component in rendering effective health care services. The model offered health care providers an effective framework for addressing issues of staff development. The assessment tool based on the model assisted nurse managers in evaluating the effectiveness of the staff development model. Changing the culture of the workplace towards one of support, nurture, learning and professional advancement needs commitment by all role players in the health sector.

References

Advisory, Conciliation and Arbitration Services (2005). Employee communication and consultation. *Online Journal of Communication* [online], 27th April 2004.Available from: http://www.aca.org.uk/publications/B06.html. [Accessed 27th April 2005].

Alspach, J. (1995). Critical care orientation: A discussion of survey results. Critical Care Nurse, 10 (6), 10–16.

Apps, J. (1994). Leadership for the emerging age: Transforming practice in practice and continuing education. Sanfrancisco. Jossey Bass

Argyris, C. and Schon, D. (1996). Organization learning II: Theory, method and practice. Reading, Mass, Addison Wesley.

Babbie, E and Mouton, J. (2001). The practice of social research. South Africa. Oxford,

Bagwandeen, M. (1993). In-service education and training South Africa. J.L van Schaik

Baird, A. (2003). What being a practice nurse really means. Practice Nursing, (14), 184-185.

Billsberry, J. (1996). The effective manager: perspective and illustrations. London, Sage.

Bogdanowicz, M. (2001). The learning organization: a diverse community of knowledge workers Proceedings of CASAE-*ACEEA* National conference held at kapi'olani community College/University of Hawaii. p.3-7.

Bond, M. and Holland, S. (1999). Skills in of clinical supervision for nurses. Buckingham and Philadephia Open University Press.

Boyer, S. (2005). Vermont nurse internship project a transition to practice model. *Online Journal of Internship Project* [online], 26th May2005 Available from: http://www.vnip.org/internshipproject.html. [Accessed 26th May 2005].

Bradle, J. (1998). Implementation of transformation model for professional practice in health care organization. Journal of Nursing Administration, 35 (6), 311-318.

Buchan, J and Dovlo, D. (2004). International recruitment of health Workers to the UK: A report for the department for international development *Online international Centre on Nurse Migration* [online] 8th September 2004. Available from: http://www.intlnursemigration.org/research.shtml. [Accessed 8th September 2004].

Canadian policy for continuous learning in the public service (2004). Training, learning and development. *Online Journal of Human Resource Management* [online], 5th July 2004. Available from: http://www.tbs-sct.gc.ca/pubs_pol/hrpubs/tb_856/pclpsc-pacfpcl_e.asp. [Accessed 5th July 2004]

Cardani, L. (2005). Corporate mission statements: A strategic management issue. *Online Journal of Human Resource Management* [online], 8th July, 2005. Available from: restaurant hospitalit.v82 pp41-43 online.http:www.web1.infotrac.group.com. [Accessed 8th July, 2005].

Central Board of Health (2002). Assessment of integrated competency training. Lusaka, Zambia.

Central Board of Health (2002). Action plan. Lusaka, Zambia.

Chapman, C. (2004). Management science: Science of managing and managing of science. interfaces, (24), 99-110.

Cohen, D. Sieren, A. Topouzi, D. (2003). Sustaining human resources capacity in Zambia. UNV Mission report.1-46

Contino, D. (2004). Leadership competencies: Knowledge, skill, and aptitudes nurses need to lead organizations effectively. Critical care Nurse, 24(3), 53-63.

David, L. (2000) Management: Building and sustaining competitive advantages. *Online Journal of Library of Congress Cataloguing*. [online]. Available 8th August 2005. Available from: http//www.web1.infotrac.galegroup.com. [Accessed 8th August 2005]

Dhoot, M. (2002). Improving staff morale. Proceedings of 2003 international conference held at the Ontario hospital, Ontario. 1-46.

Dick, B. (2002). Action research: Action and research. *Online Journal of Action Research* [online], 8thAugust 2005.Available from: http//www.scu.edu.au/schools/gcm/ar/arp/aandr.html. [Accessed 8th August 2005].

Drucker, P. (1992). The new society organization. Atlantic Harvard Business Review 70(5) 95-104)

Drucker, P. (1994). The age of social transformation. Atlantic, 274(5), 21-30.

Dussault, G. (2002). Human resources for health policies: a critical component in health policies. *Online Journal of Human Resource Management* [online], (1)1 20TH July 2005 available from: http:// www.human_resourceshealth.com/1/1/1. [Accessed 20TH July 2005]

Elden, M. Levin M. (1991). Cogeneration learning bringing participation into action research. In Whyte (ed) Participatory action research. Newbury Park, Sage.p.127-142.

Ennis, K. (2002). Head and heart in quality implementation applying the quality philosophy within Irish health institutions. Total Quality Management and Business Excellence, 15(8), 1143-1153.

Fisher, M. (1998). The distributed mind, achieving high performance through the collective intelligence of knowledge work teams. Journal of Learning Organization, (9) 41-44.

Gerber, R. and Lankshear, C. (1995). Self directed learning in a work context. Education and Training, 37 (8), 26-32.

Golafshani, N. (2003). Understanding reliability and validity in qualitative research, 8 (4), 597-606.

Gravett, S. (2004). Action research and transformative learning in teaching development. Education Action Research, (12), 259-272.

Gravett, S. Petersen, N. (2000). Academic staff development from a transformational learning perspective. *South African Journal of Higher Education*, 14 (1), 31-36.

Griffiths, M. (2003). Meeting the needs of the health care system, a refresher course for registered nurses. Continuing Education in Nursing, 34 (4), 162-170.

Habaghery, M, Salsali, M. and Ahmadi, F. (2004). A qualitative study of Iran nurses understanding and experiences of professional power. Human Resources for Health 2 (9)

Hager, M. (2002). Response rates for mail surveys of non-profit Organization: A review and empirical test.1-23.

Harder, D. and Ward, A. (1987 cited in Romig 2002). How focussed is your organization. *Online Journal Human Resource Management* [online] 20th June 2005. Available from: http://www.sidebyside.com/focusedvision.htm.[Accessed 20th June 2005].

Harvard School of Public Health, Vanderbilt University school of Nursing and Abt associates (2001). Staffing and patient outcomes in hospitals. *Online Journal of Nursing Management* [online] 27th June 2001 Available from: http://www.gao.gov/new.items/d01912t.pdf. [Accessed 21St June 2005]

Heath, H. (1998). Reflection and patterns of knowing in nursing. Advanced Nursing, (27), 1054-1059.

Hellrielgel, D. Jackson,S. and Slocum.J. (eds) (2002). Management a competency- based approach Australia, South western learning.

Henkoff, F. (1993). Companies that train best. *Online Journal of Human Resource Development* [online], 24 April 2003. Available from: http://www.nwlink.com/-donclark/hrd/sa2.html [Accessed on 24 April 2003].

Hongoro, C. and McPake, B. (2004). How to bridge the gap in human resources for health. *Online of Journal of Human Resources Management* [online] 16th October 2004. Available from: www.thelancet.com [Accessed 16th October 2004].

Horton, A. (2001). Planning, implementing and evaluating capacity development. Proceedings of 2002 international conference for service agriculture research held in the Netherlands.

Human, L. (1991). Education and development for change. Cape Town, South Africa, juta and Co LTD.

Humphris, D. (2002). Shaping a vision for a new generation workforce. *Online Journal of Management* {online}, 15th June 2003. Available from: http://www.hciu.soton.ac.uk/docs/IPPR%20paper.pdf. [Accessed 15th June 2003].

Imel, S. (1998). Transformative learning in adulthood. Eric Digest, (200), 1-6.

Inger, M. (1992). Increasing the school involvement of Hispanic parents. ERIC Digest. New York: ERIC Clearinghouse on Urban Education, Teachers College, Columbia University.

Institute for alternative futures report (2005). A guide for thinking about the future. *Online Journal of Management* [online], 20th July, 2005. Available from: http:www.altfutures.com [Accessed 20th July, 2005].

Institute of Medicine, National Academy of Sciences Washington, (1988). The future of public health intelligence of knowledge work teams. Learning Organization. (9), 41-44.

Joint learning initiative strategy report (2005). Human resources for health overcoming the crisis. *Online Journal of Human Resource Management* [online], 25th July 2005.Available from: http://www.globalhealthtrust.org/report.hml. [Accessed 25th July 2005].

Jones, S. (1999). Knowledge workers and knowledge-intense organizations, part 3: Implications for preparing healthcare professionals. Nursing Administration, 29(10), 14-21

Joost, R. (1995). Staff development for nurses southern book publishers' Cape Town. South Africa.

Keith, G. (2002). Maximizing response rate and controlling nonresponse error in survey research. [online], 16th June, 2004.Available from: http://www.roe.rutgers.edu. [Accessed 16th June, 2004].

Kienholz, A. (1999) Systems rethinking: An inquiring system approach to the art and practice of the learning organization. Foundation of information system. *Online Journal of Foundations of Information Systems* [online], 15th June, 2005 Available from: http://www.bauer.uh.edu/parks/fis/inqre2a1.htm. [Accessed 15th June, 2005].

Kim, D. (1993). The link between individual and organizational learning. Management Review. 37-50.

Knowles, M. (1998). The adult learner. Houston, Gulf publishing.

Kolehmainen-Aitken, R. (2004). Decentralization and human resources: implication and impact. *Online Journal of Human Resources Development* [online], (2) 15th July, 2004. Available from: http://www.opas.org.br/rh/areas-det.cfm?id-doc=108 &id-area=1. [Accessed 5th July, 2004].

Lacey, A. and Luff, D. (2001). Trent Focus for research and development in primary health care: An introduction to qualitative analysis, Sheffield trend focus.

Larsen, A. (1996) Learning organizations in the knowledge intens organization of the future. *Online Journal of Learning Organization* [on line], 15th June 2005 Available from: http://home.nycap.rr.com.klarsen/learnorg. [Accessed 15th June 2005].

Lewin, K. (1946). Action research and minority problems. Social Issues, 2(4), 34-46.

Lincoln, B. and Guba, Y. (1985). Naturalistic inquiry. Newsbury Park, Sage publications.

MacLean, J. (2003). Building capacity for heart health promotion. health promotion, 17(3), 202-12.

Mahlungulu, S. (2001). Spiritual care in nursing: A grounded theory analysis. Unpublished PhD in Nursing Dissertation, University of Kwazulu Natal.

Marlo, D. (2003). Creating high performing leadership team. *Online Journal of Management.* [Online], July August 2003. Available from: http://www.aiconsulting.org/success/success-lafarge.htm. [Accessed July August 2003].

Martinez, J. and Martineau, T. (1998). Rethinking human resources an agenda for the millennium. Health Policy Plan, (13), 345-358.

Mcdermont, R. (1995). Working in public learning designing collaborative knowledge work

teams, (2), 35-59.

Megginson, D. Banfield, P. and Matthews, J. (1999). Human resource development.

London,Kogan Page Limited.

Mezirow, J. (1997). Practice. New directions for adult and continuing education. San

Francisco, CA Jossey-Bass.

Mezirow, J. (2000). In Gravett, S. (2004) Action research and transformative learning in

teaching development. Education Action Research, (12), 259-272.

Midterm review report (2004) Lusaka, Zambia.

Ministry of health human resources for health (2004). A synopsis of the current staffing and

proposal for action in Zambia.

Ministry of health human resources for health (2004a). Lusaka, Zambia.

Ministry of health human resources for health (2004b). Lusaka, Zambia.

Ministry of health human resources for health (2004c). Lusaka, Zambia.

Ministry of health human resources for health national health strategic plan 2001-2005

Ministry of Health Institutional Appraisal report (2001). Lusaka, Zambia

Ministry of health, education and training policy (2000). Lusaka, Zambia.

Ministry of health, hospital policy (2003). Lusaka, Zambia.

Ministry of health, Joint mission report (2002) Lusaka, Zambia.

Ministry of health, national 10-year human resource plan for the public health sector (2001).

Lusaka, Zambia.

Neuman, W. (1997). Social methods: Qualitative and quantitative approaches. Boston, Allyn and Bacon.

Nevis, E. Dibell,A and Gould, J. (1995). Understanding organizations learning as learning systems. Sloan Management Review, 36 (2), 73-92.

North Carolina division of medical assistance (2002). Asthma: collaborative learning. Nursing Administration, 23(3), 17-25.

Ortega, R. and Molina, J. (2003). Effects of employee training on the performance of north American firms. Applied Economics Letters, (10), 549-552.

Parirenyatwa, D. (2004). Bonding system in Zimbabwe. Masvingo Bureau Bonding.

Patzer, D.(2005) Why are job descriptions important? CSRMA job description builder worksheets. (1), 1-16.

Payne, T. (1996). Mission/purpose: Managers handbook. *Journal of Human Resources Management* [online] 8th August 2005 available from: http://www.web1.infotrac.galegroup.com.[Accessed 8th August 2005].

Pearson, D. (1994). The primary health care non team, *British Medical Journal*, 309, 1387-1388.

Pedler, M.Burgoyne, J. and Boydell,T. (1996). The learning company: A strategy for sustainable development, London Mcraw-Hill.

Peel, M. (2002). Staff development, Philadelphia. Lippincott.

Phillips, J. (1996). Accountability in human resource management. Houston.TXGulf publishing company.

Polit, D. and Hungler, B. (1999). Essentials of research, methods, appraisal and utilization, 5th edition. Philadelphia, Lippincott.

Rae, L.(2000).Training programme evaluation. *Online Journal Education And Training* {online},2nd February 2004. Available from: http://www.bussinesballs.com/trainingprogrammevaluation.htm.[Accessed 2nd February 2004].

Rennick, J. (1995). The changing profile of acute childhood illness: a need for the development of family nursing knowledge. Advanced Nursing. (22), 258-266.

Ritchie, J. and Spencer, L. (1994) qualitative data analysis for applied research in: Robin, D. (2004). Vision, mission and values: Management tools for building a better workplace. *Online Journal of Management Tools for Building a Better Workplace.* [online], 2nd August 2005 available from: http://www.abetterworkplace.com/027.html.[Accessed August 2005].

Romig, D. (2002). How focussed is your organization's or team vision. *Online Journal of Performance Management* {online} 20 June 2005 Available from: http://www.sidebyside.com/focusedvision.htm. [Accessed 20 June 2005].

Rusch, j. (2001). Competency program development across a merged healthcare network. Nurses in Staff Development. 17 (5), 234.

Schryer, N. (2004). Implementing organizational redesign to support practice. Journal of Nursing Administration, 34 (9), 400-406.

Senge, P. (1990). The fifth discipline: The art of practice of the learning organization, New York. Doubleday.

Senge,P. (1994). The fifth discipline field book: strategies and tools for building a learning organization. New York. Doubleday.

Sikopo, B. (1999). Measuring and monitoring of staff performance in a reforming health systems: Chainama hospital case study. Unpublished, Central Board of Health.

Smith, A. (1994). The issues of homogeity in organizations. Issues and Observations, (4), 7-8.

Smith, K. (2001). Peter Senge and the theory and practice of the learning organization. *Online Journal of Learning Organization* [online], 15th June 2005. Available from: http://www.infed.org/thinkers/senges/senge.htm.[Accessed 15th June 2005].

Smith, M. (1982). Contemporary communication research methods. Califonia. Adsworth publishing company, Belmond.

Structural adjustment and labour report (2000), The public service reform programme. *Online Journal of Essential Action* [online], 1 5th July 2004.Available from: http://www.essentiaction.org/labour-report/zambia.html. [Accessed 5th July 2004].

Strydom, H. and Delport, C. (2002). Research of grassroot for the social sciences and human service professions second edition. South Africa. Van Schaik.

Swanepoel, B (eds) (1998). Human resource management theory and practice. Kenwyn : London, Juta & Co, Ltd.

Taylor, E. (1998). Teaching with developmental intention, in Gravett, S. (2004). Action research and transformative learning in teaching development. *Education Action Research, (12), 259-272.*

The National Centre, *(1996).* The educational quality of the workforce at the University of Pennsylvania, Washington Post.

Truelovemore, S. (1998). Training and development London, Macmillan.

Tuckman, B. (1985). Evaluating instructional programs (2nd ed.). Boston: Allyn and Bacon.

Valentine, S. (2002). Nursing leadership and new nurse. *Online Journal of Nursing* [online], 20th May, 2004 Available from:

http://juns.nursing.arizona.edu/articles/Fall%202002/Valentine.htm.[Accessed 20th May, 2004].

Wagner, I. (2000). The role of patient care teams in chronic disease management. *British Medical Journal*, 320 (7234), 526-527.

Watkins, K. Marsik, V. (1996). Building the learning organization: a new role for human resource developer. *Studies in Continuing Education*, 14 (2), 115-129.

WHO and World Heath Bank (2002). Building strategic partnership in education and in health. *Technical report series*, 860, 4.

WHO (1996). Nursing practices. *Technical Report Series* 860, 10-17.

WHO (1997). Nursing practice around the world. *Technical Report Series*, 97.5, 25-39.

WHO (1997). Sustainable development: Implication for nursing and midwifery. *Technical Report Series,* 97.1, 17-30.

WHO (1998). Regional strategy for development of human resources for health. *Technical Report Series,* 96.2, 1-20.

WHO (1998). The practical role of nursing and midwifery personnel in public health. *Technical Report Series* 842, 10-12.

WHO (2001). Strengthening nursing and midwifery progress and future directions. *Technical Report Series,* 2001.6, 42 -50.

WHO (2002). Conceptual framework for management of the nursing and midwifery workforce. *Technical Report Series*, 86.1, 1-25.

WHO (2002). Human resources development for health accelerating implementation of the regional strategy. *Technical Report Series*, 2002.2, 1-20.

WHO (2002). Placing health workers at the heart of health services delivery in Africa. *Technical Report Series,* 95.2, 2-15.

WHO (2003). Strengthening human resources capacity for effective health systems in East, Central and Southern Africa. *Technical Report Series* 96.11,20-25.

William, T. (2001). Using monitoring and evaluation to improve nursing performance in Zambia. *Online Journal of Nursing Management*. [Online], 21st June 2004.Available from: http://apha.confex.com/apha/129am/techprogram/paper-23331.htm. [Accessed 21st June 2004].

Zairi, M. and Peters, J. (2002). The impact of social responsibility on business performance. Managerial Auditing. Emerald, 17(4).

Zemke, R (1981).Thirty things we know for sure about adult learning and training. 18 (6), 45-52

Annexure 1

Permission Letters

School of Nursing
Faculty of Community and Development Disciplines
Durban 4041 South Africa
Telephone: +27 (0)31 260 2499
Facsimile: +27 (0)31 260 1543
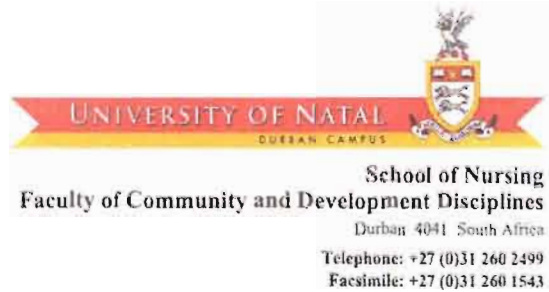
RESEARCH ETHICS COMMITTEE

Student: Miriam Libetwa

Research Title: Development and implementation of a staff development plan for nurses in one district in Zambia based on a learning organization approach.

A. The proposal meets the professional code of ethics of the Researcher:

YES √ NO

B. The proposal also meets the following ethical requirements:

		YES	NO
1.	Provision has been made to obtain informed consent of the participants.	√	
2.	Potential psychological and physical risks have been considered and minimised.	√	
3.	Provision has been made to avoid undue intrusion with regard to participants and community.	√	
4.	Rights of participants will be safe-guarded in relation to:		
	4.1 Measures for the protection of anonymity and the maintenance of confidentiality.	√	
	4.2 Access to research information and findings.	√	
	4.3 Termination of involvement without compromise.	√	
	4.4 Misleading promises regarding benefits of the research.	√	

Signature of Student: _MLibetwa_ Date: _23/10/2003_

Signature of Supervisor: _A. van Heerey_ Date: _23.10.03_

Signature of Head of School: _____ Date: _12/11/2003_

Signature of Chairperson of the Committee: _____ Date: _24 No '03_
(Professor F Frescura)

C:\WINDOWS\TEMP\ETHICS FORM.doc

196

THE UNIVERSITY OF ZAMBIA

RESEARCH ETHICS COMMITTEE

Telephone: 256067
Telegrams: UNZA, LUSAKA
Telex: UNZALU ZA 44370
Fax: + 260-1-250753
E-mail: unzarec@zamtel.zm

Dean's Office
P.O. Box 50110
Lusaka, Zambia

Assurance No. FWA00000338
IRB00001131 of IOR G0000774

Ref: 007-12-03
5 January, 2004

Ms Mirriam Libetwa, MPH, BSc Nursing, DNE, PHE, RM, RN
Central Board of Health
P.O. Box 32588
LUSAKA

Dear Ms Libetwa,

RE: SUBMITTED RESEARCH PROPOSAL
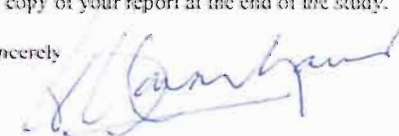
The following research proposal was presented to the Research Ethics Committee meeting on
17 December, 2003 where changes were recommended. We would like to acknowledge receipt of the
corrected version. The proposal has now been approved. Congratulations!

Title of proposal: 'Development and implementation of a staff development plan for Nurses in
one District in Zambia based on a learning organization approach'

Conditions:

- This approval is based strictly on your submitted proposal. Should there be need for you to modify or
change the study design or methodology, you will need to seek clearance from the Research Ethics
Committee.
- If you have need for further clarification please consult this office. Please note that it is mandatory
that you submit a detailed progress report of your study to this committee every six months and a
final copy of your report at the end of the study.

Yours sincerely

Prof. J. T. Karashani, MB, ChB, PhD
CHAIRMAN
RESEARCH ETHICS COMMITTEE
Date of approval: 5 January, 2004   Date of Expiry: 4 January, 2005
Please note that when your approval expires you may need to request for renewal. The request should be
accompanied by a progress report (Progress Report Forms can be obtained from the Secretariat).

The University of Natal
School of Nursing
University Of Natal
Durban 4041
South Africa

22nd October 2003

The Provincial Health Director
Lusaka Province
Central Board of Health
Box 32588 Lusaka

Re Permission to conduct a research

Dear Sir,

I'm undertaking a study that is a dissertation to be submitted to the University of Natal in fulfilment of the requirement for the degree doctor of philosophy (Nursing).

The title of my study is development and implementation of a staff development plan for nurses in one district in Zambia based on the learning organization approach. Two methods will be used namely conducting a survey and action research which will involve nursing managers, registered nurses and enrolled nurses attending workshops and having focus group discussions.

The purpose of this letter is to request for permission to conduct the research in Lusaka Urban District.

Yours sincerely

Miriam Libetwa
PhD student

The University of Natal
School of Nursing
University Of Natal
Durban 4041
South Africa

22nd October 2003

The District Director of Health
Lusaka Urban District
Central Board of Health
Box 32588 Lusaka

Re Permission to conduct a research

Dear Sir,

I'm undertaking a study which is a dissertation to be submitted to the University of Natal in fulfilment of the requirement for the degree doctor of philosophy (Nursing).

The title of my study is development and implementation of a staff development plan for nurses in a health district in Zambia based on the learning organization approach.

Two methods will be used namely conducting a survey and action research, which will involve nursing managers, registered nurses and enrolled nurses attending workshops and having focus group discussions.

The purpose of this letter is to request for permission to conduct the research in Lusaka Urban District.

Yours sincerely

Miriam Libetwa
PhD student

P.O. Box 50827
Lusaka
Tel: 235554
Fax: 236429

In reply please quote
No ....

MINISTRY OF HEALTH
LUSAKA DISTRICT HEALTH MANAGEMENT BOARD

12th February, 2004

Ms. Mirriam Libetwa
CBoH-Ndeke House
P.O. Box 32588
LUSAKA.

Dear Madam,

RE: RESEARCH UNDERTAKING-YOURSELF

Be informed that permission has been granted for you to conduct research in Lusaka District.

However, this is subject to you presenting a summary of your research proposal to this office for our perusal.

Secondly as you are undertaking this activity there should be minimal disruption of the day to day activities at the Health facilities.

Yours faithfully,

Dr. M. Kabaso
Clinical Care Expert
For/DISTRICT DIRECTOR OF HEALTH-LDHMB

200

The University of Natal
School of Nursing
University Of Natal
Durban 4041
South Africa

22nd October 2003

The Managing Director the University Teaching Hospital
P.O Box 50001
Lusaka

Re Permission to conduct a research

Dear Sir,

I'm undertaking a study which is a dissertation to be submitted to the University of Natal in fulfilment of the requirement for the degree doctor of philosophy (Nursing).

The title of my study is development and implementation of a staff development plan for nurses in a health district in Zambia based on the learning organization approach.

Two methods will be used namely conducting a survey and action research, which will involve nursing managers, registered nurses and enrolled nurses attending workshops and having focus group discussions.

The purpose of this letter is to request for permission to conduct the research in Lusaka Urban District.

Yours sincerely

Miriam Libetwa
PhD student

University Teaching Hospital

(Board of Management)

P/Bag RW 1
Lusaka - Zambia
Tel: 253947 (Switch Board)
250305 (Direct)
Fax: 250305
Telex: ZA 40299

OFFICE OF THE MANAGING DIRECTOR

Our Ref: *UTHB/DN/7/6*

Your Ref:

6th April 2004

Mirriam Libetwa
Central Board of Health
Box 32588
LUSAKA

Dear Madam

REF: **PERMISSION TO CONDUCT A REASERCH**

Reference is made to your letter dated 8th January 2004 regarding the above mentioned subject.

Management is pleased to inform you that your request to conduct your research has been approved.

Thank you.

Yours faithfully
UTH BOARD OF MANAGEMENT

T K Lambart (Dr)
MANAGING DIRECTOR

MMM/msn

202

The University of Natal
School of Nursing
University Of Natal
Durban 4041
South Africa

22nd October 2003

The Director
Chainama College Hospital
Lusaka

Re Permission to conduct a research

Dear Sir,

I'm undertaking a study which is a dissertation to be submitted to the University of Natal in fulfilment of the requirement for the degree doctor of philosophy (Nursing).

The title of my study is development and implementation of a staff development plan for nurses in a health district in Zambia based on the learning organization approach.

Two methods will be used namely conducting a survey and action research, which will involve nursing managers, registered nurses and enrolled nurses attending workshops and having focus group discussions.

The purpose of this letter is to request for permission to conduct the research in Lusaka Urban District.

Yours sincerely

Miriam Libetwa
PhD student

CHAINAMA HILLS COLLEGE HOSPITAL BOARD OF MANAGEMENT

All official communication should be
Addressed to: THE EXECUTIVE DIRECTOR
and Not to individual Officers

Tel: 283844/6
Telefax: 283824

TRAINING DEPT. COLLEGE OF HEALTH SCIENCES
P.O Box 33991
Telefax: 283827
Lusaka, Zambia

P.O. Box 30043
Lusaka
ZAMBIA

Ref: CHCHBM/MMZ/rcs/2004/1

9th January. 2004

Ms. Mirriam Libetwa
Central Board of Health
P.O. Box 32588
LUSAKA

Dear Ms. Libetwa

Re: **PERMISSION TO CONDUCT A RESEARCH**

We acknowledge receipt of your letter dated 8th January, 2004 on the above captioned subject.

We wish to inform you that permission has been granted for you to conduct a research in this institution.

Yours sincerely,

Dr. M.M. Zulu,
EXECUTIVE DIRECTOR

204

CONSENT FOR PARTICIPATION IN A RESEARCH STUDY

Dear Participant,

Iam a student at the University of Natal, Durban South Africa. Iam doing a research study in health Institutions in Lusaka District undertaking a study which is a dissertation to be submitted to the University of Natal in fulfilment of the requirement for the degree doctor of philosophy (Nursing).

The purpose of the study is to develop and implement a staff development plan for nurses in one district in Zambia based on the learning organization approach. Doing a survey using a structured questionnaire and focus group discussions will be used to collect data. The results will provide information on developing staff.

Iam therefore requesting you to participate in the study. Participation is voluntary and you have a right to withdraw from the study.

Kindly fill in the slip below and sign.

....
....
Iam willing /not willing to participate in the said study

Full name

....

Signature/Thumb print..............................Date

....

Contact Details

Miriam Libetwa
University of Natal
School of Nursing
Faculty of Nursing and Community Development
Durban 4104
South Africa
Local Telephone 097851880

THE UNIVERSITY OF NATAL DISSERTATION FOR PhD NURSING MANAGEMENT QUESTIONNAIRE NURSE MANAGERS REGISTERED NURSESAND ENROLLED NURSES
THE QUESTIONNAIRE WILL TAKE APPROXIMATELY 35 MINUTES

INSTRUCTIONS

1   **Information given will be kept strictly confidential.**

	Section A	**Social Demographic Data**

1   Age   1=25-29
                         2=30-34
                         3=35-39
                         4=40-44
                         5=45-55

2   Sex   1=male
                         2=Female

Section B   **Professional Data**

3   Position Held Position Held

Position Held	
Nursing Manager	
Registered Nurse	
Enrolled nurse	

4   Year of appointment to current position appointment year………….

Section C Activities in Human Resources Unit Section (Management Support)

5   In your opinion what are the objectives of staff development?

....

6   How do managers identify the needs of staff for training?

....

7   How are the identified needs addressed?

....

8   How is the success of staff development evaluated?......................................

9   Who is responsible for staff development in your setting?

Person	Position	Qualification	Other

10   What teaching Resources are available for staff development

Resources	Availability
Teaching materials	
Budget allocation	

11 What performance standards are available in your setting?

Serial no	Performance standards	Yes	No
1	Job description		
2	Protocols of practice		
3	Service targets		

Section D   Organizational Development Setting

12   What is the budgetary allocation for staff development in your organization?

1=   3/4 of the institutions allocation

2=   1/2 of the institutions allocation

3=   1/4 of the institutions allocation

4=   Any other explain...

13   How much does your organization spend on staff development activities?

1=   3/4 of the allocation

2=   1/2 of the allocation

3=   1/4 of the allocation

4=   Any other explain..

14   Are there policies, which support individual learning?

1=   Yes

2=   No

3=   Please give an explanation for the alternative you have chosen............................

15 Are there policies, which support collective learning?

1= Yes

2= No

3= Please give an explanation for the alternative you have chosen...........................

Section E   Communication/Collaboration

17   Indicate how often management discuss with staff on the mission, goals budgetary allocation for staff development and direction of the organization they work for

1=   Once a year

2=   Twice a year

3=   Three times year

4=   Rarely

5= Any other please explain...

18   Indicate how often management discuss with staff on the goals of their organization?

1=   Once a year

2=   Twice a year

3=   Three times year

4=   Rarely

5=   Any other please explain...

19   Indicate how often management discuss with staff on the budgetary allocation for staff development and direction of their organization?

1=   Once a year

2=   Twice a year

3=   Three times year

4=   Rarely

5=   Any other please explain...

20   Does management discuss with staff on the norms of your organization?

1=   Yes

2=   No

21   If yes when does management discuss with staff on the norms of the organization?

1=   At the time of engagement

2=   At the end of probation period

3=   At the time of being promoted

4=   At the end of each planning year

5   Any other please explain..

22   Does management discuss with staff on the expectation of your organization?

1=   Yes

2=   No

23   If yes when does management discuss with staff on the expectation of the organization?

1=   At the time of engagement

2=   At the end of probation period

3=   At the time of being promoted

4=   At the end of each planning year

5=   Any other please explain ....

24   Does management discuss with staff on the regulation of your organization?

1=   Yes

2=   No

25   If yes when does management discuss with staff on the regulation of the organization?

1=   At the time of engagement

2=   At the end of probation period

3=   At the time of being promoted

4=   At the end of each planning year

5   Any other please explain...

26   Is teamwork as a method for developing the capacities of nurses and midwives discussed in your organization?

1=   yes

2=   No

27   If yes explain..

28. If no what methods are used to develop nurses and midwives?............................

29   If you have teams do they have any authority?

1=   yes

2=   No

30. If yes explain.. ......

31   If you have teams do they have any responsibility?

1=   Yes

2=   No

32.   If yes explain...

33   Is staff involved in the development of staff development activities?

1=   yes

2=   No

34 How do members of staff know of availability of training activities?

1= The messaged is discussed at the staff meeting

2= Selected candidates are informed by a letter

3= They check for their chance on an already made list

4= Other explain...

35 In your opinion what processes need to be in place in order to develop learning

organization?...

36 What do you consider to be essential for a staff development plan in a learning

organization?...

37 What factors do you consider to be essential for effective implementation of a staff development plan in a learning organization?

38 Any other comments...

Thank you

Qualitative Data

Framework analysis -Priori issues

- Knowledge and skills of nurse managers in utilizing the available staff performance appraisal systems.
- Contributing factors to nurse managers inability to undertake capacity building activities in the wards or health centres.
- Current practice of building capacity of new staff at ward or health centre level.
- Unavailability of capacity building resources.
- Staff development policies (individual and collective learning).
- Ways in which nursing managers intended to foster a learning culture in their environment in the light of team work.

Emerging issues	Examples of participants responses
❖ Some managers were doing staff performance management. Are the systems to assess staff performance known by all managers?	"Civil service annual confidential appraisal system was in use." "We are not aware of any new appraisal system." "Most of us were last appraised in 1997." "New confidential appraisal system for staff is available but due to the large number of staff, it is only done every two years or more." "Annual confidential forms are filled in for the nurses due for promotion in accordance with the civil service practice." "Annual confidential forms are filled in for the nurses who have been selected for various training courses or for those nurses who are due for confirmation in their positions in accordance with civil service practice."
❖ What could have contributed to not adhering to a systematic way of addressing staff training needs?	"Lack of appraisal system" "Lack of or minimal involvement in the selection of staff for further training." "Few scholarships are available and selection is done at higher level" "The budget for staff development is unknown to us" "The human resources office is mainly responsible for

	staff development"
❖ What could have contributed to managers failing to evaluate training programmes?	"Training programmes are not planned and implemented by us. It is being done by them(human resources unit" "Objectives of the training programme are never communicated to us to enable us evaluate it" "There are no standard tools to evaluate the training programmes"
❖ How can nursing managers foster a learning culture in their environment in the light of team work?	"Identify a workable appraisal system" "Identify a system of work which would motivate the staff to work together" "In my department I rotate staff very often so as to build capacity in various areas and create an environment where all nurses in the department know each other both in knowledge and skills. In so doing they are able to share their experiences and learn" "Rotation of staff from one ward to another makes nurses familiar with what goes in other wards or units in health centres." "There are arranged meetings purely for capacity building for example grand rounds where there is teaching by consultants and also nurses weekly meetings for updating nurses on the latest trends."
❖ Mentoring of staff as a system of developing staff	"Newly qualified nurses are attached to some specific members of staff for periods ranging from two weeks to six months. This is for the purpose of understudying the position at hand this can be sister-in-charge or any other position. During this time a shift of both day and night is given to ensure that the new nurse is able to manage the ward without any problems." This same method is done for the second-in-charge nurse so that she can get with what the sister-in-charge does so that when rotated to any ward they will be able to cope.
❖ What might have contributed to lack of capacity building activities in your wards or health centres	"Shortage of staff in general and lack of qualified and experienced staff. The priority was to have activities done rather than to teach or learn."
❖ Lack of resources for capacity building is this a problem in your area?	"There are shortages of teaching materials. but there is very little time to teach as the wards are full of patients and there are few members of staff."

214

❖ Staff development policy (individual and collective learning) is either of these policies assisting in planning for staff development?	"Staff display apathy for learning even when messages on staff development are displayed on the board they do not bother to read them." "Group learning seems to assist"

Staff development rating scale

Serial No	Assessment Area	0	1	2	3	4
	Promote effective communication and leadership skills.					
1	Updates staff with relevant current information					
2	Ensures effective information documentation					
3	Clarifies goals and expectations in order to update staff with current trends and practice					
4	Is systematic in planning meetings, coordinating and implementing activities					
	Encourage staff self-update and sharing of information					
5	Acknowledges the juniors knowledge, skills and experience and encourages self-update					
6	Acknowledges and values effort from junior staff					
7	Encourages staff creativity					
8	Encourages staff to participate in new projects					
	Identify training needs					
9	Spends time with juniors to build contact in order to identify their strengths and weaknesses to enable planning for their development					
10	Plans for and undertakes teaching sessions to junior staff based on the identified training needs					
11	Displays ability to counsel staff					
12	Gives honest feedback to juniors in a sensitive manner					
13	Sets high standards of work by adhering to rules and regulations					
14	Keeps commitments with staff					
15	Is personally and professionally accountable					
16	Creates a user-friendly environment.					
17	Provide a conducive learning environment					
18	Maintains confidentiality					
19	Promotes teamwork among staff					
20	Inculcates team spirit					
21	Delegates responsibilities to team members					
22	Demonstrates commitment to juniors					
23	Accepts criticism					
24	Is empathetic to staff					
25	Is reliable					

Research study schedule

Phase	Activity	Period
1	Collection of survey data	January and February 2004
2	**Development of staff development model**	June to September 2004
Meeting i	Dissemination of findings to nursing officers and sisters-in-charge	June 2004
Meeting ii	Presentation of the learning organization and transformational learning	July 2004
Meeting iii	Development of the model pre-testing of the model	August 2004
3	**Development of the staff development assessment tool**	
Meeting iv	Presentation of pre-test findings Development of final staff. development of assessment tool consensus on the developed staff development assessment tool	October 2004
4	**implementation of the developed model**	February 2005
Meeting v	Feedback on the outcome of the implementation	