1-1-1996

Management skills of middle-level nurse managers in Malawi

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MANAGEMENT SKILLS OF MIDDLE-LEVEL NURSE MANAGERS IN MALAWI

BY

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A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF

MASTER OF NURSING

AT EDITH COWAN UNIVERSITY, SCHOOL OF NURSING

DATE OF SUBMISSION: February, 1996

ABSTRACT

Much has been written about the problems facing nurse managers in different countries including Malawi, yet the literature is sparse in relation to information about their perception of required management skills. There is enough evidence that nurse managers face many problems. These problems stem from different sources including organizational, economic, social or political changes. All changes within and outside the health care system affect nursing and its management. Nurse managers require relevant management skills to make valuable decisions and promote quality care, and enable them to motivate staff. Further, management skills will enable nurse managers to actively participate in policy making and financial management. In this way autonomy over nursing services can be maintained. This study took place in Malawi and explored tasks that Malawian middle-level nurse managers carry out, problems that they experience in carrying out their work, and their perceptions of management skills required in carrying out their work. Middle-level nurse managers in Malawi are known as matron and senior sisters. A two staged random sampling of 42 hospitals and 20 middle-level nurse managers was used. The hospitals included government and non-government hospitals known as CHAM (Christian Hospitals Association of Malawi). Data was collected using an interview schedule based on a conceptual framework adopted from King's Goal Attainment Theory. Field notes were taken alongside taped interviews, and administrative documents such as job descriptions were collected to provide complementary data. All interviews were transcribed and thematic analysis was used to analyze data. Results of the analysis demonstrated that middle-level nurse managers in Malawi experience

enormous problems in carrying out their work. Such problems included shortage of staff (especially registered nurses), and lack of adequate managerial knowledge of nurse managers themselves in policy making, financial management, and the setting and monitoring of nursing standards. In addition, results have indicated an increased amount of stress in the nursing profession in Malawi. Consequently, results have shown that middle-level nurse managers require management skills in resource management, setting nursing standards and financial management skills. Information obtained from this study will provide nurse managers with knowledge of the management skills they require to be more effective. The information will also be relevant for professional (management) development, as it would be used by policy makers to design management education curricula for nurses contemplating management careers or reviewing current management programs in nursing schools. In addition, the knowledge gained will form a basis for future research.

Declaration

"I certify that this thesis does not incoporate, without acknowledgement, any material previously submitted for the degree or diploma in any institution of higher education and that, to the best of my knowledge and belief, it does not contain any material previously published or written by another person except where due refernce is made in the text".

Date: 12th february 1991

ACKNOWLEDGEMENTS

The research has been conducted as part of Master of Nursing course requirements. The research has been supported by grants from Edith Cowan University, Faculty of Health and Human Sciences, School of Nursing and Australian Agency for International Development (AusAID).

I would like to express my gratitude to my supervisor Kathy Ahern for the guidance regarding the content and organisation of this thesis.

My appreciation goes to the Co-ordinator of the International Students Office, Rob Brown. Rob's guidance, support and encouragement inspired me and made it possible for me to achieve far more than I expected within a short time that I started working with him.

The Principal of Kamuzu College of Nursing, the Deen and all the academic staff for their support and encouragement during my fieldwork in Malawi. My special thanks to Nursing Sister Ms Mkanadawire and Ms Simbota for their support the times I was in hospital during my fieldwork in Malawi.

Dr. Trish Parcival for her moral support and her sense of humour helped me to pick up and put my foot down to the determination of completing this thesis.

I would also like to acknowledge Maxine Serrel for her personal effort to allocate validators in Australia for me, who willingly assessed the instrument used for data collection in this research. Thanks to the validators both in Australia and in Malawi for their interest and contributions.

The Chief Matrons and participants in this research in Malawi. Without their invaluable support and interest, this thesis would have not become a reality.

Finally, I would like to express my sincere gratitude to my family. Very special thanks to my husband Watson, for all the love, patience, support and encouragement he has demonstrated throughout the completion of this thesis. His support and patience has enabled me to complete this thesis and still keep a sense of humor. To my mother and my sister Rose for their consitant love, faith, prayers and encouragement.

In addition, I would like to acknowledge my four children Wongani, Chanju, Khazgani and Wezi. Their presence inspired me to work hard. I thank them for their support, understanding, reminding me to work hard. Their encouragement is greatly appreciated and will never be taken for granted.

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CHAPTER ONE

INTRODUCTION

The nurse is an important part of the health institution because of the multiple roles he or she plays to achieve the organisational goals. Organisational goals are the set of results towards which plans and activities are directed, such as assisting patients to attain maximum health (Gillies, 1989; Samuelson, 1985).

Role of the Middle-level Nurse Manager

In the Malawian nursing service there are two positions at middle-level nurse management and these are designated by the titles senior sister and matron. The role of these managers is to provide continuity of services, set quality control measures and manage the budget that make services possible. Matrons and senior sisters also safeguard the legality of the services as they coordinate all the activities of all nursing and non nursing services and allied health workers involved in provision of care.

Matrons and senior sisters therefore facilitate dissemination of information and supervise the implementation of government and organisational policies. This role requires strong managerial skills. Lack of managerial skills may affect the provision of quality patient care which may further lead to the bad reputation of the organisation and poor image of the profession (Fralic & Van der Walt, 1993; National Health Plan of Malawi 1986-1995; Osei-Boateng, 1992).

The Problem

Indications in many overseas and African countries are that nurse managers at all management levels face problems. A problem is a difficult situation encountered during the pursuit of work (Bailley, Trygstad & Gordoni, 1989; Cavanagh, 1991; Fralic & Van der Walt, 1993; Lanara, 1992; Naish, 1995; Osei-Boateng, 1992).

For Malawian nurse managers, Namate (1992) and National Health Plan of Malawi 1986-1995 stated that there are three major problems and four challenges that affect effective nursing management. The three major problems in Malawi include limited financial resources, shortage of nursing staff, and lack of sufficient appropriately qualified nurse managers.

Limited financial resources has meant inadequate equipment and poor maintenance of equipment and materials. Inadequate equipment has lead to over use of some equipment thereby shortening their life span. On the other hand, damaged equipment are not replaced or repaired thereby further reducing the inadequate equipment that is available (Namate, 1992). Consequently some procedures have been left undone. This has affected quality of care and has caused stress to patients, nurse managers and nurses.

Shortage of nurses meant that the few nurses who were there became over stretched, bringing stress and frustration to nurse managers, nursing staff and patients (Nurses and Midwives Council of Malawi Report, 1991; Simbota, Mbvundula, Mhango & Mtimaukanena, 1995). There are several factors which have contributed to a shortage of nurses which puts nurse managers' skills to the test. One such factor is

the expanded role of the nurse (Namate, 1992). The role expansion includes provision of family health, primary health care, combating childhood communicable diseases, environmental health, sanitation and control of acquired immune deficiency syndrome (AIDS) (The National Health Plan of Malawi, 1986-1995; Namate, 1992). Secondly, the output from both registered and enrolled nurse-midwifery schools has not parallelled either the growing population or the additional health centres and hospitals that have been built (Namate, 1992; Malawi Population and Housing Census Preliminary Report, 1987). As a result nurses work long hours in overcrowded hospitals. A third contributing factor to shortage of staff is that during the past few years there has been an increased turnover of nursing personnel because of the working conditions such as long working hours and the high patient-nurse ratio to which nurses are subjected (Namate, 1992).

The problem of insufficient numbers of appropriately qualified nurse managers affects such managerial functions as nursing service management, financial management, operations and information system management. For Malawi, this problem is felt mostly at middle-level management which is responsible for policy implementation, utilisation of resources and supervision of health care provision in hospitals in which the nurse-patient ratio is as low as 1:50 (Malawi Population and Housing Census Preliminary Report, 1987; The National Health Plan of Malawi, 1986-1995; UNICEF, 1994). This responsibility is present against a background of little influence in resource allocation, and inadequate budgetary and other managerial skills (Namate, 1992; National Health Plan of Malawi 1986-1995; and Osei-Boateng, 1992).

Background of the Research

The research took place in Malawi in Africa. Malawi is a land locked country, situated in South East Africa. It covers a total area of 118,500 square kilometres, one-fifth of which is taken up by Lake Malawi. Lake Malawi lies in the Great Rift Valley about 400 metres above the sea level. The current population is about 10,000,000 (Malawi Demographic and Health Survey 1992; National Health Plan of Malawi 1986-1995).

The country is divided administratively into three regions. The southern region which is relatively densely populated, the central region which is flat and well populated, and the northern region which is mountainous and sparcely populated. The three regions are further subdivided into districts. There are ten districts in the Southern Region, nine districts in the Central Region and five districts in the Northern Region. Map of Malawi is in Appendix A.

The National Health Policy

The purpose of National Health Policy of the Ministry of Health (MOH) is to raise the health level of all Malawians through a sound health care delivery, based on the concept of primary health care. The MOH has implemented this policy through the provision of comprehensive health care delivery networks throughout the country.

Performance of nurses has been a major concern of both the nursing profession and the public (Nurse and Midwives Council of Malawi Report , 1991). Public opinions have been expressed and shaped through the media. The public feel that

nursing standards have gone down. Both nurses and the public feel that the change of nursing training programme from hospital based to University programme has affected the expected performance of nurses and nursing standards. The actual deterioration of nursing standards has been indicated by the results of a survey conducted by the Nurses and Midwives Council of Malawi (1991).

The problems of financial limitations and the shortage of qualified nurse managers and nursing personnel, gives rise to four main challenges for nurse managers. Challenges are tasks nurse managers must fulfil even when means are not known or are difficult to come by (Bailley, et al. 1989; Gillies, 1989). The four challenges for Malawian nurse managers are provision of quality care, financial resource accountability, nurse motivation and involvement in policy making.

Providing Quality Care

The first major challenge for middle-level nurse managers is to ensure that quality nursing care is provided to all patients on a 24 hour basis in health care facilities (Namate, 1992). Quality nursing care is the established target of excellence for nursing intervention and taking action to ensure that each patient receives the agreed level of care (Gillies, 1989; McLaughlin, 1990). This is a challenge because firstly, in the face of limited financial resources, it has been difficult to acquire sufficient and appropriate technology and professional resources (Banda, 1994; Namate, 1992). Secondly, with a limited number of nurses, it is difficult to meet the health needs of the growing population (Namate, 1992; Simbota, et. al., 1995). Thirdly, an increase in formal education of the population has increased people's

awareness of the need for health services. The increase in population growth and formal education have resulted in increased attendance at the hospitals resulting in congestion in the hospital wards (Malawi Demographic and Health Survey, 1992; Simbota, et al., 1995)

Financial Resources Accountability

Like middle nurse managers of other countries (Osei-Boateng, 1993; The Nursing Report, 1995), Malawian middle-level nurse managers are not fully involved in developing a budget, but are expected by top level management and other health professionals to control costs and provide cost effective nursing care (ICN, 1993; Namate, 1992). The Nursing Report (1995) stated that middle-level nurse managers must have input into the ways in which money is allocated and spent.

Nurse Motivation

Many factors impact negatively on nurse motivation in Malawi. Fralic and Van der Walt (1993) and Osei-Boateng (1992) stated that lack of adequate autonomy especially in clinical areas, for nursing in Africa, causes anxiety and frustration for both male and female nurses. Malawi is no exception. Autonomy is a state whereby the profession sets its own performance goals and work methods, evaluates its own performance, and modifies behaviours accordingly (Gillies, 1989).

This anxiety and frustration often leads to stress. The findings of a survey conducted by the Nurses and Midwives Council of Malawi (1991), are in line with the work of Hewa and Hetherington (1993), Dionne and Pepin (1993), Fralic and Van der

Walt (1993) and Osei-Boateng (1992). The writing of these authors revealed an excessive level of organisational and personal stress in the nursing profession. Organisational stress deals with the work environment not conducive to worker satisfaction and productivity (Swansburg, 1993). Among the common causal factors of stress that lead to reduced motivation are shortage of human and material resources, fluctuations in the workload and being governed by institutional policies developed by non-nurses.

This high level of stress obviously displays itself in nurses' work behaviours. Although bedside nurses at both professional and technical levels in Malawi are adequately educated and prepared for their jobs, the working conditions overwhelm them so much that it is hard for them to sustain their zeal for work (Namate, 1992; Simbota, et. al., 1995; Simukonda & Rappsilber, 1989). The result is poor quality care, high attrition rate and low productivity (Dionne & Pepin, 1993). factors such as anxiety, stress and frustration have clear and direct implication for the level of nurse motivation in Malawi.

Involvement in Policy Making

The final challenge facing nurse managers is that of their involvement in policy making. Nurses are in a good position to understand the health care needs of the people. Cavanagh (1991), Cliff (1992), Lanara (1992), and Naish (1995), stated that nursing brings nurses close to the people and communities they serve, yet nurses generally have not had the opportunity to actively participate in meetings that discuss policy issues related to the planning of health and nursing services, a situation similar

to Malawi (Namate, 1992). For nurses to be able to influence the direction of the profession they must have more autonomy over nursing services than they do at present (Cilliers, 1989; Lanara, 1993; Naish, 1995; Yuen, 1993).

Purpose of the Research

The challenges outlined above point to the necessity of proper management skills being developed by nurse managers if health services are to be properly provided. Looking at the importance of the matrons' and senior sisters' role in health care management, and knowing the tasks and problems they face in carrying out their work, would help to identify management skills which they require to be more effective. Studies in other countries have been carried out to identify problems nursing managers face, the skills they have and those they require to be effective (Barros, 1990; McDermott, 1992; Patz, Biordi & Holm, 1991; The Nursing Report, 1995). There has, however, been no independent research carried out in Malawi to this effect. There was a need therefore for research to be undertaken to investigate problems encountered, and the skills required for effective management.

This research explored problems experienced by middle-level nurse managers in Malawi in carrying out their work. It examined the extent to which the problems and challenges described above affected individual nurse managers. It also investigated the necessary skills that middle-level nurse managers perceived to be necessary to effectively carry out their work.

Significance of the Research

Even though this research was about middle-level nurse managers, it will be of interest to nurse managers at different levels because of the interactive nature of the nursing profession. The results provide an insight into the problems experienced by middle-level nurse managers. The policy makers would find the information valuable in decision making on the skills and training required for effective management. Results of the research could be used to plan, train, deploy, and properly utilise human resources, particularly that of nursing personnel. Further, the information will help policy makers to identify staffing gaps to be filled through training and recruitment. The research has identified the management skills of nurse managers which can be applied to allow review and planning of on going nurse education for nurses who are not yet in management.

Research Questions

1. What specific management tasks do middle-level nurse managers report that they carry out in Malawian hospitals?

2. What specific problems do middle-level nurse managers in Malawi report that they experience in carrying out their work?

3. What management skills do middle-level nurse managers perceive that they require?

Operational Definitions

Role

Roles are the expected functions of the middle-level nurse manager such as ensuring quality care, planning and setting goals, controlling budgets, participating in decision making among others.

Middle-level Nurse Manager

A middle-level nurse manager is either a matron or a senior sister. A matron or a senior sister is a registered nurse responsible for supervision and coordination of nursing activities in a designated area of the institution. A middle-level nurse manager communicates all necessary information from nursing administration, medical staff and hospital administration to all nursing staff under her supervision and visa vesa.

A matron might have risen through promotion from staff nurse to senior sister then to matron or might have risen to this position after obtaining a first degree in nursing and so they might be less experienced. A senior sister is often promoted from staff nurse without or with additional qualification. If she has an additional qualification, she might have a post basic certificate or a diploma. Both matron and senior sister plays a supervisory role to ensure implementation of policies and quality care. However matron is awarded more authority than a senior sister because a matron who has attained this position through promotion would have passed through senior sister position. In theory, this may therefore mean that the matron has a wide experience than a senior sister. A matron with a degree would be considered to be

more knowkedgeable and analytical in executing his or her duties. Consequently, the matron is awarded more authority than a senior sister. However both the matron and senior sister play supervisory roles to ensure implementation of policies and maintainance of quality of care. The two positions differ therefore in years of experience and educational level but their involvement in management is the same. Job descriptions of both a matron and a senior sister are in Appendix B and C.

Span of Control

A number of health workers that can effectively be handled by each middle-level nurse manager. The manager's duty is to lead, motivate, evaluates, and correct those being lead.

Extrinsic Factors

External factors that stimulate certain behaviours. Such external factors might include working conditions, quality of technical supervision, and quality of interpersonal relations among managers, with staff and with patients.

Intrinsic Factors

Internal factors that lead to satisfaction. They include achievement, recognition, advancement, and the work itself.

Government Hospitals

Hospitals that act as referral hospitals. The services provided include out and in-patients, maternity, paediatrics and adult care funded by the government and so care is free to patients. Patient number are therefore very high with high numbers of personnel.

Christian Hospital Association of Malawi (CHAM)

Hospitals owned by churches. Services provided include out and in-patients, maternity, paediatrics and adult care. Patients are fee paying. Patient numbers are smaller as compared to the government hospitals and therefore staff numbers are also small. Administrative expectations of CHAM hospitals and those of the government hospitals are different.

Problem

A problem is a psychological state of discomfort that results from confrontation with a stimulus situation for which the individual has no ready response in his behavioural repercussion (Gillies, 1989).

Limitations and Delimitations

There were three main limitations to the research. The sample size was small which meant that the findings of the research would not be generalizable, but couldform the basis for further research which will include larger samples. Secondly, not all participants accepted to the taping of their interviews. Two participants refused

to be taped but were willing to participate in the study. This meant that the explanations of some issues by these two participants might not have been captured as thoroughly as those whose interviews were taped and transcribed. However the researcher wrote down as much information as possible from the responses during the interview and also wrote further notes concerning the interview session immediately after the interview so this risk was minimised. A third limitation was in relation to the environment in which interviews took place. Interviews took place in participants' offices because these were the most convenient venues for the participants. However, there were disturbances from phones and consultations by members of staff, that might have affected the thought process of the participants.

CHAPTER TWO

LITERATURE REVIEW

This chapter looks at the discipline of management in general and its problems in brief, and then focuses more specifically on nursing management and its problems. The reason for this approach is that there are principles of management which can be applied directly regardless of the context of application and many of the problems experienced in general management can be associated with those experienced in nursing management. However nursing is unique and needs a specialised approach to its management problems.

Factors which make nursing unique include the product of nursing which is health care delivery. Like other management fields such as education, and social work, health care does not pass through production lines which are psychologically and emotionally divorced from the workers. However in health care there is high emotional involvement from the customers and the workers because it deals with individuals who may play sick role at different levels. In providing health care nurses are involved with the intimate processes of peoples life at there time of greatest need. To understand the health care delivery system, therefore, it is necessary to understand this uniqueness and the way people act and use health care services.

The concept of health care is the way people react to illness in social and cultural settings as well as how they perceive, label, prevent and explain illness. The health care, then, includes people's beliefs and patterns of behaviours, which are

governed by cultural rules. Other factors include available intervention and type of health problems. Health care is thus organised as a special portion of the social world through interaction of these variables.

Nursing care, which is one part of the health care delivery system, should be tailored to meet individual's needs. If the person in need of health care is distressed, the purpose of action is to prevent or deal with this distress. A situation requiring nursing care has the potential to be a developmental experience in the interpersonal process between the person expressing need for help and the helping person. Consequently, care management requires a highly sensitive interpersonal skills.

A nurse manager like other managers is an integrator. He or she coordinates nursing services and the expectations of patient and relatives as she collaborates with other health care personnel. Duffield (1994) stated that for the nurse manager to be effective in his or her integrator role he or she requires a high level of communication skills. Nurse managers spend most of their working time interacting with people who are not in their normal situation. For example individuals who play a sick role may feel distressed and family members or guardians develop high levels of anxiety, these may affect their emotions. Nurse managers have a responsibility to control these emotions through effective communication. Nurse managers therefore play a unique role in this communication process as they communicate with nurses, patients, family members and other health care workers. The manner in which they communicate has a great impact on patients and nursing services.

The Concept of Management

Management is the process of planning, organising, leading and controlling the efforts of organisation members and of using all other organisational resources to achieve stated organisational goals (Fulop, Frith & Hayward, 1992). The emphasis is on people, thereby stressing on the importance of leadership, and communication.

Bryt and Masters (1990), Douglass and Bevis (1993) and McLaughlin (1990) stated that management is an organisational primary force that coordinates the activities of its units and relates those activities to the environment in which they occur. This offers a depersonalised view of management as the organisation responds to changing environmental circumstances. Fundamentally, management exercises control to maintain order: that is, control over the alternatives to be carried out with regard to the organisation of resources, allocation of those resources and the maintenance of order (Bryt & Masters, 1990).

Importance of Management

Management is important because it ensures order and smooth running of an organisation by drawing rules, regulations and policies to guide the activities of an organisation (Douglas, 1992; Houston & Marquis, 1989; Stoner, 1985). According to McLaughlin (1990) management is important to all organisations because management functions facilitate the achievement of organisational goals by avoiding future problems by forecasting future needs and problems.

If an organisation is to function effectively and achieve objectives, management is required to consciously coordinate the activities of its members (Bryt & Masters,

1990; Houston & Marquis, 1990). To achieve this important aspect, management utilises three basic skills. The first is conceptual skills which involve "the mental ability to coordinate and integrate all of the organisation's interests and activities" are applied (Stoner, 1985, p.20). Conceptual skills are necessary for analytical thinking in strategic planning to provide clear and consistent strategies with which line management can identify for example, organisational philosophy, purpose, and objectives.

Secondly, human skills which involve understanding and getting the best out of people, team building, motivating and leading are utilised (McLaughlin, 1990; Stoner, 1985). Human skills provide the manager with human resource management skills including interpersonal relationship skills. Good interpersonal relations keep the workers motivated and have proved to be an effective driving force in achieving objectives (Schwart, 1989; Stoner, 1985). For example managers can motivate staff by sharing information about the organisation. This is has been known to improve staff self-esteem and clarifies expected behaviour of both manager and those being managed. Good interpersonal relations also clarifies job performance and promotes staff commitment to the organisational goals (Swansburg, 1993).

Technical skills are the third basic component of management. Technical skills involve the ability to develop and use the tools, procedures or techniques of a specialised field (Stoner, 1985). Managers require technical skills to be able to plan for the right human and material resources, and to direct and accomplish the mechanics of the particular job for which they are responsible. Research has shown that professional expertise is vital to direct the material resources and determine appropriate skill mix (Roemer, 1993; Vengroff, Belhaj, & Ndiaye, 1991). But Nicklin

(1995) had a different view. He stated that professional expertise is not important as long as one has management skills. Nicklin's view is that management skills enable one to direct resources regardless of specialty.

On the other hand, authors like Morrison and Bauer (1993) and Von-Moltke (1992) argued that specific technical skills by managers are vital in sustaining the organisational goals. Technical skills enable the management to properly match human and material resources. For example, as the United Nations Development Program (UNDP) had to assume a greater responsibility for its project portfolio, it had to resort to strengthening the technical skills of those managing its activities to ensure that there were more sustainable patterns of development. Without proper matching of skills and other resources, the goals of the programme were likely to fail (Morrison & Bauer, 1993). This researcher shares this view because to direct services well one needs to understand the activities in relation to available resources and level of nursing skills necessary to carry the services out. Unless the manager is familiar with the field, he or she will not be able to fulfil a teaching role to staff.

Management Levels

The first level of management consists of top managers. Typical titles of top managers include Controller, Managing Director, Controller of Nursing Services and General Manager (Bryt & Masters, 1990; Fulop, Frith & Hayward, 1992; Gillies, 1989; National Health Plan of Malawi, 1986-1995). At this level managers deal with strategic management and are responsible for the overall management of the organisation. They establish operating policies by using both internal and external

information to guide the organisation's interactions with its environment (Douglass, 1984; Raph; 1985; Stoner, 1985). Top level managers attend to overall forecasting needs for the fiscal year taking into account anticipated population, policy and legislation changes (Douglass, 1984). To a large extent top level managers use conceptual and human skills (Bender & David, 1994; Stoner, 1985).

The second level of management is middle-level management. Middle-level managers direct the activities of operational managers and sometimes also those of operating employees. This level of management is involved in implementation of organisational policies. Middle level managers mostly utilise human skills rather than conceptual and technical skills (Stoner, 1985; Vroom, 1992). They assess the operation of the structure and make suggestions for its improvement and modification (Bryt & Masters, 1990).

A third level of management is operational. Managers in this category constitute the lowest level in an organisation at which individuals are responsible for the work of others. The managers here schedule daily and weekly plans for carrying out procedures and activities (Douglass, 1984). Operational managers mainly employ technical skills, followed by human skills and to a lesser degree conceptual skills (Stoner, 1985).

Managers' Roles

Managers at all levels play a variety of roles which fall into three categories (McLaughlin, 1990). First there are interpersonal roles in which managers are

representatives of their organisations. The managers are seen as figureheads, leaders, liaison persons, or mediators.

Secondly, there are information roles whereby managers function as monitors, disseminators and spokespersons. Stoner (1985) stated that managers develop networks of mutual obligation with other managers within and outside the organisation. They draw upon these relationships to win support for proposals, decisions or cooperation in carrying out various activities. Managers build relationships and use persuasion and compromise in order to influence decisions (McLaughlin, 1990; Stoner, 1985).

The third category is that of decision roles. These include being entrepreneur, resource allocator and negotiator (McLaughlin, 1990). According to McLaughlin (1990) and Stoner (1985) managers make difficult decisions. To make decisions they are required to think analytically and conceptually, to view the entire task in question in the abstract and relate it to other tasks. Through this, managers are able to balance competing goals, problems or needs and then set priorities accordingly.

Bryt and Masters (1990), Douglass (1989), McLaughlin (1990) and Stoner (1985) stated that managerial work is a complex, intertwined combination of roles. Sometimes managers play roles simultaneously in order to achieve the goals of the organisation. The above roles are carried out to perform management functions. There are a number of functions performed by managers (Morrison & Bauer, 1993; Stoner, 1985; Swansburg, 1993; Von-Moltke, 1992). Although these authors seem to present varying sets of functions, there is an apparent agreement on the five functions as presented by Bryt and Masters (1990). These are planning, organising, staffing,

leading and controlling as management functions. Communicating, delegating, motivating and evaluating have also been cited as management functions. However some of these functions complement the management functions as described by Bryt and Masters (1990). For example, delegating falls under leading; motivating is an important leadership function; evaluating is a controlling function whilst communication facilitates effectiveness of each management function.

Planning. Douglass (1989) stated that planning provides the framework for performance. It is an act of deciding in advance what is to be done, how it is to be carried out, and the setting of goals and objectives. For example, nurse managers are concerned with the numbers and kinds of patients to be cared for, the qualifications of staff to provide that care, and the physical and material resources required to get the job done.

Organising. Work is divided up and coordinated in order to achieve the organisational objectives. McLaughlin (1990) stated that organising involves delegating authority, establishing communication channels and establishing a systematic way of achieving objectives. The way activities are organised in the organisation has a great impact on the use of both human and material resources (Bryt & Masters, 1990; McLaughlin, 1990; Stoner, 1985).

Directing. Having planned and organised tasks and personnel, the manager directs the available resources towards achieving planned objectives. Directing

focuses on leading staff in the most effective manner possible to perform in ways that will help to achieve the established objectives (McLaughlin, 1990).

According to Stoner (1985), planning and organising functions deal with more abstract aspects of the management process whilst directing is more concrete. For example, the middle-level manager examines the conceptual functions of management such as planning and organising. The managers develop management plans, and selects techniques based on the philosophy of the organisation. They also supervise and evaluate those activities carried out according to plans (Bryt & Masters, 1990). The manager ensures that the actions of the organisation's members do in fact move the organisation towards the tested goals. This is a controlling function.

Controlling. Controlling evaluates individual and group performance, and examines indicators of effectiveness and efficiency through services rendered. It deals with investigation of any problem that may have developed in communication, resource allocation, and interpersonal relationships. The controlling function involves establishing standards of performance, developing measurement tools against set standards and establishing corrective measures where performance is straying too far from the organisation's set standards (Gillies, 1989; Stoner, 1985).

Human Resource Management (staffing). This function deals with the organisations' needs for people: bringing people into the organisation to work,

designing their tasks, training them, evaluating their performance and administering their compensation. Mukhi, Hampton and Barnwell (1988) stated that human resources planning, recruitment, selection and training are influenced by economic, technological, political, and sociocultural conditions. To plan human resource effectively under difficult economical situation often sighted in literature (Swansburg, 1993) is a challenge to nurse managers. Even under such circumstances, managers are expected to plan and provide adequate number of personnel with the right type of skills.

Technological advances offer a challenge to managers to find skilled labour to use the technology. Research has shown that this is a big challenge to managers because often times managers themselves have lagged behind technology (Barros, 1991: Chammings, 1993). This has in itself limited their allocation of resources and appreciation of training of staff in that regard.

The whole process of staffing offers a great challenge to managers as they carry out annual planning, budgeting and human resources forecasting (Mukhi, Hampton & Barnwell, 1988; Hanson, 1982). Various factors such as technological advances, economics of the time, external and internal political environments and the socioeconomical background of employees need to be considered. These factors are essential to retention of outstanding professional talent because the goals of an organisation are accomplished through its people. Because of the complexity and importance of staffing Bryt and Masters (1990) stated that there is need to train managers on effective human resource management.

Effective Management

Effective management deals with the ability of the managers to conserve the scarce resources the organisation has at its disposal for accomplishing its tasks (Fulop et al., 1990). It sets standards and policies that guide the activities of its members. For example effective management sets communication system that utilises different types of reports which provide background information for the decision making process (Bryt and Masters, 1992). However studies (Carley, Smith & Varandajan, 1991; Chiu & Levin, 1993; Dotchin & Oakland, 1992; Roemer, 1993; Tanaboriboon, 1992; Venroff, Belhaj & Ndiaye, 1991) have shown that management in general experiences many problems. The main seven problems include quality crisis, lack of supervisory skills of managers, general economic problems, population explosion, stress in the work-place and knowledge deficit of managers.

One general management problem is the quality crisis resulting from differing meanings on approaches to quality. This has resulted from different interpretations of the concept of quality on the producers and customers perspective. The isolation of the producers from the customers has contributed to the differing perspective. This has made it difficult to match the expectations of the customers (Dotchin & Oakland, 1992; Sullivan, 1988). Another reported contributing factor to quality crisis was the lack of management training and experience by the managers (Oakland, 1989). Further lack of standards in industries and companies has lead to quality crisis (Dotchin & Oakland, 1992).

Roemer (1993) described a second problem, which is a lack of supervisory skills by public health managers as a problem that has lead to ineffective management of community services. Poor supervisory skills have allowed some unprofitable activities to go unchecked and teaching opportunities by the supervisors were thus lost. Supervision as one way of monitoring the quality of performance was reported as being irregular, insufficient, and most of the time inappropriate. Supervisors were reported as inadequately prepared for the job. Further lack of supervisory skills lead to a negative attitude of the workers towards the supervisors who had been looked at as poorly oriented for the job. They were also said to be unproductive, unmotivated, and incapable of promoting and implementing health standards.

A third problem reported, in United Kingdom (UK) was that general management experienced general economic problems. General economic problems have lead to inadequate economic resources. Economic resources are sources of support that are in short supply, such as money, material, or personnel (Bryt & Masters, 1990). The economic problem has also lead to human resource management problems in other parts of the world (Chiu & Levin, 1993; Vengroff, Belhaj & Ndiaye, 1991). Economic problems have attributed to a change in the labour market from labour surplus to labour scarcity. Labour scarcity has further lead to improper skill mix affecting quality of service (Chiu & Levin, 1993; Riddel, 1990). In addition economic problems have lead to problems of supplying housing in rural areas especially in developing countries affecting the staffing numbers and skill mix in rural areas (Kironde, 1992; Riddel, 1990).

Fourthly it has also been reported that population explosion in many countries has lead to environmental problems such as inadequate resources to meet the growing demands (Tanaboriboon, 1992; Kaseke, 1990). Population explosion is specifically reported in Asia as having caused traffic constraints which have a direct implication on their countries' economy (Tanaboriboon, 1992). In Africa population explosion has lead to energy crisis and poor environmental conditions (Kaseke, 1990). For example, overcrowded hospitals (Namate, 1992).

Carley, Smith and Varandajan (1991) reported a fifth problem with the organisational policies which were unclear and inconsistent. Decisions were made according to what a particular manager felt was feasible. For example, politicians influenced the management decisions of some companies (Carley, Smith & Varandajan, 1991). Similar problem has been reported in other parts of the world (Chiu & Levin, 1993; Fluhartly, 1990; Tanaboriboon, 1992).

Kobayashi (1994) and Nilan (1992) reported a sixth problem of stress in the work place. The authors attributed the problem of stress to problems of population growth which has lead to economic problems. Economic problems have meant scarcity of and inadequate human and material resources which limits the performance of employees and achievement of objectives and that stresses employees. Stress has also been attributed to poor environmental conditions, and poor communication.

Finally Stager (1991) stated that problem of knowledge deficit has further lead to problems of accountability and responsibility. All these problems point to the need for management training of managers in the areas of resource management,

communication skills, supervisory skills, interpersonal skills and financial management in the face of economic problems.

Summary

Management deals with achievement of objectives through other people. It involves planning, organising, directing of leading, staffing, and controlling of both human and material resources. Management is important in an organisation because it enhances order and smooth running of organisations as it consciously coordinates the activities of its members.

To be able to coordinate organisational activities, managers regardless of level of management, require conceptual, human and technical skills. Management at all levels play a variety of roles such as interpersonal, information and decision roles. A well coordinated activities in an organisation lead to effective management. Effective management is the ability of managers to conserve scarce resources to achieve the goal.

However literature has revealed a number of problems faced by general management. These include quality crisis, lack of supervisory skills, economic problems, population explosion, unclear and inconsistent organisational policies, stress in the workplace, and knowledge deficit of most managers.

Nursing Management

This current research is concerned with nursing management and in particular, middle-level nurse managers. The concepts which have been discussed above, notably

the importance of management, skills required, the role of the manager, problems experienced and management functions can generally be applied to nursing management. However due to the unique nature of nursing and its role in society and health institution in particular, its management and problems have unique features.

Role of the Nurse

The role of the nurse can be subdivided into planning and provision of patient care, coordinating health care activities, and collaborating with physicians and members of other disciplines in the provision of care (Douglass, 1984; Gillies, 1989). A nurse is a communicator providing the link between the clients, and their families and other health care workers involved in patient care (Douglass, 1984). The ability to execute these activities will result in excellence in nursing care (McCloskey, 1995).

According to Douglass (1984), Gillies (1989) and McLaughlin (1990), the roles of a nurse can be fulfilled if there is effective management, that is, if there is a process that takes place within the organisation in accomplishing organisational goals through the use of interpersonal and technical aspects of management (Gillies, 1989). Looking at the complexity of the nursing role Duffield (1991, 1992, 1994) stated that health care service requires a great deal of creativity and managerial expertise. Hence there is a need to understand the tasks middle-level nurse managers carry out, problems they experience, and identify necessary skills required to effectively execute this important role. This is the main purpose of this research.

Background of the Research

The current research took place in Malawi and involved twenty participants selected at random from various health institutions in Malawi. The institutions which make up the health delivery services comprise the government and non-government hospitals. The government hospitals fall into two major groups, namely central and district hospitals. The non governmental hospitals are predominantly church owned and are run by the association called the Christian Hospital Association of Malawi (CHAM).

District Hospitals

District hospitals act as referral hospitals for health centers within the district. They also serve the local town population. The number of in patients averages about 400. Services include out and in-patients, maternity, paediatrics and adult health care. District hospitals run on government funds and so health care is free to patients.

Central Hospitals

Central hospitals are larger hospitals catering for about 1,000 inpatients. They act as referral hospitals for the district hospitals in a particular region which is made up of several districts. These hospitals provide specialist referral care as well as being training hospitals for attached training institutions. Central hospitals have two distinct sections paying and d non-paying. Ninety percent of the patients receive free government funded care whilst ten percent of the care is fee paying. Care is better in fee paying section because it has better equipment and follows a different admission

policy. For example, if all beds have been occupied or booked no more patients are booked in. In contrast to non-paying section, improvised beds are allowed thus admissions continue despite having no unoccupied beds in the wards. In fee paying wards, the nurse managers would be expected to be able to cost direct nursing service per patient per day in their wards to determine the cost effectiveness of care.

Personnel levels at central hospitals are higher in number than in district and CHAM hospitals. In addition, central hospitals provide community services through out-reach activities using mobile clinics.

Non Government Hospitals

Apart from government hospitals, there are also private and Christian Hospital Association of Malawi (CHAM) hospitals. Some private and CHAM hospitals are as large or larger than district hospitals with more advanced facilities. The main distinguishing factor between government and private or CHAM hospitals is that patient care in the latter is fee paying. Patient numbers and therefore administrative expectations are different from the government hospitals. Patient numbers are smaller compared to government hospitals. Admission number adhere to bed numbers unlike in the government where improvised beds are used to meet the increasing number of patients. Since patient care in CHAM hospitals is fee paying, the nurse managers would also be expected to be able to compute the cost of direct nursing service per patient per day in her hospital to determine the cost effectiveness of care. They would also be expected to design their budget requests to illustrate how patient fees for nursing service compare with nursing costs.

The government institutions provide 86% of the total outpatient and preventive health care, and 67% of the inpatient care (Malawi Demographic and Health Survey, 1992; National Health Plan of Malawi 1986-1995). The private and CHAM hospitals account for the rest.

Health Personnel

There are two groups of nurses: Enrolled Nurse/Midwives (EN) and Registered Nurses (RN) who work in all above health facilities. Enrolled Nurse/Midwives undertake two years of general nursing and one year of a midwifery training program. They follow a hospital-based program. Registered nurses (RN) obtain their nursing education at Kamuzu College of Nursing, which is a constituent of the University of Malawi. RNs undertake a three year Diploma program in General Nursing and one year of Midwifery. After two years of service, Diplomates can go back to school for a Bachelor Degree in Nursing Science. From 1995, the college conducts a generic Bachelors Degree Program which replaces the current Diploma program.

Malawi has more Enrolled Nurses than Registered Nurses (RNs) in a ratio of RN:EN of 1:6 (Nurses and Midwives Council of Malawi report, 1991). Nursing personnel form the largest population of health care workers in Malawi. However the current population of nurses to the country's growing population is inadequate giving a registered nurse-patient ratio of 1:16,500, and an enrolled nurse-patient ratio of 1:5,000 (UN and Government of Malawi, 1993).

Other health workers include doctors, paramedical, and environmental health personnel like Health Inspectors, Health Assistants and Surveillance Assistants whose roles are preventive. There are also social workers who usually work closely with a Community Nurse. Patient care attendants assist in less skilled patient care activities.

Nursing Management in Malawi

RNs enter management either through promotion or post registration training. Additional management qualifications range from certificate in management to PhDs. Some nurse managers' qualifications include nursing education with an emphasis in management. Middle level nurse managers are referred to as matrons or senior sisters and mostly work at central, district and CHAM hospitals. Participants in this research were from these hospitals.

Background of the Problem

Studies in Malawi have revealed that the nursing profession is experiencing many problems. The Nurses and Midwives Council of Malawi Report (1991) conducted a research on "factors that influence nursing care and well being of nurses". The research included all government and non-government hospitals. The findings of the research indicated that there has been a deterioration of nursing standards. Some of the major reasons for the deterioration in health standards were a shortage of nursing personnel and inadequate material resources.

Simbota, Mbvundula, Mhango and Mtimaukanena (1995) also carried out a research of "factors that affect performance of nurse/midwives in midwifery units of

midwifery training hospitals in Malawi". The research is on going and is part of the Southern Africa Development International Cooperation (SADIC) regions. The research involved all twenty training schools in the country. The findings of the research indicate that there are many factors that affect the performance of nurse/midwives in Malawi. These factors include the increased number of patients seeking health care at both government and non-government hospitals. Care in all institutions is being provided by very few doctors and nurses, leading to health personnel being overworked. This has left nurses frustrated and as a result there has been a high attrition rate which has further reduced the number of nursing personnel as identified by the Nurses and Midwives Council (1991). The increased number of patients, the shortage of nursing personnel, the frustration of nursing personnel have lead to deterioration of performance in midwifery units around the country (Nurses and Midwives Council report, 1991; Simbota, 1995).

The findings of both studies (Nurses and Midwives Council of Malawi Report, 1991; Simbota, et al., 1995) have revealed that there is lack of indicators to measure output of nursing care in Malawian hospitals. This was found to be responsible for the difficulty in measuring nursing care. The survey further revealed that there were no formal policies in many institutions, which the research suggests could be due to lack of knowledge of many nurse managers.

Whilst both of these studies provide adequate information on problems experienced by the nursing profession in Malawi, the studies did not look at problems that nurse managers experience in those regards. Namate (1992) described problems and challenges experienced by nurse managers in Malawi. Namate (1992) stated that

nurse managers in Malawi experience such problems as limited financial resources, shortage of nursing staff, and lack of sufficient appropriately qualified nurse managers as discussed in Chapter One. However, her identification of these problems was based on a literature review rather than on empirical research. No independent research has been done on nursing management. This current research which involves nurse managers specifically, sought to explore how the identified problems affect nurse managers in Malawian hospitals in carrying out their work.

Nursing Management Problems

Changes in the Health Care Environment

Changes in health care have generally had a depressing effect on the attitudes of health care workers (Chamings, 1993). Changes in the external environment have created upheavals in the internal hospital environment in general (Salyer, 1995), and Malawi is no exception (National Health Plan of Malawi, 1986-1995; Nurses and Midwives Council of Malawi Report, 1993; Simbota, et al., 1995). There has been a change in patient population numbers, for example there are more patients in older age groups generally and more out patient attendance in all age groups. There has also been considerable change in delivery of care, and the availability of resources to deliver care. The impact of these changes on nurse managers' performance in Malawi have not been investigated and this research sought to explore how these factors affect middle-level nurse managers work.

Since economies, and populations are changing, health institutions need to change to keep pace with their clientele. Success in a changing environment depends

on management's ability to venture and encourage staff members to do the same and encourage reflective thinking (Hillebrand, 1994). Since nurses make up a large proportion of health care workers, it is essential that the nurse managers should create a climate in which the nursing staff can participate freely in identification and implementation of needed changes (Hillebrand, 1994). To be able to do so, nurse managers require a high level of interpersonal skills. Different studies have shown that interpersonal skills are very important in effecting change, yet nurse managers have received a great deal for criticism of having poor interpersonal skills (Hillebrand, 1994; McCloskey, 1995). This research therefore sought to explore environmental factors that affect middle-level nurse managers' work in Malawi and investigate perceived skills required to deal with the situation.

Problems of Accurate Planning of Nursing Numbers and Skill Mix

Reduced staffing levels have brought about significant concerns regarding the quality of care resulting in a decrease in public confidence in the hospitals' performance (Duffield, 1994; Rudolph & Hill, 1994; Warr, 1995). This is a situation which is similar to Malawi (Nurses and Midwives Council of Malawi Report, 1993; Simbota, et al., 1995).

According to Warr (1995), the current staffing levels in United Kingdom levels deliver a service but they are frequently reactive to pressures on costs and rising environmental problems. As a result of this there is the problem of accurate planning of nursing staff numbers and skill mix. To be effective, managers require to plan well in advance and remain primary guardians of the quality care to be offered. Nurse

managers should develop an overall staffing program for the entire nursing unit. The manager should be able to put nursing personnel to proper use, critically analyse options in determining nursing staff requirements, and involve head nurses and staff nurses within the constitution of the overall staffing program (Adams & Overfelt, 1991; Arthur & James, 1994; Blaney & Hobson, 1988; Gillies, 1989; McElroy & Jennings, 1995; Swansburg, 1993). This is an approach that Arthur and James (1994) termed consensus or consultative method.

Consultative method encourages nurses to look critically at staffing and practice. The advantage with this method is that it is responsive to particular demands of speciality, although it could be overbidding for nursing staff because it is involving. The nurse manager first stated the number and mix of nurses required to provide minimal, safe and ideal care at different times of the day and week. The proposal is then discussed between the nurse manager and staff. This allows a critical look at the organisation of both the workload and staffing. A final staffing establishment is then agreed which is presented to the top management for approval.

What comes out of the literature is that nurse managers should also be able to provide each ward with an appropriate number of each nursing staff level to perform nursing tasks (Arthur & James, 1994; Gillies, 1989; Klemm & Schreiber, 1992; Rosswurm, 1992; Swansburg, 1993). Arthur and James (1994) stated that nurse managers have many options in determining nurse staffing requirements. Nearly all organisations have a unit of measurement which they use to determine staffing. Unit measurements commonly used in the nursing profession by hospital administrators or nursing managers are patient characteristics and numbers, nurse characteristics, work

requirements, policy requirements, standard of care, and organisational structure (Arthur & James, 1994; Gillies, 1989; Swansburg, 1993).

Patient characteristics and numbers. Patient characteristics deal with character of the patient population in terms of diagnosis, age, gender, social background, personality, and previous health status (Gillies, 1989). These factors modify ones response to illness and treatment. These characteristics were used to determine staff numbers required to provide care. On the other hand, patient numbers also known as patient census have commonly been employed to measure nursing workload for assigning numbers and categories of nursing personnel (Finkler & Kovner, 1993). An estimation of the number of patients serves in developing a staffing plan that will meet a variety of nursing care needs of the patients. Unfortunately both patient characteristics and patient numbers have failed to accurately assign numbers and categories of personnel more appropriately. As a result some health agencies developed patient classification systems to measure workload more accurately.

Patient classification system is a method of grouping patients according to the amount and complexity of their nursing care requirements (Swansburg, 1993). Its purpose is to assess patient and award each a numerical score that quantifies the volume of effort required to meet the patient's nursing needs. In most classification systems, patients are grouped with reference to their dependency on care-givers' time and ability required to provide needed care. It is the responsibility of nurse managers to develop workable patient classification system. To do this , nurse managers will need to determine the

number of categories into which patients should be divided. They should specify the patient characteristics in each category, and stipulate the type and number of care procedures that will be needed by a typical patient in each category. Further, nurse managers should determine time required to perform required procedures such as giving emotional support, and providing health teaching for patients in each category (Gillies, 1989; Hillebrand, 1994; Morrow, 1994; Swansburg, 1993). This therefore requires nurse managers to have research skills so as to be able to determine elements used to categorise patients basing on observable and measurable nurse behaviours (Gillies, 1989). Patient classification system also provides information on staff requirements by shift and by day indicating needed staff by level such as registered nurse, enrolled nurse or nursing aids (Adams, Bracci & Overfelt, 1991; Gillies 1989; Hillebrand, 1994; Morrow, 1994; Swansburg, 1993).

A patient classification system would therefore determine the number and skill levels of nursing staff required to provide care (Arthur, 1994; Finkler & Kovner, 1993). Skill mix (different skill levels) seek to provide care of the highest possible quality and to provide that care at the lowest possible cost (Chapman, 1992; Gibbs, Caughan & Griffiths, 1991; War, 1995). It assists in the development of appropriate job descriptions, and training systems by laying a basis for each job duties required and expectations (Kelly & Taylor, 1990; Nessling, 1990; Oakley & Coulstock, 1990). Each job required takes in consideration of the mental requirements, physical, skill, responsibility and

working conditions. Based on this assessment a formal job descript. s written.

Skill mix would also help in developing assessment and selection procedures for recruitment and organisational structures (McElroy & Jennings, 1995). When information has been obtained about job tasks, significant activities that characterise a specific position are scrutinised weighing the compensate factors by which to evaluate a particular job. Examples of compassable factors are mental requirements, skill requirements, responsibility attached to a position or job, and working conditions.

Lastly, skill mix forms a basis for assessing staff performance and development of performance appraisal tools. When the scope of a particular job has been decided, a tool is developed to evaluate staff performance objectively. Tools in common use include free response reporting, simple ranking, performance checklist, graphic rating, and forced choice comparison. Whichever tool is used studies have revealed that nurse managers commonly experience problem of objectivity. Their evaluation is affected by the halo effect and the horns effect. Halo effect is a tendency to overate an employee's performance basing on personal characteristics of the employee. On the other hand horn effect is a tendency to rate an employee lower than her performance basing on recent blunder which remains fixed in the manager's memory (Swansburg, 1993). Both of these problem have caused frustration to well qualified and skilled employees. Both halo and horn effects have been reported in literature elsewhere as one of the many causes of stress in nursing and high

turnover of skilled nurses (Barriball, White & Norman, 1992; Klemm & Schreiber, 1992; Rosswurm, 1992) but the situation with Malawian middle-level nurse managers in this regard is not known. This research sought to examine how Malawian nurse managers use patient characteristics to determine staff numbers and skill mix.

Nurse characteristics. Nurse characteristics include the individual's experience, qualifications, attitudes and level of motivation. According to Adams, Bracci and Overfelt (1991), Gillies (1989) and Swansburg (1993), nurse managers should link assignments and responsibilities to the nurse's knowledge level, experience, motivation and philosophical approach to work. Knowledge within the nursing staff is translated into professional nursing skills of history taking, nursing diagnosis and prescription, provision of care, evaluation, documentation and record keeping, and all other activities related to patient care (McElroy & Jennings, 1995). However McElroy and Jennings (1995) stated that misunderstanding and poor communication about staffing issues among nurse managers have been reported as problems of accurate planning of numbers and skill mix. Nurse managers often disagree upon a philosophy of staffing as the first step in designing a staffing program. Consequently, staffing programs developed fail to capture the complexity of staffing demand (Arthur & James, 1994). It is not known how communication and staffing issues such as linking nursing assignments and responsibilities to the nurses' knowledge and motivation are used as strategies in determining staff requirements in

Malawi. This research sought to examine how middle-level nurse managers use nurse characteristics in determining staff requirements.

Work Requirements. Staffing requirements are influenced by the standards and procedures carried out, including technological advances. Changes in scientific knowledge and technology will determine the number and levels of nursing personnel required. For example, fewer personnel are needed for a modern, compact hospital equipped with labour-saving devices. On the other hand, a hospital that is spread out and has few or no labor-saving devices needs more staff. Staffing for a hospital that is arranged functionally differs from one that is not structured. A less structured hospital needs more staff and other working resources to meet acceptable standards of quality and safety (Arthur & James, 1994; Nagelkerk, 1994; Uys, 1994).

Availability of supporting services like sterilising departments and clerical staff are factors which can decide staffing requirements. This is particularly true depending upon the degree to which nursing departments carry out their own supporting services, for example carrying out clerical work instead of doing nursing duties. Nurses have often times been expected to fill gaps in other disciplines such as catering or pharmacy (Houston, Clute, Ryan-Crepin, Kimball & Mattews, 1994; Rudolph & Hill, 1994). Nurse managers should avoid assuming responsibility for non-nursing services and should encourage the appropriate departments to fulfil such services (Hillebrand, 1994). This is because nurse managers rarely have enough time to plan for

controlling body. Staff establishment indicates span of control of each management level (Malay, 1993). According to Malay (1993) and Pabst (1993) span of control, is an important management factor because it determines the structure of an organisation and has financial, human resource, and quality of care implications. The authors suggested an ideal span of control of seven to twelve. However Malay (1993) and Pabst (1993) indicated that size of the span of control did not necessarily determine effective management. The authors stated that effective management is the result of the combination of many factors including experience, the skills of those controlled and the manager.

There has been no research to examine the effects of staff establishments on nursing services and nurse managers' performance more especially in Malawi. Research has been carried out however in United States and UK to examine the relationship between size of span of control and effective management. The findings in other countries are not necessarily applicable to Malawi and so this research needed to be done

Nursing Assignments. Nursing assignments are modalities of nursing practice. Types of nursing assignment methods adopted by nursing departments influence the quality and quantity of nursing staff required (Hillebrand, 1994; Swansburg, 1993). The first nursing assignment method is functional nursing. Functional method is task-oriented method in which a particular nursing function is assigned to each staff member. For example one nurse might be

responsible for administering medicines to all patients in a ward, and another for dressings. The advantage of functional assignment is that it is possible for relatively small number of nursing personnel to care for a large number of patients in a relatively short period of time. The disadvantage however of functional method is that it encourages fragmented and depersonalised patient care. With the current staffing situation in Malawian hospitals, functional method is the most likely method to be commonly used.

A second nursing assignment method is team nursing. Team nursing consists of a registered nurse as a team leader and other staff as team members. Team leader should be skilled clinician and an effective group leader to coordinate the activities of other team members. The team leader should therefore have communication, leadership, and planning skills. The advantage of team nursing is that it combines different categories of personnel, facilitate a close supervision of ancillary workers by a professional nurse who is aware of both workers and patients needs. Unfortunately often times nursing teams are poorly constructed that they are ineffective. The problems being that most young nurses lack leadership skills, and often there is shortage of nursing personnel. This places nurse managers in a difficult position to accurately plan appropriate nursing skill mix and Malawi is no exception.

Primary nursing is a third nursing assignment whereby the primary authority for nursing care decisions is left to the registered nurse who is assigned to care for the patient's total needs for the duration of the hospital stay. Primary nursing method works best in an organisation with an all

registered nurse staff. Also where the nurse manager herself has had experience as a primary nurse so as to be able to act as a coach, a resource person, and a quality control advocate. Nurse managers just like those in Malawian hospitals would find it difficult to plan required nursing numbers where registered nurses are often not adequate.

The less common nursing assignment methods include case method. this method deals with 1:1 RN:patient ratio and the provision of constant care for a specified period of time. Another method is the joint practice whereby nurses and physicians collaborate as colleagues to provide patient care in a reciprocal and complementary role rather than mutually exclusive. Further case management involves collaborative management of professional nurses, physicians and family members to facilitate care within resource obligation. Finally, managed care is unit-based care organised to achieve specific outcomes within specified timeframe utilising appropriate resources following case management plans and critical pathways. These methods require a nurse manager to first assess the abilities of other health care workers and that of professional nurses from which the nurse manager will plan the nursing skill level required. It is not known the sort of nursing assignment methods used in Malawi hence the need for this research.

Arthur and James (1994) warned nurse managers to be alert to other factors that affect the needs of the unit. Such needs may not be reflected in the methods for determining nurse staffing requirements used by the organisation. For example, an

organisation with nurse managers who have been promoted from within may wish to have a manager with formal management preparation.

Recruitment and retention. Different studies have revealed that the biggest problem faced by hospital administrators, including nurse managers is the recruitment and retention of nursing staff (Klemm & Schreiber, 1992; Rosswurm, 1992; Skubak, Earls & Botos, 1994). This is true with Malawian nurse managers (Namate, 1992; Nurses and Midwives Council report, 1991; Simukonda & Rappsilber, 1989).

"Recruitment is the process of securing of applicants to fill vacant positions" (Gillies, 1989, p. 602). Requirements of each position are specified and are normally advertised to the public through newspapers or career days. Swansburg (1993) stated that regardless of the method of advertising, an advertisement should provide detailed information about factors that attract nurses to hospitals and make them stay there. Such factors include salaries and fringe benefits, and the organisational climate (Rosswurm, 1992).

According to Klemm and Schreiber (1992), lack of additional work benefits are a major cause of retention problems. Benefits have been defined as what an employee expects from the employer over and above stipulated salary. Benefits can either be cash valued or non-cash valued services, for example programs designed to provide employees with additional value for services they provide (Klemm & Schreiber, 1992). These benefits fall under two categories: traditional and environmental benefits.

Traditional benefits can include paid leave of absence or subsidised house rent. Environmental benefits are defined as creative, responsive, and flexible means of accomplishing staffing, scheduling, and other patient-care programs that reflect the input of staff. Training is an environmental benefit and continuing education support successfully keeps staff happy (Barriball, While & Norman, 1992; Klemm & Schreiber, 1992). Klemm and Schreiber's research revealed that environmental benefits are often the deciding factors in recruitment and retention of nursing staff. Flexibility of management also enhances staff retention (Klemm & Schreiber, 1992), and most successful at retaining quality employees. An organisation that has contented employees generally attracts higher quality employment candidates more easily (Klemm & Schreiber, 1992; Rosswurm, 1992).

In a different research Kramer and Schmalenburg (1991) confirmed the relationship between intangible elements and increased job satisfaction. Their research also indicated that the low turnover rates were related to organisational structure, professional practice, management style, quality of leadership and professional development.

A survey conducted by Rosswurm (1992) compared best run corperate communities and hospitals in terms of their ability to attract and retain qualified personnel. The survey revealed many similar factors that attracted quality staff: nurse autonomy, non-rigid verbal communication, encouraging innovation, bringing out the best in each individual, the value of education, respect and caring for the individual, and striving for excellence. The factors

point to the need of good interpersonal skills of nurse managers to be able to attract and retain nurses. It was imperative therefore that an exploratory research be carried out to determine interpersonal skills required by Malawian nurse managers hence this research.

Problem of Determining the Acceptable Level of Quality Care

Nurses feel there are extraordinary demands on them by other health care workers (Dewar, 1995). For instance, nurses believe that they are expected to work overtime as and when the need exists and that they should deliver high quality care irrespective of staffing or resource shortage (Dewar, 1995). A situation similar to Malawi (Simbota, et al., 1995).

To determine the level of acceptable quality care Houston et al. (1994) and Swansburg (1993) stated that standards should be in place. Standards define nursing care outcomes as well as nursing activities and structural resources needed (Houston, Clute, Ryan-Crepin, Kimberley & Matthews, 1994). Standards are based on the philosophy and objectives of the organisation. They include performance standards for providers and are used for planning and evaluating nursing care. In setting nursing standards, staff who are going to implement those standards should be involved. Set nursing standards should periodically be evaluated and reviewed through auditing (Murray, Stackard, Blaylock, Stanta & McKee, 1994). The nursing staff are responsible for auditing nursing standards and should participate in clinical audits (Dunn, 1995).

To carry out audits information is used from different sources to provide a comprehensive assessment. Patients and personnel form the primary sources of information, whilst patients' charts and family members form a secondary source. Common sources of information are nursing rounds, observations, and records (Mark & Burleson, 1995). Studies have shown that rounds are regularly carried out by nurse managers and they provide invaluable information for decision making (Murray et al., 1994; Whale, 1993).

Nursing round is one of the controlling techniques to determine whether the goal such as quality care is being achieved. Nursing rounds take a form of clinical supervision whereby supervision is also a control technique. Both nursing rounds and clinical supervision take place in the patient care environment (Gillies, 1989; Swansburg, 1993). They can be placed on a schedule, covering such issues as patient care, nursing practice, and nursing management. The difference between the two technique is that supervision is a leadership technique as well whilst nursing round is not but requires leadership techniques to be effective (Whale, 1993).

Whale (1993) studied ward rounds in a cancer-therapy ward and found that nurse managers lacked objectivity and used their time poorly. The research also revealed that in a multidisciplinary ward round, nurse managers' behaviour was both passive and unprofessional, the lead being taken by medical staff. Personal factors such as confidence, experience, assertiveness and beliefs about nurse managers were identified as affecting their behaviour. Nurse managers were conscious of their limitations, and nursing rounds received many criticism from both patients and staff. Whale (1993) therefore recommended that nurse managers be provided with clinical

supervisory skills. Nicklin (1995) stated that clinical supervision plays an increasingly important role in ensuring safe and effective practice. These findings point to the complexity of nurse managers' work in planning and monitoring quality care. This research therefore needed to find out whether this is the case with Malawian nurse managers.

Lack of Active Involvement in Policy Making

Although there is evidence in the literature that affirms the involvement of nurse managers in policy making in other countries, nurse managers in the majority of countries still face problems in becoming fully involved in policy making Malawi inclusive (Ament, 1994; Donaho, 1990; Nagelkerk, 1994; Namate, 1992; Sharp, Biggs & Wakefield, 1991). Some of the obstacles encountered by nurse managers include lack of knowledge by nurse managers themselves, and lack of support from other health professionals. The problem is best viewed in terms of policy formulation and dissemination.

Policy formulation. According to Nagelkerk (1995) policy making requires strong leadership skills by nurse managers and understanding of the nature of policy making in their institutions. The formulation and implementation of policies is an extremely complex undertaking and requires strong leadership skills and involvement of others. Lack of managerial preparation of nurse managers has limited their leadership role in policy making. Malawian nurse managers are no exception (Hillebrand, 1994; Nagelkerk, 1995; Namate, 1992).

Farrington (1994), Nagelkerk (1994), Skubak, Earls and Botos (1994) and Swansburg (1993) have found that policies are best developed in consultation with representatives of all groups concerned in their implementation. A process of participatory management assumes that employees will follow and support policies they have helped to develop (Nagelkerk, 1994; Swansburg, 1993).

Dissemination of Policies. There are several ways of informing staff of policies. The commonest include meetings, written policies, and staff education (Mallik, 1992; Whale, 1993; Whitman, 1990). First, meetings are valued as a forum for problem solving, decision making, planning, sharing information and learning from colleagues and patients. Discussions of policies encourage critical analysis, communication and creativity. In this connection meetings of all kinds including multidisciplinary meetings are a medium for dissemination of policies (Whale, 1993; Whitman, 1990).

A second method of disseminating policies is through written material. Ament (1994), Klemm and Schreiber, (1992), and Skubak, Earls and Botos (1994) and Swansburg (1993) recommend that policies be presented in a written form such as manuals and be presented to staff members who participated in their development. Written policies provide a means for greater consistency and fairness for all concerned (Skubak, Earls & Botos, 1994). "It is not enough that policies be written down, it is also vital that the policies be communicated clearly to all employees" (Houston & Marquis, 1989, p. 151).

Finally, in depth staff education on policy formulation detailing the roles and responsibilities of the members is also a recommended means of disseminating policy (Houston & Marquis, 1989; Nagelkerk 1994). Staff education is one of the most fundamental elements of a participative approach. Many authors have written that organisations benefit through improving the provision of information to the employees (Chammings, 1993; Hirsh & Rodeck, 1991; Nagelkerk, 1994). Staff education and provision of information increases staff responsibility and autonomy over their job and gives them opportunities to learn new skills (Chammings, 1993; Nagelkerk, 1994).

However Chammings (1993) expressed disappointment that there continues to be a shortage of prepared nurse managers in many countries including Malawi (Namate, 1992; Simbota, et al., 1995). This has meant that nurse managers have continued finding problems in influencing change and directing nursing services.

Involvement of nurse managers in policy making is very important in influencing the direction of the nursing profession in Malawi because like in other countries nurses are the largest group of health care workers (Nurses and Midwives Council Report, 1991). This research sought to explore whether middle-level nurse managers in Malawi were involved in policy making and whether they experienced problems in getting involved.

Lack of Adequate Knowledge about Financial Control

Studies have revealed that many nurses are uneasy about financial management, including assessing the cost of care in the health care systems (Allen, 1995; Bailey, 1995; Buchan, 1992). It has also been shown that cost-effectiveness is a difficult issue for nurse managers to deal with, but it is needed for objective decision making (Behets, 1995; The Nursing Report, 1995). Similar problems were reported in Malawi by Namate (1992). Three specific problems that nurse managers experience with regard to budgeting are lack of budgeting skills including accounts (Bailey, 1995), lack of involvement in financial management (Buchan, 1992), and financial constraints (Swansburg, 1993; The Nursing Report, 1995). The above reported problems are also applicable to Malawian nurse managers (Namate, 1992; National Health Plan of Malawi 1986-1995). As a result, financial management is usually carried out by hospital administrators or accounting personnel (Bailey, 1995; Buchan, 1992).

Nursing costs represent a substantial portion of the overall hospital budget (Brown, 1991) which hospital administrators tend to view as excessive (Blaney & Hobson, 1988; Schroeder, 1994). The administrators' concern can also be attributed to lack of appreciation of the nature and role of nursing (Schroeder, 1994). Nurse managers must therefore be prepared consequently to defend their budgetary allocations in the interest of both the quality of patient care and working conditions (Blaney & Hobson, 1988; Brown, 1991; Schroeder, 1994; Smith, Danforth & Owen, 1994; Swansburg, 1993).

Secondly, nurses must exhibit proactive fiscal responsibility in developing budgets and reducing costs (Buchan, 1992). Nurses should therefore be familiar with the budgeting process and capable of asserting the importance of the services in economical terms (Blaney & Hobson, 1988; Brown, 1991; Buchan, 1992; Schroeder, 1994).

According to Allen (1995), Buchan (1992), Blaney and Hobson (1988), Gillies (1989), Smith, Danforth, and Owens (1994) and Swansburg (1993), current nurse managers and staff should be provided with skills in finance, accounting, fiscal planning, policy making and budgeting. In the absence of informed, educated, and effective nursing leadership, success in dealing with the new financial challenges will be limited. "If nurses ignore this issue, important decisions on resource allocation and utilisation will be made by administrators with a strong knowledge of costing but a weaker appreciation of the impact of cost-containment strategies on the quality of nursing care" (Buchan, 1992, p. 117).

The Problem of Motivating Nurses

Motivation deals with both extrinsic and intrinsic conditions that excite certain behaviours (Gillies, 1989; Swansburg, 1993). When these conditions are not satisfied motivation declines. Extrinsic conditions include salary, job security, working conditions, organisational policies, quality and technical supervision and quality of interpersonal relationship with supervisors, colleagues and subordinates. Brown (1993) stated that extrinsic factors should be maintained in both quality and quantity to prevent dissatisfaction. These become sources of dissatisfaction if they are not

equitably distributed or administered, causing low performance and negative attitudes (Brown, 1993; Gillies, 1989; Swansburg, 1993)

Intrinsic conditions include achievement, recognition, responsibility, advancement, the work itself and professional growth. These intrinsic conditions create opportunities for high satisfaction, high motivation, and high performance (Brown, 1993; Gillies, 1989). The opposite is true when intrinsic conditions are not realised.

Research has shown that nurses and nurse managers experience many stressors and dissatisfiers which are factors that stimulate a negative response in the work place The origin of such stressors include shift work and poor working conditions such as inadequate space and inadequate resources (Snape & Cavanagh, 1993; Sullivan, 1993; Vives, Caminero, Oliver, Carpo & Casado, 1994), shortage of staff (Snape & Cavanagh, 1993), organisational problems like inconsistent policies (Brown, 1993; Vives et. al., 1994) and unclear channel of authority (Alderman, 1992; Jutte, 1991). According to Alderman (1992) and Jutte (1991) uncertainties in the channel of authority lead to role conflict and role ambiguity. Role conflict is a condition that is expected by an individual when expectations for his or her role performance are incompatible, mutually exclusive or contradictory. While role ambiguity is a condition which an individual experiences when role expectations are not clear or are vague, ill-defined and inconsistent. Snape and Cavanagh (1993) have
in addition reported that nurses respond negatively and become dissatisfied when managers use force, control, threats, and repeated applications of institutional power.

These problems are also true to Malawian situation (Nurses and Midwives

Council Report, 1991; Simbota, et al., 1995) but the effect has not been investigated. This research sought to examine sources of stressors experienced by nursing staff and impinge effective nursing management in Malawian hospitals.

Brown (1993), Gillies and Pettengill (1993) and Swansburg (1993) acknowledged that there is no easy way for nurse managers to motivate nurses because human motivation is diverse, subtle and complex. Swansburg, (1993) stated that basic to motivation is the fact that each person is unique, thus within each unique individual, motivating needs differ from time to time. A nurse manager should use judgement to figure out why each person reacts in a given way to any situation (Swansburg, 1993).

Studies have also shown that motivating nurses is one of the most important skills for nurse mangers to have for maximum productivity and job satisfaction (Hewa & Hetherington, 1990; Wheeler & Riding, 1994; Yuen, 1993). Productivity in the nursing management context can be described as quality care, and nursing services provided per unit resource which include human effort (Finkler & Kovner, 1993). High levels of productivity can be achieved through mutual respect between nurse manager and members of staff (Henderson, 1995; Proulx & Pepin, 1993). To promote mutual respect there should be free interaction and communication in which expectations are clarified and promises that can not be delivered avoided (Henderson, 1995). Pryor and Mondy in Swansburg (1993) found that 75% of production workers said that their managers did not keep promises they made. From the results Pryor and Mondy concluded that broken promises anger employees and decrease productivity.

Another dimension to motivation concerns the manager him or herself. Managers motivation and commitment to organisational goals, often set a foundation for the motivation levels of staff (Dailey, 1990). For example, nurse managers should be consistent and able to maintain standards. They should create an environment in which goals can be achieved. It is their responsibility to organise, communicate, and support staff (Douglass, 1992). However it is not known how Malawian nurse managers organise, communicate with and support staff. Hence this research sought to investigate channels of communication utilised and support nurse managers offer to staff to keep them motivated.

Summary

The nurse manager operates within a framework which is defined by the following: the organisational structure, the management process, and resources available. Each of these has a bearing on the other and the effectiveness of the manager depends on the knowledge and ability to function within this framework. The literature has pointed out the need for management training if nursing is to face health service problems effectively.

In addition to the challenges and problems experienced by managers in general, nurse managers experience problems that are unique. These include changes in the health care environment, problems of accurate planning of nursing numbers and skill mix, problems of determining the acceptable level of quality care, lack of active involvement in policy making, lack of adequate knowledge about financial control, and the problem of motivating nurses. Nurse managers are involved in leading nursing

personnel in the delivery of quality nursing, formulation and dissemination of policies, and developing and managing a budget. They are also involved in motivating nurses because nurse motivation is related to satisfaction and productivity.

There is evidence to suggest that individuals are motivated most successfully when participative management is used and goals are attained. A nurse manager should be constantly aware that goal achievement is the primary reason for the existence of any organisation. Further, nurse managers should establish an effective relationship between work, individuals, and the setting in which quality is delivered.

Summary of the Literature

The concept of management is hardly captured in a single definition but is basically applied in the same way. Below are three tables summarising literature covered above. Table 1 will cover the concept of management in general. Table 2 will cover problems in general management and Table 3 will cover problems in nursing management.

Table 1
The Concept of Management

Definition	A process involving planning, organising, leading, staffing and controlling human and material resources
Importance of management	Ensures organisational stability by maintaining order and smooth running of an organisation
Management skills	Three basic management skills that facilitate coordination of activities include conceptual, human and technical skills
Management levels	Top level management, middle-level management and operational management
Managers' roles	Interpersonal, information and decision roles
Effective management	Ability to conserve resources

Table 2

Problems in General Management

Quality crisis	Resulted from differing interpretations and expectations between producers and customers, lack of management adequate managerial knowledge by the managers
Lack of supervisory skills	Has lead to ineffective management of services
Economic problems	Have lead to inadequate human and material resources
Population explosion	Has caused constraints on economy and energy crisis
Inconsistent and unclear policies	Decisions were subjective
Stress in the work place	Stress in the work place is attributed to population explosion, economic problems, poor environmental conditions, and poor communication

Table 3
Problems in Nursing management

Changes in the health care environment workers	Has had depressing effect on health care because of the increased number of patients and scarce of resources to deliver care
Problems of accurate planning of nursing personnel numbers and skill mix	Reduced staffing levels have lead to problems of skill mix
Problem of determining the acceptable level of quality care	high expectations by other health care workers, lack of supervisory skills by nurse managers in carrying out ward rounds, lack of confidence and nursing standards
Lack of active involvement in policy making	Attributed to lack of knowledge by nurse managers themselves, lack of support from other health care professionals
Lack of adequate knowledge about financial control	Has lead to lack of involvement in financial management, nurse managers feeling uneasy in assessing the cost of care in health care system, finding difficulties to deal with cost-effectiveness, and financial constraints
Problems of motivating nurses	Sources of problems are attributed to extrinsic and intrinsic conditions, poor working conditions, inadequate resources, inconsistent policies, use of institutional power by nurse managers

From the foregoing discussion it is apparent that both general and nursing management experience similar problems. For example changes in the external environment affects internal functioning of organisation such as availability of human and material resources. Population explosion and economic problems have exerted pressure on resources in organisations. The most interesting similarity is knowledge deficit both for general managers and nurse managers. It has been shown that managers in general lack managerial skills including

supervisory skills. Consequently managers need management training if organisations are to function and achieve goals.

CHAPTER THREE

CONCEPTUAL FRAMEWORK

Background

The conceptual framework that was used to guide this study was developed by utilising concepts from King's Theory of Goal Attainment (King, 1981). The use of King's Goal Attainment Theory as a guide for this study allowed the exploration of the tasks carried out by middle-level nurse managers, a description of the problems encountered, and the perceived management skills required by nurse managers in Malawi. The concepts in the theory offer an holistic approach to analysis of the working environment of nurse managers (King, 1989).

General Systems Theory

King utilised concepts of General Systems Theory developed by Von Bertalanffy (King, 1981; 1989). Von Bertalanffy (1968) studied living organisms which he saw as different components forming a whole. In his studies he utilised open systems theory which offered him various ways of looking at a phenomenon.

Open Systems Approach

The open systems approach states that there is an interrelationship between all elements and constituents of society. For example, essential factors in the society such as policies, programs and problems should always be considered and evaluated as

interdependent components of a total system (Von Bertalanffy, 1968). General systems theory is therefore concerned with wholes rather than parts (Von Bertalanffy, 1968). According to Von Bertalanffy (1968) in examining wholes, one does not merely examine the total of the parts of a system, for the whole is different from the sum of the parts. King (1981) saw this view as consistent with nursing's perspective of an individual.

King's Conceptual Framework

King (1981) stated that elements of any system include structure, function, resources, and goals. In attempt to provide structure for nursing as a discipline and a profession, King developed a systems framework. According to King (1989) the structure of a system may be reflected by a person interacting with an environment whilst functions of a system may include viewing, observing, measuring, synthesising analysing and interpreting. These functions could be carried out simultaneously within a particular situation.

Resources of a system may include both human and material required to achieve a goal. In nursing the goal of a system is health. King used this view of systems framework to determine that health concerns related to nursing could be grouped into "three dynamic interacting systems: personal systems, interpersonal systems, and social systems (King, 1989).

King identified sixteen concepts relevant to nursing and nursing practice. These concepts are authority, body image, communication, decision making, growth and development, interaction, organisation, perception, power, role, self, space, status,

stress, time, and transaction. King (1989) grouped these concepts under personal, interpersonal and social systems as a way of organising one's knowledge, skills and values.

Personal systems. King conceptualised a personal system as an individual and that understanding an individual as a whole is critical before one can understand groups and communities (King, 1989). King viewed an individual as a complex open living system coping with health needs. Individuals are rational with feelings: they react to their expectations, to other people, to events and to objects. Human beings are time oriented and aware of their past, present and future goals (King, 1981). The concepts of body image, growth and development, perception, self, space, and time are particularly relevant to the personal system.

The personal system is particularly important to this study of middle-level nurse managers because it offers a realisation that a nurse through whom nurse manager accomplishes goals has needs that must be met if he/she is to function effectively. The concept of the personal system also assists nurse managers realise that their expectations may not necessarily be congruent with nurses, patient and other health care workers. Nurse managers should therefore give opportunity to individuals to make choices and participate in decision making. It also offers nurse manager to be flexible knowing that an individual has limits to his abilities depending on age and situation.

Interpersonal systems. Interpersonal systems focus on groups of employees. Concepts relevant to interpersonal systems are communication, interaction, roles, stress, and transaction (King 1981). The interpersonal system is the system in which interaction between people takes place leading to transaction. Implicit in this system are mental acts of judgement on the part of each member involved.

The interpersonal system is relevant to this study because it shows the importance of mutual goal setting between a nurse and a nurse manager. When a nurse manager and a nurse or a patient or other health care workers interact, each one of them perceives the other as making mental judgement and engaging in some kind of mental action. Although one cannot directly observe these behaviours, some inferences are made about the others' behaviour. These inferences influence the way the individuals identify their concerns and problems and mutually set goals, and explore means to attain goals. Interpersonal systems therefore facilitate nurse managers in establishing participatory management.

Social systems. King stated that "social system is an organised boundary system of social roles, behaviours, practices developed to maintain values and mechanisms to regulate the practices and rules" (King, 1981, p. 115). Individuals within a social systems share common goals and interests and they play different roles. The roles they play are interrelated to achieve a common goal. For example quality nursing care. Nurses provide care whilst nurse

managers provide the resources and support for the nurses to achieve the common goal.

An individual functions in a social system through interpersonal relationships. For example involvement of staff in meetings gives the opportunity to nurses to participate in decision making and offer them a sense of belonging to organisational goals. It is therefore important that nurse managers know the impact of social systems or individuals and group behaviour for effective human resource management (Evans, 1991).

Although King's concepts are grouped in specific systems, they are all interrelated and so can be discussed, examined, and utilised within each system (Evans, 1991; King 1989).

Theory of Goal Attainment

King developed the Theory of Goal Attainment from her conceptual framework described above. The focus of this theory is the interpersonal systems because it focuses on holism, that is, the total human being in a specific situation (King, 1989).

King's theory utilises concepts of communication, growth and development, interaction, perception, role, self, stress, time, and transaction. The theory identifies that decision making is a shared collaborative process. It is based on the assumptions that individuals are social, sentiment, rational, reacting, perceiving, controlling, purposeful, and action-oriented beings. It also assumes that perceptions, goals, needs,

and values of both nurse managers and nurses influence interaction process. Nurses and nurse managers have a right to participate in decisions that influence their life and health services. Further the theory assumes that health professionals have a responsibility to share information that helps to make informed decisions. It also assumes that goals of health professionals and goals of recipients of health care may be incongruent. Although the theory appears to emphasise nurse-client interactive processes, this does not restrict the use of a theory to clinical setting. Its concepts can be used in any situation where interaction among people takes place (King in Henry, Arndt, DiVincenti & Marriner-Tormey, 1989).

King's theory has previously been used to study management situations. For example, it has been used to clarify the relationships among health care workers. It has also been used to help nurse managers establish common goals where they have experienced age differences, or conflicts in values and expectations (King, 1992). In addition, the theory has been used widely as a framework for the definition and delivery of quality care in clinical settings and has guided the organisation and implementation of curriculum in nursing (Gulitz & King, 1988; King, 1992; Norgan, Ettipio & Lasome, 1995; Porter, 1991; Sowell, & Lowenstein, 1994).

However the theory has also received many criticisms for example its limited use to Western culture (Carter & Dufour, 1993). The critics George (1980) and Meleis (1991) expressed concerns that the usefulness of the theory is limited to cultures which share Western sick-role attitudes.

George (1990) and Meleis (1991) felt in general that the theory lacks utility and specific, detailed definitions and guidelines (Fawcett, 1989; George, 1990; Meleis,

1991). According to Carter and Dufour (1993), such criticisms made by different authors actually support the strength and utility of the theory. "Because of the broadness of the conceptual system and theory, the nurse is able to adapt the theory to various and unique situations" (Carter & Dufour, 1993). In response to the criticisms, Porter (1991), cited in Carter and Dufour (1993) said, "if any theory is to be really serviceable, ... it must enable concerned individuals to understand the problems of here and now situations and must provide assistance when a course of action is needed" (Carter and Dufour, 1993, p. 131).

King (1989; 1992), Cater and Dufour (1993) and Evans (1993) stated that concepts in this theory do not have to be applied directly to situations because of their abstractness. But what can be applied to various situations is the knowledge of the concepts of the theory. "It is the responsibility of the researcher, educators and practitioners to develop specifics based on the theory" (Evans, 1991, p. 124). The use of the theory in this research will therefore support the strengths and utility of the theory in different settings.

The concepts in the theory are relevant to this study because of the holistic approach and comprehensiveness in the way they describe interpersonal relationships. For example, a nurse manager and nurse interactions are characterised by verbal and nonverbal in which information is exchanged and interpreted. This is accomplished through transactions in which the values, aspirations, and wants of each member of the dyad are shared through the perceptions through the self in role of nurse manager and in role of nurse. The concepts in the theory can very successfully be used as a

framework to explore middle-level nurse manager's work. Definitions of King's ten concepts follows.

Concept of communication. King (1981) defined communication as an interchange of thoughts and opinions among individuals and is a means whereby social interaction and learning takes place. To be effective, communication must take place in an atmosphere of mutual respect and desire for understanding. Communication can be verbal or nonverbal or both. There are several factors that can influence communication. These include the situations in which individuals are communicating, the roles they play, the expectations of others, the goals of each individual, and the barriers to communication (Evans, 1993; King, 1981). For communication to be most effective, an environment must exist in which individuals respect and wish to understand each other. King (1981) stated that environment provides motivation for the understanding and utilisation of information as nurse managers interact with each other, nurses, other health care workers, patients and patients' family members.

Communication has several implications for nursing management. Communication facilitates interaction with nurses, physicians and allied health professionals. It therefore requires the use of accurate knowledge and communication skills to gather information and to be able to transmit that information for decision making (King, 1994).

Concept of perception. Perception is fundamental to all human interaction (King, 1981). "Every human being perceives, and each person's perceptions are different from those of others" (Evans, 1993, p. 16). Perception is related to one's education, experiences, goals, needs, physiology, self-concept, socioeconomic status, temporal-spatial relationships, and values. King (1989) stated that perception gives meaning to one's experiences. It represents reality, influences behaviour, and forms a basis for developing a concept of self. Perception can be distorted by emotional states like anger, fear, and love (King, 1981).

Perception is basic to gathering and interpreting information in nursing management. It facilitates mutual goal setting and exploration of means to achieve goals. Perception helps nurse managers to do proper assessments, draw plan and implement those plans appropriately (King, 1992).

Concept of interaction. Interaction is a "process of perception and communication between person and environment and between person and person, represented by verbal and nonverbal behaviours that are goal-directed" (Evans, 1993, p. 41). The process of an interaction only moves forward; it is unidirectional because interaction occurs within a time-space context. Once an interaction has taken place it cannot be repeated. Interaction is influenced by values, perceptions, situation, closeness of the participants, and the interdependency of each person.

King (1994) stated that the primary purpose of interaction in nursing management is to assist individuals to cope with problems or health care concerns. Nurse managers respond through interactions with each other, between other health care workers, and with patients. It helps nurse managers clarify the shared environment. King (1994) stated that individuals involved in interaction have a right to knowledge about themselves and they have a right to participate in decisions that concern them. King (1989) further stated that health professionals have a responsibility to share information that helps individuals make informed decisions. Hence there is a need for nurse managers to involve nurses in decision making and get involved in decision making themselves.

Concept of transaction. A transaction involves both verbal and non-verbal communication between individuals. Each transaction is a serries of events in time used to achieve goals" (Evans, 1993, p. 22). A transaction involves bargaining, negotiating, and social exchange, and is influenced by role expectations and role performance (King, 1992). According to King (1994) a transaction is affected by the actions, judgements, perceptions, and reactions of others within the health care system. Value orientation patterns of nurse managers, nurses, patients and other health care workers are critical elements in transactions.

Concept of self. A concept of self is a composite of the thoughts and feelings constituting awareness of individual existence, in other words a conception of who and what one is. For example nurse manager's interaction with the environment is influenced by feedback from the interactions with nurses which give some consistent pattern of relationships. Both nurse managers and nurses have a self. Knowledge of this is important in understanding human behaviour. King (1989) stated that the self is goal directed. When the self is subjected to conflict it leads to dehumanisation and depersonalisation. This can in turn lead to powerlessness for decision making about the self. Further, it can lead to stereotyping (Norris & Hoyer, 1993).

Concept of role. A role is "a set of behaviours expected when occupying a position in a social system" (King, 1981, p. 93). Roles are learned from functioning in the social systems within the environment. Roles are complex and situational. The concept of role requires people to communicate and engage in a purposeful goal directed situation. A nurse manager has both expressive and instrumental roles. For the nurse managers to function well they should define their role. If employer and employee expectations are incongruent, role conflict results which may then reduce effectiveness of nursing management, leading to stress of nurse managers and those being managed.

King (1994) stated that the nursing management role must be clearly defined, and that education programs should provide opportunities for

socialisation into the nursing management role. Explanation of the types of role behaviour expected of nurse managers will help them and other health care workers to see the complexity of their professional role. Interactions between nurse managers and nurses, nurses and patients, and also between nurse managers and between nurses and other health professionals, are goal oriented and effective when the perceptions of those interacting are accurate.

Concept of stress. Stress is a dynamic state whereby one interacts with the environment to maintain balance for growth, development, and performance. It involves an exchange of energy and information between the person and the environment for regulation and control of stressors. All human beings experience stress in a personal and subjective manner which "is not limited by time or place" (King, 1981, p. 97).

King (1989) stated that stress is influenced by a number of factors: age, environmental background, meaning of the event, motivation, personality, predominant gender group, situation, time of the event, stressors, response and cognition. An increase in stress lowers one's ability to perceive events and make rational decisions. This may lead to decreased interactions and goal setting between individuals, and may also lead to ineffective nursing management. Subsequently, interference in each person's developmental tasks may occur. Evans (1993) stated that nurse managers can decrease stress through various techniques, which may include: provision of information to those concerned, assisting nurses to articulate their concerns, encouraging

nurses to participate in goal setting, and offering suggestions on alternative means to attain the goal.

Stress has implications for nursing management. Nurse managers at all levels are continuously confronted by stressors in many situations and therefore require adequate knowledge about stress so as to be sensitive to stressors and minimise such stress in nurses, patients, colleagues, and patients' family members.

Concept of time. Time is perceived differently in relation to the kinds of events in which a person is involved. Time is subjective, dealing with the perception of succession that connects past with present and future. It is universal, existing in every culture, and is also measurable. Time can be viewed in terms of age, order of events, and space. For the nurse managers, time influences both short and long term planning.

Concept of growth and development. Growth and development as a "function of: generic endowment, meaningful and satisfying experiences, and an environment conducive to helping individuals move toward maturity" (King 1981, p. 31). Age is an important variable in determining an individual's growth and development (Evans, 1993). Individuals can experience growth and development, moving from a potential to an actualisation of their abilities and goals. A nurse manager can assess their own and nurses' level of growth and development needs through knowledge of social systems. Knowledge of

growth and development pattern is useful if nurse managers are to professionally develop themselves, help each other and nurses through stress periods. Familiarity with normal patterns of growth and development will therefore enable a nurse manager to identify disruptions in these patterns and then think of ways to assist themselves, colleagues and nurses in establishing goals to alleviate those disruptions.

Concept of space. The concept of space is universal. It exists in all cultures but is perceived differently by each individual. It is therefore personal, situational, dimensional, and transactional. Space is associated with self-identity. Knowledge of space helps a nurse manager to understand individual and cultural behaviours that are brought to the working environment.

The meanings of these concepts in the theory do overlap. Further, the concepts influence each other. For example, perception can influence the effectiveness of communication. The inter-relatedness of the concepts makes it difficult to directly apply individual concepts in King's theory in a research like this. Therefore for the purpose of making this study more focused, interrelated concepts were collapsed into three broad groups, namely interpersonal factors, extrinsic factors and intrinsic factors. A description of each component of the new concepts is presented in more detail.

Adapted Conceptual Framework

There are three factors that make up nurse managers' work. These are interpersonal, extrinsic and intrinsic factors.

Interpersonal factors. Interpersonal factors focus on interaction pattern of groups of individuals. Perception, communication, interaction, and transaction are the interrelated concepts that have been collapsed to form this category. These concepts influence each other. For example, perception which is one's representation of reality influences communication which is the information component of interaction. Interaction is the process used to gather relevant information to set goals and engage in transaction, which is the observable behaviour of people interacting with environment (King, 1989).

Extrinsic factors. For the purpose of this research extrinsic factors have been defined as external factors within one's environment that influence behaviour. This category includes role, growth and development, and stress which are interrelated. Stress deals with one's efforts to maintain balance for growth and development and performance (role). On the other hand, growth and development deals with the experiences that enable one to move from the potential to the actualisation of goals. When growth and development needs are not met, stress sets in which affects expected behaviour (role).

Intrinsic factors. The concepts which fall under intrinsic factors are time, space, and self. The three concepts relate and influence each other in that time and space are both subjective, universal and exist in every culture. Space and time are both perceived differently by the self and are therefore associated with self-identity. Intrinsic factors are demonstrated by external behaviour. The behaviour of nurse managers and nurses is sustained by motives such as needs, wants or drives. These motives change depending on time of the event, space or situation involved and the concept of self.

The nurse managers' work is comprised of the overlapping of the interpersonal, external and internal factors within the working environment. For example, interaction as a process of perception in interpersonal factors influences role (an extrinsic factor), which is the expected behaviour in an occupied position. Role further affects the self (intrinsic factor) which deals with one's awareness of existence in a particular position. Another example involves the concept of perception. This influences communication, interaction and transaction within the environment (space). Perception forms a basis for a concept of self. The concept of self deals with one's feelings, values attitudes and commitment to do something. Self therefore influences role. Further, the self is directly linked with ones state of stress and perception of time, needs for growth and development as well as performance (role). the interaction of these new concepts is depicted in Figure 2.

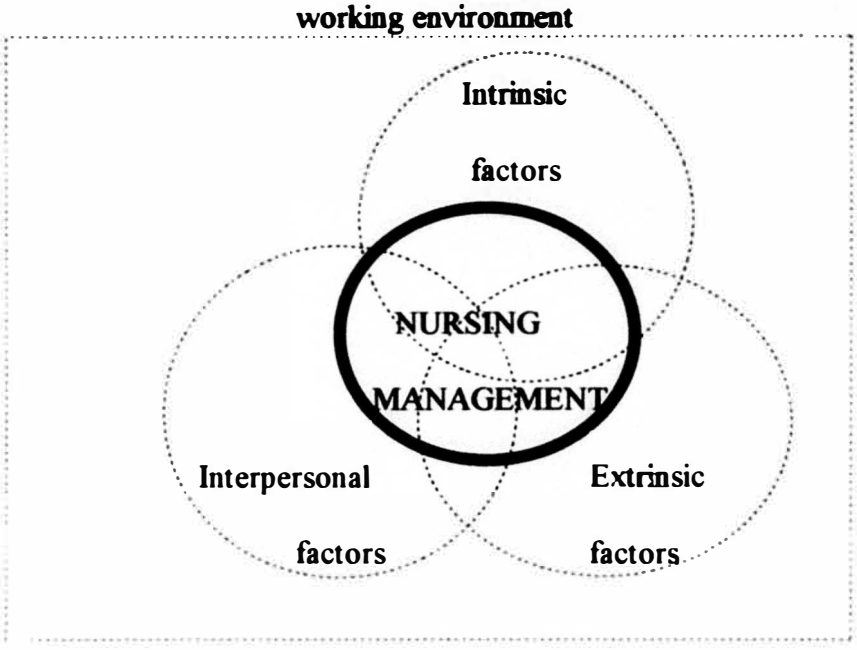

Figure 1. Adaptation of Imogen King's Human Process Method for Nursing Management.

King's Goal Attainment Theory concepts categorised under the three broad concepts developed by the researcher provide an holistic approach to the description of the middle-level nurse managers' working environment. The adapted conceptual framework guided the construction and content of the interview schedule. These questions relate directly to the concepts (see Appendix F). The details of the application of concepts in developing the interview schedule is discussed in Chapter Four. For example question on management skills required of nurse managers such concepts like perception, self, role, and growth and development were applied.

Summary

King developed her Goal Attainment Theory from her earlier on systems theory developed from General Systems Theory. The General Systems theory was developed by Von Bertalanffy. The General Systems Theory utilised open systems approach which states that there is interrelationship between all elements and constituents of society or whole. King saw this view as consistent with nursing's perspective of an individual and so she developed the systems Conceptual Framework from which she developed Goal Attainment Theory. See Figure 2 for the summary.

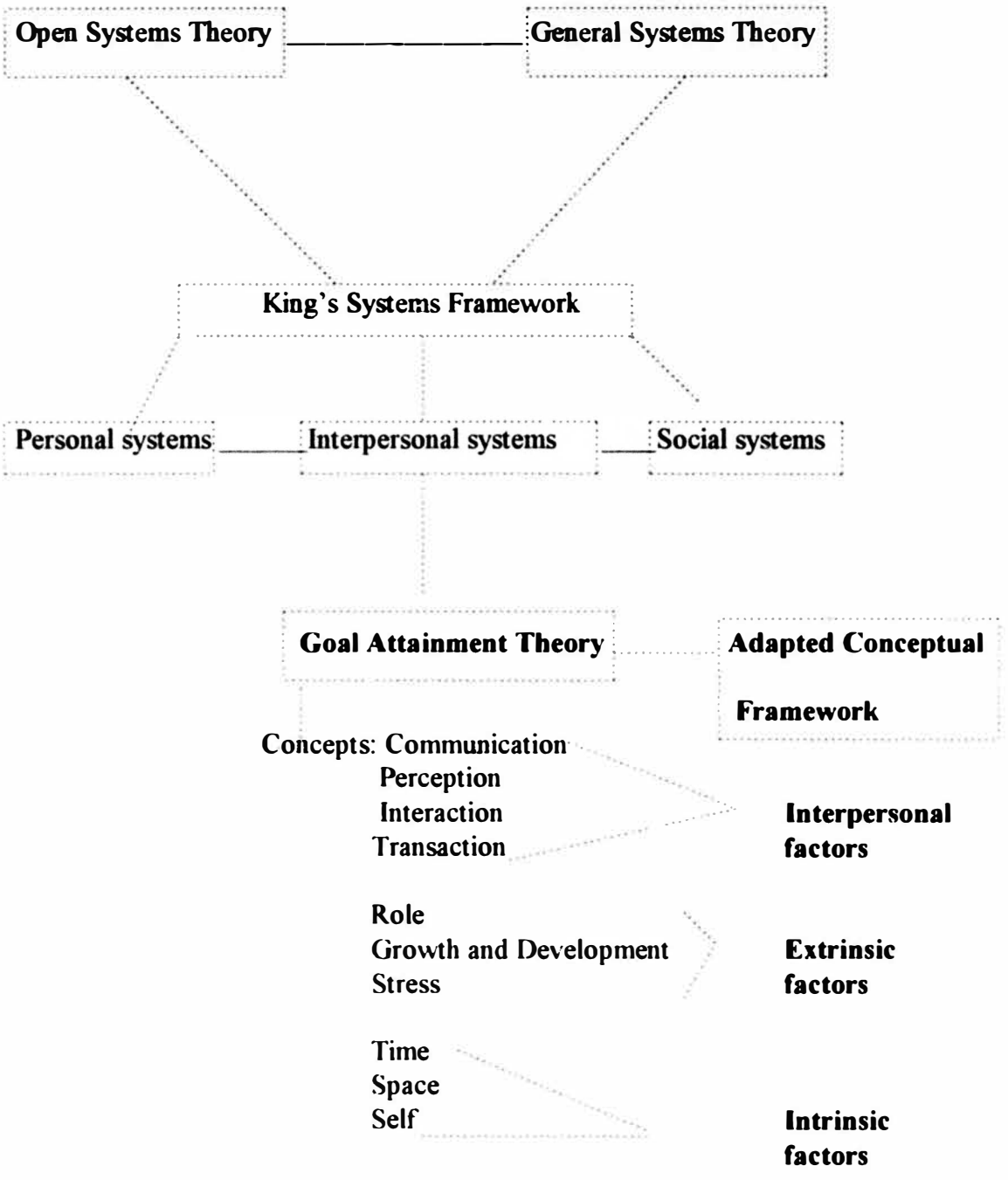

Figure 2. Schematic diagram showing the Development Process of the Conceptual Framework used in this Research

CHAPTER FOUR

METHOD OF INVESTIGATION

To explore tasks that nurse managers in Malawi carry out in Malawian hospitals, problems they experience and management skills they require to carry out their work, a descriptive design research was carried out. Burns and Grove (1993) stated that descriptive studies are designed to gain more information about characteristics within the particular field of research. Since there has been no independent research on nurse managers in Malawi, a descriptive design to explore Malawian nurse managers' working environment was carried out.

Design

The research was exploratory and descriptive in nature, guided by an interview schedule based on King's Goal Attainment Theory. The research used qualitative methods in data collection and analysis. These methods were used to identify and analyse the management tasks performed, problems experienced and skills required by Malawian matrons and senior sisters in carrying out their work. However there was a small section of the research dealing with demographic data which used quantitative techniques. For analysis of this data descriptive statistics were used.

Sampling

The research had a sample of twenty matrons and senior sisters drawn from both government and non-governmental hospitals. Owing to the fact that the research was qualitative and that one of the aims was to obtain detailed data on which future studies could be based, the sample size of twenty was considered to be adequate.

Sample design. The research used a two stage random (probability) sampling technique. At the first stage hospitals were randomly selected, and at the second stage middle level nurse managers were chosen. "Probability sample refer to the fact that every member or element of the population has a probability higher than zero of being selected for the sample" (Burn & Grove, 1993, p. 239). Probability sampling ensures some degree of precision in accurately estimating the population parameters thereby reducing sampling error. Random sampling is a method of selecting data collection unit where each unit, a member of the population, has an equal probability higher than zero of being selected. The technique requires that a sampling frame be identified or constructed (Burn & Grove, 1993).

A sampling frame is a list of all units of the population from which a sample is to be drawn (Burns & Grove, 1993). For this research the sampling frame comprised non-governmental referral hospitals, and all government (central and district) hospitals. The reason for restricting the sampling frame to these institutions was that the participants were to be the senior sisters and matrons, and it is such institutions which have the highest chances of having matrons and senior sisters on their staff. The other institutions, clinics and non

referral hospitals are rarely staffed with the targeted group of managers. In all there were 42 hospitals in the frame. The composition was three central, 21 government district hospitals and 18 non governmental hospitals

At the first stage 13 hospitals were selected using probability sampling proportional to institution size. Using the technique suggested by Harrison and Tamaschke (1984), weighting based on levels of middle level managers estimated to be in the hospitals were used as the size of the hospitals. Two central hospitals were given a weighting of four each because they have a big bed capacity, with more specialised services which require highly experienced and qualified personnel. In addition central hospitals unlike district and CHAM hospitals have all three administrative levels for example, operational nursing management which include enrolled nurses, staff nurses and sister-incharges with a unit matron or senior sister at middle-level nurse management and then the senior matron and Chief Matron at the top level management. In contrast district hospitals and CHAM hospitals management have two levels namely, operational and middle level management. With the structures just described it is apparent that there are more middle-level nurse managers at central hospitals than it is at district and CHAM hospitals. Basing on this classification the technique suggested by Harrison and Tamaschke (1984) was appropriate.

Another central hospital was given a weighting of two because it is smaller and offers less specialised services with less than 1,000 beds. All government district and non-governmental hospitals had a weight of one each.

The effect of the weights was that the central hospitals had higher chances of being selected as they represented greater numbers of middle level managers.

At the second stage of selection, middle level nurse managers were selected as follows. The weight defined above formed the criteria for selecting number of participants to the selected hospitals. In non-governmental hospitals and government district hospitals only one middle-level nurse manager was picked. Because of the fact that the non-governmental hospitals selected had only one middle-level nurse manager available, no sampling was in effect carried out. The nurse manager available was picked as the participant. A total of ten participants were selected from central hospitals. Participants were full time middle-level nurse managers with or without a nursing degree, managing either a district or CHAM hospital or a unit at central hospitals. Their typical titles are matron and senior sister.

In the case of central hospitals, a list of middle-level nurse managers from each central hospital was obtained by phone because this was the most convenient means of communication. From each list participants were selected using systematic sampling. When items in a frame appear there at random systematic sampling is equivalent to simple random sampling (Aczel, 1993). Since names on lists did not have a particular order the selected middle-level nurse managers constituted a simple random sample every third name on the list was chosen.

Instrument

Data were collected by means of interviews using an interview schedule. Interviews were used because of the flexibility of the technique which allows the researcher to explore greater depth of meaning that can not be obtained with other techniques (Burns & Grove, 1993; Patton, 1990). Further interviews permit probing in order to obtain richer, more complete data. In addition interviews capture meaningful expressions that may clarify a response. Patton (1990) stated that interviews are a form of self reporting and offers an opportunity to the researcher to observe meaningful expressions which can not be obtained through a questionnaire.

Further, unexpected responses which may reveal significant information not anticipated by the research design can be incorporated. Another advantage of interview technique lies in the fact that the researcher is able to establish and maintain rapport with the participants' level of knowledge and to monitor and ensure the effectiveness of communication between the researcher and the participants.

A semi-structured interview schedule was developed following an intensive literature search. Semi-structured interviews were selected as a means of data collection because they are well suited for exploration of the perceptions and opinions of participants regarding complex and sometimes sensitive issues. They also enable probing for more information and clarification of answers (Atkins & Williams, 1994; Barribal & While, 1995). In addition, semi-structured interview schedule acknowledges that not every word has the same meaning to every participant and not every participant uses the same vocabulary (Patton, 1990). Further, validity and reliability depend upon conveying equivalence of meaning, not upon the repeated use

of the same words in each question. Barribal and While (1995) stated that it is this equivalence of meaning which helps to standardise the semi-structured interview and facilitate comparability.

The semi-structured interviews, therefore not only gives interviews some choice in the wording to each question but also in the use of probes (Hutchinson & Skodol-Wilson, 1992). Probing questions were used in this research because probing is an invaluable tool for ensuring reliability of the data. According to Hutchinson and Skodol-Wilson (1992) probing allows for the clarification of interesting and relevant issues raised by the participants. Probing enables the researcher to explore and clarify inconsistencies within participants' accounts as it helps participants to recall information for questions involving memory (Barribal & While, 1995; Smith, 1992).

The interview questions on the instrument were designed based on the conceptual framework adapted by the researcher from King's Goal attainment Theory. The conceptual framework has been discussed in Chapter Three.

The technique developed by Lynn (1986) was used to develop the instrument. Lynn's method has two stages: the first is the development stage and the second is the judgemental. While the former is discussed here, the latter will be discussed shortly in paragraphs under validity.

The development stage of Lynn's technique involves firstly, the identification of the full content domain of research. The domain of research refers to what is to be measured (Burns & Groove, 1993). For this research, the main content domain identification was management skills with subdomains of tasks, problems, skills and perceived role. The identification of the subdomains was aided by formulating a table

of specification of what was to be measured. This table is in Appendix D. Specification refers to the focus of each question, division to the appropriate sequence and wording of questions, and "tacit assumption to the determining of the true meanings that lie behind respondents' answers" (Barribal & While, 1995, p. 331).

The second step in Lynn's method is the sampling of areas to be addressed since the subdomain can not be exhausted and generating items under each area affected by the domain. This was done after intensive literature review of each area and constant referral to the conceptual framework. The result was the interview items (see Appendix E & F). The third step is the assimilation of items into useable form (Lynn, 1986). For this research, this took the form of rewording, regrouping and putting the items into a cohesive sequence. For example it was noted that some items generated under one subdomain recurred under a different subdomain. Specific instances included items like coordination, which fell under planning, leading and organising. This was because the concept could be viewed from different headings or conditions. Some such items were reassembled, refined and put under the most suitable subdomain, since one or two questions in the interview schedule could be used to solicit data for several items generated in the summary (see Appendix G).

Validity. Burns, and Grove (1993) defined validity as the extent to which the instrument of a research reflects the construct being examined. Validity will vary from one sample to another and from population to population. In this respect "validity testing actually validates the use of an instrument for a specific group or purpose, rather than being directed toward the instrument itself" (Burns & Grove, 1993, p.343).

Face validity refers to subjects' acceptance of the test or instrument. For the purposes of this research face validity was considered by following ethical procedures. The first step was to seek an approval from the Edith Cowan University Ethics Committee in Australia and Research Technical Committee in Malawi. An approval letter from Edith Cowan University is in Appendix H and a letter to Research Technical Committee in Malawi is in Appendix I. The other step was contacting the participating hospitals prior to interviews and providing adequate explanations about the research and asking for permission to gain access to participants (see Appendix J). In addition prior each interview session participants were give information about the research and then were asked to sign a consent form upon agreeing to participate (see Appendix K). An indication of face validity was the signing of the consent forms by the participants. This is in line with what Lynn (1986) and Thomas (1992) in Burns and Grove (1993) suggested. These authors stated that the willingness of the participants to be interviewed is related to their perception that the instrument measures the content they agreed to provide.

To determine content validity in this research, the method developed by Lynn (1986) discussed above was used. The first stage of determining content validity is embedded in the development of the instrument and for this research it involved putting together the questions in the schedule.

The second step is called the judgemental stage. According to Lynn (1986), the judgemental stage is where the items and in this case the instrument are given to experts to establish if the instrument is content valid by rating the

individual items (questions) of the instrument. Validity of the entire instrument is derived from the validity of the individual items. The procedure invites an expert to rate each question using a selected method of rating. For this research the ratings developed by Waltz and Bausells (1981 in Lynn, 1986) were used, although with some adaptation. The ratings range from one (the best) to four (the worst) as follows:

1 = very relevant and succinct (brief and clear).

2 = relevant but needs minor revision.

3 = unable to asses relevance without item revision.

4 = not relevant.

As a measure of content validity, the content validity index (CVI) was used. A CVI can be calculated for an individual item on the schedule as well as for the entire instrument. For an individual item Lynn (1986) defined the CVI as the proportion of the experts who rate an item rating of one or two. This is a reflection of the number of experts agreeing that an item is suitable. According to Lynn (1986) a minimum number of experts who must agree that an item is suitable must be established in order to judge an item as valid. In terms of the CVI, the procedure is that there must be a cut off point reflecting the minimum number of experts above which a CVI indicates that an item is valid. According to Lynn (1986) the cut off point is based on a critical value which makes the proportion of the experts rating the item as suitable to be significant at five per cent level of significance. In the case of the entire

instrument, the CVI is calculated as the number of items on the instrument assessed as valid divided by the total number of items on the instrument. If this proportion is equal to or above the same cut off point used for individual items, then the instrument is deemed valid. A reproduction of the scale for assessment of validity is in Appendix L.

This research used nine experts: six in Australia and three in Malawi. The definition of 'expert' used was a registered nurse with a Master of Nursing Degree or higher, preferably with a major in education or management or a registered nurse with a Bachelor of Nursing and five years experience at management level.

The experts were given the instrument with explanatory notes (see Appendix M). As a result of the experts' feedback three items (questions 9, 10 & 22) had CVIs of 0.78; three other items (questions 11, 25 & 26) had CVI of 0.89 (see Appendix N). The rest had CVIs of one. Using the cut off point of 0.78 for nine experts the conclusion was that all items were valid. Further, the entire instrument was also deemed valid following the criterion outlined above.

As a result of the validation, the researcher retained all of the questions. However questions over which experts had not agreed were reviewed. These included length of shift and total hours worked in a week. Two participants rated these questions as 'not relevant' on the four-point scale. It turned out that these participants were not involved in determining such items and therefore judged them as not suitable However the majority rated these as suitable since they constitute part of the problems generally faced by nurse

managers. Other suggestions made by experts during the exercise were also considered. Valuable suggestions included alternative ways of asking questions. These suggestion were incorporated as probing questions.

Pilot Study

A pilot study of the schedule was conducted in Malawi. The pilot study was conducted with three participants who were middle level nurse managers. These participants, did not take part in the actual research, they were from three different settings: CHAM, district and central hospitals. One held the position of senior sister and two were matrons. The pilot study aimed at providing the researcher experience in interviewing techniques and also to time the length of each interview session. Further the pilot study was to acquaint the typist with data transcribing.

All participants concurred that the language was easy to understand and non-ambiguous. However the process of interview revealed the original arrangement of questions disrupted the participants' thought processes. The interviews would be smoother if questions on problems, skills, and perceived role followed each task immediately. This was to focus the thoughts of the participants on a particular topic as they answered the questions. The questions were reorganised accordingly (see Appendix O).

Procedure

A research proposal was presented to the Higher Degrees Committee and the Ethics Committee of Edith Cowan University. When approval was granted a letter

was written to the Research Unit Technical Committee in Malawi seeking permission to carry out this research in Malawi. The letter was accompanied by a copy of the proposal and permission was granted verbally while the researcher was in Malawi (see Appendix O).

Once access to the hospitals had been granted, initial contact with each hospital included in the sample was then made through telephone followed by a letter explaining who the researcher was and the purpose of the research (see Appendix I). A contact telephone number was also given if anyone required more information. Only one hospital used the contact telephone number to ask further detail of the research and whether the researcher had received permission from Research Unit Technical Committee. Three hospitals used the contact telephone number to cancel and re-arrange interview date and time.

Data collection took place in the months of July and August 1995. As a first step in data collection, the researcher sampled hospitals. From each hospital a list of matrons and senior sisters was obtained even where the list comprised one person. From these lists participants were selected using systematic sampling. The result was ten participants from central hospitals, four from district hospitals and six from non-governmental hospitals.

CHAM is the largest umbrella organisation for non-governmental hospitals and the sampling exercise was such that all the non-governmental hospitals selected were from CHAM. For this reason the term CHAM will be used in this write up for the non-governmental hospitals.

All the participants were interviewed individually by the researcher. During the interviews responses were noted on the schedule, and other field notes concerning proceedings of the interview were taken. The researcher also taped the interviews to provide a permanent full record of questions asked, probes used and participants' responses and reactions to questions. According to Barribal and While (1995) audio taping ensure that an identical replication of the contents of each interview is available to facilitate analysis. Further, access to the intonations and pauses recorded help validate the accuracy and completeness of the information collected. Audio taping also reduces the potential for researcher error by, for example, recording data incorrectly or cheating by logging an answer to a question that was not asked (Patton, 1990).

The tapes were transcribed at the end of each day. The researcher also collected relevant documents on items like staffing and other statistics. The field notes, administrative documents collected and the interview data were meant to provide data from different sources which would be complementary. According to Field and Morse (1990), Leininger (1985), and Patton (1990), collecting data from different sources increases both the validity and reliability of a research.

Data Analysis

According to Burns and Grove (1993), qualitative data are analysed in terms of individual responses and descriptive summaries. Mainly content analysis was employed. Narrative data derived from transcribed interviews, field notes and documents were reviewed in the context of the entire interview sessions with words,

phrases, descriptors and terms central to the research topic noted. These were enumerated in terms of the number of times specific concepts were identified. Categories were established and described, according to significant themes that emerged. To reinforce the themes, direct quotations of some responses have been used. The presentation of data took a thematic approach.

Although the research was basically qualitative, demographic data which forms a small component of the collection of the data was largely quantitative. For this data the researcher used descriptive statistics in the form of tables and bar charts to analyse and present it. Due to the fact that the sample size was small and that data was largely qualitative Microsoft Excel, was used to tabulate counts of concepts and opinions and to generate the bar charts.

Ethical consideration

Prior to the interviews the researcher made appointments to interview the participants and sent a letter to each participating hospital explaining the propose of the research (see appendix I). The researcher carried consent forms which were given to participants to read and sign as an indication of consenting to being interviewed (see Appendix J). Considering that a letter would have been made and an appointment made, the participants were giving an informed consent. Signing of the consent form was carried out just before the interview with each participant.

The letter explaining the research included the purpose of the research, the relevance of participation and anticipated benefits. Participants were not under any

All the data collected was treated as confidential. The researcher assigned numerical codes to participants and hospitals. No names were used on documents which contained research data. A master list of hospitals and participants was kept separate from research documents. Audio tapes were kept locked up with the researcher keeping the key. Only the researcher and her supervisor had access to raw data. After seven years, all notes and tapes will be erased and destroyed.

CHAPTER FIVE

RESULTS

As outlined in chapter four the research had three questions: (1) What specific management tasks do middle-level nurse managers report that they carry out in Malawian hospitals? (2) What specific problems do nurse managers in Malawi report they experience in carrying out their work? (3) What management skills do middle-level nurse managers perceive that they require? These questions were use to develop an interview schedule (see Appendix E) which guided data collection. Using concepts in Goal Attainment Theory the researcher sought to understand what the middle-level nurse managers do in executing their work. Having known tasks or what they do, the researcher felt it was vital to know the problems these middle-level nurse managers experience in carrying out their work. Information on problems experienced offers an explanation of the perceived management skills required. Data collected has been grouped according to the research questions.

The research had twenty participants selected at random from various health institutions in Malawi. Bearing in mind the differences between the hospitals, the opinion, practice and problems among the groups of the participants where distinct differences exist will be discussed where relevant.

Demographic Data

The demographic data was intended to provide a descriptive profile of the participants. The items included were gender, age, location such as central, district and CHAM hospitals, positions at work, years of experience and post-basic qualifications. Post-basic qualifications are additional professional training one attains after initial training as a nurse. Also included, under demographic data was span of control and the officer to whom the participants reported.

Distribution of Participants According to Age and Position

In the Malawian health system, there are two positions namely senior sister and matron, at middle-level nurse management. The positions are similar in their job descriptions as discussed in Chapter One. The difference is that the position of matron has more authority than that of a senior sister as explained in Chapter One. Table 4 below shows the distribution of the middle-level nurse managers by age and position.

Table 4

Age and Position

Age	Senior sister	Matron	Total
Less than 30	-	1	1
30-39	2	6	8
40-49	1	7	8
above 50	1	2	3
Total	4	16	20

Experience

Another demographic aspect was the participants' years of experience at middle-level management. Bearing in mind that there are two positions at middle-level management, the years of experience solicited from the participants spans the two positions where a participant was a the matron level. Table 2 shows the distribution of the participants by experience and type of institution.

Table 5

Experience by Institution

Years of experience	Central hcspital	District hospital	CHAM hospital	Total
0-4	8	1	4	13
5-9	2	-	-	2
Above 10	-	3	2	5
Total	10	4	6	20

Post-Basic Qualifications

In the Malawian context, all the middle-level nurse managers are registered nurses/midwives. Midwifery was a compulsory component until 1990. The post basic qualifications therefore refer to all programs, (certificate, diploma or degrees) undertaken by the participants beyond their pre-requisite General Nursing and Midwifery training. It should be noted that the basic training for Malawian RN has been three years certificate in general nursing program and one year in midwifery, or as the case for more recent RN, three years diploma and one year midwifery programs

respectively (Ministry Health Plan 1985-1995). Figure 3 presents participants according to post basic qualifications and location.

Information from background data reveals that there are individual participants who underwent more than one program. In this respect there is a concentration of skills which are of interest and therefore a multiple bar chart has been used to present the data. The figure reveals that the concentration of skills is higher in Central hospitals than the other two locations. However the figure itself did not distinguish between skills acquired from long generic programs and those from the short course of duration 6-12 weeks.

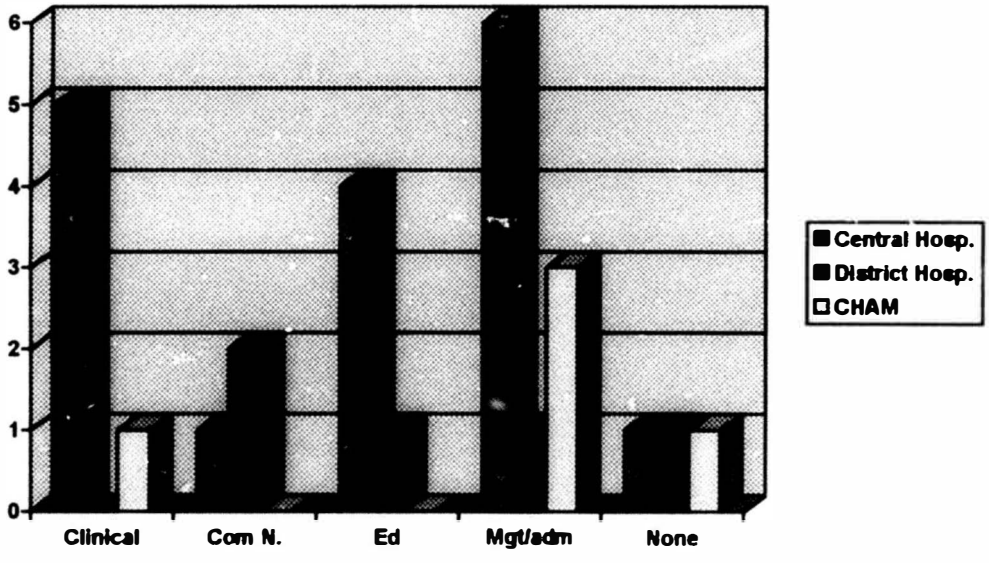

Figure 3. Area of specialty of post basic qualifications and location.

Note. Post basic qualifications have been grouped as clinical, community, education, management and administration. Clinical stands for all clinical based qualifications such as paediatric nursing, theatre nursing among others. Community nursing (Com. N), includes family planning. Key to abbreviated words is as follows: ed.= education; mgt = management; adm.= administration.

Figure 4 shows that central hospitals have higher numbers of participants with diplomas and degrees.

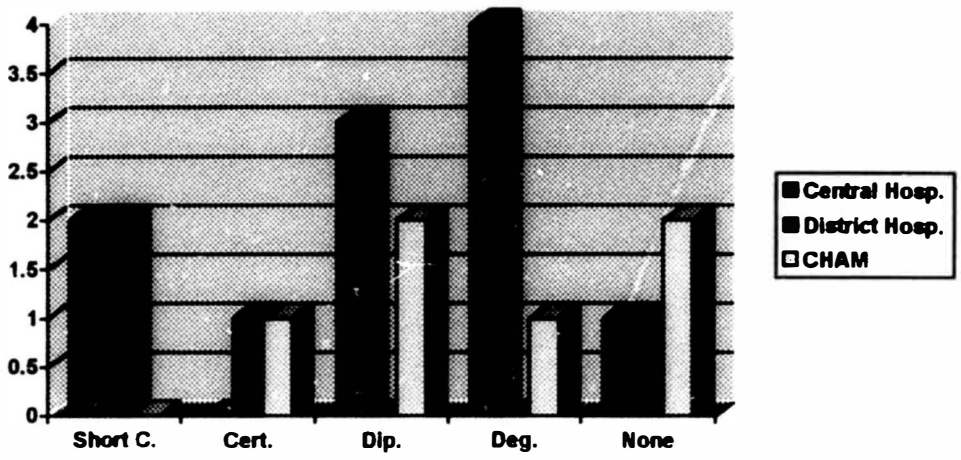

Figure 4. Participants by type of post-basic qualifications and location.

When asked to whom participants were responsible to, the majority (16) indicated that they reported to nursing or medical personnel and four reported to non health personnel. Most of those who reported to non health personnel were from CHAM hospitals. It was notable however that participants at times seemed hesitant and confused when asked to specify the officer to whom they were directly responsible.

Span of Control

Span of control refers to the number of workers that a supervisor can effectively manage. Results here show that ten participants had between five and nine registered nurses working under them while the other ten participants had four or less. Results also reveal that span of control for some participants had a large span of control in excess of 60 nursing staff that is, a combination of RNs and ENs. Finally the data collected showed that the middle-level nurse managers also supervised the activities of non-nursing staff. The non-nursing staff supervised ranged from ward clerks, patient care attendants and domestic staff and in some cases kitchen staff. Span of control that can be effectively handled by each manager is dependent upon the type of work, skills and knowledge of the workers. Span of control is important in that it influences effectiveness of the middle level nurse manager.

Table 6 reveals that the spread of levels of span of control is very different, however span of control for some participants in central hospitals was in excess of 60. The highest in the central hospital was 72 while for CHAM it was 38.

Table 6

Span of Control: a Combination of RNs and ENs

Nursing staff RNs and ENs	Central Hospital	District Hospital	CHAM Hospital	Total
10-19	1	-	-	1
20-29	1	1	5	7
30-39	1	1	1	3
40-49	2	-	-	2
50-59	1	-	-	1
Above 60	3	2	-	5

The demographic data presented above provided the context in which the research questions were addressed. The first of these questions was the tasks carried out by middle level nurse managers in Malawi.

Question 1: What specific management tasks do middle-level nurse managers report that they carry out in Malawian hospitals?

Responses to this question will be described under the broad categories of staffing, policy making, financial tasks, ensuring quality patient care and motivation of the nurses as emerging themes.

Staffing

Activities under staffing included recruitment, and staff allocation.

Recruitment. Responses to the question on staffing showed that nineteen participants (participants 01, 02, 03, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 18, 19 & 20) had a role in determining the number and type of staff recruited. Eight reported that they were involved directly in recruiting (participants 01, 02, 07, 08, 09, 11, 13 & 20) and eleven said they made recommendations. One was not involved at all (participant 17).

Results showed that participants from CHAM recruited staff directly or through committees in which they were involved. The situation for district and central hospitals was different in that the majority of the participants had no final say in staffing. The four participants (participants 10, 11, 12 & 20) from district hospitals made recommendations and requests to the Regional Nursing Officer who is responsible for a number of district hospitals in the region. This is reflected in the following response:

I am given the opportunity (here at the hospital) *to say something in terms of recruiting nursing staff but the problem with nursing is that we have to make requests to the RNO. If she has nurses then she would say. So really all what I do is to make a suggestion to the RNO indicating the type of the nurse required* (participant 10).

In the case of the central hospitals participants, nine reported that recommendations were made to the Chief Matron (CM).

We do not have much power as such whereby we can get staff for our unit. What we do we make recommendations for a particular number to the Chief matron and say according to the demands in my unit I feel the number of nurses I have got cannot cope with the workload, may be if we reached such a ratio (number). *We just give report and recommendations the CM is the last decision maker; we can not force her.* (participant 03).

It should be noted that nursing organisational structure at regional level is divided into two supervisory responsibilities. The Regional Nursing Officer is responsible for all district hospitals in the region except central hospitals. Central hospitals are managed by a Chief matron who is responsible for her hospital. Since Central hospitals provide specialised care they require undivided attention of the Chief matron to meet the hospitals' demands. RNO and CM hold the same professional status and so are both answerable to the Controller of Nursing Services.

One participant had no input into staffing and she summed up the situation as follows: "The staffing of the unit is done by the top management we do not have a choice we just have to receive and then we allocate accordingly". (participant 04).

Participants who were involved in staffing directly or indirectly mentioned a number of factors considered in determining staff requirements. The factors included the number of patients (participants 02, 03, 06, & 14), type of patients (participants 06, & 03), and policy requirements such as having a registered nurse on a shift (participants 06, 07, 12, & 14). The qualifications and experience of the nurses were also considered by nurse managers in determining staff required in a particular area or shift. These factors were common across the different types of institutions and they are reflected in the following two responses: "We can make suggestions depending on the number of patients that we have and the shifts and the qualifications as well and experience" (participant 06).

I need nurses who are knowledgeable knowing that today the diseases that we are experiencing are far much more than may be 10-20 years ago. We are talking about diseases like AIDS that we did not have in the past. Droughts which we did not have in the past which have lead to so many diseases of today so that nurses need to be competent. I need nurses who are competent. On the other hand I need competent nurses because our CHAM hospitals recruits doctors from abroad who are not

familiar with tropical diseases so that they need some guidance from the nurses (participant 07).

Staff allocation. Another aspect of staffing which was of interest to the research was whether or not the participants made decisions on allocating staff to various areas of the unit or hospital. Results showed that the participants from CHAM and those from district hospitals had this power while those in central hospitals did not. Allocations were made by top management. One participant who was in this situation had this to say: "Allocation is done by the top management. Here we are just told that we are sending you a nurse" (participant 04).

Another participant (19) reported that although she did not carry out initial allocations she could move the existing staff in her area of responsibility.

Participants who made staff allocation within their area of responsibility used a number of factors some of which were the same as those used in determining staff requirements. Allocations were based on the number of patients and work load (participants 02, 03, 06, 11, 12, 13, 14, 16 & 19), severity of conditions (participants 03, 07, 11, 14 & 15) nurses' qualifications and experience (participants 04, 05, 06, 07, 08, 09, 10, 11, 12, 14, & 19) and nursing assignments (participants 03, 04, 05, 15 & 17). Other factors although not frequently mentioned were type of shift (participants 02 & 06) and capabilities of the doctor (participants 07 & 08).

The nursing assignments methods used included 'bay' system of allocation and patient allocation. Four participants (04, 05, 15 & 17) reported that they used the bay system to allocate staff. In this system, nurses were allocated to a bay looking after a group of patients with similar attributes which required a certain type and level of nursing skill. One of the participants who used the system described it as follows:

If possible we allocate two nurses and one Patient Attendant (PA). These people do everything for those patient on their bay. **(Criteria I look for when allocating nurses is)** *at least I should have a qualified nurse. It shouldn't be only the patient attendant alone because some of the things the PA can not do alone like giving drugs, putting up IVIs. These are nurse's duties and when a doctor comes for a round a nurse should be the one to take orders not patient attendant* **(participant 04).**

Only one (participants 03) nurse manager indicated that she used patient allocation. In this system, nurses were allocated to specific patients.

Okay what we are trying to adopt now is patient allocation, where we feel the nurse will be compelled to give total or holistic care. We are trying to run away from job allocation whereby we feel the nurses won't be accountable. So far nurses are trying to, its a new change some are resistant they prefer job allocation than being given a bay to look after a certain number of patients. Accountability is increased **(participant 03).**

Criteria for allocation of staff also included the rotation requirements of the nursing staff (participants 01, 07, 12, 13 & 17). Rotations were used by nurse managers to provide nurses with a range of experiences and also to expose them to different working environments so that the nurses would be able to make an informed choice of their preferred work place.

Still other nurse managers did not have a specific criteria. Five participants (01, 09, 13, 18 & 20) described their method of staff allocation as "filling gaps" as expressed in the following response:

Okay, we do not have the real criteria usually what we do is really to fill the gaps, where we feel there is a gap. Of course we do ask them where they would like to work, just to have an idea but normally we fill where there is need (participant 01).

Policy Making

Involvement in policy formulation. The second main category of tasks that nurse managers reported were that of policy making. Results show that sixteen participants (03, 04, 05, 06, 07, 08, 10, 11, 12, 13, 14, 15, 16, 18, 19, & 20) reported that they were involved in policy making at their hospitals, three (participants 01, 09 & 17) were not involved and one (participant 02) was not sure.

Out of the sixteen participants who were involved in policy making nine were from central hospitals, four from district hospitals and three from CHAM.

The degree of involvement in policy making varied randomly. Eight participants from central hospitals and all four from district hospitals and two from CHAM said they initiated or participated in formulation. Two participants, one from central hospitals and one from CHAM indicated that they only made changes to policy handed down from top management.

Different managers used different techniques in formulating policy. Six participants (08, 10, 13, 15, 19 & 20) reported that they involved their staff in the formulation of policy. Involving others in policy making was reported as a conscious effort by the six nurse managers. This method is reflected in the response by one of the participants who used it:

As of the last year we had to involve everybody, it was general, one had to write suggestions pertaining to whatever topic under discussion and then we would come together and decide what we should do or follow. In that way we are all at the same level, at least involving everybody else because they are the ones who are going to carry out whatever we decide. I initiated the process (participant 15).

The reasons for using this approach were to make the people feel committed to the policy and also to make the policy meet the needs of the people. The other managers initiated policy by themselves or work in smaller committees.

Nurse managers determined that policies were followed by formal and informal means. Informally, they observed ward events during rounds and day

to day activities (participants 02 & 19). Formal evaluation of policy implementation included holding formal meetings (participants 02, 03 & 12), direct supervision (participants 06, 07 & 17) and formal evaluations (participant 02).

Three participants (participants 04, 16, & 14) indicated that they assessed policies and made changes where it was seen to be necessary to do so. Assessment was done from a practical point of view.

In my surgical unit we have realised that most of our things are missing and we have made it as our pilot project in controlling missing things, how we can do it, so I have started a day before yesterday to go back to the old system we had in the olden days whereby during the visiting hours we had to have someone on the door with cards. So that we have 2 visitors per patient per time and if they have big bags then they do not have to enter with those big bags and we are trying our best to minimise luggage in our wards and we have already started that (participant 04).

One participant pointed out that changes and implementation of changes to policy were not necessarily carried out uniformly at one institution (participant 04). For example to curb theft of equipment and other hospital items, no bags were allowed in one ward. This policy however was not being carried out in other wards despite the fact that theft was evident in these wards as well. However, policies were reviewed annually (participants 12 & 16).

Dissemination of policy. Dissemination of the policy was also seen as one of the elements of policy making. Method used to disseminate policy include education (participants 11, 13, 18 &19), meetings (participants 03, 10 & 11), supervision (participants 05, 07, 08, 12 & 19) and printed copies made available to staff through notice boards, circulars, and manuals (participants 03, 04, 06, 13, 14, 15, 16, 18 & 20). The methods outlined above were used by the participants who reported that they had participated in policy making. Those who were not involved (participants 01, 02, 09 & 17) in policy making used similar approaches to disseminate whatever policy was handed to them.

Financial Tasks

Activities under financial tasks included budgeting, costing, inventory control, repair and maintenance.

Budgeting. Eight participants (03, 04, 11, 12, 13, 15, 16 & 20) reported that they were involved in budgeting. Four of these were from central hospitals, three from district and one from CHAM. The extent of their involvement varied from one participant to another. Three participants (11, 12 & 13) from district hospitals and one (participant 13) from CHAM stated that they were involved at the hospital level that is at the top most level of a particular hospital management. Two participants (04 & 15) indicated that they were involved only at unit or departmental level at a particular hospital.

Five participants (14, 18 & 19 from central hospitals and 01 & 02 from CHAM), stated that their involvement in budgeting was only indirect in that they provided the information regarding what their unit requirements were. One of these participants had this to say: "I was once involved in a way that I was told to write the needs of my unit, I was supposed to compile a list and then somebody took that list and costed the things that I had listed" (participant 019).

Seven participants (05, 06, 06, 07, 08, 09 & 10) said they were not involved in budgeting at all. However, there did not appear to be any doubt in the minds of the participants regarding the importance of budgeting and that they should be involved:

We do not have nursing budget here. But its a thing that we want that nurses should be involved in their budget. In fact we have already started because each ward reports back to this office things that they have ordered on monthly basis, that will help to estimate of the things that we need. As of now the administrator develops a budget (participant 08).

The reasons given by the participants for involving nurse managers in budgeting were that nursing made up a larger portion of health care workers in comparison to other types of health care staff (participant 07). Further, nurses were involved in patient care which use a greater part of resources

(participants 03, 04 & 07). One participant (11) specifically indicated that nurses handled many resources and so knowledge of budgeting would have helped them to acquire the resources they needed.

Costing. Costing as a task was mentioned by four participants(03, 04, 13 & 15). These also happened to have reported that they were involved in drawing budgets.

Costs and inventory control. All participants except three (participants 03, 05 & 14) from central hospitals and one (participant 10) from district hospitals stated that they carried out some form of inventory control. The results show that the activities included in inventory control were ordering and stock taking of linen, drugs (from internal pharmacy) and some equipment, including supervision of disposal of unwanted items.

Besides inventory control participants reported that they were supposed to control costs in general. Those who carried out cost control measures used rationing of materials (participants 06, 08 & 09) and moral suasion (participants 05, 07, 13, 14, 15 & 17) in that they encouraged staff to be responsible in the use of materials by discussing with nurse during ward rounds. Only four participants (03, 05, 08 & 18) reported that they were involved in maintenance of equipment. Two participants (15 & 20) followed a principle of ordering that is, ordering some more only when the first stock is about to run out not when there was still enough items to use. One of the cost

control measures mentioned by seven participants (03, 04, 07, 13, 16, 17 & 19) was staff orientation to proper use of any new facilities in the hospital/unit. This was to ensure proper use and prevent damage which was costly.

Quality Care

Eight participants (05, 06, 07, 10, 13, 15, 18 & 19) indicated that they were involved in setting nursing standards. Three participants (01, 11 & 14) were not involved while four participants (02, 08, 09 & 20) were not sure whether they were involved at all. Six participants (03, 04, 10, 12, 14, 16 & 17) indicated that there were no standards in their institutions as expressed by two participants: "As of now we do not have nursing standards so that we can say this the standardised care which we want our patients to get at this hospital" (participant 03).

Currently they are saying that there are nursing standards but I don't know whether they are nursing standards because we have been told that a committee has been formed at the Nurses and Midwives Council to set standards for the nation. As of now we just follow procedure manuals and policies but otherwise I haven't seen any document called nursing standards which we have to follow (participant 14).

It was however interesting to note that at one institution participants gave contradictory responses. Some said nursing standards were being formulated at the time whilst others said nursing standards were in place. Participants who earlier on indicated that they set standards, reported that they involved members of staff in the

process. Some participants participated in the committees developing nursing standards. Participants who were not sure of their involvement in setting nursing standards show confusion about the differences between standing orders, procedure manuals and standards. They thought that standing orders, procedure manuals are the same.

Seven tasks came up from various participants as activities which helped to maintain quality care. These were supervision, communication, in-service education, teaching, support, enforcement, involvement in planning of nursing activities and safety.

Supervision. Supervision in this study deals with inspection of the work of others, evaluating the adequacy of performance, approving or correcting where necessary. Fourteen participants (01, 02, 03, 07, 08, 09, 10, 11, 12, 14, 15, 17, 19, & 20) concurred with each other on the idea of using supervision to ensure quality care. Participants who had this idea comprised half of those from central hospital and nearly all of the district and CHAM hospitals participants. The views of these participants can be summed up in the responses of participants 01 and 17. "To ensure quality we do supervisory visits in the departments. Apart from that we are always in contact with the heads of departments, meetings are held once every month where we discuss things of that nature" (participant 01).

We ensure quality care during the ward rounds when we check on the daily up keep of the patients. We actually observe on the patients how things (nursing activities) *are*

happening, we also look at the nursing records and the reports which the nurses write and also during meetings we discuss and then we know that standards are being maintained (participant 11).

According to participants 02, 03, 11, 14, 15 and 20, supervision took the form of ward rounds. Activities carried out included checking nursing activities, teaching where necessary, and made sure patients files were well arranged and documented. Supervision was also undertaken to solve minor day to day problems experienced in the wards These activities were summed up by participant 03.

In my unit I have a ward supervisory tool like a checklist. Not actually to look at the standards but to at least see that some of the activities are done on the patients like on that checklist, we look at patient care; check whether vital signs are done. Look at the records, charts , check whether files have right documents inside and we also look at the basic nursing care whether it has been provided. We check patients' diagnosis and treatment whether the right treatment has been prescribed and is given accordingly. We also check on the documentation of care because we have found out that our nurses are very poor in documenting whatever they have done. There are activities that they say they have done but in actual fact there is no documentation to support that. We also check whether right charts have been utilised. We also check whether the evaluation of patient care has been done. So those are some of the things we look at on patient care but apart from that we check the ward organisation, the

way patients have been organised, organisation of their treatment room, linen room, drug cupboard. We also check whether they have enough material resources because they can not work without material resources. So we look at their equipment whether they have enough things like BP machine thermometers, check whether their autoclaves, or steriliser is working or oxygen cylinders are full. We also check their care resources in the wards, at times they have problems with the care resources like gloves, syringes, galipot and receivers, so that we can assist where possible. We also check whether they have enough cleaning resources, disinfectants for their wards. We check on their books, we check in drug cupboards to see how they care for their drugs, whether they are labelled. we encourage them to use the drugs that are nearly expiring. And then we also check sisters office, procedure room and treatment room toilets and general cleanliness of the ward (participant 03).

The most predominantly mentioned tool in supervision was a checklist and a notebook in which the participants wrote their observations (03, 14 15 & 20). It was interesting to note that none of the participants mentioned use of quality assurance methods such as patient care audits, patient care profile analysis, or quality circles to maintain standards. In fact seven participants (03, 04, 08, 10, 14, 16 & 17) indicated the absence of standards. Standard in this study is a descriptive statement of the desired level of performance against which to evaluate the quality of performance. The absence of standards is reflected in the following response: "So I thought by preparing this tool may be whilst waiting for the nursing standards may be it can assist us to achieve some

of the things rather than just waiting for standards to be developed" (participant 03).

One problem that came up was that supervision was undertaken only when there was a problem in the ward. This was expressed by participant 14:

Most of the time the matron goes for supervision when something has happened which is a bad thing and she goes there shouting at the nurses but she should be going there even when nothing bad has happened. She should be going for supervision as often as possible (participant 14).

As a task for ensuring quality care, in-service education was mentioned by four participants (04, 10, 12 & 16) who stated that in-service education was used to fulfil the manager's teaching role. Apart from supervision and in-service education, communication appeared to occupy an important part in maintaining quality care. This view was held by participants 02, 03, 11, 13, 19 and 20. Various channels of communication were used including informal chatting, telephone, circulars, writing and reading reports, and oral communication were used.

Sometimes it is through casual chatting, then you know that may be we are on the right track or there is something wrong and if we have a standard it means we want to reach an objective so we i[illegible]o achieve our objectives (participant 13).

Nurse Motivation

The fourth activity, nurse motivation was mentioned by all participants as a very important task for middle-level nurse managers.

I think a matron plays a big role, the matrons plays a big role in the sense that it depends with the matron either to retain nurses or to chase them away. The fact that you are getting to motivate them, if your role is to portray that I am here and I know everything and I can do it alone in one way or the othe.' you are chasing the nurses. And the moment you chase the nurses away, for sure the nursing standards are lowered. For sure all the activities in the hospital are lowered down to earth. So that as a motivator the matron should aim at retaining nurses. Without a matron on the other hand, I can see the hospital collapsing so that it is a big position and it should be looked at as such it shouldn't be overlooked whether the doctors or the administrators they shouldn't overlook this role of the matron, because she plays a big role to motivate and stabilise nurses (participant 07).

Four participants (01, 04, 08 & 12) said that, although they felt that motivating nurses was important they had concerns over lack of support from top management. This lack of support tended to demotivate the middle-level nurse managers. "To begin with the matron should be motivated herself" (participant 08).

Six activities were identified as tools that participants used to motivate nurses. These included performance appraisal, good interpersonal relationship, creativity and staff development.

Performance appraisal. All participants showed that they realised that appraisal was an important tool to motivate nurses. This was illustrated by the following comments: "She should supervise them and evaluate them, you give them encouragement after evaluating them you tell them their weaknesses and their strengths" (participant 02).

Staff appraisal is going to help me in so many ways through staff appraisal I can easily know the areas of weakness, where staff may need help, staff appraisal is also going to help me to know the areas that already improved may be they need to be given encouragement, they are doing fine but only need encourage. Staff appraisal will also help me identify people who can go for further education. It would also help me identify those to be given rewards. People need incentives (participant 07).

However eight participants indicated that performance appraisal was not carried out for varied reasons (participants 03, 04, 10, 11, 12, 13, 14 & 20). These participants stated that it was not easy to carry out performance appraisal because of pressure of work and lack of confidence. The lack of confidence arose because nurse managers themselves were not being appraised by top management and so felt uncomfortable to appraise others. Participant

13 specifically stated that because of pressure of work on the part of nurse managers, it was difficult to adequately assess the strengths and weaknesses of staff. The rest of the participants said performance appraisal was not being carried out because there was no guide (performance appraisal form). In some institutions a guide was being developed by a committee.

Interpersonal relationship. Good interpersonal relationship was mentioned by fifteen participants (01, 03, 04, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17 & 20) as a tool in nurse motivation. Six participants (03, 07, 08, 09, 12 & 17) put forward elements of good interpersonal relationships. These included personal characteristics, courtesy, encouraging, being a role model and keen and initiative. Four participants (04, 11, 13 & 15) indicated that courtesy was important in motivating nurses. Participant 11 summed up nurse motivation activities as follows

I feel when you are with the nurses, not all the time that you should be shouting at them at least praise them when they do something good. Give them a chance to be leaders somewhere may be in a class, you say can you do this rather than the matron doing it, give them a chance to risk and be creative on their own and then you see them doing a good job (participant 11).

The least mentioned activities were encouraging nurses on a job well done job (06), creativity of the nurse manager to set an example (11), staff development

(01) and giving staff a chance to risk, thus not supervising nurses too closely (07, 08 & 11).

Meetings

Meetings are not part of the tasks of management but they are a means of accomplishing the management activities and they are discussed here because of their frequent use. In the study nineteen participants (01, 02, 03, 04, 05, 06, 07, 08, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19 & 20) indicated that meetings occupied an important part of activities in hospitals or units. These participants mentioned that they attended meetings of various types and meetings were organised according to positions, subject or discipline and some were general in nature. Examples of meetings based on positions were: matrons, registered nurses, enrolled nurses, senior staff and management meetings. Twelve participants mentioned the following examples as meetings based on discipline: infection control (participants 03 & 19), financial (participant 12), drugs (participant 11), clinical (participant 20), medical (participant 07), in-service education (participants 03, 8, & 17) and audit meetings (participants 02, 04 & 19). Meetings were generally found to be very useful. However only one participant said specifically that the meetings were important. "So far I haven't attended any since I started. It is important (to attend meetings) because you acquire more knowledge from people's experiences" (participant 01).

Eight participants(01, 02, 07, 08, 10, 11, 12 & 13) mentioned that they attended interdisciplinary committee meetings. Regarding the reasons for attending these meetings, three participants (01, 04 & 16) shared the view that it is at these meetings

that managers discussed how to improve patient care, and learnt from each other and appreciated other peoples' view points. However, there were some problems associated with meetings. One such problem was that not everything that nurse managers suggested at the meetings got support from other members. "Not really but some do not understand nursing issues and so takes long to support a suggestion" (participant 20).

Participant 09 shared the same view as fellow managers about importance of meetings but did not attend most of the meetings because of shortage of staff. She could not even initiate a meeting in her department because of shortage of staff, "there was no time to spare" she said.

Question 2: What specific problems do middle-level nurse managers in Malawi report they experience I carrying out their work?

The second research question was aimed at finding out specific problems the participants experienced in carrying out their work. This question received largest level of response. The responses will be discussed here under five general themes: problems relating to staffing, motivation of staff, quality care, policy making and financial management. Under each of these themes numerous other problems came up but only the major and more frequent ones will be discussed.

Problems Relating to Staffing

Responses to the problem relating to staffing indicated that there were three aspects to the problem. The first was that of inadequate numbers of staff, the second was that of inappropriate mix and then the problem of turnover.

Nearly all participants who commented on the problem stated that there was shortage of staff in their hospitals or units. Particularly that registered nurses were scarce. Cited lack of nurse managers involvement in staffing as a compounding factor. Lack of involvement was particularly true for the participants from central and district hospitals as most of their involvement went as far as making recommendations. The result was that the numbers of nurses recruited for the hospitals and units were not enough or were not the appropriate type. Four participants (participants 02, 03, 11, & 14) reported that they requested more staff but were not given enough. This was

especially true for registered nurses and those with specialised qualifications such as surgical nursing (participant 04). The extent of the problem is described by participant 04:

It would be very nice if the nurses allocated to us were those who have specialised, in those particular areas like in orthopaedic ward we do not have anybody who has gone to specialise at the moment. And in surgical nursing, it is a neglected area, nobody is sent for speciality at all.

Although some participants were involved to a large degree in recruitment, their powers were limited by an establishment passed down from top management and the result was inadequate staff. This was true for the six participants (01, 02, 07, 08, 09 & 13) from CHAM. The problem of turnover was cited by nine participants (01, 02, 03, 08, 09, 11, 12, 13 & 19). The reasons for high turnover were attributed to inconsistent policies, with regard to promotions, and continuing education. the effects have been discussed under motivation. Another reason for high turnover was lack of proper staff accommodation especially in districts and CHAM hospitals.

Problems Related to Motivation

Motivation was affected by a wide range of factors and areas reported as sources of problems included shortage of staff, long working hours, lack of staff appraisal, poor working conditions and inconsistent policies.

Shortage of staff. Ten participants (01, 02, 03, 06, 07, 10, 13, 16, 17 & 20) reported that shortage of staff affected staff motivation. Participants explained that shortage of staff meant that staff available were spread too thinly. As a result the staff were not usually allocated to their interests but rather the needs of the institution or unit. Five participants (07, 09, 11, 12 & 13) indicated this as a possible cause of demotivation in staff because their interests were not considered because of shortage. The problem of shortage was further worsened by high staff turnover. Four participants (01, 02, 07 &13) from CHAM hospitals, two from the central hospitals (participants 03 &19) and two from district hospitals (participants 11 & 12) stated that a major factor leading to high turn over was inconsistent policies.

Related to the problems of shortage of staff was the mix of skills and personal characteristics of nurses. Five participants (03, 07, 10, 14 & 19) reported that they had relatively fewer registered nurses than enrolled nurses. Using the total numbers of registered nurses and enrolled nurses reported by participants the average ratio of registered nurses to enrolled nurses was 1:5. This however ignored the distribution of registered nurses to various hospitals and units. In some specialised units there were more registered nurses than enrolled nurses. Two participants reported a ratio of registered nurses to enrolled nurses of 4:1. This was reported by participants in central hospitals where deliberate policy is to have more registered nurses in areas like maternity. There is evidence however that in other areas the ratios have been low. Nine participants (01, 02, 07, 08, 09, 10, 11, 12 & 13) reported ratios of

1:8 or lower. The lowest being 1:17. This put pressure on registered nurses regarding carrying out tasks that required high skills.

Long working hours. In discussing shortage of staff some participants linked it to long working hours. Others discussed long working hours as a problem in its own right. Regardless of the context sixteen participants (01, 02, 03, 04, 05, 06, 07, 08, 10, 11, 12, 13, 14, 16, 17, 18, & 19) from the various types of the hospitals cited long working hours as a problem in staff motivation. Eleven (all CHAM and district hospital participant and one central hospital participant) reported that the longest shift was 12 hours. Four participants (03, 16, 17 & 18) reported 14 hours and two (participants 04 & 14) said 14.5 hours. The last two groups were both from central hospitals. All these long shifts were identified as night shifts. The shortest shifts were reported as ranging from 4 to 6 hours. However one participant (03) reported a longer than average short shift of 8.5 hours.

When participants were asked on the total number of hours worked by bed-side nurses in a week, the figures ranged from 36 to 42 hours. One participant (07) reported a minimum of 30 hours while there was another (participant 15) who mentioned that bed-side nurses worked 56 hours per week. One result mentioned by nurse managers of long working hours by ward nurses was the effect on the quality of work.

They work better when they work shorter shift than when they are working long shift. The reasons they give is that 'I am alone running three departments' as a result she just supervises instead of doing the actual work. Where as when they work less hours there are more nurses on duty workload is distributed (participant 02).

There is a different when they are on a short shift, they work less hours so usually they work hard while on a long shift they are usually tired and you find that some complaints arise from patients (participant 14).

Eleven participants (01, 04, 07, 09, 10, 11, 12, 13, 14, 19 & 11) reported that nurses on long shift appeared tired, exhausted and emotions were also affected. Although long working hours were reported as a problem as per se, one participant reported that its effects were minimised when there was a compensation in the form of allowance or extra money.

I have seen that here in this unit nurses are motivated because of this part time. If there is a problem of shortage, I have seen them offering to work more hours. Some even offer to work long hours. Since we started this some nurses work up to 56 hours (participant 15).

Staff appraisal. Four participants (03, 04, 14 & 15) reported that lack of staff appraisal was a demotivating factor. As put by one participant, staff did not know their strengths and weaknesses.

One thing that we are also lacking which can be used as a motivating factor, is performance appraisal. Its not being practiced at this hospital and so the nurses just work they are not appraised they don't know their strengths and weaknesses so I think that could have been one way of motivating nurses. Unless somebody knows her performance then one will not improve and will just continue the way she is working (participant 15).

Inconsistent policies. Another demotivating factor mentioned was the inconsistent organisational policies. Participants reported that areas of concern included promotions, continuing education, maternity leave entitlement and differences in treatment between health personnel. According to the results these affected the types of hospitals differently. Four participants (01, 02, 07 & 13) from CHAM hospitals said that granting of maternity leave was inconsistent: "I have a problem with a policy concerning married people and maternity leave. CHAM gives maternity leave to those who are married only and not to other nurses who are not married" (participant 02).

Participants from central hospitals mentioned the differences in treatment between doctors, nurses and clerks. It was the policy of the hospitals to provide transport to night staff, housing to staff whenever available on first come first serve. The two participants (03 & 19) reported that in times of hospitals financial problems doctors continued to be provided with transport under emergency situations or not while nurses were asked to find their own

transport. Clerks who were at the same rank as some nurses would get housing quicker than nurses. To illustrate the problem one of them cited a recent situation as follows:

For example last week the hospital haa a fuel crisis. Nurses were told to come for night duty at 5.00 pm and nurses did not like this, it wasn't easy for both of us the nurses and managers because nurses did not want to come on duty. The reason for them to refuse coming to work was that although the situation was like that (fuel crisis) junior doctors were still being provided with transport to go for lunch and no transport was available for the nurse to come on night duty. So anyway we had to resolve this with the management and they had to come on usual time (participant 19).

Participants from district hospitals cited lack of promotions and opportunities for further education which were available to their colleagues in central hospitals.

And sometimes the nurses are demotivated because of lack of promotions, they are on the same rank for a long time. Even if you impart knowledge to them, at the time you are talking or teaching them they will say yes, yes we are going to do but when they go to their working place, they don't do so you know they are demotivated (participant 12).

I think we have problems because when we tell nurses about the Ministry of Health's (MOH) intentions like promotions, upgrading and these things never come. Nurses become demotivated and they don't listen to you and it is even a barrier to work because what was promised is not effected. Sometimes training opportunities are not given to district nurses. Our nurses only hear that nurse so and so from a central hospital has gone to school and so they (nurses) think may be the matron is not trying enough on their behalf. As a result they all want to go to the central hospitals, so they are demotivated like that (participant 11).

Whatever the specific circumstances, the problems related to inconsistent policies were reported as responsible for high turnover, which further reduced the already thinly spread staff to the extent that available staff failed to meet the demand.

Poor working conditions. Another problem which participants (01, 02, 04, 05, 06, 07, 08, 09, 10, 11, 12, 13, 14, 16, 18 & 19) reported as affecting motivation was poor working conditions. Participants described poor working conditions in terms of high patient numbers, increased disease incidence, and inadequate facilities and other resources compared to patient numbers.

The patient numbers reported gave rise to nurse-patient ratios varying between 1:30 to 1:50. These ratios ignore overall nurse and patient numbers in a unit and ignored their distribution according to shifts or bays. Specific cases

reported by three participants were 200 patients being looked after by four nurses during the day and one nurse during the night; 125 patients being looked after by 3 nurses during the day and one nurse during the night; 90 patients for four nurses during the day and two nurses at night. Two participants summed it up as follows:

The first problem is about staff, as you know the hospital is understaffed that is the biggest problem. We would like to provide quality care but we fail because of the number of the staff that we have. We cannot cope with the number of patients that we have in our wards. On average we have about 200 patients taken care by four nurses working on a straight shift, but then when you come in the evening and at night you find that there is only one nurse and even in other wards have no nurse. We depend on nurses, so we have real problems (participant 02).

I am managing to have three nurses against 125 patients. And at night I have only one nurse . In 3B I have five nurses against 90 patients because of the type of nurses that I have. For the Medical wards I am having an average of four nurses against 90 patients and at night I have two against 90 (participant 03).

This supported the data that the nurses became over stretched and dissatisfied. The sheer high patient numbers also meant that the facilities like beds, room space and toilets were inadequate. As an example one participant reported that a ward with 69 beds would admit 80 patients which meant

putting improvised beds on the floor for other patients: "We are forced to put patients on mats which are very difficult to disinfect but what else could we do at least sleeping on the mat is better than sleeping on the floor" (participant 03).

Overcrowding, nurses are really working under pathetic conditions because the wards are really very full and at times you would not find a space to move in a trolley and some of the patients are on the flow on improvised beds and when you are giving nursing care you have to bend straining your back, all those things really affect care **(participant 14).**

This problem was common across all hospitals. Sixteen participants (01, 02, 03 04, 05, 07, 08, 09, 10, 11, 14, 15, 16, 17, 18 & 20) indicated that lack of resources meant that desired nursing care activities were not done which left nurses dissatisfied of their work. The high numbers of patients put pressure on a few nurses to provide basic care.

Incidence of disease. Regarding disease incidence, three participants (03, 07 & 19) reported that there was a high incidence of infectious diseases like AIDS and tuberculosis but the nurses were not adequately protected.

I really have tough time, because now with the increase of HIV/TB in my unit, my nurses are saying that they are at risk. My nurses are not getting anything pertaining

to risk allowance and they are not protected. Gloves are not normally enough. I do understand their worry because truly they are exposed. Worse still their allocation to each medical ward is two years and which has not been shortened despite that they are working in a high risk area. They work the same as those in less risky areas.. I have tried to convince the CM that something should be done to expose them for less hours per day (participant 03).

One participant (02) stated that she experienced problems in motivating nurses because she did not have management qualifications. It was however interesting to note that four participants (01, 08, 15 & 18) had no problems in motivating nurses. Participants who did not have problems with regard to motivation stated that they were always in contact with staff, they encouraged participation in meetings, used open type of communication whereby staff were encouraged to contact the matron anytime when necessary. "I don't really have problems to motivate nurses may be because I sometimes work with them rendering nursing care. When somebody is alone I also go to help" (participant 01).

I personally I have no problem with these nurses. If she has a problem she informs me and I will ask her whether she has that negative attitude or whatever, talk to her politely, teach her and encourage her, listen to her whatever she is trying to tell me, I have to listen attentively and encourage her to be open and reveal anything whenever it is necessary. She shouldn't fear anything. We work hand in hand (participant 08).

Problems Related to Quality Care

Eighteen participants (01, 02, 03, 04, 05, 07, 08, 09, 10, 11, 12, 13, 14, 15, 16, 17, 19 & 20) stated that lack of both human and material resources affected quality care. This was because among other factors the quality of care was a function of facilities available, number of nurses and their level of motivation.

Shortage of resources. Considering the patient numbers inadequate facilities discussed under motivation above, participants concurred that quality care would remain low despite the high expectations from the public.

The big problem is shortage of staff because if there is only one nurse or two then they usually run up and down the wards and therefore miss out the basic nursing care. And the other thing is inadequate resources. They can make some improvisations but they still fail because most of the things are not there, especially for dressings sometimes there are no gloves in the wards so it is a bit difficult. Despite all these factors the public expects high standards of care like it used to be as they normally say and so they always complain that in the olden days nursing care was of higher standard than now, things have gone down. When you try to explain to them that it is because we do not have enough resources, to them its like just an excuse that you want to get away with it. In true sense the public is really complaining (participant 17).

To some extent, really the public expects us to perform to a certain standards but due to problem of resources, shortage of manpower we are unable to perform to their expectations. So most of the time you find the public reacting saying the nurses are not taking care of the patients, they are rude and in that way you also become demoralise with that kind of attitude from the public because we feel we are really trying our best but yet the public cannot appreciate whatever we are doing so we feel may be it is just as well to perform to the way you can manage. After all even if I work hard the public is not appreciating why should I bother (participant 14).

Nursing standards. Nursing standards and performance measurement tools were reported by five participants (03, 04, 14, 15 & 19) as problems in monitoring quality of care provided. In addition, insufficient numbers of registered nurses was a major concern by nurse managers and they strongly felt that this affected quality care in that knowledge and skills were low among enrolled nurses.

If you look at my staff, most of them are EN so their capabilities are not as good as the RN. So because in this ward I initiated that nursing process should be used, they are failing to do nursing process so what about the standard because in the standard we are following a nursing process we assess whatever and then at the end of the day we evaluate the care. I would have loved to have 1:1 or 1:2, RN:EN at ward level. Nursing process would be easily initiated in the ward because they would not see it as

a waste of time. Having many EN is a barrier now and even when the standards are set in the future because of the problem of knowledge. The RN on duty has a tough time to teach them and tell them to prioritize care. To provide quality care we need more RNs than ENs (participant 03).

Financial Management Problems

In discussing the financial management problems three main aspects of the problem emerged: insufficient money allocated to hospitals, lack of involvement in planning and drawing of a budget and lack of sufficient knowledge in budgeting on the part of the participants.

Insufficient financial resources. Ten participants (02, 04, 06, 07, 09, 10, 11, 12, 14, & 20) stated that even when a budget was in place, money allocated was still not enough to meet the budget. It was interesting to note that this problem affected various participants regardless of the type of hospital and whether or not they were involved in budgeting. Problems cited in this regard were difficulties in acquisition of equipment and material resources needed to provide quality care:

We do have problems because like now we are short of allot of material resources that puts us at a corner because we do not have enough resources to give quality care. There are some things that we need to provide quality care, things like back rest which we need to provide care. We could improvise that with pillows but then we

do not have enough pillows. We do not even have enough linen and disposable syringes even if we strive to give effective care but without enough working resources like disposable syringes, we are forced to resterilise a syringe which we wouldn't like to do we are forced to do activities that if we had money we would have not. There are other several materials that we run short in the wards because of finance, these are a barrier to quality care that we would have loved to give our patient (participant 03).

One participant (11) stated that having inadequate funds meant that it was difficult to have up to date documentation of care because of lack of stationery. This further led to problems in monitoring care. Lack of money also affected effective supervision to health centers to monitor provision of care (participants 10, 11, 12 & 20). In this connection one participant stated that she wished she had a skill to lobby for financial assistance from big organisation for her unit.

Lack of involvement. Lack of involvement of the participants in financial management was cited by nine participants (01, 02, 03, 04, 05, 06, 07, 11, 15 & 19) as a problem. The participants stated that lack of involvement in planning and budgeting meant implementation of cost control measures were difficult for the nurse managers. As a result, control was being carried out by those not involved in provision of care like the hospital administrator, pharmacist and stores clerks.

They just tell us those people who issue that those things are in short stock therefore the things that you have you have to control. But I need to be involved so that indeed I know what things are in short supply (participant 06).

Half the time we are completely ignored, we talk about the administrator who does not even know about the hospital issues but is there managing the money, you are pointing out, I want this its a priority he does not even understand. Why don't you give me my own budget and I can make use of it where I feel things are appropriate. Matrons have got to be involved, matrons have got to learn financial management and utilise it (participant 07).

Lack of knowledge in budgeting. Nurse managers' lack of sufficient knowledge in budgeting was mentioned as a problem by seventeen participants (01, 02, 03, 04, 05, 06, 07, 08, 10, 11, 12, 14, 15, 16, 17 19 & 20). One participant felt it was difficult to understand financial management language and so she could not really follow on how money allocated to nursing was being managed.

I think I need knowledge in financial management, I will have a better understanding of the way money is allocated in different sections as of now they are allocating funds, monthly cash-flow which we are having problems in buying what we had budgeted for. Although they try to explain to us what they have done, we can not

understand very well the accounting language, so may be after having some knowledge in financial management, we can then understand why things are done in such a way and we can no longer be cheated and we can have a fact to argue rather than now where we say YES , OKAY, OKAY because they are the experts in financial management and we are just managers (participant 03).

Two participants (09 & 18) simply stated that they were not interested. One participant specifically felt that she was too old to know and get involved in financial management.

Policy Making Problems

Lack of knowledge by both nurse managers and other health care workers in policy formulation was a major set back in having good policies in most institutions (07, 09 & 11). One participant reported that some of the policies adopted for the institutions were detrimental to nursing. She stated that most hospital policies were made at the management meetings involving a whole institution at which nurse managers represented the nurses. The participants stated that since the nurse managers lacked knowledge in policy making they ended up simply supporting what was proposed whether good for nursing or not.

Nurse managers have a big role in making policies for the hospital because they are the ones who are nurses and they are the ones who can make best policies for their fellow nurses. Most of the time we are pushed by our fellow doctors because of the

things which have happened and in conjunction with the doctors we make such policies which are not appropriate to nursing. I feel we should be able to sit down on our own and make our own policies and say this is what we want. We should also be able to stand up and defend our suggestions. There are other doctors/professors who are very understanding they would respect and support us (participant 03)

Two participants (10 & 11) from the district hospitals and one (participant 07) from CHAM stated that there was room of making policies for individual institutions. However since the majority of nurse managers lacked the basic knowledge, such policies were not made. This resulted in an institutions having inadequate guiding policies.

In some cases policy making was not a problem. Eight participants (03, 06, 07, 11, 12, 15, 18 & 19) felt confident with the process of policy making but lacked support from other health care workers who themselves did not know how to formulate policies. As a result no policies were developed in those institutions to guide management of services.

It was however interesting to note that five participants (01, 02, 08, 09 & 17) indicated that they were not involved in policy making at all but were expected to implement and reinforce the passed down policies. They said this created a problem on their part in that they failed to explain and justify some of those policies: "Sometimes I have problem because these policies have been set by somebody else and so it is not easy to explain to somebody else and understand" (participant 02). Participants reported that this was putting them in conflict of their role whereby they were looked

at by nurses as not being supportive and representatives of the nurses.

Question 3. What management skills do middle-level nurse managers perceive that they require?

In the proceeding questions the focus was on the tasks that middle nurse managers in Malawi carry out and the problems they experience. Whether or not these tasks are carried out and problems tackled properly depends largely on the skills that nurse managers have. The third research question was aimed at finding out the skills that nurse managers perceived as important to have. When asked the question, responses fell into four broad categories namely; skills to motivate staff, skills to be able to formulate policies, skills to maintain quality care and skills to participate in financial management. Each of these have further been broken down to several specific areas.

Motivation Skills

From the research the participants concurred on the fact that to be able to motivate staff communication, counselling, problem solving, supervision, leadership, listening, performance appraisal and teaching skills are required. Out of these areas, communication skills seemed to top the list in that it was mentioned by seven participants (01, 05, 07, 11, 14, 17, & 20). Three participants (07, 08 & 09) mentioned that listening was an important skill. The perceptions in communication skills were summarised in the following responses. "Well I think I would love to have communication skills, especially when it concerns discussing and resolving our

problems, sometimes I feel that it is very difficult to deal with that because of not having communication skills" (participant 01).

I think communication is an important skill, as a nurse manager I would like to attain because every day there is an aspect of communication for the work to go on well, you have to communicate with your personnel and if you are the best communicator it means things will be going on well. And of course, another skill is performance appraisal that I would like to acquire (participant 14).

Four participants (09, 11, 14 & 15) reported that performance appraisal skills were also required. Out of these four, two simply stated that they required the skill. The other two (03 & 14) went a bit further stating that they do not carry out performance appraisal but if they were to carry it out, it should be done properly in order that it is appreciated.

The other skills, supervision (05), teaching (05 & 09) and counselling (17) were brought up by very few participants and without much explanation. However supervision, teaching and counselling were discussed as tasks carried out by middle level nurse managers. Two participants (06, & 16) stated that problem solving was one of the skills required.

Skills Required in Relation to Quality Care

Specific skills that participants indicated included first, skills necessary to set nursing standards (05 & 17). Participants 03, 04, 05, 06, 07, 10, 13, 14, 19 and 20

showed an important realisation that it was managers' responsibility to maintain quality care but failed to identify required skills.

It is important to have standards setting skill, we might not meet them but at least you know that somewhere you have set the standard. You can easily know that you are failing to meet standards, and can find out what you can do then to come up to a certain level (participant 07).

One participant (06) specifically related motivation through performance appraisal to quality care.

We should give credit where it is due in so doing that particular somebody will be motivated to do even better or sometimes you can think of rewards even at ward level. Again if there are any promotions you can recommend basing on an open staff appraisal and I think that is going to be better in motivating staff in promoting quality care (participant 06).

One participant (14) felt that she required human resource management training because she realised that it was an important aspect of management. She felt that as a manager if she did not manage her staff properly then the performance of the staff would affect standards. One participant (19) indicated that she required personnel management (which is basically the same as human resource management) but could not specify. "I think I would like to know about personnel management. (specific

areas under personnel management) The problem is that I do not even know what is covered in personnel management. I have no idea at all (participant 19).

Financial Management Skills

This question included concepts like general financial management and budgeting skills. In this study fourteen participants (02, 03, 04, 05, 07, 08, 09,10,11, 13, 14, 15, 16, 17, 19 & 20) perceived that financial management or budgeting skills were required by nurse managers. Six of these participants, (09, 10, 11, 15, 16 & 17) singled out budgeting as an important skill to have. Typical reasons for requiring financial management skills were active participation in budget planning, proper utilisation of resources and need for their own autonomy over matters that concern nursing.

Personally I feel I should have a skill in financial management and apart from that, I think I need a skill in a getting other donor funds to help, a skill whereby I can negotiate for funds and they (the donors) would come to assist us as a unit. I don't know what is included in finance, but whenever I see all these problems, and I wish I was able to negotiate with non-governmental Organisations (NGO) so that they can assist us as a unit rather than waiting for the top management to do everything for us. There are many other options like having a big walk, or making something for sell. money from this could be used to employ part-time nurses for our unit to ease the problem of shortage of staff, just to assist ourselves (participant 03).

She has to be involved. You know what, at any hospital I always feel the matron has a big part in the sense that most of the workers in the hospitals are nurses and if the matron has 3/4 of the workers and if she is not involved in the budget, so what's that. Half the time we are completely ignored, we talk about the administrator who does not even know about the hospital issues but is there managing the money, you are pointing out, I want this its a priority he does not even understand, why don't you give me my own budget and I can make use of it where I feel things are appropriate. Matrons have got to be involved, matrons have got to learn financial management and utilise it (participant 07)

Policy Making Skills

Thirteen of the participants (01, 02, 06, 07, 09, 10, 11, 12, 13, 14, 16, 17 & 20) indicated that they required some training in policy making. As expressed by one participant one needs to know the process involved. "I think there must be some training in that because for somebody to be able to formulate policies you should know the process involved, as it is done now we just guess. Otherwise we do not have skills (participant 14).

Just as with staff motivation skills there were some who were not sure of the policy making skills required by nurse managers (participants 04 & 05). One participant (19) reported that she did not know what policy making skills were. "I don't even know what they are, may be if I new what they are I would say may be I

can benefit from this or that. So I do not know them" (participant 19). However some participants were confident to say they did not need any additional skill (participants 03, 8, 13, 15, & 18).

Summary

This research was guided by three research questions which were on specific management tasks that middle-level nurse managers report that they carry out in Malawian hospitals, specific problems they experience in carrying out their work, and management skills they perceive that they require. These questions together with the conceptual framework guided the construction of an interview schedule which was used in data collection.

Data included demographics such as gender, age, location, experience, post basic qualifications and span of control. Descriptive statistics were used to analyse this kind of data. Results show that most middle-level nurse managers in Malawi are within the age group 30-49 with less than four years experience. These managers have acquired a wide range of post basic qualifications which have been grouped into clinical, community nursing, education and management. There is a high concentration of skills in central hospital compared to other types of hospitals.

A thematic approach has been used to analyse the qualitative data which revealed the common tasks carried out, problems encountered and aspirations in terms of skills (see Table 7). Further discussion of the results and conclusions will be presented in chapter 6.

Table 7

Summary of Results

Tasks	Problems	Skills
Staffing. Matrons and Senior sisters from government hospitals made recommendations to the CM and RNO CHAM participants recruited and allocated staff	-Lack of adequate involvement in staffing -Shortage of staff especially -RNs resulting in inappropriate skill mix -High turnover	Most of the participants failed to identify skills required but for those who did, they felt they need human resource management
Policy Making. 16 were involved in either initiating or actual formulating policies or making revisions and changes. Three were not involved and one was not sure. All were involved in implementation through ward rounds, meetings, and formal evaluation	-Lack of knowledge by both nurse managers and other health care workers	Participants were not sure of specific skills required but they generally felt they require policy making skills
Financial control. Limited involvement, mostly indirectly providing a list of requirements, carrying out inventories, repair and maintenance. Cost control activities included rationing of resources, encouraging staff to be responsible, following principles of ordering and	-Lack of involvement, knowledge -Insufficient funds leading to to difficulties in acquiring resources and carrying out required supervision in health centers	All participants felt uneasy about budgeting and most of them felt they needed budgeting or financial management skills

conducting orientation to proper use of new equipment		
Quality care. Contradictory answers came up. Some were involved in setting standards, some were not, some were not sure and others indicated the absence of those standards. They were all involved in maintaining quality through communication, supervision (ward rounds) inservice education, involvement in planning activities and safety.	Shortage of human and material resources Low level of staff motivation including the managers themselves Lack of standards	Most of the participants felt motivation skills were very important. some felt human resource management skills were required
Motivation. Participants felt their role was important in motivating nurses. Their activities involved performance appraisal, ensuring good interpersonal relationship, creativity and staff development, meetings	Shortage of staff, long working hours lack of staff appraisal, poor working conditions, inconsistent policies, high incidence of diseases	Communication skills Counselling skill Listening skills Problem solving skills Performance appraisal skills Teaching skills

CHAPTER SIX

DISCUSSION

The findings of this research suggest that indeed middle level nurse managers in Malawi experience problems in carrying out their work. Middle-level nurse managers from all three hospital categories carried out similar tasks, experienced common problems and had common perceptions on skills required to effectively carry out their work.

All the middle-level nurse managers interviewed were female. This was not surprising because in the Malawian case there are no male nurses at middle-level management within hospital system. This is explained by the fact that Malawi trained male nurses in the early 1960s and discontinued the programme.

Age, Experience and Additional Qualifications

Another area of interest in the research was the experience which people had in current position. The results suggested that the greatest proportion that is 13 matrons had been in the same position for a period of less than four years. This could be because that there are more young nurses in middle management positions. In addition this could be because the greater level of training required to obtain these positions now is more likely to be undertaken by younger nurses. It could also be

that more posts have been created at middle-level management which has given an opportunity for many young nurses to rise to this position.

The middle-level nurse managers comprising of matrons and senior sisters were in the age range from 30 to above 49 years old. Age is a factor that provides valuable insight into a manager's level of maturity and perceptions (Evans, 1991; King, 1989). Management experience depends on ones role perception in an organisation. For example in this research two participants felt satisfied with the situation of not being involved in financial management. They did not perceive that they had financial management problems and that financial management skills were necessary. In contrast, younger participants perceived that there were financial management problems and that financial management skills were certainly required. From these findings it is apparent that age critically influences development and implementation of policies in nursing and nursing management profession.

The research also explored whether or not nurse managers had acquired additional qualifications. There were higher proportion of trained participants in central hospitals than in other locations. Further there were more registered nurses in central hospitals than in district hospitals and CHAM hospitals. The reasons for this might have been influenced by the policy of providing higher levels of nursing staff in central hospitals. Central hospitals provide highly skilled care with advanced technology that require well trained personnel. Further central hospitals have the highest out-patient and inpatient numbers with large bed capacity (National Health Plan, 1986-1995).

Findings of this research support those of Arthur and James (1994), Nagelkerk (1994), Swansburg (1993) and Uys (1993). These authors stated that bed capacity, complexity of pro dures carried out in patient care, and organisational structure influences the quality, quantity and placement of nursing personnel. However on the other hand results revealed that participants in central hospitals had higher opportunities of continuing education. This was a concern by the participants in district and CHAM hospitals. Some participants specifically stated that they were made to believe that conditions of service and opportunities were the same, in both types of hospitals but in reality things were different. As a result of such inconsistencies there was an increased turnover of registered nurses from CHAM and district hospitals, which further reduced the staff quality and levels.

It was perhaps interesting that from the researcher's observation of the way in which participants reacted to the questions in the schedule. The age and years of experience of the participants seemed to have little effect on the performance and perceptions of the majority of the participants. These findings are in contradiction with the findings reported by Stitchler (1990). Stichler examined the effects of collaborative behaviour, organisational climate, and job stress on job satisfaction and anticipated turnover in nursing. The findings indicated that the age of a nurse manager had an effect on the collaborative behaviour and job satisfaction and had predictive validity with anticipated turnover which accounted for 31% of the variance. However Pabst (1993) stated that a combination of age, experience and qualifications were vital for effective management. On the other hand, Pabst did not

state the number of years and type of qualification necessary for effective management.

When asked to indicate to whom participants were answerable, the data indicated that nurse managers were answerable to a variety of officers, some of whom were not nursing personnel. Combining the categories of Regional Nursing Officer (RNO), Chief Matron (CM), Senior Matron (SM), Principal Nursing Officer (PNO), and matron, then the majority, fourteen participants were answerable to a nursing officer. Six participants were answerable to a District Health Officer (DHO), others to a Medical Superintendent who is a physician, and still others to an administrator who is neither a nurse nor a physician or board of trustees composed of mostly non-nursing personnel. A board of trustees is a management committee that consists of both nurses and non-nurse members who are heads of departments and are appointed by management or elected by constituents as determined by management. The committees serve useful functions in the organising process of nursing and organisational administration.

It was observed that participants from the same hospital reported to different officers. Although the participants did not indicate this as a problem but it showed that the line of authority was not clear to the participants. The danger with this is that of incongruent expectations of the officer to whom the participants reported and those of the participants. The likely result is role conflict. The results of this research are in agreement with the findings of Alderman (1992) and Jutte (1991) which indicated that uncertainties in the channel of authority led to role conflict and role ambiguity. The findings of this research point to the need for further research in this

regard to provide substantial information for decision making to correct the present uncertainties.

Participants also expressed concern over the fact that they lacked support from the top management. It is likely that participants expected support from wrong people to whom they were responsible to but yet they were not. This could have lead to misguided expectations of the support participants perceived. It can only be speculated that this was because of the lack of appreciation of the middle-level nurse managers' role by top management. It could also be that top managers have had no training in management and this affects the level of support they are able to provide.

These findings have an implication on the extrinsic factors in the conceptual framework. King (1989) stated that role expectation including channels of communication facilitates performance and should be clarified to the parties involved.

Span of Control

Span of control varied from one type of hospital to another. These findings can be explained by applying the results of Pabst (1993) findings who carried out a study on span of control. The results revealed that managerial span of control was influenced by many factors including philosophy, goals, and care delivery system. Further the findings were that physical layout also influence span of control. This current research has shown that there is a difference in span of control numbers between government and CHAM hospitals. An explanation of this could be that the numbers of employees were stipulated by government, thus institution's staff establishment mentioned by participants. Staff establishments are drawn based on

types and complexity of services which therefore also determine levels of staff competencies and numbers required. Most CHAM hospital do not offer specialised services as stipulated by Ministry of Health and they have less layers of management (National Health Plan 1986-1995). This is in agreement with Malay (1993) who stated that some of the factors that determined or influence span of control were number of employees and their competence levels at a particular hospital as defined by authorities. In contrast to the ideal span of control of seven to twelve suggested by Malay (1993) and Pabst (1993) the findings of this research are far from the ideal span of control. However Molay (1993) and Pabst (1993) indicated that size of the span of control did not necessarily determine effective management. The authors suggested that effective management is the result of the combination of many factors including experience, the skills of those controlled and the manager. The implication of span of control on effective management needs further research in Malawi. The findings of research from different countries can not necessarily be applied to Malawi. Further research to examine the relationship of size of span of control and effective management needs to be done

This research has however shown that a large span of control may be difficult for nurse managers to supervise adequately. It should be noted that participants in this research supervised two or more wards. For those in central hospitals they supervised a unit which could have had two or more wards whilst those in district and CHAM hospitals they supervised the whole hospital thus adult and children care. Other participants in district and CHAM hospitals supervised both in and out-patient

department. They also supervised rural hospitals, health centers and clinics under their hospitals' administration.

The following discussion looks at the findings of this research in relation to research questions and literature. A number of conclusions are drawn from the research along with implications for nursing management in Malawi and recommendations for further research.

Specific Management Tasks Middle-level Nurse Managers Report that they Carry out in Malawian Hospitals

The first research question was concerned with tasks perfomed by middle level nurse managers in Malawian hospitals. The research identified several tasks performed by the middle level nurse managers. Among the tasks reported were, staffing, financial management, policy making, supervision and motivation of nurses.

Staffing

Results of the research confirmed the involvement of nurse managers in staffing in that 19 out of the 20 participants reported taking part in staffing activities. Regarding the issue of staffing literature suggests that nurse managers should be involved in staffing (Adams & Oliverfelt, 1991; Arthur & James, 1994; Blaney & Hobson, 1988; Gillies, 1989; McElroy & Jennings, 1995; Swansburg, 1993). Further these authors suggested that options in determining staff requirements should be analysed critically and nurse managers should be involved.

These results are also in line with conceptual framework which is guiding this research which indicates one's right to participate in decisions that affect him or her. For example in staffing decisions, nurse managers have a responsibility to obtain and share information with top management concerning the appropriate numbers and skills of nursing staff required. Such information helps top management to make appropriate decisions to meet the demand.

From the research staffing can be analysed in terms of recruitment and allocation. From participants at the central hospitals, typical remarks were that recruitment and allocation were done by top management. This was possibly because of the extra management layer present in central hospitals, as outlined in Chapter Four. Whatever the cause, there was no evidence of the consultative method suggested in literature. For example some nurse managers could only deploy new staff as instructed by top management but only reshuffle existing personnel to achieve the desired balance in the staffing of their units. Two participants specifically indicated that they did not have powers to change the allocation advised by the top management. This finding has an implication for nursing management. According to King (1989), middle-level nurse management effectiveness is influenced by the interactions with both top and operational management. Such interaction offers consistent pattern of relationship which is important in understanding human behaviour. When such patterns are disrupted as in this case where no consultation was present, conflict results which leads to powerlessness in decision making about one's work (Norris & Hoyer, 1993). It is therefore imperative that nurse managers role in staffing be clarified for effective management of nursing services.

Responses of participants from district hospitals showed that they did not recruit staff directly. However, they had authority to allocate staff sent to them by top management. The six participants from CHAM carried out the task of staffing in full.

Criteria used by participants in determining staff requirements conform with what was suggested in the literature by Arthur and James (1994), Finkler and Kovner (1993), Gillies (1989) and Swansburg (1993). There are however some additional methods used by participants in this research which include doctors capabilities and filling of gaps.

A criterion of staffing which did not come up in literature but mentioned by participants was the doctors' capabilities. Although mentioned by only two participants it is an interesting factor according to the setting of the research. Malawi has very few doctors of its own and often receive doctors from other parts of the world. Some of these are not familiar with local conditions or tropical deceases. Having adequate numbers of experienced registered nurses often help the doctors. Another criteria used by the participants in allocation of staff to different wards was what they termed "filling of gaps".

Filling of gaps meant allocating nursing personnel to the wards with high shortage. The problem with this approach as mentioned by the participants was that the interests of members of staff were not considered. Staff were allocated according to the needs of the wards or hospital. Participants realised the implications of this approach that it might have been responsible for the problems of motivation as discussed later. Another problem with the method 'filling of gaps' was that

qualifications, skills and experience of both enrolled nurses and registered nurses were not considered as important. Participants stated that if they were to fill those gaps with the right skills then most of the wards or activities would not be done. Whilst at the moment the method is currently delivering care, it is costly because allot of supervision is required. It also leads to ineffective management because the objective is work to be done rather than quality of work.

Filling of gaps can be related to the conceptual framework in terms of extrinsic and intrinsic factors. In extrinsic factors, filling of gaps would be explained as a behaviour of nurse managers influenced by external factors such as shortage of staff. In an effort to bring balance in the workplace, nurse managers would resalt to allocating staff to areas with great demand rather than considering interests of staff. Such actions inflicts staffs' self in intrinsic factors affecting their self-esteem, interests and performance.

The factor that participants in this research did not mention as influencing staffing numbers was time required to provide emotional support and health education to patients. Hillebrand (1994), Morrow (1994) and Swansburg (1993) stated that this is an important factor to be considered because it determines the appropriate skill mix. Gillies (1989) indicated that the ability to measure nursing activities in terms of time demands nurse managers to have research skills. Research skills will enable nurse managers to categorise patients and plan appropriate staff numbers and skills basing on observable and measurable nurse behaviours.

The fact that participants in tis research did not mention this factor may be suggest that nurse managers in Malawi lack such skills. This is an important

revelation in this research and it points out to the need for research skills by Malawian nurse managers.

The findings point out to the importance of resource management skills of nurse managers so as to be able to operate effectively within the limited resources they have without sacrificing the quality of care.

Policy Making

Results indicated that sixteen nurse managers were involved in policy making. Their involvement ranged from formulation to revision of policy. Three were not involved and one was not sure.

An interesting result came from CHAM. Out of the six CHAM participants three were involved in policy making while two were not. One was not sure. It so happened that all the three who indicated involvement had training in management. The implication of this is that lack of management training limits the extent of nurse managers involvement in policy making.

For those participants both from CHAM and government hospitals who were involved, the level of involvement differed. Some were involved in policy formulation process, others only made changes to policies handed down by top management. In whichever activity, involving others in policy making was reported as a conscious effort by six managers. This was designed to make the people feel committed to the policy and to ensure that the policy met the needs of the people. This point has been supported by Farrington (1994), Nagelkerk (1994), Skubak, Earls and Botos (1994) and Swansburg (1993) who all concluded that policies are

best developed in consultation with representatives of all groups concerned in their implementation.

This point also supports the conceptual framework with regards to the factors grouped in the interpersonal category. King (1989) stated that people have a right to knowledge and participate in decision making on matters that concern them. The point is also supported by Swansburg (1993) who stated that participatory management assumes that employees will follow and support policies they have helped to develop.

Financial Management

Activities reported under financial management included budgeting, costing, and inventory control. Involvement in financial management varied. Some participants simply provided a list of requirements, others were involved in actual budgeting and costing. Still other participants carried out inventory control.

From the research there is evidence of nurse managers' involvement in financial management, but only to a limited extent. The major reason given for this lack of involvement by the participants was that nurses made up a large proportion of health care workers in comparison to other types of health care staff and their involvement in patient care used a greater part of financial resources. Involvement of nurse managers in financial management therefore would ensure proper planning of cost effective care and allocation of available resources in the most effective and least wasteful manner. Lack of nurse managers' involvement has repercussion that there might be lack of proper human and material resources to provide service. This is

ventimately costly (Blaney & Hobson, 1988; Brown, 1991; Buchan, 1992; Schroeder, 1994).

Results of this research reflect the importance of financial management skills to nurse managers. The role of the middle-level nurse managers in financial management is vital. Nurse managers need to be involved to prevent nursing services being undermined since they are in a better position to appreciate the requirements of nursing (Bailey, 1995; Behets, 1995; Naish, 1995; Nursing Report, 1995). Another major reason for involvement particularly in budgeting, is that nurse managers will be in a better position to control costs because they will have an understanding of the process of resource allocation and costs involved. Results of this research support the view of Namate (1992), who stated that nurse managers in Malawi lack financial management skills. The implication of this lack of financial management is limitation in acquisition of appropriate equipment and material resources and their maintenance.

Ensuring Quality Care

A third task reported was ensuring quality care. Participants reported various activities which were related to quality care. These included staffing, resource management, nurse motivation and nursing standard. It suffices to mention here that the resource allocation among other factors, is a function of the level of resources. Resource allocation has been dealt with under financial management above. Nurse motivation will be discussed under its own heading below. This section will look at nursing standards.

Participants were asked to comment on nursing standards in their institutions to establish whether or not participants were involved in setting nursing standards, and whether the standards were in place. The results pointed to three conclusions, namely: that there was lack of uniformity regarding the involvement in setting standards; there was lack of practice guidelines or there were no specified standards in most hospitals, and there was a knowledge deficit regarding the idea of standards among the participants.

Lack of uniformity can be seen in the responses given by participants from central and district hospitals. Out of the four district hospital participants, only one said she was involved in setting standards. Five participants from central hospitals reported that they were involved, while five said there were no specified standards in their institutions. Some of the latter five were from the hospitals where the others had said they were involved in setting standards. These contradictory responses give rise to doubt that participants have understanding of a standard and gives doubt to the existence of the standards in these hospitals.

The lack of practice guidelines was indicated by the number of participants who reported that they were not involved or said there were no standards. These results were comprised of five participants from central hospitals, one from a district hospital and one from CHAM. Lack of practice guidelines was also reported by Simbota et al. (1995).

Lack of knowledge was evidenced by four participants who indicated that they were not sure. Further, there were cases where participants reported that they were involved in setting standards but later in the interview would ask for an

explanation of the concept of nursing standards. Some participants understood nursing standard as procedure manuals, policy or standing orders. However it cannot completely be ruled out that participants' responses might be a problem because of the wording of the question, a point which might have been missed during a pilot study.

Regarding the maintenance of quality care, participants reported several activities which were used. This was apparently whether or not nursing standards were in place. The activities included ward rounds/supervision, in-service education communication, ad hoc teaching, and support and involvement in planning of nursing activities. Out of these, the activity which was most frequently mentioned was ward rounds/supervision. Participants reported that tools they used to guide supervision were a check list that is a list of items or activities necessary to be done to qualify the completion of an objective, notebook used for note taking, and setting specific objectives for the purpose of a round. For example the manager may go around only to check on the cleanliness of the ward and so he or she will clearly stipulate factors to look for. Results also indicated that there were participants who did not use any of the above but would go on rounds asking whether there were problems.

An interesting aspect of the results was that participants expressed concern at how some managers carried out supervision. The concern was that supervision was carried out only when there was a problem and often the managers would simply shout at the nurses. The latter supports the finding of Whale (1993) that nurse managers lacked objectivity and used their time poorly. From these findings it can be concluded that nurse managers require supervisory skills.

Motivating Nurses

A fourth task that came up in the research was motivation of nurses. Participants felt that they had a big role to play in motivating nurses. They saw that their role was very important in stabilising nurses. The main objectives of the task was to ensure that nurses are committed to standards established and to improve staff retention. Results showed that participants used different tools to motivate nurses. The tools included performance appraisal, good interpersonal relationships, creativity, and staff development.

The participants who mentioned performance appraisal underscored its importance as a tool for motivation. From the responses participants showed that they realised that performance appraisal was important to keep nurses motivated for three main reasons. Firstly, nurses would be made aware of their strengths and weaknesses. Secondly, appraisal would help the managers to identify areas that needed improvement through education, counselling or merely encouragement. Finally, appraisal would identify those who were eligible for promotion. However four participants indicated that performance appraisal was not being carried out for varied reasons. The participants stated that it was not easy to carry out performance appraisal because of pressure of work and lack of confidence.

The lack of confidence arose because nurse managers themselves were not being appraised by top management and so felt uncomfortable about appraising others. This is a very important finding in the sense that it shows that there was lack of role models for the participants. This may further point to a lack of similar skill in

top management, an area that may call for further research to identify areas that top management require to set a good example for the middle and operational management.

Fifteen participants indicated that a good interpersonal relationship was very important in motivating nurses. Elements of a good interpersonal relationship mentioned were personal characteristics, courtesy, encouragement, being a role model, and initiative. An example was that nurse managers should be supportive of members of staff. Nurses should be praised when they have done well, rather than being shouted at when they have done poorly. Three participants expressed concern over the fact that even the top management do not encourage members of staff. Members of staff were only summoned to the Chief or Senior Matron's office when they have done something bad. As pointed out earlier, the role which top management plays in motivating nurses also raises concerns. It may be concluded that all nurse managers require motivational skills.

Lack of motivation skills has an implication in nursing and nursing management. Motivation levels of nurses influence quality of service, and effectiveness of management is judged by the public and colleagues on the quality of care provided. Therefore it is imperative that nurse managers be equipped with good interpersonal relationship skills. Good interpersonal relationship have proved to be the core for staff motivation (Gillies, 1989; Swansburg, 1993).

Nineteen participants mentioned meetings as being very important. They stated that it was at these meetings that they discussed how to improve patient care, learnt from each other and appreciated the points of view of other health care

professionals and colleagues. It is apparent that nurse managers contribution to institutions decisions was in meetings. However, participants experienced a problem in influencing health care decisions in their institutions. Unlike many studies where such problems are associated with gender differences (Schwartz, 1992), participants in this research had different views.

Participants' problems emanated from the fact that some of the members of senior decision making bodies like board of trustees, interdisciplinary meetings lacked an appreciation of the role of the nursing service and so took too long in supporting nurse managers' suggestions. Further, older participants felt that the younger nurses opposed their suggestions. These findings could be related to what Hillebrand (1994) and Young (1995) indicated as leadership challenges that need to be addressed by nurse manager at all levels. Several participants presented the views that nurse managers should be able to deal with this and present objective evidence that will support their suggestions and provide solutions to health care problems. For nurse managers to effectively participate in meetings and influence decision making, management training is required.

These findings have an implication drawn from the conceptual framework. The concept of time in the conceptual framework is viewed in terms of age, order of events, and space. This relates to the way nurse managers present their suggestions. They may need to be more assertive and sensitive to group characteristics of the people involved. This points to the need for interpersonal skills.

Specific Problems that Middle-level Nurse Managers in Malawi Report they Experience in Carrying out their Work

The second research question was aimed at finding out specific problems the participants experienced in carrying out their work. The responses will be discussed here under five general themes: problems relating to staffing, motivation of staff, quality care, policy making and financial management. Under each of these themes numerous other problems arose, but only the major and more frequent ones will be discussed.

Problems Relating to Staffing

Responses to the problems relating to staffing indicated that there were three aspects to consider. The first is that of inadequate numbers of staff, the second is that of inappropriate mix, and the third is the problem of turnover.

Nearly all participants who commented on the problem stated that there was a shortage of staff in their hospitals or units. This was especially true for registered nurses and those with specialised qualifications. Nineteen participants cited lack of nurse managers' full involvement in staffing as a compounding factor. This problem was particularly true for the participants from central and district hospitals as most of their involvement went only as far as making recommendations. The result was that the numbers of nurses recruited for the hospitals and units were not enough or were not of the appropriate type.

Nine participants cited the problem of staff turnover. This high turnover was attributed to inconsistent policies with regard to promotions, maternity leave and

continuing education. The effects of such inconsistencies have been discussed under motivation. Another reason for high turnover was lack of proper accommodation, especially in districts and CHAM hospitals. The problem of housing accommodation involves the employer's commitment to meeting staff needs. However with the current economic constraints this problem poses a dilemma to policy makers. These findings parallel the results of Karonde (1992) and Kasese (1990) in studies on problems of supplying housing in rural areas.

Problems Related to Motivation

Six factors were reported as sources of problem in motivating nurses: shortage of staff, long working hours, lack of staff appraisal, poor working conditions and inconsistent policies. Long working hours topped the list. Sixteen participants cited long working hours as a problem in motivating nurses.

The longest shift ranged from 12 to 14.4 hours with the total number of hours per week ranging from 36 to 42 hours. Participants reported that nurses were often tired, exhausted, and emotionally so affected after working a long shift that most of the basic activities were left undone. In this regard the level of motivation was directly related to quality care. Although long working hours were reported as a problem per se, one participant reported that its effects were minimised when there was compensation in the form of an allowance or extra money.

These findings are in accordance with those of Klemm and Schreiber (1992) and Kramer and Schmalenburg (1992), who noted that there is a relationship between awarding of incentives or benefits and levels of motivation. Since participants in this

research did not deal with personnel salaries or wages, they used a different approach to motivate nurses. Some nurse managers initiated awarding of a medal to the best nurse of the year. Most of the managers offered an extra day off to members of staff. These incentives are reported to be effective only for a short while. Looking at the complexity of the participants' work, it is likely that good interpersonal relations would be the best solution as previously discussed. People need to be valued and praised for the work they do. This researcher agrees with a second view about strengthening interpersonal relationships rather than monetary rewards. Monetary rewards may be temporary measure influenced by changes in one's needs.

The problem of shortage of staff was frequently mentioned in relation to long working hours. This was because there were too few nurses against many patients. Reported nurse patient ratios were 1:30 to 1:50. These ratios are far higher than those reported in the literature (Duffeld, 1992; Gillies, 1989; Swansburg, 1993). From these figures it is obvious that nurses in Malawi work under enormous pressures.

Nursing staff shortage was most critical on registered nurses. The registered-enrolled nurse ratio varied depending on the category of the hospital. Central hospitals had more registered nurses because of their structure and type of services offered. However, lower levels of 1:17, mostly in CHAM and district hospitals, were also reported. The problem adds to those described above in terms of increased demands on the registered nurses in their teaching role. One participant indicated that these registered nurses are given wards to supervise in addition to providing direct patient care. The situation poses a big task on policy makers to find ways of

easing the pressures faced by the nursing profession as well as other health care workers in Malawi.

Poor working conditions were reported by sixteen participants to affect motivation levels of staff. Participants described poor working conditions in terms of high patient numbers, increased disease incidence, and inadequate facilities and other resources relative to patient numbers. These problems discouraged nurses from carrying out some of the activities they would have wished to do for their patients. One participant indicated that nurses did not want to work in certain wards because they felt they were more at risk. Many nurses had gone on sick-leave. The problem was exacerbated because of nurses' perception that top management was not appreciative of their efforts.

With high patient numbers it was hard for the nurses to meet patient demands for quality care. The gap between these expectations and the reality demotivated nurses and caused them to give up, as reported by participants. The findings have an implication drawn from extrinsic factors listed in the conceptual framework. Extrinsic factors influence behaviour and perceptions of one's role based on the experiences acquired in the situation.

The extrinsic factors reported in this research as affecting motivation have been reported in the literature (Brown, 1993; Snape & Cavanagh, 1993; Sullivan, 1993; Vives, et al., 1994). Authors acknowledge that there is no easy way for nurse managers to motivate nurses because human behaviour is diverse, subtle and complex. However nurse managers positive attitude towards staff can make a difference. Open communication, inviting suggestions from staff on how to deal with

the problems makes staff feel worthy thereby acting positively supporting the decisions of management.

Problems Relating to Quality Care

Four problems emerged pertaining to quality care. These were lack of human and material resources, lack of nursing standards, lack of performance measurement tools, and high public expectations.

All participants stated that shortage of resources has meant that a lot of activities were left out in preference to a selected few. Further, and related to the problem of shortage of human resources, was the fact that registered nurses were relatively fewer than the enrolled nurses. This was a point of concern by participants because the situation affected quality care adversely.

Over the past years the public has expressed concern regarding the deteriorating quality of nursing services. This point was noted by the Nurses Council of Malawi (1990). The problem here is that a major contributing factor to the deterioration of standards is the lack of resources. When the public lays the blame entirely on the nurses they feel helpless and later give up, leading to a further decline in the services.

Another problem mentioned was the lack of nursing standards and performance measurement tools. The implication for the nursing profession in Malawi is that it is going to be difficult to measure quality of care and the indicators for deterioration of care are at risk of being ignored. Preventable occurrences may go unnoticed resulting in poor quality care.

Problems Related to Financial Management

Under financial management, three major problems emerged and these were insufficient funds, lack of involvement evidenced by the majority not taking part in financial decisions and insufficient knowledge in budgeting.

The problem of insufficient funds emanates from economic problems that Malawi is facing. From the nursing point of view, Behets (1995), Naish (1995) and The Nursing Report (1995) suggested that with the growing economic problems in many countries, policy makers need a vigorous approach to nurse managers' preparation in financial management. The aim is to assist nurse managers defend their cause among other decision makers and to be able to institute meaningful financial control measures. The need for preparing nurse managers in financial management and accounts has been widely documented (Allen, 1995; Buchan, 1992; Blaney & Hobson, 1988; Gillies, 1989; Smith, Danforth, & Owens, 1994; Swansburg, 1993).

Regarding lack of involvement, there seemed to be no difference whether the participants had obtained higher professional qualifications or not. Lack of knowledge was mentioned by the participants and this concurred with what Namate (1992) indicated. However this research revealed one consequence of this problem, namely that the middle level nurse managers who lacked financial management knowledge felt cheated on how nursing funds were allocated and utilised. This further led to stress among nurse managers and limited participation in cost control implementation. This finding appears not to have been documented in the literature. This is a very important point in the Malawian situation, where nurse managers have

not fully participated in budgeting in the past. The trend went unchecked, possibly because nurse managers felt the situation was satisfactory. But now that nurse managers have developed a perception of being cheated (to use the words of the participants themselves), it shows a move towards an understanding of their role in financial management, and this is a positive sign. To help nurse managers understand financial management, a further research in this area will be required to explore the degree of their involvement at different levels of management, including the operational managers who are directly involved with the use of resources in patient care. The understanding of financial management would assist nurse managers to control cost and facilitate the provision of cost-effective care.

Two participants indicated that they were not interested in acquiring financial management skills. They indicated that they were satisfied with the status-quo. Although this was a small proportion of the sample, this result provided some insight into what transaction, role, and perception under interpersonal and extrinsic factors in the conceptual framework can explain. These participants two participants were both aged over 50 years and had worked in middle level management for over ten years and were in the group of participants who had had no preparation in management. It may well be that lack of preparation limited their perception of the role they could play in financial management. Additionally, the fact that they had been in middle level management for over ten years may have resulted in complacency because the burdens of such planning, resource acquisition and control were on other staff.

Using King's concepts, time (under intrinsic factors) can be viewed in terms of age, order of events and space (environment). The concept of time indicates that

age is an important variable in the growth and development of an individual. Age is related to maturity where one is able to make independent decisions regardless of whether they are right or not. The level of growth and development, progresses in phases and ultimately reaches its satisfaction level (maturity). The result of this research indicates the importance of age in management. Age of nurse managers can influence level of innovation, creativity and willingness to institute change in the organisation.

Problems Pertaining to Policy Making

Participants brought up three main problems experienced in relation to policy. The problems were lack of knowledge on the part of nurse managers in policy issues, lack of support from fellow nurses, and lack of involvement in policy making. The latter was reported by the six participants who were not involved in policy making.

Lack of knowledge limited nurse managers' involvement in policy making. It was reported that some of the policies adopted by the institutions were detrimental to nursing. The participants stated that, since nurse managers lacked knowledge in policy making, they ended up simply supporting what was proposed. Lack of knowledge was therefore seen as a major set-back. This is yet another area of concern to the nursing profession in Malawi. It points to the same ineffective leadership noted by Namate (1992). Some participants strongly felt that a matron's position was very important for the effective management of nursing services. Without a matron, nursing services would collapse. Middle-level nurse managers therefore require strong leadership skills so as to be assertive in their dealings.

In addition, participants with higher qualifications felt that middle-level nurse managers require training in management above the diploma level. However it was interesting to note that some of the nurse managers with a degree not specific to management showed limited understanding of policy making process. One such participant specifically stated that they used guess work to formulate some of the nursing policies. She said they did not know exactly what to do in formulation process. It may be concluded that such programmes are weak in management and may need strengthening. Further research is required to examine this correlation.

Policy making has an implication for nursing management. Nurse managers at all levels are confronted with many problems in the health care system, such as competing for scarce resources. Nurse managers therefore require adequate knowledge about policy making.

Management Skills that Middle-level Nurse Managers Perceive that they Require

In the preceding discussion the focus was on the tasks that middle nurse managers in Malawi carry out and the problems they experience. Whether or not these tasks are carried out and problems tackled properly depends on the skills that nurse managers have. The third research question aimed at finding out the skills that nurse managers perceived as important to have. When asked the question, responses fell into four broad categories, namely: skills to motivate staff, skills to be able to formulate policies, skills to maintain quality care and skills to participate in financial management. Each of these have further been broken down into several specific areas.

Motivation Skills

From the research, the participants agreed that to be able to motivate staff one requires good communication and counselling skills, problem solving ability, supervision skills, leadership, ability to listen, performance appraisal systems and teaching skills. Out of these areas, communication skills seemed to top the list in that it was mentioned by seven participants. Participants stated that communication skills were important because they facilitated problem solving. Participants also felt that their work involved a great deal of communication as they coordinate nursing activities. Communication was also seen to facilitate counselling, performance appraisal and teaching roles. This finding is in line with the conceptual framework because communication is seen as facilitating interaction with nurses, physicians and all other health care workers. Communication therefore has some implications for nursing management. It facilitates nurses' integrators role and requires use of accurate knowledge and communication skills.

Although the majority of the participants identified the skills required to motivate staff, a few were not sure or could not think of any. Three participants said they were not sure but mentioned some skills after explanation. One participant, although not sure of the perceived skills, thought that management qualifications were an important factor.

Quality Care Skills Required

Participants realised that maintaining quality care was the responsibility of middle level nurse managers and therefore the ability to set standards would help them. The middle-level nurse managers require skills to motivate nurses as motivation is an integral factor in maintaining nursing standards.

Financial Management Skills

With only two exceptions, the participants expressed interest in acquiring financial management skills. The reasons were to be able to plan and implement control measures which were being carried out by hospital administrators, pharmacists and stores clerks who are not involved in nursing care. This argument supports the warning given by Buchan (1992): "If nurses ignore this issue, important decisions on resource allocation and utilisation will be made by administrators with strong knowledge of costing but weaker appreciation of the impact of cost-containment strategies on the quality of nursing care" (Buchan 1992, p. 117).

Policy Making Skills

It was interesting to note that participants who had indicated involvement earlier on felt they needed skills in policy making. The reason was that they spent most of the time guessing rather than knowing the policy making process. Thirteen participants indicated that they required training in policy making. It was further interesting to note that even those nurse managers with higher professional qualification indicated that they did not know how to develop policies.

There is apparently no similar research specifically focusing on perceived policy making skills of nurse managers to which these findings in the current research could be compared. In most cases, conclusions have been made from nurse managers' lack of involvement. This research therefore provides an important revelation of neglect in this area which forms an important foundation in equipping managers for their task.

Implications for Nurse Managers

The role of the middle-level nurse manager is crucial in promoting quality care, managing resources and directing nursing services (Allen, 1995; Dunn, 1995; Nicklin, 1995; Weston, Bruster, Lorentzon & Bosanquet, 1995). If nursing structures are poorly designed, poorly staffed, or poorly equipped in terms of supplies and equipment, then quality of available care will continue to deteriorate (Hanrock, 1991; Weston et al. 1995).

Viewed in this context, the results of this research indicate a number of problems experienced by middle-level nurse managers in Malawi. Issues of staffing, motivation, quality care and procurement of material resources were particularly strong areas which need consideration by nurse managers if nursing care is to succeed.

From this research and the literature available, it is evident that nurses and particularly middle-level nurse managers perform a number of tasks. This calls for serious thought in addressing the issues of staffing. Staffing can be looked at from two angles: first the numbers of staff, and secondly the skills of the staff. Whatever

the cases the input of middle-level nurse managers in staffing is vital (Dunn, 1995; Heim, 1995; Weston, et al. 1995).

Particular problems with motivating nurses are revealed by these research findings. Motivation is an area where the role and responsibility of nurses needs clarification. Primary responsibility for motivating nurses lies with the employer because organisational policies concerning continuing education and promotions are formulated by the employer. On the other hand, nurse managers play an important role in day-to-day nursing service management in supporting, representing and appraising staff, and bringing problems to the attention of the top management. Greater emphasis on priming middle level nurse managers for their role in nurse management on the units or hospitals and the development and dissemination of management policies is therefore required (Whale, 1993).

Identifying the professional responsibility to provide direction of nursing service is also an interdisciplinary issue. Participants articulated a desire to be involved in policy making, and developing and controlling a nursing budget. Reported lack of involvement of nurse managers in policy making and financial management is unacceptable and clearly indicates a need for a coordinated approach to health service planning, and clearer demarcation of the roles and responsibilities of different health professionals (Dunn, 1995; Heim, 1995; Weston, et al. 1995).

Quality care is another area of concern. Not only is quality of care adversely affected by low nurse-patient ratios, lack of material resources and low nurse motivation, results also reveal that lack of adequate knowledge and skills in setting

nursing standards and monitoring of quality care is a factor that needs prompt addressing.

Conclusion

The literature has revealed a number of similar problems being faced by nurse managers at all management levels (Arthur & James, 1994; Heim, 1995; Skubak, Earls & Botos, 1994; Weston, et. al. 1995). Such problems include lack of involvement in matters that concern nursing, lack of problem solving skills, shortage of nursing personnel and lack of trained nurse managers.

It is hoped that the empirical evidence presented here provides a starting point from which the policy makers can begin to prioritize management skills and address deficiencies in nursing management. The baseline results provided by this research may also help nurse managers to prioritize areas for further research.

Summary

The purpose of this research was to explore the problems experienced by the middle level nurse managers in Malawi in carrying out their work. Further objectives which were related to the concept of problems were to investigate necessary skills that middle level nurse managers perceived to be necessary to effectively carry out their work. The results will provide an insight on the problems experienced by middle-level nurse managers. The information could be used in decision making on the support, skills and training required by middle-level nurse managers in Malawi for effective management.

The research took place in Malawian government and non government hospitals. Government hospitals have an approximate bed capacity of 1,000 for central hospitals and 500 for district hospitals. Non-government hospitals' bed capacity ranged from 200 to 600. For this research the participants were the middle-level nurse managers (matrons and senior sisters) in central and district and CHAM hospitals. The sample size of twenty participants was involved in the research. Data was collected using interviews conducted during normal working days in the participants' offices within the hospitals.

As explained in Chapter Three the interview schedule was developed using a conceptual framework adapted from Kings Goal Attainment Theory. It should therefore be noted that data collection has been influenced by the concepts in the theory. The concepts guided the construction of the questions used for data collection. Further in relation to data collection, the concepts provided an ideal situation in relation to middle-level nurse managers' work. For example, communication facilitates interaction with nurses physicians allied health professionals.

The demographic and background data pertaining to the participants included characteristics of the middle level nurse managers in terms of gender, age, position, location, experiences, professional qualifications and span of control. The above characteristics were included because they have a major influence on the job performance, perceptions and management skills important for effective management.

The research involved twenty middle-level nurse managers from three central, four district and five CHAM hospitals. Sixteen participants in this research were

matrons and the rest were senior sisters. Of these ten participants were from central hospitals, six were from CHAM and four came from district hospitals.

Table 8

Summary of the Tasks, Problems and perceived Skills required by Malawian Middle-level Nurse Managers

Tasks	Problems	Perceived Skills
Staffing included recruitment and staff allocation	Sources of problems included shortage of staff inappropriate skill mix high staff turnover	Human resource management Research skills
Policy making involved formulation and revision of policies, dissemination of policies	Lack of knowledge Lack of support Lack of involvement	Leadership and policy making skills
Motivating nurses involved staff appraisal, good interpersonal relationship, staff development encouraging participation in meetings	Shortage of staff Long working hours Lack of staff appraisal Poor working conditions Inconsistent policies	Communication, Counselling, Problem solving, Supervisory. Leadership, Listening, Performance appraisal, Interpersonal and Teaching skills
Quality care. Maintained through ward rounds, supervision, staffing, inservice education	Lack of human and material resources, Lack of standards Lack of performance measuring tools High public expectations Lack of knowledge in setting nursing standards Lack of supervisory skills	Staff motivation, Supervisory, Resource management and Skills to set nursing standards and performance measuring tools
Financial management. Included budgeting, costing, and inventory control	Insufficient funds Lack of involvement Lack of knowledge in financial management	Financial management skills

Recommendations for Further Research

Based on the findings of this research, a number of recommendations regarding future research directions can be made.

Since this was the first study in Malawi to explore the tasks that middle-level nurse managers carry out, the problems they experience in carrying out their work, and their perceptions regarding necessary management skills, further study needs to be undertaken. The future study will determine whether or not the tasks, problems and perceived skills identified indeed reflect middle-level nurse manager's work. Future research should therefore be extended to other district, CHAM, and private hospitals to broaden the sample so as to generalise the findings.

To keep touch with what is going on in the workplace, a research department should be established at central hospitals and at the Regional Nursing level for district hospitals. Such research will provide current and practical information for decision making, and will form a better basis for suggestions in institutional policy direction which will benefit the nursing profession. However, implementation of such nursing research departments requires careful assessment, planning, and a commitment to the beliefs that quality service requires research-based nursing information. This commitment

begins with the top management, but if it is to be lasting, it must gradually permeate the entire nursing staff and hospital systems generally, with nurses taking the leading role.

The participants in this study indicated that they lacked support from the top management, and that many nurses perceived that top management was not appreciative of their efforts. Future research should attempt to identify if this is a common problem and if so, replication of this sort of study with modification to the instrument would be recommended. Modification to the current instrument will be necessary because it was developed for middle-level nurse managers, who are directly involved with management of operational managers and sometimes operational staff. In contrast, top level nurse managers are directly involved with the management of middle-level nurse managers and indirectly involved with activities of operational management. In this case such questions like number of hours worked by bedside nurses are not applicable, whilst how top level nurse managers keep middle-level nurse managers and nurses motivated is applicable. However modifications should follow intensive literature review of top level nurse management role.

Managers of professional nurses will only be successful to the extent that they are able to close the gap between the public's expectations and actual nursing practice. The variables that are involved in this equation are

multiple and complex, and because they are dynamic they require constant analysis and adjustment. Hence there is a strong need for research skills for nurse managers.

Hospital Administrators and Accountants need to be aware of the market economy, but not lose sight of the need for the co-operation of nurse managers and nurses. Since nurse managers adopt a logical approach as well as a person-centred focus, their involvement in budgeting will dramatically enhance the direction of financial management in Malawi. It is recommended therefore that nurses at all levels including those not in management should be prepared and be encouraged to participate in positive negotiations and decision making in financial management and accounting. Before deciding to train nurse managers in financial management, an intensive assessment should be carried out to determine the appropriate level of financial management and accounting required.

The current study has highlighted extensive inequities in the availability of appraisals of nurses. If the appraisals have the potential to maximise the abilities of individual nurses, then it is important that each individual within the nursing team be offered the opportunity to develop and increase their contribution to meet the needs of the organisation. It is imperative therefore that an appropriate appraisal system be made available to

all nurses in the clinical area within a comprehensive and organised framework.

Nursing should control its own quality of service. Quality control should be with the Nurses and Midwives Council of Malawi, in collaboration with the Nurses Association of Malawi. The planning of quality care should take into account the long-term goals of the profession as well as the immediate learning needs of individual nurse managers. To identify nurse managers' learning needs in this regard, and to ascertain felt needs, normative needs, and comparative needs, exploratory research is required. It is imperative that the nursing profession and its members control their own quality if nursing service and the public needs are to be best served.

The current study has revealed lack of clear nursing practice guidelines such as nursing standards. Future research is needed to explore whether there are nursing philosophies in hospitals and how managers utilise those in decision making regarding resource and nursing management including setting of nursing standards.

An exploratory research project needs to be done to investigate the benefits available to nursing staff at different levels. Based on the findings it would also be necessary to conduct a two-staged exploratory descriptive study. It would first investigate criteria used by policy makers or employers

to allocate benefits to nursing staff at different levels. Secondly, it would examine nursing staff's awareness of the benefits available to them. Information from this sort of study would restore trust and confidence of employees to their employer. On the part of the employer , this would activate a sense of responsibility in allocating benefits. This study has also indicated that inconsistencies in allocation of benefits causes stress in nursing personnel. Further the study has revealed a direct negative effect of stress to quality of nursing service. Consequently, there is a need for prompt attention to the matter.

Results show that participants in this study were not clear about their line of authority. It is recommended that nurse managers and all nurses have clear job descriptions indicating the officer to whom they are responsible. Clarity of such a line of authority line needs attention to avoid role conflict. Further, an exploratory descriptive study using role theory needs to be done to determine the existence and extent of role conflict in this regard.

Sound management development programs are needed in Malawian hospitals to prepare nurses for management positions. Participants in this study have indicated a strong need for management training, and orientation when they have been promoted to the new position. Out of twenty participants in this study only four participants had a first degree and one had a Master degree of Nursing. This is an important indication that promotion

from within is the most promising source of managerial talent. The individualised development programs such as workshops, in-service education or short courses in university education would be necessary. The programs should also involve operational managers to prepare them for their future roles. Individuals who aspire to be managers have a responsibility to be clear about the role they wish to fulfil and the expectations of that position.

Results show that documentation is not usually and properly done in the clinical area. Looking at the importance of documentation an exploratory study should be carried out to examine the documentation system currently in place. Further a study should be carried out to identify problems nurses themselves (self-reporting) experience in documentation. Results of the study would provide a basis to review the current documentation system and develop a more practical documentation system. Results would also assist the development of reinforcement measures to ensure that documentation is carried out.

Some nurse managers indicated that they lacked confidence in their management roles, and felt detached from their clinical experience where they felt more confident. The policy makers should devise line of authority and promotion in each specialised nursing field. This would conserve skills and promote creativity in a familiar and area of interest by the managers which may enhance quality of service.

The current level of stress among nurses and nurse managers is a matter of concern. Future studies should examine the determinants of stress as well as the level of job satisfaction and career commitment of registered nurses among whom high turnover has been reported. It would also be useful to explore how nurses cope with stress from a personal point of view and how those coping strategies could be positively be developed and shared.

Nurse managers face a challenging future. Strategic choices must be made that will support nursing management. These choices must be made on the basis of information that characterises the middle-level nurse manager, on the management skills required, and on the resources available to execute their role. Results of this study suggest that, in addition to problems identified such as lack of managerial knowledge in financial management, developing nursing standards, formulation of and involvement in policy making, and carrying out a staff appraisal, other possible attributes of the internal and external environment still need to be investigated. For example on the internal environment, there is need for further research on the effects of large span of control (as revealed in this study) on structure of an organisation, financial and human resource management, and quality of care.

On the other hand, the study has revealed the importance of establishing an appropriate number and skill mix of nursing staff at district,

CHAM and at unit level. The manner in which human and financial resources are distributed have profound consequences for those giving and receiving care. Policy makers as an example (of the external environment of nurse managers work), should devise ways of having constant input from middle-level nurse managers in resource management. Further research into the relationship between nursing input and management effectiveness will be necessary to add strength to this argument.

There appears to be a great need for the function of the ward round to be understood by the managers. This would enable each participant to be clear about their role. Such issues as nurse participation and decision making need to be considered. Training needs should be explored. These may encompass assertiveness, negotiation and leadership skills, and communication skills. Understanding of roles and training needs may indeed make the ward rounds more effective.

Most of the participants in this study had worked in their current position for less than four years. Some of them had previous management experience, others were younger and had less nursing experience, whilst still others had achieved a higher level of nursing education. The young nurse managers with less nursing experience tended to have a higher level of nursing education. It may be suggested that nurse managers in this position have graduated from nursing programs which had leadership course content.

Further studies are recommended to provide comparative data on performance of those without management preparation but with a wide working experience and those with high levels of nursing education.

With the current turnover revealed in the study, it is recommended that each organisation collaborates with its employees, to clarify job roles and develop selection criteria to assist in identifying people who are likely to persist in challenging jobs. Personnel turnover is costly in terms of financial expenditure, impaired team functioning, and loss of management potential. Lowered morale due to personnel turnover causes understaffing, overburdening of remaining staff, and deterioration of patient care. It is therefore imperative that turnover in Malawi take a more positive way of retaining staff.

The association between the age of nurse managers and the need for participation in policy making and financial management would be an interesting area for investigation. Young nurse managers in this study have expressed need to broaden the scope of their management role especially in the area of financial management and policy making. It is envisaged therefore that the more young nurse manager there are the more nursing profession may gain its full autonomy over nursing services. To build on this study, the relationship between an individual nurse manager's practice and the desire for management training could be investigated.

The current study has also revealed that nurse managers with higher levels of nursing education not specific to management showed limited understanding of their management role with regard to policy making, developing nursing standards, appraising staff, and financial management. It is recommended that new graduates (albeit with higher educati ר) should be carefully oriented to their new position. It would also be recommended that academicians carry out follow up research to evaluate the performance of their graduates. The information obtained from such a study will assist in refining the management component of the program if necessary.

Participants in this study felt strongly that there was a direct relation between motivation and high standards of care. A randomised, controlled study to compare this relationship is therefore recommended.

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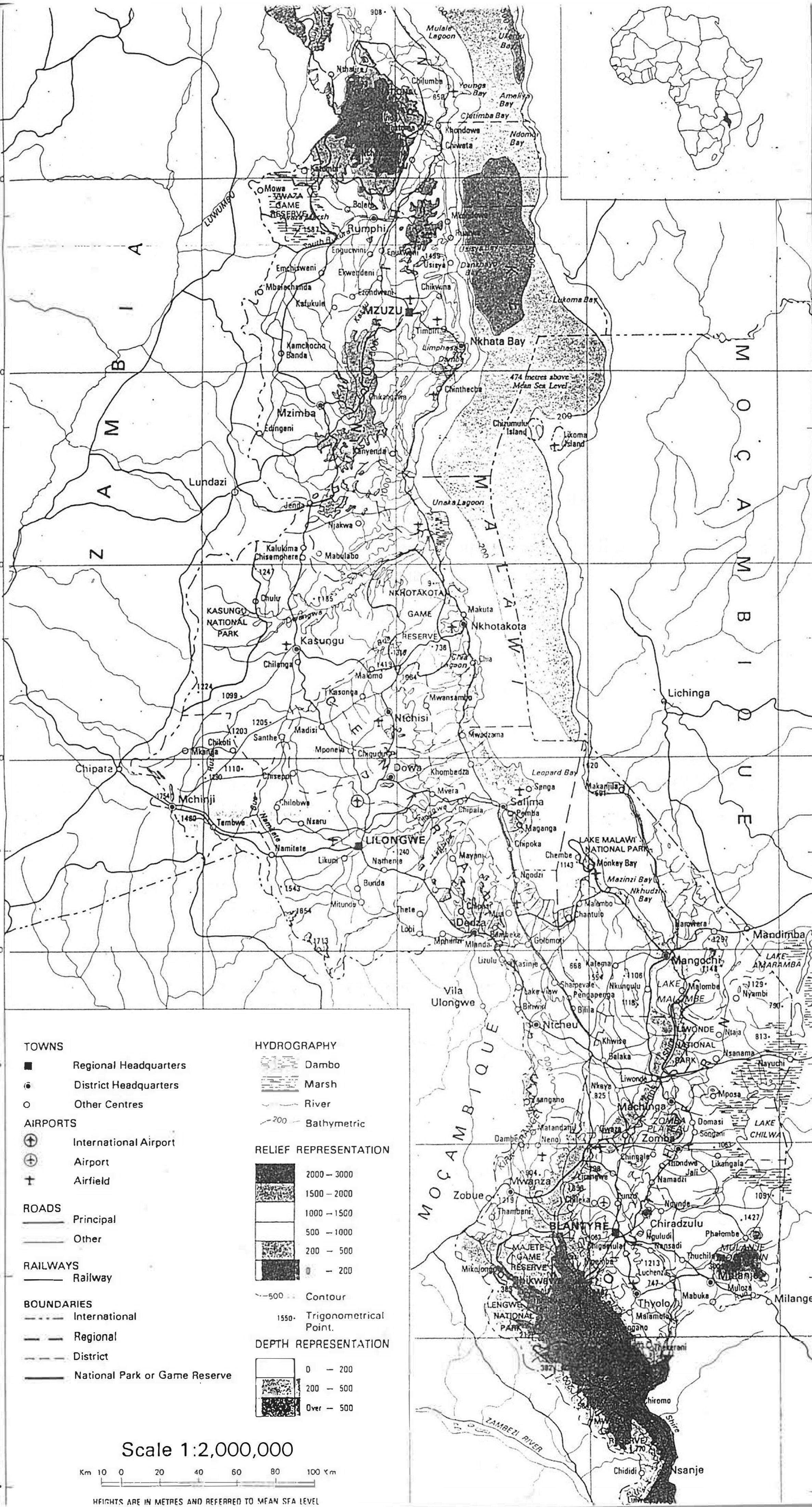


TOWNS
Regional Headquarters
District Headquarters
Other Centres
AIRPORTS
International Airport
Airport
Airfield
ROADS
Principal
Other
RAILWAYS
Railway
BOUNDARIES
International
Regional
District
National Park or Game Reserve
HYDROGRAPHY
Dambo
Marsh
River
Bathymetric
RELIEF REPRESENTATION
2000 – 3000
1500 – 2000
1000 – 1500
500 – 1000
200 – 500
0 – 200
Contour
Trigonometrical Point.
DEPTH REPRESENTATION
0 – 200
200 – 500
Over – 500
Scale 1:2,000,000
Km 10 0 20 40 60 80 100 Km
HEIGHTS ARE IN METRES AND REFERRED TO MEAN SEA LEVEL
ZAMBIA
MOÇAMBIQUE
LAKE MALAWI
474 metres above Mean Sea Level
MZUZU
LILONGWE
BLANTYRE
Rumphi
Nkhata Bay
Mzimba
Lundazi
Kasungu
KASUNGU NATIONAL PARK
NKHOTAKOTA GAME RESERVE
Nkhotakota
Ntchisi
Dowa
Salima
Mchinji
Chipata
Dedza
Ntcheu
Vila Ulongwe
Mangochi
LAKE MALOMBE
LIWONDE NATIONAL PARK
Machinga
Zomba
ZOMBA PLATEAU
LAKE CHILWA
Mwanza
Chiradzulu
Mulanje
Milange
Thyolo
Chikwawa
MAJETE GAME RESERVE
LENGWE NATIONAL PARK
Nsanje
Chiromo
ZAMBEZI RIVER
Lichinga
Mandimba
LAKE AMARAMBA
LAKE MALAWI NATIONAL PARK
Monkey Bay
Chizumulu Island
Likoma Island
Zobue
Unaka Lagoon
Leopard Bay
Lukoma Bay
11°
12°
13°
14°
15°
16°
17°
8800
8700
8600
8500
8400
8300
8200

APPENDIX B

Matron's Job Description

a. Title : Matron

b. Grade : CTO/PO

c. Responsible to : Chief Matron

d. Reports to : Chief Matron

e. Requirements :

i. Registered Nurse/
Registered Nurse/ Midwife

ii. Member of Nurses and Midwives Council of Malawi

iii. Member of National Association of Nurses in Malawi.

f. **JOB FUNCTIONS**

The Matron is responsible for Administration of nursing in a unit of the hospital. She is directly responsible for directing and supervision of nursing services in the unit.

Duties and Responsibilities

- Assures appropriate plans are made to meet the total nursing needs of patients utilising the nursing process.
- Maintains an environment which is conductive to the physical, spiritual and psychological well being of patient and staff.
- Co-ordinates the activities of nursing and non-nursing departments to ensure optimal care for the individual patient. Develops a staffing pattern which meets the needs of patients on a 24 hour basis.
- Allocates patient assignments in accordance with the individual needs of each patient and ability of the staff member.
- Implement policies and contributes to formulation and review of policies effecting nursing.

- Supervises all nursing activities related directly and indirectly to patient care.
- Gives direct nursing care to patients when required to meet patient's needs.
- Ensures that doctors prescriptions are carried out and accurate documentation is maintained o patient's chart.
- Ensures that all patients records are accurately maintained including patient progress and nursing activities.
- Provides ward conferences for the promotion of quality nursing care patient care.
- Establishes and maintains patient and guardian education for individual and groups.
- Provides necessary information to patients and families for continuity of care and/ or rehabilitation.
- Counsels and encourages self-evaluation and guides individual members of staff.
- Maintains regular periodic written evaluations of staff.
- Orientates new staff and maintains an ongoing orientation for all personnel in the unit.
- Recognises the individual's potential for growth and stimulates development of the individual.
- Reviewing of admission, nursing notes, observations and subsequent nursing procedures.
- Assists in determining budgetary needs for personnel, supplies equipment and physical facilities.
- Promotes optimum utilisation of personnel, supplies and equipment.
- Assists in planing for and contributes to the learning experience for all cadres of students.
- Ensures that inventories are carried out at regular intervals and accurate records maintained.

- Ensures that all accidents and incidents are accurately documented and promptly reported.

- Maintains an up-to-date personnel and policy manual procedure manual.

- Assures that signed standing orders are periodically reviewed and updated.

- Ascertains that staff concerns and problems are presented at ward sister meetings and information and decisions from ward sister meetings are reported back to staff.

- Participates as a member of such committee as delegated by the matron.

APPENDIX C

Senior Sister's Job description

a. **Title** : **Ward/Unit Nursing Sister**

b. **Grade** : **S. T. O.**

c. **Responsible to** : **Matron**

d. **Reports to** : **Unit Matron**

e. **Requirements** :

i. **Registered Nurse/ Registered Nurse/ Midwife**

ii. **Member of Nurses and Midwives Council of Malawi**

iii. **Member of National Association of Nurses in Malawi.**

f. **JOB SUMMARY:**
The Unit Sister is :-

1. **Responsible for Administration of Nursing Unit.**

2. **Directs and supervises the nursing services and management of allocated patient care unit. Plans and guides activities to provide maximum patient care.**

3. **Participates in the orientation and education programmes contributing towards the development of the nursing staff.**

4. **Maintains smooth functioning of services rendered by nursing personnel with those rendered by other personnel of other departments.**

5. **Supervises assignments and activities of professional and student nurses and assists in the evaluation of their performance.**

6. **Acts upwards and downwards in the nursing department as required.**

g. DUTIES

1. **PATIENT CARE**

- Assesses daily staffing needs in allocated Nursing Units and makes necessary changes

- Anticipates and attempts to prevent problems and where necessary investigates complaints. Follow up incident and report.

- Solves problems arising out of staffing, nursing care and administration with other members of the nursing staff.

- Makes detailed rounds of assigned units at least once each day.

- Aids in the maintenance of a suitable environment for patients with particular emphasis on safety factors.

- Gives direct nursing care to patients when required to meet patient's needs.

- Ensures that Doctors' prescriptions are carried out and accurate documentation is maintained on patient's chart.

- Ensures that all patients records are accurately maintained including patient progress and nursing activities.

- Assures appropriate plans are made to meet the total nursing needs of the patients utilising the nursing process.

- Ensures that patient assignments are in accordance with the individual needs of each patient and ability of the staff member.

- Reviews admission, nursing notes, observations and subsequent nursing procedures.

- Assures that signed standing orders are periodically reviewed and updated.

2. **UNIT MANAGEMENT**

- Arranges the day to day movement of staff within ward and departmental units and to record changes.

- Advises and guides ward sisters on duty rosters.

- Helps with personnel problems on units.

- Checks the day to day cleanliness of ward and departmental units in consultation with domestic supervisor.

- Interprets and enforces present policies, rules and regulations.

- Checks drug records and books and examines drug orders on each ward and unit once each month.

- Checks unit inventories every three months.

- Receives report from night duty nurses and reports to the unit matron.

- Ensures that staff and student nurses wear the uniform of the hospital and that staff are neat in appearance at all times.

- Acts upwards and downwards in the nursing department as required.

- Relieves in nursing office and participates with other Unit Nursing Sisters weekends and holidays coverage of nursing service.

- Informs ward sisters of new equipment, drugs and services.

- Controls trials and follow up of new equipment in ward units.

- Meets with ward sisters once each month to ensure good communications.

- Attends meetings as called and acts as a n ember of other committees as requested.

3. **EDUCATION:**

- Assists in planning and carrying out a programme oriantation of new staff members to the unit.

- Assists in planning and carrying out a staff in-service educational programme.

- Assists the ward sister in activities to co-ordinate the needs of nursing services and the educational needs of student nurses in the unit.

- Co-operates with nurse tutors in the organisation and supervision of the training programme for student nurses.

- Recognises the individuals potential for growth and stimulates development of the individual.

- Establishes and maintains patient and guardian education for individual and groups.

- Assists in planning for and contributes to the learning experience for all cadres of personnel

4. **EVALUATION**

- Obtains reports from ward sisters on registered staff members and reviews these with the ward sister when necessary

- Helps to evaluate registered staff and arranges requests for change to other units.

- Makes recommendations for staff promotions and post graduate courses.

5. **RESEARCH**

- Studies records of turnover rates, accidents, narcotic losses, incident slips and special studies as requested.

6. **EMERGENCY**

- Directs her staff in any capacity whatsoever in the event of any emergency situation in which may arise within the hospital, also in emergency situations such as minor or major disaster in which the hospital may be involved.

6. **HAZARDOUS CONDITIONS**

- To be alert and to encourage her staff to be alert to and report upon any situation which may constitute a hazard.

7. **SELF DEVELOPMENT**

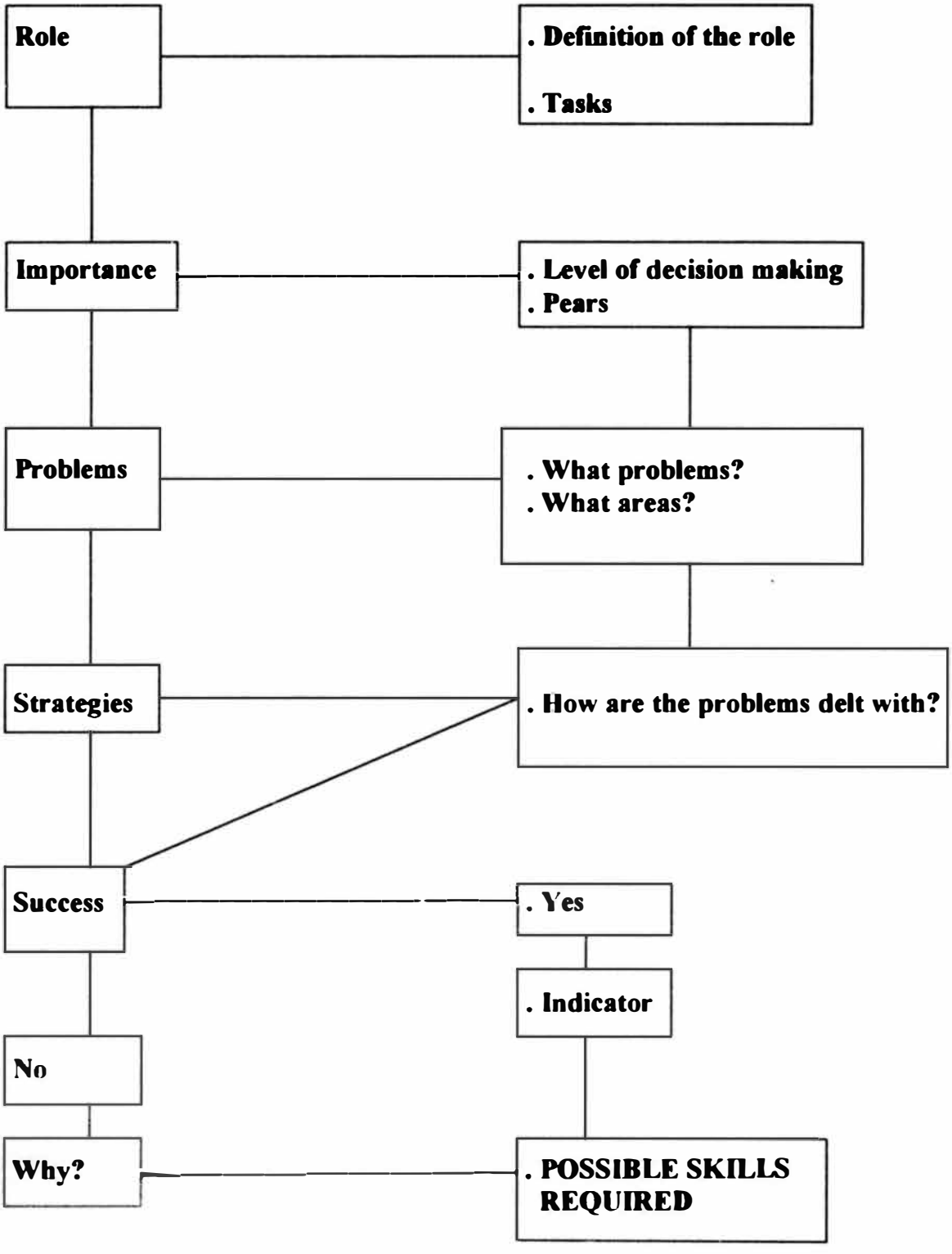
- To be aware of current development in nursing.

- To attend and participate in the following meetings:

  (a) Staff conference
  (b) In-service programme
  (c) Voluntary participation on committees as requested.

APPENDIX D

Table of Specification



APPENDIX E

Interview Schedule

Date: _____ Hospital Code No.:_____

Participant Code No _____

SEX: [ ] F [ ] M AGE:_____

LOCATION: [ ] District [ ] Central [ ] General [ ] Private

POSITION: [ ] Matron [ ] Senior Sister

Years of experience in current position:_____

Additional qualifications since initial registration:_____

Number of nurses under your control:_____

Number of non-nurses under your control:_____

To whom are you answerable?:_____

1. I am interested in the specific management tasks that you carry out in your area of responsibility in relation to the following:

A. (i) Are you involved in setting nursing standards?

If no _ Who sets the standards?

If yes _ How do you set standards?

(ii) How do you ensure standards are maintained?

(iii) What do you do if standards are not maintained?

B. (i) **What input do you have into the staffing of the unit/hospital?**

(ii) **How do you allocate staff to different tasks in your unit/hospital?**

(iii) **What is the usual length of the longest shift and shortest shift worked by bed side nurses?**

(iv) **What is the average number of hours worked by a nurse per week in reality?**

(v) **What other health workers do you work with?**

(vi) **How do you relate and communicate with other health care workers?**

(vii) **How do you maintain effective communication with**

-nurses

-other health workers

C. (i) Are you involved in developing nursing budget?

(ii) If yes: At what level and what input do you have in budgeting?

If no: Who draws the budget?

(iii) What role do you play in controlling costs?

D. (i) What input do you have in policy making in relation to your unit/hospital?

(ii) How do you facilitate the implementation of these policies?

(iii) What sort of meetings are you involved in at unit/hospital level?

(iv) Are you involved in interdesciplinary meetings?

2. Are there any problems you face in carrying out your work with regards to

(a) quality care?

(b) nurse motivation?

(c) involvement in policy making?

(d) financial management?

3. What management skills do you think you require to

(a) promote quality care?

(b) motivate nurses ?

(c) be involved in policy making?

(d) participate in financial management?

4. What is your perception of the matron's and senior sister's role with regards to

(a) quality care?

(b) nurse motivation?

(c) policy making?

(d) financial management?

5. **Do you have anything else you want to say?**

Thank you for your help.

APPENDIX F

Interview Questions and Related Concepts from the Conceptual Framework

Date: _____ Hospital Code No.:_____

Participant Code No.:_____

SEX: [ ] F [ ] M AGE:_____

LOCATION: [ ] District [ ] Central [ ] General [ ] Private

POSITION: [ ] Matron [ ] Senior Sister

Years of experience in current position:_____

Additional qualifications since initial registration:_____

Number of nurses under your control:_____ _____

Number of non-nurses under your control:_____

To whom are you answerable?:_____

1. I am interested in the specific management tasks that you carry out in your area of responsibility in relation to the following:

A. (i) Are you involved in setting nursing standards? ***(role)***

If no _ Who sets the standards? ***(role)***

If yes _ How do you set standards? ***(role and transaction)***

(ii) How do you ensure standards are maintained? ***(role and transaction)***

(iii) What do you do if standards are not maintained? ***(role and transaction)***

B. (i) What input do you have into the staffing of the unit/hospital? ***(role)***

(ii) How do you allocate staff to different tasks in your unit/hospital? ***(stress and transaction)***

(iii) What is the usual length of the longest shift and shortest shift worked by bed side nurses? ***(stress)***

(iv) What is the average number of hours worked by a nurse per week in reality? ***(stress)***

(v) What other health workers do you work with? ***(interaction)***

(vi) How do you relate and communicate with other health care workers? ***(communication)***

(vii) How do you maintain effective communication with

-nurses ***(communication)***

-other health workers ***(communication)***

C. (i) Are you involved in developing nursing budget? ***(role)***

(ii) If yes: At what level and what input do you have in budgeting? ***(interaction and transaction)***

If no: Who draws the budget? ***(role)***

(iii) What role do you play in controlling costs? ***(role and transaction)***

D (i) What input do you have in policy making in relation to your unit/hospital? ***(role)***

(ii) How do you facilitate the implementation of these policies? ***(role)***

(iii) What sort of meetings are you involved in at unit/hospital level? ***(communication and interaction)***

(iv) Are you involved in interdisciplinary meetings? ***(communication and interaction)***

2. Are there any problems you face in carrying out your work with regards to

(a) quality care? ***(role)***

(b) nurse motivation? ***(role)***

(c) involvement in policy making? ***(role)***

(d) financial management? ***(role)***

3. What management skills do you think you require to

(a) promote quality care? ***(perception, self, role time, growth and development)***

(b) motivate nurses ? ***(perception, self, time, role, growth and development)***

(c) be involved in policy making? ***(perception, self time, growth and development and role)***

(d) participate in financial management? ***(perception, self, time, growth and development and role)***

4. **What is your perception of your role with regards to**

   (a) quality care? ***(perception, growth and development and space)***

   (b) nurse motivation? ***(perception, growth and development and space)***

   (c) policy making? ***(perception, growth and development and space)***

   (d) financial management? ***(perception, growth and development and space)***

5. Do you have anything else you want to say?

Thank you for your help.

APPENDIX G
ASSIMILATION OF ITEMS AND VALIDITY CONSTRUCT

TASKS

Subdomain	Items generated	Usable items	Matching questions
Planning	:*Assessing and setting objectives*	.Identification of Problem/needs .Setting goals	**(1Ai)**
	:*Plan human, material andl physica resources*	.Requirements for provision of care	**(1Aii)**
	:*Formulation of policies*	.Input into organizational policies	**(1Di)**
		.Implementation of policies	**(1Dii)**
Organising	:*Coordination*	.Organising human and material resources .Liaison person among nurses, between nursing staff and other health workers	**(1Bv)**
	:*Interpersonal relationships*	.Transaction	**(1Bvi)**
	:*Delegation*	.Criteria used to delegate responsibilities	**(1Dii)**
Directing/ Leading	:*Supervision*	.Observing, teaching, coaching and/or working with	**(1Dii)**
	:*Motivation*	.Involving operational staff in unit plans and activities that affect them eg; schedules .Logical presentation of valuable information .Make employees feel self and their contribution worthwhile	**(1Dii)**

	:*Assertiveness*	.Decision making .Influence eg in meetings	(1Diii)
Controlling	:*Setingt standards* . *structure* . *process* . *outcome*	.Standards :type of nursing staff required to provide care :Nurse-patient ratio :Performance measurement tools eg checklist	(1Ai)
	:*Information management*	.Reports, records, and decision making	(1Aii)
	:*Evaluating work of employees and patient care*	.Performance appraisal, nursing conferences and auditing etc	(1Aii)
	:*Developing and controling budget*	. Budgeting .Level of involvement .Cost control measures eg; inventories	(1Ci) (1Cii) (1Ciii)
	:*Establishing corrective measures*	.Discipline, counsel, to ensure that staff is of high quality	(1Aiii)
Managing people	:A *master staffing plan based on the needs of the patients*	.Schedule staff working hours Staff requirements	(1Bi, iii, iv)
	:*Method of staffing that allows the unit mode of patient care delivery to be effectively implemented*	.Type of nursing staff required for patient care	(1Bii)
	:*Establishing the requirement for each position at operational level*	.Job descriptions	(1Bii)
	:*Assisingt in the development of each employee to meet job requirements*	On-going or continuing education	(1Dii)

Communication

:*Forms of communication*	.circulars charts, report books etc (1Bvi)
:*accessibility to information*	.Procedure manuals, ward schedules, special requests and personnel policies (1Bvi)
:*Effectiveness*	.Clarity and accuracy of means (1Bvii)_

PROBLEMS IN RELATION TO

Quality of care	:*Provision of quality care*	.Setting standards and planning care
	:*Audit*	.Method of auditing :Reporting techniques :Feedback
	:*Environment factors*	. Space, climate, noise level, lighting, location, institutional age, offices for managers and ancillary staff etc.
	:*Performance appraisal*	.developing and reviewing performance appraisal forms methods of measuring performance
	:*Maintaining quality*	.Discussions .Exchange of information and ideas .Research
	:*Expectations* .*provider of services* .*recipient of services*	.Protocol of performance .Expects quality care in a safe, caring and supportive environment (2A)

Nurse motivation	:*Time off*	.Policy offering additional time
	:*Organisational and personal factors*	.Human and material resources .workload .policies .autonomy **(2B)**
Policy making	:*Involvement* :*Assertiveness* :*Implementation*	.Level of involvement .Influencing decisions .Facilitation **(2C)**
Financial management	:*Budgeting*	.involvement in budgeting .Cost control measures Cost-effective care
	Financial resource allocation	.acquisition of technology and equipment

---

MANAGEMENT SKILLS

To promote quality care	:*Technical skills*	.area of expertise .monitor care .report writing .record keeping
	:*Human skills*	.motivate staff .direct employees .accountability
	:*Conceptual skills*	.coordination .collaboration .communication
	:*Diagnostic skills*	.assessment of organizational and personnel needs and problems

		.problem-solving
	:*coach and mentor skills*	.teaching/coaching .planning .creating a supportive and helping climate (3A)
Nurse motivation	:*Technical skills* .	.assessment of demotivating factors .productivity
	:*Human skills*	.staff needs
	:*Conceptual skills*	.group dynamics
	:*Diagnostic skills*	.resource allocation
	:*Coach and mentor* skills	.supportive relationships (3B)
Involvement in policy-making	:*Technical skills*	.developing and interpreting policies and.procedures
	:*Human skills*	.involvement of operational level staff in policy making
	:*Diagnostic skills*	.monitoring and review of policies
	:*Coach and mentor*	.helping operational level staff develop policies and procedures in accordance to organisational policies (3C)
Financial management	:*Technical skills*	.budgeting
	:*Conceptual skills*	.cost effective measures
	: *Diagnostic skills*	.accountability (inventory)
	Coach and mentor	.cost control (3D)

PERCEIVED MANAGERIAL ROLES WITH REGARD TO

Quality care	:*Interpersonal roles*	.Consultant and coordinating activities	
		.maintaining effective horizontal and vertical relationships	
		.planning logistics of nursing car	
	:*Decisional roles*	.analysis of working conditions	
		.procedures for handling supplies and equipment	
		.change agent	
		.quality assurance (control) activities	
	Informational roles	.dissemination of information	
		.continuing education	**(4A)**
Nurse motivation	:*Interpersonal roles*	.social interaction	
		.coordinating human and other activities	
		.hierarchical arrangements	
		.job descriptions	
	:*Informational roles*	.records	
		develop personnel policies and procedures	
		.communication system	
	:*Decisional roles*	.problem-solving	**(4B)**
Policy making	:*Interpersonal roles*	.communicate the policies	
		.regular meetings with staff	
	:*Decisional roles roles*	.formulating policies	
		.examining the organizational philosophy	
		.keep policies up to date	
	:*Informationa*	.utilise all media	
		.report writing	**(4C)**
Financial resource	:*Interpersonal roles*	.liaise with financial manager	
		.involve staff continuously	

:*Decisional roles*	.**Budgeting** .**setting goals** .**establishing cost controlling measures** .**allocating financial resources** .**involved in budgeting** .**cost control measures** .**cost effective care** .**workload**
:*Informational roles*	.**internal and external variances** .**investigate causes of variances** **(4D)**

APPENDIX H
Approval Letter from ECU

EDITH COWAN UNIVERSITY
PERTH WESTERN AUSTRALIA
CHURCHLANDS CAMPUS

Pearson Street, Churchlands
Western Australia 6018
Telephone (09) 383 8333
Facsimile (09) 387 7095

Committee for the Conduct of Ethical Research

Ms Maureen Chirwa
[redacted]

Dear Ms Chirwa

Re: **Ethics Approval**

Code: 95-62

Project Title: *Management Skills of Middle-level Nurse Managers in Malawi*

This project was considered by the Committee for the Conduct of Ethical Research at its meeting on 26 May 1995.

I am pleased to advise that your project has been cleared for implementation, subject to the proposal being approved by the Faculty Higher Degrees Committee.

Period of approval is from 1 July 1995 to 28 February 1996.

Yours sincerely

ROD CROTHERS
Executive Officer

31 May 1995

Please note: Researchers are required to submit an ethics report as an addendum to that which they submit to their Faculty Research Committee or to the Office of Research and Development.

cc: Supervisor, Ms K Ahern
Secretary, Higher Degrees Committee

APPENDIX I

A Letter seeking Approval

[redacted]

15th May, 1995

The Chairman,
Research Unit Technical Committee,
P.O. Box 30377,
Lilongwe 3.

Through: The Principal,
Kamuzu College of Nursing,
P/B 1,
Lilongwe.

Dear Sir,

APPROVAL TO CARRY OUT RESEARCH IN MALAWIAN HOSPITALS

I am undertaking research at Edith Cowan University (Australia), in the Faculty of Health and Human Sciences. In my research, I am investigating specific management tasks of middle nurse managers in Malawian hospitals, problems experienced in carrying out their work, and skills required to carry out their work more effectively.

I would like to apply for pemission to carry out this research in Malawian hospitals. I have enclosed a research proposal which has been submitted to the Edith Cowan University Higher Degree and Ethics Committees. Enclosed also is a copy of the letter from the sponsors of this course. Data collection is scheduled for July and early August. Your prompt response in this regard will very much be appreciated.

Yours faithfully,

Maureen Leah Chirwa (Nee Banda)

APPENDIX J

Letter Seeking Permission

Kamuzu College of Nursing,
P.O. Box 415,
Blantyre, Malawi.

28th June, 1995.

_____
_____
_____
_____

ATTENTION: The Chief Matron

Dear Sir/Madam,

CONDUCTING EDUCATIONAL RESEARCH

I am a postgraduate registered nurse student at Edith Cowan University (Australia) in the Faculty of Health and Human Sciences. As part of the programme, I will undertake research in which I am investigating specific management tasks of matrons and senior sisters in Malawian hospitals, the problems they experience in carrying out their work, therefore the management skills that they perceive that they require to carry out their work effectively.

The basis of the study is that the position of matrons and senior sisters form a very strategic part of the management in the delivery of health care and it is unique in that it provides the link between top management (policy makers) and direct care givers. Because of the importance and unique role they play, I would like to obtain information from them directly. In this connection, I would like to ask for permission to get access to matrons or senior sisters at your institution.

For the data collection, a guided interview will be used and is expected to last one hour. No names will be recorded and the information obtained will be kept strictly confidential. Information from the study will be valuable to nurse managers at different levels for it will provide an insight into the problems experienced by matrons and senior sisters. The information could be used in decision making on the type of

skills required for effective management and therefore training needs of matrons and/or senior sisters. A report will be available to all participating hospitals.

If you have any questions about the study, please contact me on this address and telephone numbers: Kamuzu College of Nursing, P.O. Box 415, Blantyre - 631644 (Office) or [redacted]

Yours sincerely,

Maureen Leah Chirwa (Mrs)

APPENDIX K

INFORMED CONSENT

RESEARCH TITLE: Management Skills of Middle-level Nurse Managers in Malawi

RESEARCHER: Maureen Leah Chirwa, RN, Cert. Mid, BA (Cur) Nursing

I am a postgraduate registered nurse student undertaking research at Edith Cowan University (Australia) in the Faculty of Health and Human Sciences. I would like to investigate the tasks carried out and problems experienced by matrons and senior sisters in carrying out their work. The researcher would also like to investigate management skills required by matrons and senior sisters to be more effective. Although the study will not benefit you directly, it will provide insight on the problems experienced and therefore skills required for effective management. The information could also be used by policy makers in decision making on training and support required by matrons and senior sisters for effective management.

The study and its procedures have been approved by the appropriate people and review committees of Edith Cowan University (Australia) and Health Research Committee (Malawi). The study involves no foreseeable risks or harm to you. The procedure involves answering some questions during an interview. Tape recording may be carried out. However, tape recorder may be turned off at anytime. Participating in this study will take approximately one hour. You are free to ask any questions about the study or about being a participant and you may call me at 631644 (O) or 644404 (H) if you have further questions.

Your participation in this study is voluntarily, and you are under no obligation to participate but your participation will be valuable and important. You have the right to withdraw at anytime without penalty.

Your identity will not be revealed while the study is being conducted or when the study is reported or published. All study data will be collected by the researcher, stored in the secure place, and shared only with a research supervisor.

I (the participant) have read the information above and any questions I have asked have been answered to my satisfaction. I agree to participate in this study, realising I may withdraw at any time.

I agree that the research data gathered for this study may be published provided I am not identifiable.

_____ _____

Participant Date

_____ _____

Researcher Date

APPENDIX L

Cut off Point for Validity

Table 2. Proportion of Experts (Above the Line) Whose Endorsement Is Required to Establish Content Validity Beyond the .05 Level of Significance

Number of Experts	Number of Experts Endorsing Item or Instrument as Content Valid								
	2	3	4	5	6	7	8	9	10
2	1.00								
3	.67	1.00							
4	.50	.75	1.00						
5	.40	.60	.80	1.00					
6	.33	.50	.67	.83	1.00				
7	.29	.43	.57	.71	.86	1.00			
8	.25	.38	.50	.63	.75	.88	1.00		
9	.22	.33	.44	.56	.67	.78	.89	1.00	
10	.20	.30	.40	.50	.60	.70	.80	.90	1.00

Note: The caution over using the standard error of the proportion when $n \leq 10$ (Downie & Heath, 1974) does not apply in this situation because only when $p > q$ is there significance, and any nonunique $p(\times)q$ solutions are irrelevant.

APPENDIX M

Explainatory Notes to Experts

To the evaluator,

VALIDATION OF AN INTERVIEW SCHEDULE

I am a postgraduate registered nurse student at Edith Cowan University, and I am carrying out research on Management Skills of Middle-level Nurse Managers in Malawi.

I would like to ask you to review the questions of the interview schedule to establish whether they can obtain the data required for the research. For this exercise the main questions and areas to be covered have been summarised in broad terms. A rating scale to be used has been provided. Please follow the instructions carefully. If in doubt, please contact me on [redacted] (for those in Australia) and 631644 (O) or [redacted] for those in Malawi.

For purposes of analysing the data you are kindly requested to write your names, qualifications and experience in the spaces provided at the front page. You are also asked to identify important areas not included in the instrument and to evaluate the items in terms of readability.

Thank you. Your help is appreciated.

Sincerely,

Maureen L. Chirwa.

Particulars of the evaluator

NAME OF REVIEWER : _____

PROFESSIONAL QUALIFICATIONS : _____

ADDITIONAL QUALIFICATIONS : _____

YEARS OF MANAGEMENT EXPERIENCE: _____

SIZE OF YOUR ORGANIZATION: _____

INSTRUCTIONS

1. **Please read the copy of the interview questions and specific areas to be covered under each question.**

2. **After reading the questions and information intended to be obtained, please rate the relevance of the questions to management by indicating the code number that best rates the question.**

3. **Write the codes against each question. The following is the key:**

    1 = very relevant and succint (brief and clear)
    2 = relevant but needs minor revision
    3 = not relevant to management in general
    4 = unable to asses relevance in the context it is used for

Please note: ***This is an interview schedule, participants will not be required to write their answers on the sheets. The interview schedule will only be used to guide the interview sessions. Bearing this in mind you are not required to actually complete the questions, you are only required to determine if the content of each question is relevant to management.***

VALIDATION OF AN INTERVIEW SCHEDULE

Section A

This section will cover tasks that nurse managers do or are supposed to do in carrying out their work. Questions intended to obtain relevant data will be written in bold followed by specific areas to be covered. Note that some of the tasks have been combined because the same questions could be used to obtain data under a different heading.

Rating

Planning and Controlling

The following are questions pertaining to planning and controlling

1A. (i) Are you involved in setting nursing standards? _____

If no _ Who sets the standards? _____

If yes _ How do you set standards? _____

(ii) How do you ensure standards are maintained? _____

(iii) What do you do if standards are not maintained? _____

1B. (i) Are you involved in developing the nursing budget? ___

(ii) If yes: At what level and what input do you have in budgeting? _____

If no: Who develops the budget? _____

(iii) What role do you play in controlling costs? _____

Specific areas to be covered on planning in the interview are:

(a) Assessing and setting goals and standards
(b) Planning human, material and physical resources
(c) Formulation of policies

Have you any important areas that have not been included under this heading? (Please specify) _____

_____

_____

_____

Other specific areas to be covered under controlling in the interview are:

(a) Setting standards
(b) Information management

(c) **Evaluating work of employees and patient care**
(d) **Developing and controlling budget**
(e) **Establishing corrective measures**

Have you any important areas that have not been included under this heading? (Please specify) _____

_____

_____

_____

Organising, Managing people and Communication:
The following are questions to be covered under organising, managing people and communication are:

1C. (i) What input do you have into the staffing of the unit/hospital? _____

(ii) How do you allocate staff to different tasks in your unit/hospital? _____

(iii) What is the usual length of the longest shift and shortest shift worked by bed side nurses? _____

(iv) What is the average number of hours worked by a nurse per week in reality? _____

(v) What other health workers do you work with? _____

(vi) How do you relate and communicate with other health workers? _____

(vii) How do you maintain effective communication with

-nurses _____

-other health workers _____

Specific areas to be covered on organising, managing people and communication in the interview are:

Organising

(a) Coordination
(b) Interpersonal relationships
(c) Delegation

Have you any important areas that have not been included under this heading? (Please specify). _____

Managing people

(a) A staffing plan based on the needs of the patients and staff requirements
(b) Method of staffing that allows the unit mode of patient care delivery to be effectively implemented
(c) Establishing the requirement for each position at operational level
(d) Assisting in the development of each employee to meet job requirements

Have you any important areas that have not been included under this heading? (Please specify) _____

Communication

(a) Forms of communication
(b) Accessibility to information
(c) Effectiveness

Have you any important areas that have not been included under this heading? (Please specify) _____

Directing/Leading:

The following are the questions pertaining to directing/leading:

(i) **What input do you have in policy making in relation to your unit/hospital?** _____

(ii) **How do you facilitate the implementation of these policies?** _____

(iii) **What sort of meetings are you involved in at unit/hospital level?** _____

(iv) **Are you involved in interdisciplinary meetings?** _____

Specific areas to be covered on directing/leading in the interview are

(a) **Supervision**
(b) **Motivation**
(c) **Assertiveness**

Have you any important areas that have not been included under this heading? (Please specify) _____

_____

_____

_____

Section B

This section will cover general problems nurse managers face in carrying out their work with regard to quality care, nurse motivation, involvement in policy making and financial management. Note only one question is asked to obtain data under these headings.

Question

Are there any problems you face in carrying out your work with regards to _____

Quality of care

Specific problems relate to

(a) Provision of and maintaining quality care
(b) Auditing
(c) Environment factors
(d) Performance appraisal
(e) Expectations

Have you any important areas that have not been included under this heading? (Please specify) _____

_____

_____

_____

Nurse motivation

(a) Time off
(b) Organisational and personal factors

Have you any important areas that have not been included under this heading? (Please specify) _____

_____

_____

_____

Policy making

(a) Involvement

(b) Assertiveness
(c) Implementation

Have you any important areas that have not been included under this heading? (Please specify) _____

_____

_____

_____

Financial management
(a) Budgeting
(b) Financial resource management

Have you any important areas that have not been included under this heading? (Please specify) _____

_____

_____

_____

Section C
This section will include management skills of nurse managers in regard to promotion of quality care, motivating nurses, involvement in policy care and financial management. Please note that only one question is asked to obtain data under these headings.

Question
What management skills do you think you require to _____

Promote quality care
(a) Area of expertise
(b) Motivate staff
(c) Coordination
(d) Collaboration
(d) Communication
(e) Assessment of organisational and personnel needs
(f) Problem-solving
(g) Teaching/coaching and planning
(h) Creating a supportive and helping climate

Have you any important areas that have not been included under this heading? (Please specify) _____

_____

_____

_____

Should any of these areas <u>not</u> be included under this heading? (Please specify)_

_____

_____

_____

Motivate nurses

(a) Assessment of demotivating factors
(b) Group dynamics
(c) Resource allocation
(d) Supportive relationships

Have you any important areas that have not been included under this heading? (Please specify) _____

_____

_____

_____

Should any of these areas <u>not</u> be included under this heading? (Please specify)_

_____

_____

_____

Be involved in policy-making

(a) Developing and interpreting policies and procedures
(b) Involvement of operational level staff in policy making
(c) Helping operational level staff develop policies and procedures in accordance to organisation
(d) Monitoring and review of policies

Have you any important areas that have not been included under this heading? (Please specify) _____

_____

_____

_____

Should any of these areas <u>not</u> be included under this heading? (Please specify)_

_____

_____

_____

Financial management

(a) Budgeting
(b) Establishing cost effective measures
(c) Accountability

Have you any important areas that have not been included under this heading? (Please specify) _____

_____

_____

_____

Should any of these areas <u>not</u> be included under this heading? (Please specify)_

_____

_____

_____

<u>Section D</u>

This section will cover perceived managerial roles of nurse managers with regard to quality care, nurse motivation, policy making and financial management. <u>Also note</u> that only one question is asked to obtain data under these headings.

Question

What is your perception of your role with regards to _____

Quality care

(a) Consultant and coordinating activities
(b) Maintaining effective horizontal and vertical relationships
(c) Planning logistics of nursing care
(d) Analysis of working conditions
(e) Establishing quality assurance (control) measures
(f) Dissemination of information
(g) Continuing education

Have you any important areas that have not been included under this heading? (Please specify) _____

_____

_____

_____

Should any of these areas <u>not</u> be included under this heading? (Please specify)_

_____

_____

_____

Nurse motivation

(a) Social interaction
(b) Coordinating human and other activities
(c) Developing clear job descriptions
(d) Develop personnel policies and procedures

(e) Communication system
(f) Problem-solving

Have you any important areas that have not been included under this heading? (Please specify) _____

_____

_____

_____

Should any of these areas <u>not</u> be included under this heading? (Please specify)_

_____

_____

_____

Policy making

(a) Formulating and communicating policies
(b) Reviewing the organisational philosophy
(c) Report writing

Have you any important areas that have not been included under this heading? (Please specify) _____

_____

_____

_____

Should any of these areas <u>not</u> be included under this heading? (Please specify)_____

_____

_____

_____

Financial resource

(a) Liaise with financial manager
(b) Budgeting
(c) Establishing cost controlling measures

Have you any important areas that have not been included under this heading? (Please specify) _____

_____

_____

_____

Should any of these areas <u>not</u> be included under this heading? (Please specify)_

_____

Thank you for your help

APPENDIX N

Results from the Experts

CONTENT VALIDITY													
NO. OF EXPERTS			9										
					RATINGS						RATING	PROP	Valid/not
Question					Expert						1 OR 2		Valid
	1	2	3	4	5	6	7	8	9				
1	2	1	1	2	1	1	1	1	2		9	1	valid
2	2	1	1	1	1	1	1	1	1		9	1	valid
3	1	1	1	1	1	1	1	1	1		9	1	valid
4	2	1	2	1	1	1	1	1	1		9	1	valid
5	2	1	1	1	1	1	1	1	1		9	1	valid
6	1	1	1	1	2	1	2	1	1		9	1	valid
7	1	1	1	1	1	1	1	1	1		9	1	valid
8	1	1	1	1	1	1	1	1	1		9	1	valid
9	1	1	3	1	4	1	1	1	1		7	0.78	valid
10	1	2	4	2	4	1	1	1	1		7	0.78	valid
11	2	3	1	1	1	1	1	2	1		8	0.89	valid
12	1	4	3	1	1	1	1	2	1		7	1	valid
13	1	1	1	1	1	1	1	1	1		9	1	valid
14	1	1	2	1	1	1	1	1	1		9	1	valid
15	1	1	1	1	1	1	1	1	1		9	1	valid
16	1	1	1	1	1	1	1	1	1		9	1	valid
17	1	1	1	1	2	1	1	1	2		9	1	valid
18	1	1	1	2	2	1	1	1	1		9	1	valid
19	1	1	1	2	1	1	1	2	1		9	1	valid
20	1	1	2	1	1	1	1	1	1		9	1	valid
21	1	1	1	1	1	1	1	1	1		9	1	valid
23	1	1	1	1	1	1	1	1	1		9	1	valid
24	1	1	1	1	1	1	1	1	1		9	1	valid
25	1	1	4	2	1	1	1	2	1		8	0.89	valid
26	1	1	4	2	1	1	1	1	1		8	0.89	valid
27	1	1	1	1	1	1	1	1	1		9	1	valid
28	1	1	2	1	1	1	1	1	1		9	1	valid
29	1	1	1	1	1	1	1	1	1		9	1	valid
30	1	1	1	1	1	1	1	1	1		9	1	valid
NO. ITEMS RATED BY EXPERT	30	30	30	30	30	30	30	30	30				
TOTAL ITEMS RATED										270			
NO. OF ITEMS RATED 1 OR 2										261			
PROPORTION RATED 1 OR 2										0.967			
INSTRUMENT RATING (CUT OFF POINT	0.78)									VALID			

APPENDIX O

Rearranged Interview Questions on the Interview Schedule

Date: _____ Hospital Code No.:_____

Participant Code No.:_____

SEX: [ ] F [ ] M AGE:_____

LOCATION: [ ] District [ ] Central [ ] General [ ] Private

POSITION: [ ] Matron [ ] Senior Sister

Years of experience in current position:_____

Additional qualifications since initial registration:_____

Number of nurses under your control:_____

Number of non-nurses under your control:_____

To whom are you answerable?:_____

I am interested in the specific management tasks that you carry out in your area of responsibility in relation to the following:

1. Are you involved in setting nursing standards? _____

   If no Who sets the standards? _____

   _____

   If yes How do you set standards? _____

   _____

   _____

2. How do you ensure standards are maintained? _____

3. What do you do if standards are not maintained? _____

4. Are there any problems you face in carrying out your work with regards to quality care? _____

5. What management skills do you think you require to promote quality care?

6. **What is your perception of the matron's and senior sister's role with regards to quality care?** _____

_____

_____

7. **What input do you have into the staffing of the unit/hospital?**

_____

_____

_____

8. **How do you allocate staff to different tasks in your unit/hospital?** _____

_____

_____

_____

9. **What is the usual length of the longest shift and shortest shift worked by bed side nurses?** _____

_____

_____

_____

10. **What is the average number of hours worked by a nurse per week in reality?**

_____

_____

_____

What other health workers do you work with? _____

_____

_____

12 **How do you relate and communicate with other health care workers?**

_____

_____

_____

How do you maintain effective communication with

-nurses _____

_____

_____

-other health workers _____

_____

14. **Are there any problems you face in carrying out your work with regard to motivate nurses ?** _____

15. **What managemet skills do you think tou require to motivate nurses?**

16. **What is your perception of the matron's and senior sister's role with regard to nurse motivation?** _____

Are you involved in developing nursing budget? _____

18. **If yes: At what level and what input do you have in budgeting?** ___

If no: Who draws the budget? _____

21. **What management skills do you think you require to participate in financial management?** _____

_____

_____

_____

22. What is your peception of the matron's and senior sister's role with regard to financial management? _____

_____

_____

_____

23. What input do you have in policy making in relation to your unit/hospital?

_____

_____

_____

24. How do you facilitate the implementation of these policies? _____

_____

_____

_____

25. **What sort of meetings are you involved in at unit/hospital level?** ___

_____

_____

_____

26. Are you involved in interdesciplinary meetings? _____

_____

_____

_____

27. are there any problems you face in carrying out your work with regard to involvement in policy making? _____

_____

_____

_____

28. hat management skills do you thing you require to be involved in policy making? _____

_____

_____

_____

29. What is your perception of the matron's and senior sister's role with regard to policy making? _____

30. **Do you have anything else you want to say?**

Thank you for your help.