UNIVERSITY OF GHANA

MANAGEMENT PRACTICES OF NURSE MANAGERS IN THE GREATER ACCRA REGION, GHANA

BY

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DECLARATION

I certify that this thesis has not already been submitted for any degree and is not being submitted as part of candidature for any other degree. I also certify that the thesis has been written by me and that any help that I have received in preparing this thesis; and all sources used, have been duly acknowledged in this thesis.

…… ……..

Adelaide Maria Ansah Ofei Date

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CERTIFICATION

We hereby certify that this thesis was supervised in accordance with the procedures laid down by the University.

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DEDICATION

This work is dedicated to the memory of my dear late husband, Dr. Kwadwo Ansah Ofei, my children, Selma, Yaw Titi, Kwadwo Ansah and Kwaku Quartey for their immense support and encouragement. It is also dedicated to my mother, Madam Faustina Haizel Commeh and my sisters, Mrs. Mary Magdalene Abude and Ms. Ewurafua Dadson whose tireless and enormous efforts gave me the courage to complete this work.

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ABBREVIATIONS/ACRONYMS

AACN	American Association of Critical-Care Nurses
ANA	American Nurses Association
ART	Anti-Retroviral Therapy
CPD	Continuous Professional Development
ENs	Enrolled Nurses
ENT	Ear, Nose and Throat unit
GHS	Ghana Health Service
IOM	Institute of Medicine
IT	Information Technology
ICT	Information Communication Technology
LDP	Leadership Development Programme
LEKMA	Ledzokuku Krowor Municipal Assembly
MSc	Master of Science
MSH	Management Science for Health
MPhil	Master of Philosophy
NGOs	Non-Governmental Organizations
NMC	Nursing and Midwifery Council
NMs	Nurse Managers
QRN	Qualified Registered Nurse
OPD	Out Patient Department
ORT	Oral Rehydration Therapy
PML	Princes Marie Louis
RCH	Reproductive and Child Health
RGN	Registered General Nurse
RNs	Registered Nurses

SD	Standard Deviation
UK	United Kingdom
VCT	Voluntary Counseling Therapy
WACP	West African College of Psychiatrists

ABSTRACT

Nurses have a major role in providing high-quality care to patients. The nurse manager has 24-hour responsibility and accountability and is 'pivotal' to the delivery of effective, efficient and quality health care. However, many of the nurse managers play their roles without adequate formal preparation and have to battle with shortage of resources, especially staff as well as challenges from other health professionals in an effort to manage the unit. The study examined the perceived and preferred management practices of nurse managers at the unit level. Quantitative data was collected from 552 nurses who were randomly selected from district and regional hospitals of Ghana Health Service and the Accra Psychiatric hospital all in the Greater Accra region. There was generally weak satisfaction of the practice of management and significant difference between perceived and preferred management practices. Nurses would prefer adequate formal preparation to the position of a nurse manager to ensure assertiveness, proactiveness, confidence, commitment and competence. Even though all the nurse manager variables played significant roles in predicting nurse managers' practice of management, experience as nurse has the most significant effect. The practice of management does not depend just on knowledge and skills in management and leadership but also experience. It is hoped that nurses would be given the requisite formal preparation before ascending to this challenging position considering the demands of the unit. The position of the nurse manager should also be competitive based on established performance contract.

CHAPTER ONE

1.0 INTRODUCTION

1.1 Background of the Study

Health care systems are confronted with the formidable task of improving and guaranteeing the health and well-being of people. Recognizing that resources are never adequate, a rethinking and restructuring of priorities is inexorable at all levels. As nursing staff is the largest and most costly resource in health care facilities, many organizations spend much of their time and energy trying to maximize the productivity of nurses. Inevitably, these organizations are drawn to the role of the nurse manager in the unit, who is the pivot on which staff engagement, productivity, quality outcomes and positive experiences rest (Shirey, Ebright & McDaniel, 2008; Cathcart, Greenspan & Quin, 2010; DeCampli, Kirby & Baldwin, 2010; Espinoza, Lopez-Saldana & Stonestreet, 2009; Hawkins, Carter & Nugent, 2009; Wendler, Olson-Sitki & Prater, 2009). The delivery of highest quality and safest nursing care begins with retaining experienced nurses (Shirey, McDaniel, Ebright, Fisher & Doebbeling, 2010) and nurse managers are widely accepted as the most influential force in patient and staff satisfaction due to their role in work environments (Shirey *et al*., 2008; Hawkins, Carter & Nugent, 2009).

Responsibilities once performed by nurse executives have now been integrated into the nurse manager's scope of practice. Indeed, within clinical units, the nurse manager is unswerving present, providing service even during their “off days”. Thus, the nurse manager has 24-hour responsibility and accountability and is ‘pivotal’ to the delivery of effective and efficient quality health care. Additionally, nurse managers are uniquely positioned with a front-row view of the intricacies of nurse-patient, nurse-physician and nurse-interdisciplinary team dynamics. They are

expected to oversee the daily demands of the unit's operations while developing an environment that fosters nursing excellence and promotion of an engaged nursing staff (Espinoza *et al.*, 2009). Nurse managers are also the vital link between senior executives and nurses as they interpret the mission and vision of the hospital into reality. Retention of staff is incumbent on the manager and nurse managers who feel supported by their organizations reciprocate this support with their staff (Anthony, Standing & Glick, 2005). Balancing these dynamics and nurturing a healthy work environment requires a rare blend of talent, knowledge, and skills as well as empowerment by management.

Given the challenges of today's healthcare environment, taking on the ever-expanding role of the nurse manager is an enigma. Besides, in a system where demand frequently outstrips financial and human resources, hospital and quality performance are widely scrutinized and patient outcomes are considered a direct reflection of a nurse manager's effectiveness in fulfilling the role. Again, given the impact of the nurse manager on retention, satisfaction, productivity and outcomes, hospitals are astute to seek ways to better appreciate this critical role and nurture a work climate that develops, engages and empowers nurse managers (Espinoza *et al,*. 2009; Smokler & Malecha, 2011). Furthermore, the complexity of the nurse manager's role coupled with the sheer number and variety of responsibilities raises the question of whether the nurse manager's role is configured unrealistically (Shirey *et al*., 2008). Research has characterized the nurse manager role as frustrating, overwhelming, and demanding (Wendler *et al.*, 2009). Being a successful leader of clinical staff requires mastery of the skills of management embedded in the nurse manager's practice and is more complex than the application of management theories to actual situations (Benner, Tanner & Chesla, 2009). Thus, if organizations hope to withstand a growing nursing shortage, they must be committed to understanding the role, reconfiguring it for

success and finding ways to support, protect, and rejuvenate leaders who are responsible for managing their most precious resources.

The role of the nurse manager is now widely recognized as one of the most overburdened roles in health care (Anthony *et al*., 2005; Health Care Advisory Board, 2000; Porter-O'Grady, 2003). Not having adequate time to complete work, being torn in multiple directions, excessive team meetings and numerous daily interruptions increase the stress and complexity of a nurse manager's job (Shirey *et al*., 2010). Organizational red tape, interpersonal conflict, especially with support staff, in acquisition of resources for the unit, changing regulatory requirements, multiple simultaneous hospital initiatives and system inefficiencies are also factors that increase job stress (Shirey *et al*., 2010). Being an experienced sensor, or someone who is able to perceive developing issues, requires the nurse manager to spend an adequate amount of time on the unit in order to nip problems in the bud (Shirey *et al*., 2008). These efforts emphasize the complex role of the nurse manager and the need to develop the knowledge, skills and attitudes essential for effectiveness and efficiency. In this way strong leaders for middle management (Chase, 2010) are developed to confidently execute the role of the nurse manager successfully.

This notwithstanding, not much is being done for the Ghanaian nurse manager (Asamani, Kwafo & Ansah Ofei, 2013). Many nurse managers assume this complex role with little or no knowledge or skills in management, thus defying the confidence necessary for the position. The nurse manager has to manage the unit based on his or her technical knowledge and on-the-job experience of management from senior colleagues (DeCampli *et al.*, 2010; Marrelli, 2004). The lack of competence in management coupled with the low educational level of some nurse managers in Ghana make them more vulnerable to their other health professionals at the unit level who have higher academic degrees. Many nurse managers are patronised upon by these

other health professionals; who intimidate them by their presence. The management of the unit, therefore, is by the dictates of these health professionals who also by their training are handicapped in the scientific knowledge and skills of management. The nurse manager, thus, moves along with little recognition even among his or her own colleagues. Furthermore, whereas there are so many evidence-based nursing practice, little empirical research has been done to establish the management practice of nurse managers. What has been written is anecdotal (Everson-Bates, 1992; Jaco, Price & Davidson, 1994) and based on small, limited scale studies.

Management is the purposeful harmonious manipulation of organizational resources and the environment to achieve organizational goals. While all health care teams depend upon a range of supportive enabling services, nursing is dependent on its own enabling machinery to ensure that it functions effectively (Lemin, 1979). Nursing management is human and patient-centred with the nursing process as its framework to influence patient care through professionals delivering the expected care. Therefore, strong leadership and critical thinking are essential to the surviving and thriving of the nurse manager role. Nurse managers must possess administrative confidence, appropriate educational preparation, skills to manage business deals, broad clinical expertise and a thorough understanding of management principles. Management at the unit level then is important for any health care facility as this is the operational arena and platform for the actualization of goals and efficiency. How then can the nurse manager manage the challenges of the unit effectively and efficiently with their apprenticeship capability?

1.1.1 The Evolution and Changing Role of Nurses and Nurse Managers in Ghana

Management practice of nurse managers in Ghana cannot be articulated without reference to history. The historical perspectives of nursing in Ghana play a key role in the attitudes of nurses, particularly nurse managers. The perception and intimidation of other health professionals to the nursing profession stem from the humble beginnings of nursing in Ghana. The practice and management of nursing in Ghana is an enigma that can be extrapolated from its history.

Prior to the inception of the nursing profession in Ghana, the care of the sick was the prerogative of the elderly female members of the community. The advent of colonialism and Christianity brought along western principles of health care and in 1878 the first two European nurses arrived in the Gold Coast to care for the European officials. More nurses arrived by 1899 onwards to establish a permanent nursing service. The nurses obeyed the call to duty like the military and they were willing to sacrifice their lives if required (Holden, 1991).

The European nurses worked in the hospitals, assisted the medical officers and trained local workers to assist them. The training of indigenes started with boys as caring for strangers was perceived as unacceptable for girls in those days (Sumani, 2005). The profession then was considered strange since their main duties revolved around cleaning of chronic wounds, rinsing of blood stained bed sheets and bathing of patients (total patient care). People from good homes were also not encouraged to enroll as nursing was not yet perceived as a bread weaning activity and generally, had a low socio-economic status. Again, working in these new institutions, where white doctors practised an unknown healing system appeared unattractive.

With the expansion of the health team, the training of nurses began with the majority of the nurses being men. Recruitment of candidates constituted a formidable challenge and no native of intelligence would like to be a nurse as the pay was low, and conditions of service were generally poor (Owusu, 1995). The nursing sisters gave simple instructions to all, but formal education to those who could read and write; lessons were given in human anatomy and physiology, surgical and medical nursing and first aid techniques. This took place in hospitals in Accra (Korle-Bu), Cape-Coast, Sekondi and Kumasi and students were assessed on the ward. The successful ones were awarded the Director of Medical Services Certificate and were appointed Second Division Nurses in the Civil Service with opportunity to rise to the First Division.

The first midwifery school was established at the maternity block of the Korle-Bu teaching Hospital in 1928. Many girls who had some form of secondary education opted for the midwifery programme which was considered more feminine and acceptable as a profession. The quest for western health care, coupled with the alarming rate of maternal and infant mortalities, as well as high morbidity of both Africans and Europeans due to life threatening diseases, led to an increase in the demand for nurses. This led to the accelerated training of higher caliber of nurses comparable to the standard of the British trained nurses in the mid-1940s (Addae, 1996). Formal nursing training, thus, commenced in 1945 with the establishment of the first State Registered Nurses' School in the country. Candidates for the course were selected from secondary school graduates. But with limited number of girls with secondary education, middle schools leavers with good grades were considered to spend a year in a pre-nursing school prior to the commencement of the programme.

The content and criteria for the training were regulated in the Nurse Ordinance which was established and maintained by the Nurses Board in 1946. Students after completion of the State Registered Nurse programme could register with the Nursing Council of England and Wales; they were recognized as nurses in the UK. After graduation, the nurses continued with post-basic training in midwifery for eighteen months. According to Owusu (1995), the first group started work in 1950 and it was the first time native nurses wore the same uniforms as their British colleagues. Discipline was rigid during training and this enabled the students to cultivate social values as well as have adequate time for studies (Akiwumi, 1995).

Another programme of lower standard was started at the same time to satisfy the numerical demand for nursing personnel (Qualified Registered Nurse (QRN)); candidates were from the middle schools only and did not go through the pre-nursing school. Though the course outline was similar to the SRN programme, coverage was more superficial with omission of some courses. Whereas the SRN training demanded trained tutors to give instruction, the QRN training could use any qualified SRN to teach the pupils. The training of QRNs could be attached to a hospital with only 50 beds whilst an SRN school must only be attached to a hospital with good clinical facilities which would give the students all the requisite clinical experiences of the programme (Regional hospitals and Teaching hospitals).

By independence in 1957, a total of 211SRNs and more than 100 QRNs have been trained and attached to the various health care facilities in the country (Otoo, 1968). Dynamic changes and developments in nursing characterized the first few years of independence in Ghana. Many Ghanaian nurses were given post-basic training in midwifery and public health in order to replace the departing British sisters occupying the various hierarchies in nursing. A ten-year

development plan on Health for Ghana was developed in 1961 to review the educational system and make suggestions towards the improvements of the profession. The training of auxiliary nurses (Community Health Nurses) to support the public health nurses and the inclusion of obstetric care in nursing education to allow nurses to deal with obstetric emergencies and to independently work in remote areas were all acknowledged. The training of the QRNs stopped in 1968 and in 1970 a new nursing training course "comprehensive nursing care" was initiated and other nursing schools were opened; Sekondi, Cape-Coast, Tamale, Koforidua and Agogo.

The termination of QRN training led to increased workload and a gap in the supply of nurses, thus in 1973, the Enrolled Nurses (ENs) training was started. The training was shorter and less detailed and the objective was to meet the needs of the wards until sufficient trained nurses were available, thus, the programme seized in the 1980s.

A major milestone in nursing education reforms in Ghana was the establishment of the Nursing Department of University of Ghana in 1963 to offer continuous education to nurses as well as tutorship and administrative programmes to nurses. It was the first University programme in tropical Africa to prepare tutors for Schools of Nursing and to provide leadership for advancement of all aspects of nursing (Chittick, 1965). Since 1980, students have been able to pursue Bachelor Degree programmes in both Arts and Sciences at the Nursing department. Now all the public universities as well as some private universities offer nursing degree programmes. The University of Ghana, School of Nursing since 2000/2001 academic year started training nurses in post graduate studies (MSc and MPhil). Currently, it is the only institution offering graduate studies in nursing in Ghana.

During the first three decades after independence, the hierarchy within the profession was strictly adhered to, with the Principal Matron being the head of Nursing Services in the country. The name has since been changed to Director of Nurses and Midwives and all the regions are being administered by Chief Nursing Officers. The day-to-day management of the ward was primarily the responsibility of the ward sisters (nurse managers) most of whom have just the basic nursing and post basic nursing certificates. Until the year 2000 when the certificate State Registered Nursing (Basic Nursing) programme was changed to a Diploma awarding programme, management was not a taught course in basic Nursing programmes. They maintained a high level of discipline; with regular check ups to ensure cleanliness and conducive environment for patient care. Uniforms of nurses were checked regularly for neatness and cleanliness and junior colleagues had great respect for these ward in-charges as they acted as role models and mentors in coaching these young nurses.

The working reality of nurses mirrors the general development and situation of Ghana. Political unrest which led to various military regimes from the mid- 60s up to the early 1990s, affected the socio-economic development of the country as well as the health sector. For instance, during Ft. Lt. Jerry John Rawlings' regime in the 1980s, working facilities decreased dramatically; due to reduction in the government budget allocation to health (Twumasi, 2005). Many health workers, especially nurses and doctors, left the country to the developed world. This endeavour aggravated the already dwindling numbers of health personnel in health care organizations. During that period and up to the turn of the millennium, nurses were generally respected for their sacrificial service in caring for patients. Nurses were solely responsible in meeting the needs of patients, such as feeding, bathing, bed making, medication, etc.; patients' relatives were not allowed to assist or carry out any of these activities whilst the patient was on admission.

Regrettably, the situation is different today. Nurses have allowed patients' relatives and other professionals within the health care fraternity to take over their core duties as professional nurses. There is an undeniable fact that there is shortage of nurses as well as increased workload due to the large nurse-patient ratio. Usually, one or two nurses are observed taking care of large numbers of patients (40) in the morning shifts; whereas in the afternoons and nights, mostly a nurse takes care of the whole unit. According to Basavanthappa (2009), the nurse-patient ratio must be 1:17, in the morning, 1: 25 in the afternoon and 1:33 in the night since workloads are reduced during those times. Nonetheless, the situation has remained same since the inception of nursing from the colonial era. Thus even though the early nurses did maintain the integrity and core values of the profession, it is a challenge now. The pride and confidence of the nursing profession has waned; many nurses find it difficult to wear their uniforms outside the hospital environs. Nurse managers are in a position to redeem this dire situation given the right support and empowerment to effectively and efficiently manage the units since it is the operational level of all healthcare facilities; the interphase between management and patients.

1.1.2 Historical Perspectives of Nurse Manager Role Development

Traditionally, the "head nurse" or the "in-charge" was uniquely positioned to supervise the intricacies of nurse-patient, nurse-physician and nurse-interdisciplinary team dynamics. Her proficiency was judged by the quality of her relationships with physicians and nurses, and her clinical acumen and the organizational know-how she used to support the work at the unit level (Rankin & Campbell, 2006). The best head nurse, typically, is the one who is able to take the message of the nursing administration to the staff in the unit and work through those principles even against the needs of staff. This situation still persists and junior colleagues simply abhor this practice and perceive nurse managers to be unassertive enough to exert their own thoughts and that of their staff.

Camey (2006)acknowledged that skills used by modern nurse managers were being utilized by their predecessors long before terms such as management, leadership, empowerment, change management, decision making and quality improvement entered the lexicon of modern management theory. Even in the absence of formal recognition of the role in the 19th century, matrons in management and leadership of the nursing workforce utilized these management skills without any formal training or education or recognition from peers or hospital managers. The matrons inadvertently have successfully passed down those skills to successive generations of nurse managers. This is due to the fact that most of the matrons are mothers managing their homes and find the unit an extension of their homes, and women generally learn these skills through socialization both at home and in school while at the same time learn how to be subservient to their male counterparts.

Nurse managers are professional registered nurses with years of experience of nursing as well as the philosophy and the values of the health care organization. The nurse manager is to intervene on emergency situations and be able to bring resolutions to calm or remedy the situation. She would normally learn to manage the unit by working as a junior nurse until progressive promotions to the grade of a senior nursing officer which would then qualify her to become the nurse manager. Managerial experience has been associated with fluid work styles, less overtime (Dunn & Schilder, 1993) and more effective coping (Shirey *et al*., 2010) by managers. It was not until a decade ago that management was introduced as a taught course in the training of nurses at both the certificate and diploma levels in Ghana. Becoming a nurse manager, therefore, was through apprenticeship or succession planning that was not formally acknowledged.

The healthcare re-engineering efforts of the 1990s significantly expanded the scope of the nurse manager's responsibility (Shirey *et al*., 2008) and many different titles emerged for the nurse manager role, implying a sense of uncertainty about how to structure the work of the front-line nursing leader (Rankin & Campbell 2006). In Ghana, the role of the nurse manager has been illuminated by the job description of the Ghana Health Service (GHS) since 2006 and this was part of the health reforms of the 1990s. After the enactment of the GHS and the Teaching Hospitals Act in 1996, the Service needed to outline jobs for its professionals and that of the nurse manager was also evolved. This is the only literature in Ghana that clearly outlines the roles and responsibilities of the nurse manager and clearly depicts the expanded role.

Nurse managers are the vital link between senior management and clinical nurses as providers of care. They influence organizational culture and outcomes for patients and staff to ensure job satisfaction and ultimately, staff retention (Lee & Cummings, 2008). Nurse managers are also responsible for managing conflicts created by changes external to the organisation, and for managing intra-organizational and interpersonal conflicts. In so doing, they control or influence the total climate of a patient care unit (Al-Hamdan, Shrikri & Anthony, 2011).

What is clear, however, is that the nurse manager now, according to the GHS job description, has enormous responsibilities; provision of leadership, provision of therapeutic environment for patient care, provision of supervision and mentorship for staff, provision of safety and security for both staff and patients and the management of the unit as a whole. Nurse managers ensure availability of the right skill mix for the delivery of nursing care during every shift, advocate the rights of patients and promote confidentiality of information concerning patients and carry out other delegated assignment by the Department manager.

Indeed, the job description of the GHS has a tall list of responsibilities for the nurse manager. This list is quite challenging to sustain without any form of formal preparation. There is, therefore, the need to ensure that nurses are prepared and capable of delivering the complex and dynamic responsibilities demanded of the nurse manager. The constant demand involved in executing this broad scope of responsibility takes its toll on nurse managers. For instance, Shirey *et al*. (2008) revealed that, despite the nurse managers' claim that they love their work, they also reported significant work-life imbalance including having mostly bad days at work with little support in the workplace, experiencing sleep disturbances and demonstrating signs of emotional and physical exhaustion. It is, therefore, essential for nurse managers to be adequately supported and empowered to enable them endure the challenges and better manage them.

1.1.3 The Role of the Nurse Manager

Nurse managers play a key role at the unit level to ensure that the vision, mission and goals of the organization are translated for their attainment through team work. These front-line administrators of nursing units may be assigned titles such as ward manager, unit in-charge or "Maa" by many junior colleagues. Surakka (2008) in her description of the underlying premises of nurse managers' work realised that the descriptions fit nowhere. Many nurse managers reported isolation and guilt imposed upon them by both staff and superiors and as one nurse manager wrote: the ''office of thanks'' is more rarely open than the ''office of blame" and that the nurse manager was an "emotional dumping ground" for others (Surakka, 2008). The purpose of the nurse manager's job is to take a lead role in the assessment, planning, implementation and evaluation of nursing care at the unit level in accordance with required standards. Nurse managers ensure efficient management of human and material resources for nursing service delivery in the unit (Ghana Health Service, 2006).

The nurse manager is to establish and maintain effective communication with staff, patients and visitors, whilst discussing management of condition with patient and relatives as part of ongoing education of patients and families. The nurse manager is also to organize and attend unit meetings as required and liaise appropriately with the department manager or health facility management to ensure that an open and effective communication is maintained. Again, the nurse manager is to ensure involvement of staff in relevant discussions or developments that are responsible to the demands placed on the unit and to effectively work in teams with staff and other health workers (Ghana Health Service, 2006).

The nurse manager also performs personal and people development role by developing and maintaining continuing personal and professional development to meet the changing demands in the area of nursing care. He or she should monitor his or her own performance against agreed objectives and ensure the appraisal of staff performance at the unit level. The nurse manager takes a lead role in the identification of training needs for staff and coordinates education and development for the nursing staff at the unit level. This may include providing input into in-service and staff development programmes, orientation and induction of all new staff at the unit level. Again, the nurse manager takes a lead role in the clinical supervision of the nursing staff and students, ensures Continuing Professional Development (CPD) of the staff and keeps log of own performance and in-service training log for purposes of appraisal for staff at the unit level (Ghana Health Service, 2006).

The management roles of the nurse manager include responsibility for effective day-to-day management, ensuring regular availability of supplies and other logistics, coordinating and supervising roster planning, monitoring and documenting all leave for the nursing staff, planning

and budgeting for nursing care activities, preparing and submitting regular reports on nursing activities, ensuring complete and accurate documentation on nursing care activities, promoting a positive image and devising improved job methods for increasing efficiency all at the unit level (Ghana Health Service, 2006).

The nurse manager must participate in clinical audit, take care of own safety and ensure the safety of other staff and that of patients at the unit level. She ensures that GHS and Facility safety policies, arrangements, assessments, etc. are disseminated to all nursing staff and also ensures adherence to the health and safety policies, guidelines or protocols in the department. Additionally, the nurse manager ensures that accidents or incidents or ill health, failings in equipment, etc. are reported and recorded, whilst assisting in ensuring planned preventive maintenance of plant and equipment at the unit level (Ghana Health Service, 2006).

Nurse managers participate in the development of quality assurance systems for monitoring quality and for investigating incidents and complaints at the unit level. He or she ensures that nurses in the unit comply with quality assurance guidelines and participate in the monitoring and evaluation of nursing practice in the facility. They are consistent with current quality developments relevant to area of work and related services as well as ensure dissemination to staff. They identify and investigate poor quality promptly, identifying contributing factors and agreeing on methods for addressing them. Additionally, nurse managers must be actively involved in clinical supervision and peer review (Ghana Health Service, 2006).

The post holder must at all times work in accordance with the GHS/NMC Code of Professional Conduct and Disciplinary Procedure, strictly adhere to the provisions of the Patient's Charter

and participate in National Health Programmes. The skills and abilities required of nurse managers are good writing and verbal communication skills, supervisory skills, demonstrated ability to work on own initiatives, excellent problem solving skills and computer skills. The nurse manager needs to be self-motivated or needs to have the ability to motivate others whilst possessing a flexible attitude and commitment to the needs of the organization (Ghana Health Service, 2006).

1.2 Statement of the Problem

Much has been written about the importance of implementing care based on evidence-based practices, but the importance of using evidence-based practices for managing the delivery of care has not received the same attention. Research has characterized the frontline nurse manager role as frustrating, overwhelming and demanding (Wendler *et al*., 2009). Nurse managers are plagued with human resource issues, such as management of change, coping with increasing spans of control, supervision of personnel, staff development and most often step in as frontline nurses when their units are short of staff (Richmond, Book, Hicks, Pimpinella & Jenner, 2009). However, new managers are often promoted from within direct care nurse ranks, given limited or no formal training and then expected to work effectively and efficiently (DeCampli *et al*., 2010; Marrelli, 2004). Although these new managers may bring key skills such as communication, planning, prioritization and documentation to the role, they often lack skills in managing and leading, which require formal education and training (Richmond *et al*., 2009). Given the importance of nurse managers in creating a healthy work environment for all staff, it is imperative to understand their role, appreciate the challenges they encounter and create more realistic support and empowerment.

Ghana has for many decades implemented a lot of interventions to strengthen it's health system but the focus has always been at the management level. For instance in 2008, the leadership Development Programme (LDP) initiated by the Management Sciences for Health (MSH) aimed at building senior managers' leadership capacities at national, regional and district levels within the GHS was initiated. The LDP has since been scaled up to all the regions with support from some international NGOs. None of these interventions focused on operational managers or supervisors such as the nurse manager whose contributions are crucial to the strengthening of health systems. Nurses constitute about 70 percent of the workforce of health facilities, wield a lot of power and use of most of the scarce resources (GHS, 2006), yet their management and practice have always been neglected. Not much attention has been given to the development and empowerment of nurse managers (Asamani *et al*., 2013; Duffield, Roche, Blay & Stasa, 2010; Asigri, 2009; Colongi, 2009; Cohen, Stuenkel & Nguyen, 2009, Paliadelis, 2008; Bondas, 2006; McGuire & Kennerly, 2006) who constitute the fulcrum of health care facilities. Many of the nurse managers get into the position through apprenticeship.

Managing the complexities of a clinical unit requires the nurse manager to have a broad range of skills and capabilities (Asamani *et al*., 2013; Duffield *et al*., 2010; Asigri, 2009; Cohen *et al*., 2009; Colongi, 2009; Paliadelis, 2008; Bondas, 2006; McGuire & Kennerly 2006) to enable confidence and competence in managing the unit to reduce turnover (Duffield *et al*., 2010). The humble beginnings of Nursing in Ghana as observed from the above narratives continue to plague the assertiveness of nurse managers. Many nurse managers are intimidated by other health professionals due to their comparatively higher educational background and fluency in the Queen's English, thus though nurse managers are supposed to manage the units, in many instances these other health professionals take over the management of the units. Nurse

managers are seen adhering to the dictates and instructions of these colleagues (Basavanthappa, 2009).

Nursing patients in the unit requires the creation of a therapeutic environment that ensures both patient and staff satisfaction. The creation of positive work environment and hospital culture (Upenieks, 2003) is, however, fostered by strong nurse leaders (Cohen *et al*., 2009; Colongi, 2009; McGuire & Kennerly, 2006) particularly nurse managers. The management role of the nurse manager encompasses both clinical and managerial functions (Paliadelis, 2008). Nursing education, however, prepares nurses to be good clinicians, but not to be good managers, which is why the transition from nurse to manager must be managed well to eschew role conflicts (Duffield, 1991). Human and leadership skills, besides effective communication are of great importance for staff involvement and motivation (Oroviogoicoehea, 1996). Wilmot (1998) acknowledged that if the process for changing the nurse manager's role is characterized by inadequate support and preparation along with a lack of clarity, the consequence will be inability to develop this demanding but nevertheless exciting role.

Furthermore, pay and working conditions of nurses continue to be wretched (Asigri, 2009; Talley, 2006) especially at the unit level due to dwindling resources and outmoded equipment. The situation has been further compounded by the numerous private Universities in Ghana, especially in Accra, offering admission to nurses for graduate programmes. Many newly qualified nurses, especially the registered nurses (diploma), embarked upon graduate programmes without approved study leaves; hence, combining education with official duties. Artificial shortage of nurses is being experienced in many units. Whereas on the duty roster many nurses must report for duty; a nurse or a health aide reports for duty. Yet again, the issue

of inadequate trained nurses is severely compromised by the losses due to pregnancy, nursing mothers and resignations, as many nurses are females. How then do nurse managers manage the unit with fewer trained nurses?

In a lot of units in Ghana now, one or two nurses normally would come on duty with the nurse manager even though the number of patients on admission exceeds forty (40). This defies the nurse manager's ability to organize nursing functions using some of the prescribed models of nursing care. Nursing care is rendered on demand or based on what the limited number of nurses can offer during their shift and this is what is damaging the public image of nursing; some patients' demands are met by relatives.

Few decades ago, professional nursing in Ghana was, generally, comparable to that of larger county-type hospitals in the United States. Nurses were very conscientious, dedicated and sympathetic; nurses showed keen interest in their patients, treated patients humanely and strived to make patients' stay in the hospital pleasant (Thomas, 1961). Nurses demonstrated great familiarity with patients' clinical course and treatment, and cooperated fully with the physician (Thomas, 1961) in helping to restore the individual to a productive life or peaceful death (Henderson, 1978). The question is; Can you say same about Ghanaian nurses today? The assumption here is that the degree of effectiveness and efficiency of the unit shall depend not only on nurse manager's knowledge and skills of management but also their competencies and influence of professionalism.

Current management practices advocate staff involvement in decision making (Basavanthappa, 2009) for effective commitment; however, Azaare and Gross (2011) reported the employment of

intimidation and minimal consultation by nurse managers in controlling their staff in Ghana. Nurse managers are expected to create a positive environment for clinical work, take on expanded roles and responsibilities with adequate training, education, resources or support (Wright, Rowitz & Merkle, 2000; Mathena, 2002). Regrettably, the continuing ill preparedness for this role continues to be documented (Asamani *et al*., 2013; Douglas, 2008; Bondas, 2006) and Ghana cannot be exempted. How then do nurse managers effectively handle their responsibilities?

Empirical documentation on the roles of nurse managers to establish conclusive evidence that isolates sound evidence-based nursing management practice as a result of training in management is absent. The only literature found that examined roles of nurse managers used Katz's (1955) conceptual framework which examined the broad competencies (Chase, 2010) of nurse managers. There is also paucity of literature in the knowledge and practice of formal planning of nurse managers (Asamani *et al*., 2013; Jasper & Crossan, 2012) as most literature focuses on care planning rather than resource planning among nurse managers. A solid understanding of critical management and leadership skills serves as the basis for developing strategies for building expert leadership and management skills, and attention should be directed at how to better mentor nurses for leadership roles and succession planning. This study, therefore seeks to examine the management practice of nurse managers at the unit level.

1.3 Purpose of the Study

The purpose of this study is to examine how nurse managers manage the nursing units and the implications for patient and staff satisfaction. It is hoped that the results of this study shall help

nurse managers to effectively play their challenging roles as linchpins in the health care delivery system effectively and efficiently.

1.4 Research Questions

The questions developed for the study were:

(1) How do nurse managers plan nursing activities at the unit level?

(2) How do nurse managers organise the unit for work?

(3) How do nurse managers coordinate activities with staff and other health care professionals?

(4) How do nurse managers control the unit to ensure achievement of goals?

1.5 Objectives of the Study

The general and specific objectives developed for the study are the following:

1.5.1 General Objective

The general objective of the study is to examine the application of the basic principles of management at the unit level by nurse managers.

1.5.2 Specific Objectives

The specific objectives of the study are to:

1. Examine how nurse managers plan for nursing activities at the unit level.

2. Investigate how nurse managers organise nursing activities at the unit level.
3. Find out how nurse managers coordinate with staff and other health care professionals at the unit level particularly the medical officers; and
4. Examine how nurse managers control their units.

1.6 Hypotheses of the Study

Hypothesis was tested to establish causal relationships between the independent variables (training in management, experience as a nurse, experience as a nurse manager and qualification of nurse manager) and dependent variables (individual nurse manager activities created for planning, organizing, coordinating and control). The hypothesis developed for the study is outlined below.

H_0: Training in management, qualification of nurse manager, experience as a nurse, and experience as a nurse manager have no significant effect on the nurse managers' management practice.

H_1: Training in management, qualification of nurse manager, experience as a nurse and experience as a nurse manager have significant effect on the nurse managers' management practice.

1.7 Significance of the Study

This study provides the opportunity to vividly examine management practices of nurse managers in the Greater Accra region and its implications for development of nurse managers for effective and efficient delivery of quality nursing care. A consideration of the nature of management and nursing management provides insights which can help practitioners' transition from nurse to

manager. The study would also develop new theoretical knowledge in the study of nursing management. As argued earlier, management studies are mostly confined to the business world, competitive environments and factors that influence efficiency and effectiveness. Nursing management has seldom been the focus of such studies. This study would therefore contribute tremendously to knowledge in nursing management, especially in Ghana and other developing countries.

Winch, Creed and Chaboyer (2002) as well as Walker (2003) asserted that sound practice based on sound research-based evidence are undisputedly needed given the complexity of today's health care environments. The findings of this research would therefore provide sound research-based evidence that would guarantee sound evidence-based management practice that would equip the nurse manager with knowledge, skills and attitudes to foster a culture of collaborative decision making and positive patient and staff outcomes.

1.8 Operational Definition of Variables

Table 1.1 outlines the conceptual and operational definition of research variables developed for the study. The operational definition tries to give a brief contextual description of variables developed to examine the management practices of nurse managers at the unit level.

Table 1:1 Operational Definition of Variables

Variable Name	Conceptual Definition	Operational Definition	Measure
Planning	The formalization of what is intended to happen at some time in the future; concerns actions taken prior to an event, typically formulating goals and objectives and then arranging for resources to be provided in order to achieve the desired outcomes.	The nurse manager and staff collectively select goals, objectives and future courses for the unit and decide how to achieve the desired outcomes. It also encompasses gathering and analyzing information in order to make these decisions. It also includes evaluation of previous plan/activities at the unit level.	Questionnaire to elicit perceived and preferred planning of the unit.
Organising	Determining activities and allocating responsibilities for the achievements of plans; coordinating activities and responsibilities into appropriate structure.	The nurse manager and staff of the unit determine which activities are needed to reach goals and objectives, and decide who to perform what task, and then allocate responsibilities for the achievement of plans as well as coordinating activities and responsibilities into an appropriate structure for the achievement of goals.	Questionnaire to elicit perceived and preferred organization for the unit.
Coordinating	Involves the synchronization of activities toward established goals.	Nurse manager ensures the synchronization of activities toward the achievement of objectives of the unit. Basically the nurse manager establishes a process of linking activities within and without the unit by effective communication of information and documentation.	Questionnaire to elicit perceived and preferred coordination at the unit level.
Controlling	Ensuring plans are properly executed; assuring the health care organization functions as planned.	The nurse manager ensures that plans are properly executed and takes corrective action if needed at the unit level.	Questionnaire to elicit perceived and preferred control of the unit.
Age	The chronological period of time (in years) that a human being has lived.	20-29 years, 30-39 years, 40-49 years, 50-59 years, and 60 years or older.	Questionnaire
Gender	The sex of the participants in the study.	Male or Female	Questionnaire
Marital status	Current married situation of the participant	Married, single, widowed, divorced, and other (specify)	Questionnaire
Length of service as a nurse or midwife	The chronological period of time (in years) that a nurse manager practice as either a nurse or midwife.	Less than one year, 1-5 years, 6-10 years, 11-15 years, 16-20years, and don't know.	Questionnaire
Length of services of your nurse manager	The chronological period of time (in years) that a nurse manager has held the nurse manager position they currently held.	0-5 years, 6-10 years, 11-15 years, 16-20 years, above 20 years, and don't know.	Questionnaire
Rank	The current designation of the participant in the health care organization.	Staff nurse/midwife, senior staff nurse /midwife, nursing or midwifery officer, senior nursing or midwifery officer, principal nursing or midwifery officer.	Questionnaire

Variable	Conceptual Definition	Operational Definition	Measure
Basic qualification	The fundamental formal nursing education of participant.	Certificate, diploma and first degree.	Questionnaire
Qualification of your nurse manager	Highest formal education of the nurse manager after the basic nursing programme.	Post-basic programme, first degree, masters, and other.	Questionnaire
Training in management of the nurse manager	Formal training in management that the nurse manager has received to prepare him for the position of nurse manager.	Yes or No.	Questionnaire
Duration staff has worked with the nurse manager.	The chronological period of time (in years) that the participant has worked with the nurse manager.	Less than 1 year, 1-2 years, 3-4 years, 5-6 years, 7-8 years, 9-10 years, and more than 10 years.	Questionnaire
Type of unit.	The unit of the health care organization the participant works in.	Emergency, maternity, surgical, medical, theatre/recovery, OPD, specialized, and other.	Questionnaire.
Workload of the unit	The workload in the unit of the participant.	Very heavy always, heavy always, heavy sometimes and not heavy.	Questionnaire`
Nurse manager	A registered nurse who manages one or more defined areas within nursing services (ANA, 2009). An individual who has a line management position for designated patient care services which includes delivery of patient care, fiscal and quality outcomes.	A nurse leader that is given the responsibility for the quality of nursing care given to a number of patients in a defined area of the hospital (unit). This person has mentoring, safety, performance, development and maintenance responsibility for nursing staff. Staff nurses report to him/her. He/she is the in-charge and is responsible for the management of the unit by planning, organising, coordinating, and controlling to bring about efficiency and effectiveness as well as patient and staff satisfaction.	Questionnaire
Nurse	A caregiver, who has graduated from a state-approved nursing programme, passed the nursing and midwifery council examination for nurses and has been granted a license by the council to practice nursing in the country. The nurse thus, advocates for patient's rights, promotes health, educates patients and families, and strives to eliminate pain and suffering.	A professional or technical nurse, who has graduated with a degree, diploma or certificate form an approved nursing program, passed the NMC examination for professional and auxiliary nurses and has been granted a license by the NMC to practice professional or auxiliary nursing in Ghana. The nurse therefore, advocates for patient's rights, promotes health, educates patients and families, and strives to eliminate pain and suffering. He/she develop a plan of care, working collaboratively with physicians, the patient, the patient's family and other health care team members that focuses on promotion of health, and managing illness, to improve quality of life.	Questionnaire.

Source: Questionnaire for Survey, 2013

1.9 The Structure and Organization of the Study

The study is presented with the following outline:

Chapter one gives the background to the study. It also outlines the purpose of the study, the problem statement and the objectives of the study. Chapter two examines the conceptual framework, theoretical basis of the study and literature supporting the study. This is to gain an idea on the theories of management, specifically systems theory and the classical theory that form the basis for this study. Literature was reviewed on the concept of management, the principles and functions of management, and nursing management at the unit level. Chapter three examines the research methods for the study. The study design is exploratory descriptive approach using quantitative methods to describe management practice of nurse managers at the unit level. The outcome of the study is presented in Chapter four and Chapter five focuses on the discussion of the outcome of the study. Chapter six sets out the summary, conclusions and recommendations of the research.

CHAPTER TWO

2.0 LITERATURE REVIEW

Introduction

The nurse manager's role and how it is implemented in healthcare organizations have always been a critical issue for quality health care over the past two decades. This area persistently intrigues researchers as it serves as a pivotal influence impacting patient care and staff outcomes as well as the success of the organization. This role encompasses multiple responsibilities, which include the management of clinical practice, human and supply resources, finances and regulatory compliance standards, along with supportive supervision and development of personnel. To accomplish this, nurse managers need to continually build personal skills in clinical and management competencies.

This chapter reviews literature on the concept and practice of management. It also provides a conceptual understanding of management practice at the unit level and related issues to the core functions of planning, organizing, coordinating and control. Firstly, the review explores the concept of management and the principles of management which form the basis for the practice of management. Secondly, the review critically assesses the practice of management by the nurse manager in relation to the four core functions of management and its related issues at the unit level. Finally, previous studies on managerial practices at the unit level are also reviewed in relation to efficiency and effectiveness.

2.1 Concept of Management

In studying the management practices of nurse managers at the unit level, this study oriented itself to the concept of management. With its multi-disciplinary approach management is

considered as one of those bodies of theory and practice whose concern might be described as 'rational intervention in human affairs'. This intervention according to Hannagan (2000) requires a steady interaction between theory and practice in a process of inquiry. Managing staff in the units by nurse managers can therefore be facilitated by constant interventions and reinforcement with knowledge in management as the thought of management has been marked by constant change (Hannagan, 2000). Peters (1987) described management as being systematized and professionalized with a variety of theories. The classical school of management theory is based on Adam Smith's idea of "rational man": the idea that people tend to choose a course of action that maximizes their personal gain. In managing the unit, nurse managers create structure, implement processes for nursing and facilitate positive outcomes (Anthony, Standing, Glick, Duffy & Dumpe, 2005). Taylor and Fayol believed that the control of human behaviour could be obtained by putting a logical structure into place (Hannagan, 2000). The logical structure would ensure equitable and fair distribution of duties among staff.

In studying management practices, management theorists have concerned themselves with the individual organization members, groups and power relations in the organization. Management practice at the unit demands professionalism to ensure patient safety and quality of care. This demands that staff be scientifically selected, scientifically educated and developed, as well as intimate and friendly co-operation between management and labour (Hannagan, 2000). The importance of this study could be best understood from the conceptualization of management practice in classical management theory, where structure and principles are necessitated for the practice of management. Managing the unit cannot be possible without processes, procedures, rules and regulations. The nurse manager must be highly perceptive of the environment to be able to perceive challenges early enough to nib them in the bud. According to Fayol, scientific

forecasting and proper methods of management, ensures satisfactory results and argued that management is a skill which managers can learn (Koontz *et al*, 1984).

Fairness and equity in the management of staff at the unit level are so essential that their absence create dissatisfaction among staff and inefficiencies in patient care. The classical management theorists primarily advocated matching people with tasks to maximize efficiency, identifying principles that would lead to the creation of the most efficient system of organization and management. Weber's theory essentially looked at the depersonalization and promotion of uniformity which advocates fair and equal treatment of all workers (Hannagan, 2000). At the hierarchical level of authority in the unit are nurse managers, who supervise and influence the behavior of staff to ensure efficiency and effectiveness. Incidentally, many nurse managers manage the units using personal sentiments such as favouritism and nepotism. A common practice among nurse managers is the use of "Maa" which signifies close relation in our cultural setting. Depersonalization of management practices therefore must be enhanced at the unit level for harmony to prevail among staff.

From the conceptualization of management given above, the importance of cooperation between management and labour is essential. The degree of cooperation is dependent on non-financial inducements, such as informal organization which aids communication, as well as meeting individuals' needs and maintaining cohesiveness (Tomey, 1988, 193-194). Work at the unit level must be collaborative; therefore, the nurse manager should have personal interest in people, responding to their needs and that of the patients to enhance positive workplace climate. The nurse manager should trust and respect colleagues to bring about a cohesive team.

Nurse managers should acknowledge management as a process of bringing together all staff for the purpose of achieving organizational goals. Strategies must be developed in order to achieve this objective. Follet declared that management is a social process which aims at motivating individuals and groups to work towards a common goal, and contends that managers should never give orders to employees, but should analyze the situations together; taking cues from the situation (Koontz *et al.*, 1984). The practice of management is therefore unique and nurse managers should endeavour to acknowledge the efforts of staff to create value in their minds. This would ensure that staff respond to the responsibilities of the unit without much persuasion but rather with pride and possession.

The qualities or values of the nurse manager are important to the practice of management and its outcome in the unit and beyond. According to Fayol industrial activities can be conceptualized into six groups: technical, commercial, financial, security, accounting and managerial. He argued that the five were well known and devoted his attention to the sixth group (managerial) which always posed a challenge to the manager. Management was defined in terms of five functions, namely planning, organising, commanding, coordinating and controlling (Koontz *et al*., 1984). The study of management practice at the unit level will be conducted in relation to the sixth group (managerial) and other contextual variables. The functions of planning, organizing, coordinating and control will be used as the dependable variables of the study. Research has highlighted a number of crucial contextual variables which appear to influence the management practice of managers (Koontz, *et al*., 1984). These contextual variables include the experience, the educational, the physical, the mental, the moral, and the technical qualities of the manager (Koontz *et al*., 1984). The study is based on the paradigm of relationship between the managerial process (dependent) and values of the manager (independent) and its outcome.

The systems theory provides the framework for the study of management practice in the unit, as the practice affects and is affected by the different needs of the various functional management areas as well as their various requirements in the whole organization. The systems theory is based on the premise that organizations have similar characteristics like other living organisms and views the organization as a complex whole made up of subsystems with a common objective. As a system, the unit functions by acquiring various inputs from its external environment, transforming them as outputs into the environment. All elements must receive sufficient and appropriate inputs in order to provide sufficient outputs. In order to attain cost-effectiveness and survive, the system must be open both internally and externally and interact with its environment by changing its structure and internal processes. The subsystems are interdependent and a change in one part affects the others. In resolving challenges within the unit, nurse managers must view the unit as a dynamic whole and attempt to anticipate both the intended and unintended effects of their actions on other parts of the health care facility. This requires a high degree of communication and the breakdown of barriers between the various departments and functions of the unit.

The nature of management practice at the unit level contends that managers do not just act out the classical managerial functions – planning, organising, coordinating and controlling but have interpersonal roles, informational roles and decision roles (Koontz *et al*., 1984), and their activities include reflection and action (Robbins & Coulter, 2007). Managerial roles are quite complex and demands ample preparation in order to be effective and efficient. Managers are thus encouraged to recognize the ability of the people they manage and to push decision making as near as possible to the point of action. Ouchi (1981) emphasized collective decision making and group responsibilities, on quality control based on periodic meetings and on lifetime commitment to an organization. Organizational goals could be achieved by participatory

decision making, so that responsibility becomes a collaborative function of the product of the team process.

Hannagan (2000) observed that if management can be seen as a synthesis of ideas culminating in choices made intuitively, then it can be described as an art. Modern management is essentially about managing people and processes in a rapidly changing environment. Decisions may be based on "hunch" or intuition, where experience becomes essential, and can be due to the organizational culture. Nursing practice and management is based mostly on intuition and nurses have to practice for adequate amount of time to acquire those "hunches". Nurse managers are immensely endowed due to their 24-hour-responsibility of the units (Shirey *et al*., 2008). Culture is an important factor in the art of management, because for any organization to operate effectively it must, to some extent, have a generally accepted set of beliefs and assumptions. This collective experience is influenced by the social, economic and political context of the organization. The art of management is characterized as reflection in action.

Surveying the development of management thoughts, there has been a trend from individualism to collective management, and from a focus on efficiency to a greater regard for well-being of personnel but elements from each era maintain their validity and can be used by nurse managers. There is, however, no clear notion of scientific underpinnings of managing or who or what competent managers are? The varying approaches, each with its own semantics and a fierce pride to protect the concepts and principles from attack or change, make the theory and science of management difficult for practitioners to understand and utilize.

2.1.1 Principles of Management

Management is not an activity that exists in its own right but a description of a variety of activities carried out by those members of organizations whose role is that of a "manager". The principles of management which form the basis of this study have been best described by the classical management theorists, especially Henri Fayol, Frederick Taylor and Max Weber. This section will look at the principles put forward by these theorists.

Henri Fayol identified fourteen principles of management which are not absolutes but capable of adaptation according to need. These principles are division of labour, authority, discipline, unity of command, unity of direction, subordination of individual interest to general interest, remuneration, centralization, scalar chain, order and equity, stability of tenure of personnel, initiative and esprit de corps (Cole & Kelly, 2011).

Managing the unit requires a revolution from the nurse manager and staff. Taylor acknowledged that scientific management would require a complete mental revolution on the part of both management and workers. He identified the following: develop a science for each operation to replace opinion and rule of the thumb; determine accurately from the science at the correct time and method for each job; set up a suitable organization to take all responsibility from workers except that of actual job performance; select and train the workers; accept that management itself is governed by the science developed for each operation and surrender arbitrary power over workers, that is cooperate with them (Cole & Kelly, 2011).

Max Weber's interest in organization is on authority structures and identified three basic types of legitimate authority namely, traditional, charismatic and legal rational authority. Weber ascribed

legal rational authority to 'bureaucracy'. The main features being a continuous organisation of functions bounded by rules, specified spheres of competence, a hierarchical arrangement of offices or jobs, appointment to offices made on grounds of technical competence, the separation of officials from the ownership of the organization, official positions existing in their own right and job holders having no rights to a particular position and rules, decisions and actions are formulated and recorded in writing. This bureaucratic structure described by Weber has been adopted by all public service and can be observed at the unit level.

The above principles that prevail in management provide a rational approach to the organization of work and enable tasks and processes to be measured with considerable degree of accuracy. This provides information for improvements in designs and performance which enhances productivity, thus increase incentive package for the workers; facilitating worker satisfaction. The principles of management encourage effectiveness and efficiency at both the operational and management levels. The principles even though helpful to the organization, alienate the workers from their social interest. Rigid adherence to methods and procedures over which one has no discretion can lead to fragmentation of work which may generate 'carrot and stick' approach to motivation; a situation where pay is tightly geared to output. Planning and control of workplace activities are placed exclusively in the hands of management and if care is not taken malicious compliance can result.

2.1.2 Functions of Management

Fayol's approach to management has an overarching effect on contemporary management. To manage, according to Fayol, is to "forecast and plan, to organize, to command, to coordinate and to control". Forecasting and planning look into the future drawing up a plan of action.

Organizing is seen in structural terms, and commanding is described as "maintaining activity among the personnel". Coordinating is seen as an essentially unifying activity. Controlling ensures that things happen in accordance with established policies and practice (Koontz *et al*., 1984). This study considers the four roles of a manager proposed by Fayol, namely planning, organizing, coordinating and controlling.

2.1.2.1 Planning

Planning of nursing activities by nurse managers is very essential to the effectiveness and the efficiency of the unit (Basavanthappa, 2009). Planning formalizes all future intended activities in the unit by the formulation of goals and objectives as well as the arrangement for the provision of resources in order to achieve a desired outcome (Cole & Kelly, 2011). Planning enables self-regulation and efficient progress towards goal attainment. It is an influential strategy which translates intentions into behavior and forms the basis of managerial functions. Thoughtful planning results in a blueprint, showing the action steps necessary for the achievement of future goals with timelines (McEachen & Keogh, 2007). Planning is rational, dynamic and integrative cyclical process that sketches a complete future mental picture. Planning begins with the assessment of the planning environment, data collection and data analysis, strategy formulation or setting targets, alternatives development, appraisal and selection of alternatives, implementation of plans, then monitoring and evaluation.

2.1.2.2 Organising

An organization exists in relation to its dynamic environment that provides resources and limitations and continually must adapt to it. Management makes its greatest contribution in organizations and is required to pay attention to structuring personnel and their work. The

structuring of activities implies the degree to which behavior is overtly defined at the unit level (Basavanthappa, 2009). This involves the degree of specialization in task allocation, the degree of standardization of unit routines and the degree of formalization. Organizing provides the means of coordinated efforts which are directed at making more productive, effective and efficient results. The process depends on the four "Ps" which form the basis for organization. The four "P" are: purpose, process, person (target group) and place (setting). Organization enhances managerial efficiency by providing the structure within which functions are performed and ensures optimum use of human efforts through specialization and use of resources. Organizations provide scope for training and development of managers as well as creative and innovative ideas of working whilst facilitating coordination. Furthermore, organizations provide the framework within the managerial functions of planning, direction and control take place for successful performance of work.

2.1.2.3 Coordinating

Coordination is one role of the nurse manager that is quite challenging at the unit level and between units of the health care system. According to Basavanthappa (2009), coordination is the integration, synchronization or orderly pattern of group efforts in the organization towards the accomplishment of common objectives. Coordination at the unit level must be timely, quantified and directional. It is the concerted effort of requisite quality and quantity arranged at the proper time through deliberate action. Coordination must permeate all phases of management at the unit level. Brech (1965) defines coordination as the balancing and keeping the team together by ensuring a suitable allocation of working activities to the various members and seeing that these are performed with due harmony among the members.

As dependency increases, the amount of coordination also increases. Typical mechanisms include departmentalization, centralization or decentralization through the hierarchy of formal authority, formalization, standardisation, mutual adjustment, liaison, line and staff roles, informal networks and workflow systems. Thus, coordination is seen as a response to problems caused by dependencies. The need for coordination at the unit is essential due to diverse and specialized activities, extent of interdependence among the professional groups, personal rivalries and prejudice as well as conflicts of interest. Coordination is highly dynamic in character as it tries to eliminate weaknesses and inconsistencies and focus on new strengths and forces. Adequate coordination within an organization enhances quintessence of management, creative forces, unity of direction and high employee morale. Coordination involves effective communication, planning, supervision, leadership, departmentation and direct contact.

2.1.2.4 Controlling

The nature of control at the unit level by nurse managers is variable and depends on many contextual variables. Control, according to Cole and Kelly (2011), is a process which brings about adherence to goals or targets through the exercise of power or authority. Controlling assures strategy implementation and the attainment of goals, the management of finances and use of financial resources, the management of risk, protection of assets, the behaviour of employees in terms of performance and goal attainment, operations management in terms of transformational processes, inventory and quality and organizational change. Appropriate controls can help managers look for specific performance gaps and areas for improvement. Further, information obtained through control helps prevent surprise and disaster, providing early warning of a potential performance challenge. The control process in an organization consists primarily of monitoring and evaluation of performance.

Control involves setting standards, measuring performance against those standards, reposting the results and taking action (Basavanthappa, 2009). Mosley, Pietri and Mosley (2008) defined control as the management function that involves comparing actual performance with planned performance and taking corrective action, if needed, to ensure that objectives are achieved. Planning and controlling are closely related; whereas, planning sets the pace, controlling keeps it on course. Control in nursing may include nursing auditing and facilitative supervision which are woefully absent in many units.

2.2 Management of Nursing Units

Nursing is a major component of the health system, and nurses make up the largest group of the workforce in the system. Nursing services are necessary for virtually every patient seeking health care in the health system. Since nursing is such an important component of the health system and the delivery of nursing services is tied to other areas of the health system, the nurse needs to understand the health system to effectively deliver quality care within it. Wallick (2002) argues that the managing role includes competencies such as analytical thinking, knowledge in management, work environment analysis, business knowledge, leadership and visioning. Nursing management uses a systematic body of knowledge that includes concepts, principles, and theories applicable to all nursing management situations. A nurse manager who has applied this knowledge successfully in one situation can be expected to do so in new situations. Nursing management occurs at units and executive levels; it is frequently termed administration (Roussel, 2000: 24).

In most hospitals, the nursing department has the majority of clinical staff and the highest expenditure. Failure to manage the unit well can have severe cost and quality implications.

Foster (2000) asserted that the work of nurse managers is complex, multi-layered and guided by different leadership and management approaches. Nonetheless, it could be argued that every nurse is a manager because as a responsible, accountable and autonomous practitioner, he or she must plan, organize, motivate and control to effect quality patient care (An Bord Altranais, 2000). Yet authority, responsibility and legitimate power are not routinely invested in every nurse to manipulate the environment and resources to achieve organizational goals. Whilst one does not have to be a leader to manage and a manager to lead, researchers have recognized how these skills can be intertwined and employed synonymously to realize organizational goals (Marquis & Huston, 2000).

Indeed, there is a growing body of knowledge available to suggest that management practices can be employed to achieve better outcomes, but these practices are not based on top down, authoritative, management styles (Anderson & McDaniel, 1999). Rather, emerging theory and research suggest that communication, participation in decision making, and relationship-oriented leadership, result in better outcomes (McDaniel & Driebe, 2001). Nurse managers create structure, implement processes for nursing care and facilitate positive outcomes (Anthony *et al*., 2005). Advocating and allocating available resources to facilitate effective, efficient, safe and compassionate care based on standards of practice are the cornerstone roles of the nurse manager. Furthermore, McEachen and Keogh (2007) declare that the unit of the nurse manager is a business unit that has income and expenditure and is expected to bring in more income than is expended on patient care. But how many nurse managers or nurses are aware of this assertion. Resources are used without any reference to cost or supply and accountability is one responsibility that is mostly shirked with unwarranted excuses.

Skytt, Ljunggren, Sjoden and Carlsson (2008) in their study of the roles of the first-line nurse manager realized that the strongest managerial roles of first line managers are those of a coordinator and a professional. As a coordinator the manager examines minutes, reports and memorandums to ensure no errors occur in the operations under his or her leadership, whereas as a professional, the manager actively participates in the daily patient care. This role is supported by the role of a broker or lobbyist, emphasizing negotiations with decision makers. This is what is needed in the Ghanaian nurse manager to enable them function better.

The response an organization exhibits as a result of planning, organizing, directing, coordinating and controlling resources can be described as organizational behaviour. Responsive organizational behaviour is characterized by rapid decision-making and effective execution. How organizations structure management functions to most effectively achieve organizational objectives has its roots in organizational theory. Nursing leaders, therefore, need to consider the evolving nature of organizational theories as the healthcare environment becomes increasingly more complex (Sterman, 2000).

Sterman (2000) conceded that the design of organizational structure can significantly impact both clinical and administrative performance in complex nursing systems. For instance, centralized decision-making characterized by hierarchical organizational structure (classic organizational theory) is impractical in a dynamically changing environment such as a nursing unit. Rather, decentralized control through distributed networks (modern organizational theory) provides more rapid and effective communication. Emerging information technologies and informatics applications promote distributed networks in health care and nurse managers need to embrace this innovative technology to enhance efficiency and effectiveness (Sterman, 2000).

Management practice at the unit level is highly centralized in Ghana and many nurse managers love this entrenched position over their nursing colleagues.

Clancy (2008) asserted that managing in a complex environment requires nurse managers to instill independent decision-making skills in their nursing staff. This is referred to as command without control, where leadership provides the overall direction but creates experts who can resolve challenges through their own initiative and innovation. In nursing this is observed in emergency situations where the nurse is demanded to makes quick decisions to save lives. Nurses are however accountable to the outcome of decisions made. The job of management is to guide these nurses and help the unit make the best use of its resources to achieve its goals.

2.2.1 Planning Practices of Nurse Managers at the Unit Level

Nurse managers are expected to identify challenges, design and implement innovations to help their unit achieve patient outcome targets while reducing costs to increase efficiency (McCallin & Franklin, 2010). As a strategy to effectively accomplish these roles, the nurse manager has to plan well to take responsibilities for the day-to-day administration of the unit. The knowledge and practice of formal planning of nurse managers, however, have become an issue of great concern. Not much scholarly attention has been given to planning and much of the literature on the concept of 'planning' focuses on care planning rather than resource planning among nurse managers (Asamani *et al*., 2013; Jasper & Crossan, 2012).

In planning for the unit, the mission, vision, goals and objective of the hospital cannot be ignored; they are the driving force setting the strategic direction for the hospital (Cole & Kelly,

2011). Nurse managers must, therefore, be encouraged to have vision for their units. Gregory (1995) acknowledged that though, most nurse managers could describe their vision of an ideal nursing unit, seldom is the "unit vision" developed by the staff written down and then “lived up to”.

Nurse managers generally work on short term planning for the unit, but participate in strategic planning with management as well (McEachen & Keogh, 2007). Asamani *et al*. (2013) in their study of planning among nurse managers in district hospitals in Ghana found that although the practice of planning is almost universal, half the participants have no knowledge of the planning process. Asamani *et al*. (2013) acknowledged that the universality of planning was due to the fact that planning was mandatory. Nurse managers were required under regional and local hospital policies to submit their plans of action to senior-level management. Only 14% of nurse managers have formal plans and 47% of nurse managers plan on a quarterly basis whereas 37% plan on a yearly basis. The study asserted that planning is widely participatory and only 2% plan without any form of consultation. There is a weak but positive correlation between nurse managers’ level of education and their knowledge of the planning process. The knowledge gap is traced to a lack of educational preparation before their appointment which is quite common with the nursing profession (Griffith, 2012; Jasper & Crossan, 2012; Curtis, Sheerin & de Vries, 2011).

Clancy (2003) and McCallin and Frankson (2010) in their study of nurse managers concluded that most nurse managers used shortcuts without any form of structured planning in managing issues. The principles of organization theory, however, hold that planning before action improves the quality of most actions. Every management decision made by nurse managers ultimately has a direct or indirect effect on patient outcomes as well as that of the unit as a

whole. Therefore, the need for thorough planning cannot be overemphasized. This style of nurse managers using shortcuts in decision making has been attributed to inadequate educational preparation for the managerial position (Azaare & Gross, 2011; Pillay, 2011).

Planning can be formal and informal (Curtis *et al*., 2011; Robbins & Davidhizar, 2007), strategic, tactical or operational (Jasper & Crossan, 2012; Cherry & Jacob, 2008). In informal planning, nothing is written down and there is little or no sharing of goals. Planning is general in nature and lacks continuity, as it is usually made by an individual who has not shared information with colleagues (Robbins & Davidhizar, 2007). Hence, there is no record or knowledge of the transaction that has taken place. Unlike informal planning, Robbins and Davidhizar (2007) stated that formal planning involves definite goals covering a period of time; which can be weeks, months or even years. Formal planning is the preferred planning for nursing management.

Another dimension used in describing planning is the direction; strategic planning, is long term and has top down approach as well as giving the direction for the management. Tactical planning is for middle level management; establishing goals in line with the strategic goals for the annual management of the department. Operational planning is short term extending for at least three to sixth months but not more than a year with the development of objectives to achieve the goals of the organization as well as the mission. Nurse managers are the largest group of operational managers in hospitals (Jasper & Crossan, 2012; Pillay, 2011) and are central to implementing strategic objectives. McCallin and Frankson (2010) described nurse managers as ‘the center of action’ when hospital leaders want something implemented.

Brews and Hunt (1999) argued that in unstable environments planning capabilities are far better developed and formal plans more amenable to change. Environment neither moderates the need for formal planning nor the direction of the planning/performance relationship, but does moderate firm planning capabilities and planning flexibility. Ansoff (1994) however, contended that formal planning is beneficial in both stable and unstable environments while Mintzberg (1994) favoured logical incrementalism, especially in unstable environments. The impact of environment on planning and performance relationship in general remains unclear. However, a cross-sectional study at Dangme West District in the Greater Accra Region of health care managers showed that planning was basically informal or non-existing, especially in the private facilities, due to the relatively homogenous nature of the district (Ansah Ofei, 2011).

Modern managers are faced with a situation in which change is the only 'constant' on which they can 'rely'. One certainty in their lives is that things will not be the same in a year, three years or five years from now. The difficulty is to decide what these changes will be, and it can be argued that it is only by planning that the nature of the changes taking place can be fully charted and understood. Managers take into account possible changes in deciding a course of action, in the form of contingency plans (Hannagan, 2000).

Without planning, the efforts of the facility may not well be coordinated and nurse managers and staff may be heading in different directions. Planning consists of elaborate written document or series of reports on agreed procedures, actions, and understanding. Planning thus ensures that the future and unexpected eventualities are taken into account. Daily routines can lead to the future being forgotten if everybody is too busy to consider medium- or long-term challenges (Hannagan, 2000).

In the past, scientific management, by emphasizing the codification of routine tasks, encouraged the planning of operations. The plan, therefore, should be able to capture the pertinent needs of the unit such as training and development for staff, supervision, resources, etc. Taylor's work-study method in terms of strategy is a system of planning and control to establish a pattern which is not overwhelmed by operational details. Marquanett (1990) acknowledged that it is the responsibility of planning to make sure that the entire organisation knows very well what its customers' needs are, how customer expectations are changing, how technology is moving and how competitors serve their customers. The nurse manager hence works in an environment of stimulus-response and he or she develops work in a clear preference for action.

Wong (1998) in her case study of nurse managers as a professional-managerial class realized that whereas department operation managers spent most of their time (41%) in the areas of planning and quality improvement, ward managers spent less time (10.0%) performing those tasks. Planning no doubt is essential to every manager's work regardless of the level, as it provokes critical analysis of usage of resources, behaviour and performance. Plans should be flexible to avoid rigidity and encourage spontaneity and creativity in the work of nurse-managers.

Planning is all about decision making and nurses in health care practice make decisions within a multifaceted environment, which affects the decision-making process. In the literature on nurse decision-making, three broad categories present themselves in terms of affecting elements that seem to determine the quality of the decision-making outcomes: the decision-maker, the task and the setting where the decision-making process takes place. The nature and background of the decision-maker consists of knowledge, experience, intuition and cognitive capacity (Tanner,

1983; Pardue, 1987; Hamers *et al*., 1994) which underpin the ability of the nurse to make sense of the content of the decision-making task. An important knowledge source, which has been highlighted by Radwin (1998) as an attribute of nurses' experience, is the learning of antecedents and consequences of specific decision-making situations where the phenomenon of 'knowing the patient' (Jenny & Logan, 1992; Radwin, 1995; Liaschenko, 1997) plays a crucial role. Planning, therefore, depends on the experience and the technical, educational and moral attributes of the nurse manager and nurses.

2.2.2 Organising Practices of Nurse Managers at the Unit Level

The practice of nursing includes physical, emotional and intellectual work designed to meet complex and multifaceted patient needs (Chaboyer & Creamer, 1999). Nurse managers, therefore, need excellent skills in organising to effectively deal with the nursing environment. The way in which nursing and nursing staff are organized has been shown to predict work motivation and job satisfaction (Jenny & Logan, 1992; Radwin, 1995; Liaschenko, 1997) and research contends that organisation of nursing is associated with ward characteristics. For instance, Duffield *et al.* concluded in their study that models of care are not prescriptive but are varied according to ward circumstances and staffing mix (Duffield *et al*., 2010). A high registered nurse or health care assistants ratio increases the likelihood of primary and modular nursing whereas a larger number of beds in the ward decreases it due to the greater accountability and responsibility allocated to individual nurses. Ward characteristics are also associated with aspects of job satisfaction; employees in larger wards are less satisfied with supervision and opportunities to develop skills than staff in small wards. A greater number of features of nursing models are related to nurses' satisfaction with supervision than to any other specific satisfaction (Makinen *et al*., 2003).

Research on nursing care and nurses supports the argument that nursing care and the nursing practice environment make a difference in patient outcomes (Ponte *et al*, 2004; Hall, Doran & Pink, 2004). In hospital settings, there are at least three theoretical models to organize nursing: functional, team and primary nursing. Functional or task-oriented nursing is a mechanistic approach to the delivery of care, where task completion and maintaining the ward routine takes precedence over the needs of individual patients. Work is divided into separate tasks, which are allocated to the appropriate nurses according to the perceived level of skill required to perform the tasks (Coakley & Scoble, 2003). Team nursing usually comprises a 'leader' with major responsibilities for coordinating personnel, resources and patient activities for a defined period of time. Nurses are assigned into separate teams and the leader allocates the work to team members and is responsible for total nursing care. The team plans the nursing for the span of duty and accountability is shared depending on the tasks of individual nurses (Coakley & Scoble, 2003). In primary nursing, registered nurses have 24-hour total nursing responsibility for individual patients for the patients' entire stay in the unit. Primary nurses are accountable for comprehensive patient care and are assumed to collaborate with all other parties caring for their patients (Seago, 2001).

Lundgren and Segesten (2001) in their study of organisation of nursing activities, realized that organisation of work has changed from a partly fragmented to a more coherent one. There is growing evidence that nurses do not always work according to the theoretical models described above. Wards are sometimes organized differently from attributes of organizational systems (Ryan & Loque, 1998). For example, a modification of team and primary nursing is modular nursing. In modular nursing the unit is organized around relatively small geographical groupings of patients, called modules. Nursing personnel are permanently assigned to a module and the responsibility for the total care is distributed for the group (Tomey, 2000). In Ghana,

organisation of nursing care typically does not follow any individual module but a collection of aspects of all the individual modules can be observed due to ward characteristics such as number of beds, nurse/patient ratio, the education or skills of nurses or the speciality of the ward (Adams & Bond, 1997). These additional factors have been found to affect nurses' well-being as well as job satisfaction (Adams & Bond, 2000).

Research shows that wards are organized on a more complex basis where attributes from across different organizational systems are found to coexist (Adams & Hardey, 1992). Functional, team and primary nursing, which represent chronological developments in the organization of hospital nursing, remain dominant in UK nursing, even though newer systems, such as case management and patient-focused care systems are beginning to emerge (Adams & Bond, 1995). Each system is said to comprise a distinctive set of practice features related to work focus, continuity of care, division of labour and individualization of care. These practice features, shaped by different management and care ideologies, have implications for the organizational structure of the ward.

Where nurses work within devolved power structures, collaboration with medical staff and other health care professionals is greater (Ersser & Tutton, 1991). The authority and responsibility for care relationships have no significant impact on nurses' perceptions of the degree of cohesion existing within the ward nursing staff. The cohesiveness of ward nurses has been found to be strongly associated with high levels of 'professional practice' (Adams & Bond, 1995) and, high standards of professional practice, and also nurse cohesion, can be achieved regardless of how authority and responsibility for care is managed within a ward (Adams, Bond & Hale, 1998).

The duality in a ward's attitude to sharing authority and responsibility for care militates against achieving collaboration with medical staff, lowers perceptions of the standards of nursing practice achieved, increases nurses' feelings of imbalance between work load and resources and undermines nurses' job satisfaction. A potential lack of clarity about lines of responsibility and accountability appears to impede the work of others in the multidisciplinary team and deprives nurses of the opportunity to create better working relationships and enjoy their work more fully. Centralized power and authority on the other hand, while not achieving such high levels of collaboration or ease of working compared with devolved power structures, achieves higher levels compared to the dual system, and the highest level of job satisfaction amongst nurses (Adams *et al*., 1998).

Nurses working in the health care environment are often under pressure 24 hours a day. While working with others who face the same pressures; they are short on time and patience (McNeese-Smith & Nazarey, 2001). This type of stressful environment is bound to lead to conflict. Interpersonal conflict includes verbal abuse, threats, intimidation, humiliation, excessive criticism, innuendo, exclusion, discouragement, psychological harassment and hostility (Farrell, 2001; McKenna, Smith, Poole & Coverdale, 2003). These behaviours can cause distress to the point that some nurses want to leave the profession (Wheeler, 2001; Mckenna *et al*., 2003). Even in the best relationships, conflicts can mar the effectiveness of work activities. Understanding and handling conflicts, therefore, is a challenge facing both employees and employers in the health care environment. There is no relationship between registered nurses personality factors and methods used to deal with conflict (Whitworth, 2008). It is, therefore, important for the nurse manager to have the ability to manage and resolve conflicts in the unit. Putting a structure for organisation of nursing activities is essential for effectiveness and efficiency and nurse managers must be empowered to accomplish this function.

2.2.3 Coordinating Practices of the Nurse Manager at the Unit Level

In order for various persons engaged in fulfilling the different tasks of the organisation to achieve its objective, coordination becomes necessary to ensure harmony. Coordination is needed to prevent overlapping, conflict and constant inter-department friction, to enable employees to take a broad overview of administration instead of a narrow departmental one, and to see that the right people and right resources are available in the right quantity in the right circumstances at the right time (Basu, 1994). Coordination is a necessary precondition of all successful management.

Effective coordination is recognized to be a vital component of high quality healthcare delivery. Although coordination is a common aim, there are no universally agreed means by which it can be achieved. Coordination presents an on-going challenge to those delivering health care services. Coordination necessarily involves making decisions. Decision making by members of the healthcare team is recognized to be a complex issue, influenced by both hierarchical factors (Cott, 1998) and processes of team-working (Cook *et al*., 2001).

In a study of a number of children's hospitals in the UK and Denmark, Beringer, Fletcher and Taket (2006) emphasized that staff could identify both challenges and harmony within coordination and thus be able to prioritize coordination issues. Coordination is collective; involving individuals from different groups which make their respective roles in coordinating care often ambiguous. Care coordination is based on tacit way of knowing, that is informally received, which creates diversity in practice. Care coordination can be usefully conceptualized as a "structurated" process which continually produces and reproduces itself by staff using rules and resources to 'instantiate' care coordination through action (Beringer *et al*., 2006).

Care coordination as a "structurated" process has various implications such as diversity which could be constraining, introducing inefficiency and inconsistency, or enabling, introducing flexibility and responsiveness to the way staff coordinate care. The individuality of care coordination, similarly, has both hindering and facilitating effects. Being a "structurated" process should be regarded as neither a "good" nor a "bad" thing but one which, by being dynamic in nature, provides opportunities for positive change. The challenge this presents is to recognize the dynamic nature of care coordination and make this a positive attribute. Rules and resources involved in care coordination must be made explicit to staff – bringing them into the realm of discursive consciousness. Staff can then add this to the knowledge they already possess about care coordination, thereby enabling them to make creative and practical use of the rules and resources available to them in the daily challenges of coordinating care (Beringer *et al*., 2006).

Care coordination is widely recommended as a means by which providers of health care can meet demands for efficiency and effectiveness, yet failures in coordination continue to frustrate staff and to feed the media. For example, in the United Kingdom (UK) the findings of the public inquiry into the management of care of children receiving complex heart surgery in Bristol singled out the lack of coordination between services as a factor that contributed to the documented failures in care (Kennedy, 2001). The Danish health service has also been criticized in relation to challenges of coordination, in particular lack of continuity and failures in communication between patients and staff (Hurst, 2002).

In the absence of a universally agreed model of care coordination, ways of providing coordinated health care have developed in ad hoc fashion in response to local conditions and resources. The evidence of whether the task of coordinating care should be shared between a

group of people or should be the responsibility of one person remains equivocal. Nor is it known whether the sharing of coordination activities is more likely to lead to duplication or omission (Smeenk *et al*., 2000).

Beringer *et al*. (2006) acknowledged that in preference to written resources, staff in both the UK and Denmark rely heavily on spoken information to coordinate care and that the importance of spoken information is reflected in the volume and quality of the information staff presented in ward rounds, handovers and meetings, all of which rely on the resource of spoken information. "Communication" is named as the single most important factor that facilitated coordination. The spoken word is perceived by staff to have an immediacy and flexibility that is suited to use in the coordination of care in an environment where the healthcare needs of patients are constantly changing and one in which written resources are lacking. Anecdotally, this form of coordination is widespread in health care delivery in Ghana. Reliance on spoken rather than written information introduces weaknesses to the coordination of care in relation to the acquisition of coordination 'know-how' by new staff members (Beringer *et al*., 2006).

As health care includes multidisciplinary activities, information and communication about the care is essential for the safety and comfort of the patient (Ruland, 2000; Simpson, 2003). One of the main tools available to health care personnel for communication is the patient record (Iakovidis, 1998; Ruland, 2000). The patient record is also important for quality development of care, which assures a delivery of good and safe care (Ball, Weaver & Abott, 2003; Simpson, 2003). Nursing documentation represents one essential part of the patient record (SOSFS, 1993; Ruland, 2000). Nursing records need more clarity and need to be more comprehensive regarding specific nursing information to fulfil their purpose of communicating care and to constitute a

basis for quality development in care (Tornvall & Whilhelmsson, 2008). Documentation is beneficial to daily nursing and increases patient safety as well (Bjorvell, Wredling & Thorell-Ekstrand, 2003).

Manias and Street (2001) and Coombs and Ersser (2004) conceded that "Position" is an important authoritative resource that staff used both consciously and tacitly in care coordination. Thus, hierarchies, both within and between professional groups, are found to be an active influence on care coordination, and this is evident in who should do which activities. For example, auxiliary nursing staff in Ghana would explicitly speak to the "nurse in charge" about responsibilities beyond him or her before undertaking any action, even though the individual can confidently accomplish those tasks.

Waterman *et al*. (1996) describing the introduction of new coordination processes into the roles of clinical staff in a hospital setting found confusion about boundaries and responsibilities to be a hindrance to the implementation of these roles. Boundaries are also of concern to Rushmer and Pallis (2003) who argued that clearly defined boundaries are essential for successful inter-professional working.

The strategy which caregivers apply to enhance continuity of care, is regarded as coordination of care (vanAchterberg, Stevens, Crebolder, De Witte & Philipsen, 1996).This should involve all staff, but the value of limiting the number to a minimum is important. However, sharing of responsibility for coordination has drawbacks (Sloper, 2004). This supports the argument that lack of clarity about who is responsible for care coordination may lead to omission rather than duplication of activities (Smeenk *et al*., 2000).

Modes of coordination and control in hospital units are affected by task conceptions, technology, unit size and staff professionalism. Unit size, for example, is seen as a function of the type of work the unit performs or is perceived to perform. The more routine and predictable patient care tasks are, the greater the number of procedures and patients that may be handled with a given amount of professional nursing care (Comstock & Scott, 1977). When units are large and the ratio of RNs to all nursing personnel is low, there is less opportunity for nurses to interact in a collegial manner, and greater likelihood that such nurses would perform in an administrative rather than a professional capacity (Alexander, 1980).

Whether nursing tasks in the unit are highly predictable or perceived to be highly predictable apparently matters little in terms of how these tasks are coordinated in the unit. Rather, coordination is seen to be a function of the structural configurations that these technological characteristics engender. Team nursing incorporates at least two distinct meanings: (1) It may imply the existence of a control mechanism that operates within the established authority hierarchy in the hospital and which increases vertical differentiation by the addition of a new structural layer; and (2) It may also imply the existence of lateral coordination through patient care conferences and frequent team meetings that facilitate collaborative relationships between professional care providers. These two forms of coordination are found to be differentially predicted by the structural variables of staff professionalism and unit size.

Routines facilitate coordinated action by pre-specifying the tasks to be performed and the sequence in which to perform them. Routines capture the lessons learned from previous experiences, enabling a process to be replicated without reinventing the wheel (Levitt & March, 1986). By using routines to codify best practices, individual capabilities can be transformed into organizational capabilities, and therefore into potential sources of competitive advantage

(Nelson & Winter, 1981). Total quality management relies heavily on the use of standardized work to capture and implement previous learning and thereby creating a platform for further improvements (Deming, 1986; Adler & Borys, 1996). In healthcare settings, routines have long existed in the form of protocols. More recently, protocols have evolved into clinical pathways, which combine protocols used by different members of the care provider team into a single document, outlining the tasks to be completed and decisions to be made by each function, and the sequence in which they are to be performed.

According to organization design theory, routines work by reducing the need for interaction among participants and are, therefore, a relatively low-cost way to coordinate work. Relational coordination reflects the role that frequent, timely, accurate, problem-solving communication plays in the process of coordination, but it also captures the oft-overlooked role played by relationships. It has been argued that coordination does not occur in a relational vacuum; rather, coordination is carried out through a web of relationships (Gittell, 2002).

Specifically, coordination is carried out through relationships of shared goals, shared knowledge, and mutual respect. Strong relationships ensue in effective coordination of work processes; people respect the work of others and value their contributions which eventually affect the frequency, timeliness, accuracy, and problem-solving nature of communication. High levels of relational coordination thus facilitate effective management of task interdependencies, which enables performance improvement along both quality and efficiency dimensions. In the context of hospital care, relational coordination among members of cross-functional care provider groups is associated with improved quality of care and reduced lengths of hospital stay (Gittell *et al.*, 2000).

Hospitals are large, complex and dynamic organisational entities. There are a large number of distinct health professions with associated communities of practice and with different political standing in the hierarchy. This span from a variety of utterly mundane artefacts such as report templates and archives to high-tech equipment like x-ray machines requiring competent and specialised users. The trajectory of a patient during a stay spawns a comprehensive set of work tasks. This underscores how complex work in hospitals is, and the need for coordination between the different professionals, tools and artefacts as argued by Schmidt and Simone (1996): "Actors tacitly monitor each other, they perform their activities in ways that support co-workers' awareness and understanding of their work; they take each other's past, present and prospective activities into account in planning and conducting their own work." Nurse managers thus need empowerment to be able to manage the unit effectively.

2.2.4 Control Practices of Nurse Managers at the Unit Level

Throughout the history of management, managers have experimented with a variety of control methods and McClure *et al.* (1983) argued that autonomy and control of nursing practice are associated with a healthy work environment and professional practice thereby ensuring job satisfaction and nurse retention (Kramer & Schmalenberg, 2004). Nicholas and Beynon (1977) contended that control strategies may reflect demographic changes and wider cultural movements which may extend into the life of employees and their family life generally (Gramsci, 1976). Thus, control innovations tend to emerge and gain popularity under specific historical, cultural and social circumstances and, to some extent, would change in response to changes in sociopolitical ideas and movements.

Managers, Collins (1996) contended, are engaged in an ongoing struggle to maintain control, and to secure discipline over workers. Rose (1999) argued that an understanding of the process of governance represents the key to understanding the process by which managers secure the consent of subordinates in the workplace. Governance relates not to imposition of control but to the realignment of control whereby managerial concerns are aligned with the mainstream rhetoric and concerns of democratic societies. Governance, hence, grants legitimacy to managerial action and also facilitates management control.

Control is rooted in work design initiatives that are also rooted in "psy" sciences which, accordingly, play a key role in framing relations at work (Rose, 1999). Control, as a function of management, involves influencing human behaviour with a view to help ensure that people behave in ways that lead to the attainment of organizational goals (Fisher, 1998). Orlikowski (1991) described two forms of managerial controls, namely administrative and professional controls. Administratively, organizations typically utilize a variety of control devices designed to influence the behaviour of employees. Some of these control mechanisms entail rules and procedures that directly influence employee behaviour and/or their output. Examples are well defined job descriptions, career ladders and incentive schemes. Work knowledge is therefore embedded in bureaucratic rules of the organisation and employees' firm specific skills. A manager's judgment about employee performance thus gains a seal of objectivity and reinforces the apparent neutrality of bureaucratic policies, procedures and rules. A social structure is typically created within the organisation to articulate a control environment (Orlikowski, 1991).

Professional control may be indirectly achieved through a shared culture where employees share common norms and values that order perception, influence attitude and shape behavior

(Birnberg & Snodgrass, 1988; Knights & Wilmot, 1987; McDonough & Leifer, 1986; Ouchi, 1979). Under professional control, individuals are indoctrinated in a shared ideology and philosophy of norms that help them to derive unanimous rules and procedures to suit specific tasks with varying conditions (Abernethy & Stoelwinder, 1994). The nursing profession has both the administrative and professional controls.

Merchant (1985) noted that under professional control, individuals do, by their own accord, what is best for the organization as they are self-directed and influenced by social pressure. Individuals are formally induced, enforced and monitored by external social or professional institutions. These professionals are vested with specific authority within the organization depending on their specialization (Orlikowski, 1991), and professional norms and standards determine the tasks of particular groups within the organization.

Control over practice is defined as a professional nursing function made up of a variety of activities and outcomes that extend beyond clinical decision making (Aiken & Patrician, 2000; Kramer & Schmalenberg, 2008). Some authors have argued that control over practice is associated with professional autonomy. These authors recognize control over practice as the ability of a nurse to participate in decision making within the workplace. Control over practice has also been described as an important element of the nursing professional practice environment which contributes to job satisfaction (Foley *et al*., 2002; Duffield *et al*., 2009). This is not different from what control over practice is; that is self-regulation and self-determination of professional issues, practices, and standards by professionals. In nursing, control of nursing practice is operationalized through shared governance; that is participative management and decentralization. Shared governance is a nursing management innovation that legitimizes nurses'

control of nursing practice while extending the influence (input and decision making) of nurses at all levels to administrative areas previously controlled by management (Hess, 1995). Shared governance is a structural configuration of councils and committees that provide formal mechanisms that ensure nurses' responsibility, right and power to make decisions and to control nursing practice.

Laschinger and Wong (1999) stated that "most shared governance efforts are seen by staff as chiefly structural, with staff nurses on councils and committees but without the authority to have significant control over professional practice, thus leading to cynicism and unwillingness to assume accountability for client outcomes". Cynicism, unwillingness to be accountable and lack of decision making are also reported in a nationwide survey of staff nurses working in hospitals that supposedly had shared governance systems in place (Havens, 1994). Best practices that promote control of nursing practice are providing access to power, promoting widespread participation, using recognition to reinforce participation, taking pride in and acknowledging outcomes, accomplishments, and actions of the shared governance, and having evidence-based practice team.

Kramer *et al.* (2009) asserted that control of nursing practice and a patient-centered culture promote both the quality of nurses' work environments and the quality of patient care. Control of nursing practice enables nurses to improve the context of nursing practice; use of evidence-based practices enables nurses to improve the quality of care provided to patients. Culture is the normative glue that preserves and strengthens the group and provides the healing warmth essential to quality care. Walk the talk is one of the best practices through which the values of unit and hospital culture are lived and control of nursing practice by nurses can be achieved.

2.3 Implications of Management on Staff and Patient satisfaction

The management of health care personnel especially nurses takes place in a complex environment involving a variety of professionals, extensive use of materials and equipment, and an array of services that extend beyond health care to include food, hospitality and instruction. This challenging environment places a great deal of stress on nurses. Nurses strongly influence patient satisfaction through their performance and interactions with patients. Accordingly, it is vital that nurse managers understand concepts such as staff satisfaction and how the levels of satisfaction relate to patient satisfaction and overall patient experiences. This can be achieved through adequate preparation of the nurse manager for the position instead of the current apprentice-based approach used mostly in Ghana.

Nurse managers find themselves increasingly confronting the complex interrelationship between staff satisfaction and retention of nurses, and the quality of care and patient satisfaction experiences. While some improvements in care quality can be reached through investments in technology and infrastructure, the most dramatic improvements are achieved through people. Previous studies have concluded that unsatisfied health care employees negatively affect the quality of care which adversely affects patient satisfaction and loyalty to a hospital (Atkins, *et al.,* 1996; Fahad Al-Mailam, 2005). Attempts must therefore be made to ensure that nurse managers have the proficiency to promote staff satisfaction.

Nurses perform duties that directly and indirectly influence the quality of patient care and satisfaction. Brown (2002) noted that nurse managers face the challenge of repairing “broken” relationships with nurses because of changes in management policies over time. During the health reforms in the 1990s, health care organizations tried to adopt cost cutting strategies promoted by the MOH, thereby taking the focus away from the quality of care to patients. This

conflict ultimately left nurses feeling disengaged and unempowered in their roles in delivering patient care and at odds with the financial performance initiatives of health care administrators (Brown 2002). Nurse managers thus find it quite challenging to manage the unit during this period as nurses are more likely to leave because they feel unappreciated (Fukuyama, 1995).

Curran (2001) assert that nurses exhibit loyalty to patients but often do not feel the same level of loyalty to their employer because they feel hospital executives are not in touch with the demands of patient care. This finding highlight the importance of creating engaged nurses and the important role of nurse managers in this process. Other studies have shown workplace culture, organizational communication and managerial styles, trust and respect, leadership, and organizational reputation all influence staff commitment (Lockwood, 2007). Several studies have shown how staff empowerment and commitment impact staff satisfaction and loyalty to the organization. Hospitals that routinely achieve high staff satisfaction scores tend to have the following in common (1) accessible leadership, (2) frequent communication, and (3) staff are empowered to satisfy patients (Fassel, 2003).

A study of nurses and midwives in London hospitals determined that the three main factors influencing their job satisfaction were patients, the inherent characteristics of nursing, and the nursing team (Newman, *et al*. 2002). Additionally, Newman, *et al*. found that improving working conditions was more important than increased pay. While pay for performance activities may lead to increased satisfaction and higher quality of care, these reward systems tend to be short-lived in comparison to other recognition or engagement programmes. Allowing nurses to provide higher quality care to patients, the nurses tend to take greater pride in their job and feel good about the organization and its values. Wagner (2006) realized that the primary factor in staff satisfaction and loyalty is the staff's relationship with his or her immediate

supervisor. This finding further demonstrates the need for nurse managers to be concerned with staff satisfaction as hospitals struggle with nursing shortages. It also is in line with Curran's (2001) findings that nurses indicated management that is out of touch with the realities of patient care lead to lower nurse satisfaction and loyalty. The quality of relationships including communication between management and employees not only impacts the employees themselves but also has an impact on organizational effectiveness by affecting productivity and turnover rates (Brunetto & Farr-Wharton, 2006). When nurse managers help nurses feel engaged and offer them the support and resources necessary to provide quality patient care, nurses are not only more satisfied with the nurse manager but also remain more loyal.

Nurses' satisfaction has been found to have several impacts on the quality of care delivered which ultimately influences the level of patient satisfaction (Newman *et al*., 2001). Atkins et al. (1996) showed that employee dissatisfaction negatively impacts the quality of care and ultimately has an adverse effect on patient loyalty and in turn hospital profitability. According to Fahad Al-Mailam (2005), quality leadership in hospitals helps foster an environment that provides quality care which is linked with patient satisfaction. Organizations who seek to improve patient satisfaction and encourage return visits or customer loyalty should focus on improving the quality of care. This again gets at the point that management plays an integral role in the level of care provided even when they are not directly involved. The concept of management suggests that the best way to satisfy patients is by viewing employees as internal customers and that by understanding and meeting employees' needs, wants, expectations, and concerns their level of satisfaction will increase thereby leading to better quality of care and higher patient satisfaction (O'Neill, 2005; Bitner *et al*., 1990; Hesket *et al*., 1997; Testa *et al*., 1998). The findings from Peltier *et al.*'s studies (2003, 2004, and 2007) suggest that by focusing on improving the quality of care, health care organizations can not only improve patient

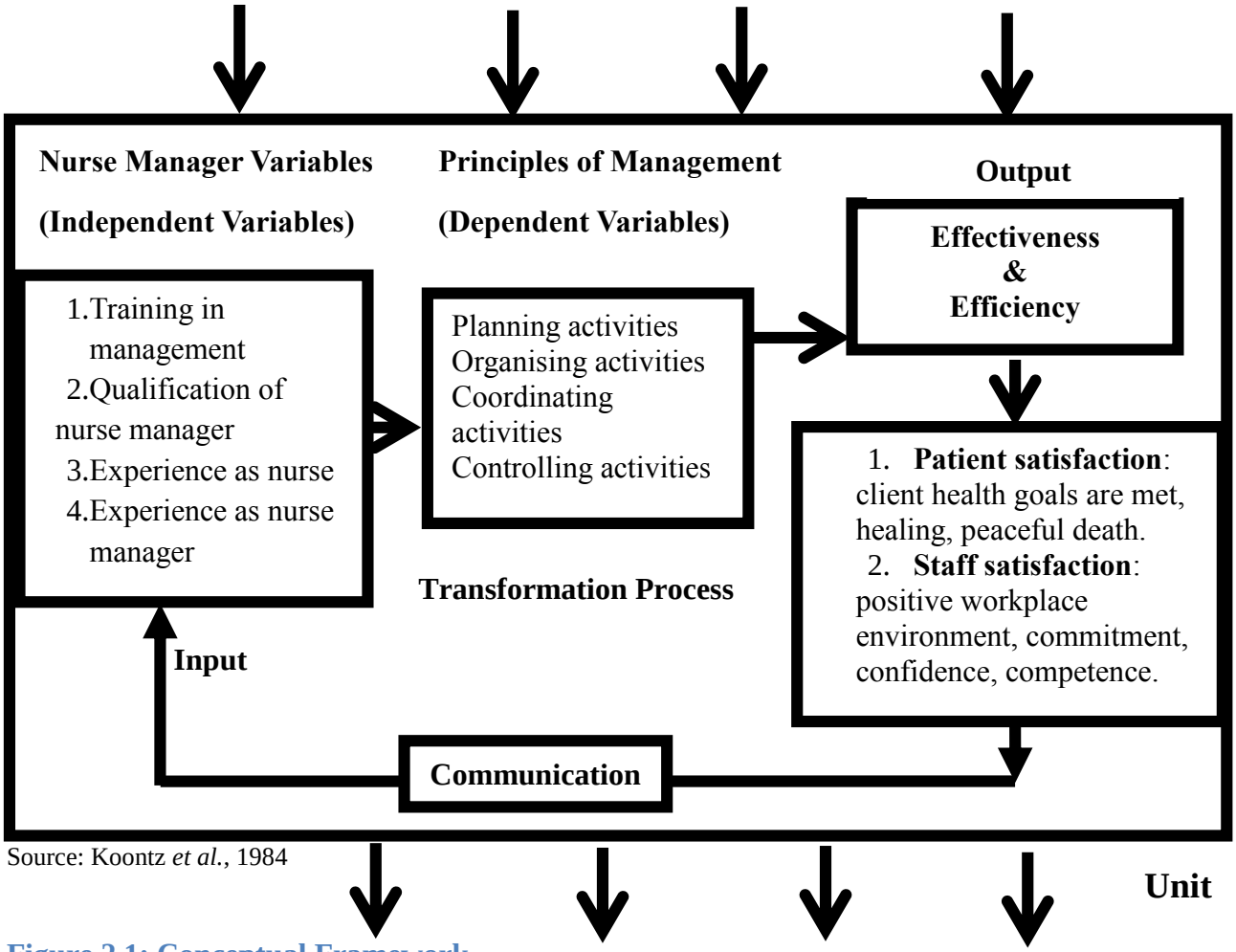
satisfaction, but also improve staff satisfaction and loyalty to the organization. This in turn will further impact the quality of care because of the interrelationship of this chain. Thus, hospital departments that have higher levels of employee satisfaction provide better experiences for patients. People performance, the idea of improving organizational success by better connecting employees to customers, accentuates the importance of people and what they do personally, particularly in an increasingly electronic and mechanized workplace. The importance of the nurse manager in creating work climates that promote staff satisfaction that promotes patient satisfaction is therefore well lauded.

2.4 The Conceptual Framework

A review of literature in a variety of journals and management books revealed numerous personal and situational or work-related factors that influence nurse managers' aspirations to management practice in the unit (Basavanthappa, 2009). The conceptual framework developed from the literature to guide this study is based on two theories; Fayol's administrative management and the systems theory. According to Koontz *et al.* (1984), no practising manager can overlook the systems approach. A framework from a system's perspective was developed for the study of management practice to affirm the importance of outcomes to the unit and the hospital as a whole as well as the external environment. The framework provides a structure of significant variables and their relationships.

According to Meyer and O'Brien-Pallas (2010), a unit in the health care organization is a social structure that is conceptualized as an open system comprising of supportive, maintenance, adaptive, service and management subsystems which interact with other units in the hospital. Management practice affects all the subsystems of the unit. According to Koontz *et al.* (1984),

Fayol described some managerial values that are essential to the practice of management. These values are training in management, qualification of nurse manager, experience as nurse and experience as nurse manager. The researcher believes that these values of the nurse manager influence management practice in the unit and are essential for effectiveness and efficiency (Koontz *et al.*, 1984). The study considered the contextual variables of the nurse manager as inputs required for the transformation process (principles of management).



Source: Koontz *et al.*, 1984

Figure 2.1: Conceptual Framework

Fayol defined management as planning, organising, coordinating and controlling, which forms the transformation process in the unit (dependent variables) (Koontz *et al.*, 1984). The process yields output of efficiency and effectiveness that further defines patient satisfaction and staff

satisfaction. The nurse manager variables, therefore, determine the extent to which these principles can be fully practised in the unit. Planning the unit by the nurse manager considers putting in place an action plan for managing the unit. This plan can only be possible by the evaluation of all actions based on previous plans as well as environmental analysis of the unit and the hospital as a whole. Organizing ensures that there is a structure established for implementation of defined roles and responsibilities. Coordination enables effective communication from within and without the unit to ensure that efforts of staff are worthwhile. Control, on the other hand, ensures that activities are performed according to plan and corrective actions taken to ensure that there is efficiency and effectiveness.

O'Rourke (2007) described the nurse manager as a linchpin, a central cohesive source of support and stability for the hospital. Nurse managers work across both horizontal and vertical boundaries in the organizational hierarchy to control performance (Ouchi & Dowling, 1974), to ensure accountability (Jaques, 1990), to create channels of appeal (Weber, 1978) and to enable staff access to resources and managerial support (Blau, 1968; Kanter, 1977). This fosters high quality communication and relationships with nurses and other professionals through physical movements, interpersonal skills and conversations (Gittell, 2003).

The units as open systems is maintained by being open to new ideas, new management techniques, and the input of human and material resources to produce the nursing care needed by patients, family and the community as a whole. Continuous professional education ensures that the unit becomes a learning organization that reproduces itself and sustains patient and staff satisfaction as well as advance nursing practice. The inputs are utilized by the nurse managers to bring about comprehensive transformation phase. The output is resolution of nursing needs and

challenges of patients, with improvement, accomplishment of health care goals and healing, or succumbing to a peaceful death (Henderson, 1978). Clinical knowledge, experience, effective communication, management knowledge and skills, support and commitment from the staff are essentially the attributes needed to convincingly authenticate the management capabilities of the nurse manager. These attributes give empowerment to the nurse managers and the transformation process. Planning, organizing, coordinating and controlling would ensure that challenges during implementation would be fixed for efficient use of resources and positive workgroup climate which would culminate into patient and staff satisfaction.

2.4 Summary

The objective of this study is to provide a comprehensive review of the key principles of management. The key principles of management described by the classical management theorists, namely Henri Fayol, Frederick Tailor, Max Weber and others, have been reviewed for this study, together with some empirical studies on the practice of management. The classical management theory is mechanistic in nature; mainly interested in securing efficiency and effectiveness in the organization. The scientific management theory focuses on matching people and tasks to maximize efficiency, administrative management focuses on identifying the principles that would lead to the creation of the most efficient system of organisation and management.

The principles of management are thus relevant to the practice of management by nurse managers as these are exceedingly important to the sustenance and existence of health care organizations. In managing the unit, the nurse manager would have to create structure for

efficient and effective delivery of quality health care and this would be possible if there exist principles such as discipline, equity, rules and regulations, team spirit, etc. The principles reviewed in this literature are planning, organizing, coordinating and controlling at the operational level. These can enable effectiveness and efficiency thus ensuring both client and staff satisfaction. Nurse managers are recognized as the most important group of managers to the hospital; they control majority of the resources. It is therefore important that nurse managers are empowered and given the necessary support to be able to plan, organize, coordinate and control their units effectively to enable the vision and mission of the organization be achieved in real time with efficiency. Management thus is the ability to organize resources and coordinate the execution of tasks necessary to achieve a goal in a timely and efficient manner.

CHAPTER THREE

3.0 RESEARCH METHODS

Introduction

Chapter 2 presented an extensive literature review of the main concepts of the study including the conceptual framework and the theoretical background of the study. This chapter describes the research methods and design employed to examine and describe the perception of nurses about management practices of nurse managers at the unit level in secondary and primary health delivery facilities in the Greater Accra region, Ghana. The research methods are described in terms of the design, context, population, sample size, sampling technique, data collection tools, data management and ethical clearance.

3.1 Study Design

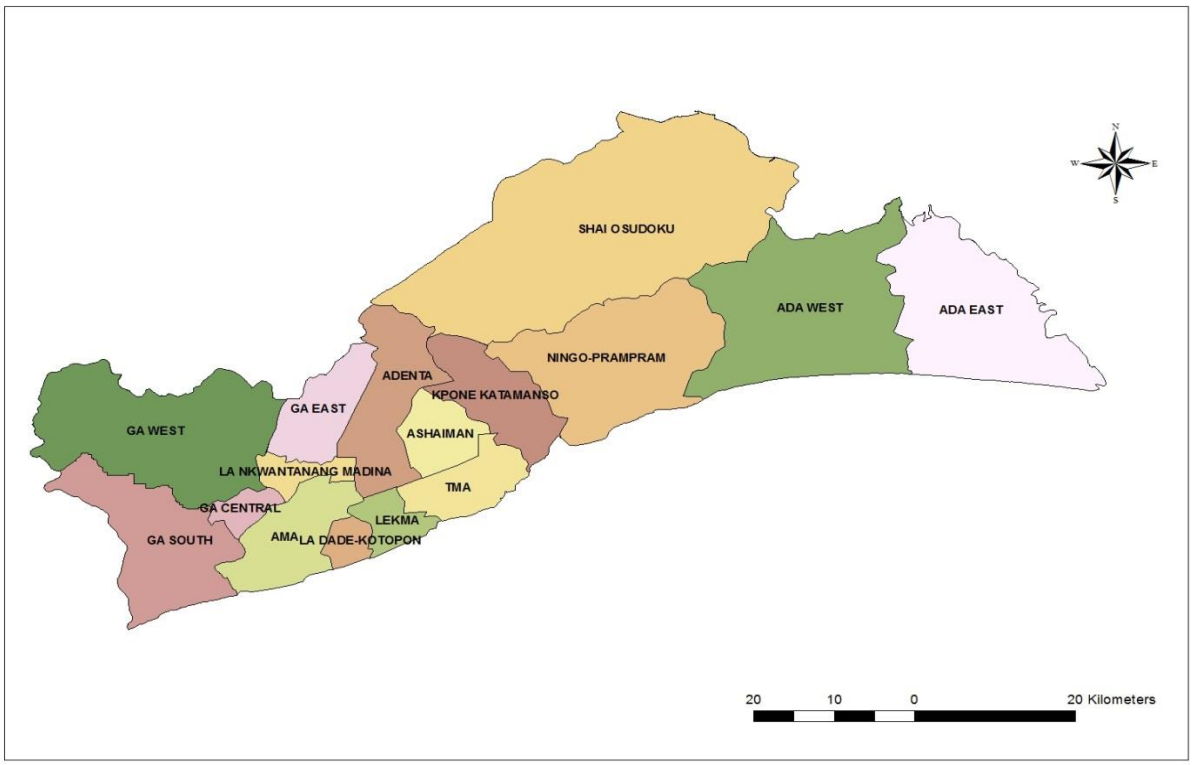
The research questions for the study suggest exploratory descriptive study design (Wood & Kerr, 2011) for examining the phenomenon of management practices of nurse managers at the unit level in secondary and primary health delivery systems (regional and district hospitals) as well as some specialized hospitals in the Greater Accra Region, Ghana. The exploratory descriptive study design was chosen because it offers the researcher a wealth of experiential information for understanding the phenomenon of management practice in its natural setting. Again, the design offers the researcher the opportunity to access primary data and the ability to analyze the data to explain the predictors of behavior concerning the phenomenon of management practice. This method was also economical, relatively manageable and offered the researcher original data

adequate for generalization to the population of interest. This enabled the researcher to make conclusive suggestions about management practices of nurse managers at the unit level.

Exploratory descriptive quantitative approach was employed to facilitate the examination of the phenomenon of management practice at the unit level. Although the level of knowledge generated from exploratory descriptive studies was less than ideal, it provided data that identified variables, described relationships, predicted behaviours and contributed to increasing the understanding of the questions being asked. This approach was employed to describe the phenomenon of nursing management since there is paucity of literature and not much has been done in this area.

3.2 Study Area

The Greater Accra Region is in the south and the smallest of all the regions in Ghana. It has both deprived or "overseas zones" though Greater Accra is the capital region of Ghana. The region occupies a total land surface of 3,245 square kilometers or 1.4 per cent of the total land area of Ghana but is the second most populated region, with a population of 2,905,726 in 2000, accounting for 15.4 per cent of Ghana's total population. The political administration of the region is through the local government system and is divided into ten districts but six new districts have been created recently making the total number of districts in the region to be sixteen. There are ten district hospitals in the region, all of which were utilized for the study, together with the regional hospital, Children's hospital and the Accra Psychiatric hospital.



Source: Dodowa Research Centre, 2014

Figure 3.1: Greater Accra Region and Districts

The study setting was primary and secondary health care facilities of the Ghana Health Service as well as some specialized hospitals in the Greater Accra region, Ghana. The region was selected because it has both deprived and endowed districts which mimic other districts across the length and breadth of Ghana. The hospitals have all the inclusion criteria for the study including existence of all the different grades of the nursing profession and other health professionals. The Ghana Health Service (GHS) was established in 1996 under Act 525 to ensure access to health services to the population. The service is governed by the GHS Council which may directly issue instructions or apply its discretion at all levels through the Director-General and/or Deputy Director-General. The GHS is responsible for the operational management required to deliver quality health services to the people of Ghana. Administratively the GHS is organized at 3 levels: National level, Regional level (secondary level) and the District Level (primary level). Functionally, the GHS is organized at Five (5) Levels: National

Level, Regional Level, District Level, Sub-district Level, and the Community Level. Table 3.1 shows the facilities utilized for the study.

Table 3:1 Health Care Facilities

No.	Name of Health Care Facility	Number of Participants
1	Abokobi Health Centre	1
2	Accra Psychiatric	55
3	Achimota	51
4	Ashiaman	6
5	Dangme East District	18
6	Dangme West District	25
7	Dansoman Polyclinic	1
8	Ga East Municipal	1
9	Ga South Municipal	41
10	Ga West Municipal	56
11	Kaneshie Hospital	32
12	LEKMA Hospital	25
13	La General Hospital	33
14	Maamobi General Hospital	32
15	Madina Polyclinic	1
16	PML Children's Hospital	27
17	Ridge Regional Hospital	82
18	Tema General Hospital	40
19	Tema Polyclinic	25
Total		**552**

Source: Field data, 2013

The district hospital is the first-level referral hospital and the apex of the service delivery in the district health system and provides out-patient and in-patient clinical services, public health services and maternity services with limited surgical procedures. Clinical services such as obstetrics and gyaenacology, child health, medicine, surgery, accident and emergency and non-clinical support services. The hospital also provides training and technical supervision to health centres, 24-hour service, laboratory and other diagnostic techniques and referral services. The district hospitals serve populations of 100,000 to 200,000 people in clearly defined geographical areas. The district hospital should have a minimum of 100 and a maximum of 200 beds. Staffing at the district hospital includes a medical officer, medical assistants, sufficient nurses and midwives and at least one qualified administrator. The district provides 24-hour service and the

ratio of hospital bed to clinical nurses should be 1:3 provided that the occupancy rate is higher than 60%.

Brief descriptions of three of the facilities which are designated for special services are given below. The Ridge Regional hospital is a secondary health care facility and a referral facility. The hospital provides specialized care involving skills and competence not available at the district level. It provides services to a geographically well-defined area of a population of about 1.2 million and forms an integral part of the regional health system. The hospital has about200 beds. The personnel include medical professionals such as general surgeons, general medical physicians, pediatricians, ophthalmologists, gyaenacologists, general and specialized nurses and midwives. The hospital offers general clinical services such as medicine, general surgery and anesthesia, paediatrics, obstetrics and gyaenacology, dental services, psychiatry, accident and emergency services, ear, nose and throat services, ophthalmology and dermatology services. Other services that the hospital provides are laboratory and diagnostic services, teaching and training, supervision and monitoring of district activities and technical support to the district.

The Accra Psychiatric Hospital was built in 1904 and was then called Lunatic Asylum. It was commissioned in 1906 to accommodate 200 patients. The hospital consisted of four wards; Female, Male, General and Criminal wards. The Lunatic Asylum later underwent modifications and extension and was renamed the Psychiatric Hospital with a bed capacity of 600. The Hospital is responsible for the treatment, welfare, training and rehabilitation of the mentally ill. The University of Ghana Medical School has a department established at the hospital for undergraduate training in Psychiatry and graduate training under the West African College of Psychiatrists (WACP). The hospital thus has a symbiotic relationship with the Ghana Medical

School. Nurses from all over the country are affiliated to this hospital for their 6-months proficiency training in Psychiatry. Clinical problems handled in both training and practice include a range of euro-psychotic issues, manic-depressive illnesses, schizophrenia, epilepsy, alcohol and drug abuse.

Princess Marie Louise (PML) Children's Hospital is a 74 bedded facility founded in June 1926 during the British Colonial Administration. In the 1930s, Dr. Cicely Williams, a Jamaican who was seconded to the then Gold Coast (now Ghana) discovered during her period of work the causes and symptoms of what is now known as Kwashiorkor. As a result of the discovery of Kwashiorkor, a nutritional disorder, the Hospital was formerly a Nutritional Rehabilitation Centre, but now caters for a number of childhood illnesses. The Hospital renders both preventive and curative health services. Indeed, the hospital actually serves beyond the population of Greater Accra region since clients come from both within and without the region. The main units in the Hospital are the Out Patient Department (OPD), special clinics (A.R.T. and VCT centre), Oral Rehydration Therapy corner, emergency ward, in-patients units (4 units), laboratory unit/Blood bank, X-Ray unit, Reception (communication services), Catering unit, Dietetics unit, Environmental health unit, Security unit, Transport unit, Medical records unit, Laundry unit, Accounts department, Internal audit unit, Mortuary unit, Nutrition rehabilitation centre or corn mill, Family Planning unit, Reproductive and Child Health Unit, General Administration, Nursing Administration, Social Welfare Unit, Disease Control Unit, Ophthalmic services unit, Dental Unit, Ear Nose and Throat Unit, Mothers' Hostel for the accommodation of mothers and Ayalolo Community Clinic.

3.3 Study Population

The target population is clinical nurses working in all the selected hospitals in the Greater Accra Region. The clinical nurses are either professionals or auxiliaries and have been certified by the Nursing and Midwifery Council (NMC) to practise nursing in Ghana. The nurses must have worked for at least three months or more in a hospital with the nurse manager. This professional experience would enable the nurses to provide adequate information about the management practices of nurse managers at the unit level.

Students, generally, were exempted from the study as well as those who refused to be involved in the study but students who were professional nurses and had at least two years' working experience were employed for the pilot study. Students were exempted from the study because the researcher was only interested in working experience of nurses with nurse managers. The training period of nurses will not offer them adequate knowledge about the management practices of nurse managers.

3.4 Sample Size

The study employed 552 participants from all the health care facilities described above. The sample size was calculated using the population of nurses (both professionals and auxiliaries) working in GHS facilities in the Greater Accra Region. The total population of nurses in the GHS was 17339 (Human Resource Directorate, GHS, 2012), a confidence level of 95% and expected frequency of 50% was chosen using the Epi–info version seven software for the calculation. The sample size was calculated to be 376 using the descriptive population survey model. This figure was, however, increased by 10% to 404 to make room for increased participation which ensured generalization of the outcome of the study.

3.5 Sampling Technique

According to Polit and Beck (2008), sampling is the process of selecting a portion of the population who meet the criteria for inclusion in the study of a phenomenon to represent the entire population so that inferences about the population can be made. Simple random sampling approach was employed to select nurses for the study. The researcher with the support of research assistants selected participants from the units by asking potential participants to pick from a bowl a "Yes" or "No" rolled up pieces of papers. Those who picked the "No" were declined participation in the study. In addition to ensuring that the participants met the inclusion criteria for the study, the researcher and the research assistants ensured that the nurses have practised for at least three months in the hospital or have worked with the nurse manager for at least three months.

3.6 Data Collection Tool

The study used questionnaire to collect data from the nurses as the researcher intended to describe the phenomenon of management practice as well as examine causal relationships between the independent (qualities of nurse managers) and dependent (management practice) variables. The questionnaire (Appendix B) was made up of five sections (A, B, C, D, & E); each section was used to examine an aspect of the phenomenon of management practice. Section A of the questionnaire began with a series of questions that provided key socio-demographic and occupational information of participants, such as age, sex, number of years of practice, grade, basic qualification of nurses, qualification of nurse manager, experience of the nurse manager, management or administrative training of the nurse manager, type of unit and duration of work with the nurse manager. This ensured that the perceptions of nurses about management practice of nurse managers could be gathered.

Section B catalogued the managerial practice of planning. This Section was made up of mostly closed ended questions with two open ended questions to elicit the planning function of the nurse manager. A table with twenty-two (22) items that describes how the nurse manager plans the unit with nurses was designed with a Likert scale ranging from 1 to 5 (1 = not at all, 2 = to a small extent, 3 = to some extent, 4 = to a large extent and 5 = to a very large extent) to examine the perceived (real situation) as against the preferred management practice of nurse managers. Five additional questions were also designed to examine the rate of using plans, how often the units plan, time spent on planning and general comments or suggestions about planning the unit and how to improve upon it.

Section C compiled the organising activities of the nurse manager at the unit level with his or her colleagues. Questions raised tried to measure the extent to which organizing was practised by the nurse manager. The questionnaire provided twenty six (26) descriptive statements of the organizing behaviour of nurse managers. Twenty four (24) of the questions were in a table with a Likert scale which ranged from 1 to 5 (1 = not at all, 2 = to a small extent, 3 = to some extent, 4 = to a large extent, 5 = to a very large extent) to examine the perceived and preferred organizing behaviour of nurse managers by the nurses. Only one open ended question to explore sentiments on organizing was asked here to reveal the state of organizing and how it can be improved.

Section D was based on the coordinating function of the nurse manager. Twenty-two (22) items were developed to examine the coordinating behaviour of the nurse managers at the unit level that enhances harmony between nurses and other health care professionals. Twenty (20) of the items were in a table with a Likert scale ranging from1 to 5 (1= not at all, 2=to a small extent,

3=to some extent, 4=to a large extent and 5 = to a very large extent) to examine the perceived as against the preferred coordinating behaviour of nurse managers that would strengthen and enhance management practice.

Section E was constructed using the controlling activities of the nurse manager. A table with twenty-three (23) items was developed with a Likert scale ranging from 1 to 5 (1 = not at all, 2 = to a small extent, 3 = to some extent, 4 = to a large extent and 5 = to a very large extent) to examine the perceived as against the preferred control practices of nurse managers at the unit level which facilitates achievement of goals. Two additional questions were designed to measure the level of satisfaction of nurses about the control skills of the nurse manager and how the control practice can be improved. A table with two additional questions about client and staff satisfaction was designed with a scale ranging from 1 to 5 (1 = not at all, 2 = to a small extent, 3 = to some extent, 4 = to a large extent and 5 = to a very large extent) to examine relationship between the research variables and the outcome of management practice in the unit.

3.7 Data Gathering

Data gathering refers to the collection of relevant information from a selected population under a precisely defined condition in a systematic and objective manner regarding a phenomenon under investigation for the purpose of demonstrating the reality or otherwise about that phenomenon. To gain a full understanding of the management practices of nurse managers, quantitative data were gathered through the use of questionnaires.

Once consent was obtained from management of the hospital, data collection proceeded in earnest using three processes. This involved identification of research assistants who were

mostly former students or colleagues of the researcher working in the selected hospitals. The research assistants were vividly briefed about the study and its intent. Upon enquiring about the number of nurses on roll in the facility, the researcher then counted the questionnaires (about two thirds of the number of nurses on roll) and left them with the research assistants. The researcher also left behind copies of the consent form and the rolled up "Yes" or "No" pieces of papers to ensure randomization of selected participants. Telephone numbers of these research assistants were collected for intermittent communication with the researcher within the period of gathering data and to resolve any hitches that might ensue. Approximately, a period of three weeks was used to collect data from the La General, GA West, Accra Psychiatric, PML Children's, Achimota, and Dangme West hospitals as well as Tema polyclinic. The researcher made several visits to the facilities to ensure that the process was successful and also to collect completed questionnaires.

The second process involved the distribution of the questionnaires directly to the participants by the researcher and collecting them later by research assistants. With this process, the researcher went round the units and distributed the questionnaires to the nurses. Due to the heavy workload of nurses, the researcher normally left behind the questionnaires with the nurses to complete overnight. Several visits to the units were made to collect questionnaires. Research assistants were met during this time. After vivid explanation of the study and its intent, they were task to distribute and collect completed questionnaires. Copies of the consent form, the "Yes" or "No" pieces of papers and the questionnaires were left with the research assistants to continue with the data gathering. The researcher then visited the hospital weekly to collect completed questionnaires. During the collection, the researcher carefully assessed each questionnaire to ensure that it had been fully completed. This process was used for Ga South, Dangme East, Maamobi General and Ridge Regional hospitals as well as Kaneshie polyclinic.

The last process was the involvement of serving personnel of GHS working in the Greater Accra region who were students in the University of Ghana School of Nursing as participants. The researcher went to lecture halls of levels 200 to 400 and informed them about the study. Those who were interested to be participants raised their hands and after informed consent, the questionnaires were distributed to them to be collected the next lecture day. A student was normally tasked to collect the completed questionnaires and submit them to the researcher after careful scrutiny to ensure that it had been fully completed by the participant. Thus, those facilities with one participant were in this category.

In all, the researcher used six months from October 2012 when permission was sought from the Greater Accra Regional Health Directorate to March 2013, when all the completed questionnaires were collected. In all five hundred and fifty two (552) questionnaires were retrieved. Completion of the questionnaires took place in either the units or participants' home. Data collection continued throughout all shifts until all data were generated. Data gathered were scrutinized carefully to ensure that all sections were duly completed before collection.

3.8 Data Management

To ensure data quality, due consideration was given to research questions and hypotheses in designing the instruments. Thus, a questionnaire with sections that fully reflected and captured the substance of the research questions and the hypotheses proposed was developed and piloted. Outcome of the pilot study was further used to improve the questionnaire. Some questions were eliminated from the tables whereas some questions were improved. In addition, new questions were developed to improve the research tool.

Research assistants were recruited and trained to assist with the data collection. Data was collected by both the researcher and research assistants. For reliability purposes, the researcher and research assistants scrutinized all completed questionnaires before accepting them for consistency and completeness. Data editing and verification were manually done before data entry into the computer to ensure that errors were minimized before analysis.

3.9 Reliability and Validity of the study

Validity refers to the soundness of the study evidence and reliability is the accuracy and consistency of information obtained in a study (Polit & Beck, 2009). Validity of the instrument was established initially through face and content validity. Face validity is the opinion of outside experts indicating the tool is a true measure for which it is intended (Neumann, 2003). Face validity was ensured by the physical arrangement of questions to reflect research questions and objectives. Face validity was supported by the review of the research instrument by the supervisors of the thesis; ensuring that all the sections of the instrument reflected the research questions under study. The proposal was also sent for ethical clearance at the Nugochi Memorial Institutional Review Board. The researcher equally ensured that all the objectives hoisted for the study have been captured by the questionnaire and the questions were specific, simple and precise. The arrangement of the questionnaire was also structured to exhibit maturity and logical presentation of all the aspects of nursing management.

In addition to the above, content validity of the instrument was ensured using the outcome of the pre-test to refine the instrument to eschew all ambiguities. The researcher also thoroughly conceptualized the constructs of the study to ensure adequate capturing of the content domain. Extensive review of literature was conducted and the questionnaire was structured in sections to

cover all the variables under investigations. Lastly, the questionnaire was scrutinized by peers and supervisors.

Reliability was established by editing of the instrument by both the researcher and the supervisors to reflect the objectives and hypotheses developed for the study. The instrument was pre-tested with 50 students at the School of Nursing, University of Ghana who were serving officers and were not working in GHS facilities in the Greater Accra Region. Most of these nurses worked in district and regional hospitals. The Cronbach's alpha coefficient of the instrument was .968.

3.10 Data Analysis

Data analysis was both descriptive and inferential. All items on the questionnaire were carefully coded for efficient data analysis. Data was analysed with the SPSS version 16.00Statistical Package. Data analysis was carried out in two stages. The first stage explored bivariate relationships between demographic characteristics and unit characteristics using frequencies, means and percentages. Descriptive statistics such as the mean and the standard deviation were calculated and compared to describe the aspects of the principles of management (planning, organising, coordinating and controlling), as well as the relationship between perceived and preferred management practices of the nurse manager by the nurses.

The second stage was multivariate analysis, using 'multiple linear regression and post hoc analysis to examine causal relationships between demographic data of the nurse manager to the aspects of principles of management. Where a significant statistical difference existed, a univariate analysis (general linear models) was employed to analyse the variables that showed

statistical significant difference. Thus, multiple comparisons were made to establish the exact predictor of nurse manager behaviour. A p-value of <.05 was considered statistically significant in all association tests.

3.11 Ethical Consideration

Ethical clearance was sought from the Institutional Review Board (IRB) of the Noguchi Memorial Institute for Medical Research, University of Ghana, Legon (IRB 003/12-13). This was done by presenting the project proposal, participant information sheet and volunteer agreement form to the IRB (Appendix C).

With the ethical clearance secured from the IRB, Nugochi, and an introductory letter from the Public Administration and Health Service Management Department (Appendix G), permission was sought from the Greater Accra Regional Health Directorate and the Accra Psychiatric Hospital to use their premises as study areas. Introductory letters were given to management of hospitals directly under the regional office such as the Children's Hospital, Ridge Regional Hospital, Tema General, LEKMA, La General, Dangme West and East district Hospitals and Ga West and South Hospitals. Whereas, from the regional office, an introductory letter was given to the Accra Metropolitan Health Directorate (Appendix L); the directorate in turn gave the researcher introductory letters to Kaneshie and Maamobi General Hospitals.

These introductory letters were sent to the various administrative units of the selected hospitals. Permission was then granted to the researcher to initiate the data gathering process. A support staff was then instructed to take the researcher round the hospital and to introduce her to all nurse managers and staff at the unit level.

After institutional consent, individual consent was obtained by randomly identifying potential participants in the units by either the researcher or research assistants. The researcher established privacy and confidentiality through facilitated negotiation and renegotiation to protect and respect the participants' human rights and not to disclose any of the information divulged to the researcher. Additionally, anonymity was maintained by means of a numerical coding system which was coordinated by the researcher and her assistants. Furthermore, the purpose, nature and educational implications of the study, who qualifies to participate in the study, issues of voluntary participation were explained to the participants. Again, respondents were informed about the risks associated with the study and what the information gathered would be used for. Once respondents agreed to participate, they signed a volunteer agreement form (Appendix A) indicating that they have understood the purpose and nature of the study and voluntarily agreed to participate in the study. Language for the study was specific, simple and void of any ambiguity.

3.12 Summary

The chapter looked at the research methods for the study. A quantitative exploratory descriptive design was used to describe the phenomenon of management practice in primary and secondary hospitals in Greater Accra region as well as some specialized hospitals. Ethical clearance was sought from the Nugochi Memorial Institute, University of Ghana. Permission for data gathering was sought from management of the selected hospitals. Random sampling technique was employed to engage 552 nurses who have worked for at least three months in the selected hospital. Students were exempted from the study but serving officers who were students were selected as participants for the study. Self-administered questionnaires were used to gather data from participants at the unit level. Voluntary participation, anonymity and confidentiality were ensured throughout data collection with accurate description of the study's intent, educational

value and risks to participants for informed consent. Completed questionnaires were carefully scrutinized for comprehensiveness before collection.

CHAPTER FOUR

4.0 PRESENTATION OF RESULTS

Introduction

The purpose of this chapter is to present analysis of the preferred and perceived management practices in the unit by nurses and the implications of nurse manager characteristics on management practice in hospitals. The data were analysed to address the core issues relating to the objectives and the apriori assumptions of the study:

4.1 Socio-Demographic Characteristics of Participants

To examine management practices of nurse managers at the unit level, the study looked at the socio-demographic characteristics of nurses employed for the study and their relationships with nurse managers.

Table 4:1 Socio-Demographic Characteristics of Nurses

Variables: Rank	Gender		Total
	Male	Female	
SN/SM	64 (30.2)	148 (69.8%)	212 (100.0%)
SSN/SSM	13 (14.6%)	76 (85.4%)	89 (100.0%)
NO/MO	11 (16.2%)	57 (83.8%)	68 (100.0%)
SNO/SMO	3 (8.6%)	32 (91.4%)	35 (100.0%)
EN	35 (28.5%)	88 (71.5%)	123 (100.0%)
Rotation (completed)	1 (20.0%)	4 (80.0%)	5 (100.0%)
Total	**127 (23.9%)**	**405 (76.1%)**	**532* (100.0%)**
Basic qualification of nurses			
Certificate	50 (23.6%)	162 (76.4%)	212 (100.0%)
Diploma	66 (24.2%)	207 (75.8%)	273 (100.0%)
First degree	11 (18.6%)	48 (81.4%)	59 (100.0%)
Total	**127 (23.3%)**	**417 (76.7%)**	**544* (100.0%)**
Duration of Work with Nurse Managers			
<1year	32 (27.8%)	83 (72.2%)	115 (100.0%)
1-2years	50 (26.2%)	141 (73.8%)	191 (100.0%)
2-4years	20 (22.0%)	71 (78.0%)	91 (100.0%)
4-6years	6 (21.4%)	22 (78.6%)	28 (100.0%)
6-8years	1 (20.0%)	4 (80.0%)	5 (100.0%)
8-10years	0 (.0%)	2 (100.0%)	2 (100.0%)
>10years	1 (8.3%)	11 (91.7%)	12 (100.0%)
Don't know	14 (16.1%)	73 (83.9%)	87 (100.0%)
Total	**124 (23.4%)**	**407 (76.6%)**	**531* (100.0%)**
Age group			
20-29years	98 (29.5%)	234 (70.5%)	332 (100.0%)
30-39years	15 (14.3%)	90 (85.7%)	105 (100.0%)
40-49years	9 (16.1%)	47 (83.9%)	56 (100.0%)
50-59years	4 (11.4%)	31 (88.6%)	35 (100.0%)
≥60years	0 (.0%)	2 (100.0%)	2 (100.0%)
Total	**126 (23.8%)**	**404 (76.2%)**	**530* (100.0%)**

*Variable has missing values
Source: Field data, 2013

The study was able to capture data from all the ranks of practising nurses at the unit level. Whereas the minimum age of participants is 20 years, the maximum age is 66 years, the mean age is 31.11 years and the standard deviation is 8.871 years.

Table 4.2: Socio-Demographic Characteristics of Nurse Managers

Variables	Frequency	Percentage (%)
Qualification of Nurse Manager		
Post-basic	255	47.8
First Degree	250	46.9
Masters	27	5.1
Other	1	0.2
Total	533*	100%
Training in Management		
Yes	424	79.8
No	107	20.0
Total	531*	100%
Experience as Nurse		
0-5 years	43	8.0
6-10 years	63	11.7
11-15 years	80	14.8
16-20 years	41	7.6
Above 20 years	182	33.7
Don't know	131	24.3
Total	540*	100%
Experience as Nurse manager		
> 1 year	24	4.4
1-5 years	276	50.7
6-10 years	74	13.6
11-15 years	32	5.9
16-20 years	16	2.9
Don't know	122	22.4
Total	544*	100%

*Variable has missing values
Source: Field data, 2013

Out of the 533[1] participants' nurse managers, 47.8% of them have post-basic qualification in nursing whereas only 5.1% have Masters' Degrees. Out of the 531[2] participants' nurse managers 79.8% of them have had training in management.

4.2 Planning Practices of Nurse Managers at the Unit Level

The perception of nurses about the planning practices of the nurse manager at the unit level was described using the quantitative approach.

[1] Variable has missing values
[2] Variable has missing values

4.2.1 Perceived Planning Practices of the Nurse Manager at the Unit Level

To describe the perception of nurses about the planning practices of nurse managers at the unit level, out of the 541[3] participants, 2.2% perceived that the nurse manager and staff do not plan at all for the unit, 12.8% thought that planning is done to a small extent, 38.6% perceived that the unit plans to some extent, 32.7% perceived that to a large extent the unit plans whereas, 13.7% perceived that the nurse manager and staff plan to a very large extent. The mean is 3.43 and the standard deviation is .953. For collective preparation of duty roster, out of the 552participants, 5.8% perceived that nurse managers do not prepare the duty roster with staff at all, whereas 29.2% perceived that to a very large extent nurse managers and the staff collectively prepare the duty roster. The mean is 3.61 with a standard deviation of 1.195. Table 4.3 presents the results.

Table 4.3: Perceived and "Preferred"[4]Planning Practices of Nurse Managers

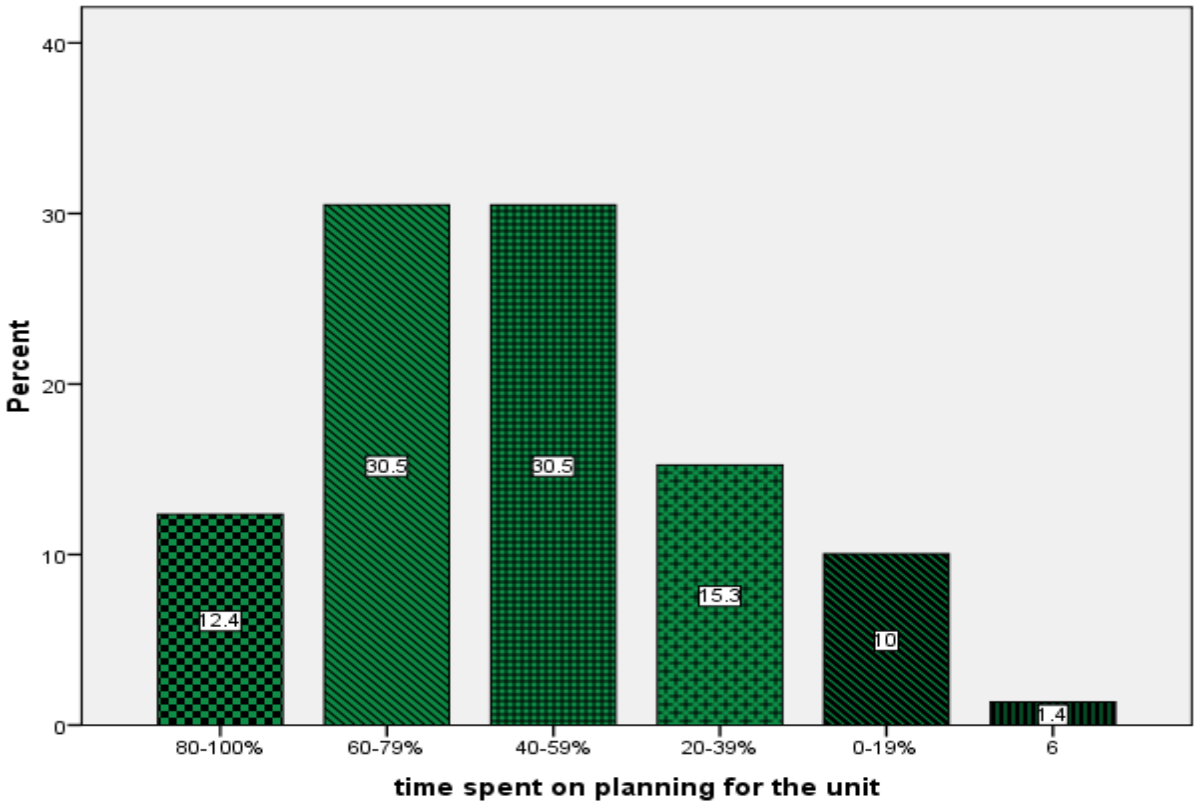
Planning with the nurse manager	Perceived		Preferred		Difference
	Mean	SD	Mean	SD	
Planning in the unit	3.43	.953	4.33	.786	.90
Description and explanation of decisions by nurse manager	3.52	1.027	4.30	.807	.78
Written plans in the unit	3.25	1.190	4.29	.863	1.04
Development and review of protocols & procedures by NM& staff	3.28	1.088	4.30	.851	1.02
Involvement of subordinates in decision making	3.52	1.057	4.33	.812	.81
Conduction of environmental analysis with staff	3.16	1.150	4.21	.877	1.05
Formulation of operational goals and objectives with staff	3.17	1.143	4.22	.863	1.05
Selection and formulation of operating plan from the alternatives	3.10	1.097	4.11	.933	1.01
Follow-up by NM & staff to the proposed course of action	3.34	1.091	4.24	.874	.90
Implementation of the plan with staff	3.50	1.082	4.32	.857	.82
Evaluation of previous plan	3.19	1.164	4.26	.867	1.07
Knowledge of the hospital mission	3.51	1.228	4.39	.887	.88
Vision for your unit	3.60	1.152	4.43	.806	.83
Effective communication with subordinates about the plan	3.52	1.093	4.36	.802	.84
NM plans on new ideas and encourage creative thinking	3.44	1.123	4.35	.843	.91
NM plans for supervision	3.57	1.103	4.34	.886	.77
NM plans for staff training and development	3.23	1.235	4.33	.879	1.10
NM plans for mode of organising nursing care	3.36	1.088	4.29	.869	.93
NM plans for the attitude of staff	3.32	1.110	4.24	.912	.92
NM plans for acquisition of resources for quality nursing care	3.63	1.085	4.46	.764	.83
Budget for your unit	2.83	1.317	4.23	.925	1.40
Collective preparation of the duty roster with colleagues	3.61	1.195	4.40	.888	.79
Total	**3.21**		**4.31**		**1.10**

Source: Field data, 2013

[3] Variable has missing values
[4] See section 4.2.5 for details

4.2.2 Perception of Nurses about Time Spent on Planning for the Unit

A large proportion of the participants 61% perceived that between 20 to 79% of their time is spent in planning for the unit. Correlation between time spent on planning for the unit and usage of plan is r = .312 with p< .01. Correlation between the time spent on planning and frequency is r = .262 with p< .01. Figure 4.1 shows a bar chart illustration of the results.

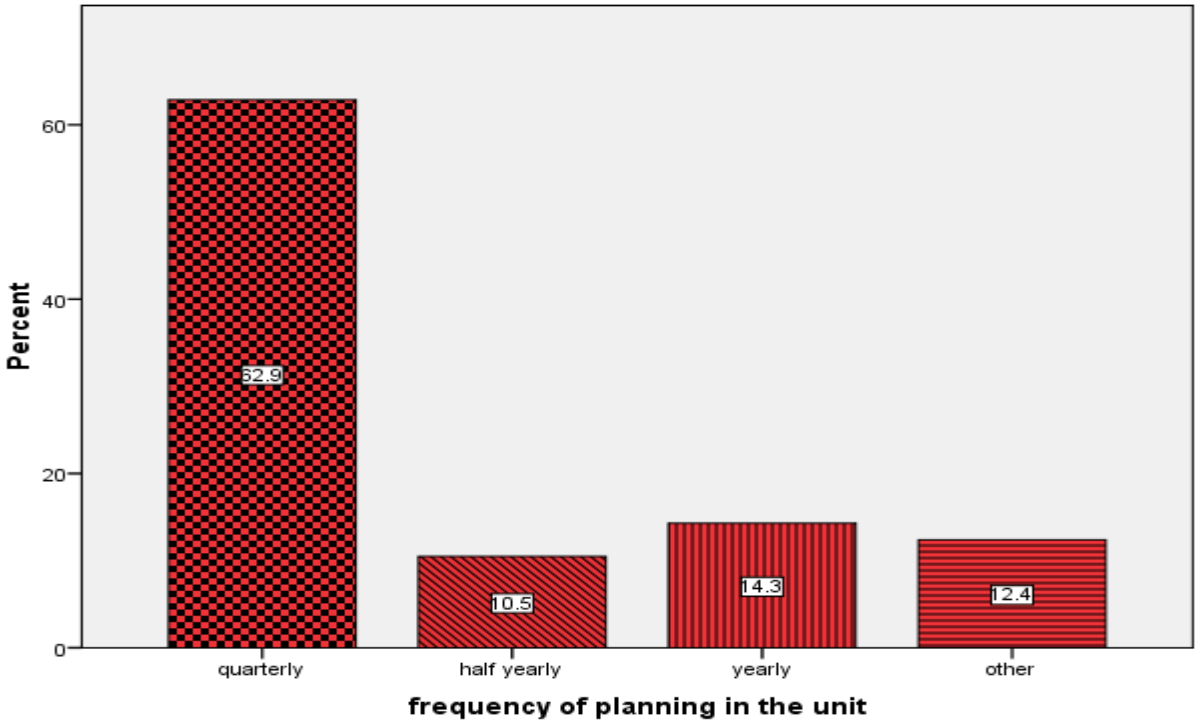


Source: Field data, 2013

Figure 4.1: Perception of Nurses about Time Spent on Planning for the Unit

4.2.3 Frequency of Planning for the unit

Majority (62.9%) of the respondents have quarterly plans. Correlation between frequency of planning and usage of plans is r = .312 with p<.05. Figure 4.2 shows the results.

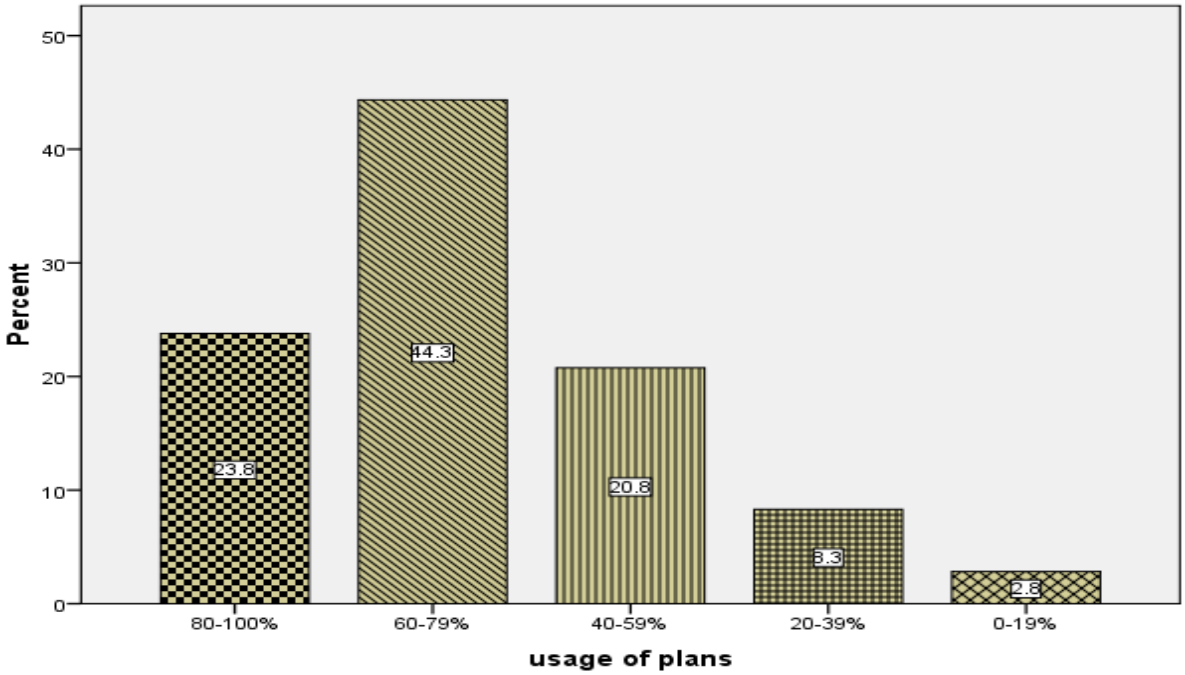


Source: Field data, 2013

Figure 4.2: Frequency of Planning at the Unit Level

4.2.4 Usage of Plans at the Unit Level

For usage of plans at the unit level, about 68% of the participants acknowledged that over 60% of the plans put together are utilized by the units, whereas only 11.10% of participants utilize less than 40% of the plans. Pearson correlation between usage of plans with frequency of planning and time spent on planning yielded the following outcomes; r = .312 with a p< .05, and r= .513 with a p< .05 respectively. Figure .4.3 illustrates the results.



Source: Field data, 2013

Figure 4.3: Usage of Plans by the Unit

4.2.5 Preferred Planning Practices of the Nurse Manager at the Unit Level

Generally, nurses at the unit level wished that planning would be enhanced as shown in Table 4.3 above. All the averages as compared with the perceived planning with the nurse managers increased and the standard deviations are also narrow. This depicts the urgency about the need of nurses for improved conditions at the unit level.

4.2.5.1 Collective Planning

Nurses would prefer the nurse manager to provide more description and explanation of decisions adopted. About 86% of the participants wished that to a large extent there should be increased involvement of subordinates in decision making. Out of the 552 comments generated from the nurses, 21.2% of the participants assert that planning at the unit level must involve all staff and even the patients should be encouraged to contribute to planning.

4.2.5.2 Nurses should be prompted about the Planning

Nurses were of the opinion that adequate information and time should be given prior to the planning process to allow many of them to participate.

4.2.5.3 Formal and Comprehensive Planning

Nurses alleged that planning must be written and pasted at vantage points to remind staff of what they intend to achieve within the period. Planning at the unit level must be structured and enforced.

4.2.5.4 Frequency of Planning

The frequency of planning preferred by participants was mostly quarterly and yearly plans but monthly plans were also suggested by some participants.

4.2.5.5 The Plan

Out of 552 participants, 3.6% were satisfied with planning in the units. However, some, though satisfied, would prefer the process to be more structured and regular. Participants are also of the view that plans should serve as guides, and must be implemented and reviewed regularly to ensure their achievement.

4.3 Organizing Practices of Nurse Managers at the Unit Level

The perception of nurses about the organising practices of nurse managers at the unit level was examined using the questionnaire.

4.3.1 Perceived Nurse Managers' Organization at the Unit Level

Out of the 532[5] respondents, 2.45% acknowledged that the nurse manager do not communicate effectively at all with staff on issues of assignment, 9.6% stated that the nurse manager communicate to a small extent, 31.7% said to some extent, 33.2% said to a large extent whilst 19.6% stated to a very large extent. The mean is 3.60 with a standard deviation of .997. Table 4.4 shows the details.

Table 4.4: Perceived and Preferred Organising Practices of the Nurse Manager

	Perceived		Preferred		
Nurse managers' organisation of the Unit	**Mean**	**SD**	**Mean**	**SD**	**Difference**
NM communicates effectively with staff on issues of assignment	3.60	.997	4.40	.745	.80
NM delegates with appropriate authority and resources	3.52	.988	4.39	.749	.87
Unit uses a model for organising nursing functions	2.98	1.117	4.25	.857	1.27
NM interacts easily and offers support where necessary	3.62	.970	4.40	.775	.78
Tasks in the unit have been well defined	3.48	1.041	4.41	.785	.93
Patient care accomplished by series of distinctive tasks by nurses	3.66	.907	4.39	.778	.73
Nurse have 24-hour responsibility for the care planned	3.71	1.026	4.40	.857	.69
Nurses organised to render comprehensive tasks within teams	3.51	1.001	4.34	.819	.83
Nurse manager deals with challenges and resolves conflicts	3.67	.986	4.42	.806	.75
NM establishes supportive relations to facilitate work	3.66	.975	4.44	.741	.78
NM ensures there is adequate resources for work	3.64	.984	4.45	.809	.81
NM ensures cohesion among unit nurses'	3.60	1.007	4.42	.781	.82
NM coordinates effectively activities in the unit	3.69	.981	4.48	.762	.79
NM collaborates with medical staff	3.82	.971	4.52	.689	.70
NM collaborates with other health care providers	3.75	1.001	4.43	.802	.68
NM has devolved power structures within the unit	3.40	1.076	4.30	.790	.90
NM has team building skills	3.51	1.101	4.39	.792	.88
NM has influence over the timing of unit and patient events	3.51	1.045	4.45	1.922	.94
NM has influence over human and financial resources in the unit	3.35	1.128	4.31	.893	.96
NM ensures client and staff satisfaction	3.56	1.033	4.39	.866	.83
NM ensures staff accountability to patient care	3.66	1.017	4.44	.759	.78
NM creates a positive work climate for colleagues	3.58	1.033	4.48	.775	.90
NM ensures staff is shortlisted for promotion	3.21	1.176	4.44	.782	1.23
NM ensures staff receive training on the job (self-development)	3.38	1.131	4.49	.781	1.11
Total	**3.54**		**4.41**		**.87**

Source: Field data, 2013

[5] Variable has missing values

4.3.2 Preferred Nurse Managers' Organisation Practices at the Unit Level

Nurses no doubt would prefer a change in the way activities are organised at the unit level. This is observed, generally, from the increased means as observed from Table 4.4. For instance, the mean for nurse managers having team building skills increased from 3.51 to 4.39 with standard deviation from 1.101 to .792 respectively.

4.3.2.1 Organising Skills of Nurse Managers

Out of the 514[6] respondents who commented, 22.0% conceded that they are very satisfied with the organizational skills of the nurse manager, 70.8% were satisfied, 2.4% didn't know, 1.2% were very dissatisfied whereas, 3.5% were just dissatisfied with the skills of the nurse manager.

4.4 Coordinating Practices of Nurse Managers at the Unit Level

The coordinating practices of nurse managers at the unit level were described using the perception of nurses.

4.4.1 Perceived Nurse Managers' Coordination Practices at the Unit Level

Out of the 522[7] respondents, 14.0% agreed that coordination of care to a very large extent is formal, 25.3% agreed to a large extent, 33.0% agreed to some extent, 19.7% agreed to a small extent, with 6.1% conceding that coordination of care is not formal at all. The mean is 3.21 and the standard deviation is 1.101. Table 4.5 presents the results.

[6] Variable has missing values
[7] Variable has missing values

Table 4.5: Perceived and Preferred Coordinating Practices of Nurse Managers

Coordinating activities of nurse managers	Perceived		Preferred		Difference
	Mean	SD	Mean	SD	
Coordination of care in the unit is formal	3.21	1.101	4.33	.808	1.12
Coordination in the unit is well structured manually	3.28	1.088	4.28	.848	1.00
Coordination in the unit is structured with ICT	2.48	1.341	4.23	.977	1.75
Coordination in the unit is done informally	3.02	1.122	3.96	1.191	.94
Work in the unit is standardized	3.32	.986	4.32	.927	1.00
Handing over in the unit is done at the bedside	3.59	1.153	4.38	.914	.79
Documentation in the unit is adequate	3.66	1.010	4.48	.785	.82
All information generated from patients is documented.	3.58	1.029	4.44	.788	.86
Procedures/interventions carried out for clients are documented	3.71	1.037	4.55	.722	.84
Effective communication between nurses and other colleagues regarding patient care.	3.73	1.001	4.54	.715	.81
Good interpersonal relationship between nurses and other colleagues' especially medical staff.	3.78	1.014	4.55	.702	.77
Hierarchies within professional groups play key role	3.63	1.023	4.42	2.302	.79
Confusion in the boundaries of coordination	2.66	1.249	3.69	1.452	1.03
All aspects of patient care are handed over to staff	3.68	1.036	4.41	.821	.73
Nurses join doctors on ward rounds	3.73	1,128	4.46	.831	.73
Nurses devote time to listen to patients' complaints	3.81	1.043	4.53	.746	.72
Nurses' devote time to give adequate information to patients concerning their conditions.	3.67	.996	4.51	.757	.84
NM coordinates effectively all activities in the unit	3.70	.979	4.55	.719	.85
NM has good interpersonal relationship with staff	3.89	1.022	4.64	1.460	.75
Good interpersonal relation among all nurses	3.85	1.047	4.58	.719	.73
Total	**3.50**		**4.40**		**.89**

Source: Field data 2013

4.4.2 Preferred Nurse Managers' Coordination Practices at the Unit Level

Out of the 491[8] respondents, 51.5% agreed that coordination to a very large extent should be well structured with ICT, 28.3% to a large extent, 14.3% to some extent, 3.7% to a small extent and 2.2% did not believe at all that coordination at the unit level should be well structured with ICT. The mean is 4.23 with a standard deviation of .977 depicting that most of the participants believed that ICT is the best way the unit can be structured. See table 4.5 for details.

4.4.2.1 Interpersonal Skills

Out of 318[9] respondents that remarked on how to improve coordination at the unit level, 16.4% gave varied suggestions on interpersonal relations. They argued that if there is trust and good

[8] Variable has missing values
[9] Variable has missing values

interpersonal relationship between nurses and equal treatment of all staff, coordination at the unit level would be effective. It is, therefore, necessary to improve interpersonal skills among staff in the various units. Nurse Managers must encourage and strengthen good interpersonal skills; interact freely with staff, build more ties with staff and correct them in a simple but vibrant manner. Interpersonal relations with patients and family should also be enhanced to boost client satisfaction. Significantly, nurse managers must respect every individual in the unit, and thus create more room for calm and cordial relationships.

4.4.2.2 Effective Communication

Out of 318[10] respondents, 7.9% remarked on effective communication at the unit level to boost coordination. Nurses must communicate well among themselves and with other health care team members. Communication must preferably be in a common language such as the English and this must be promoted by the nurse managers. Dialogue must also be encouraged at the unit level among the clinical team members.

4.4.2.3 Training and Information Technology (IT)

Out of 318[11] respondents, 3.46% suggested that regular training on coordination should be organised for staff to improve coordination at the unit level. For IT at the unit level, 2.51% remarked that structured information system would improve coordination. IT should be introduced to the units to enhance coordination of care.

[10] Variable has missing values
[11] Variable has missing values

4.4.2.4 Collectivism

Out of 318[12] comments, 12.26% made varied remarks about the involvement of staff at the unit level. Nurses argued that there must be full involvement of staff in decision making and problem solving at the unit level. Nurses must be encouraged to share ideas and concerns which would improve coordination at the unit level. Every slight effort of staff must be acknowledged while eschewing all sentiments of discrimination.

4.4.2.5 Team work and Listening

Out of 318[13] comments, 3.14% observed that nurses must work as a team in the unit to improve coordination. Group interest must be promoted as well as the encouragement of team work. About 3.14% also noted that nurse managers should always listen to complaints from both staff and clients. They must not just listen but understand and empathized with each other to improve coordination.

4.4.2.6 Documentation, Formalization, Supervision and Monitoring

Out of 318[14] comments, 2.51% mentioned the importance of documentation in coordination. Nurses should be motivated to improve documentation and nurse managers should ensure that all information generated from clients are documented. About 3.77% also remarked on formalization of coordination at the unit level. Coordination of care must be formal and well structured. Nurses acknowledged that coordination needs improvement and standardization. Protocols must be standardized and well documented and made available to all units with boundaries well spelt out. For effective supervision and monitoring, 2.2% argued that it is essential to ensure that all staff are accountable for their actions.

[12] Missing values
[13] Missing values
[14] Missing values

4.4.2.7 Delegation and Division of Labour

Out of 318[15] comments, 5.03% remarked on delegation and division of labour. Nurses asserted that coordination can be improved by assigning duties to staff and ensuring that performances are monitored to promote client wellbeing. Nurses also opined that nurse managers by delegating some responsibilities and synchronizing them effectively will boost coordination at the unit level. Job descriptions and boundaries should be well defined and staff should be informed about their job descriptions to enhance harmony at the unit level. About .94% also remarked on motivation of staff in order to improve work efficiency.

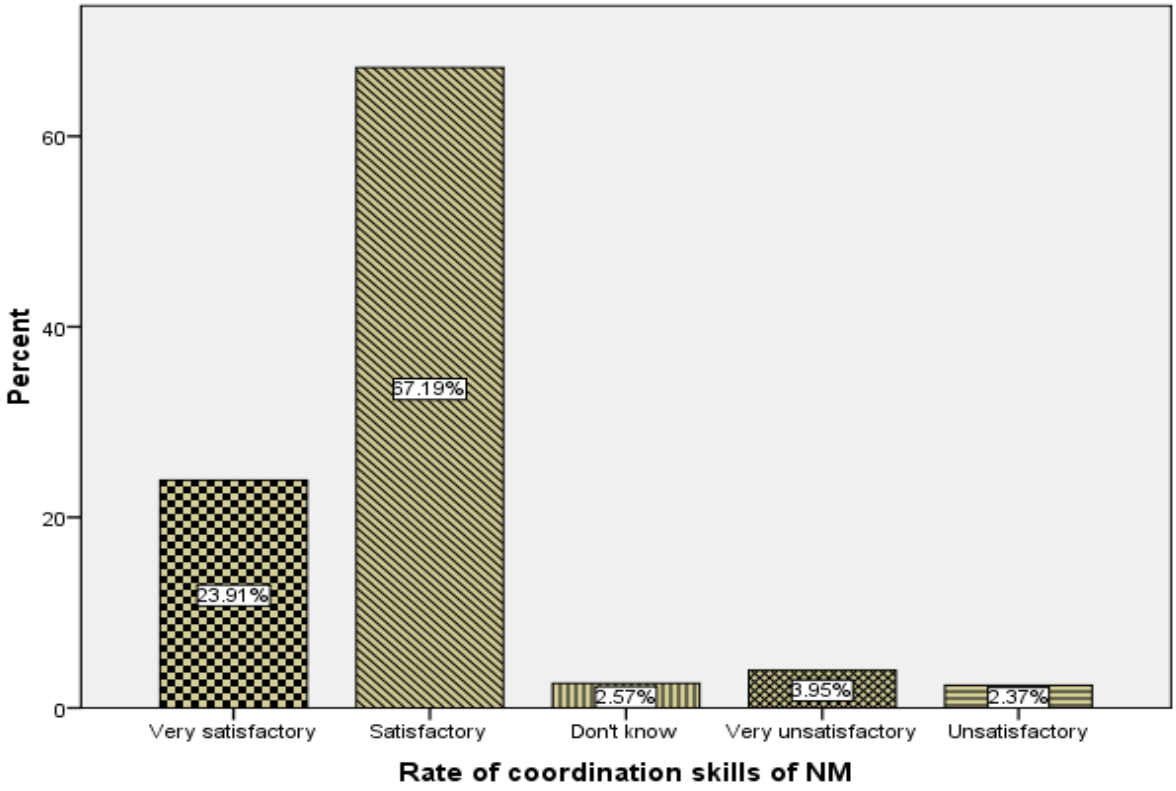
4.4.2.8 Staff Meeting

Out of the 318[16] comments generated from the respondents, 3.77% were about staff meetings. The nurses argued that by periodically reviewing and discussing complaints with staff, organising end of year get-together to improve socialization and frequent ward conferences and durbars to voice out grievances, nurse managers and stakeholders could abundantly improve coordination at the unit level. About 1.57% believed that coordination at the unit level is good whereas .94% believed that coordination can be improved. One recommended that handing over must be done at the bed side with 62% asserting that nurses must not condescend on each other. The nurse manager must ensure that every staff in the unit abides by the rules and regulations of the unit.

4.4.3 Coordination Skills of the Nurse Manager

Correlation of the nurse managers' coordination skills with type of unit shows that r = -.091 at p<.05. Figure 4.7 illustrates the results.

[15] Missing values
[16] Missing values



Source: Field data, 2013

Figure 4.4: Nurses' Perception of Coordination Skills of Nurse Managers

4.5 Control Practices of Nurse Managers at the Unit Level

The perception of nurses were sought to describe the control practices of nurse managers at the unit level.

4.5.1 Perceived Control Practices of Nurse Managers at the Unit Level

Out of the 525[17] respondents, 22.3% agreed that nurse managers must to a very large extent understand the governance of the hospital, 38.1% said that they must understand the governance of the hospital to a large extent, 28.8% stated to some extent, 9.3% said to a small extent

[17] Missing values

whilst1.5% said not at all. The mean is 3.70 and the standard deviation is .967. Table 4.6 shows the presentation of the results.

Table 4.6: Perceived and Preferred Control Practices of Nurse Managers

Control strategies used by the nurse manager	Perceived		Preferred		Difference
	Mean	SD	Mean	SD	
NM understands the governance of the hospital	3.70	.967	4.43	.715	.73
NM has developed rules and regulations for control	3.48	.976	4.40	.749	.92
Nurses work according to job descriptions	3.62	1.010	4.46	.737	.84
NM encourages self-directedness among staff	3.38	.968	4.29	.824	.91
NM gives constructive criticism	3.32	.968	4.41	2.478	1.09
NM is tolerant of people's mistakes and responsible for own mistakes	3.29	1.066	4.24	.906	.95
NM acknowledges all efforts made by staff	3.50	.976	4.41	.775	.91
NM trusts subordinates' competence	3.56	.931	4.39	.773	.83
NM improves team spirit	3.53	.962	4.44	.771	.91
NM encourages cooperation and coordination	3.63	.941	4.47	.725	.84
NM supervises work in the unit	3.74	1.011	4.51	.744	.77
NM coaches and mentors junior staff	3.72	.988	4.49	.741	.77
NM deals with challenges and conflicts in the unit	3.63	.988	4.38	.818	.75
NM appraises staff and organises for training	3.35	1.082	4.42	.780	1.07
NM has a firm control of the unit	3.64	.987	4.43	.798	.79
NM is able to control other professional in the unit	3.48	1.005	4.37	.804	.89
NM encourages accountability of staff	3.59	.949	4.38	.803	.79
NM gives due positive feedbacks	3.55	.987	4.41	.748	.86
NM organises durbars for staff where ideas are shared.	3.34	1.122	4.39	.795	1.05
Unit maintains a logbook for staff (attendance & time)	3.69	1.220	4.47	.793	.78
There is clear division of labour in the unit.	3.42	1.079	4.41	.796	.99
NM uses a lot of intimidation in controlling the unit	2.61	1.314	3.47	1.553	.86
NM employs minimal consultation in controlling unit	3.18	1.093	4.11	1.066	.93
Total	**3.48**		**4.36**		**.86**

Source: Field data 2013

4.5.2 Preferred Control Practices of Nurse Manager at the Unit Level

Out of 482[18] respondents, 54.1% admitted that to a very large extent they will prefer nurse managers to develop rules and regulations for controlling the unit, 33.2% said to a large extent, 11.0% to some extent and 1.7% to a small extent. The mean is 4.40 with a standard deviation of .749. Table 4.6 shows tabulation of the results.

[18] Missing values

4.5.2.1 Responsive Behaviour of Nurse Managers

Out of the 338[19] comments about how to enhance control at the unit level, 11.83% will prefer nurse managers to be more responsive at the unit level. The nurses advocated that nurse managers must be compassionate, make frequent checks during working hours to ensure that all report for duty and be affiliated to staff to help resolve the many challenges they habitually encounter. Nurses also proposed that nurse managers must be assertive, punctual to work and ensure that activities are done professionally. They must resolve conflicts and maintain control at the unit level. Again, nurse managers should acknowledge all efforts of staff so as to promote accountability among colleagues.

Out of 338[20] comments, 6.51% declared that nurse managers are effective in maintaining control at the unit level but this can be further improved by being more cordial. Nurse Managers must be encouraged to keep up the good work being executed by them.

4.5.2.2 Rules and Regulations

Out of 338[21] comments, 8.88% advocated firm and fair control at the unit level with adequate rules and regulations. Nurse managers must be role models, and be firm in dealing with staff but at the same time ensure flexibility to allow for adherence to rules and regulations. The control at the unit level by nurse managers must also be extended to other professional groups to make it more binding.

[19] Missing values
[20] Missing values
[21] Missing values

4.5.2.3 Division of Labour and Supervision

Out of 338[22] comments, 5.92% proposed clear division of labour at the unit level. They acknowledged that nurse managers must ensure nurses are assigned duties based on their professional status. Control at the unit level can be improved by giving feedback to staff. About 13.31% made varied suggestions about supervision at the unit level. Nurses advocated that control can be improved by appropriate daily supervision, holding of regular meetings to debrief staff and sharing of ideas about how to forge ahead. Team spirit must be encouraged and monitoring and evaluation enhanced. Poor feedback needs to be improved by good communication.

4.5.2.4 Interpersonal Relations and Training

Out of 338[23] comments, 6.51% schemed about enhancement of interpersonal relations of staff. Nurses advocated that by ensuring harmony and good interpersonal relations at the unit level, control will improve. Nurse managers must relate well with all staff and be able to reward diligent staff by at least verbal recognition. Cooperation and coordination need to be encouraged and nurse managers must be creative with ideas. The attitude of the nurse manager must be that of courtesy, collaboration, proficiency and availability to staff. Discipline and mutual respect are equally required in maintaining control in the units. About 3.55% expressed that control can be improved with training; nurse managers must be given the technical know-how on how to control the unit by regular workshops.

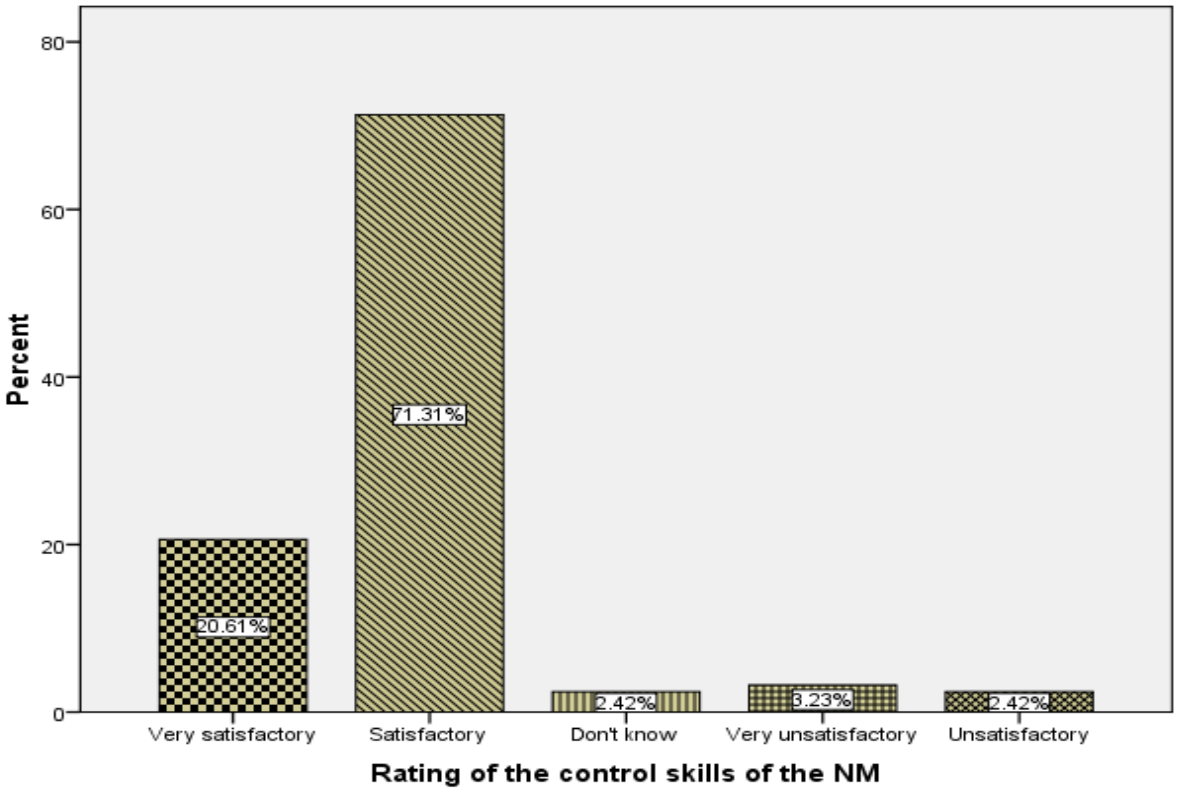
[22] Missing values
[23] Missing values

4.5.2.6 Collectivism

Out of 338[24] comments, 2.96% believed that control can be enhanced with adequate involvement of all staff to ensure accountability. Nurse managers should share challenges with all staff and be open to sharing of ideas from colleagues. They need to tone down on ordering people around and participate fully in the activities of the unit.

4.5.3 Control Skills of Nurse Managers at the Unit Level

Majority of the respondents (71.31%) agreed that control skills of the nurse managers are satisfactory. Correlation between control skills of nurse managers and work experience of the nurse manager is r = -.126 at p< .05. Figure 4.8 depicts outcome of the analysis.



Source: Field data, 2013

Figure 4.5: Nurses' Perception of Nurse Managers' Control Skills

[24] Missing values

4.6 Implications of Management Practice at the Unit Level

Out of 521[25] respondents, 17.5% were satisfied to a very large extent with management practice at the unit level, 31.5% were satisfied to a large extent, 35.9% were satisfied to some extent, 10.7% were satisfied to a small extent whilst 4.4% were not at all satisfied with management practice. The mean is 3.47 and the standard deviation is 1.039. Table 4.7 shows the results.

Table 4.7: Implications of Management Practice at the Unit Level

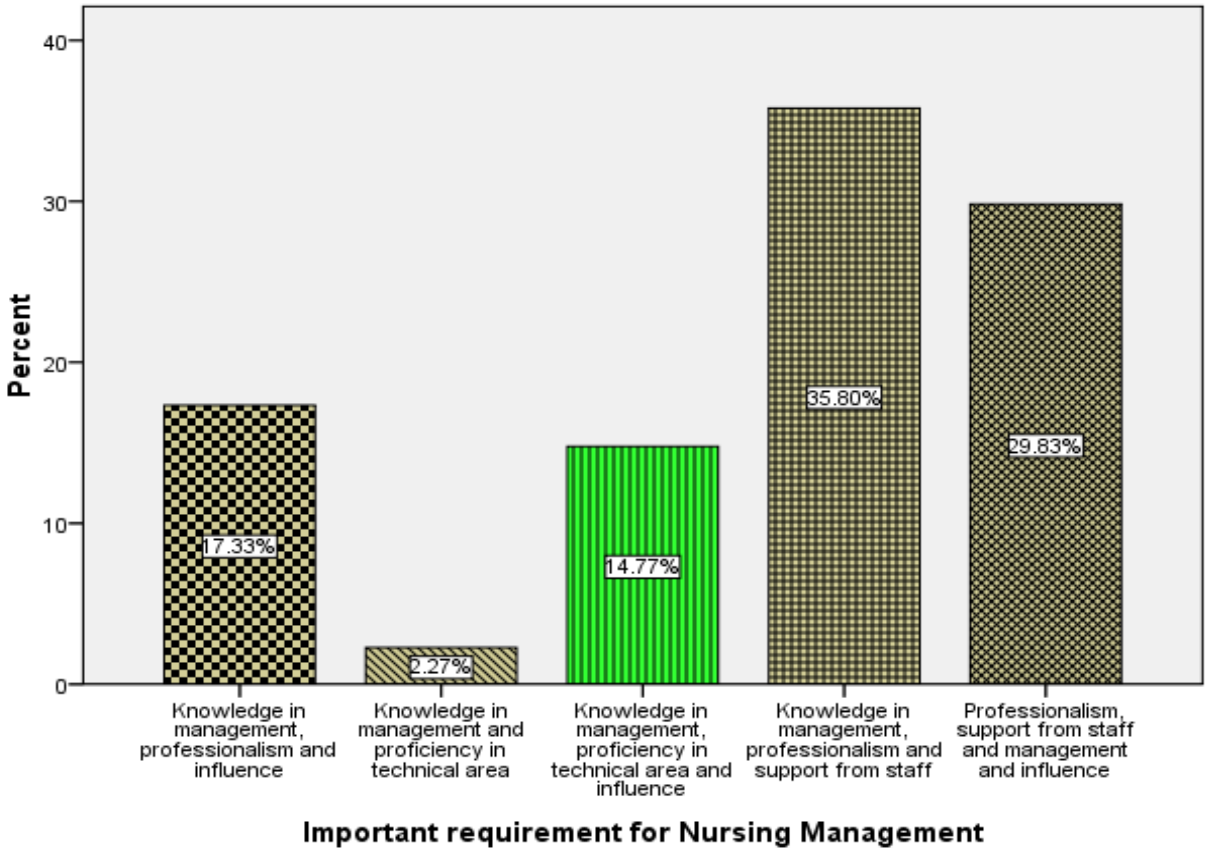
Implications	1(%)	2(%)	3(%)	4(%)	5(%)	Mean	SD
Staff satisfaction	4.4	10.7	35.9	31.5	17.5	3.47	1.039
Client satisfaction	1.3	9.6	38.0	34.5	16.6	3.55	.924
NM need for knowledge in management	6.6	15.4	31.8	28.7	17.5	3.55	1.133
Good Image of nurses with other Health professionals	1.0	5.6	33.3	41.5	18.6	3.71	.866
Healthy work environment	7.3	17.3	33.0	29.0	13.2	3.24	1.110
Effectiveness of nursing care in the unit	1.2	9.5	33.8	38.3	17.3	3.61	.919
Efficiency of nursing care in the unit	0.6	9.4	33.5	40.4	16.2	3.62	.885
Work environment positive for growth	5.2	15.4	35.2	29.6	14.6	3.33	1.065
Effective exchange of information with other units	4.6	11.7	36.0	30.4	17.1	3.53	2.335

Source: Field data, 2013

4.6.1 Key Requirement for Management Practice at the Unit Level

Out of 352[26] respondents, 35.8% acknowledged that knowledge in management, professionalism and support from staff are the most essential requirements for management practice at the unit level. Figure 4.9 shows a bar chart representation of the results.

[25] Missing values
[26] Missing values



Source: Field data, 2013

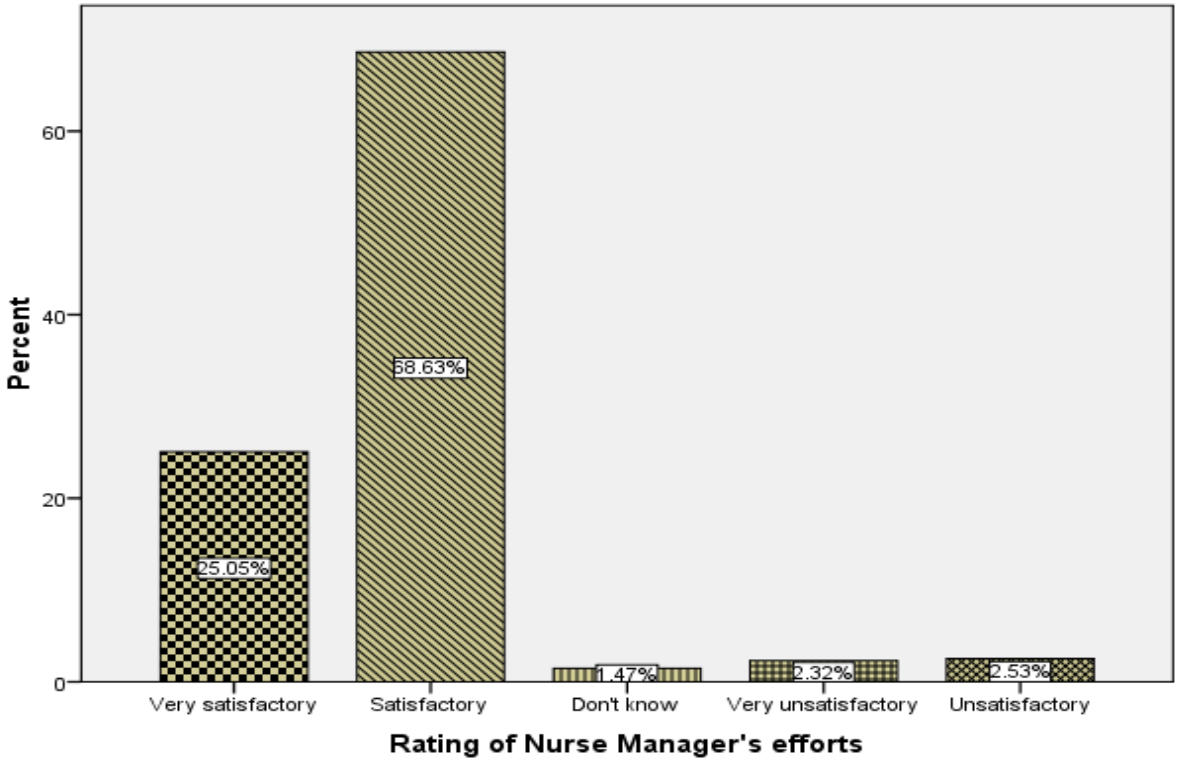
Figure 4.6: Requirement for Management Practice

4.6.2 Rating of Nurse Managers' Efforts at the Unit Level

Out of 461[27] respondents, 80% claimed that their nurse managers have had training in management and 20% claimed that their nurse managers have not had training in management. From the 369 respondents who claimed their nurse managers have had training, 23.85% of them asserted that the efforts of nurse managers to be very satisfactory, 70.46% said efforts of nurse managers were satisfactory, 2.98% were very dissatisfied with the efforts of the nurse managers, 1.63% also claimed efforts of the nurse managers were unsatisfactory whereas 1.08% did not really know. With the 20% respondents who claimed their nurse managers did not have training

[27] Missing values

in management, 27.17% were very satisfied with the efforts of their nurse managers, 63.04% were satisfied, 3.26% did not know and only 6.52% were dissatisfied; no one was very dissatisfied with the efforts of the nurse managers at the unit level. The χ^2 = 12.741, df =4 and p-value = .013 (p<.05). Figure 4.10 shows the results of the analysis.



Source: Field data, 2013

Figure 4.7: Rating of Nurse Managers' Efforts at the Unit Level

4.7 Hypotheses Testing

Hypotheses were developed and tested for all the activities developed under the four functions of management. The outcome is in the subsequent sessions.

4.7.1 Planning Practices of the Nurse Manager at the Unit Level

H_0: Training in management, qualification of nurse manager, and experience have no significant effect on nurse managers' practice of planning.

A two-way ANOVA was employed to test the hypothesis for all the managerial variables on dependent variables for planning the unit by the nurse managers.

Table 4.8: Effects of Managerial Variables on Nurse Managers' Planning Practice

Source (Managerial Variables)	F	Sig.
Qualification of NM	.084	.987
Training in Management	.362	.835
Experience as Nurse	3.772	.005*
Experience as NM	1.336	.255

Source: Field data, 2013

From Table 4.8, it is observed that the hypothesis is partly supported by the data since experience as a nurse has a significant effect on nurse managers' practice of planning at the unit level $[F_{(4,\ 497)} = 3.772,\ p = .005]$. The other variables have no significant effect on nurse managers' practice of planning at the unit level. Hence, post hoc analysis of the levels of work experience as related to nurse managers' practice of planning is presented in Table 4.9.

Table 4.9: Post Hoc Analysis of the Effect of Experience as Nurse on Extent of Planning

	(I) Work experience	(J) Work experience	Sig.
LSD	0-5 years	6-10 years	.172
		Above 20 years	.572
	6-10 years	11-15 years	.018*
		16-20 years	.016*
	11-15 years	0-5 years	.490
		6-10 years	.018*
	16-20 years	0-5 years	.327
		6-10 years	.016*
	Above 20 years	16-20 years	.071

Source: Field data, 2013

From the post hoc analysis, it is indicative that nurses who have experience for 6 (six) years and above are more likely to plan for the unit. Increased years of experience enable proficiency; however, beyond 20 (twenty) years, experience is no longer relevant.

4.7.1.1 Written Plan

H_0: Training in management, additional qualification, and experience have no significant effect on nurse managers having a written plan.

Table 4.10: Effects of Managerial Variables on having a Written Plan for the Unit

Source	Mean Square	F	Sig.	R^2
NM qualification	1.199	.908	.404	.004
Training	4.860	3.680	.056	.009
Experience as nurse	2.823	2.138	.060	.025
Experience as NM	.587	.444	.849	.006
NM qualification * training	4.627	3.504	.031*	.017
Training * experience as NM	3.724	2.820	.016*	.033

Source: Field data, 2013

From Table 4.10, the null hypothesis is retained since none of the independent variables is significant at .05 level. However, a significant interaction is observed between nurse managers qualification and training in management $[F_{(2, 409)} = 3.504, p= .031, R=17\%]$ and also between training in management and experience as a nurse manager$[F_{(5, 409)} = 2.820, p= .016, R=33\%]$. This implies that training in management will have a significant effect on having a written plan only when the nurse manager has additional qualification or is experienced as a nurse manager.

4.7.1.2 Describing and Explaining of Decisions

H_0: Training in management, additional qualification, and experience have no significant effect on nurse managers' ability to describe and explain decisions.

Table 4.11: Effects of Managerial Variables on Nurse Managers' Ability to Describe and Explain Decisions

Source (Managerial Variables)	Mean Square	F	Sig.	R^2
NM qualification	2.578	3.054	.551	.003
Training	2.753	3.092	.079	.008
Experience as nurse	4.416	4.960	.000*	.057
Experience as NM	.546	.613	.720	.009
NM qualification * training	3.438	3.861	.022*	.019
NM qualification * experience as nurse	2.366	2.657	.004*	.061

Source: Field data, 2013

The two-way ANOVA results presented in Table 4.11 show that experience as a nurse has a significant effect on nurse managers' ability to describe and explain decisions to staff *[$F_{(5, 499)}$= 4.960, p=.000]* and the change is accounted for by 57%. Thus, the hypothesis is partly supported by the data. Furthermore, significant interactions are observed between nurse manager qualification and training in management *[$F_{(2, 499)}$ = 3.861, p=.022, R=19%]* as well as nurse manager qualification and experience as a nurse *[$F_{(10, 499)}$ = 2.657, p=.04, R=61%]*.To identify the specific years of experience as a nurse that accounts for the significant effect, a post hoc analysis was carried out as presented in Table 4.12.

Table 4.12: Post Hoc Analysis of Experience as a Nurse to Nurse Managers' Ability to Describe and Explain Decisions to Staff

	Work experience (I)	Work experience (J)	Sig.
LSD	0-5 years	6-10 years	.001*
		Above 20 years	.001*
	6-10 years	16-20 years	.045*
		Don't know	.022*
	11-15 years	6-10 years	.019*
		16-20 years	.179
	16-20 years	6-10 years	.045*
		11-15 years	.179
	Above 20 years	Don't know	.018*

Source: Field data, 2013

The multiple comparisons above indicate that at least experience of 0-5 years and 6 – 10 years *(p=.008)*, as well as 0-5 years and above 20 years *(p=.010)* as a nurse have a significant effect

on the nurse managers' ability to describe and explain decisions to staff. The other periods of experience make no significant difference.

4.7.1.3 Development and Review of Protocols and Procedures

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' and staff development and review of protocols as well as procedures.

Table 4.13: Effects of NM Variables on NM and Staff Development and Review of Protocols and Procedures

Model		Mean Square	F	Sig.
	Regression	5.720	5.011	.001[a]
	Residual	1.141		
	Total			

- Predictors: (Constant), Experience as NM, Qualification of NM, Training in Management, Experience as Nurse
- Dependent Variable: NM and Staff develop and review protocols and procedures (perceived)

Source: Field data, 2013

The summary result of the two-way analysis clearly shows a significant relationship between the dependant variable and the predictors of nurse manager behaviour of developing as well as reviewing protocols and procedures. Thus, the hypothesis is strongly supported. Further analysis revealed qualification of NM *($p=.041$)* and experience as NM *($p=.011$)* as being significant. This predicts that qualification of NM and experience as NM will promote NM and staff development and review of protocols and procedures in the unit to reflect the changes within the health sector.

4.7.1.4 Involving Subordinates in Decision Making

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to involve subordinates in decision making.

There is no significance between the predictor variables and the dependent variable *[$F_{(4, 498)}$ = .562, p=.690]*. The hypothesis is therefore rejected and the null hypothesis accepted.

4.7.1.5 Conduction of Internal and External Analysis with Staff

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to conduct internal and external analysis of the environment with staff.

Table 4.14: Effects of Managerial Variables on NM Ability to Conduct Internal and External Environmental Analysis with Staff

Source (Managerial Variables)	Mean Square	F	Sig.	R^2
NM qualification	1.124	.933	.394	.005
Training	1.321	1.097	.296	.003
Experience as nurse	4.329	3.595	.003*	.042
Experience as NM	.413	.343	.914	.005
NM qualification * training	2.448	2.033	.132	.010
NM qualification * experience as nurse	2.389	1.984	.034*	.047

Source: Field data, 2013

The result presented in Table 4.14 shows that experience as a nurse has 42% chance on nurse managers' ability to conduct internal and external analysis of the environment with staff *[$F_{(5, 496)}$= 3*.595, *p=.003, R=42%]*. Thus, the hypothesis is partly supported by the data. Furthermore, significant interaction is observed between experience as a nurse and NM qualification *[$F_{(10, 496)}$= 2.389, p=.034, R=47%]*. To identify the specific years of experience as a nurse that accounts for the significant effect, a post hoc analysis is carried out as presented in Table 4.15.

Table 4.15: Post Hoc Analysis Experience as a Nurse on Nurse Managers' Ability to Conduct Internal and External Analysis with Staff

	Work experience (I)	Work experience (J)	Sig.
LSD	0-5 years	6-10 years	.002*
		11-15 years	.629
	6-10 years	16-20 years	.001*
		Above 20 years	.001*
	11-15 years	6-10 years	.002*
		16-20 years	.471
	16-20 years	6-10 years	.001*
		Don't know	.050*
	Above 20 years	0-5 years	.086

Source: Field data, 2013

The multiple comparisons above indicate that at least experience of 6-10 years and 16 – 20 years as a nurse have a significant effect on the nurse managers' ability to conduct internal and external analysis of the environment with staff (*p=.033)* after which additional years of experience make no significant difference.

4.7.1.6 Formulation of Goals and Objectives with Staff

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to formulate goals and objectives with staff.

Even though the hypothesis is partly supported *[$F_{(4, 497)} = 2.605$, $p = .035$]* by experience as NM (p=.030), test of between-subjects effect is not significant.

4.7.1.7 Selection and Formulation of Operating Plan from Alternatives

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to select and formulate the operating plan from objectives.

The ANOVA for multiple regression is $[F_{(4, 487)} = 1.794, p \geq .05]$, the alternative hypothesis is therefore rejected and the null hypothesis accepted.

4.7.1.8 Follow up on Proposed Course of Action

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to select and formulate the operating plan from objectives.

The ANOVA for multiple regression is $[F_{(4, 494)} = 1.333, p \geq .05]$. The hypothesis is rejected and the null hypothesis accepted.

4.7.1.9 Implementation of Plan with Staff

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to implement plan with staff.

Table 4.16: Effects of Managerial Variables on NMs' Ability to Implement Plan with Staff

Source (Managerial Variables)	Mean Square	F	Sig.	R^2
NM qualification	1.520	1.326	.267	.006
Training	1.206	1.052	.306	.003
Experience as nurse	2.507	2.187	.055	.026
Experience as NM	2.541	2.217	.041*	.032
NM qualification * training	3.685	3.215	.041*	.016

Source: Field data, 2013

The hypothesis is partially supported $[F_{(6, 495)} = 2.217, p = .041]$ by experience as nurse manager. This means that experience as a nurse has 32% significant influence on nurse managers' ability to implement plans with staff. There is also interaction between NM

qualification and training in management. Thus, nurse managers with training in management and additional qualification are more likely to implement plans with staff.

4.7.1.10 Evaluation of Previous Plan

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to evaluate previous plans.

From the data, the hypothesis $[F_{(4, 492)} = 1.136, p \geq .05]$ is rejected since there is no significant relationship between the nurse manager variables and ability to evaluate previous plans.

4.7.1.11 Knowledge of Hospital Mission

H_0: Training in management, qualification of NM, and experience has no significant effect on nurse managers' knowledge on hospital mission.

From the analysis it is observed that the hypothesis is partly supported by the data since experience as a nurse has a significant effect on knowledge of hospital mission $[F_{(5, 495)} = 2.915, p = .013]$. The other variables have no significant effect on knowledge of the hospital mission. Interaction is observed between nurse manager qualification, training in management and experience as nurse manager $[F_{(3, 495)} = 2.964, p = .032, R = 21\%]$. This implies that nurse managers, who have practised for a while, have additional qualification and training in management would know about the mission of the hospital. Multiple comparism is not significant.

4.7.1.12 Vision for the Unit

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to have a vision for the unit.

From the analysis the hypothesis is partially supported by the data since experience as nurse has a significant effect on the nurse manager's ability to have a vision for the unit *[$F_{(5, 495)}$ = 3.060, p= .010, R= 36%]*. Experience as a nurse; accounts for 36% chance of the nurse manager developing a vision for the management of the unit. Post hoc analysis is not significant.

4.7.1.13 Effective Communication at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to communicate effectively.

Table 4.17: Effects of Managerial Variables on NM's Ability to Communicate Effectively

Source (Managerial Variables)	Mean Square	F	Sig.	R^2
NM qualification	.756	.673	.511	.003
Training	.107	.095	.758	.000
Experience as nurse	2.331	2.075	.068	.025
Experience as NM	1.867	1.662	.129	.024
Training * Experience as NM	3.169	2.821	.016*	.033

Source: Field data, 2013

Table 4.17 shows that all the managerial variables do not individually have significant influence on nurse managers' ability to communicate effectively. However, training in management and experience as nurse manager interact to significantly influence the nurse managers' ability to communicate effectively *[$F_{(5, 495)}$ = 2.821, p=.016, R=33%]*. We can therefore infer that, nurse managers who have had training in management and experience as a manager would communicate effectively.

4.7.1.14 Encouraging New Ideas and Creative Thinking

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to encourage new ideas and creative thinking among staff.

From the analysis; the hypothesis is strongly supported *[$F_{(5, 496)} = 4.602$, $p = .001$]* by training in management *($p=.002$)* and experience as nurse manager *($p=.021$).* This implies nurse managers who have had training in management and experience as a manager are apt to encourage new ideas and creative thinking among staff.

4.7.1.15 Planning for Supervision

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to plan for supervision.

From the analysis, it is observed that the hypothesis is partly supported by the data since experience as a nurse has a significant effect on nurse manager's ability to plan for supervision in the unit *[$F_{(5, 493)} = 3.130$, $p=.009$]*. The other variables have no significance on nurse manager planning for supervision. Interaction is observed between nurse manager qualification and experience as nurse *[$F_{(10, 493)} = 1.940$, $p=.039$, $R=46\%$]*. We can therefore infer that, nurse manager qualification would only influence his or her ability to plan for supervision only when he or she has a prior experience as a nurse. Post Hoc analysis was not significant.

4.7.1.16 Planning for Staff Training and Development

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to plan for staff training and development.

Table 4.18: Effects of Managerial Variables on NMs' Ability to Plan for Staff Training and Development

Source (Managerial Variables)	Mean Square	F	Sig.	R^2
NM qualification	.344	.240	.787	.001
Training	1.593	1.109	.293	.003
Experience as nurse	3.324	2.314	.043*	.028

Source: Field data, 2013

From the table above, we can infer that experience as a nurse has a significant effect which is explained by the 28% chance of nurse managers' ability to plan for staff training and development $[F_{(2,\ 493)} = 2.314,\ R=.028,\ p = .043]$. The hypothesis, therefore, is partially supported.

4.7.1.17 Planning for Organizing Nursing Care

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to plan for mode of organizing nursing care.

From the analysis, it is observed that the hypothesis is partly supported by the data $[F_{(4,\ 496)} = 2.402,\ p = .049]$. Experience as a nurse has a significant effect on nurse managers' ability to plan for mode of organising nursing care $[F_{(5,\ 496)} = 3.939,\ p=.002,\ R=46\%]$. The other variables have no significance. Significant effect is also observed with interaction between experience as a nurse and experience as a nurse manager on nurse managers' ability to plan for mode of organising nursing care $[F_{(18,\ 496)} = 1.857,\ p = .018,\ R=76\%]$. Hence, to come up with a mode for organising nursing care, nurse managers need to be experienced both as a nurse and as a

manager. A worth of experience is, therefore, necessary for this responsibility of the nurse manager. Multiple comparism was insignificant.

4.7.1.18 Planning for Staff Attitude

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to plan for staff attitude.

Tests of between-subject effect revealed a significant effect of experience as a nurse on the nurse managers' ability to plan for attitude of staff $[F_{(5, 496)}, = 2.482, p=.031, R = 30\%]$. Interaction is observed between nurse manager qualification and experience as a nurse on nurse manager's ability to plan for staff attitude $[F_{(10, 496)}, = 2.153, p=.020, R= 50\%]$. It can then be inferred that planning for staff attitude depends much on educational background and experience generally.

4.7.1.19 Planning for Resource Acquisition

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to plan for acquisition of resources.

Observation from the multiple regression analysis revealed that there is no significance between nurse manager variables and nurse managers' plan for acquisition of resources $[F_{(4, 497)} = 1.135, p \geq .05]$.The null hypothesis therefore is accepted.

4.7.1.20 Budgeting for the Unit

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to budget for the unit.

Form the multiple regression analysis, it is observed that all the managerial variables made no significant difference on the nurse managers' ability to budget for the unit *[$F_{(87,493)}$=1.264, p=.070]*. The null hypothesis therefore is accepted.

4.7.1.21 Collective Preparation of Duty Roster

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to collectively prepare the duty roster.

Tests of between-subjects effects depicted significant effect of experience as a nurse on nurse managers' ability to collectively prepare the duty roster *[$F_{(5, 498)}$ = 2.573, p= .026, R=30%]*. The hypothesis is therefore partially supported. Interaction is observed between nurse manager qualification and experience as a nurse *[$F_{(10, 498)}$ = 2.047, p=.028, R=48%]* on ability of the nurse manager to collectively prepare duty roster with staff. Post Hoc analysis was not significant.

4.7.2 Organising Practices of Nurse Managers at the Unit Level

Hypotheses were developed for all the activities under the organising practices of nurse managers and tested with managerial variables. The results are presented in the adjoining sessions.

4.7.2.1 Effective Communication of Assignments

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to communicate effectively on issues of assignment.

From the multiple regression analysis, the hypothesis is rejected *[$F_{(4, 493)} = 1.040$, $p \geq .05$]* and tests of between-subjects effects were not significant.

4.7.2.2 Delegation at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to delegate at the unit level.

Table 4.19: Effects of Nurse Manager Variables on NM's Delegation at the Unit Level

Source (Managerial Variables)	Mean Square	F	Sig.	R
NM qualification	3.622	3.863	.022*	.019
Training	.843	.899	.344	.002
Experience as nurse	2.502	2.668	.022*	.032
Experience as nurse manager	.610	.651	.690	.009
Training * experience as nurse manager	2.132	2.274	.047*	.027

Source: Field data, 2013

Table 4.19 shows that experience as a nurse *[$F_{(5,496)} = 2.668$, $p = .022$, $R = 32\%$]* and NM qualification *[$F_{(2, 496)} = 3.863$, $p = .022$, $R = 19\%$]* have significant effect on nurse managers' delegation practices. The hypothesis therefore is supported. Training in management and experience as nurse manager *[$F_{(2,496)} = 2.274$, $p = .047$, $R = 27\%$]* have significant influence on nurse managers' delegation practices. However, post hoc analysis showed no difference in the various levels of experience as a nurse.

4.7.2.3 Models for Organising Nursing Functions

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to use a model for organising functions at the unit level.

From the multiple regression analysis, no significant effect is found between the managerial variables and the unit using a model for organising nursing functions $[F_{(4, 490)} = 2.489, p = .43]$. The null hypothesis is therefore accepted.

4.7.2.4 Interaction and Support of Staff in the Unit

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to interact easily and offer support to staff.

From the multiple regression analysis, no significant effect is found between the managerial variables and nurse managers' ability to interact easily and offer support to staff $[F_{(5, 493)} = .568, p \geq .05]$. The null hypothesis is therefore accepted.

4.7.2.5 Well Defined Tasks at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to well define tasks at the unit level.

Multiple regression analysis indicated that no significant effect is between the managerial variables and nurse managers' ability to have well defined tasks at the unit level *[$F_{(4, 491)}$ = .737, $p \geq .05$]*. The null hypothesis is therefore accepted.

4.7.2.6 Accomplishment of Care by Distinctive Tasks

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to ensure that patient care is accomplished by distinctive tasks.

The multiple regression analysis depicted significant effect between experience as a nurse and nurse managers' ability to ensure that patient care is accomplished with distinctive tasks *[$F_{(5, 487)}$ = 2.294, p = .045, R=28%]*. The hypothesis is therefore partially supported.

4.7.2.7 Primary Nursing

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to use primary nursing at the unit level.

The multiple regression analysis indicated a significant effect between experience as a nurse manager and nurse managers' ability to use primary nursing at the unit level *[$F_{(4, 483)}$ = 2.559, p= .002]*. The alternative hypothesis is thus partially supported. All other managerial variables were not significant.

4.7.2.8 Team Nursing

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to use team nursing at the unit level.

From the multiple regression analysis, significant effect is observed between experience as a nurse and the nurse managers' ability to use team nursing at the unit level *[$F_{(5, 487)}$, = 2.926, p=.013, R=35%]*. The hypothesis, therefore, is partially supported. Interaction is also observed between training in management and experience as a nurse manager on the nurse managers' ability to employ team nursing at the unit level *[$F_{(5, 487)}$, = 2.820, p=.016, R=34%]*. Hence, the use of team nursing in organising nursing functions is influenced *(34%)* by experience as nurse manager and training in management. Team nursing is widely employed in Ghana.

4.7.2.9 Dealing with Challenges and Resolving Conflicts

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to deal with challenges and resolve conflicts at the unit level.

Computer output for the multiple regression analysis depicted the hypothesis to be partly supported since experience as a nurse has significant effect on nurse managers' ability to deal with challenges and resolve conflicts *[$F_{(5, 488)}$ =3.711, p=.003, R=44%]*. The other variables have no significance on nurse managers' ability to deal with challenges and resolve conflicts. Interaction is also observed between nurse manager qualification, experience as nurse and experience as a nurse manager on nurse managers' ability to deal with challenges and resolve conflicts *[$F_{(9, 488)}$, = 1.946, p=.044, R=42%]*. It can then be inferred that dealing with challenges

and resolving conflicts at the unit level depends on 42% chance if the nurse manager has additional qualification, and experience in both nursing and the practice of management.

4.7.2.10 Establishing Supportive Relations to Facilitate Work at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to establish supportive relations to facilitate work at the unit level.

The ANOVA for multiple regression analysis showed that experience as a nurse has a significant effect on nurse managers' ability to establish supportive relations to facilitate work at the unit level $[F_{(5, 487)} = 2.266, p=.047, R = 28\%]$. Thus, the hypothesis is partly supported by the data.

4.7.2.11 Ensuring Adequate Resources for Work at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to ensure adequate resources for work at the unit level.

ANOVA for multiple regression showed that training in management has a significant effect on nurse managers' ability to ensure adequate resources for work at the unit level $[F_{(1, 489)} = 6.854, p=.009, R=17\%]$. Thus, the hypothesis is partly supported by the data. Furthermore, significant interaction is observed between experience as a nurse and nurse manager qualification $[F_{(10, 489)} = 1.887, p=.045, R=45\%]$ on nurse managers' ability to ensure adequate resources for work at the unit level. To identify the specific length of experience as a nurse that accounts for the significant effect, a post hoc analysis was done but it was not significant.

4.7.2.12 Ensuring Cohesion among Nurses

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to ensure cohesion among nurses at the unit level.

The ANOVA for multiple regression relating managerial variables to nurse managers' ability to ensure cohesion among nurses at the unit level, revealed no causal significant effect. The null hypothesis is retained $[F_{(4, 488)} = 1.549, p \geq .05]$.

4.7.2.13 Effective Coordination of Activities at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to coordinate activities effectively at the unit level.

From the computer out for the multiple regression, there is significant effect of experience as nurse manager on nurse managers' ability to coordinate activities effectively at the unit level $[F_{(6, 487)} = 2.174, p = .045, R\ 32\%]$. Thus, the hypothesis is partially supported by the data. This implies that, experience as nurse manager influences nurse managers' ability to coordinate activities effectively.

4.7.2.14 Collaboration with Medical Staff

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to collaborate with medical staff at the unit level.

From the multiple regression analysis, there is significant effect of experience as nurse on nurse managers' ability to collaborate with medical staff at the unit level *[$F_{(5, 486)}$ = 2.297, p =.045, R= 28%]*. Thus, the hypothesis is partially supported by the data. This implies that, experience as a nurse influences nurse managers' ability to collaborate with medical staff at the unit level. Furthermore, interaction is observed between nurse manager qualification and experience as nurse on the nurse managers' ability to collaborate with medical staff at the unit level *[$F_{(10, 486)}$ = 2.323, p = .011, R=55%]*.

4.7.2.15 Collaboration with Other Health Care Providers

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to collaborate with other health care providers at the unit level.

From the ANOVA for multiple regression, the null hypothesis is retained since none of the independent variables was significant at .05 level *[$F_{(4, 486)}$ = .847, p ≥ .05]*.

4.7.2.16 Devolved Power Structures at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to devolve power structures at the unit level.

The ANOVA for multiple regression showed that experience as a nurse has significant effect on nurse managers' ability to devolve power structures at the unit level *[$F_{(5, 484)}$* =2.485, *p=.031*,

R=30%]. Thus, the hypothesis is partly supported by the data. Multiple comparison analysis was not significant.

4.7.2.16 Team building skills of Nurse Managers

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' team building skills at the unit level.

The ANOVA for multiple regression showed that all the managerial variables are not individually significant in influencing nurse managers' team building skills at the unit level *[$F_{(4, 489)} = 2.263$, $p \geq .05$]*. However, nurse manager qualification and experience as nurse interact to significantly influence the nurse managers' team building skills at the unit level *[$F_{(10, 489)} = 2.019$, $p=.030$, $R=48\%$]*. We can therefore infer that, a nurse manager's qualification would only influence his or her ability to build team skills at the unit level only when he or she has prior experience as a nurse and vice versa.

4.7.2.17 Influencing Time and Patients' Events at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to influence time and patients' events at the unit level.

From the ANOVA for multiple regression, we could infer that experience as a nurse explains 28% of nurse managers' ability to influence time and patients' events at the unit level *[$F_{(5,486)} = 2.315$, $R=.28$, $p=.043$]*. Given that there is significant effect between one of the managerial variables and the dependent variable, the hypothesis therefore, is partially supported.

Furthermore, experience as a nurse interact with qualification of the nurse manager which explains51% of nurse managers' ability to influence time and patients' events *[$F_{(10, 486)}$ = 2.141, R=.51, p=.021]*. Additionally, interaction is observed between nurse manager qualification, experience as a nurse and experience as a nurse manager which explains 43% chance of nurse managers' ability to influence time and patients' events *[$F_{(9, 486)}$= 2.006, R=.43, p=.037] at* the unit level.

4.7.2.18 Influencing Human and Financial Resources at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to influence human and financial resources at the unit level.

The ANOVA for multiple regression showed that experience as a nurse has significant effect on nurse managers' ability to influence human and financial resources at the unit level *[$F_{(5, 484)}$* =2.524, *p=.029, R=31%]*. Thus, the hypothesis is partly supported by the data. Multiple comparison analysis was not significant

4.7.2.19 Ensuring Patient and Staff Satisfaction at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to ensure patient and staff satisfaction.

The ANOVA for multiple regression, though, showssignificant effect between managerial variables and nurse managers' ability to ensure patient and staff satisfaction *[$F_{(4, 483)}$ = 2.582, p ≤ .05]*. Individually, however, none of the nurse manager variables has significant effect. The hypothesis is therefore accepted. Interaction is observed between qualification of nurse manager,

experience as a nurse and experience as a nurse manager on the ability of the nurse manager to ensure patient and staff satisfaction *[$F_{(4, 483)}$ = 2.337, p = .014, R = 51%]*. This implies that to ensure patient and staff satisfaction at the unit level, the nurse manager needs education as well as experience in the hospital environment.

4.7.2.20 Ensuring Accountability of Patient Care at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to ensure accountability of patient care at the unit level.

The ANOVA for multiple regression, though, showsgeneral significant effect of managerial variables to nurse managers' ability to ensure accountability of client care *[$F_{(4, 484)}$ = 3.877, $p \leq$ .05]*. Individually none of the nurse manager variables has any significant effect. The hypothesis will therefore be accepted. However, interaction is observed between qualification of nurse manager, experience as a nurse and experience as a nurse manager on the ability of the nurse manager to ensure accountability of client care *[$F_{(10, 484)}$ = 2.917, p = .002, R = 68%]*. This implies that to ensure accountability of client care at the unit level, the nurse manager needs education as well as experience in the hospital environment as it accounts for 68% chance.

4.7.2.21 Creating a Positive Work Climate at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to create a positive work climate at the unit level.

The ANOVA for multiple regression, though, showsno significant effect of nurse manager's variables on nurse managers' ability to create positive work climate *[$F_{(4, 488)}$ =.969, $p \geq .05$]*. The null hypothesis, therefore, is accepted. However, interaction is observed between qualification of nurse manager and experience as a nurse on the ability of the nurse manager to create positive work climate *[$F_{(10, 488)}$ = 1.952, p =.037, R = 47%]*. This implies that to create a positive work climate at the unit level, the nurse manager needs education as well as experience in the hospital environment.

4.7.2.22 Short listing Staff for Promotion

H_0: Training in management, qualification of NM and experience have no significant effect on nurse managers' ability to ensure that staff is shortlisted for promotion.

The ANOVA for multiple regression shows that experience as a nurse has significant effect on managers' ability to shortlist staff for promotion *[$F_{(5, 482)}$ = 3.150, p=.008, R = 38%]*. Thus, the hypothesis is partly supported by the data. Furthermore, significant interaction is observed between experience as a nurse and nurse manager qualification *[$F_{(10, 482)}$ = 2.621, p=.004, R = 62%]*. It can, therefore, be inferred that additional education and experience gives courage and confidence to nurse managers in the performance of their duties.

4.7.2.23 Self-development on the Job

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to ensure self-development on the job at the unit level.

Tests between-subjects effects show that experience as a nurse has significant effect on nurse managers' ability to ensure self-development on the job *[$F_{(5, 488)}$ = 4.014, p=.001, R = 48%]*. Thus, the hypothesis is partly supported by the data. Furthermore, significant interaction is observed between experience as a nurse and nurse manager qualification *[$F_{(10, 488)}$ = 2.785, p=.002, R = 65%]*. It can therefore be inferred that additional education and experience gives courage and confidence to nurse managers in developing junior colleagues. To identify the specific years of experience as a nurse that accounts for the significant effect, a post hoc analysis was done.

Table 4.20: Post Hoc Analysis of Experience as a Nurse to Nurse Managers' Ability to Ensure Self-development on the Job

	0 – 5 years	6 -10 years	11 - 15 years	16 - 20 years	Above 20 years
0 – 5 years	-	-.57	-.72*	-.33	-.64
6 –10 years	-	-	-.1	-.24	-.07
11 – 15 years	-	-	-	.39	.08
16 – 20 years	-	-	-	-	-.31
Above 20 years	-	-	-	-	-

* The mean difference is significant at the .05 level

Multiple comparison analysis above indicates that at least experience of 0 to 5 years and 11 to 15 years *(p = .013),* and 0 to 5 years and above 20 years *(p=.015)* as a nurse have a significant effect on the nurse managers' ability to ensure self-development on the job.

4.7.3 Coordinating Practices of the Nurse Manager at the Unit Level

Hypotheses were developed for all the activities under the coordinating practices of the nurse managers and tested with the managerial variables. The results are presented in the adjoining sessions.

4.7.3.1 Formal Coordination of Care

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to ensure that coordination of care is formal at the unit level.

The ANOVA for multiple regression, though, showed no significant effect of managerial variables on nurse managers' ability to ensure formal coordination of care at the unit level *[$F_{(4, 482)} = .368$, $p \geq .05$]*. The null hypothesis is therefore accepted. However, interaction is observed between qualification of nurse manager and experience as a nurse manager on the ability of the nurse manager to ensure formal coordination of care at the unit level *[$F_{(8, 482)} = 2.347$, $p = .018$, $R = 45\%$]*. This implies that to have formal coordination of care at the unit level, the nurse manager needs education as well as experience in the management of the hospital environment.

4.7.3.2 Manual Coordination of Care at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to manually structure coordination of care well at the unit level.

ANOVA for multiple regression analysis indicates significant effect of managerial variables to nurse managers' ability to manually well structure coordination of care ***[***$F_{(4,484)} = 3.258$, $p = .012$*]*. Significant effect is also observed between qualification as nurse manager *($p = .008$)* and experience as a nurse manager *($p = .024$).* Well-structured coordination of care at the unit level, therefore, depends on experience generally. The hypothesis is therefore supported but multiple comparison analysis is not significant.

4.7.3.3 Structured Coordination with ICT at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to well structure coordination with ICT at the unit level.

Multiple regression analysis indicates a significant effect of managerial variables on nurse managers' ability to well structure coordination with ICT ***[***$F_{(4,483)} = 4.140, p \leq .05$***]***. Significant effect is observed between experience as a nurse *(p = .019)* and experience as a nurse manager *(p = .002)*. The use of ICT in coordination of care therefore depends on experience generally. The hypothesis is supported but multiple comparison analysis was not significant.

4.7.3.4 Informal Coordination at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to have coordination done informally at the unit level.

Multiple regression analysis indicated significant effect between managerial variables and nurse managers' ability to informally coordinate care at the unit level ***[***$F_{(4,476)} = 3.141, p \leq .05$***]***. Significant effect is observed between experience as a nurse manager (p = .019) and nurse managers' ability to informally coordinate care at the unit level. Informal coordination of care in the unit therefore depends on experience generally. The hypothesis is, therefore, supported but multiple comparison analysis is not significant.

4.7.3.5. Standardisation of Work at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to standardise work at the unit level.

The tests between-subjects effects indicated that experience as a nurse has significant effect on nurse managers' ability to standardise work at the unit level $[F_{(5, 479)} = 2.630, p = .024, R = 33\%]$. Thus, the hypothesis is partly supported by the data. Furthermore, significant interaction is observed between nurse manager qualification, training in management and experience as a nurse manager on work standardisation at the unit level $[F_{(3, 479)} = 3.677, p = .012, R = 27\%]$. Standardisation of work at the unit level, thus, depends on the nurse managers' qualification, experience and training in management.

4.7.3.6 Bedside Handing Over at the Unit Level

H_0: Training in management, qualification of NM and experience have no significant effect on nurse managers' ability to ensure that handing over is done at the bedside at the unit level.

ANOVA for multiple regression indicated that there is no significant effect between managerial variables and handing over at the bedside $[F_{(4,467)} = .429, p \geq .05]$. The null hypothesis is therefore accepted.

4.7.3.7 Adequate Documentation at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to adequate documentation at the unit level.

ANOVA for multiple regression indicated that there is no significant effect between managerial variables and adequacy of documentation at the unit level *[$F_{(4,481)}$ = .528, $p \geq .05$]*. Thus, the null hypothesis is accepted. However, interactions are observed between experience as nurse manager and training in management on adequacy of documentation at the unit level *[$F_{(5,481)}$ = 2.242, p = .050, R = 28%]*, as well as nurse manager qualification, experience as a nurse and as a nurse manager on adequate documentation at the unit level *[$F_{(9,481)}$ = 2.080, p =.030, R = 45%]*. Adequate documentation of activities at the unit level, thus, depends on qualification, training and experience.

4.7.3.8 Documentation of Patient Information at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to ensure that all information generated from patients are documented at the unit.

ANOVA for multiple regression indicated there is no significant effect between managerial variables and ensuring that all information generated from patients are documented *[$F_{(4,484)}$ = .556, $p \geq .05$]*. The null hypothesis is therefore accepted.

4.7.3.9 Documentation of Interventions at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to ensure that all procedures or interventions on client care are documented at the unit level.

The ANOVA for multiple regression indicated that nurse manager qualification has a significant effect on nurse managers' ability to ensure that all procedures/interventions are documented at the unit level *[$F_{(2, 487)}$ = 3.830, p=.023, R = 19%]*. Thus, the hypothesis is partly supported by the data. Furthermore, significant interactions are observed between nurse manager qualification and experience as a nurse *[$F_{(10, 487)}$ =2.196, p=.017, R = 52%]* as well as nurse manager qualification and experience as a nurse manager *[$F_{(8, 487)}$ =1.962, p=.050, R = 38%]*.

4.7.3.10 Effective Communication between Nurses and other Colleagues

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to ensure effective communication between nurses and other colleagues regarding care at the unit level.

ANOVA for multiple regression indicated no significant effect between managerial variables and nurse managers' ability to ensure effective communication between nurses and other colleagues regarding care at the unit level ***[***$F_{(4,488)}$ *=.339, p ≥.05]*. The null hypothesis is therefore accepted.

4.7.3.11 Interpersonal Relationship between Nurses and other Colleagues

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to ensure good interpersonal relation between nurse and other colleagues especially medical officers at the unit level.

ANOVA for multiple regression indicated no significant effect of managerial variables on nurse managers' ability to ensure good interpersonal relation between nurse and other colleagues especially medical officers at the unit level *[$F_{(4,488)}$ = .339, $p \geq .05$]*. The null hypothesis is therefore accepted.

4.7.3.12 Hierarchies within Professional Groups

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to ensure that hierarchies within professional groups play a key role in coordination at the unit level.

ANOVA for multiple regression indicated no significant effect of managerial variables on nurse managers' ability to ensure that hierarchies within professional groups play a key role in coordination at the unit level ***[***$F_{(4,484)}$ = .594, $p \geq .05$*]*. The null hypothesis is therefore accepted.

4.7.3.13 Confusion in the Boundaries of Coordination

H_0: Training in management, qualification of NM, and experience have no significant effect on confusion in the boundaries of coordination at the unit level.

ANOVA for multiple regression indicated no significant effect of managerial variables on confusion in the boundaries of coordination ***[***$F_{(4,483)}$ = .855, $p \geq .05$*]*. Thus, the null hypothesis is accepted. However, interactions are observed between nurse manager qualification and training in management on confusion in the boundaries of coordination *[$F_{(2,483)}$ = 3.072, p = .047, R =*

15%], as well as training in management, experience as a nurse and as a nurse manager on confusion in the boundaries of coordination *[$F_{(6,483)}$ = 2.699, p =.014, R = 39%]*.

4.7.3.14 Handing Over at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to ensure that all aspects of patient care are handed over to staff at the unit level.

The ANOVA for multiple regression indicated that nurse manager qualification has a significant effect on nurse managers' ability to ensure that all aspects of client care are handed over to staff *[$F_{(2,\ 479)}$ = 3*.411, *p=.034, R = 17%]*. Thus, the hypothesis is partly supported by the data. Furthermore, significant interaction is observed between nurse manager qualification and experience as a nurse on nurse managers' ability to ensure that all aspects of client care are handed over to staff *[$F_{(10,\ 479)}$ =3.043, p=.001, R = 72%]*.

4.7.3.15 Ward Rounds and Communicating on Nursing Care at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to ensure that nurses join doctors on ward rounds and communicate on nursing care at the unit level.

Multiple regression analysis indicated no significant effect between managerial variables and nurse managers' ability to ensure that nurses join doctors on ward rounds and communicate on nursing care*[$F_{(4,480)}$ = 1.356, p ≥.05]*. Thus, the null hypothesis is accepted. However, interaction

is observed between nurse manager qualification and experience as nurse *[$F_{(10,480)}$ = 2.553, p = .005, R = 61%]* on nurse managers' ability to ensure that nurses join doctors on ward rounds and communicate on patient care.

4.7.3.16 Listening to Patients' Complaints at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to ensure that nurses devote time to listen to patients' complaints at the unit level.

The ANOVA for multiple regression indicated that nurse manager qualification has a significant effect on nurse managers' ability to ensure that nurses devote time to listen to patients' complaints *[$F_{(2, 486)}$= 3.556, p=.029, R = 18%]*. Thus, the hypothesis is partly supported by the data. Furthermore, significant interaction is observed between nurse manager's qualification and experience as a nurse on nurse managers' ability to ensure nurses devote time to listen to clients' complaints *[$F_{(10, 486)}$= 2.422, p=.008, R = 57%]*.

4.7.3.17 Giving of Adequate Information to Patients at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to ensure that nurses devote time to give adequate information to patients regarding their condition at the unit level.

ANOVA for multiple regression indicated no significant effect between managerial variables and nurse managers' ability to ensure that nurses devote time to give adequate information to

patients regarding their condition *[$F_{(4,488)}$ = 1.997, p ≥.05]*. Thus, the null hypothesis is accepted. However, interaction is observed between nurse manager qualification and experience as a nurse *[$F_{(10,488)}$ = 1.894, p = .044, R = 45%]*. It can therefore be inferred that additional education and experience gives courage and confidence to nurse managers to engage them in rendering quality nursing care to patients. To identify the specific years of experience as a nurse that accounts for the significant effect, a post hoc analysis was done.

Table 4.21: Post Hoc Analysis of Experience as a Nurse on Nurse Managers' Ability to Ensure that Nurses Devote Time to Patients to Give Adequate Information

	0 – 5 years	6 -10 years	11 - 15 years	16 - 20 years	Above 20 years
0 – 5 years	-	-.62*	-.37	.50	-.46
6 –10 years	-	-	.24	.12	.16
11 – 15 years	-	-	-	.15	-.09
16 – 20 years	-	-	-	-	.04
Above 20 years	-	-	-	-	-

Source: Field data, 2013

From the post hoc analysis, it is indicative that, experience as nurse accounts for significant difference between nurse managers who have at least 10 years' experience as nurse and their ability to encourage nurses to devote time in giving patients adequate information about their condition*(p= .048)*. Furthermore, there is no significant difference between the other years of experience as a nurse.

4.7.3.18 Effective Coordination of Activities at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to effectively coordinate all activities at the unit level.

Tests between subjects effects indicated that nurse manager qualification has significant effect on nurse managers' ability to coordinate effectively all activities at the unit level *[$F_{(2, 480)}$ = 3.968, p=.020, R = 20%]*. Thus, the hypothesis is partly supported by the data. Furthermore, significant interaction is observed between nurse manager qualification and experience as a nurse on nurse managers' ability to coordinate effectively all activities *[$F_{(10, 480)}$ =1.945, p=.038, R = 47%]*.

4.7.3.19 Interpersonal Relationship with Staff at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to enable good interpersonal relations with staff and colleagues at the unit level.

ANOVA for multiple regression indicated no significant effect between managerial variables and nurse managers' ability to enable good interpersonal relations with staff and colleagues *[$F_{(4,487)}$ = .757, p ≥.05]*. Thus, the null hypothesis is accepted. However, interaction is observed between nurse manager qualification and experience as a nurse *[$F_{(10,487)}$ = 1.873, p = .047, R = 45%]*. Further interaction is observed between nurse manager qualification, experience as a nurse and experience as a nurse manager on the dependent variable *[$F_{(10,487)}$ = 2.127, p = .026, R = 46%]*. It can therefore be inferred that additional education and experience is necessary in enhancing good interpersonal relations among staff.

4.7.3.20 Interpersonal Relationship of Nurses at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to ensure good interpersonal relations among all nurses at the unit level.

ANOVA for multiple regression indicated no significant effect of managerial variables on nurse managers' ability to ensure interpersonal relations among all nurses $[F_{(4,486)} = .596, p \geq .05]$. Thus, the null hypothesis is accepted.

4.7.4 Control Practices of Nurse Managers at the Unit Level

Hypotheses were developed for all the activities under the control practices of the nurse manager and tested with managerial variables. The results are presented in the adjoining sessions.

4.7.4.1 Understanding the Governance of the Hospital

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to understand the governance of the hospital.

ANOVA for multiple analysis indicated that there is no significant effect of managerial variables on nurse managers' ability to understand the governance of the hospital $[F_{(4,487)} = .684, p \geq .05]$. Thus, the null hypothesis is accepted. However, interaction is observed between nurse manager qualification and experience as a nurse $[F_{(10,487)} = 2.609, p = .004, R = 61\%]$. Further interaction is observed between nurse manager qualification, and experience as nurse manager on the dependent variable $[F_{(8,487)} = 2.628, p = .008, R = 50\%]$.

4.7.4.2 Development of Rules and Regulations for Control at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to develop rules and regulations for controlling at the unit level.

ANOVA for multiple regression indicated no significant effect between managerial variables and nurse managers' ability to develop rules and regulation for controlling at the unit level *[$F_{(4,488)} = 1.419$, $p \geq .05$]*. Thus, the null hypothesis is accepted. However, interactions are observed between nurse manager qualification and experience as nurse *[$F_{(10,488)} = 2.447$, $p = .008$, $R = 58\%$]*, nurse manager qualification and experience as nurse manager *[$F_{(8,488)} = 2.111$, $p = .034$, $R = 41\%$]*, training in management and experience as nurse *[$F_{(5,488)} = 2.689$, $p = .021$, $R = 33\%$]*. Further interaction is observed between experience as a nurse and experience as a nurse manager on the dependent variable *[$F_{(16,488)} = 1.7658$, $p = .035$, $R = 66\%$]*. To develop rules and regulations for controlling the unit demands that the nurse manager has some level of experience, education and training in management. Thus, matured nurse managers are expected to have firm control over their units.

4.7.4.3 Working According to Job Description at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to ensure that nurses work according to job description at the unit level.

ANOVA for multiple regression indicated no significant effect between managerial variables and nurse managers' ability to ensure that nurses work according to job description *[$F_{(4,488)} = 1.419$, $p \geq .05$]*. Thus, the null hypothesis is accepted. However, interactions are observed between nurse manager qualification and experience as nurse *[$F_{(10,488)} = 2.022$, $p = .030$, $R =$*

48%], and training in management and experience as a nurse *[$F_{(5,488)}$ = 3.249, p = .007, R = 39%]*.

4.7.4.4 Encouragement of Self-directedness of Staff

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to encourage self-directedness of staff.

ANOVA for multiple regression indicated no significant effect between managerial variables and nurse managers' ability to encourage self-directedness of staff *[$F_{(4,480)}$ = 2.010, p ≥.05*]. Thus, the null hypothesis is accepted. However, interaction is observed between nurse manager qualification and experience as a nurse on nurse managers' efforts to encourage self-directedness of staff *[$F_{(10,480)}$ = 2.042, p = .028, R = 49%]*.

4.7.4.5 Giving of Constructive Criticisms at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to give constructive criticisms at the unit level.

ANOVA for multiple regression indicated no significant effect between managerial variables and nurse managers' ability to give constructive criticisms *[$F_{(4,480)}$ = 2.010, p ≥.05]*. Thus, the null hypothesis is accepted.

4.7.4.6 Tolerating Peoples' Mistakes and Taking Responsibilities

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to tolerate peoples' mistakes and be responsible for their own mistakes.

ANOVA for multiple regression indicated that there is no significant effect between managerial variables and nurse managers' ability to tolerate peoples' mistakes and be responsible for their own mistakes $[F_{(4,489)} = 1.035, p \geq .05]$. Thus, the null hypothesis is accepted.

4.7.4.7 Acknowledgement of Staff Efforts at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to acknowledge all efforts of staff at the unit level.

ANOVA for multiple regression indicated no significant effect between managerial variables and nurse managers' ability to acknowledge all efforts of staff $[F_{(4,483)} = .212, p \geq .05]$. Thus, the null hypothesis is accepted.

4.7.4.8 Trusting of Subordinates' Competence

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to trust subordinates' competence.

The two-way ANOVA results indicated that experience as a nurse manager has significant effect on nurse managers' ability to trust subordinates' competence *[$F_{(6, 483)}$= 2.634, p=.016, R = 38%]*. No further significant effects were observed.

4.7.4.9 Improvement of Team Spirit at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to improve team spirit at the unit level.

ANOVA for multiple regression indicated that there is no significant effect of managerial variables on nurse managers' ability to improve team spirit at the unit level *[$F_{(4,481)}$ = 1.394, p ≥.05]*. Thus, the null hypothesis is accepted. However, interaction is observed between training in management and experience as nurse on nurse managers' efforts to improve team spirit at the unit level *[$F_{(5,481)}$ = 3.019, p = .011, R = 37%]*.

4.7.4.10 Cooperation and Coordination at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to encourage cooperation and coordination at the unit level.

ANOVA for multiple regression indicated that there is no significant effect between managerial variables and nurse managers' ability to encourage cooperation and coordination at the unit level *[$F_{(4,483)}$ = .500, p ≥.05]*. Thus, the null hypothesis is accepted.

4.7.4.11 Supervision of Work at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to supervise work at the unit level.

Tests between-subject effects indicated that experience as a nurse has significant effect on nurse managers' ability to supervise work at the unit level $[F_{(5, 481)} = 2.514, p=.029, R = 31\%]$. No further significant effects is observed. But interaction is found between nurse manager qualification and experience as nurse $[F_{(5, 481)} = 2.290, p=.013, R = 55\%]$.

4.7.4.12 Coaching and Mentoring of Junior Staff at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to coach and mentor junior staff at the unit level.

ANOVA for multiple regression indicated that there is no significant effect between managerial variables and nurse managers' ability to coach and mentor junior staff $[F_{(4,481)} = .141, p \geq .05]$. Thus, the null hypothesis is accepted.

4.7.4.13 Dealing with Challenges and Conflicts at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to deal with challenges and conflicts at the unit level.

ANOVA for multiple regression indicated no significant effect between managerial variables and nurse managers' ability to deal with challenges and conflicts at the unit level *[$F_{(4,478)}$ = .643, $p \geq .05$]*. Thus, the null hypothesis is accepted.

4.7.4.14 Nurse Manager Appraises Staff and Organises Training

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to appraise staff and organise training at the unit level.

The ANOVA for multiple regression indicated no significant effect between managerial variables and nurse managers' ability to appraise staff and organise training *[$F_{(5, 485)}$* =.927, p ≥.05*]*. Thus, the null hypothesis is accepted. However, significant interactions is observed between nurse manager qualification and experience as a nurse manager *[$F_{(10, 485)}$ =2.105, p=.023, R = 50%]*.

4.7.4.15 Firm Control of Activities at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to have firm control at the unit level.

The ANOVA for multiple regression indicated no significant effect between managerial variables and nurse managers' ability to have firm control at the unit level *[$F_{(4, 476)}$* = .998,p ≥.05*]*. Thus, the null hypothesis is accepted. However, significant interaction is observed between nurse manager qualification and experience as a nurse manager *[$F_{(10, 476)}$ = 2.356, p=.010, R = 57%]*.

4.7.4.16 Ability to Control other Professionals at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to control other professionals at the unit level.

The ANOVA for multiple regression indicated no significant effect between managerial variables and nurse managers' ability to control other professionals at the unit level *[$F_{(4, 484)}$ = 1.726, p ≥.05]*. Thus, the null hypothesis is accepted. However, significant interaction is observed between nurse manager qualification, training in management and experience as a nurse *[$F_{(3, 484)}$ = 2.699, p=.045, R = 20%]*.

4.7.4.17 Accountability at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to encourage accountability at the unit level.

The computer output for the multiple regression showed that experience as a nurse has significant effect on nurse managers' ability to encourage accountability at the unit level *[$F_{(5, 481)}$= 2.318, p=.029]*. Thus, the hypothesis is partly supported by the data. Furthermore, significant interactions are observed between nurse manager qualification and experience as a nurse *[$F_{(10, 481)}$ =2.539, p=.006, R = 60%]* as well as nurse manager qualification and experience as nurse manager *[$F_{(8, 481)}$ = 2.557, p=.010, R = 49]*.

4.7.4.18 Giving of Due Positive Feedback at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to give due positive feedback.

The ANOVA for multiple regression indicated no significant effect between managerial variables and nurse managers' ability to give due positive feedback *[$F_{(4, 480)}$ = 2.528, p ≥.05]*. Thus, the null hypothesis is accepted. However, significant interactions are observed between nurse manager qualification and training in management *[$F_{(1, 480)}$ = 5.065, p=.025, R = 13%]*, nurse manager qualification and experience as nurse manager *[$F_{(1, 480)}$ = 1.978, p=.048, R = 39%]*.

4.7.4.19 Organization of Unit Durbar for Staff and Sharing of Ideas

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to organise unit durbar for staff and share new ideas.

The ANOVA for multiple regression indicated no significant effect between managerial variables and nurse managers' ability to organise unit durbar for staff and share new ideas *[$F_{(4, 474)}$ = 2.987,p ≥.05]*. Thus, the null hypothesis is accepted. However, significant interaction is observed between nurse manager qualification and experience as a nurse *[$F_{(10, 474)}$ = 2.055, p=.027, R = 50%]*.

4.7.4.20 Logbook for Time Keeping at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to have logbook for time keeping at the unit level.

ANOVA for multiple regression indicated no significant effect of managerial variables on nurse managers' ability to have logbook for time keeping at the unit level $[F_{(4,479)} = .566,\ p \geq .05]$. Thus, the null hypothesis is accepted.

4.7.4.21 Division of Labour at the Unit Level

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to have a clear division of labour at the unit level.

Table 4.22: Effects of Managerial Variables on Nurse Managers' Ability to have a Clear division of labour at the unit level.

Source (Managerial Variables)	Mean Square	F	Sig.	R
NM qualification	.591	.551	.577	.003
Training	.087	.081	.776	.000
Experience as nurse	4.574	4.262	.001*	.051
Experience as nurse manager	2.322	2.163	.046*	.032
Training * experience as nurse manager	2.699	2.514	.031*	.049
NM qualification * experience as nurse	2.165	2.017	.029*	.031

Source: Field data, 2013

Table 4.22 indicates significant effects between experience as a nurse $[F_{(4,481)} = 4.262,\ p = .001,\ R = 51\%]$ and experience as nurse manager $[F_{(4,481)} = 2.163,\ p = .046,\ R = 32\%]$ on nurse managers' ability to have clear division of labour at the unit level. The hypothesis is therefore supported by the data. Interactions are also observed between nurse manager qualification and experience as nurse $[F_{(4,481)} = 2.017,\ p = .029,\ R = 31\%]$ as well as training in management and experience as nurse manager $[F_{(4,481)} = 2.514,\ p = .031,\ R = 49\%]$. Nurse managers having clear

division of labour at the unit level is influenced by training in management, experience and qualification.

4.7.4.22 Use of Intimidation in Controlling the Unit

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' ability to use a lot of intimidation in controlling the unit.

Multiple regression analysis indicated significant effects of managerial variables with nurse managers' ability to use a lot of intimidation in controlling the unit $[F_{(4,482)} = 4.980, p \leq .05]$. The hypothesis therefore is accepted. Significant effect is also observed between experience as nurse manager ($p = .000$) and experience as nurse ($p = .014$). It can be inferred that experience generally influence the nurse managers' ability to use a lot of intimidation in controlling the unit.

4.7.4.23 Employing Minimal Consultation in Controlling the Unit

H_0: Training in management, qualification of NM, and experience have no significant effect on nurse managers' employing minimal consultation in controlling the unit.

Multiple regression analysis indicated significant effects of managerial variables with nurse managers' ability to employ minimum consultation in controlling the unit $[F_{(4,476)} = = 4.516, p \leq .05]$. The hypothesis therefore is accepted. Significant effect is observed between experience as a nurse manager ($p = .000$). It can therefore be inferred that experience as a nurse manager influence the nurse managers' ability to use minimum consultation in controlling the unit.

4.8 Summary

This chapter presented the results of the study. The study used both descriptive and inferential statistics to analyse the data. Participants for the study were 552 even though missing values were identified with some of the questions. Participation of the study shows categorical representation of all the ranks within the nursing fraternity.

Descriptive statistics was employed to describe the state of management practice of nurse managers in the unit and nurses' preference for change. Results presented indicate that management practices in the unit are weak and nurses would prefer improvement. Individual management skills (planning, organizing, coordinating and control) of the nurse managers were rated high though the activities delineated for the skills scored average. Implications of management practice in the unit also showed average responses, thus generally nurses would prefer nurse managers to improve upon their management practices in the unit to enhance patient and staff satisfaction.

Multiple regression analysis was employed for hypothesis testing of managerial variables (independent) and management practice (dependent) to illustrate factors influencing managerial behaviours. Post hoc analysis was further carried out to confirm the exact influence of managerial practice.

CHAPTER FIVE

5.0 DISCUSSION OF FINDINGS

Introduction

The previous chapter presented the results of the study. This chapter would discuss the findings of the study. The major objective of this study was to explore management practices of nurse managers at the unit level using the administrative management theory and the systems approach. The approach was adopted because the framework provides a holistic and synergetic definition to the practice of management by considering all the principles of management as it transfers inputs into outcomes at the unit level. The scheme for discussion is based on the objectives and assumptions of the study.

The working hypothesis of the study was that managerial variables (training in management, qualification of nurse manager, experience as a nurse and experience as a nurse manager) have no significant effect on the practice of management (planning, organising, coordinating and controlling). An explorative descriptive quantitative approach was employed to study the management practices of nurse managers at the unit level. A random sampling technique was employed to select 552 nurses from 19 selected public hospitals in Greater Accra region.

Data analysed revealed weak satisfaction of management practices at the unit level. Nurses would prefer nurse managers to improve upon their performance. For instance the average difference between perceived (3.21) and preferred (4.31) planning practices of the nurse manager in the unit is 1.1. Data also suggested that participative approach to management would

be best appreciated by the nurses at the unit level. The need for adequate preparation for the nurse manager is therefore obligatory.

5.1 Planning Practices of the Nurse Manager at the Unit Level

Rezaiyan (2004) acknowledged that structured planning is necessary for the continuation of contemporary structure of organizations due to their complex nature. Contrary to Asamani *et al.* (2013) assertion that there is universal planning in district hospitals in Ghana, this study revealed that some units (2.2%) do not plan at all. Planning at the unit level was quite moderate (3.43) and nurses would prefer improvement since planning forms the basis for enhanced management. According to Asamani *et al*. (2013) the universal planning at the unit level was due to the fact that hospital administration demands annual plans from the nurse managers. Hence, even though there were plans at the unit level, the use of the planning process was not very common; the current study also affirmed this assertion. There was weak knowledge of the planning process; all the steps involved in the planning process scored average (3.21).

Planning was described by Basavanthappa (2009) as an intellectual process of making decisions, it can therefore be inferred that due to inadequate preparation of many nurse managers for the position, they failed to plan and simply copied previous plans which were hardly utilized. Further analysis revealed that experience as a nurse was essential for planning at the unit level. Nurse managers who have practised as nurses for eighteen (18) years for diploma holders and 10 years for graduates are more likely to plan for the unit. Experience therefore plays a major role in managing the units though, many young nurses complain about the "first come first serve" syndrome in nursing. The young cohort of nurses believes that many nursing leaders today do not deserve their designation due to the exhibition of timidity towards other professional groups

in the health team and their lack of resilience towards nursing colleagues. This study however, proves otherwise.

According to Asamani *et al*. (2013) only 14 % have written plans, this study observed that about 65% of the participants have some form of written plans at the unit level. As explained earlier, submission of plans is mandatory hence, nurse managers are coerced to come up with plans but nurses would prefer an improvement in this. Clancy (2003) and McCallin and Frankson (2010) acknowledged that most nurse managers used shortcuts without any form of structured planning in managing issues. Discussion with nurses for instance, revealed that the plans at the unit level are simply copied from previous plans with only changes to dates. Nurses reiterated that apart from the dates that are changed, no adjustments were made to the plans hence you cannot even call those plans incremental plans. The importance of planning has been acknowledged by many researchers (Ansoff, 1991; Heruabadi & Marbaghi, 1996; Delmar & Shane, 2003) and it is important that nurse managers are encouraged to make use of their plans. The plans must not be rigid but flexible enough to serve as guides for managing the units. Further analysis depicts that training in management, qualification and experience as a nurse manager account for putting together a written plan. This confirms the assertion by many theorists that planning is a rational and intellectual process. Hannagan (2000) also contended that having a written plan is essential as daily routines can lead to the future being forgotten. Hence, the need to build capacity of nurse managers on management and leadership skills is far-fetched and management must be encouraged to organise periodic training sessions for them.

Marquis and Huston (2006) affirmed that planning bridges the gap and facilitates actualization of goals, but for this to occur; nurse managers need to describe and explain decisions to staff and

involve subordinates in decision making. Moderate responses were realized in the study with wide variations and nurses would prefer increased participative approach to decision making at the unit level to enhance commitment to set goals. Nurse managers' ability to describe and explain decisions was based on experience as a nurse coupled with the nurse manager's qualification and training. The study, thus, agrees that the nature and background of the decision-maker is important; that is the knowledge, experience, intuition and cognitive capacity (Tanner, 1983; Pardue, 1987; Hamers, Abu-Saad & Halfens; .Hamers *et al*., 1994) which underpin the ability of the nurse to make sense of the content of the decision-making task. An important knowledge source, highlighted by Radwin (1998) as an attribute of nurses' experience, was the learning of antecedents and consequences of specific decision-making situations where the phenomenon of 'knowing the patient' (Jenny & Logan, 1992; Radwin, 1995; Liaschenko, 1997, 23-38) plays a crucial role. It is therefore paramount for nurse managers to have adequate experience and preparation in terms of coaching and mentoring with continuous performance improvements.

Protocols are guiding statements adapted for use in the local context and contain detailed operational information (Duff, Kitson, Seers & Humphris, 1996) to enable particular clinical practice guidelines to be implemented (Manias & Street, 2000). It is used to reduce traditional variations in the practice styles of health professionals (Hunter, 1994). Structured protocols enable nurses to practise more autonomously, increase their confidence in making clinical judgements and also assist them in practising exemplary care (Manias *et al*., 2005). Development and review of protocols by nurse managers and staff is one task which is quite absent in the Ghanaian nursing context. Obsolete procedures adopted from the British are still being used and is no wonder that nurses are agitating for improvement. For instance, the procedure for bed making in nursing in Ghana consists of hot water bottles. One may ask if there

is any need for that in this our hot environment. But it is part of the procedure. Protocols are ongoing plans that need to be periodically reviewed to factor in current trends in the environment. Just as Manias, Aitken and Dunning (2005) advocated that experienced health professionals should encourage nurses to comply with protocols and make clinically reasoned decisions. The study also realised that experience is essential for the development and review of protocols. By providing peer support and acting as role models, experienced health professionals can also demonstrate to nurses how effective protocol use is to quality patient care. This stems from the fact that protocols are standardized performances of best practices developed over time; hence the need for experience and advance professional knowledge for its review is imperative.

In their practice, nurses constantly make decisions in a dynamic context including complex situations. Besides affecting elements related to the decision maker and the task itself, the setting where the decision-making process takes place are of decisive importance to the quality of the decisions made. Nurses prefer nurse managers to augment environmental analysis to enable them better manage the constant change that comes with management practice. Becoming interested in environmental analysis; nurse managers become analytical and visionary in attempts to model their units and have control over future developments. The study agrees with other studies that knowledge, experience, intuition and cognitive capacity of the decision maker are important (Tanner, 1983; Pardue, 1987; Hamers *et al*., 1994). The experience must at least be 6 years. It is, therefore, significant that nurse managers are urged to periodically analyze their environments since they operate in a stimulus-response environment.

The mission and vision of an organization are very essential according to Cole and Kelly (2011) since they set the strategic direction. It is important that nurse managers as leaders of the operational level of hospitals have working knowledge of the vision and mission. Knowledge of

the mission of the hospital and development of vision for the administration of the units are fair. Experience as nurse plays a key role, though interactions were observed between the other managerial variables as predictors of behaviour. Cole and Kelly (2011) remarked that having a vision will stimulate action between manager and staff for them to bridge the gap. The study confirmed this assertion by Gregory (1995) that though many nurse managers could describe their vision of an ideal nursing unit, seldom is a "unit vision" developed by the staff, written down and then "lived up to". Many of the nurse managers the researcher had a chat with confirmed they have a vision but have only either shared it with just their deputies, still nursing it in their minds or have shared it with some staff verbally. Only one unit had the vision boldly displayed. Nurse managers must therefore have periodic training in management and also encouraged to take formal university courses. This would enable them to appreciate the fundamentals of management and its effect on unit performance.

It is widely accepted that building and maintaining a good nurse-patient relationship is an essential aspect of the treatment and healing process and that effective communication skills are key to achieving this. It equally goes without saying that patients spend more time communicating with nurses than with any other healthcare professional group (Wright, 2012). Training in management and experience as nurse manager interact to predict effective communication of nurse managers with staff and enable nurse managers to encourage new ideas and creative thinking from staff. Just as Garon (2012) supported the importance of the manager in setting the culture of effective communication in the unit, the present study also supports effective communication with staff as well as encourages new ideas and creative thinking.

The contents of the plan and/or deciding on what to plan for at the unit level are greatly influenced by experience as a nurse, though interactions with training in management,

experience as nurse manager and qualification did also influence nurse manager's ability. Experience, hence, bring to fore issues that nurse managers need to consider when planning at the unit level. Supervision in a multi-professional team environment such as the unit has been described to foster collaboration (Hyrkas & Appelqvist-Schmidlechner, 2003) among the teams. It is, therefore, essential that the nurse manager plans specifically for supervision to ensure conducive environment for work.

Nurse managers are fairly familiar with the process of planning as all the scores in the study for the planning process had average of more than three (3.00). This is also confirmed by Asamani *et al*. (2013) who realized that though there is universal planning at the unit level, half of the participants have no knowledge of the planning process. Overall budgeting scored less (2.83) with a wide variance and this affirms the fact that nurse managers do not normally put together budgets for the running of units. Nurse managers simply put together resources that would be needed for operations for a given period and the hospital administrators complete the budgeting process.

Collective preparation of the duty roster is one vital responsibility of nurse managers that is critical for managing the unit since time is a good source of power in nursing due to the 24-hour service that nurses' offer to clients. Accordingly, time can be used as concession to motivate staff and to encourage them. In the nursing profession, this is called "dot off". Hence, asking nurses to be involved in the preparation of their duty roster is highly appreciated by nurses. Provision is given to the nurses to opt for the schedule they prefer to run taking into account their social commitments within the period. Many theorists in nursing advocate this since the advantages override other approaches. Only 5.8% of nurse managers do not collectively prepare

the duty roster with staff; this is quite good and nurse managers need to be encouraged. Experience as a nurse accounts for 30% chance of the nurse managers' ability to collectively prepare the duty roster with staff, whereas interaction of qualification and experience as a nurse also accounts for 48% chance. Thus, even though nurses do normally discredit long service for the appointment as nurse managers, this study has indicated that experience is very essential to the practice of management at the unit level.

Frequency of planning for the current study as compared to Asamani *et al*. (2013) is quite similar. Quarterly plans were more used (62.9%) in the current study. This may be due to the fact that quarterly plans may have been prescribed by the nursing administration. Time spent on planning for the unit, according to the study, is quite encouraging. There is relatively positive correlation between time spent on planning and usage as well as the frequency. Therefore, if nurse managers are encouraged to develop plans to run their units, they would more likely use the plans. Again, contrary to what Wong (1988) declared in her study that ward managers spent less time on planning, the current study realised that averagely nurse managers spent about 40 – 59% of their time to plan. This is commendable and nurse managers should be applauded and urged to continue.

Just as Kramer and Schmalenberg (2003) declared that lack of involvement in practice-related decision making is a major source of nurses' job dissatisfaction. This study shows that nurses would desire to have a participative decision making to facilitate commitment, confidence and competence of staff. Shared decision making represents nurses' control over practice, which is associated with positive nurse outcomes; such as job satisfaction (Macphee, Wardrop & Campbell, 2010). Nurses would, therefore, appreciate more if nurse managers inform them

earlier about planning for full participation. Planning at the unit level must also be well structured and comprehensive such that management practice can be improved. Just 3.6% of the participants are satisfied with the state of planning at the unit level. This is woefully unacceptable and nurse managers need to be encouraged to involve subordinates in the planning or effectively communicate the plan to subordinates to enhance effective implementation.

5.2 Organising Practices of the Nurse Manager at the Unit Level

Organizing, according to Basavanthappa (2009), invites creative and innovative ideas to work through adopting human relations approach, and thus provides the framework within which managerial functions take place for successful performance of work. Organizational structure is dynamic and it is people in their infinite variety occupying positions and interacting in prescribed ways to achieve a purpose. Nursing at the unit level is dynamic due to the stratified nature of personnel and their interpersonal relations with other professional colleagues, clients, families, etc. Organizational structure at the unit level, therefore, illuminates the stratified nature of nursing personnel and has always been prescribed, though this prescription has not always been definite due to shortage of nurses at the unit level. Mosley, Pietri and Mosley (2008) recounted that the very fact that one person is a boss over others and workforce is diverse, poses a challenge for communication. The need for nurse managers to communicate effectively with staff to ensure cohesiveness and efficiency in rendering quality nursing care to clients therefore cannot be over emphasized. The study realized a moderate (3.6) effective communication of nurse managers with staff on issues of assignment, and nurses would prefer it to be improved (4.4) to enhance coordination.

Delegation, according to Mosley *et al*. (2008) is a process whereby leaders distribute and entrust activities and related authority to other people in the organization. Nurses acknowledged that nurse managers do delegate with appropriate authority and resources but improvement would be appreciated. Delegation is very vital in managing the unit as many nurses assume managerial responsibilities without formal training. It is, therefore, essential that nurse managers allow subordinates to take active roles in managing the unit to prepare them adequately for the future, though the process must be structured and done cautiously. Delegation, thus, can sufficiently be used as a form of succession planning for nurses if managed well and nurse managers should be urged to delegate given that the right condition prevails. Further analysis revealed that experience as a nurse predicts 32% chance of the nurse manager's ability to delegate in the unit. Interaction was also observed between experience as a nurse manager and training in management (27%) to predict this behaviour. Experience, therefore, is very important when it gets to delegation where you need to delegate activities that you can teach or coach another to perform.

Makinen et al. (2003) contended that organization of nursing activities and nursing staff predict work motivation and job satisfaction, and is also associated with ward characteristics. This study asserts this fact and both nurses and nurse managers acknowledged that movement of staff is always done when there is shortage or duty roster (time) is altered to lessen heavy workload on nurses and to avoid stress. Many researches (McGillis-Hall *et al*., 2004; Aiken *et al*., 2002a; Aiken *et al*., 2002; Ritter-Teitel, 2002) done in organising of nursing functions emphasized the influence of staff characteristics. A high registered nurse/health care assistants ratio increases the likelihood of primary and modular nursing whereas a larger number of beds in the ward decreases it due to the greater accountability and responsibility allocated to individual nurses. Other works done previously in Ghana but not published concluded that there is no one model of

care used in caring for patients in Ghana. What the researchers observed was a mixture of functional and team nursing. This study also affirms this fact. Thus the use of models for organising nursing care is low (2.98) but the desire to have a definite model for nursing care persists (4.25). Significantly, none of the managerial variables was significant to the use of models for organising nursing functions because not until the numbers and mix of nurses improve at the unit level, not much can be done. Managing the unit with models in Ghana would be a mirage.

Kivimaki *et al*. (2000) asserted that full adoption of organizational models may take several years during which time job satisfaction among staff may be affected by stress of change. This shows the variability of using models for nursing care in Ghana and the difficulty of having adequate numbers and mix of staff at the unit level. The duty roster is always altered to ensure there are enough nurses on duty to render quality nursing care. For instance, one nurse manager declared that work is shared (functional) but when she comes with one or two nurses, this becomes impossible, hence they work together. This challenge is preventing the nursing profession from coming up with definite models for organizing nursing care. This challenge however, continues unabated due to the skewness of distribution of nurses in favour of the more affluent regions, which are in the southern half of the country (AHWO, 2010).

The study is in concert with Duffield *et al*. (2010) who conceded that models of care are not prescriptive but are varied according to ward circumstances and staffing levels based on complex clinical decision making skills. Team nursing is the most common model used in Ghana, though the other models can be observed to some extent. The study observed a moderate use of the team nursing model in the units by nurse managers and experience as a nurse (35%)

accounts for it. Though, training in management and experience as nurse manager (34%) also influence the nurse manager to use team nursing at the unit level. This observation was due to the fact that most of the units had more auxiliary nurses than professional nurses. Thus instead of having a ratio of 6:4 for professional and auxiliary nurses working at the unit level which is the standard for practising nursing, in many instances this proportion is impossible due to the mix of nurses available. Nurse managers, therefore, contend with the use of nursing models that embrace nurses' satisfaction with supervision (Makinen *et al*., 2003).

Generally, nurses perceived nurse managers to have average skills and knowledge in terms of organising and would prefer enhancement of all the variables concerning organization of the unit. Nurse managers moderately interact easily with staff and offer support, and have well defined tasks at the unit level. Nurses preferred improvement in these responsibilities of nurse managers to make their work environs favourable for growth and productivity. Patient care accomplished by distinctive tasks is a common practice in nursing, especially in Ghana, where tasks have been well defined and shared daily among staff. Average score was observed and nurses desired improvement. Again, experience as a nurse predicted 28% chance for this behaviour.

Conflict is an inevitable part of life and is prevalent among registered nurses working at the unit level. Even in a congenial environment, conflicts can mar the effectiveness of work activities. Dealing with challenges and resolving conflicts that ensue at the unit level is one endeavour crucial to all managerial work. Although there is no relationship between registered nurses' personality factors and methods used to deal with conflicts (Whitworth, 2008), this study observed significant effect between experience as a nurse (35%), as well as significant

interactions between nurse manager qualification, experience as a nurse and experience as a nurse manager (42%) on nurse managers' ability to deal with challenges and resolve conflict in the unit. Dealing with conflict at the unit level, therefore comes with experience; being confident, competent and committed to nursing practice and having a good relationship with staff are essential to the creation of climates convenient for work.

Prince (1997) recounted that concepts such as empowerment, governance, leadership and participative decision-making have replaced the traditional authoritarian style of management. For effective organization of work at the unit level therefore, the nurse manager needs to establish supportive relations to empower nurses. Experience as a nurse was very significant in establishing supportive relations and accounted for 28% chance as nurses learn to cope better in the unit with experience. Nurse managers' behaviour significantly impacts staff; the mood and behaviour that the nurse manager displays create a lasting impression on the team's behaviour as a whole (Porter-O'Grady, 2003). Thus, in creating this supportive environment, staff nurses are able to work in a positive climate to enable quality nursing care and experience nurses are created and kept by nurse managers (Shirey *et al*., 2010).

Ensuring adequate resources for work is one characteristic of the unit. This is unique to every nurse manager due to the peculiar nature of hospitals; where resources are always inadequate. Requisition of logistics is a weekly routine; a day within the week is designated for acquiring resources from the stores but where there is a challenge, it takes the ingenuity of the nurse manager to get adequate resources for work at the unit level. Nurses would prefer enhancement in nurse managers' ability to secure adequate resources for work. Training in management, experience as a nurse and the nurse manager's qualification improve this skill. Thus, training,

experience and qualification build up the nurse managers' confidence and interpersonal relation capabilities.

Nurse managers collaborate well with colleagues when they have adequate experience and good qualification. It is no wonder many nurses are yearning for additional qualification. This makes them more assertive and competent to defend their rights and advocate patients' rights at the unit level. Experience also accounts for the nurse managers' ability to devolve power structures at the unit level. Ersser and Tutton (1991) acknowledged that where nurses work within devolved power structures, collaboration with medical staff and other health care professionals is greater. Thus, it is important to consider experience when appointing or selecting nurses for this position to ensure harmony among staff at the unit level and to facilitate work. Shirey *et al.* (2008) acknowledged that experience is very vital to the nurse managers' job as they are able to perceive developing issues early enough to nip the challenges in the bud.

The duty roster is a significant tool to organising nursing care since there are several variations in nurses' work. The duty roster is severally adjusted to enable the unit offer 24hours service in a day and seven days service in a week. The preparation of the duty roster comes with some form of expertise which must ensure equity and fairness. Thus, many nurse managers have identified staff nurses to carry out this function successfully with some supervision, although some also prefer to do it themselves. There was extensive interaction among staff before the preparation in some units to ensure harmony and acceptability. The duty roster is developed to reflect the type of unit, the capability of staff, peculiar preferences for day offs, staff mix and workload. The extensive interaction of staff during the preparation of the duty roster was acknowledged by some nurses as a form of motivation. The nurses declared that by asking them for their preferences, the nurse managers portray how valuable they are to the unit, hence their

commitment to the duty roster. Nurses in other units where there was lack of consultation were dissatisfied and would prefer some form of involvement. There is, therefore, the need for nurse managers to continually engage nurses in all decision making at the unit level to ensure effective cooperation.

Technical and team competence are necessary to achieve high reliability to ensure safe patient care. Nurses have a key role in assuring effective team performance through the transfer of critical information. Nurses also need to recognize and identify important clinical and environmental cues, and act in order to ensure that the team progresses along the optimal course for patient safety (Miller, Riley, & Davis, 2009). The study established a moderate ability of nurse managers in building team skills and nurse managers' qualification and experience as a nurse were very significant. The need for prior experience as a nurse cannot be ignored any longer. For the ability of the nurse manager to influence time and patients' event at the unit level; experience and qualification of the nurse manager enhanced this responsibility.

Requisition of logistics is a weekly routine in all the institutions used for the study. Averages were used for the distribution and the stocks at the unit level were normally locked and keys kept by the nurse managers to ensure accountability. But units such as the emergency or critical care have established other forms of control. Nurse managers who keep the key claimed that a couple of times that they have left the key behind, nurses could not account for items taken away. Thus to ensure proper accountability, they would leave behind adequate resources for shifts during their absence. This notwithstanding, nurses would normally be found running around hospitals looking for items that they may have in abundance in their stock. This canker has been going on for decades and every nurse can attest to this fact. Nurse managers need to be encouraged to come up with strategies that would encourage proper accountability. Nurse managers must also

be urged to build trust and facilitate shared leadership among colleagues to enable them leave behind the store keys. Though some units have adequate stock taking strategies, others do not have due to the ignorance of nurse managers. The locking away of stock by the nurse manager is ostensibly to prevent pilfering and irresponsibility. Periodic training of nurse managers and adequate preparation for this position is very relevant and hospitals must be encouraged to provide periodic training.

Assurance of satisfaction by nurse managers to both client and staff was moderate. Qualification of the nurse manager significantly (51 percent) enhanced client and staff satisfaction at the unit level. Ensuring accountability of patient care is assured when the nurse manager has additional qualification and experience (68%). Adams *et al.* (1998) conceded that a potential lack of clarity about lines of responsibility and accountability appear to impede work at the unit level and deprive nurses of the opportunity to create better working relationships. The responsibility of the nurse manager, therefore, is more enhanced if the individual is highly educated and has experience to institute strategies for accountability.

Creating a positive environment for work to be accomplished is needed in any therapeutic setting and nurse managers were doing a fairly good job but there is room for improvement. Creating this therapeutic environment for work by the nurse manager is predicted by qualification of the nurse manager and experience as a nurse (47%). Ensuring self-development of staff on the job was also fairly done by the nurse managers and experience significantly ensured self-development of staff. Between 5 to 15 years of experience as a nurse specifically accounts for this ability of the nurse manager. Experience in nursing, therefore, cannot be easily ignored.

In all, an overwhelming majority of nurses were satisfied with the organising skills of the nurse managers but would still prefer enhancement of the skills. As Basavanthappa (2009) puts it, organizing provides the framework within which managerial functions take place for successful performance of operating work. Thus, the nurses reiterated that regular training would be of immense help to nurse managers.

5.3 Coordinating Practices of the Nurse Manager at the Unit Level

Coordination is essential to all successful management and well-coordinated work processes yield higher-quality outcomes and efficiency in health care delivery (Basu, 1994). Coordination of care according to the study was moderately formal but with wide variation. This affirms the assertion by Beringer *et al*. (1998) that there are both challenges and harmony with coordination hence, the need to prioritize coordination issues. The study established that qualification of the nurse manager and experience as a nurse manager (45%) ensured formal coordination in the unit. Coordination in health care is about mutual assistance, support, and cooperation among constituent members within groups, as well as between other groups at the unit level (Cole & Kelly, 2011). Nurse Managers are, therefore, encouraged to devote effort and time to make decision of coordination since the health care team is recognized to be a complex one due to the hierarchical factors and team-working processes (Cook *et al*., 2001). Experience and qualification of the nurse manager is, therefore, imperative if coordination of care at the unit level must be successful.

Coordination of care was moderately structured manually with a wide variation at the unit level. The practice of coordination of care is critical for efficiency and effectiveness, and just as Beringer *et al*. (2006) asserted that there was much reliance on spoken rather than written

information at the unit level, the study also realized that the units relied heavily on spoken information. This, however, introduces weakness to coordination of care. Nurses are expecting improvement in both the formal and manually structured coordination at the unit level to facilitate work outcomes. Sloper (2004) argued that coordination of care should involve all staff, but the value of limiting the number to a minimum is important. It is, therefore, necessary for nurse managers to decide with core members of team the structure and formalization of coordination of care, after which the decision must be effectively communicated to other colleagues. The qualification of a nurse manager and the experience as a nurse manager were significant for this behaviour. It could be inferred that coordination of care involves a tacit way of knowing informally received information, and which creates diversity in practice as acknowledged by other researchers (Beringer *et al*., 2006).

The absence of ICT at the unit level was an issue of concern to the researcher. It is an accepted fact that technology, though having its own challenges enhances work processes and outcomes tremendously. Thus, it is timely for nurses generally to agitate for computerization of nursing processes to ensure efficiency and effectiveness at the unit level. Overhauling of work at the unit level is necessary to take account of current technology so as to lessen the workload and unnecessary adventures in and around the units. It is also crucial to talk about the need to increase ad hoc supervision to ensure that individuals will not use the IT system for pleasure. Well-structured coordination with ICT was predicted by experience.

Care coordination though widely recommended for efficiency and effectiveness, failures in coordination persists to frustrate staff and feed the media (Kennedy, 2001). Informal coordination, nevertheless, cannot be ignored in clinical practice. Care must be practised such

that information received from patients or colleagues are documented to spurn the challenges that confront this situation. The study confirms Kennedy's assertion that coordination of care continues to be a challenge for staff. Nurses acknowledged the need to improve informal coordination at the unit level. The study established that experience as a nurse manager was vital to informal coordination at the unit level. Experienced nurse managers would manage better informal coordination at the unit level.

Total quality management relies heavily on the use of standardised work to capture and implement previous learning, thus creating a platform for further improvements (Deming, 1986; Adler & Borys, 1996). Work standardisation, therefore, is essential for every unit in the hospital and must constantly be improved. Work standardisation at the unit level is technical, consequently the need for qualification and work experience to enable better standardisation to facilitate improved performance outcomes must be exhilarated since the unit is the fulcrum of any hospital. Standardisation then cannot be ignored at the unit level; rules and resources involved in care coordination must be made explicit to staff. Moderate standardization of work was recognised by the study with experience as nurse significantly influencing its exhibition (33%) as well as the qualification of nurse manager, training in management and experience as nurse manager.

The study confirmed the lack of continuity and failure of communication between staff and clients as challenges of coordination common to health services (Hurst, 2002). Documentation in nursing is significant not only for continuity of care but also for legal purposes, and nurses must be admonished, no matter how stressful it is, to document all activities or information acquired from either the patients or other sources. Nursing documentation represents one essential part of the patients' record (SOSFS, 1993; Ruland, 2000) that needs more clarity and has to be more

comprehensive regarding specific nursing information to fulfil their purpose of communicating care and to constitute a basis for quality development in care (Tornvall & Wilhelmsson, 2008). Documentation is beneficial to daily nursing and increases patient safety as well (Bjorvell, Wredling & Thorell-Ekstrand, 2003).

Documentation can also be secondary data for research which can lead to evidence-based practice in nursing and must be encouraged by nurse managers at the unit level. Documenting all the activities or information accrued in the performance of the nurses' duties cannot be ignored and every effort must be geared towards effective documentation in the unit. The nurse manager must ensure that staff are given adequate training on documentation in-house. Experience, training and qualification played major roles in ensuring adequate documentation in the unit. Thus, all the managerial variables were relevant for adequate documentation in the unit. The role that adequate documentation plays in health care delivery is so important to clinical practice that frequent pronouncement must always be made to prompt staff.

Communication failure has been mentioned as an important bane to coordination (Hurst, 2002). Effective communication and good interpersonal relationship between nurses and other colleagues regarding patient care is imperative for both client and staff satisfaction. There would always be conflicts between nurses and other colleagues in the performance of individual duties but how these are managed would be of much concern to the nurse manager. The nurse manager needs to ensure that there is effective collaboration between all groups working at the unit level irrespective of their designation, to promote harmony.

The study also confirmed the findings of Waterman *et al*. (1996) who acknowledged that the presence of confusion in the boundaries of coordination can hinder implementation of roles. Confusion in the boundaries of coordination had the least score both at the perceived and preferred sections, both with wide variations. This clearly shows the extent of confusion at the unit level in terms of coordination. Rushmer and Pallis (2003) expressed concern about boundaries and argued that clearly defined boundaries are essential for successful inter-professional working. Every nurse would attest to the fact that unless boundaries are well structured and tasks well designated and assigned properly, staff will always shy away from responsibilities. Schmidt and Simone (1996) also argued that the trajectory of a patient during a stay spawns a comprehensive set of work tasks. This underscores how complex work in hospitals is, and the need to coordinate between the different professionals, tools and artefacts. Beringer *et al*. (2006)also emphasised that staff could identify both challenges and harmony within coordination and thus be able to prioritise coordination issues which are based mainly on tacit way of knowing, informally received which creates diversity in practice. There is, therefore, the need to put in place a well-structured coordination system to abjure any ambiguities, but which is amenable to changes as suggested by Beringer *et al*. (2006).

Handing over at the unit level was also moderately done and this is quite disturbing due to its uniqueness to coordination of care in terms of continuity. Smeenk *et al*. (2000) contended that in the absence of a universally-agreed model of care coordination, ways of providing coordinated health care develop in an ad hoc fashion in response to local condition and resources. Handing over essentially ensures continuity of care at the unit level and forms an essential aspect of the work of nurses. Nurse managers must firmly ensure that this significant aspect of the nurses' job is maintained to promote effective and efficient nursing care. The qualification of the nurse manager was very significant to handing over at the unit level. Apart

from that, qualification and experience as a nurse interact to also influence the handing over process (72%). This figure is significantly high and strengthens the need for education and experience in the practice of nursing management and the magnitude of the responsibilities that the nurse manager has to handle.

This study is in conformity with the findings of Manias and Street (2001) as well as Coombs and Ersser (2004) that conceded that hierarchies within professional groups play a key role in coordination. Nurses would prefer some form of improvement though the variation is quite wide. This might suggest that some nurses do not really see the need for any facilitation.

The nurse managers' ability to encourage nurses to listen to clients' complaints was quite adequate though there is the need for improvement. Chan *et al.* (2011) advised that nurses should think beyond time in the discourse of effective nurse-patient communication as this contributes to improved patient-centred care. Predictor of this role was the nurse manager's qualification (18%) though interaction between the qualification and experience as a nurse (57%) was also significant. Devoting time to give adequate information to patients regarding their condition was moderate, and interaction between qualification of the nurse manager and experience as nurse (45%) had significant effect. The nurse manager should have had at least 5 to 10 years of experience as a nurse to be able to encourage nurses to devote time to give information to patients. The two roles are enshrined in the patients' chatter of the GHS thus; it is the patients' rights to receive adequate information concerning their condition from health providers. Nurses' communication behaviour was closely related to their perception of communication and there is the need for a paradigm shift in thinking about communication as requiring time. The current study is in concert with Chan *et al*. (2011) who confirmed that nurses

must recognise the value of short, iterative interaction and chit-chats as quality communication for knowing their patients and providing patient-centred care (Chan *et al.,* 2011). Patient-centred care is achieved through effective communication when patients' thoughts and feelings are elicited and discussed (van Dulmen, 2003: 195) to allay anxiety and reassure the patient.

Enhanced interpersonal skill by nurse managers is one thing that nurses are intimately seeking at the unit level. Nurses throughout the study stressed the need for good interpersonal skills among staff working at the unit level. They acknowledged that improvement in interpersonal skills at the unit level would embrace respect among staff and create a positive working environment for patient care. Nurses reiterated that having good interpersonal relation with the nurse managers would ensure fairness and equity within the units, and which would facilitate job satisfaction. This demand by the nurses is certainly important for coordination. For instance, Gittel (2002) declared that strong relationships ensue in effective coordination; people respect the work of others and value their contributions which eventually affect the frequency, timeliness, accuracy and problem-solving nature of communication.

Relational coordination, it is argued, facilitates effective management of task interdependencies, improving performance along quality and efficiency dimensions. This is currently what is lacking in the Ghanaian health care setting where there has always been power struggle between medical officers and the other health professional groups especially nurses. Advocating improved interpersonal relations at the unit level between individuals and among groups is a task that the nurse manager should continue to promote to enhance both client and staff satisfaction. Experience and the qualification of the nurse manager played key role in ensuring relational

coordination at the unit level. Effective coordination, therefore, comes with experience as well as further education in the nursing profession which enables maturity of the nurse manager.

Nurses to a large extent would like coordination of care in the unit to be structured using information technology in the hospital. Nurses believe that there are a lot of inefficiencies in the management of the health care organizations due to the overdependence on manual way of doing things which leads to repetitions and delays in the system. Improvement in interpersonal skills, effective communication, participation of staff in decision making, training especially in IT skills, team work, active listening of nurse managers, documentation, formalization, supervision and delegation were what the nurses are advocating in order to improve coordination. The nurses affirmed that frequent meetings where issues are effectively deliberated upon without fear or inhibition are ways of advancing coordination and the course of nursing as a whole. The coordination skills of nurse managers, generally, were judged to be satisfactory and nurse managers need to be commended to improve their confidence in managing the units.

5.4 Control Practices of Nurse Managers at the Unit Level

Control according to many researchers is one of the most critical functions due to its fastidious continuous focus on organizational effectiveness and performance evaluation (Merchant, 1985; Aldrich & Mueller, 1982; Brewster, 1986; Mintzberg, 1979; Storey, 1985). McClure *et al*. (1983) argued that autonomy and control of nursing practice are associated with a healthy work environment and professional practice thus, ensuring job satisfaction and nurse retention (Kramer & Schmalenberg, 2004; Foley *et al*., 2002; Duffield *et al*., 2009). It is therefore in line with these assumptions that the control function of the nurse manager must be prudently explored so as to contribute to evidence-based practice.

The study revealed that nurse managers fairly understood the governance of the hospitals in which they practised and nurses acknowledged that this must be amended to take advantage of the prevailing opportunities. Kramer, Schmalenberg and Maguire (2008) acknowledged that structure with best managerial practices makes shared governance possible through partnership, ownership, accountability and equity. Nurse managers must, therefore, be empowered and encouraged to involve colleagues in the management of the unit (shared leadership and governance) to enhance commitment which would embrace partnership, ownership, accountability and equity among staff. This would enhance the sociopolitical stance of the nurse managers in their struggle for acquisition of scarce resources and pride among staff. This would also boost their courage and compel them to inaugurate effective control strategies which would improve generally the image of nurse managers among staff, especially their junior colleagues. Understanding the governance of the hospital was facilitated by qualification and experience as appreciation of the governance system develops with advancement in the commitment and shared leadership of the working environment.

The study established two forms of managerial controls described by Orlikowski (1991), namely administrative and professional controls. Administratively, there were policies and protocols, rules and regulations, as well as the job descriptions of individuals to control the units. Significantly, most of these on-going plans have been with the profession for ages and have not been reviewed since their conception. Nurses were, therefore, agitating for improvement; policies, protocols, rules and regulations are supposed to be reviewed regularly to take advantage of environmental dynamism. As nurses advanced in their work, they become more passionate about their profession and persevere to preserve professional ideologies and philosophies. It is no wonder that qualification of the nurse manager and experience as a nurse enhanced the promotion of culture for the practice of nursing which has been described as the glue that

preserves and strengthens the group and provides healing warmth essential for quality care (Kramer *et al*., 2009).

Nurse managers moderately enable nurses to work according to job descriptions. This behaviour was more enunciated when the nurse manager has a higher qualification and experience as a nurse. Just as Fisher (1998) recounted that control influences human behaviour and ensures that people behave in ways that lead to the attainment of organizational goals. Nurse managers usually try to manage the unit with available resources. But due to immense shortage of nurses generally, this becomes impossible at times and nurses are allowed to work according to the demands of patients or contingencies. Auxiliary nurses are normally observed performing functions of professional nurses without any due protection. This practice is accepted internally but when errors occur, the nurse will not be shielded by anyone and the law will take its course. It is, therefore, significant that nurse managers ensure that nurses work according to job descriptions or provide adequate support in such situations.

Nurse managers are also around to give constructive criticisms where necessary as well as being tolerant of peoples' mistakes while taking responsibility for their actions. To instill in subordinates self-worth, nurse managers moderately acknowledge efforts of staff, trust subordinates competence, improve team spirit and encourage cooperation and collaboration at the unit level. Experience as a nurse, qualification of the nurse manager and training in management greatly enhance nurse managers' ability in fulfilling all these roles successfully. Thus a social structure as described by Orlikowski (1991) is created at the unit level for effective control.

Nurse managers moderately maintained professional control through encouragement of self-directedness, supervision, coaching, mentoring and appraisal of staff. In embarking upon these responsibilities, nurse managers are able to share professional values and norms which order perception, influence attitude and shape behaviours as recommended by many researchers (Birnberg & Snodgrass, 1988; Knights & Wilmot, 1987; McDonough & Leifer, 1986; Ouchi, 1979). Nurse managers are therefore tasked with the indoctrination of nursing ideologies and philosophies to junior colleagues. This formally induces and enforces junior colleagues to adhere to the tenets of the profession. This naturally inculcates in the young cohort of nurses the culture of accountability and ethical behaviour, thus ensuring patient safety. Experience as a nurse, training in management and qualification account for the execution of these responsibilities by the nurse manager.

Dealing with challenges and conflicts by nurse managers are issues pertinent at the unit level due to the number of professional groups involved in patient-centred care. Collins (1996) contended that managers engage in an ongoing struggle to maintain control and secure discipline over workers. The nurse manager becomes the fulcrum around which the unit revolves. The nurse manager, therefore, needs conflict resolution skills in order to ensure harmony of work at the unit level. Hence the nurse managers' capability now is encouraging but adequate improvement is needed for effectiveness and efficiency. Nurse Managers must be given some experiential training on conflict resolution to be able to employ it abundantly at the unit level with confidence to all the professional groups.

The giving of due positive feedbacks to subordinates is very essential in management. It assists in molding preferred characters for work at the unit level, and nurse managers must be

encouraged to do it constantly. Although, the study noted an average response, the nurses demanded improvement. Interaction between nurse manager qualification and training in management were the predictors of this role. This stresses the need for management to encourage continuous professional development programs for nurse managers and formal advanced courses in order to improve their performance and instill in them modern management skills.

Nicholas and Beynon (1977) noted that control strategies may reflect demographic changes and wider cultural movements which may generally extend the life of employees and their family. Involvement of staff in decision making is quite significant to management practice at the unit level and one way to ensure that is through organising of durbars to facilitate sharing of ideas. Although durbars were quite common at the unit level, the nurses' expectations were that this could be increased to enhance participation of staff which would encourage commitment to objectives as well as confidence and competence in the execution of duties. This would also boost consultation among nurse managers with colleagues because in any political setting lobbying, coalitions and consultations are quite common if decisions are to be made and if a good working climate is to be promoted. Nurse manager qualification and experience as a nurse enhance this role by 50%. These are skills that develop over time with consistent practice and formal knowledge.

Use of intimidation in control was quite minimal and this is quite significant in management where individuals should not be either compelled or forced to carry out responsibilities entrusted to them. It is important to reiterate that in a profession such as nursing where control over practice is associated with professional autonomy, intimidation must not be entertained. Softer

approaches such as providing access to power, promoting widespread participation, using recognition to reinforce participation, taking pride in and acknowledging outcomes and accomplishments, actions of shared governance and/or shared leadership as well as having evidence-based practice team should be promoted. Thus, the afore-mentioned approaches would ensure self-regulation and self-determination of professional issues, practices and standards by staff as promulgated by Flexner (1910). Experience generally influenced the nurse managers' ability to use minimal intimidation at the unit level.

Maintenance of logbook or time book is another intriguing issue in nursing. Logbooks are used basically in assessing punctuality of staff at the hospital level and in many instances the book is kept at the nursing administration to maintain control. But where the book is kept away from the administration, individuals write anytime earlier than arrival to ensure that those who will come later will also be within the regular reporting time. Again, nurses would want improvement in the use of the logbook as in many instances nurses record just the reporting time and not departure; making its usage incomplete. Another significant issue recorded during data gathering was individual time scheduling of units due to peculiar characteristics of the hospital. This confirms Nicholas and Beynon (1977) assertion that control strategies may reflect demographic changes and wider cultural movements which may extend into the life of employees and their family life generally (Gramsci, 1976). Thus, to prevent risk and stress to staff who stay far away from the hospital, afternoon staff for instance close an hour earlier than the normal time in some hospitals. In other units, logbook is not kept at all since staff report early to work and would only stay away due to emergencies. Thus, control innovations tend to emerge and gain popularity under specific historical, cultural and social circumstances and, to some extent, would change in response to changes in sociopolitical ideas and movements.

Preferred control behaviour of nurse managers advocated by the nurses is the institutionalisation of both administrative and professional forms of controls described by Orlikowski (1991), and interpersonal relations. Control as designated by Rose (1999) is rooted in work design initiatives that are also rooted in "psy" science which accordingly play a key role in framing relations at work. Thus, nurse managers should ensure flexibility as well as imbuing in the younger cohort of nurses the culture of the profession to ensure that capable nurses manage the units. The control strategies used by nurse managers were generally good but had rather a very weak negative correlation with work experience as a nurse manager. Interestingly, experience as a nurse manager does not really influence the control skills of the nurse manager. The question then is what really influences the control skills of the nurse managers, could it be training, the personality or character of the individual, or what; this must be further investigated.

5.5 Implications of Management Practice at the Unit Level

Previous studies have concluded that unsatisfied health care employees negatively affect the quality of care which adversely affects patient satisfaction and loyalty to a hospital (Atkins, et al, 1996; Fahad Al-Mailam, 2005). Nurse managers play a vital role at the unit level and work directly with nurses and other health care staff in delivery quality care to clients. This role links management and employees, and has a direct impact on organisational performance, including quality of care, financial stability and patient satisfaction (Shirey, 2006; Gallo, 2007; Lucas, Laschinger & Wong, 2008). The current study showed that there is moderate staff and patient satisfaction agreeing with the fact that the role of the nurse manager is pivotal in the hospital, and thus facilitates the attainment of organisational goals and objectives (Oroviogoicoehea, 1996; Anthony *et al*., 2005). The current study confirmed the findings of Shirey (2006) which alluded that the nurse manager has an impact upon work environments by decreasing stress and increasing communication, job satisfaction and patient safety which influence staff commitment.

Effective nurse managers provide support and guidance to staff (Squires, 2004), and are the 'glue' that holds hospitals together (Parsons, 2003). Nurse managers in the current study ensured moderate positive environment for growth with effective exchange of information with other units. Technological advancements and globalization have added to the complexity of hospitals and organisations, resulting in rapid and relentless changes. It is, therefore, essential that nurse managers would adequately be empowered to take up their role effectively.

Nurse managers must understand the complexities of this environment and translate change in a meaningful way for staff, partners and clients (Malloch & Porter-O'Grady, 2009). To do that, the nurses in the current study acknowledged that nurse managers need proficiency and knowledge in management. Knowledge in management, professionalism and support from staff are the strategies that most nurses believed are indispensable requirements for nursing management. Generally, efforts of the nurse managers in the current study were quite good and critical analysis of the results depicted that though, training in management is significant, it is not the only predictor of effective nurse manager performance. This was firmly affirmed by the multiple regression analysis that showed that experience as nurse plays a key role in the capability of the nurse manager in management practice.

5.6 Summary

Management practice of nurse managers at the unit level was average and nurses would prefer improvement in the proficiency and knowledge of nurse managers in management by the adoption of a more integrative approach. Planning at the unit level was inadequate and nurses advocated maximum participation. Organisation of activities at the unit level by nurse managers was average. Extensive consultation during the preparation of the duty roster promoted harmony and acceptability as well as motivation of staff. Formal coordination of care was moderate at the

unit level. The use of IT was absent. Hierarchies were prominent in coordination and nurses were advocating for better interpersonal skills from nurse managers. Both administrative and professional control practices were present at the unit level. Intimidation was minimal in controlling the unit. Ad hoc control practices by nurse managers promoted conformity to practice and autonomy in nursing. Although all the managerial variables; qualification of nurse manager, training in management, experience as a nurse and experience as a nurse manager played major roles in predicting the behaviour of nurse managers in the performance of key management activities, experience as a nurse largely had more significant effects on management practices.

CHAPTER SIX

6.0 SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Introduction

Chapter five discussed the findings of the study. In this chapter, the summary, conclusions, contribution to knowledge, insights gained, as well as recommendations for further research are presented. The exploration of the practice of management and the challenges posed by the demands of the environment have been immensely enriching and exciting. It is hoped that a number of issues relating not only to management practices at the unit level but also to conducting quantitative research have been emphasized.

6.1 Summary and Conclusions

Management practice of nurse managers continues to evolve unswervingly within the dynamic health care system. Nurse managers are pivotal in achieving current and future ideals, goals and objectives. In many instances, the roles and responsibilities of nurse managers remain implicit rather than explicit. Nevertheless, nurse managers are charged with the responsibility of establishing a professional practice environment that ensures quality patient care and quality of work life for staff nurses as well as organizational effectiveness and efficiency. Thus, adequate preparation and support of nurses that enable successful management practice of nurse managers are encouraged to promote effectiveness and efficiency in the healthcare climate.

The focus of this study was on the management practice of nurse managers at the unit level of primary and secondary hospitals as well as some specialist hospitals in the Greater Accra Region, Ghana. To study the management practice of nurse managers at the unit level, the study examined how nurse managers plan for nursing activities in the unit, investigated how nurse managers organise nursing activities in the unit, explored how nurse managers coordinate with staff and other health care professionals and, finally, examined how nurse managers control their units. The reason for this approach comes from the basic assumption in classical management theory and the systems theory that managerial characteristics and the holistic use of the principles of management at the unit level will yield effectiveness and efficiency, thus ensuring patient and staff satisfaction.

Previous studies on principles of management have suggested that amidst organizational ambiguity, the increase in patient acuity complicates the work setting by placing greater demands on managers and their staff nurses. The knowledge and practice of formal planning by nurse managers has therefore become an issue of great concern. Planning as a self-regulatory tool would enable efficient progress towards goal attainment by allowing nurse managers to wholly focus on their management practice as it translates intentions into behaviour. Organising increases managerial efficiency and provides structure within which the functions of management can be performed; eschewing delay, duplication or confusion in performance, friction or rivalry among personnel. Coordination is needed at the unit level to prevent overlapping, conflict and constant interdepartmental friction, to enable staff take a broad overview of management instead of a narrow departmental one and to see that the right people and right resources are available in the right quantity in the right circumstances at the right time. Control practices of the nurse manager which tend to be innovative, emerged and

gained popularity under specific historic, cultural and social circumstances, and to some extent would change in response to changes in socio-political ideas and movement.

These studies, coming from mainly management and nursing management studies, have argued that the principles of management are essential for the practice of management at the unit level. Nurse managers accordingly need to be given adequate preparation in terms of proficiencies and knowledge to enable them practice successfully.

A central argument of this study was that training in management, qualification of the nurse manager, experience as a nurse and experience as a nurse manager have no significant effect on the practice of management at the unit level. The study established that the practices of planning, organising, coordinating and controlling were quite weak at the unit level and nurses would prefer improvement in these practices. From all the managerial variables that were proposed to have significant effect on the practice of management, experience as a nurse was the most significant. The study therefore suggested adequate preparation and empowerment for nurse managers in the form of structured work experience as a nurse for at least ten years, formal education and regular management and leadership training workshops.

The practice of management differs in diverse ways, and in order to conduct an empirical study on management practice at the unit level, it was necessary to develop a conceptual scheme to help establish common features of the nurse manager, as well as the principles of management. To this end, the classical theory (Fayol's Administrative Management) and the systems theory were adopted as the major framework for the study. Managerial variables

such as training in management, qualification of nurse manager, experience as a nurse and experience as a nurse manager (independent variables) interacted with the principles of management (dependent variables) to yield positive outcomes such as staff and patient satisfaction.

The exploratory descriptive design was adopted not only to test the hypothesis but also to provide a basis for describing the perceived and preferred individual activities under each of the principles of management and predictors of nurse manager behaviours. A sample of 552 nurses was randomly drawn from 19 selected primary, secondary and specialized hospitals in the Greater Accra Region, Ghana. Sample drawn adequately represented all the ranks in the nursing fraternity. Data was collected from nurses at the unit level of selected hospitals largely but then some data were also collected from service personnel at the lecture halls of the School of Nursing, University of Ghana. Collection of data was assisted by research assistants whom the researcher engaged in the hospitals to help with distribution and collection of completed questionnaires.

The analysis of the research was done at the unit level; the researcher used the questionnaire to examine the nature of planning, organising, coordinating and controlling of activities by the nurse managers. Documentary evidence from journals, text books and annual reports as well as the researcher's own assessment were also used to describe the management practices of nurse managers. Both descriptive and inferential statistics were employed in the study. Descriptive statistics involved coming up with frequencies, percentages, mean, and standard deviation of perceived and preferred management practices of the nurse managers at the unit level. Inferential statistics involving the use of correlation, multiple regression analysis and

post hoc analysis were employed to explore relationships and predictors of behaviour. The mean difference of significance was considered effective at $p < .05$.

The study clearly outlined the deficiencies of the nurse managers. Key among them was the relatively uncompetitive nature of the position, the inadequate preparation for the position and lack of empowerment. Many of the participants remarked that adequate preparation in terms of leadership and management training would be relevant for the work and wished that management would indulge. Nurses reiterated that for nurse managers to be proactive, assertive and efficient at their roles, they would require empowerment; essentially regular training in leadership and management, and provision of adequate resources.

The call for adequate preparation of nurse managers is long overdue. Nurse managers play a vital role in the health care system of Ghana and are essentially responsible for the utilization of the scarce resources at the operational level. The need for enacting a policy to structure and standardise their training and practice, therefore, cannot be overemphasised. Structured in-service training should therefore be developed to address their peculiar needs to enable them lead the units effectively and efficiently. In addition, promotion to the position of nurse manager should not only be based on seniority or just long service but performance. Policy to address this issue must be developed with the assistance of nurse managers to acknowledge their sentiments. Nurse managers must also be monitored and evaluated regularly with adequate feedback to enable them mature in their practice.

Performance review of nurse managers is another critical issue that needs to be dissected dispassionately to ensure that the position is duly acknowledged by all. Realistic targets must be contracted and reviewed regularly and non-performers withdrawn or given some time to reform. Performers, on the other hand, must be rewarded to influence other colleagues. It is clear that restructuring of the nurse manager position through policy would standardise the practice of nursing management and bring about competiveness as well as efficiency and effectiveness.

It is, however, important to recognize that leadership/management theories developed for management and business may not be a 'best fit' for clinical nursing practice and clinical nursing management. More attention should be paid to how to promote experiential leadership and management education pertinent to nurse managers at the unit level, and make the educational content or curriculum specific to the needs of the learners (nurse managers). It is important to appreciate the fact that nurse managers are followed not for their vision or creativity but that they translate their values and beliefs about care, nursing, respect and responsiveness into action. Nurse managers are significant to the mission and vision of hospitals, and thus need support, empowerment and understanding to remain focused and aligned to their values.

Experience as a nurse had significant effect on performance of managerial functions, but the other variables equally played significant roles in predicting behaviour of management practice of the nurse manager. Strategies that organizations need to implement to help staff nurses develop as prospective managers are therefore essential. These strategies should include offering staff nurses opportunities for leadership development courses, projects or

committee work, shadowing managers, delegation, coaching, mentoring and acting positions; creating management succession programmes; providing recognition for effective leadership performance; communicating the positive side of management roles; support from the corporate level for visibility of managers and shared governance models; as well as restructuring manager roles to ensure reasonable spans of responsibility. What is most critical is the examination of manager roles to identify clear role expectations and reasonable workloads for overall effectiveness and the implementation of succession planning programmes that include opportunities for staff nurses to learn and develop the requisite skills to assume management roles whilst eschewing try and error mode of practices.

6.2 Contribution to Knowledge

Management practice at the unit level was average and nurses would prefer improvement in the proficiency and knowledge of nurse managers in management by the adoption of a more integrative approach. Plans in the units were mostly copied from previous plans with modification to dates but often not fully utilized. There was a weak perception of shared vision among nurse managers. Nurses advocated early notification of meetings to enable maximum participation. Nurse managers spent averagely 40-59 percent (%) of their time in planning, and quarterly plans were mostly favoured. There was a relatively positive relationship between planning and usage of plans.

Moderate communication of nurse managers with staff and other health care professionals must be improved. Delegation was appropriate but must be enhanced to promote autonomy of nursing staff. No one model was used for nursing care; a combination of functional and team nursing was observed. The duty roster plays a significant role at the unit level but equity and

fairness must be ensured to embrace commitment. Extensive consultation during the preparation of the duty roster promoted harmony and acceptability as well as motivation of staff.

Formal coordination of care was moderate with much reliance on spoken rather than written information. The use of IT was absent but nurses believed that coordination of care can be well structured with IT to promote efficiency. Documentation must be encouraged to enhance effective and efficient coordination of care. There was confusion with the boundaries of coordination. Handing over was moderately done. Hierarchies were prominent in coordination and nurses were advocating for better interpersonal skills from the nurse managers.

Nurse managers fairly understood the governance of health care facilities. Both administrative and professional control practices were present at the unit level. Intimidation was minimal in controlling the unit. Ad hoc control practices by nurse managers promoted conformity to practice and autonomy in nursing. There was inadequate use of the logbook and control of nursing units was structured according to demographic and cultural characteristics. Fairly significant positive relationship existed between intimidation in adherence with patient satisfaction, effectiveness and efficiency of nursing care as well as positive work environment.

Although all the managerial variables; qualification of nurse manager, training in management, experience as a nurse and experience as a nurse manager; played major roles in

predicting the behaviour of nurse managers in the performance of key management activities. Experience as a nurse largely had more significant effect on management practices. Thus, the issue of seniority is relevant to management practice, however, there should be additional study to explore further the nature and extent of experience needed for successful management practice.

6.3 Insights Gained

The classical management theories particularly the scientific management, administrative management and Weber's bureaucratic theories are all relevant to the practice of management at the unit level. It is significant for the nurse manager to know these theories and utilize them effectively at the unit level for efficiency. For instance, nurse managers would have to create structure, define tasks and fairly share responsibilities for effective and timely accomplishment, disregarding the emotions of staff at times in order to please patients. This is in line with Taylor's scientific management theory where there is delineation between management and workers.

At the unit level, nurses cannot expressively operate without the existence of adequate principles since omissions, once they occur, cannot be fixed; with human lives. Thus, the practice of nursing is guided by several principles such as processes, conventions, ideologies, values and philosophies which are imbued in students. This can be attributed to the Administrative Management theory of Henri Fayol that outlined that management is best practised with principles which must be enforced. Nurse managers must ensure equity and fairness among staff in order to create the therapeutic environment for patient care. To render quality care to patients, staff must work together effectively in teams to promote the mission

of the hospital. Centralization is very common to nurse managers although decentralization is much preferred. Thus, all the principles promulgated by the Administrative Management theory are not far-fetched in nursing management.

Management practice at the unit level is accomplished in accordance with the systems theory; that whatever action taken at the unit level has a rippling effect on the other areas and the hospital as a whole. Nurse managers must, therefore, weigh their actions very well before implementation and there must be effective coordination within the unit and without the unit to ensure harmony in the hospital. Since, there is this assertion from the systems theory that the whole works better than the individual segments.

In employing the quantitative approach to the study, the researcher was able to diligently explore all the functions of management together and its outcome such as patient and staff satisfaction. Information given by the participants was validated by extensive observation by the researcher. Analysis of field data gave holistic and vivid picture of the variables reviewed.

Concomitantly, the researcher learnt how to continually improve upon the strategy of interviewing or engaging participants as the process evolved. The approach of engaging participants improved throughout the process of data collection. Frustration of working with nurses was also experienced at its peak; the researcher had to visit the units severally to collect questionnaires only to be informed that the person is closed and gone or would be coming in the night though; proper scheduling had been done. Additionally, due to

workloads, the researcher had to sit and wait for long hours just to interview participants. The virtues of patience and diligence were thus extensively learnt during this phase of the study.

Working independently as a researcher had a heavy toll on the researcher especially with data analysis. The research instrument was developed without critical thinking about the analysis. This challenge was realized after data had been coded for analysis and the intended method for analysis then had to be critically validated using the objectives and assumptions for the study. Thus, the researcher now knows that the development of the research instrument should be done in synchrony with the anticipated method of data analysis.

The researcher furthermore realized that good leadership at the unit level extends not just to the nursing staff but generally to all the health care team members. Efficiency and effectiveness could be felt and staff at the unit level are always found attending to patients rather than sitting and chatting with colleagues as is normally observed. Nevertheless, the challenges that hospitals face with issues of financing and leadership behaviour are relatively important to the practice of management.

Experience reigns supreme in management practice at the unit level and nursing management must be well structured to ensure that best practices are learnt by staff since most of the competencies developed are through experiential learning in the unit. Management practice in the units currently is mediocre. This notwithstanding, attention must be given to nurse manager empowerment to strengthen their effectiveness and confidence as the study indicates that improved management practice would improve unit outcomes.

6.4 Implications for Future Research

The present study provides direction for future research in nursing management. All the findings that emerged from the data analysis symbolized management practice by the nurse manager at the unit level. Recommended future studies include:

1. The study clearly depicts inconclusive arguments about the efforts of nurse managers at the unit level and future research should investigate that.
2. The role of experience and additional qualification to nursing management must also be explored critically in the future to elucidate the current findings.
3. Further research into the personality or the character of nurse manager in influencing control practices at the unit level.
4. Well-designed research to both inform the delivery of nursing management and the development of effective preparation as well as for on-going education so that nurse managers are able to meet the expectations that the hospital places upon them now and in the future.

6.5 Limitations of the Study

The study aimed to explore the practice of management at the unit level. The quantitative approach was used to gather data but, generally, due to the technical nature of the research instrument and the educational background of some nurses, most questions had to be explained vividly before the nurses could complete the questionnaires. This probably might have affected some of the responses that were generated.

The selection of the contextual variables was derived from the theoretical understanding of the classical functions of management. Research has indicated a variety of managerial functions that other researchers can equally use in managing the unit. Hence, it is possible that other researchers using other functions and research designs could arrive at different findings. Furthermore, the external validity of the research was ascertained by the significant effects obtained by testing empirically accepted hypotheses in nursing management about the significance between nurse managerial variables and the contextual variables (principles of management).

The focus of the study was just Greater Accra region; inclusion of other regions may also generate different results and a more comparative approach to the study of nurse manager management practices.

In spite of the limitations on the validity of the research, our results in general did confirm the hypothesized significance between the research variables. This suggests the adequacy of the research methods adopted to bring empirical evidence to bear upon the research problem.

6.6 Recommendations

Based on the findings from the study, the following recommendations are suggested with the aim of improving management practice in the unit and nursing administration generally.

6.6.1 National level

Support from the national level is crucial for the recognition and success of the reforms in nursing management as advocated. The role at the national level is to give direction and support to the structured in-service training and policy formulation for the appointment of nurse managers. Liaising with all stakeholders of nursing is essential; such as the Nursing and Midwifery Council, the Ghana Registered Nurses and Midwifery Association, the Human Resources Directorate of the GHS, College of Nurses and Midwives and other agencies. The underlying recommendations are provided to help strengthen operations of the nurse manager at the unit level:

1. Structured In-Service Training (SIST) program for nurse managers should be developed by the Human Resource Development Directorate of the GHS with inputs from the College of Nurses and Midwives, Nursing and Midwifery Council and the Ghana Registered Nurses and Midwives Association.
2. Structured performance appraisal template for nurse managers must be developed for periodic assessment.
3. Appointment to the nurse manager position must be competitive and opened to all provided the performance criteria are met.

6.6.2 Regional/District level

The regions have an important role in supporting the districts through facilitation, coaching, monitoring and supervision. This can be done through:

1. The regional training unit in collaboration with the Chief Nursing Officer (CNO) should organise periodic workshops using the SIST curriculum to upgrade the knowledge, skills and attitudes of newly promoted nurse managers in the region.

2. Structured performance appraisal must be institutionalized in the regions and nurse managers must be asked to develop contracted targets for their units.
3. Recognition in the form of awards must be developed for deserving managers based on performance.
4. Nurse managers must be given the opportunity to upgrade themselves through formal education to strengthen their knowledge, proficiency, confidence and commitment in their various fields.

6.6.3 Facility level

The facilities must define their needs based on the requests of clients and staff as well as the environment in order to create competitive advantage.

1. The Nursing Administration should appropriately appraise nurse managers with realistic targets.
2. Units should be encouraged to come up with shared visions that would be openly displayed to reassure patients of the services they render.
3. Institutionalisation of structured management practice at the unit level to ensure that best practices are transferred to the younger cohort of nurses.
4. Young nurses with potential for leadership should be identified and groomed for the nurse manager position (succession planning).
5. Delegation should be employed assiduously to expose the young cohort of nurses to management practice and leadership.
6. Nurse managers should enhance participative decision making at the unit level such as shared leadership to embrace commitment and pride in the health care team.

7. The nursing administration should liaise with management and the In-Service Training (IST) coordinator to ensure that nurse managers have periodic training on relevant management and leadership courses to facilitate effectiveness and efficiency of the units.
8. Nurse managers should be encouraged to plan for strategy, attitude and the day-to-day management of the units in relation to their environments.

REFERENCES

Abernethy, M. A.& Stoelwinder, J. U. (1994). The role of professional control in the management of complex organisations. *Accounting Organisations and Society*, 20:1, 1-17.

Adams A.& Bond S. (1995). *Nursing Organisation in Acute Care: The Development of Scales. Report no. 71, Centre for Health Services Research.* Newcastle upon Tyne.: University of Newcastle upon Tyne.

Adams A.& Bond S. (1997). Clinical specialty and organizational features of acute hospital wards. *Journal Advanced Nursing*, 26, 1158–1167.

Adams A. & Bond S. (2000). Hospital nurses' job satisfaction, individual and organizational characteristics. *Journal of Advanced Nursing*, 32, 536–543.

Adams A. & Hardey M. (1992). Primary panacea? *Nursing Times* , 88(26), 34 35.

Adams A., Bond S.& Hale C. (1998). Nursing organizational practice and its relationship with other features of ward organization and job satisfaction. *Journal Advanced Nursing*, 27, 1212 – 1222. .

Addae, S. K. (1996). *History of Western Medicine in Ghana 1880-1960.* Durham.: Durham Academic Press.

Adler, P.& Borys, B. (1996). Two types of bureaucracy:E nablinga nd coercive. *Administrative Science Quarterly*. 41 61-89.

Africa Health Workforce Observatory (AHWO). (2010). *Ghana Health Workforce Observatory: Human Resource for Health Country Profile.* World Health Organization.

Aiken, L. H.&Patrician, P. A. (2000). Measuring Organizational Units of hospitals: the revised Nursing Work Index. *Nursing Research*, 49, 146-153.

Aiken, L. H., Clarke, S. P., Sloane, D. M., Sochalski, J.& Silber, J.H. (2002a). Hospital nurse staffing and patient mortality, nurse burnout, and job dissatisfaction. *JAMA*, 288(1): 1987-1993.

Aiken, L. H., Clarke, S. P.& Sloane, D. M. (2002). Hospital staffing, organisational support, and the quality of care: cross-national findings. *International Journal of Quality Health Care*, 14(1) 5-13.

Akiwumi, A. (1992). *Higher Education for Nurses.* Woeli Publishing Services.

Akiwumi, A. (1995). State Registered Nurses (SRN): 1945-1995. *Unpublished speech*, Accra.

Alexander, J. A. (1980), Structural Determinants of Professional Role Orientations: The Case of Hospital Staff Nurses. Dissertation. Stanford University.

Aldrich, H.& Mueller, S. (1982). *The evolution of organisational forms: technology, co-ordination and control. Research in Organisational Behaviour,*. Greenwich, CT, pp. 33-7: JAI Press,.

Al-Hamdan, Z., Shukri, R.& Anthony, D. (2011). Conflict management of styles used by nurse managers in the Sultante of Oman. *Journal of Clinical Nursing.*, 20, 571-580.

Altranais, A. B. (2000). *The Scope of Nursing and Midwifery Practice Framework.* Dublin.: An Bord Altranais.

Anderson, R. A.& McDaniel, R. R. (1999). *Health Care Management Review*, 24(1):7–16.

Ansah Ofei, A. M. (2011). Assessment of Strategic Management Practice of Malaria Control in the Dangme in the Dangme West District, Ghana. *Health*, 3(6) 343-356.

Ansoff, I. (1991). Critique of Henry Mintzberg's @The design school: reconsidering the basic premises of strategic management. *Strategic Management Journal*, 12 (6): 449-461.

Ansoff, H.I. (1994), "Comment on Henry Mintzberg's strategic planning", *Long Range Planning*, Vol. 27 No.3, pp.31-2.

Anthony, M.K., Standing, T.S., Glick, J., Duffy, M. & Dumpe, M.L. (2005). Leadership and nurse retention: the pivotal role of nurse managers. *Journal of Nursing Administration.*, 35(3), 146-155.

Apker J., Propp K., Wendy S., Ford Z.& Hofmeister N. (2006). Collaboration, credibility, compassion and coordination: professional nurse communication skill sets in health care team interactions. *Journal of Professional Nursing*, 3, 180–189.

Asamani, J. A., Kwafo. E. O.& Ansah Ofei, A. M. (2013). Planning among nurse managers in district hospital in Ghana. *Nursing Management.*, 20(8), 26-31.

Asigri, D. S. (2009). *Nursing in a Disreputable State.* Retrieved from ghanaweb.com: http://www.ghanaweb.com

Atkins, P. M., Marshall, B. S. & Javalgi, R. G. (1996), Happy employees lead to loyal patients, *Journal of Health Care Marketing* 16, 4, 14-23.

Azaare, J.& Gross, J. (2011). The Nature of Leadership Style in Nursing Management. *British Journal of Nursing*, 20(11): 672-80.

Ball, M. J., Weaver, C. & Abbott, P. A. (2003). Enabling technologies promise to revitalize role of nursing in era of patient safety. *International Journal of Medical Informatics*, 69: 29–38.

Barnett, T., Namasivayam,& Narudin, D. A. A. (2010.). A critical review of the nursing shortage in Malaysia. *International Nursing Review*, 57, 32-39.

Basavanthappa, B. T. (2009). Nursing Administration, 2nd Edition. Jaypee Brothers Medical Publishers.

Basu, K. (1994). The Traveler's Dilemma: Paradoxes of Rationality in Game Theory. *American Economic Review*, 84(2): 391.395.

Benner P., Tanner C.& Chesla C. (2009). *Expertise in Nursing Practice, 2nd edn.* New York, NY.: Springer Publishing Co.

Benner P., Sutphen M., Leonard V.& Day L. (2010.). *Educating Nurses: A Call for Radical Transformation.*San Francisco, CA.: Jossey-Bass.

Beringer, A., Fletcher, M.&Taket, A. (2006) Rules and resources: A structuration approach to understanding the coordination of children's inpatient health care.*Journal of Advanced Nursing*, 56 (3). pp. 325-335. ISSN 0309-2402.

Blau, P. M. (1968). The hierarchy of authority in organisations. *American Journal of Sociology* 73, 453-467.

Bjorvell, C.,Wredling, R.&Thorell-Ekstrand. (2003) Prerequisites and consequences of nursing documentation in patient records as perceived by a group of Registered Nurses.

Birnberg, J. G.& Snodgrass,C. (1988). Culture and control: a field study. *Accounting Organisations and Society*, , 13, 447-64.

Bitner, M. J., Booms, B. H. & Tetreault, M. S. (1990), The service encounter: diagnosing favorable and unfavorable incidents, *Journal of Marketing* 54, 71-84.

Bondas, T. (2006). Paths to nursing leadership. Journal of Nursing Management, 14: 332–339. doi: 10.1111/j.1365-2934.2006.00620.x .

Brech, E. F. L. (1965). Organization: The Framework of Management. In B. T. Basavanthappa, (2009). Nursing Administration, 2nd Edition. Jaypee Brothers Medical Publishers.

Brews, P. J.& Hunt, M. R. (1999). Learning to plan and planning to learn: resolving the planning school/learning school debate. *Strategic Management Journal.* 20(10), 889-913.

Brewster, C. J. (1986). Typology of management controls. *Proceedings of the Fourth Annual Conference on Organisational Control of the Labour Process.* Aston, UK.

Brown, C. L. (2002), A theory of the process of creating power in relationships, *Nursing Administration Quarterly* 26, 2, 15-33.

Burns, N.& Grove, S.K. (2005). *Thepractice of nursing research: conduct, critique, and utilization*. 5thedn. Missouri: Elsevier: 52

Camey, M. (2006). Nurses as Managers. A History of Nursing Management in Ireland and Britain. In G. M. ed., *In Care to Remember. Nursing and Midwifery in Ireland.* (pp. 185-197). Cork.: Mercier Press.

Carroll, T.L.& Adams, B.A. (1994). The work and selection of first-line nurse managers 1982-92. *Journal of Nursing Administration*, **24**, 16-21.

Cathcart, E. B., Greenspan, M. & Quin, M. (2010). the making of a nurse manager: the role of experiential learning in leadership development. journal of Nursing Management, 18(4): 440-447.

Chaboyer, W.& Creamer, J. (1999). Intellectual work of the critical care nurse: Applications from a qualitative study. *Australian Critical Care.*, 12(2):66-69.

Chan, E. A., Jones, A., Fung, S.& Chu Wu, S. (2011). Nurses' perception of time availability in patient communication in Hong Kong, *Journal of Clinical Nursing*, 21: 1168–1177.

Chase, L. K. (2010). Nurse Manager Competencies, University of Iowa.

Cherry, B.& Jacob, S.R. (2008). *Contemporary Nursing: Issues, Trends, & Management. 4th Edition.* St. Louis: Mosby Elsevier.

Chittick, R. (1965). Post-basic Nursing in the University of Ghana. *International Journal of Nursing Studies*, 2: 39-42.

Clancy, T. R. (2008). Managing Organizational Complexity: Directing.

Clancy, T. R. (2003). Quality Improvement: getting to how. *Health Services Research* , 38, 2, 509-513.

Coakley, E.& Scoble, K. (2003). A reflective model for organizational assessment and interventions. *The Journal of Nursing Administration*, 33(12): 660-669.

Cohen, J., Stuenkel, D.& Nguyen, Q. (2009). Providing a healthy work environment for nurses: the influence on retention. *Journal of Nursing Care Quality*, 24, 308-315.

Cole, G. A.& Kelly, P. (2011). Management: Theory and Practice. 7th Edition. Hampshire, UK

Colonghi, P. (2009). Mentoring? Take the LEAD. *Nursing Management*, 40, 15-17.

Collins, D. (1996). Control and isolation in the management of empowerment. *Empowerment in Organisation*, 4:2, 29-39.

Comstock, D. E.&Scott, W. R. (1977), Technology and the structure of subunits: Distinguishing individual and work effects. *Administrative Science Quaterly*, 22: 177-202.

Cook, M. J. (2001). The renaissance of clinical leadership. *International Nursing Review.*, 48(1): 38-46.

Coombs, M.&Ersser, S. (2004), Medical Hegemony in Decision Making - A Barrier to Inter disciplinary working in Intensive Care? *Journal of Advanced Nursing,* 46(3): 245-252.

Cott, C. (1998). Structure and meaning in multidisciplinary teamwork. *Sociology of Health and Illness* 20 *(*6*):* 848-873.

Creswell, J., Plano&Clark, V. (2011). *Designing and Conducting Mixed Methods Research, 2nd edn.* Thousand Oaks, CA: Sage Publications Inc.

Curran, C. R. (2001), Stay, Say, and Serve, *Nursing Economic* 19, 2, 41-42.

Curtis, E., Sheerin, F.& de Vries, J. (2011). Developing Leadership in Nursing: the impact of education and training. *British Journal of Nursing.*, 20, 6, 344-352.

DeCampli, P., Kirby, K. K. & Baldwin, C. (2010). Beyond the classroom of coaching: preparing new nurse managers. critical Care Nursing Quarterly, 33(2): 132-137.

Delmar, F.& Shane, S. (2003). Does business planning facilitate the development of new venture? . *Strategic Management Journal* , 24, 1165-1185.

Deming, W. E. (1986). *Out of the Crisis.* Cambridge, MA.: Massachusetts Institute of Technology Center for Advanced Engineering,.

Donkor, N. T.& Andrews, L. D. (2011). 21st century nursing practice in Ghana: challenges and opportunities. *International Nursing Review*, 58, 218-224.

Douglas, M. (2008). Management roles in nursing: current issues, perspectives and responses. *Journal of Nursing Management*, 16, 1765-1767.

Duff, L. A., Kitson, A. L., Seers, K.&Humphris, D. (1996). Clinical guidelines: an introduction to their development and implementation. *Journal of Advanced Nursing*, 23: 887–895.

Duffield, C. (1991). First-line nurse managers: issues in literature. *Journal of Advanced Nursing*, 16: 1247-1253.

Duffield, C.& Franks, H. (2001). The role and preparation of first-line nurse managers in Australia: where are we going and how do we get there? *Journal of Nursing Management*, 9: 87-91.

Duffield, C., Roche, M. A., O'Brien-Pallas, L. L., Diers, D. K., Aisbett, C., Aisbett, K.& Homer, C. S. (2009). *Nursing Workload and Staffing: Impacts on Patients and staff.* Sydney: University Of Technology.

Duffield, C., Roche, M.,Diers, D.,Catling-Paull, C.&Blay, N. (2010). Staffing, skill mix and the model of care, *Journal of Clinical Nursing*, 19: 2242–2251.

Duffield, C. M., Roche, M. A., Blay, N.& Stasa, H. (2010). Nursing unit managers, staff retention and the working environment. *Journal of Clinical Nursing*, 20: 23-33.

Dunn, K.&Schilder, E. (1993). Novice and Expert Head Nurses: A competitive Study of Work Activities and Behaviours. Canadian Journal of Nursing Administration. 6(1): 10-15.

Ersser, S.& Tutton E. (1991). *Primary Nursing in Perspective.* London: Scutari Press.

Espinoza, D. C., Lopex-Saldana, A. & Stonestreet, J. S. (2009). The pivotal role of the nurse manager in healthy workplace: implications for training and development. critical Care nursing Quarterly, 32(4): 327-334.

Everson-Bates, S. (1992). First-line nurse managers in the expanded role. An ethnographic analysis. *Journal of Nursing Administration*. 22(3):32-37.

Fahad Al-Mailam, F. (2005), The effect of nursing care on overall patient satisfaction and its predictive value on return-to-provider behavior: A survey study, *Quality Management in Health Care* 14, 2, 116-120

Farrell, G. (2001). From tall poppies to squashed weeds: why don't nurses pull together more? *Journal of Advanced Nursing*, 35: 26–33.

Fassel, D. (2003). Building better performance, *Health Forum Journal* 46, 2, 44-45.

Fisher, J. (1998). Contingency theory, management control systems and firm outcomes: past results and future directions. . *Behavioural Research in Accounting*, 10: 47-64.

Flexner, A. (1910). *Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaming.* New York, NY: Carnegie Foundation.

Foley, B. J., Kee, C. C. Minick, P., Harvey, S. S.& Jennings, B. (2002). Characteristics of Nurses and Hospital Work Environments that Foster Satisfaction and Clinical Expertise. *Journal of Nursing Administration*, 32(5): 273-282.

Foster, D. (2000). The Development of Nurses as Managers: The Prevalence of the Self-Development Route. *Journal of Nursing Management*, 8(4): 193-199.

Fretwell, J. (1982). *Ward teaching and learning: Sister and the ward learning Environment.* Royal College of Nursing. London.

Fukuyama, F. (1995), *Trust: The social virtues and the creation of prosperity*, New York: Free Press.

Gallo, K. (2007). The new nurse leader: a leadership development program paves the way to success. *Nurse Leader,* 5 (4): 28–32.

Garon, M. (2012). Speaking up, being heard: registered nurses perceptions of workplace communication, *Journal of Nursing Management*, 20, 361–371.

Gerrish, K.&Lacey, A. (2007). The research process in nursing, Oxford: Blackwell Publishing.

Ghana Health Service. (2006). *Job Description.* Accra.

Ghana Health Service, (2012). *Annual Report*. Human Resource Directorate

Gittell, J. H. (1998). Beth Israel Deaconess Medical Center: Coordinating patient care. *Harvard Business School Case, Cambridge, MA,*, 899-213.

Gittel, j. H., Fairfield, K. M., Bierbaum, B., Head, W., Jackson, R., Kelly, M., Laskin, R., Lipson, S., Siliski, J., Thornhill, T.& Zuckerman, J. (2000), Impact of Relational Coordination on Quality of Care, Postoperative Pain and Functioning, and Length of Stay: A nine-hospital study of surgical patients. *Journal of the Medical Care*, 38(8): 807-819.

Gittel, J. H. (2002). Coordinating Mechanisms in Care Provider Groups: Relational Coordination as a Mediator and Input Uncertainity as a Moderator of Performance Effects. *Management Science,* 48(11): 1408-1426.

Gittell, J. H. (2003). A theory of relational coordination. In *Positive Organisational scholarship: Foundations of a New Discipline* (K. S. Cameron, J. E. Dutton, & Quinn, eds.), pp. 279-435. Beret-Koehler Publishing, San Francisco, CA.

Gramsci, A. (1976). Selection from Political Writings (1910-1920), selected and edited by Q. Hoare, translated by Matthews, London, Lawrence & Wishart.

Gregory, C. S. (1995). Creating a Vision for a nursing unit, *Nursing Management*, 26(1):38-41.

Griffith, M. B. (2012). Effective succession planning in nursing: a review of the literature. *Journal of Nursing Management*, 20(7): 900-911.

Hall, L.M., Doran, D.& Pink, G.H. (2004). Nurse staffing models, nursinghours, and patient safety outcomes. *Journal of Nursing Administration.* 34(1):41-5.

Hamers, J., Abu-Saad, H.&Halfens, R. (1994). Diagnostic process and decision making in nursing: a literature review. *Journal of Professional Nursing*, 10: 154–163.

Hannagan, T. (2002). *Management: Concepts and Practices. 3rd Edition.* England: Pearson Education Limited.

Havens, D. S. (1994). Is governance being shared? *Journal of Nursing Administration*, 24(6):59–64.

Hawkins, A., Carter, K. & Nugent, M. (2009). Nurse manager orientation AACN Advanced Critical Care, 20(1): 55-70.

Health Sector Support Office (HSSO) of Ghana *(*2001*).*Community Health Nursing in Health Care Delivery in Ghana*. HSSO, Accra.*

Herman, J. E.& Reichelt, P. A. (1998). Are first-line nurse managers prepared for team building? *Nursing Management.*, 29, 68-72.

Heruabadi S.&Marbaghi A. (1996).Management of nursing and midwifery. Tehran: Publication of Iran medical sciences University and health services.

Heskett, J.L., Jones, T.O., Loveman, G.W., Sasser, W.E. & Schlesinger, L.A. (1997), Putting the service profit chain to work, in Lovelock, C. H., Patterson, P. G. and Walker, R. H. (eds), *Services Marketing*, Prentice-Hall, Englewood Cliffs, NJ.

Hess, R. G. (1995). Shared governance: nursing's 20th century Tower of Babel. *J Nurs Adm.*, 25(5):14–17.

Holden, P. (1991). Colonial Sisters: Nurses in Uganda. In P. Holden & J. Littlewood, *Anthropology and Nursing.* (pp. 67-83.). London.: Routledge.

Hudson-Thrall, T. (2006).Nurturing your nurse managers. *H&HN: Hospitals and Health Networks*, 80: 40. 71-74.

Hunter, D. J. (1994). From tribalism to corporatism. In Challenging Medicine (Gabe J, Kelleher D & Williams G eds). Routledge, London, pp. 1–22.

Hurst, J. (2002). The Danish health care system from a British perspective, *Health Policy*, 59(2): 133-43.

Hyrkas, K.&Appelqvist-Schmidlechner, K. (2003). Team supervision in multiprofessional teams: team members' descriptions of the effects as highlighted by group interviews, *Journal of Clinical Nursing.*

Iakovidis, I. (1998). Towards personal health record: current situation, obstacles and trends in implementation of electronic health care record in Europe. *International Journal of Medical Informatics* 52: 105–115.

Institute of Medicine, (IOM) (2003). *Keeping Patients Safe: Transforming Nurses Work Environment.* Washington, DC, USA.: National Academies Press, 500 Fifth Street, NW,.

Institute of Statistical, Social and Economic Research at the University of Ghana *(*2003*)* State of the Ghana Economy. *University of Ghana Publishing, Accra.*

Jaco, P. R., Price, S. A.& Davidson, M. (1994). The Nurse Executive in the Public Sector: Responsibilities, activities and Characteristics. *Journal of Nursing Administration*, 24: 55-62.

Jaques, E. (1990). In praise of hierarchy. *Harvard Business Review* 68, 127-133.

Jasper, M.& Crossan, F. (2012). What is Strategic Management? *Journal of Nursing Management*, 20(7): 838-546.

Jenny, J.& Logan, J. (1997). Knowing the patient: one aspect of clinical knowledge. IMAGE: Journal of Nursing Scholarship 24, 254–258.1992; J. Liaschenko, Knowing the patient. In Nursing Praxis: Knowledge and action (Thorne S. & Hays V. eds). SAGE, Thousand Oaks, CA, pp. 23–38.

Katz, D.&Kahn, R. L. (1978). *The social psychology of organisations*. John Wiley & Sons, New York, NY.

Kanter, R. M. (1977). *Men and Women of the Corporation.* New York: Basic Books.

Kanter, R. M. (1993). *Men and women of the corporation*. New York, NY: Basic Books, Inc.

Kennedy, I. (2001). The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995: Learning from Bristol. Department of Health.

Kisseh, D. A. (1968). Development in Nursing in Ghana. *International Journal of Nursing Studies*, 5: 205-219.

Knights, D.& Wilmot, H. C. (1987). Organisational culture as management strategy: a critique and illustration from financial services industry. . *International Studies of Management and Organisation*, 17:3, 40-63.

Koontz, H., O'Donnell, C.&Weihrich, H. (1984). *Management.* 8thedn. McGraw-Hill Book Co., Singapore.

Koivula, M. (2008). Ward sisters' objectives in developing nursing and problems with development. *Journal of Nursing Management*, 9(5): 287-294.

Kramer, M.& Schmalenberg, C. E. (2004.). Magnet hospital nurses describe control over practice. *West Journal of Nursing Reseach*, 25(4):434–452.

Kramer, M., Maguire, P. & Schmalenberg, C. (2006). Excellence through evidence: the what, when, and where of clinical autonomy. *Journal of Nursing Administration*, 36(10):479–491.

Kramer, M., Maguire, P.& Schmalenberg, C. (2007). Excellence through evidence: structures enabling clinical autonomy. *Journal of Nursing Administration*, 37(1); 41–52.

Kramer, M., Schmalenberg, C.& Maguire P. (2008). Structures and practices enabling staff nurses to control nursing practice. *Western Journal of Nursing Research*, 30(5):539–559.

Kramer, M., Schmalenberg, C., Maguire, P., Brewer, B. B., Burke, R., Chmielewski, L., Cox, K., Kishner, J., Krugman, M., Meeks-Slostrom, D.& Waldo, M. (2009). Walk the Talk: Promoting Control of Nursing Practice and a Patient-Centered Culture. *Critical Care Nurse*, 29:3, 77-93.

Laschinger H. K.& Wong C. (1999). Staff nurse empowerment and collective accountability: effect on perceived productivity and self-rated work effectiveness.*Nursing Economics*, 17(6):308–316.

Lee H.H.& Cummings G.G. (2008). Factors influencing job satisfaction of frontline managers: a literature review. *Journal of Nursing Management.*, 16(7), 768-783.

Levitt, B.& March, J. (1986). Organizational learning.*Annual Rev. Sociology*, 14 319-340.

Lin, M. N., Wu, J. H., Tseng, K. H., Lavler, J. J.& Vestel, K. (2007). Management Development: A study of Nurse Managerial Activities and Skills. *Journal of Healthcare Management.*

Lockwood, N. R. (2007), Leveraging employee engagement for competitive advantage: HR's strategic role, *HRMagazine* 52, 3, 1-11.

Lucas, V., Laschinger, H.& Wong, C. (2008). The impact of emotional intelligent leadership on staff nurse empowerment: the moderating effect of span of control. *Journal of Nursing Management*, 16: 964–973.

Lundgren, S.& Segesten, K. (2001). Nurses' use of time in a medical–surgical ward with all-RN staffing. *Journal of Nursing Management*, 9: 13–20. doi: 10.1111/j.1365-2834.2001.00192.x.

Macphee, M., Wardrop, A.& Campbell, C. (2010). Transforming workplace relationships through shared decision making, *Journal of Nursing Management*, 18: 1016-1026.

Mahon, A.& Young, R. (2006). Health care managers as a critical component of the health care workforce. In M. M. C. Dubois, *Human resources for Health in Europe.* (pp. 116-139.). Berkshire: Open University Press.pp116-139.

Malloch, K.& Porter O'Grady, T. (2009).*The Quantum Leader: Applications for the New World of Work.* Jones and Barletta, Toronto.

Mäkinen, A., Kivimäki, M., Elovainio, M.& Virtanen, M. (2003). Organization of nursing care and stressful work characteristics. *Journal of Advanced Nursing*, 43: 197–205. doi: 10.1046/j.1365-2648.2003.02694.x.

Manias, E.& Street, A. (2000). Legitimation of nurses' knowledge through policies and protocols in clinical practice. *Journal of Advanced Nursing*, 32: 1467–1475.

Manias E.& Street, A. (2001), Nurse-doctor interactions during critical care rounds. *Journal of Clinical Nursing,* 10(4): 442-50.

Manias, E.,Aitken, & Dunning, (2005). How graduate nurses use protocols to manage patients' medications, *Journal of Clinical Nursing*, 14: 935–944.

Mark, B.A. (1994). The emerging role of the nurse manager: implications of educational preparation. *Journal of Nursing Administration*, 24: 48-55.

Marquis, B. L.& Huston, C. J. (2006). *Leadership Roles and Management Functions in Nursing: Theory and Application.* Philadelphia: Lippincott Williams & Wilkins.

Marrelli, T. M. (2004). *The Nurse Manager's Survival Guide: Practical Answers to Everyday Problems.* 3rd ed. St. Louis, MO: Mosby.

Marriner-Tomey, A. (2009). *Guide to Nursing Management and Leadership. 8th edn.* St Louis: Mosby Elsevier.

Mathena, K. A. (2002). Nursing manager leadership skills. *Journal of Nursing Administration.*, 32: 136-142.

Marquis B.& Huston C. (2000). *Leadership Roles and Management Functions in Nursing, 3rd edn.* Philadelphia, PA: Lippincott, Williams and Wilkins.

McBachen, I.& Keogh, J. (2007). *Nurse Management Demystified: A Self-Teaching Guide.* The McGraw-Hill Companies, USA.

McCallin, A. M.& Frankson, C. (2010). The role of the charge nurse manager: a descriptive explorative study. *Journal of Nursing Management*, 18: 3, 319-325.

McClure, M. L., Poulin, M. A. & Sovie, M. D. (1983). *Magnet hospital: Attraction and relation of Professional Nurses.* Kansas City, MO: American Academy of Nursing.

McDaniel R., & Driebe D. (2001). Complexity science and health care management. *Advances in Health Care Management*, 2: 11–36.

McDonough, E. & Leifer, R. (1986). Effective control of new product projects: the interaction of organisational culture and project leadership. *Journal of Project Innovation and Management*, 3: 149-57.

McGillis Hall, L.& Donner, G. J. (1997). The changing role of hospital nurse managers: a literature review. *Canadian Journal of Nursing Administration*, 10: 14-39.

McGillis Hall, L., Doran, D.& Pink, G. H. (2004). Nurse Staffing Models, Nursing Hours and Patient Safety Outcomes, *Journal of Nursing Administration,* 34(1): 41-5.

McGuire, E.& Kennerly, S. M. (2006). Nurse Managers as Transformational and transactional Leaders. *Nursing Econimics,* 24: 179-185.

McKenna, B. G., Smith, N. A., Poole, S. J.& Coverdale, J. H. (2003). Horizontal violence: experiences of nurses in the first year of practice. *Journal of Advanced Nursing*, 42 (1), 90–96.

McNeese-Smith, D. K.&Nazarey, M. (2001). A nursing shortage: building organizational commitment among nurses/practitioner application. *Journal of Healthcare Management*, 46 (3): 173– 188.

Merchant, K. A. (1985). *Control in business organisations.* Boston, MA.: Pitman,.

Meyer, R. M.& O'Brien-Pallas, L. L. (2010). Nursing services delivery theory: an open system approach. *Journal of Advanced Nursing*, 66: 2828-2838.

Miller, K.,Riley, W.& Davis, S. (2009). Identifying key nursing and team behaviours to achieve high reliability, *Journal of Nursing Management*, 17: 247–255.

Mintzberg, H. (1973). *The nature of managerial work*. New York: Harper & Row.

Mintzberg, H. (1979). *The structuring of organisations.* Englewood Cliffs, NJ.: Prentice Hall.

Mintzberg, H. (1994). The Rise and Fall of Strategic Planning: Reconceiving the Roles for Planning, Plans, Planners, Free Press.

Mosley,D. C., Pietri, P. H.& Mosley, D. C. (2008). *Supervisory Management: The Art of Inspiring, Empowering, and Developing People.* 7th Ed. Thomson South-Western. US.

Munhall, P.L. (2011). *Nursing Research: A Qualitative Perspective*. 5th edition. Jones & Bartlett Learning, LLC. US: 492.

Nelson, R. & Winter, S. . (1981). *An Evolutionary Theory of Economic Change.* Cambridge, MA.: Belknap/Harvard University Press,.

Nelson, R. (2004). The nurse poachers. *The Lancet*, Volume 364, Issue 9447, Pages 1743 - 1744, doi: 10.1016/S0140-6736(04)17418-7.

Newman, K., Maylor, U.& Chansarkar, B. (2001), The nurse retention, quality of care and patient satisfaction chain, *International Journal of Health Care Quality Assurance* 14, 2, 57-64.

Newman, K., Maylor, U.& Chansarkar, B. (2002), The nurse satisfaction, service quality and nurse retention chain: Implications for management of recruitment and retention. *Journal of Management in Medicine* 16, 4/5, 271-291.

Neuman, W. L. (2003), Social Research Methods: Qualitative and Quantitative Approaches, 5th Edition, Allyn& Bacon, Incorporated.

Nichols, T.&Beynon, H. (1977), *Living with Capitalism: Class Relations and the Modern Factory* (London: Routledge& Kegan Paul,.

Ofori, R.&Dampson, D. G. (2011), *Research Methods & Statistics Using SPSS*, Amakom-Kumasi: Payless Publication Limited.

O'Neill, M. (2005), Employee care, a vital antecedent to customer care in the health care industry, *International Journal of Health Care Quality Assurance Incorporating Leadership in Health Services* 18, 2-3, 131-151.

O'Rourke, M.W. (2007). Role-based nurse managers: A linchpin to practice excellence. *Nurse Leader*, August, 44-53.

Orlikowski, W. J. (1991). Integrated information environment or matrix of control? The contradictory implications of information technology. *Accounting Management and Information Technology*, 1: 9-42.

Oroviogoicoechea, C. (1996). The clinical nurse manager: a literature review. *Journal of Advanced Nursing*, 24: 1273-1280.

Otoo, S. N. (1968.). A Pattern of Training for the Nursing Service in Ghana. *Ghana Medical Journal*, 79-86.

Ouchi, W. G.& Dowling, J. B. (1974). Defining the span of control. *Administrative Science Quarterly*,19: 357-365.

Ouchi, W. G. (1979). A conceptual framework for the design or organisational control mechanisms. *Management Science*,833-48.

Ouchi, W. (1981). *Theory Z: How American Business Can Meet the Japanese Challenge*. Addison-Wesley. ISBN 0-201-05524-4.

Owusu, M. (1995). *History of Professional Nursing from the Gold Coast Era. The Golden Jubilee of SRN training in Ghana.* Accra.

Paliadelis, P. S. (2008). The working world of nursing unit managers: responsibility without power. *Australian Health Review*, 32: 256-264.

Pardue, S. (1987). Decision-making skills and critical thinking ability among associate degree, diploma, baccalaureate, and master's prepared nurses. *Journal of Nursing Education*, 26: 354–361.

Parsons, M.L.&Stonestreet J. (2003). Factors that contribute to nurse manager retention. *Nursing Economics*, 21 (3): 120– 126.

Parsons, ML.&Stonestreet, J. (2004). Staff nurse retention. Laying the groundwork by listening. *Nursing Leadership forum*, 8 (3): 107-113.

Peltier, J., Nill, A.& Schibrowsky, J. A. (2003), Internal marketing, nurse loyalty and relationship marketing: An exploratory study of German nurses, *Health Marketing Quarterly* 20, 4, 63-82.

Peltier, J., Pointer, L.& Schibrowsky, J. A. (2007), Internal marketing and the antecedents of nurse satisfaction and loyalty, *Health Marketing Quarterly* 23, 4, 75-108.

Peltier, J., Schibrowsky, J. A., and Nill, A. (2004), Crossing Cultures, *Marketing Health Services*, Spring, 26-33.

Peters, T. (1987). *Thriving on Chaos: Handbook for a Management Revolution.*HarperCollins Publishers.

Pillay, R. (2011). The Skills Gap in Nursing Management in the South African Public Sector. *Public Health Nursing*, 28(2): 176-185.

Polit, D.F.& Beck, C.T. (2008).*Nursing Research: Generating and Assessing Evidence for Nursing Practice.* 8thedn. Lippincott Williams & Wilkins, Philadelphia, PA.

Ponte, P.R., Kruger, N.& DeMarco, R. (2004). Reshaping the practice environment: the importance of coherence. *Journal of Nursing Administration.*, 34(4): 173-179.

Porter-O'Grady, T. (2003). A different age for leadership, part 1. *Journal of Nursing Administration*, 33(2): 105–110.

Prince, S. B. (1997). Shared governance: sharing power and opportunity. *Journal of Nursing Administration*, 27(3): 28–35.

Quinn, J. B. (1980). *Strategies for change: Logical incrementalism.* Homewood, IL. Irwin.

Radwin, L. (1995). Empirically generated attributes of experience in nursing. *Journal of Advanced Nursing*, 27: 590–595.

Radwin, L. (1998). Empirically generated attributes of experience in nursing. *Journal of Advanced Nursing*,27: 590–595.

Rankin, J.& Campbell, M. (2006). *Managing to Nurse: Inside Canada's Healthcare reform.* Toronto, ON: University of Toronto Press.

Richmond, P. A., Book, K., Hicks, M., Pimpinella, A. & Jenner, C. A. (2009). C.O.M.E. be a nurse manager. *Nursing Management.* 40(2): 52-54.

Ritter-Teitel, J. (2002). The impact of restructuring on professional nursingpractice. *Journal of Nursing Administration*, 32(1): 31-41.

Robbins, B.& Davidhizar, R. (2007). Transformational leadership in healthcare today. *The Health Care Manager*, 26(3): 234-239.

Robbins, S.& Coulter, M. (2007). *Management*. 9thedn. Pearson Prentice Hall, New Jersey.

Rose, N. (1999). *Governing the soul: The shaping of the private self.* Aldershot.: Gower.

Roussel, L. (2000). Conceptualization of Nursing Administration: Theory and Concepts. In L. Roussel, with R. C. Swanaburb& R. J. Swansburg. Management and Leadership for Nurse Administrators. 4th Edition.

Ruland, C. M. (2000).Va°rdinformatikHuranva¨ndningavinformations – ochkommunikationsteknologikanutvecklava°rdochomva°rdnad (Health care informatic. How to use the information and communication technology to develop care and nursing). Bokfo¨ rlagetNaturochKultur, Stockholm. [In Swedish].

Rushmer, R.&Pallis, G. (2003), Inter-Professional Working: The Wisdom of Integrated Working and the Disaster of Blurred Boundaries, Public Money & Management, 23(1): 59-66. DOI: 10. 1111/1467-9302.00342.

Ryan A.A.& Loque H.F. (1998). Developing an audit tool for primary nursing. *Journal of Clinical Nursing*, 7: 417–423.

Schmidt, K.& Simone, C. (1996). Coordination Mechanisms: Towards a Conceptual Foundation of CSCW Systems Design. *Computer Supported Cooperative Work (CSCW)*, (5), pp. 155- 200.

Seago, J. (2001). Nurse staffing, models of care, and interventions. In K. M. K.G. Shojania, *Making health care safer: a critical analysis of patient safety practices.* pp. No. 01-E058. 427-451). Washington, DC:: Agency for Healthcare Research and Quality: Evidence/Technology Assessment No. 43 (AHRQ).

Shirey M.R. (2006) Stress and coping in nurse managers: two decades of research. *Nursing Economics*, 24 (4): 193–211.

Shirey, M. R., Ebright, P.& McDaniel, A. (2008). Sleepless in America: Nurse Managers Cope with Stress and Complexity. *Journal of Nursing Administration*, 38 (3), 125-131.

Shirey, M. R., McDaniel, A. M., Ebright, P. R., Fisher, M. L.& Doebbeeling, B. N. (2010). Understanding nurse manager stress and work complexity: factors that make a difference. *Journal of Nursing Administration*, 40, 82-91.

Simpson, R. L. (2003). The role of IT in health care quality assessment. *Nursing Administration Quarterly*, 27, 355–359.

Skytt, B., Ljunggren, B.&Carlsson, M. (2007). Reasons to leave: the motives of the first-line nurse managers' for leaving their posts. *Journal of Nursing Management*, **15**, 294-302.

Skytt, B., Ljunggren, B., Sjoden, P.& Carlsson, M. (2008). The Roles of the First-line Nurse Manager: Perceptions from Four Perspectives. *Journal of Nursing Management*, 16: 1012-1020.

Sloper, P. (2004). 'Facilitators and barriers for co-ordinated multi-agency services', *Child: Care, Health and Development*, 30(6): 571–580.

Smeenk, F. W., de Witte, L. P., Nooyen, I. W.&Crebolder, H. F., (2000). Effects of transmural care on coordination and continuity of care. *Patient Education & Counseling*, 41, 73-81.

Smokler, Lewis, P. & Malecha, A. (2011). The impact of workplace incivility on the work environment the manager skills, and productivity. Journal of Nursing Administration, 41(suppl. 7-8): S17-S23.

SOSFS (1993).Socialstyrelsensallma¨nnafo¨ reskrifterochra°dompatientjournallagen 20 (Swedish Board of Health and Welfare, General advice about the Patient Record Act). [In Swedish].

Squires A. (2004). A dimensional analysis of role enactment of acute care nurses. *Journal of Nursing Scholarship*, 3 (36), 272–278.

Sterman, J. D. (2000). Business Dynamics: Systems Thinking and Modeling for a Complex World.

Storey, J. (1985). The means of management control. *Sociology*, 19:2, 193-221.

Sumani, M. (2005). The Role of the Nurse in Present Day Health Delivery System. *Speech Delivered on 10th Anniversary of NTC Alumni Association.* Accra.

Surakka, T. (2008). The nurse manager's work in the hospital environment during the 1990s and 2000s: responsibility, accountability and expertise in nursing leadership. . *Journal of Nursing Management*, 16: 525–534. doi: 10.1111/j.1365-2834.2008.00901.x.

Talley, B. (2006). Nurses and nursing education in Ghana: creating collaborative opportunities. *International Nursing Review*, 53: 47-51.

Tanner, C. (1983). Chapter one: research on clinical judgement. In Review of Research in Nursing Education (Holzemer W. ed.). Slack Inc, Thorofare, NJ, pp. 1–32.

Testa, M. R., Skaruppa, C. & Pietrzak, D. (1998), Linking job satisfaction and customer satisfaction in the cruise industry: implications for hospitality and travel organizations, *Journal of Hospitality and Tourism Research* 22, 1, 4-14.

Thomas, A. L. (1961). Medical Impressions of Ghana, West Africa. *Journal of the National Medical Association.*, 53(4), 335-345.

Tomey, A.M. (2000). *Guide to Nursing Management and Leadership, 6th edn.* . St Louis. : Mosby.

Tornvall, E.&Wilhelmsson, S. (2008). Nursing documentation for communicating and evaluating care.*Journal of Clinical Nursing*, 17, 2116–2124.

Twumasi, P. A. (2005). *Medical Systems in Ghana.* Accra.: Assembly Press.

Upenieks, V. (2003). Nurse Leaders' perceptions of what compromises successful leadership in today's acute inpatient environment. *Nursing Administration Quarterly*, 27:140-152.

vanAchterberg, T., Stevens, F. C. J., Crebolder, H. F. J. M., De Witte, L. P.&Philipsen,H. (1996), Coordination of care: effects on the continuity and quality of care. International.*Journal of Nursing Studies*, 33(6): 638-650.

vanDulmen, S. (2003). Patient-centredness (editorial). Patient Education and Counseling, 51, 195–196. p. 195.

Wagner, S. E. (2006), Staff retention: From "satisfied" to "engaged," *Nursing Management* 37, 3, 24-29.

Wallick, W. G. (2002). Health Care Managers' Roles, Competencies and Outputs in Organizational Performance Improvement. *Journal of Health Care Management*, 47(6): 390-401.

Walker, K. (2003). Why evidence-based practice now? A polemic. *Nurse Inquiries*, 10(3): 145-155

Waterman, H., Waters, K. &Awenat, Y. (1996). The introduction of case management on a rehabilitation floor. *Journal of Advanced Nursing, 24,* 960–967.

Weber, M. (1978). *Economy and society: an outline of interpretive sociology*. (E. Fischoff, H. Gerth, A. M., Henderson *et al*. trans. Vol 2.). University of California Press, Berkeley, CA.

Wheeler, P. (2001). The Myers Briggs type indicator and applications to accounting education and research. *Issues in Accounting Education*, 16 (1), 125–150.

Whitworth, B. S. (2008).Is there a relationship between personality type and preferred conflict-handling styles? An exploratory study of registered nurses in southern Mississippi, *Journal of Nursing Management*, 16, 921–932.

Willmot, M. (1998.). The new ward manager: an evaluation of the changing role of the charge nurse. *Journal of Advanced Nursing*, 28, 419-427.

Winch, S., Creedy, D. &Chaboyer, W. (2002). Governing nursing conduct: the rise of evidence-based practice. *Nurse Inquiry*; 9(3): 151-161.

Wong, F. K. (1998). The Nurse-Manager as a Professional-Managerial Class: A Case Study. *Journal of Nursing Management*, 6: 343-350.

Wong, C. A.& Cummings, G. G. (2007). The Relationship Between Nursing Leadership And Patient Outcomes: A Systematic Review. *Journal of Nursing Management*, Volume 15, Issue 5, pages 508–521.

Wood, M. J. & Ross-Kerr, J. C. (2011). *Basic steps in planning nursing research: From question to proposal* (7th Ed.). Sudbury, MA: Jones and Bartlett Publishing

Wright, K., Rowitz, L.& Merkle, A. (2000). Competency development in public health leadership. *American Journal of Public Health.*, 90: 1202-1207.

Wright, R. (2012).Effective Communication Skills for the 'Caring' Nurse. The Great Teachers: Tertiary Place.

Zori, S.& Morrison, B. (2009). Critical Thinking in Nurse Managers. *Nursing Economic$*, 27(2): 75-80.

Zori, S., Nosek, L. J.& Musil, C. M. (2010). Critical Thinking of Nurse Managers Related to Staff RNs'Perceptions of the Practice Environment. *Journal of Nursing Scholarship.*, 42:3, 305-313.

APPENDICES

Appendix A: Participant Information Leaflet and informed consent

UNIVERSITY OF GHANA BUSINESS SCHOOL

DEPARTMENT OF PUBLIC ADMINISTRATION

PARTICIPANT INFORMATION LEAFLET AND INFORMED CONSENT

Title: **NURSING MANAGEMENT OF NURSE MANAGERS AT THE WARD LEVEL IN THE GREATER ACCRA REGION**

Primary investigator: Adelaide Maria Ansah Ofei, PhD candidate (Health Service Management)

Address: Department of Public Administration and Health Service Management

University of Ghana Business School

Legon

General Information about the Research

The study involves research of nurse managers and nurses on the ward. The objective of the study is to explore how Nurse Managers plan, organise, staff, lead, control and coordinate activities onward, explore the competencies of Nurse Managers considered effective and successful for practice, explore the influence of professionalism on nursing management, investigate factors that influence nursing management at the ward level, and explore the implications of these characteristics for client satisfaction, staff satisfaction and nursing practice.

The purpose of the study is to explore nursing management on the ward by nurse managers, and the competencies of Nurse Managers considered effective and successful for practice and implications of these characteristics for staff and client satisfaction. It is hoped that the results of this study shall help nurse managers to effectively play their challenging roles as linchpins in the health care delivery system.

If you agree to take part, you shall be one of the nurse managers in an in-depth interview, or nurse in a focus group discussion, who shall be selected to talk about your experience or perception on nursing management at the ward, how nurse managers handle their multiple obligations and continuous challenges on the ward. You will also talk about your lived experiences as a nurse manager or your everyday practice as a nurse manager in an effort to manage the ward effectively to ensure satisfaction of clients and staff. Your experiences with colleagues as you manage the ward and how factors such as professionalism, competencies influence nursing management and their implications for selection and development of nurse manager for positive outcomes. The interviews shall be audio taped with your permission to capture vividly all that transpired during the sessions.

You will also be expected to complete a questionnaire. You shall be expressing your expectation and perception about your work as a nurse manager or your expectation and perception of nurse managers with particular reference to nursing management. We are interested in the managerial transformation process of nurse managers which no doubt ensures efficient use of resources with objectivity and thus increasing the role of the entire health care delivery system thus, ensuring quality health care to people living in Ghana.

If you decide to take part, you will be interviewed privately at a time that you will choose. You will be interviewed several times until we fully understand the situation. The study will be ongoing for a year. At the beginning, the focus will be on the challenges of nursing

management and at the end, the role of some factors such as professionalism, competencies that influence nursing management. Nurse Managers play a pivotal role in health care by managing scare resources; managerial functions enhance the productivity of nurse managers positively.

Possible risks and discomforts

The study procedures involve no foreseeable risks to you or your ward/unit. You may benefit by sharing your experiences with the researcher and learning about nursing management and research in nursing. The outcome of the study shall be shared with you in a workshop that will enhance your knowledge and skills in nursing management.

Possible Benefits

There are several benefits to be derived from this study. Essentially The study will allow all participants to critically reflect on our management practices on the ward and the extent to which it can be improved. The researcher intends to educate participants on the knowledge and skills of management and can up with best practices that would enhance staff and client satisfaction. It is anticipated that preferred mode of management practice will be discussed intensively to help nurses reassess themselves such that they can reposition nursing effectively within the health care system.

Confidentiality

All information obtained during the course of this study is strictly confidential. Your name will not be mentioned anywhere in the study. The study data will be coded so that it will not be linked to your name. Your identity will not be revealed while the study is being conducted or when the study is reported in scientific journals. All the data that has been collected will be stored in a secure place and not shared with any other person without your permission.

Compensation

You will not be paid for taking part in the study.

Voluntary Participation and Right to Leave the Research

Your participation in this study is voluntary. You are under no obligation to participate. You have the right to withdraw anytime, and your relationship with colleagues will not be affected.

Contacts for Additional Information

In case you have any questions, which are not fully explained in this leaflet, do not hesitate to ask the investigator. You can call me, Adelaide Ansah Ofei on 0244653065 (cell) or any of my supervisors, Dr. T Buabeng at 0208166400 (cell) and Dr. P Mwini-Nyaledzigbor at 0274131004 (cell) if you have any questions concerning the study. You should not just agree to take part except that you are completely satisfied with all the procedures involved in the study.

Your rights as a Participant

This research has been reviewed and approved by the Institutional Review Board of Noguchi Memorial Institute for Medical Research (NMIMR-IRB). If you have any questions about your rights as a research participant you can contact the IRB Office between the hours of 8am-5pm through the mobile number 0302916438 or email addresses: nirb@noguchi.mimcom.org or HBaidoo@noguchi.mimcom.org.

VOLUNTEER AGREEMENT

The above document describing the benefits, risks and procedures for the research title "**NURSING MANAGEMENT OF NURSE MANAGERS AT THE WARD LEVEL IN THE GREATER ACCRA REGION"** has been read and explained to me. I have been given an opportunity to have any questions about the research answered to my satisfaction. I agree to participate as a volunteer.

_____ _____

Date Signature or mark of volunteer

If volunteers cannot read the form themselves, a witness must sign here:

I was present while the benefits, risks and procedures were read to the volunteer. All questions were answered and the volunteer has agreed to take part in the research.

_____ _____

Date Signature of Witness

I certify that the nature and purpose, the potential benefits, and possible risks associated with participating in this research have been explained to the above individual.

_____ _____

Date Signature of Person Who Obtained Consent

AppendixB: Research questionnaire

UNIVERSITY OF GHANA BUSINESS SCHOOL

UNIVERSITY OF GHANA

LEGON

RESEARCH QUESTIONNAIRE FOR NURSES

Dear Respondent,

This questionnaire is in respect of a research being carried out on **"Management of Nursing/Midwifery Units by nurse managers in the Greater Accra region of Ghana"**. It is purely for academic purpose and your responses shall be kept in strict confidence and will not be disclosed to anyone. You also reserve the right to withdraw from the study but your participation is much valued and appreciated. Your consent is implied by completing the questionnaire.

Please kindly take some time off your busy schedule and fill out this questionnaire honestly. Thank you.

Name of Hospital……..

Type of hospital	1) Regional	[ ]	2) Urban district	[ ]
	3)Peri-urban district	[ ]	4) Rural district	[ ]

SECTION A- DEMOGRAPHIC CHARACTERISTICS OF THE NURSE/MIDWIFE

(Please indicate by writing or ticking (√) what applies to you)

1. Age: ……..

2.	Gender:	1) Male	[ ]	2) Female	[ ]
3.	Rank:	1) Staff Nurse/midwife	[ ]	2) Senior staff nurse/midwife	[ ]
		3) NO/MO	[ ]	4) SNO/SMO	[ ]
		5) Enrolled Nurses	[ ]	6) PNO/PMO	[ ]

4. Basic Qualifications:

1) Certificate	[ ]	2) Diploma	[ ]
3) First Degree	[ ]		

5. What is the highest qualification of your nurse manager? (Pls. choose the most appropriate answer)

1) Post-Basic Diploma/certificate	[ ]	2) First Degree	[ ]
3) Masters Degree	[ ]	4) Other (specify) ……	

6. Which unit are you working in? 9) Other (specify) ……

1) Emergency	[ ]	2) Maternity	[ ]
3) Surgical	[ ]	4) Medical	[ ]
5) Children	[ ]	6) Theatre	[ ]
7) OPD	[ ]	8) Specialized unit	[ ]

7. Has your nurse-manager (NM) received any training in management/administration? (Please indicate).

1) Yes	[ ]	2) No	[ ]

8. How long has your NM worked as a nurse/midwife? ……

9. How long has your NM worked as a nurse manager on the ward? .....

10. How long have you worked with this nurse manager? .....

11. How heavy is your ward? 1) Very heavy always [ ]

2) Heavy always [ ]

3) Heavy sometimes [ ]

4) Not heavy [ ]

SECTION B: PLANNING IN THE UNIT

How does planning takes place in your unit? [Use the numbers 1-5 to indicate how you perceive planning to be executed on your unit and how you would prefer planning to be executed in your unit. Key: **1=Not at all, 2=to a small extent, 3= to some extent, 4= to a large extent, 5 = to a very large extent**]

		Perceived					Preferred				
	Planning with the nurse manager	1	2	3	4	5	1	2	3	4	5
1	Do you plan in your unit?										
2	Nurse manager describes and explains decisions										
3	Is your unit plan written?										
4	NM and staff develop and review protocols & procedures										
5	NM involves subordinates in decision making										
6	NM conducts internal and external analysis with staff										
7	NM formulates operational goals and objectives with staff										
8	NM selects and formulates the operating plan from alternatives										
9	NM follow-up to the proposed course of action										
10	NM implements the plan with staff										
11	NM evaluate previous plan before new plan is develop with staff										
12	Do you know the mission of the hospital?										
13	Do you have a vision for your unit?										
14	NM communicates effectively with subordinates on plan										
15	NM plans on new ideas and encourage creative thinking										
16	NM plans for supervision										
17	NM plans for staff training and development										
18	NM plans for mode of organising nursing care										
19	NM plans for the attitude of staff										
20	NM plans for acquisition of resources for quality nursing care										
21	Do you have a budget for your unit?										
22	NM collectively prepare the duty roster with colleagues										

23. How will you rate the usage of plans in your unit?

1) 80-100% [ ] 2) 60-79% [ ]

3) 40 59% [ ] 4) 20-39% [ ]

5) 0-19% [ ] 6) Other (specify) ……

24. How often do you plan in the unit?

1) Quarterly [ ] 2) Half yearly [ ]

3) Yearly [ ] 4) Other (specify) ……

25. How much of your time do you spend in planning for your unit?

1) 80-100% [ ] 2) 60-79% [ ]

3) 40-59% [ ] 4) 20 39% [ ]

5) 0-19% [ ] 6) Other (specify) ……

26. If you are not satisfied with how planning is done in the unit, how will you like it to be done?

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27. Comments on planning.

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SECTION C. ORGANISING THE UNIT

How do you organise your unit for patient care? [Use the numbers 1-5 to indicate how you perceive organisation of nursing care on your unit and how you would prefer organisation of nursing care to be on the unit. [**Key: 1=Not at all, 2=to a small extent, 3= to some extent, 4= to a large extent, 5 = to a very large extent**]

		Perceived					Preferred				
	Activity by nurse manager and the team	**1**	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**
1	NM communicates effectively with staff on issues of assignment										
2	NM delegates with appropriate authority and resources										
3	The unit uses a model for organising unit functions										
4	NM interacts easily and offers support where necessary										
5	Tasks in the unit have been well defined										
6	Patient care is accomplished by series of distinctive tasks by nurses										
7	Nurse have 24-hour responsibility for the care planned and provided to the patient										
8	Nurses are allocated to carry out comprehensive set of activities within teams										
9	Nurse manager deals with challenges and resolves conflicts										
10	NM establishes supportive relations to facilitate work										
11	NM ensures there is adequate resources for work										
12	NM ensures cohesion among unit nurses'										
13	NM coordinates effectively activities in the unit										
14	NM collaborates with medical staff										
15	NM collaborates with other health care providers										
16	NM has devolved power structures within the unit										
17	NM has team building skills										
18	NM has influence over the timing of unit and patient events										
19	NM has influence over human and financial resources in the unit										
20	NM ensures client and staff satisfaction										
21	NM ensures staff accountability to patient care										
22	NM creates a positive work climate for colleagues and other healthcare providers										
23	The NM ensures staff is shortlisted for promotion										
24.	NM ensures staff receive training on the job (self-development)										

25. How will you rate the organising skills of your nurse manage? (Please tick (√) the one that is applicable)

1) Very satisfactory [ ] 2) Satisfactory [ ]

3) Don't know [ ] 4) Very unsatisfactory [ ]

5) Unsatisfactory [ ]

26. Comments on organising

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SECTION D. COORDINATING

How is coordination of care practised in the unit? [Use the numbers 1-5 to indicate how coordination of activities is practised in the unit and how you would prefer coordination to be practised in the unit. Key: **1=Not at all, 2=to a small extent, 3= to some extent, 4= to a large extent, 5 = to a very large extent**]

		Perceived					Preferred				
	Coordinating of activities by nurse managers	**1**	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**
1	Coordination of care in the unit is written or formal										
2	Coordination in the unit is well structured manually										
3.	Coordination in the unit is structured with information system (computer)										
4.	Coordination in the unit is done informally										
5.	Work in the unit is standardized										
6.	Handing over in the unit is done at the bedside of clients										
7.	Documentation in the unit is adequate										
8.	All information generated from clients or colleagues are documented.										
9.	All procedures or interventions carried out for clients are documented										
10.	There is effective communication between nurses and other colleagues regarding patient care.										
11.	Good interpersonal relationship between nurses and other colleagues' especially medical staff.										
12.	Hierarchies within professional groups play a key role in coordination										
13.	There is confusion in the boundaries of coordination										
14.	All aspects of patient care are handed over to staff										
15.	Nurses join doctors on ward rounds and communicate on nursing care to medical team.										
16.	Nurses devote time to listen to clients' complaints										
17.	Nurses' devote time to give adequate information to clients concerning their conditions.										
18.	NM coordinates effectively all activities in the unit										
19.	The NM has good interpersonal relationship with staff and other colleagues										
20.	There is interpersonal relationship among all nurses in the unit										

22. How do you rate the coordination skills of the NM? (Please indicate by ticking (√))

1) Very satisfactory [ ] 2) Satisfactory [ ]

3) Don't know [ ] 4) Very unsatisfactory [ ]

5). Unsatisfactory [ ]

23. How else do you think coordination in the unit can be improved by NMs?

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SECTION E CONTROL

How do nurse-managers control the unit? [Use the numbers 1-5 to indicate how you perceive control been maintained in the unit and how you prefer control to be managed in the unit. Key: **1=Not at all, 2=to a small extent, 3= to some extent, 4= to a large extent, 5 = to a very large extent**]

		Perceived					Preferred				
	Control strategies used by the nurse manager	**1**	**2**	**3**	**4**	**5**	**1**	**2**	**3**	**4**	**5**
1	The NM understands the governance of the hospital										
2	The NM has developed rules and regulations for controlling the unit										
3	Nurses work according to job descriptions										
4	The NM encourages self-directedness among staff										
5	NM gives constructive criticism										
6	NM is tolerant of people's mistakes and responsible for own mistakes										
7	The NM recognises all efforts made by staff and acknowledges them										
8	NM trusts subordinates' competence										
9	NM improves team spirit										
10	NM encourages cooperation and coordination										
11	NM supervises work in the unit										
12	NM coaches and mentors junior staff										
13	NM deals with challenges and conflicts in the unit										
14	NM appraises subordinates and organises for training for staff to update their knowledge, skills and attitudes										
15	NM has a firm control of the unit generally										
16	NM is able to control other professional who work in the unit										
17.	The NM encourages accountability of staff										
18.	The NM gives due positive feedbacks										
19.	NM organises unit durbars for staff where ideas are shared.										
20.	There is a logbook for staff in the unit to record arrival on duty										
21.	There is clear division of labour in the unit.										
22.	The NM uses a lot of intimidation in controlling the unit										
23.	The NM employs minimal consultation in controlling unit										

24. How do you rate the control skills of the NM? (Please indicate by ticking (√))

1) Very satisfactory [ ] 2) Satisfactory [ ]

3) Don't know [ ] 4) Very unsatisfactory [ ]

5). Unsatisfactory [ ]

25. In your own way how does your nurse manager maintain control in the unit and how can it be improved?

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AppendixC: Ethical Clearance

NOGUCHI MEMORIAL INSTITUTE FOR MEDICAL RESEARCH
Established 1979
A Constituent of the College of Health Sciences
University of Ghana

INSTITUTIONAL REVIEW BOARD

Phone: +233-302-916438 (Direct)
+233-289-522574
Fax: +233-302-502182/513202
E-mail: nirb@noguchi.mimcom.org
Telex No: 2556 UGL GH

Post Office Box LG 581
Legon, Accra
Ghana

My Ref. No: DF.22
Your Ref. No:

5th September, 2012

ETHICAL CLEARANCE

FEDERALWIDE ASSURANCE FWA 00001824 **IRB 00001276**

NMIMR-IRB CPN 003/12-13 **IORG 0000908**

On 5th September, 2012, the Noguchi Memorial Institute for Medical Research (NMIMR) Institutional Review Board (IRB) at a full board meeting reviewed and approved your protocol titled:

TITLE OF PROTOCOL : **Nursing Management of Nurse Managers at the Ward Level in the Greater Accra Region**

PRINCIPAL INVESTIGATOR : **Adelaide Maria Ansah Ofei, PhD Candidate**

Please note that a final review report must be submitted to the Board at the completion of the study. Your research records may be audited at any time during or after the implementation.

Any modification of this research project must be submitted to the IRB for review and approval prior to implementation.

Please report all serious adverse events related to this study to NMIMR-IRB within seven days verbally and fourteen days in writing.

This certificate is valid till 4th September, 2013. You are to submit annual reports for continuing review.

Signature of Chairman: .....
Rev. Dr. Samuel Ayete-Nyampong
(NMIMR – IRB, Chairman)

cc: Professor Kwadwo Koram
Director, Noguchi Memorial Institute
for Medical Research, University of Ghana, Legon

AppendixD: Introductory Letter to Tema General

SCHOOL OF NURSING
COLLEGE OF HEALTH SCIENCES
UNIVERSITY OF GHANA
LEGON

Tel.No. (233)-021-513250
(233)-028-9108374
E-mail: nursing@ug.edu.gh

P.O. Box LG.43
LEGON, GHANA

January 9, 2013

The Medical Director,
Tema General Hospital,
Tema.

Dear Sir/Madam,

RESEARCH WORK
MRS. ADELAIDE MARIA ANSAH OFEI

I write to introduce the above-mentioned student pursing PhD in Public Administration at University of Ghana Business School, Legon to have her research work in your hospital.

As part of the requirements of the programme, she has chosen to research on the topic "**Nursing Management of the Nurse Managers at the Unit Level in the Greater Accra Region**".

I would be most grateful if you would give the necessary assistance.

Thank you.

Yours faithfully,

Dr. Prudence P. Mwini-Nyaledzigbor
Lecturer

AppendixE: Introductory Letter to PML hospital

In case of the reply the number
and the date of this letter
should be quoted.

GHANA HEALTH SERVICE
REGIONAL HEALTH SERVICES
GREATER ACCRA REGION
P. O. BOX 184
ACCRA.

Tel: 021-226203

My Ref. NO CA 291/325/01N

29TH OCTOBER 2012

You're Ref. No.
……

THE MEDICALDIRECTOR
P M L HOSPITAL
ACCRA

RESEARCH WORK
MS ADELAIDE MARIA ANSAH OFEI

I write to introduce the above-mentioned student pursuing PHD in Public Administration at University of Ghana Bussiness School, Legon to have her research work in your District Hospital.

As part of the requirements of the programme, she has chosen to research on the topic **"Nursing Management of the Nurse Managers at the unit level in the Greater Accra Region."**

I would be most grateful if you would give the necessary assistance.

Thank you.

HELENMARY BAINSON (MS)
DEPUTY DIRECTOR OF NURSING SERVICES
FOR: REG.DIR OF HEALTH
GREATER ACCRA REGION

AppendixF: Introductory letter to Municipal Health Directorate, Ashiaman

In case of the reply the number and the date of this letter should be quoted.

GHANA HEALTH SERVICE
REGIONAL HEALTH SERVICES
GREATER ACCRA REGION
P. O. BOX 184
ACCRA.

Tel: 021-226203

My Ref. NO CA 291/325/01N

5th November 2012

You're Ref. No.
……

THE DIRECTOR
MUNICIPAL HEALTH DIRECTORATE
ASHIAMAN

RESEARCH WORK
MS ADELAIDE MARIA ANSAH OFEI

I write to introduce the above-mentioned student pursuing PHD in Public Administration at University of Ghana Bussiness School, Legon to have her research work at your Institution.

As part of the requirements of the programme, she has chosen to research on the topic **"Nursing Management of the Nurse Managers at the unit level in the Greater Accra Region."**

I would be most grateful if you would give the necessary assistance.

Thank you.

DR LINDA VANOTOO
REG.DIR OF HEALTH
GREATER ACCRA REGION

AppendixG: Introductory letter to Accra Psychiatric hospital

12th December, 2012

The Chief Psychiatrist
Accra Psychiatric Hospital
Accra

Dear Sir/Madam,

LETTER OF INTRODUCTION

The bearer of this note, Mrs. Adelaide Maria Ansah Ofei is a student of the University of Ghana Business School, Legon, undertaking a course leading to the award of Ph.D Degree in Public Administration.

As part of the requirements of the programme, she has chosen to research on the topic:
Nursing Management of Nursing Manager at the Unit Level in Greater Accra, Ghana.

I would be most grateful if you would give her the necessary assistance to facilitate her data collection.

Thanks for your cooperation.

Yours faithfully,

Prof. E.K. Sakyi
Head of Department

AppendixH: Introductory letter to Achimota hospital

In case of the reply the number and the date of this letter should be quoted.

GHANA HEALTH SERVICE
REGIONAL HEALTH SERVICES
GREATER ACCRA REGION
P. O. BOX 184
ACCRA.

Tel: 021-226203

My Ref. NO CA 291/325/01N

29TH OCTOBER 2012

You're Ref. No.
.....

THE MEDICALDIRECTOR
ACHIMOTA HOSPITAL
ACCRA

RESEARCH WORK
MS ADELAIDE MARIA ANSAH OFEI

I write to introduce the above-mentioned student pursuing PHD in Public Administration at University of Ghana Bussiness School, Legon to have her research work in your District Hospital.

As part of the requirements of the programme, she has chosen to research on the topic **"Nursing Management of the Nurse Managers at the unit level in the Greater Accra Region."**

I would be most grateful if you would give the necessary assistance.

Thank you.

HELENMARY BAINSON (MS)
DEPUTY DIRECTOR OF NURSING SERVICES
FOR: REG.DIR OF HEALTH
GREATER ACCRA REGION

AppendixI: Introductory letter to Ridge Regional hospital

In case of the reply the number and the date of this letter should be quoted.

GHANA HEALTH SERVICE
REGIONAL HEALTH SERVICES
GREATER ACCRA REGION
P. O. BOX 184
ACCRA.

Tel: 021-226203

My Ref. NO CA 291/325/01N

29TH OCTOBER 2012

You're Ref. No.
……

THE MEDICALDIRECTOR
RIDGE REGIONAL HOSPITAL
ACCRA

RESEARCH WORK
MS ADELAIDE MARIA ANSAH OFEI

I write to introduce the above-mentioned student pursuing PHD in Public Administration at University of Ghana Bussiness School, Legon to have her research work in your District Hospital.

As part of the requirements of the programme, she has chosen to research on the topic **"Nursing Management of the Nurse Managers at the unit level in the Greater Accra Region."**

I would be most grateful if you would give the necessary assistance.

Thank you.

HELENMARY BAINSON (MS)
DEPUTY DIRECTOR OF NURSING SERVICES
FOR: REG.DIR OF HEALTH
GREATER ACCRA REGION

AppendixJ: Introductory letter to Dangme West hospital

In case of the reply the number and the date of this letter should be quoted.

GHANA HEALTH SERVICE
REGIONAL HEALTH SERVICES
GREATER ACCRA REGION
P. O. BOX 184
ACCRA.

Tel: 021-226203

My Ref. NO CA 291/325/01N

29TH OCTOBER 2012

You're Ref. No.
.....

THE MEDICALDIRECTOR
DANGME WEST DIST.HOSPITAL
DODOWA

RESEARCH WORK
MS ADELAIDE MARIA ANSAH OFEI

I write to introduce the above-mentioned student pursuing PHD in Public Administration at University of Ghana Bussiness School, Legon to have her research work in your District Hospital.

As part of the requirements of the programme, she has chosen to research on the topic **"Nursing Management of the Nurse Managers at the unit level in the Greater Accra Region."**

I would be most grateful if you would give the necessary assistance.

Thank you.

HELENMARY BAINSON (MS)
DEPUTY DIRECTOR OF NURSING SERVICES
FOR: REG.DIR OF HEALTH
GREATER ACCRA REGION

AppendixK: Introductory letter to La General Hospital

In case of the reply the number
and the date of this letter
should be quoted.

GHANA HEALTH SERVICE
REGIONAL HEALTH SERVICES
GREATER ACCRA REGION
P. O. BOX 184
ACCRA.

Tel: 021-226203

My Ref. NO CA 291/325/01N

29TH OCTOBER 2012

You're Ref. No.
……

THE MEDICALDIRECTOR
LA GENERAL HOSPITAL
ACCRA

RESEARCH WORK
MS ADELAIDE MARIA ANSAH OFEI

I write to introduce the above-mentioned student pursuing PHD in Public Administration at University of Ghana Bussiness School, Legon to have her research work in your District Hospital.

As part of the requirements of the programme, she has chosen to research on the topic **"Nursing Management of the Nurse Managers at the unit level in the Greater Accra Region."**

I would be most grateful if you would give the necessary assistance.

Thank you.

HELENMARY BAINSON (MS)
DEPUTY DIRECTOR OF NURSING SERVICES
FOR: REG.DIR OF HEALTH
GREATER ACCRA REGION

AppendixL: Introductory letter to Accra Metro Health Directorate

In case of the reply the number and the date of this letter should be quoted.

GHANA HEALTH SERVICE
REGIONAL HEALTH SERVICES
GREATER ACCRA REGION
P. O. BOX 184
ACCRA.

Tel: 021-226203

My Ref. NO CA 291/325/01N

5th November 2012

You're Ref. No.
.....

THE DIRECTOR
METRO HEALTH DIRECTORATE
ACCRA

RESEARCH WORK
MS ADELAIDE MARIA ANSAH OFEI

I write to introduce the above-mentioned student pursuing PHD in Public Administration at University of Ghana Bussiness School, Legon to have her research work at Mamprobi Polyclinic, Maamobi Hospital and Kaneshie Polyclinic.

As part of the requirements of the programme, she has chosen to research on the topic **"Nursing Management of the Nurse Managers at the unit level in the Greater Accra Region."**

I would be most grateful if you would give the necessary assistance.

Thank you.

DR LINDA VANOTOO
REG.DIR OF HEALTH
GREATER ACCRA REGION

AppendixM: Introductory letter to Ga South Municipal hospital

In case of the reply the number and the date of this letter should be quoted.

GHANA HEALTH SERVICE
REGIONAL HEALTH SERVICES
GREATER ACCRA REGION
P. O. BOX 184
ACCRA.

Tel: 021-226203

My Ref. NO CA 291/325/01N

29TH OCTOBER 2012

You're Ref. No.
……

THE MEDICAL DIRECTOR
GA SOUTH MUN. HOSPITAL
ACCRA

RESEARCH WORK
MS ADELAIDE MARIA ANSAH OFEI

I write to introduce the above-mentioned student pursuing PHD in Public Administration at University of Ghana Bussiness School, Legon to have her research work in your District Hospital.

As part of the requirements of the programme, she has chosen to research on the topic **"Nursing Management of the Nurse Managers at the unit level in the Greater Accra Region."**

I would be most grateful if you would give the necessary assistance.

Thank you.

HELENMARY BAINSON (MS)
DEPUTY DIRECTOR OF NURSING SERVICES
FOR: REG.DIR OF HEALTH
GREATER ACCRA REGION

AppendixN: Introductory letter to Ga West Municipal hospital

In case of the reply the number and the date of this letter should be quoted.

GHANA HEALTH SERVICE
REGIONAL HEALTH SERVICES
GREATER ACCRA REGION
P. O. BOX 184
ACCRA.

Tel: 021-226203

My Ref. NO CA 291/325/01N

29TH OCTOBER 2012

You're Ref. No.
.....

THE MEDICALDIRECTOR
GA WEST MUN.HOSPITAL
ACCRA

RESEARCH WORK
MS ADELAIDE MARIA ANSAH OFEI

I write to introduce the above-mentioned student pursuing PHD in Public Administration at University of Ghana Bussiness School, Legon to have her research work in your District Hospital.

As part of the requirements of the programme, she has chosen to research on the topic **"Nursing Management of the Nurse Managers at the unit level in the Greater Accra Region."**

I would be most grateful if you would give the necessary assistance.

Thank you.

HELENMARY BAINSON (MS)
DEPUTY DIRECTOR OF NURSING SERVICES
FOR: REG.DIR OF HEALTH
GREATER ACCRA REGION