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THE ROLE AND FUNCTION OF THE CHIEF PROFESSIONAL NURSE IN ACADEMIC HOSPITALS IN THE TRANSVAAL PROVINCIAL ADMINISTRATION

by

MARGARET HELEN HART

Submitted to the Faculty of Medicine, University of the Witwatersrand, Johannesburg, in accordance with the requirements for the degree of

MASTER OF SCIENCE IN NURSING

Supervisor: Miss D. Lee

1994

DECLARATION

I declare that:

THE ROLE AND FUNCTION OF THE CHIEF PROFESSIONAL NURSE IN ACADEMIC HOSPITALS IN THE TRANSVAAL PROVINCIAL ADMINISTRATION

is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references.

I declare that permission to undertake the dissertation was passed by the Committee for Research on Human Subjects of the University of the Witwatersrand, and the protocol number is 28/8/91.

MARGARET HELEN HART

_____ day of _____ , _____

ABSTRACT

The purpose of this study was to investigate the role and function of the chief professional nurse in academic hospitals in the Transvaal Provincial Administration where she occupies a middle management position. Through questionnaires, interviews and a time documentation record this descriptive study investigates several aspects of the chief professional nurse. The results are analysed and set against a review of the literature on middle management in hospitals both locally and overseas.

The first section of the questionnaire furnishes a biographical profile, and provides insights about her job description and the positive and negative aspects of her job. The second section reveals her role and functions and the amount of time spent on the various activities. The third section determines the amount of satisfaction she receives from her job. The final instrument is a time documentation record which offers a more accurate indication of the amount of time spent on the various activities.

The findings which emerge reveal a group of chief professional nurses who spend most of their time on administration with less on education, patient care/consultation, and very little on professional development and research. Job satisfaction is much the same as that found in similar studies on nurses in South Africa but high levels of dissatisfaction with remuneration and working conditions exist.

From these results conclusions and recommendations are formulated.

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CHAPTER 1

ORIENTATION TO THE STUDY

1.1 INTRODUCTION

There are thirteen categories of nursing personnel in the Transvaal Provincial Administration, six of which are in management (see table 1.1).

TABLE 1.1 Grades of nursing personnel in the Transvaal Provincial Administration in 1993

1.	Director
2.	Deputy director
3.	Chief nursing service manager
4.	Senior nursing service manager
5.	Nursing service manager
6.	Chief professional nurse
7.	Senior professional nurse
8.	Professional nurse
9.	Senior enrolled nurse
10.	Enrolled nurse
11.	Senior auxiliary nurse
12.	Auxiliary nurse
13.	Student/pupil

The top two positions, those of director and deputy director[1] are head office positions at the Department of Hospital Services in Pretoria.

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[1] Subsequent to the commencement of this study the post of deputy director was created for top nursing management posts in academic hospitals but is yet to be filled.

There are four categories of nursing personnel in management positions in academic hospitals. The chief nursing service manager holds the top nursing management position in each of the academic hospitals, while those in middle management positions are senior nursing service managers, nursing service managers and chief professional nurses. In some academic hospitals the chief professional nurse is regarded as part of the clinical rather than managerial personnel. Senior professional nurses are first-line nursing managers in charge of wards/units in clinical positions. The category under investigation in this study is the chief professional nurse.

Middle management positions for nurses in South Africa are relatively new phenomena and have only been created in the latter half of this century (see page 25). The first middle managers in the nursing hierarchy in academic hospitals of the Transvaal Provincial Administration were appointed in the 1960's (see table 1.2). Those in supervisory positions above the rank of sister held the posts of matrons grades I to IV.

In 1969 the matron's titles were changed and the matrons grades I to IV became senior matrons. These senior matrons were also known as zone matrons or area supervisors and were in supervisory positions responsible for several wards in a specific area. The senior matrons were required to be registered nurses with at least four years post registration clinical experience and where appropriate they were required to possess a qualification in a speciality and particular proficiency in their area of supervision. It was intended that they should also have qualifications in nursing education and nursing administration (Searle in van Tonder 1984: 3). From 1971 a new nomenclature was introduced but the number of grades of professional nurses remained the same (see table 1.2).

TABLE 1.2 Changes in grades of professional nursing personnel in the Transvaal Provincial Administration

BEFORE 1/4/1964		FROM 1/10/1969		FROM 1/1/1971		FROM 1/10/1982	
LEVEL	POSITION	LEVEL	POSITION	LEVEL	POSITION	LEVEL	POSITION
1	Chief matron	1	Chief matron	1	Chief matron (Special grade)	1	Chief nursing service manager
2	Principal matron	2	Principal matron	2	Chief matron	2	Senior nursing service manager
3	Senior matron	3	Senior matron	3	Principal matron	3	Nursing service manager
4	Matron grade I	4	Matron/Senior sister	4	Senior matron	4	Chief professional nurse
5	Matron grade II	5	Sister	5	Matron/Senior sister	5	Senior professional nurse
6	Matron grade III	6	Staff nurse	6	Sister	6	Professional nurse
7	Matron grade IV						
8	Sister grade I						
9	Sister grade II						
10	Sister grade III						

(Transvaal Provincial Administration Organisation and Work Studies Report 25/79 1979: 10; Searle & Robertson 1988: 41)

In 1979 the Transvaal Provincial Administration's Division of Organisation and Work Studies published a report (subsequently referred to here as the TPA O. & W. Report 25/79) on the possible need for the creation of a post of principal sister on the same horizontal level as that of the senior matron. This followed an analysis of the job descriptions of senior matrons and senior sisters, which indicated that their functions were very similar (professional, administrative and educational). The justification for the principal sister's post was based on time and motion studies which indicated that both the senior matron and senior sister spent too little time on patient care and education. The feasibility of introducing a different category of nurse into the ranks of academic hospitals in the Transvaal Provincial Administration was examined, so that nurses who wished to remain in clinical practice could receive promotion and the remuneration which accompanied it. Prior to this, promotion to more senior posts was only possible in the fields of education or administration. It was intended that the role of this category of nurse be more clinically (professionally) and educationally orientated and it was anticipated that this would improve the quality of nursing care given to patients. It was not intended that the principal sister would replace the senior matron, but that more posts would be created in the new structure for clinical supervisors. This would also result in a smaller span of control i.e. four instead of eight wards, which would make her clinical expertise more available. In the same report, the point was stressed that senior matrons who had eight wards under their control, were responsible for as many as one hundred and eighty patients (22,5 patients per ward). Assuming that all their time was spent on patient care, the maximum time devoted to each patient was 2,5 minutes per week. Such demands made it impossible for the senior matron to fulfil her tasks. Delegation through the senior sister was not possible because she was fully committed to her own administrative responsibilities (TPA O. & W. Report 25/79 1979: 1-4).

In 1982 following an investigation into nursing conditions, a new dispensation for nursing was implemented. Nursing posts were restructured and the number of categories reduced. There was no reduction in the number of supervisory ranks but the titles of all grades of professional nursing personnel were changed to accommodate the problem of gender which was in keeping with worldwide trends. The title of senior matron changed to that of chief professional nurse (Searle & Robertson 1988: 41). Within the hierarchy of nursing personnel, the chief professional nurse was in a line position between the nursing service manager (above) and the senior professional nurse in charge of the ward (below). This was the position in 1993 when the present research was undertaken (see table 1.2).

The first person to study the role and function of the middle manager in South African hospitals, and more specifically that of the area supervisor, was van Tonder. The investigation was carried out in a number of Transvaal Provincial hospitals in 1983 (before the changes recommended by the TPA O. & W. Report 25/79 had taken place). In her findings she concluded that the main functions of the area supervisor could be classified as administrative, professional and teaching (van Tonder 1984: 136). A limitation of her study was however that the amount of time spent on each of these functions was not established (van Tonder 1984: 137). Van Tonder put forward a number of recommendations, one of which was that a comparative study be carried out on the area supervisor and that this should be done once the chief professional nurse or principal sister had gained sufficient experience in the post (van Tonder 1984: 139). The present study acknowledges the recommendations which van Tonder made in 1983 and adopts this as a point of departure for research into the role and function of the chief professional nurse with particular reference to the way in which her duties are spread across the functions of patient care, education, administration, research and professional development.

The recommendations made in the TPA O & W Report 25/79 became a reality in the mid eighties when principal sisters were appointed in chief professional nurse posts in the larger hospitals in the Transvaal Provincial Administration. This created an opportunity for advancement for nurses who wished to remain in the clinical field. The principal sister's role and function was to be similar to that of the clinical nurse specialist in the United States of America where emphasis was placed on the professional (clinical) and educational aspects of nursing. The chief professional nurses who had been senior matrons acted in more of an administrative capacity. It was however intended that they should also change to be more clinically and educationally orientated.

The planning for the post of principal sister was done in times of plenty when South Africa enjoyed an economic boom in the late nineteen seventies. By the time the appointments of principal sisters had taken place in the mid nineteen eighties, the country had been overtaken by an economic recession which resulted in severe cutbacks in hospital services and it was not possible to create more chief professional nurse posts. The principal sisters who had been appointed found themselves in a position similar to that of their administrative counterparts, supervising many wards and attending to administrative details with little time to perform clinical functions. The role and function of the chief professional nurse had not yet been investigated, and the present study is directed to problems associated with this position.

In this instance, a distinction has been drawn between the role and function of the chief professional nurse in smaller and in larger hospitals of the Transvaal Provincial Administration. Van Tonder (1984: 136) found that the

size of the health service or hospital and the number of services provided by it influenced the role and function of the area supervisor. In smaller hospitals, the chief professional nurse is in charge of the hospital, and in this capacity the administrative function is paramount. Such individuals have little time for professional or educational activities. For this reason, the role and function of the chief professional nurse in smaller hospitals falls beyond the scope of the present investigation as she is not in a middle management position. The research is concerned only with the latter situation, namely the chief professional nurse in larger academic hospitals. This historical background relating to the development of the position of the chief professional nurse allows the researcher to proceed to examine the role and function of this person.

1.2 THE POSITION OF THE CHIEF PROFESSIONAL NURSE

The position of the middle manager has been described as being at the crossroads of clinical practice and administration (Alpert & Conroy 1990: 77), a role which inevitably attracts elements of dichotomy and ambiguity. There is no uniformity of opinion as to whether the nurse manager's emphasis should be in the clinical or in the administrative arena. Some sources see the maintenance of both elements for the successful implementation of the nurse manager's role (Alpert & Conroy 1990: 77), while others see the middle manager in an obstructive role because of problems in upward and downward communication (Stevens 1980: 209). Gillies (1989: 371) has said that the individual filling this position is "caught between the antithetical expectations of bosses and line workers, with the result that they experience persistent role conflict and job dissatisfaction". Supervisors are seen as administrators by those below them but are seen as part of the clinical work

force by those above them. This has been called biculturalism, a phenomenon where the supervisor moves back and forth between labour and management. The conflict arises from the fact that the supervisor is exposed to a number of different viewpoints on a daily basis in many instances opposing or contradictory to one another (Gillies 1989: 371). Because of this inherently ambivalent position and the stresses, conflicts and contradictions it incurs, it is important that the informed opinion of past research be presented. This is dealt with in chapter 2.

Peripheral to, but part of the central issue of the present study which seeks to analyse the role and function of the chief professional nurse, is a related issue, that of the relationship between middle and first-line nursing managers. This issue and the attendant underlying conflicts which have emerged have been described by Stevens (1985: 246) and have also been referred to in the South African context in an article by Scorpio (1989: 36). The middle manager (chief professional nurse) has impinged on the role of the first-line nursing manager (senior professional nurse) and as a result the senior professional nurse no longer commands the respect which she previously claimed. Before the proliferation of matrons, the sister in charge of the ward held the most important position in the hospital by virtue of her responsibilities and duties. She was therefore highly respected by all nursing and medical personnel. She had extensive clinical knowledge, experience and expertise and was highly regarded as a clinician and as an educator, since her duties bridged the gap between both functions, and these duties were acknowledged. Some of the nurses who should currently occupy these positions in hospitals have been promoted to chief professional nurses or nursing service managers and their clinical expertise may not be maximally utilised. They have become part of the administrative framework of hospitals

and are remote from the patient (Scorpio 1989: 36). As Williams and Cancian (1985: 20) observe, here one has a typical hierarchical model in which authority is highly centralised, a process which leads to the destruction of initiative among those providing direct patient care, in this instance of course the senior professional nurse.

In the present study this issue of highly specialised clinicians spending most of their time functioning as administrators is central to the research. The job descriptions of chief professional nurses are broad and poorly defined (see appendix A), which can lead to role ambiguity and job dissatisfaction. Infante (1986: 96) has said of this problem: "Role definition and role clarity of each person involved are essential to the smooth functioning of the nursing service". The evidence presently available shows that the direction in which the chief professional nurse is moving in Transvaal Provincial Administration hospitals has a considerable element of ambiguity so that an investigation of this role and function is appropriate and desirable at this time.

1.3 STATEMENT OF THE PROBLEM

Van Tonder (1984: 103) defined the role and function of the area supervisor a decade ago. Since then however, the area supervisor's movement into clinical areas has been accompanied by a retention of many administrative functions and duties. Definition of role and function are therefore necessary, as is also the amount of time devoted to each of her various functions. Another possibility, that of removing the chief professional nurse from her supervisory position in charge of several units/wards and appointing her to the position of a first-line manager in charge of a unit/ward (the position now held by the senior professional nurse), has also made it necessary to investigate her role and function.

The author will seek to answer the following questions:

- what functions (administrative, clinical, educational and research) are being carried out by the chief professional nurse?
- how much time is being spent on the various functions?
- what level of job satisfaction is experienced?

1.4 PURPOSE OF THE STUDY

The purpose of this study is to determine the role and function of the chief professional nurse in the Transvaal Provincial Administration's academic hospitals. It follows logically the work of van Tonder (1984) since it was after this that the position of chief professional nurse was introduced. It's aim is also to establish the extent to which the duties of chief professional nurses follow the criteria laid down in their job descriptions, and to assess whether job satisfaction is being attained. Recourse will be had to a time documentation record (diary) which will establish the time spent by chief professional nurses on each and all of their duties. From the investigations listed it will be possible to recommend the role and function this category of nurse should play in the hierarchy of nursing management and in particular whether the chief professional nurse should be in charge of wards/units, a supervisor or a clinical nurse specialist. These recommendations will be realised through a formal set of objectives.

1.5 OBJECTIVES

The objectives of the study are to

- determine the personal particulars, education, qualifications and experience of the chief professional nurse

- determine what managerial preparation she received for the post of chief professional nurse and whether this preparation met her needs
- identify the areas supervised, whether circumscribed by territory, patient condition, specialised function or time of work (shift)
- determine her span of control
- examine aspects of her job description
- establish the positive and negative aspects of the job and identify problems experienced by the chief professional nurse
- identify the functions performed and clarify the functions associated with her role
- determine how much time she allocated to the various functions
- measure the amount of job satisfaction she obtained
- determine the use being made of the chief professional nurse

1.6 IMPORTANCE OF THE STUDY

The importance of the present study to nursing administration emanates from the fact that the Transvaal Provincial Administration hospitals are facing a decreasing nursing complement, and ever increasing demands and expectations in health care. Since all categories of nursing personnel must be fully utilised in terms of their ability and therefore in the best interests of patients, it follows that the chief professional nurses must also be used effectively as specialists to improve the quality of care and to advance nursing practice. It is apparent from what has been said here, that the chief professional nurse represents a link in a hierarchical chain. The analogy of a nursing service to a chain is appropriate. One weak link can render the whole ineffective. Chief professional nurses who are dissatisfied with their role and function may cause dissatisfaction in other ranks in the nursing hierarchy and in extreme cases the absence of job satisfaction due to role

ambiguity could lead to chief professional nurses leaving either the institution or the profession.

1.7 DEFINITION OF TERMS FOR THE PURPOSE OF THIS RESEARCH

Since technical terms are employed throughout this dissertation, these are listed in the section which follows.

Academic hospital - a referral hospital attached to a medical school with training facilities for doctors, nurses and paramedical personnel (called a teaching hospital in earlier days).

Administration - a collection of processes which must always and everywhere be performed where two or more persons work together to reach specific objectives such as the production of goods (for example medicines) or the rendering of services (for example nursing of the sick) (Cloete 1975: 1). In the United States of America the term administration generally refers to those activities carried out by the upper echelons of the hierarchy, whereas those carried out by the lower rungs are termed management (Mellish & Lock 1992: 2). The term administration is used synonymously with management in this dissertation.

Chief professional nurse - a registered nurse (preferably with post basic qualifications in administration and a clinical speciality) who is appointed in an administrative/clinical supervisory capacity. In an academic hospital she is usually responsible for several wards/units in a specific area and serves as the principle link between top and first level nursing management.

Clinical nurse specialist - a registered nurse with a post-basic clinical qualification (preferably at a masters level) practising in her field at an advanced level and with adequate authority to influence decision-making (Uys&Dewar 1988: 71). (It should be noted that in the South African case, the number of post graduate clinical nurse specialists at the masters' level is insignificant, and the definition is at present therefore only theoretically appropriate. There are many professional nurses with additional qualifications in their specialties at diploma level who function very well as clinical nurse specialists).

Function - the key activities carried out by nurses (Stevens 1985: 77).

Job description - a written account of the organisational relationships, responsibilities, specific duties and working conditions of a particular job (Gillies 1989: 599).

Job satisfaction - the degree of worker's satisfaction with their working conditions, working environment and particularly with the chances of self-fulfilment. Also defined as - a pleasurable or positive emotional state resulting from the appraisal of one's job or job experiences (Locke cited in Kaplan, Boshoff & Kellerman 1991: 3).

Management - see administration.

Manager (lower or first level) - one who has responsibility for administering direct nursing care to a small group of patients (Douglass 1992: 262).

Manager (middle) - one who directs activities of other nurses that lead to implementation of the broad operating policies of the organisation (Douglass 1992: 262).

Manager (top level) - one who has broad and general responsibility for establishing overall policies and goals for the management of the organisation; responsibility for all the activities of the facility that require nursing services (Douglass 1992: 262).

Patient care (direct) - care which brings the nurse into direct contact with patients and families, for example, the assessment of patient's physiological and psychological needs, the formulation of a nursing diagnosis, planning and implementation of patient care, providing education to patients and families, and communicating patient information to nursing and paramedical staff.

Patient care (indirect) - care not given directly to patients but which influences their care, such as participating in the development of and effecting standards of nursing practice; assisting nursing staff in obtaining and recording relevant nursing data; helping in the development, modification and evaluation of nursing care plans; identifying needs for patient education, clinical procedures, protocols and policies; and disseminating relevant research findings.

Role - the expected and the actual behaviours associated with a position (Hardy & Conway 1988: 165).

Role ambiguity - disagreement on role expectations associated with a lack of clarity in those expectations (Hardy & Conway 1988: 197).

Role conflict - a condition in which the focal person perceives existing role expectations as being contradictory or mutually exclusive (Hardy & Conway 1988: 203).

1.8 OUTLINE OF THE STUDY

The first chapter of the dissertation is devoted to the *raison d'être* of the study. The problem is stated, the research questions are posed and the purpose, objectives and importance of the research are discussed. Terms are defined and the essential elements of the dissertation are detailed.

Chapter 2 reviews books, articles and other sources relevant to the middle manager, clinical supervisors and clinical nurse specialists and considers other relevant aspects of the research such as time documentation, job satisfaction and job descriptions.

The methodology used in the research is outlined in chapter 3.

Chapter 4 deals with the analysis, description and interpretation of the research findings.

Chapter 5 details the limitations of the study, summarises the research findings and presents conclusions and recommendations for further research.

The list of references represents those used throughout the dissertation and a list of works consulted, whether reference was made to these or not.

The following are found in the appendices: job descriptions, the questionnaire and time documentation record, letters requesting and granting permission for conducting the research and statistical tables and figures not used in the text.

CHAPTER 2

LITERATURE STUDY

2.1 INTRODUCTION TO THE LITERATURE

The literature relating to the nursing manager in the nursing profession is extensive and diverse. It has found its best expression and development in the United States, which is not surprising since management analysis and management studies have progressed more rapidly in that country than in any other part of the industrialised world. Other English-speaking western countries have not been slow to turn their attention to management problems in nursing and especially to those that impact on the middle manager. When reviewing the literature relevant to the present study all the appropriate research contributions from diverse geographical areas are used.

A starting point has to be found, and it seems apposite that the origins of the hospital matron are important, because it was from this very noteworthy individual that all managerial categories have evolved. The treatment of this literature review, is therefore, in the first instance historical. It starts with the period just prior to that which witnessed the emergence of Florence Nightingale, the doyen of the profession and traces management roles and functions to the present day. From this point the review spreads laterally to examine a host of related phenomena which can be enumerated as a set of (in some instances) contentious and intractable issues. These embrace the question of role conflict, that of transition from clinical nurse to manager and the levels and the types of managers with their roles and functions. Of importance are line and staff functions, upward and downward responsibilities and the process of transferring information and communicating. The monitoring

and evaluating role of the middle manager is assessed as also the teaching functions, the problems associated with middle management and attempts which have been made to alter the middle manager's role. Orientation and staff development, span of control, time management studies, job satisfaction and job descriptions are all reviewed in this chapter. A temporal review of the development of managers in Britain is followed by similar developments in South Africa as a precursor to examining specific elements of middle management.

2.2 HISTORICAL REVIEW OF NURSING MANAGEMENT

2.2.1 The early matrons

In Great Britain the period immediately prior to the Florence Nightingale era (1860) was characterised by two types of medical institutions, the voluntary hospitals and the Poor Law establishments. Within the latter, the poor, the sick and the old were sheltered in workhouses. Medical attention for the sick poor came from the Poor Law medical system. This was administered centrally by the Local Government Board which was the precursor of the present Ministry of Health. Locally there were Boards of Guardians who administered the Poor Law establishments with funds from local rates, and later from central government (White 1986: 49).

The individuals who administered the voluntary hospitals and workhouses were a male steward or master and a female matron (a lay person with no training as a nurse). Very often the matron was the wife of the master (White 1986: 49; Searle 1988b: 5). Matrons oversaw all female staff, which in the voluntary hospitals included nurses, although their lack of nurse training

confined their supervision to administration only. The nursing sisters reported to the doctors whose patients were under their control, while the matron reported to the master or steward of the hospital. Matrons in Poor Law establishments had similar duties. However, here nursing was performed by female paupers. From this it is noted that matrons were instruments of control rather than care. White (1986: 50) encapsulates this by saying that in both the voluntary and the public hospitals matrons were responsible for the patient environment.

2.2.2 The Nightingale era

Florence Nightingale was the principle figure to emerge in nursing at the end of the nineteenth century. She insisted on nurses being under the control of trained matrons (a major departure from the previous era) and quite rapidly certificated nurses moved into these positions. By 1890 most of the matrons in the larger hospitals in Britain were trained nurses, and not surprisingly they took more control of the nurses' and sisters' duties and their training, and separated the ward sister from her dependence on the doctor whose patients she cared for. The authority and responsibility of the matron increased as the education of nurses improved, as the infirmaries of the nineteenth century became the general hospitals of the twentieth and as (in 1929) the Poor Law infirmaries left the control of Poor Law committees, were transferred to Public Health committees, and became municipal hospitals.

The emergence of the modern matron, Florence Nightingale's protege, was an important milestone in British nursing, and because of the subsequent influence of British nursing on the nursing profession all over the world, this individual carried the profession forward substantially more than had

been the case with any other administrative development. She has been described as being from the upper classes, cultured and educated. The importance of the class structure in Britain at the time should not be underemphasised since this source of recruits lent a credibility, an acceptance and a respectability to the profession it had not previously known. The new matron had leadership and administrative ability, was dedicated to her job, worked long hours, and because hospitals were small was able to manage all its functions on her own. She replaced the 'housekeeper' matrons firstly in voluntary and later in Poor Law hospitals (White 1986: 50). As a result Robertson (1984: 128) has with justification said that "these lady matrons changed nursing from low class work carried out by uneducated and often immoral drunk nurses into a profession". Within twenty years matrons or lady superintendents were installed in every hospital irrespective of size in Great Britain, and the status of the profession had been transformed. Further authority accrued to these hospital matrons after 1936 when local authorities were empowered to build their own hospitals.

As hospitals became larger, it was found that the matron could no longer cope with the wide range of responsibilities which confronted her and additional categories of nursing personnel were appointed to assist her. Despite this, the role and function of the matron remained largely unchanged until after the Second World War when the educational and household functions which had been important elements of her work were delegated to other people (Searle 1988b: 38).

2.2.3 Role conflict, ambiguity and loss of territory

Health was nationalised in Britain in 1946 when the Labour Government passed

the National Health Service Act. Three streams of nurses were affected: those from voluntary hospitals, those from municipal hospitals and those from the few remaining Poor Law hospitals. Quickly the authority of the matron, sacrosanct since the Nightingale era, was eroded. Hospital administrators and superintendents were appointed as new departments and divisions proliferated. A tripartite structure emerged involving the matron, the hospital secretary, and the medical nominee. Matrons lost control of all non-nursing departments and also of the patient's environment. Nurses quickly realised that the matron was no longer the final arbiter of control, that she had been deposed to a secondary position in the hierarchy and that in many instances she could be bypassed when grievances or disciplinary matters were to be addressed. Not only this, but in terms of the National Health Service's restructuring, hospitals were put into groups, each with a Group Secretary and Hospital Management Committee, but without a Group Matron. This placed the matron in a secondary position of control further weakening her status (White 1986: 52-53).

2.2.4 Conflicting values: nurse or manager?

The flat hierarchical structure of the British nursing service has been blamed for many of the problems that have subsequently developed. With very few grades between those of sister and matron, the system was ill-equipped to develop new posts as the service expanded and departments proliferated. Although many hospitals and health authorities made ad hoc arrangements and created new positions with new titles, the nursing structure became static. White (1986: 54) has aptly described it as a situation in which "...nursing was trying to function in a modern bureaucracy with a Nightingale structure and failed to find a footing in the power complex". There was clearly a need

for specialist posts both in administration and in clinical areas.

The Salmon Committee grew out of this situation. Unfortunately the profession was not consulted and perhaps this was one reason why the report was so readily accepted. Salmon introduced numbered grades each of which could be fitted to a post, as a consequence of which clinical and non-clinical posts proliferated in Britain after 1967.

Another problem emanating from the flat organisational structure of British nursing in the pre-Salmon era was its inability to respond to the National Health Service bureaucracy's vertical structure. There were many levels of administrators but only a few levels of the grade of matron. Inevitably in terms of salary and status the matron's position relative to her peer group was further undermined.

White (1986: 55) describes another important change in the matron's role which emerged at this time. The matron had (largely for the historical reasons outlined earlier) been recognised as a nurse, she also represented other nurses, she spoke for them, interpreted their roles and problems and acted as a leader and role model. Her position on most committees was that of a nurse. All this was changed when the National Health Service began its operations. Matrons found themselves sitting with the management on Hospital Management Committees (not with nurses). They found similarly, that on Joint Consultative Committees they sat with management (and not with nurses). From this invidious situation a gulf developed between the staff (who brought national problems to their meetings) and management (including matrons) for whom such problems were beyond their authority. They were regarded not as 'us' but 'them'. Matrons also questioned their own role. Were they nurses

(their traditional role) or were they managers (their newly-perceived role)? Unfortunately any acknowledgement of the latter was short-lived as hospital managements rejected them as managers. From this emerged the role confusion, the conflict, the lack of understanding and the unhappiness. Most matrons acknowledged that their tradition and their training made them ill-equipped to be managers. They had neither the attributes nor the skills. White (1986: 55) reports that many left their jobs for more congenial ones. Others tried to continue in their new roles, but in the traditional mode of the period before nationalisation (Sofer in White 1986: 56). With a new management structure this led to problems which were explained by Sofer in terms of their attributes and personalities. These suited the old jobs admirably but were quite inappropriate for the new. Some matrons finding themselves in the new environment attempted to cloak themselves with the management mantles of their peers, they tried to adopt their style, values and behaviour. They abandoned the altruism and emotive approach of the old-style matron, and resorted to objective information in decision making, to budgetary restraints and to political manipulation, which contrasted with the vociferous and authoritarian style of the old matron. Some, but relatively few matrons, grasped the new challenge successfully, and in time, as chief nursing officers, they survived in the power game of the new service. Their nursing values were compromised as they were compelled to become members of the bureaucracy and adopt the fiscal values of their bureaucratic peers (White 1986: 56).

What has been described here is the transition of the matrons in the British nursing service to managers and the concomitant changes in their value system. What is the relevance of this transition to the matron in the South African nursing service? The parallels are inescapable, and not surprising, since the South African experience followed closely that of the British model to which

it was firmly tied by cultural and professional bonds, traceable to the early days of the nineteenth century. It is to this analogous position that attention now turns.

2.2.5 The South African Experience

Nursing management in South Africa has been moulded by the historical influences of the Dutch and British systems, an outcome of the country's colonial history. As a British Colony at the end of the nineteenth century when the first nursing management changes took place, South Africa followed the British system and adopted many of its ideas. Those who also played an important role in modern nursing from the mid-nineteenth century in South Africa were the Roman Catholic sisterhoods from Europe and the Anglican orders from England. Women from these religious orders who had trained overseas were sent out to work as nurses on mission stations in the Cape Colony, Natal and the Orange Free State and many of these hospitals started training nurses. Large hospitals were established as a result of the development of the diamond fields in Kimberley and the gold fields in the Transvaal and these were initially managed by matrons from such religious orders. After the Unionisation of South Africa many of the larger hospitals became Provincial hospitals and were taken over by lay nurses (Mellish 1984: 89-91).

Towards the end of the nineteenth century the most important individual in nursing in South Africa was Sister Henrietta Stockdale from the Anglican sisterhood of Saint Michael and All Angels in Bloemfontein. She was the counterpart of Florence Nightingale and was a very capable administrator and organiser. Apart from organising nursing services and hospital facilities, she instituted training for nurses at Carnarvon hospital which later became

the Kimberley hospital, well known as a nurse training school. Students from this hospital subsequently staffed many of South Africa's hospitals and were responsible for initiating the training of nurses at these. Sister Henrietta became the matron in charge of the hospital in Bloemfontein and later at the Kimberley hospital. She organised a private nursing service for patients in their homes and started a maternity home in Kimberley where midwives were trained. She established a branch of the Royal British Nurse's Association in Kimberley and was also a member of the Matron's Council of Great Britain and of the International Council of Women. Like Florence Nightingale she had persuasive talent and influential friends and had the support of governors, politicians, leaders in industry and commerce, leaders in the church and the medical profession and the leading women in society. She campaigned ceaselessly for state recognition of nursing and through her influence the Cape Colony was the first in the world to register nurses in 1891 (Searle 1965: 142-146; Searle 1987: 72-73; Searle 1988a: 18).

The pattern of hospital practice in South Africa at the end of the nineteenth century was characterised by widely spread small hospitals with relatively few registered nurses. The nursing at the time was done by laymen under the supervision of 'experienced' matrons (Searle 1961: 13). The matron's main function was the organisation and supervision of the resources provided by the hospital and because the hospital was small in size and as the matron worked long hours, she could manage all these functions (Searle 1961: 13).

The Transvaal Provincial Administration came into being at the time of Union in 1910. At that time hospitals in the Transvaal were voluntary hospitals subsidised by the Province. Each hospital was autonomous and made its own policy decisions. In 1946 the Free Hospitals Ordinance No. 15 of 1946 was passed which led to the establishment of the Provincial Hospital Service and

resulted in changes such as central decision making (Searle 1988: 49). Hospitals became larger and more complex and additional supervisory personnel were appointed to assist the matron. This pattern was typical of centralised management systems which have tall organisational structures with many layers between top nursing management and the professional nurse (Kerfoot & Johnson 1987: 22). In the course of time the complexity of hospital services led to further subdivisions of supervisory personnel until the concept of the zone matron was introduced. Area supervisors or zone matrons were appointed in the late sixties to assist in a supervisory capacity (van Tonder 1984: 1).

Academic or teaching hospitals were established with the development of medical faculties, the first being the medical school of the University of the Witwatersrand which has been associated with the Johannesburg General hospital since 1919. Between 1925 and 1947 the Non European Hospital in Johannesburg, Baragwanath hospital and Tara (psychiatric) hospital also became associated with the medical school of this university. The medical school of Pretoria University started at the H.F. Verwoerd Hospital in Pretoria. After the Second World War, the Coronation and J.G. Strijdom hospitals were included as academic (teaching) hospitals at the medical school of the University of the Witwatersrand, and Kalafong and Ga-Rankuwa hospitals were formally attached to the medical schools of the University of Pretoria and the Medical University of South Africa respectively. There are seven medical faculties in South Africa, each of which is linked to one or more hospitals. Three of these are in the Transvaal. They provide care at primary, secondary and tertiary level, train health workers and conduct research (Centre for Health Policy 1994: 25).

2.2.6 The role of the chief professional nurse in the Cape Provincial Administration and the Natal Provincial Administration

The two academic hospitals in the Cape Provincial Administration both abandoned the system of zoning or ward supervision by chief professional nurses in the late nineteen eighties. This was done independently and autonomously but they both achieved the same goal of ensuring maximum and economical use of skilled nursing personnel.

At Groote Schuur Hospital the concept of 'head nurse' was introduced to replace the area supervisor. The rationale for this was the outcome of an acute shortage of experienced nursing staff. It also followed changes from a centralised to a decentralised system and the introduction of strategic planning. The changeover was a four year process involving much discussion and many workshops. The system involves having the hospital divided into areas or pavilions, each having several service points or units (wards). A senior nursing service manager is at the head of each pavilion and under her is a nursing service manager. Each service point or unit has a head nurse in charge who may be a chief professional nurse or a senior professional nurse, but the head nurse position is tied to function, not to rank. The head nurses are all specialists in their fields. The units are run by participative management and decision making is decentralised. The nursing service manager now functions as a middle manager, is a resource person for head nurses and assists specific head nurses if there is a problem. Control is organised through a committee system and a quality assurance programme.

A parallel system was used initially for the changeover. Those Chief professional nurses who wished to be head nurses were put in charge of units; others remained area supervisors (especially the older chief professional

nurses). All new chief professional nurse appointments were given positions as head nurses. This changeover was a difficult process and not without problems. Some of the chief professional nurses involved felt devalued and felt that they had lost status.

There are still some problems with regard to after hour coverage for the nurse in charge of the hospital (from 16:00 to 19:00, weekends and public holidays). In the past these hours were covered by a chief professional nurse, but after the change nursing personnel from the administrative section, for example nursing service managers or personnel from the education department (clinical), took over the responsibility of being in charge of the hospital. This has put a great burden on these personnel, and some compromise has had to be reached whereby the head nurses also have a turn at doing this duty. However, their units cannot be compromised, as this duty means being away from their units for a certain number of hours each week or month. At present at least one head nurse (chief professional nurse) must be on duty in each pavilion and she acts as an advisor for the other units after hours (van der Walt 1994: personal communication).

The changes at Tygerberg Hospital were similar to those at Groote Schuur Hospital which have been described above. In 1988 chief professional nurses were functioning as area or zone matrons and were doing the same work as nursing service managers. Unpublished research carried out by Bruwer in 1990 showed that the zone matrons spent only twenty five percent of their time in a 'hands on' position or clinical role. Changes were instituted and the chief professional nurses increased their clinical role to fifty percent and functioned in much the same way as a clinical nurse specialist. In 1993, a three tier modular system or management model was introduced and senior nursing personnel were divided into teams, each with a nursing service manager

with four to five chief professional nurses under them. Each chief professional nurse was placed in charge of a ward in her particular speciality. The transition took place gradually over a period of four to five months. As with Groote Schuur hospital, not all the wards have a chief professional nurse in charge, this depends on the type of speciality.

Problems have also been experienced with these changes. The older chief professional nurses do not mind being in charge of wards, but some find it physically taxing. They no longer have as many shifts from 07:00 to 16:00 because they have to work similar hours to other professional nurses in the ward in order to cover their wards. This entails working some long shifts from 07:00 to 19:00 and also doing weekend duties.

Despite the problems, the changes have gone some way towards relieving the shortage of skilled nursing personnel, and chief professional nurses at these hospitals are putting their clinical expertise to much better use. With a shorter organisational structure there is greater decentralisation, and the chief professional nurses in charge have better control of their wards and more autonomy (Bruwer 1994: personal communication).

The Natal Provincial Administration's hospitals have been plagued by a lack of funds and therefore have not been able to fill senior nursing posts for many years. There are very few chief professional nurses at Natal's academic hospital, King Edward VIII. Due to a lack of funds many chief professional nurse posts have been frozen and the incumbents have been promoted to nursing service managers. Most of the remaining chief professional nurses are in specialist areas and are in clinical rather than administrative fields acting more like clinical nurse specialists (Stewart 1994: personal communication).

2.2.7 Summary of historical literature

In concluding this historical section of the literature the important trends which reveal social and professional changes within the nursing profession are identified, initially in Britain but subsequently introduced in South Africa.

In the pre-Florence Nightingale period the position of matron was filled by women drawn from the lower socioeconomic classes of British society. They were individuals who had no formal training since training establishments and institutions for nurse education had not been developed. Nursing at this time was therefore associated in the minds of the public with women of the working classes. Florence Nightingale has been credited with elevating the vocation to a professional level, partly because her work and influence bestowed upon it an educated upper-class image, since she and her followers were drawn from this group, but also, and perhaps most importantly, because she instituted formal education and training and a singularly significant vocational ethos. After Florence Nightingale therefore, the nursing profession attracted young women who were well-educated, and who came from what were perceived to be good families, families whose members were counted among leaders of the professions, the commercial and industrial classes and the landed community. In this way a profession was created and established.

From within the nursing community the luminaries became matrons, women whose stature and esteem grew professionally during the latter part of the nineteenth century and the first half of the twentieth. The hospital matron achieved her most prominent position at about the time of the Second World War when almost all aspects of hospital control devolved upon her. As has been shown, the challenge to the matron's pre-eminent position began in the post-

war period as the profession struggled to adapt to innovative management styles which were introduced from commerce and industry. The problems these caused culminated in the Salmon Report of 1947 which exacerbated the matron's position, her professional and organisational role was reduced, role conflict ensued and rifts developed between nurses and the matrons responsible for them. The same problems surfaced in South Africa both because of the historical association with Britain and because South African nurses had followed a similar evolutionary path to that of their British nursing counterparts.

The development of the matron historically is presented here as a precursor to a discussion of the nurse in middle management.

2.3 LEVELS AND TYPES OF NURSING MANAGERS

All established professions have evolved, and in doing so have developed their own accepted practices and procedures for both creating professional structures and for using personnel. Nursing is no exception in this regard. The nursing structure is hierarchical with directors and associate or assistant directors in top management positions overseeing supervisors who in turn have head nurses reporting to them (Stevens 1985: 243). The classification of such managers depends upon the level at which they operate and the responsibilities attached to their posts (Douglass 1992: 8). A common denominator of most health organisations is a trilogy or tripartite nursing management system nominally described as top, middle and lower or first level managers (Douglass 1992: 105). Some however have only two management levels, described as the top and middle levels of management (Wilhite 1988: 14). Management titles depend upon the country or institution in which they occur

but the contemporary practice, at least from an official point of view, is to use titles which do not reflect gender. Considerable confusion exists in the United States and elsewhere between titles, reporting relationships and the responsibilities of top and middle managers (Wilhite 1988: 7).

Top managers are a small group relative to the profession as a whole. Their's is the task of establishing operating policies and giving guidance to their organisations and ensuring that their environmental interaction is appropriate (Douglass 1992: 105). The titles given to such top managers in the hospitals under the control of the Transvaal Provincial Administration are that of chief nursing service manager, senior nursing service manager and nursing service manager.

As the name implies, middle management is the job between top managers and first-line managers. The position involves not one job but many with the term middle management encapsulating the many roles between the upper and lower management levels (Stevens 1985: 243). The middle manager has the task of coordinating the work of several units, receiving broad overall strategies and policies from above and translating them into specific objectives and programmes (Douglass 1992: 8). The South African counterpart of this middle manager in the American system is the chief professional nurse. She, in the same way, supervises wards/units in her area and reports to managers above her and has subordinate managers reporting to her.

At the lowest level of responsibility is the first level manager, an individual who is responsible for supervising the work of others and who is in charge of a ward or unit (Douglass 1992: 105). These are first-line managers who are known as head nurses, charge nurses or sisters in charge of

wards. Stevens (1985: 243) notes that such nurses' responsibilities are characterised by duties which are geographically defined within an institution. Gillies (1989: 370) sees the first-line manager as being a coordinator or supervisor. However in the present study the coordinator or clinical supervisor is called a middle manager. In the Transvaal Provincial Administration's academic hospitals this individual is the senior professional nurse with the traditional title of 'sister'. Because this study concerns the middle manager only, the other grades of management (those above and below) are discussed only in so far as their roles impinge on that of the middle manager.

2.4 THE ROLE OF THE NURSE IN MIDDLE MANAGEMENT

Many titles have been used to describe the middle manager in nursing. These range from supervisor (Stevens 1985: 243) and coordinator (Douglass 1992: 105; Doheny, Cook & Stopper 1987: 166) to area supervisor, zone matron and senior matron (van Tonder 1984: 6) (the latter are descriptions which apply only to the South African nursing system). Many authors indicate that different institutions employ different titles. Although the middle manager in the Transvaal Provincial Administration's academic hospitals is still commonly called 'matron' (the term inherited from the British system) the current title is chief professional nurse.

Torrington and Weightman (1987: 74) suggest that very few nurses aspire to middle management, primarily because it is regarded as a transitory position. It falls between positions involving routine activities or technical specialities on the one hand, and those of senior management on the other. As such it is not a well documented role, it is little understood and is

seldom the preoccupation of academics whose attention has tended to be drawn to the study of positions at the top of organisational hierarchies. Stevens (1985) and Mintzberg (1988) are exceptions to this and have made important contributions to our understanding of the middle manager. Steven's approach assesses the relationship of the middle manager to management levels above and below her, while Mintzberg adopts a more interactional and structured view. The work of these authors forms the basis of the following section.

To Stevens (1985: 244), a middle manager is one who has responsibility only for lower level managers rather than direct responsibility for staff. The middle manager differs from top management in that she is excluded from the team which has an overall view of the institution. Despite this limited role and responsibility, the middle manager covers many and varied roles. A factor contributing to this is the middle manager's departure from traditional roles and the adoption of new ones. In the United States for example, the geographical area of middle management (in which medical nursing, surgical nursing and obstetrical nursing may have been the sole role of the individual) has given way to the specialist role, which may involve, amongst others, nursing systems, quality assurance, budgeting and resource management or staff development. Stevens (1985: 243) also notes that in some organisations some middle management positions have been eliminated, while in others middle or high level managers manage non-nursing units or functions as well. This process has given rise to new patterns and trends. In an attempt to categorise and classify the middle manager's position Stevens (1985: 244) has identified territory, patient condition, function and work time as important criteria which circumscribe the middle management position. These are elaborated upon as follows:

1 **Territory or geography.** A supervisor or middle manager may have her job defined by nursing care units assigned to her; she is responsible for a delegated number of care units linked typically by their geographical proximity.

2 **Patient condition.** A middle manager may be assigned to cover all areas that deal with a specific type of patient; she may be supervisor of spinal cord injury units and clinics, supervisor of obstetrics. Often the patient condition criterion and territory criterion join since all patients of a single type tend to be geographically grouped.

3 **Specialized function.** Middle managers may be assigned by function rather than by territory, e.g., inservice education, staff/scheduling, home care.

4 **Time of work or shift.** In the United States, evening and night middle managers fall into this category, typically assuming responsibility for larger units than is the case for day managers.

Stevens (1985: 244) qualifies this classification by saying that in cases where one of the criteria is extended another may be limited. So, for example, supervisors with responsibilities over a period of twenty four hours would, in all probability supervise a smaller number of units than those with eight hour responsibilities. In the same way night supervisors might have many more units than day supervisors, but would not have the added burden of long-term planning, borne by the latter. Inservice middle managers are similarly disposed. The responsibility for education in a large number of units is compensated for by a lack of direct involvement in patient care. So the role and function of the middle manager hinges on whether she is in a line or in a staff function. The line function is that which ensures the goals are achieved by staff who are below the middle manager in the hierarchy. The

staff function is an advisory one in which the middle manager is expected to give information and advice. This advice may be scientific, technological, informational or simply supportive (Haimann 1989: 168).

2.4.1 Line Middle Management Positions

Douglass (1992: 105) notes that, depending on the size and philosophy of an institution, middle-level managers may encompass many levels in an organisation. Their's is usually a line position with responsibility for a group of head nurses. In this position the middle manager has two major functions. The first is a responsibility for her own department and for major decision making concerning that department. A second responsibility is that of linking top and first level management (Stevens 1985: 244; Gillies 1989: 370).

2.4.1.1 The linkage function

Limited references were found on the linkage function but Stevens (1985) elaborates on this aspect considerably. The linkage function has various complex elements because middle management is a conduit for messages throughout the nursing managerial structure. It carries goals, policies and purposes downward to first-line managers, and in the opposite direction it monitors information (the state of the units) up to executive management (Stevens 1985: 244). Sherman (1989: 32) uses the term 'communicating' to describe this linkage function. This involves listening to all personnel, maintaining effective horizontal and vertical relationships and publicising the achievements of personnel to higher management.

The linkage function is not as simple as it might at first appear. Middle management is more than just a conduit. It must not only convey the executive's goals to first-line managers, it must also explain, support, and sell those goals. The middle manager must contribute to the broadening of the understanding of first-line managers, so that they can attain goals which are beyond day-to-day operations. In addition, middle managers must act as authorities and consultants so that first-line managers can achieve the objectives that have been determined by the executives or top managers of the organisation.

Middle managers are also expected to be innovative. They should evolve their own goals specific to the area of managerial responsibility. They should also help their first-line managers set goals for their domains. A mutual goal-setting strategy of this type requires considerable skill on the part of the middle manager since the first-line managers are far less experienced and this may tempt the middle manager to dictate all goals to them. This brings the function of the middle manager into play: the middle manager is the chief developer (educator) for upcoming managers. So the first-line managers must be given the freedom and managerial responsibility needed to develop managerial skills. As a result of this the middle manager frequently acts as a consultant, helping the first-line manager to analyze issues and problems, suggesting resources, but not providing the answers for her.

Another linking function comes from the middle manager's wider knowledge of the nursing world. She has knowledge of the institutional systems beyond those of the nursing division. She also knows which people in other departments may be useful to first-line managers in certain circumstances. In fact the linkages of the middle manager often extend well beyond the base

institution; she knows how to use community resources. So one of her major teaching functions is to introduce her first-line manager to the wider picture, a greater expanse of resources than those of the unit, the nursing division, or the home institution. She teaches the first-line managers to identify the resources and how to manipulate the systems, so that they work effectively in delivering care to patients.

The middle manager may or may not also function as a clinical expert. There are many examples of supervisors who have become expert clinicians and expert managers. In others there are examples of middle managers functioning primarily as managers, focusing on making the system work, but even in this instance they are capable of recognizing and responding to clinical emergencies. If this basic clinical expertise is lacking, the middle manager will not know which systems and which resources to use under different circumstances.

The middle manager also has a responsibility for monitoring and evaluating because she is, according to Stevens (1985: 245), "indoctrinating" new managers who are in most cases inexperienced. Middle managers must assess first line managers under their control to establish their competency. Although assistance and support must be provided where necessary, the middle manager must refrain from intervening. However, if a first-line manager is unable to perform satisfactorily she should be replaced. These actions do not imply that the middle manager has no direct personal responsibility for management and managerial decision making. What it implies is that the middle manager should limit decision making to those issues which are embraced specifically within her advanced level of management. She should not make head nurse level decisions in lieu of the head nurse. The middle manager

serves as a giver of advice to the first-line managers below her, especially when they must make decisions in unprogrammed areas and when they have to deal with new or unique problems.

The primary domain for middle management decisions lies with the nursing systems and nursing managers rather than directly with patients or staff. All middle managers should act as their own systems analysts. They should see that the supply lines, communication systems, and systems of care delivery function at peak performance. They must be the facilitators at their level of management getting the work done by providing the right environment wherever that is possible. The logistical questions in a complex institution like a hospital are difficult and require more than ad hoc solutions, and the middle managers are the individuals in the hierarchy who are ideally equipped to deal with systems problems since they have an overview of the functioning of the total organisation or at least a good portion of it.

The middle manager serves as a horizon-lifter in her relations with first-line managers, helping them to develop a wider conception of the managerial role. She acts as a troubleshooter, educator and consultant. If this encapsulates middle management linkage with first level managers, what is her role in the other direction?

The next major responsibility of the middle manager is upward in the hierarchy to the top nurse executive (or her superior). The responsibility for conveying the state of the department to the division level is borne by middle management. It is an assessment which must be accurate for effective planning by top management. There are two likely causes of inaccuracy: the supervisor/middle manager may wish to mask her own inefficiencies in running

her department, or she may have a false image of events and developments from subordinate managers. Nurse executives should not tolerate middle managers who fail to see or reflect the state of the departments under their control.

Middle management may also have some degree of participation in or observation of top management, but the primary function remains the responsibility for maintaining the equilibrium of the unit which constitutes the department. So the middle manager is responsible for solving problems that involve more than simply one patient or one unit but rather the wider responsibility for setting goals and solving problems for groups of patients (Stevens 1985: 244-246).

2.4.1.2 The management role

Various authors use different management concepts to describe the activities of a nurse manager. Sullivan and Decker (1992: 39) see the traditional functions of management as planning, staffing, organising, directing, controlling and decision making. Sherman (1989: 31) identified seven functional roles in nursing management which are planning, organising, staffing, leading, communicating, decision making and controlling. Kirsch (1988: 21) refers to the acronym POSDCORB to describe the traditional management concepts of planning, organising, staffing, directing, coordinating, reporting and budgeting. Most management however is done through personal interaction and takes up eighty percent or more of a manager's time. It is this interaction with others which Mintzberg (cited in Kirsch 1988: 28-29) has conceptualised in ten management roles which are divided into three major categories: interpersonal, informational, and decisional roles. They have been adapted for the middle manager (table 2.1).

TABLE 2.1 Functions of the middle manager in Mintzberg's model of management roles

Role	Description
INTERPERSONAL ROLES	
I Figurehead	Represents the subunit (department, division) at organisational meetings and committees
II Leader	Implements philosophy and goals of the nursing organisation. Directs and supervises delivery of services at the subunit level. Has responsibilities for hiring, training, and firing subordinates.
III Liaison	Serves as a liaison for the subunit with other professional groups in the organisation. Serves as a member/officer of professional and community groups.
INFORMATIONAL ROLE	
IV Monitor	Implements reporting systems and information systems at the subunit level. Receives reports, makes rounds, and is visible and available to staff. Monitors quality of care, use of personnel, equipment, and supplies at unit level.

TABLE 2.1 (continued)

V Disseminator	Communicates organisation policy to subordinates. Provides subordinates with feedback regarding information of importance. Holds regular conferences and meetings and is available to staff for communication.
VI Spokesman	Speaks for the subunit at meetings and conferences with nursing executives and with other health care professionals. Represents the nursing organisation to V.I.P. visitors.
DECISIONAL ROLES VII Entrepreneur	Participates in strategy formation. Seeks ways to initiate and implement change in the delivery of nursing services.
VIII Disturbance Handler	Manages and guides the subunit in times of change and unrest. Handles disturbances at the subunit level.
IX Resource Allocator	Determines budget for subunit and distributes resources to meet the needs of the subunit. Provides for economical use of resources. Schedules and manages own time.
X Negotiator	Negotiates with other subunits and executive levels for resources. Participates in labour contract negotiation.

(Mintzberg cited in Kirsch 1988: 28 - 29).

There are many similarities in the middle management functions of Stevens and Mintzberg and most of them can be viewed in parallel. Stevens for example describes the middle manager as a link pin between top and first-line management conveying goals, policies, and purposes downwards and also explaining, supporting and selling these goals. Mintzberg sees this as part of the informational role of disseminator in which organisational policy is communicated to subordinates. Stevens says the middle manager should have linkages with the community and with other professional groups. Mintzberg places this function in the informational role of liaison in which the middle manager serves as a liaison between the subunit and other professional groups in the organisation and as a member or officer of professional and community groups.

Turning once again to the South African context and applying these ideas, Van Tonder (1984) chose a select group of twenty two criteria to describe the role and functions of the area supervisor in some Transvaal Provincial Hospitals. These functions were broadly classified into administrative, professional and teaching functions. The administrative functions were organising, personnel functions (provision, utilisation and development of personnel), control functions, statistical functions and research functions. In her professional role the area supervisor acted as a leader and advisor, gave support to subordinates, set nursing care standards and evaluated nursing care. The teaching functions involved inservice education, continuous education, orientation, clinical teaching, teaching of post registration students and the evaluation of registered nurses. Van Tonder (1984: 136) found that the size of the health service or hospital and the number of specialised services provided by the hospital were primary considerations affecting the role and function of the area supervisor.

Seen from another viewpoint, the role of the chief professional nurse as envisaged in the TPA 0 & W Report 25/79 can be compared to the role which was proposed for the clinical nurse specialist in South Africa at the national workshop (convened by concerned nurses at the University of Natal, in Durban in 1988). This included direct patient care, indirect care (consulting and teaching), research, and management (managing change) (Uys, L.R. & Dewar 1988: 76). This role closely resembles the contemporary role and function of the chief professional nurse, but makes no reference to the time that should be devoted to each of these components.

2.5 PROBLEMS OF MIDDLE MANAGEMENT

Many sources attest to the intractability of the role held by middle managers because of the many roles they play and because of the numerous and different areas of responsibility which they are required to manage (Gillies 1989: 371; Haimann 1989: 4; Marchetti 1985: 33; Darling & McGrath 1983: 30). Problems manifest themselves when role changes occur as for example when nurses are promoted or move from the purely clinical domain to that of manager. Pressures come from changes in peer relationships, often arousing feelings of jealousy and resentment which bring with them a measure of alienation (Marchetti 1985: 32). Also reported is the lack of time for close relationships with other managers which results in feelings of loneliness (Darling & McGrath 1983: 30). Nurse patient relationships are no longer close as was the case with bedside nursing (from which much of the professional reward is derived) and job satisfaction declines as managerial tasks cease to be fulfilling (Darling & McGrath 1983: 30).

Stevens (1985: 246) concurs with the view noted here that the middle

management position is one of the most difficult to enact in the nursing hierarchy, principally because its roles are so ill defined. Inability to clarify the role she says, has led many institutions to eliminate it, giving head nurses more authority (Stevens 1985: 246). Job descriptions for nursing management positions very often bear little resemblance to what is expected and in some instances are not available at all. So prospective middle managers accept positions with job descriptions in management which are ambiguous. They move into their new roles and become confused as to their positions and levels of authority. Inevitably they ask the question, is this a management position, or is it a charge position? Is there any real power or is it necessary to check with someone else before carrying out changes or making decisions? Middle managers who find they lack the authority to do the job as they understand it, feel resentment (Marchetti 1985: 32).

White (1986: 46) traces the development of this ambiguity to the separation of clinical and administrative functions of clinical nurses and nurse managers. This dichotomy is worth elaborating upon for the insights it affords. The question is posed: why and how did the Administrative School, of which the middle manager is a part, develop? Abdellah (cited in White 1986: 46) claims it grew from two circumstances; the growing complexity of nursing, and the need to legitimise nursing as a profession. The Administrative School was overtaken by two subsequent developments, the emergence of the Academic School and subsequently the Clinical School. The latter was due to a rebellion (discernable also in South Africa) within the ranks of nurses who were against the need to gain recognition through the path of administration and teaching. In supporting this view, Melosh (1982: 35) noted a growing distance between nurses in the field and their leaders and a preoccupation for the upgrading of the profession. Theirs was a restrictive

strategy of professionalisation. They sought to make the education of nurses more academic, a concomitant of which was to rid themselves of the apprenticeship form of training. Herein lay the seeds of persistent internal conflict. In America this conflict was between the professionalists who sought to professionalise nursing through baccalaureate preparation and the clinicians (the diploma nurses who were hospital school graduates) who were antagonistic to the idea and sought to enforce the values of apprenticeship training. The conflict between these groups was further exacerbated by employment practices where commonly diploma nurses were preferred to their more academically qualified counterparts, and where in some instances the latter found themselves in positions where they reported to the former (Melosh 1982: 209).

Another dimension of the same problem, namely "the emerging chasm between nursing administrators and nursing staff" examined by Donnelly, Mengel and Sutterly (1980: 77), is the Queen Bee syndrome. Because of its relevance it is briefly noted here. These authors believe the syndrome is an outgrowth of the feminist movement. It describes antifeminist behaviour in women who have careers in leadership positions. They explain the position in the following way:

> The Queen Bee performs successfully in two roles that appear to be in conflict: the career female role, and the traditional female role. In the work setting, the Queen Bee aligns herself with males and seeks their approval, while in an attempt to reduce competition, she requires women who report to her to perform in the traditional female role ... (Donnelly *et al* 1980: 77).

The importance of the Queen Bee syndrome lies in the negative effect it has on the organisation. Two such effects are recognised: the Queen Bee may actively work towards improving her organisation while failing to train subordinates (who may subsequently threaten her position), or she may support the status quo. Research into the syndrome shows that it "becomes more predominant in progressively higher levels of nursing management" (Donnelly *et al* 1980: 77).

Froebe & Bain (1976: 31) believe that the professional-administrative conflict has existed for several decades. They put the matter succinctly by saying: "By and large, nurses are actively resisting organizational-administrative controls and nursing administrators are resisting the resistance ...". Having identified the conflict, White (1986: 48) turns to British nursing, which, because of its impact on South African nursing's development provides useful insights. In Britain, questioning the unity of nursing was regarded as disloyal. Despite this however the pluralism of nursing is now accepted and is revealed in value systems between different categories of nurses, particularly after the introduction of the National Health Service in 1948, and the subsequent nationalization of hospitals. During this period the bureaucracy grew rapidly and the structural and administrative change witnessed the emergence of matrons as powerful nurse managers. An ethical change could also be detected in which responsibility shifted from the patient to the Health Service. With it came a reconstruction of nursing's values, goals and strategies with consequences for education and nursing structure. Parallels are presently evident in South African nursing. White's research objectives are similar to those of the present author, "a case study of the development of matrons to managers" and selecting ways of strengthening the professional authority of nurses in contrast to managerial authority, maturing

and developing the profession against the facts of economics and politics (White 1986: 48).

Another problem confronting middle managers according to Stevens is the delineation of territory. Although they may be in charge of a specific area, they often feel they belong nowhere except in corridors, stairways, lifts and their offices (Stevens 1985: 246). The present author found that the term 'corridor matron' was used to describe the chief professional nurse in academic hospitals in the Transvaal. The head nurse has strategic advantages over the supervisor in that she physically belongs to a particular ward or unit and is in control of it.

The head nurse has another advantage in that she knows what her job is. Even if her role is not thought out, even if her work objective is not defined, she can allow the events of her ward to direct her activity, and retire with a feeling of accomplishment at the end of the day. The supervisor, on the other hand, usually asks herself, "What is my role, and how do I go about fulfilling it?" The answer to this question is ambiguous because the role of the supervisor is usually one of her own making. Her job is limited or productive, depending on her ability to use creativity, insight, and to influence others. She proves her value by altering the domain of the head nurse. Even if the supervisor has good ideas, it is very difficult for a head nurse to accept these ideas from a person she regards as competition (Stevens 1985: 246).

There have been many recent attempts to alter the supervisor's role. Most have attempted to soften the competitive response to the position. The title has been changed to that of coordinator (Schweiger & Huey 1983: 40), and job

descriptions have been altered to define the nursing supervisor as a resource person. Despite these however, attempts to change the image of the supervisor have had very little effect in those instances where the position retains line authority over the head nurse. Such alterations in image do not change the essential problem inherent in the supervisor's role. The problem, as perceived by Stevens, is that the commonly assigned supervisory tasks are merely extensions of the head nurse's responsibilities rather than discrete, separate functions. This is indicated by the fact that the supervisor might be expected to be more expert in patient care decisions than in planning for staffing, but these tasks can be handled by the head nurse. So the supervisor is expected to do the same job as the head nurse, but she is expected to do it more effectively. The difference in the two jobs is quantitative, the supervisor and the head nurse have the same job. The supervisor has a greater number of patients, but not different patients, she has greater knowledge, but she uses it to make the same kind of decisions (Stevens 1985: 246).

This lack of clarity in job differentiation is revealed in the manner in which the average supervisor deals with the head nurses who report to her. There is a common tendency for the supervisor to relate to each head nurse separately and individually. Whatever she does with the head nurse is often only an extension of what is happening on that particular head nurse's ward. So the supervisor has neither a synthetic nor a distinctive function. Her functional unit, similar to that of the head nurse, is the individual ward. The basic failure in role differentiation undoubtedly, according to Stevens (1985: 246) is the reason so many supervisors spend excessive time checking employee time cards, transferring employees from one ward to another, or other trivial duties. These they have managed to usurp as their own prerogative.

Stevens (1985: 246) suggests that middle management's impotence and role ambiguity may be the source of both upward and downward communication problems. In the first instance, the nursing supervisor may have the human tendency to minimize problems in her wards in order to prevent stressful relations with the nursing director. This may cause frustration for the head nurse, since she is expected to continue working while awaiting higher-level decisions. In the second instance, a nurse executive may face similar communication obstacles in trying to make changes at the patient care level. Clearly a director should transmit objectives and plans through the defined lines of authority, using the supervisor as the channel of authority. The supervisor, to support her position of authority, should be the person to interpret objectives and plans at the head nurse level.

Even if the supervisor implements the director's intentions and plans, the head nurse, may decide to comply only in so far as it is necessary, and in doing so reassert her own ideas (protecting her territorial rights). It also happens that the director may bypass the supervisors in an effort to get results, either by holding meetings with the head nurses or by placing both supervisors and head nurses in a common group for meetings she herself conducts. Both methods serve only to confirm what the head nurse already suspects - the infirmity of the supervisory role.

Some of the problems besetting middle managers can be compared with those of the clinical nurse specialist in the United States, because both have similar roles (Babich 1988: 6). In the United States, the clinical nurse specialist is a post graduate professional nurse who has specialised in a field of nursing (Babich 1988: 6). The specialist nurse carries out the sub-roles of practitioner, educator, consultant, researcher, change agent and more recently

staff advocate (Storr 1988: 265). Although her role in the United States is now well established it has not been without problems. Harrell and McCulloch (1986: 44) describe these as role ambiguity, lack of support, lack of legal basis for advanced practice and inappropriate use of the title, lack of authority, resistance from staff nurses, lack of hard data to demonstrate worth, encroachment on clinical time by teaching or administrative functions and competition from the nurse practitioner. Babich (1988: 11) suggests that because the role expectations of the clinical nurse specialist are so diverse that its implementation has been frustrating both to the individual concerned and to the nursing administrator. Accountability is another problem and has to do with the individual's place in the nursing structure and particularly whether she should be in a staff or a line position. There are pros and cons to both positions (Stevens 1980: 225; Babich 1988: 10).

2.6 POSSIBLE SOLUTIONS TO PROBLEMS IN MIDDLE MANAGEMENT

2.6.1 A system of divided function

Stevens (1985: 247) suggests that if middle managers are to be retained in the nursing structure, their positions must be strengthened and they must be given job functions different from those of the extended head nurse.

A possible restructuring is to analyze the nursing management components and to assign each supervisor specific management functions. Three middle managers could attend to evaluation and improvement of patient care, staffing and regulation of personnel, and administrative processes and nursing systems. Each middle manager would then be responsible for guiding and directing all head nurses in relation to her speciality (Stevens 1985: 247). In this way

the head nurse would react less negatively to the supervisor who has only a partial interest in her territory, and this would make it easier for her to accept the guidance offered. The system of divided function must be carefully handled because it creates a matrix management under which each supervisor must ensure that problems which do not directly affect her are referred to the proper supervisor (Stevens 1985: 247).

There is another advantage inherent in this system which assists the nurse executive. Once the functions have been divided, the staff meetings attended by the supervisor would benefit from a changed focus. Conversation would no longer fall into a meaningless recital of patient admissions, discharges and deaths. Staff meetings would become refocussed and more dynamic and problem-solving, they would become decision-making sessions rather than simply informational reports (Stevens 1985: 247).

2.6.2 Creation of large functional units

If middle managers and their work were to be retained in the traditional hierarchical line, further adjustments could be made. A functional unit larger than the patient ward could be created. If a supervisor managed four units with a common functional basis, this unifying factor could be used to establish common goals and direction. In this way disparate units would be moulded into a single functional team. Staff meetings could be held with head nurses to set common goals and to solve common problems. Personnel could be transferred to meet workload changes on a daily basis. This would be an example of cooperation within the new functional unit. It would also allow head nurses to interchange personnel and in this way orientate each nurse to the appropriate wards, to their equipment, and to patient needs. Relocating

staff would cause less resistance because workers would be prepared for such interchanges. In the same way head nurses would orientate themselves to their sister wards so that they would be available when staff were off duty (Stevens 1985: 248).

If this structure was adopted, the supervisor would have a territory of her own, the larger (combined) unit. She would function in the larger unit as a whole and would not interfere in the everyday functions of head nurses. She would assist the unit in evolving group goals and in coordinating activities. She would meet head nurses in staff meetings rather than individually and her contribution would be consultative and developmental, the latter in so far as she would build management skills in her head nurses (Stevens 1985: 248).

2.6.3 Elimination of the role of middle manager

One solution to the problems of the middle manager is to dispense with the position altogether. Stevens (1985: 248) has shown that the middle management position has taken on greater complexity under new matrix management and in 24-hour responsibility plans. This is because, under such a system head nurses have total control of the work environment. The supervisory level could be abandoned and the head nurse could be given more authority.

Johnston (1983: 22) tells of head nurses at the Greater Southeast Community Hospital in Washington, D.C., being upgraded to department heads (middle management) when the organisation was decentralised. Initially problems were encountered but once management had addressed the issues of clinical credibility, self esteem and self confidence, the head nurses became competent department heads.

The argument in favour of eliminating the middle manager in South Africa and the consequences of this organisational move have been referred to in an earlier section (see page 25) and are elaborated upon in a subsequent chapter.

2.6.4 Administrative nurse specialist

Another possible solution to the problem described above is to decentralise the service. Houston and Bevelacqua (1991: 47) have described how a hospital in Houston, Texas, has decentralised nursing services so as to give more power to nurse managers, and so create opportunities for professional growth. Here a post of administrative nurse specialist was created to foster and nurture this new organisational culture. Within the American nursing hierarchy the administrative nurse specialist is a post graduate professional nurse with experience in first-line management positions. Her roles are not dissimilar from those of the clinical nurse specialist and her primary functions and responsibilities are administration, management and leadership.

Schweiger and Huey (1983: 41) also advocate the introduction of an administrative coordinator whose role is administrative in nature while the clinical coordinator's role remains clinical.

2.6.5 The clinical nurse specialist in a management role

Some authors advocate using the clinical nurse specialist in a middle management role. Advocates of this view are Williams and Cancian (1985:20) who believe that the clinical expert should not only provide direct nursing care, but should also be a ward administrator. For this reason some hospitals in the United States have introduced coordinators into their services,

individuals who have positions similar to those of the chief professional nurse in South Africa. However, as Schweiger and Huey (1983:40) remind us coordinators can only function well if their roles are carefully defined in relation to existing structures.

Wallace and Corey (1983: 13) contend that the clinical nurse specialist can be accommodated by combining administrative power and professional power in middle management. They recommend blending clinical specialist nursing and manager roles as a strategy during budgetary cuts to retain clinical expertise in the institutional setting. They profess that a high degree of professional autonomy has resulted from this blending.

As with the middle manager, a matrix organisation has been suggested as an alternative to a bureaucratic system where clinical nurse specialists would more fully use their expertise (Anders 1976:40).

2.6.6 Case manager

Douglass (1992: 105) suggests that the case manager should coordinate and oversee the work of nurses and other interdisciplinary personnel in and out of the health agency in the interests of a selected group of patients. Examples of this might be control of renal dialysis patients or patients who have had cardiac bypass surgery.

2.6.7 Quality assurance nurse

Kibbee (1988: 30) refers to a new professional called the quality assurance nurse who is taking her place in middle management and assuming a variety of

titles, with a primary function which is to assess and evaluate indicators of nursing care. These individuals conduct problem-focused studies and provide continuous, systematic monitoring of nursing processes and outcomes. They share the common duties and needs of an emerging discipline which establishes their new position in the profession and provides opportunities for building skills and being the mentors of others.

Strasen (1989: 6) says that nurse middle managers who have been affected by restructured roles and responsibilities experience similar feelings to middle managers generally and they cite lack of control, inadequate rewards and a lack of recognition for the difficult job they perform, the lack of interest in the organisation, especially its focus on financial and quality results, and the paucity of concern for the employees as the main factors contributing to their frustration (Strasen 1989: 6).

The span of control is the next issue which must receive attention. It is one of the aspects of management which is a part of the present study.

2.7 SPAN OF CONTROL

Span of control is an organisational concept which refers to the number of persons a manager can effectively supervise (Bernhard & Walsh 1990: 41). Gillies (1989: 16) claims that a supervisor can exert a fairly wide span of control (10 to 15 workers, occasionally 20 or more) when all subordinates perform similar tasks of a routine nature and when there is little interdependence among their activities. However, when subordinates must accomplish complex tasks, when work is characterized by uncertainty, and when there are many independent activities, supervisors can effectively supervise

fewer workers (perhaps 5). McFarland, Leonard & Morris (1984: 104) concur to some extent when they say that "the principle of span of control in classic organisation theory suggests that there should be a limited number of subordinates reporting to one superior". In fact in most organisations the nursing supervisor has from two to eight head nurses (or key areas) under her supervision (Stevens 1980: 207). This number underscores the management principle concerned and satisfies the director's need to limit contacts. In instances where a middle management layer has been introduced merely to satisfy span of control, more problems have been created than solved (Stevens 1980: 208). Stevens (1985: 247) fails to develop this argument in a subsequent edition of her work, possibly because many institutions in the United States no longer have middle managers, or because their job functions have changed from being extensions of head nurse duties to specific management functions, for example, patient care or personnel.

Returning to this subject in the literature on the chief professional nurse in South Africa, the TPA O & W Report 25/79 (1979: 3), one notes that the senior matron had on average of eight departments or senior professional nurses in charge of wards under her control (see page 3). Van Tonder (1984) chose not to determine the span of control in her research on area supervisors in Transvaal hospitals, an omission which is picked up in the present study, one aspect of which is to establish how many persons the chief professional nurse supervises.

2.8 FUNCTIONS OF THE NURSE IN MIDDLE MANAGEMENT

Role and function are often used synonymously to describe what managers do. Van Tonder (1984) broadly classified the functions of the area supervisor in

selected Transvaal Provincial Administration hospitals into administrative, professional and teaching components.

Thus these functions are the same as those used by Brownlee (1983: 14) in research done on the sisters in charge of the ward. She classified their activities into four traditionally broad categories: nursing care, administration, teaching and research. This supports the view which is put forward in the TPA O & W Report 25/79 (1979: 1-2) that the activities of the senior matrons and senior sisters were very similar. However the amount of time spent on the various functions differed, with the senior matron spending most of her time on the administrative function.

For the purpose of this study, the functions of the chief professional nurse are classified in terms of her responsibilities: clinical, educational, administrative, research and professional development. The activities within this classification are based on those used by Robichaud and Hamric (1986) to determine how clinical nurse specialists in the United States spent their time. The categories are set out below (see page 77).

1 Patient care/consultation
- 1.1 Direct patient care
- 1.2 Indirect patient care
- 1.3 Consultation

2 Education

3 Administration
- 3.1 Planning
- 3.2 Organising
- 3.3 Finance

3.4 Personnel

3.5 Procedures

3.6 Control

4 Research

5 Professional development activities

2.9 ORIENTATION AND STAFF DEVELOPMENT FOR MIDDLE MANAGERS

There are many references in the literature to orientation and staff development of top and first-line managers, but very few concerning the education of middle managers (Dunne, Ehrlich & Mitchell 1988: 12). The first college-based management courses for nurses originated in the United States. In the United Kingdom a one-year course for nurse administrators was started at the Royal College of Nursing in 1944 (Rowden 1984: 5) and in South Africa in 1951 (Searle 1988a: 47), but these were for potential matrons in top management positions. Formalised training for middle managers was only started in Britain in the middle sixties (Rowden 1984: 5).

Some authors have recognised the need for management development programmes for middle managers (Dunne *et al* 1988; Kirk 1987; Marchetti 1985). Darling and McGrath (1983: 32) have observed, in this context, that training for a management job is usually done informally and is frequently never completed because of pressures of other work. They say further that there are very few true training programmes for individuals entering the ranks of management and most of these are characterised by little or no follow-up. Forrest (1983: 139) reinforces this contention by claiming that historically the basic education of nurses does not prepare them for management roles, and that most of those who become managers find themselves in those positions because of

their skills in clinical areas. It is readily apparent therefore that their elevation to management is underpinned by false or spurious premises. Forrest (1983: 139) says that even courses specifically designed for nurse management are deficient because they are concerned with the training of behavioural skills rather than with quantitative or analytical skills. Forrest calls this the 'hurdle process' of training which as its name implies is training interspersed with impediments, obstacles or hurdles which have to be negotiated before the ensuing phase can be tackled. The opposite of this would be a training path represented by a continuous process of education.

Dunne *et al* (1988: 11) contend that in an economically competitive health care environment, middle level managers must now perform their roles with a higher level of managerial and leadership skills than was previously the case. This requires what they call a systematic and consistent approach to development which will assist them in meeting role responsibilities. The programme they proposed for middle level managers included orientation, ongoing development and evaluation. Forrest (1983: 144) endorses this saying it has long been recognised that clinical skills require constant updating and if this is the case, the same must be true of the management skills.

Kirk (1987: 7) also found that the management development needs of nurse executives differed from those of nurse managers (middle managers). The vision of the former is broad and focused on the future, whereas the latter's primary responsibility is on day-to-day operations and expectations. Nurse managers organise and coordinate groups of people so that they can achieve organisational, departmental, and personal goals. They support the Nurse Executive's functions by providing information, monitoring results and planning. Kirk also suggests that as managerial roles become more complex,

organisations will look at the content of their development programmes and establish through research the needs of managerial personnel.

Because of the similarities of the roles of chief professional nurses and those of clinical nurse specialists, comparisons are again appropriate here especially in so far as orientation and staff development are concerned. In the United States orientation studies of clinical nurse specialists (DiMauro & Mack 1989: 77) have established the importance of the orientation process. They found that it affects the role development of the clinical nurse and is one way of eliminating role confusion. Those institutions without orientation programmes found evidence of frustration and rejection by colleagues, and in extreme cases it could be identified as a reason for an individual leaving the profession. Orientation programmes guide clinical nurse specialists through the introductory phase of their role in the institution, and through this they acquire the understanding of the nursing department's service and educational philosophy. Because clinical nurse specialists are adult learners with varied work experience, educational preparation and personal expectations, good orientation programmes tend to be individualised.

Returning, for comparative purposes to the South African case, one notes that few studies on management training for nurse managers have been undertaken. Van Tonder (1984: 58) pointed to the lack of managerial preparation among nurses and has shown that although two thirds of area supervisors had between one and three post basic qualifications, only a third of these were in the areas of their specialities, and only half had qualifications in nursing administration. A fifth of her respondents had spent less than five years as sisters in charge of wards before being promoted to area supervisors.

Pretorius' (1990: 148-153) research on management training for professional nurses revealed that the employers of professional nurses developed their own management training programmes and that a climate appropriate to management development in the nursing profession did not exist. Post basic training played an important role in preparing individuals for the managerial role, but the courses were theoretical and did not meet practical requirements.

In 1985 the Training Institute of the Commission for Administration introduced courses for public servants. One of these was the Junior Manager's course, intended for officials and employees of the public service in supervisory positions. It aimed at enhancing the employees' efficiency, knowledge and insight, and encouraging their involvement in management activities. It became compulsory for all chief professional nurses to attend the Junior Manager course which extended over ten working days. The course was originally held at the Training Institute in Pretoria, but several of the larger hospitals now have nursing personnel presenting these courses for nurses. The course content embraces the management processes (policy making, organising, finance, personnel management, procedures and control) and management skills, for example leadership skills, aspects of communication, delegation, handling conflict, decision-making and other topics. It is presented through lectures, group discussions, brain storming, practical work sessions, proficiency exercises, case studies and video material. It offers practical guidelines to the junior manager for handling and implementing management practices. Because of its short duration it is mainly theoretical, but practical application is emphasised throughout. It is the responsibility of the chief professional nurse to put the skills learnt into practice and to apply them in the working situation. In some institutions there are periodical evaluations of personnel who attended these courses.

Nurses who are promoted to managerial positions in the Transvaal Provincial Administration are also informally orientated in some hospitals.

2.10 TIME MANAGEMENT STUDIES

Robichaud and Hamric (1986: 31) have said that little has been written on activity documentation. There are however a number of different techniques which have been used to establish the time spent by nurses on various activities. One of these is the observation of personnel, another is the documentation of activities by personnel themselves. Some examples of such studies are described below.

In Brownlee's study on the sisters-in-charge of hospital wards, done by the staff of the Department of Nursing Science at the University of South Africa, the observations were carried out by twenty one individuals at seventy four units over five weeks. The activities recorded were classified according to patient care, administration, teaching and research. The objective was to establish the amount of time spent on each function (Brownlee 1983: 16-18).

In another study by Hendrikson, Doddato and Kovner (1990: 31) to determine how nurses spent their time, a seven day observation was carried out on each of the two busiest shifts during the day and night on one of six major services (medicine, surgery, orthopaedics, neurology, obstetrics and gynaecology). Each service was randomly chosen and observed for one week, the total being six weeks. Six trained observers were used, and they took observations every fifteen minutes during an eight hour shift. The observations were summed and the amount of time spent on each activity for each service was calculated.

Robichaud and Hamric (1986: 33) made use of a time documentation record for recording the activities of clinical nurse specialists. The clinical nurse specialists were required to document how they spent their time by recording their activities during each hour of the day. A month's data was averaged and evaluated against predictions by the clinical nurse specialists themselves and by clinical nursing directors. Discrepancies were found between the predicted and the actual times, and there were wide actual ranges. Robichaud and Hamric concluded that this type of documentation proved not to be quantitatively sufficient. However, they felt it could be used as a component of evaluation for clinical nurse specialists and as a means of obtaining structural information in the development of her role and function.

In another study done by Hedtcke, MacQueen and Carr (1992: 18) a daily activity log was filled in by Home Health Nurses to see how much time they spent on daily activities. They also wanted to determine the average number of patients nurses cared for each day. A two week period was chosen for the study following which the data were coded and analysed.

It is clear from the studies noted above that both methods of time measurement have limitations. Principal amongst these in the observation method is the expense in terms of time taken and the number of qualified observers that have to be employed. In the second method, that of personal documentation, there are the impediments of accuracy and reliability, since establishing the accuracy of responses remains beyond the scope of the investigator. In the final instance the results obtained from both methods reflect no more than a small sample of the activity.

Malone (1986: 1376) feels that it is essential for a clinical nurse specialist

to spend at least half her time practising her specialty. This is supported by research done by clinical nurse specialists in Cincinnati which suggested a model for time allocation in which fifty per cent was spent on clinical practice, thirty percent on internal consultation and research with industry, government and other health care agencies, ten per cent on internal mechanisms of the consultation department, including peer review and participatory management, and ten per cent on publication and other professional growth activities in collaboration with staff nurses. This is a flexible guideline for time management except for the time commitment to clinical practice which should not drop below fifty per cent (du Preez 1988: 31).

2.11 JOB SATISFACTION

Gillies (1989: 396) defines job satisfaction as "one's affective response to one's job". Kaplan, Boshoff and Kellerman (1991: 3) and Cavanagh (1992: 704) cite Locke's (1983) definition of job satisfaction as "a pleasurable or positive emotional state resulting from the appraisal of one's job or job experiences".

There are many reasons why job satisfaction is important in the nursing profession. Cavanagh (1992: 704) identifies the following:

1 Satisfaction in the job situation, because it is an intrinsic aspect of the work, is something valued in itself by many nurses. This is important as nursing is a profession which is varied and is characterised by contrasting episodes of great stress and great joy.

2 The satisfaction which nurses experience in their jobs because of the close association with patients impacts on the latter's well being.

McFarland *et al* (1984: 182) have shown that absenteeism is linked to poor job satisfaction and may influence the performance of nurses on duty. The converse is also true, namely that greater job satisfaction leads to greater productivity. Seen from the perspective of the patient, research by McFarland *et al* (1984: 182) shows a greater level of contentment when the nursing staff achieve high levels of job satisfaction. It has also been shown that job satisfaction, morale and stress in the work situation influence patient care.

3 Cavanagh (1992: 704) addresses the issue of staff turnover and shows that satisfaction at work lessens the likelihood of changing jobs. In the case of the nursing profession, which has customarily had a high rate of turnover this is a significant issue. McFarland *et al* (1984: 182) approach the subject from another perspective noting that as productivity and security of tenure increase, so too does job satisfaction. The opposite also obtains, and is directly related to absenteeism and turnover of staff.

In so far as conceptual issues are concerned, Vessey (cited in McFarland *et al* 1984: 182) has identified three aspects involving the job, the individual and the interaction of these two as prime determinants of job satisfaction. These clearly have ramifications in the choice of the middle manager and in the description of her job. In a research study undertaken by McFarland *et al*, various categories of nursing staff were questioned to establish which aspects of their jobs gave them the most or least satisfaction. From the findings it could be seen whether the nurse concerned possessed the abilities and skills needed to do the job and whether the job satisfied the needs of the nurse (McFarland *et al* 1984: 189).

Personality differences, job differences and differences in values have also been identified by Gruneberg (1979) and Locke (1983) (cited in Cavanagh 1992: 704) as being major perspectives in worker's satisfaction.

Theoretical modules have also been constructed to describe and explain the nature of job satisfaction. These have been classified by Campbell, Dunnette, Lawler & Weick (1970 cited in Cavanagh 1992: 705). Examples of content theories are Maslow's hierarchy of need theory and Herzberg's motivator-hygiene theories.

Although there is no agreed definition of job satisfaction, there is greater consensus with definition than there is with assessment of job satisfaction (Traynor & Wade 1993: 128). Many studies have been done to identify factors which influence job satisfaction using different variables. The results of a meta-analysis researched in the United States by Blegan (1993: 36-41) provides a quantitative summary of the literature on nurses' job satisfaction. Blegan looked at over two hundred published and fifty unpublished studies before selecting forty eight which satisfied certain criteria. From these the relationship between nurses' job satisfaction and the variables most frequently associated with it were determined. Some of the variables had labels with conceptually similar phenomena and were therefore combined under one variable. The thirteen variables most often linked with nurses' job satisfaction are listed as follows:

Age

Autonomy (centralisation [-], participation, powerlessness [-],
discretion, personal control)

Commitment (loyalty, alienation [-])

Communication - peers (group cohesion, social integration)

Communication - supervisor (instrumental communication, leader support)

Education

Fairness (distributive justice)

Locus of control

Professionalism (work motivation, career commitment)

Recognition (feedback)

Routinisation (variety [-], specialisation)

Stress (burnout)

Years experience (tenure)

A negative sign [-] denotes variables that imply a relationship with satisfaction in the direction opposite to that of the primary label. Four of these were personal attribute variables or personality traits (age, education, years experience, and locus of control). Nine were organisational features or job attributes (stress, commitment, supervisor communication, autonomy, recognition, routinisation, peer communication, fairness and professionalism).

The results showed that job satisfaction was negatively associated with stress and positively with organisational commitment. Those moderately associated with job satisfaction were autonomy, communication with supervisor, recognition, routinisation, communication with peers, fairness and locus of control. Those with low correlations were age, education, turnover and professionalism. No single factor stood out as the major explanatory variable. Although job satisfaction was most strongly associated with stress, the causes of this stress also included lack of autonomy, poor communication and low recognition.

Two studies which examine the job satisfaction of nurses were those of McFarland *et al* (1984) in the United States and Kaplan *et al* (1991) in South Africa. Both used the short form of the Minnesota Satisfaction Questionnaire of Weiss, Davis, England and Lofquist (1967: 24). This has twenty items, each of which measures the satisfaction of certain job aspects (see page 82). McFarland *et al* compared the job satisfaction results of different categories of nurses (clinical nurse specialists, supervisors and staff nurses). These were displayed graphically to illustrate similarities and differences in job satisfaction among the three categories (McFarland *et al* 1984: 187-189). Kaplan *et al* compared the job satisfaction of South African nurses with that of members of thirteen other professional groups in South Africa. They found that South African nurses had numerically the lowest average for extrinsic, autonomic and overall job satisfaction and were in the penultimate group on the intrinsic job satisfaction scale when compared with the other professions. They also compared the job satisfaction of South African nurses with that of American nurses and found that South African nurses experienced substantially less job satisfaction than their American counterparts (Kaplan *et al* 1991:3-7)

Kaplan *et al's* findings can only be seen as alarming for both the nursing and the medical profession in South Africa. Inter alia they found that conditions of employment affected nurses both physically and mentally. Turnover and abandonment of professional careers were linked to dissatisfaction, while there were indications of progressively fewer entrants to the profession. They noted that shortages produced by dissatisfaction would affect the quality of both patient and medical care in the country. They concluded that circumstances and events surrounding employment practices lay at the heart of nurses' dissatisfaction and these need to be identified and attended to urgently (Kaplan *et al* 1991: 6).

2.12 JOB DESCRIPTION

Stevens (1985: 77) devotes considerable space to defining analysing and appraising the job description, its objectives, its form and content, its requirements, its ingredients and its most significant elements. She says that when a number of objectives are considered together, and the actions required to attain these objectives are achieved, these are usually called functions, so functions can be defined as the broad, key activities that taken together and successfully completed assure attainment of the group of objectives. Within this definition a critical term is the 'key activities' noted above. These are differentiated into the specific tasks and responsibilities of which they are comprised which in turn are sorted once again, this time into the relevant job constellations. The job description emerges from the constellation of job functions. All other elements needed to define the job description are included. Stevens (1985: 78) offers a seven-point plan which ensures an adequate inclusive and encapsulating job description. The elements include a job title; a job coding or number which would indicate the level and the classification anticipated in relation to all other jobs within the division or institution; the reporting relationships (both to whom the aspirant candidates would be responsible and for whom responsible); a description in summary or outline of the position, its key functions and major areas of responsibility; a more substantive list of responsibilities and tasks; any real or potential hazards which may be associated with the position, be they environmental, psychological, physiological, chemical or biological; and finally details of the qualifications, both educational and experiential, for the position. Stevens (1985: 80) says that one may often anticipate an additional requirement that the job would attract individuals who have identifiable personal

characteristics, these being those commonly needed for commitment, satisfaction and success in the job. Gillies (1989: 176) has suggested that keeping a diary provides extensive job information from which a job description can be written. Well-written job descriptions provide the criteria from which nurses' performance can be evaluated.

The job descriptions which have been prepared for aspirant chief professional nurses since the inception of the rank in the middle eighties in the Transvaal Provincial Administration follow very closely that outlined by Stevens. Some elements are personalised since each institution in the Transvaal Provincial Administration's hospital system prepares its own job descriptions which reflect local requirements and idiosyncrasies. A typical job description, which encapsulates the contents and objectives of a number of such descriptions follows, and from this it is apparent that the objectives of Stevens and Gillies are incorporated.

The job descriptions which have been used in the present context (see appendix A) call for the delivery of a high standard of patient care as well as the ability to participate in formal and informal teaching of subordinates. They call for the ability to develop personnel according to the philosophy of the institution concerned. Basic qualifications are required, as also a knowledge of rules and regulations pertaining to professional ethics and standards as laid down by statutory authorities. Additional qualifications are a recommendation. Personality characteristics are required such as the need to be positive in attitude, to have good working relationships with staff and colleagues, to be emotionally mature, and psychologically stable, to be a good listener and to have the ability to communicate effectively. Professional responsibilities include the provision of comprehensive nursing care,

consistent with the philosophy, the objectives and the policy of the hospital concerned, the implementation of the scope of practice according to different nursing categories, the projection of a professional image, and the maintenance and initiation of an holistic approach to patient care. Also part of the professional responsibility of the aspirant chief professional nurse is the need to be familiar with the tenets of the South African Nursing Council and those of the South African Nursing Association, more especially their purpose and functions, their rules and regulations and their policies. These are collectively called professional responsibilities.

The educational responsibilities are divided between personnel and patients. For the former these are to plan, programme, implement and evaluate inservice training, to orientate staff, write appraisal reports, conduct workshops and symposia, teach students in the clinical setting and keep abreast of developments through research and formal and informal education. For the latter the responsibility is broadly defined as planning and giving education to patients and their families according to their needs.

A third broad area of responsibility is that of administration. This devolves upon the area of deputising, interpreting policy, managing units, accounting for all professional and non-professional activity during a specified shift, keeping statistics, controlling drugs, evaluating patient care and patient audits, ensuring that nurses' appearance and uniforms conform to determined standards, investigating and reporting on irregularities, ordering equipment and ensuring compliance with emergency, disaster and contingency plans and the training for these. Budgetary considerations represent the last of the responsibilities in this category. Here supervision of personnel, the use of stock, and the maintenance and use of equipment are important in planning and

budgeting for the financial year under consideration.

The final area of responsibility covers two discrete areas, one of which is research (which is a category distinct from that noted above) and here the effort is twofold: to identify the departmental omissions and commissions which need to be researched and to participate in broader research projects. The second relates to medico legal risks involving prevention on the one hand, and the collection and collation of reports relating to such incidents on the other.

All job descriptions follow the basic rubric described here although a common omission is the absence of any reference to research. There are however minor deviations which are pertinent to particular positions, as for example those requiring exceptional personality characteristics (the nursing of psychiatric patients might be an example) and all job descriptions have embracing and encompassing clauses which ensure that an omission can be accommodated. This usually takes the form of a concluding statement which allows the employer to reserve the right to review the job description either at regular intervals or from time to time when deemed necessary and appropriate.

The Commission for Administration has outlined very broad 'job contents descriptions' for all nursing categories. These act as a guide when new posts are created but are not intended to replace more detailed job descriptions. The prescribed job contents for the post class chief professional nurse is as follows:

Nursing practice

Control the identification of the needs for nursing care, the formulation and implementation of nursing programmes and the execution thereof.

Co-ordinate the in-service training of nursing units.

Nursing training

Instruct students in nursing.

(Commission for Administration. Personnel Administration Standard (PAS) 1986: 2).

2.13 CONCLUSION OF LITERATURE REVIEW

The review of the literature presented here points to the lack of clarity and of role definition and to problems which have emerged for nurses in middle management (Hamric 1983: 44; Harrell & McCulloch 1986: 44; Stevens 1987: 246). Understanding the problems outlined in this review provides a basis for this study. This commences with an examination of methodological considerations and is followed by an analysis of the data. Once completed, the congruency between the South African situation of middle management and that collectively presented in the literature on the subject can be established.

CHAPTER 3

METHODOLOGY

3.1 RESEARCH DESIGN

A nonexperimental exploratory descriptive research method was used to investigate the role and function of the chief professional nurse in academic hospitals of the Transvaal Provincial Administration.

In this chapter, the methods and procedures employed to accomplish the purpose of the research are presented. A multi data estimation method giving rise to three instruments was used.

3.2 TARGET POPULATION

The individuals participating in the research were chief professional nurses from academic hospitals in the Transvaal Provincial Administration. Chief professional nurses in smaller hospitals act chiefly as administrators and their role and function differ from that of chief professional nurses in academic hospitals. They were therefore excluded from this research.

3.3 SAMPLE

It was initially the author's intention to survey the total population of chief professional nurses in academic hospitals in the Transvaal Provincial Administration. This seemed appropriate as they constituted a relatively small group (see table 3.1).

TABLE 3.1 Numbers of chief professional nurses at academic hospitals in the Transvaal Provincial Administration - 1993

Hospital	Posts available	Posts filled	Vacancies
1	51	41	10
2	8	8	0
3	21	19	2
*4	24	21	3
5	39	38	1
6	11	11	0
7	30	27	3
8	21	21	0
TOTAL	205	186	19

* Excluded

On the first of January 1993 two hundred and five posts were available for chief professional nurses in the academic hospitals of the Transvaal Provincial Administration. Of these one hundred and eighty six were filled. There were nineteen vacancies, some of which were posts attached to clinics which were no longer under the control of hospitals (Transvaal Provincial Administration Hospital Services Nursing Statistics 1993). One hospital was excluded because it was not a training hospital for student nurses, and it was felt that the role and function of these chief professional nurses would differ from those at the other hospitals. Two academic hospitals were used for the pilot study and approval to carry out the survey was refused in two

other hospitals. The study was therefore carried out at three academic hospitals, all of which serve the Black community. All chief professional nurses were drawn from this race group.

TABLE 3.2 Number of chief professional nurses participating in the research and number of questionnaires and time documentation records returned

HOSPITAL	NUMBER OF CHIEF PROFESSIONAL NURSE POSTS	CHIEF PROFESSIONAL NURSES INTERVIEWED AND GIVEN QUESTIONNAIRES	NUMBER OF QUESTIONNAIRES RETURNED	NUMBER OF TIME DOCUMENTATION RECORDS RETURNED
A	41	12	11	6
B	19	18	15	7
C	21	11	11	11
Total	81	41	37	24

There were eighty one chief professional nurses at the three hospitals used in the present study. Of the forty one who were interviewed, thirty seven completed the questionnaires. Only twenty four completed the time documentation records. In one of the three hospitals the number of chief professional nurses who agreed to participate was relatively small. In each hospital some chief professional nurses were on leave and some did not wish to become involved. The thirty seven chief professional nurses represented forty six per cent of the total population of chief professional nurses who were potentially available for the study.

3.4 DESCRIPTION OF THE RESEARCH INSTRUMENTS

Three research instruments were used. Data were collected through the medium of interview, questionnaire and a time documentation record (diary).

3.4.1 Questionnaire: section 1

Section 1 of the questionnaire was developed by the author and was used to obtain the participants' personal details, their education and training, their experience, orientation, the geographical location of their work, as well as information on their job descriptions, and their likes and dislikes concerning their jobs. Although most of these questions were close-ended, some were open-ended (see appendix B).

3.4.2 Questionnaire: section 2

Section 2 of the questionnaire was used to obtain data relating to the activities performed by chief professional nurses (see appendix B). These activities were based on those used by Robichaud and Hamric (1986: 32) to investigate the role and function of the clinical nurse specialist in the United States of America. Robichaud and Hamric emphasised the clinical aspects and had few administrative activities so these were adapted to make the questionnaire more appropriate for nurse managers in South Africa as the administrative component plays a large role among the activities of chief professional nurses. A five point Likert rating scale was used to obtain the data.

The functions of the chief professional nurse are based on the six major role

components of the clinical nurse specialist as described by Robichaud and Hamric (1986: 32) and are as follows:

1 **Patient care/consultation** which is divided into direct patient care, indirect patient care and consultation.

- **Direct patient care** involves those activities that bring the chief professional nurse into direct contact with the patient and his family. Patient education is included in this category.
- **Indirect patient care** involves time spent with nursing staff in coordination and guidance in providing quality nursing care, for example, planning patient care, report writing and conducting patient rounds.
- **Consultation** involves evaluating patients which have been referred by other health authorities where specialised knowledge or assistance is given.

2 **Education.**

In so far as education is concerned, the instrument has subcategories which reflect geographical areas. The education of all personnel, both formal and informal, the education of the community and preceptorship fall into this category.

3 **Administration.**

These components differ considerably from those of Robichaud and Hamric, and include the administrative processes of policy making/planning, organising, financing, personnel administration, work procedures and control.

- **Policy making/planning.** The first part of the management process is policy making, planning, programming and decision making, an area which is unlikely to affect middle managers because they are

seldom involved at this level. These aspects of policy making and planning are usually carried out by more senior levels of management, except at the departmental level.

- **Organising.** The organisational aspect involves the decision making process at unit level, attendance at weekly meetings, the improvement of the nursing service, the implementation of policy, reporting activities and situations and effecting positive change.
- **Finance.** In this section the concern is for budgeting, motivating for new equipment, cost containment and cost effectiveness.
- **Personnel administration.** This category encompasses all aspects of personnel management and considers the following: interviewing, advice on appointments, staff allocation, staff requirements, evaluating performance appraisals, counselling, disciplinary activities, the preparation of memoranda on personnel, the collection of statistics relevant to personnel and involvement in labour disputes.
- **Procedures.** These ensure the availability of appropriate policy manuals, they ensure that regulations are maintained, they interpret and recommend nursing service policies, and they evaluate and change these from time to time.
- **Control.** Control is the term used for evaluating nursing achievement and nursing records and participating in audits. It is part of the analysis of statistics relating to planning and evaluation, particularly with regard to emergencies and inspections, to assess environmental and safety considerations, to control drugs and the quality of care.

4 **Research.**

Under this heading information relating to collaboration and the generation of research is collected, as also that of the research preceptor who guides and directs research activity.

5 **Professional development.**

Professional development activities involve self directed learning, seeking educational opportunities, attending continuing education courses and writing for publication (other than research).

3.4.3 Minnesota Satisfaction Questionnaire

The third instrument used was the Minnesota Satisfaction Questionnaire which was developed by Weiss, England, Dawis and Lofquist in 1967 to measure job satisfaction (see appendix B). There are two forms, the long form which consists of a hundred items and the short form which consists of twenty items. Each item refers to a degree of satisfaction which Weiss *et al* (1967: 1) call a 'reinforcer' in the work environment. Each 'satisfaction item' corresponds to a 'scale title', for example, 'being able to keep busy all the time' is the satisfaction item for the scale title 'activity' (see appendix C). The short form Minnesota Satisfaction Questionnaire is based on a subset of the long form and has been tested for reliability and validity by the original authors (Weiss *et al* 1967: 23) and by South African researchers (Kaplan *et al* 1991: 4). The short form Minnesota Satisfaction Questionnaire was used in preference to the long form as it was easier to administer and because it had already been used in other studies undertaken in South Africa (Boshoff *et al* 1989; Kaplan *et al* 1991), and therefore allowed comparisons to be made more readily.

The wording of some of the questions differed slightly from the original as it included changes made by Boshoff *et al* (1989) (see appendix B). Examples of these changes are:

6 'Superior' is used instead of 'supervisor'.

12 The way company policies are put into practice. The word 'company' has been omitted.

Directions and item rating instructions for the respondents appeared on the first page of the Minnesota Satisfaction Questionnaire. The respondent indicates a level of satisfaction with the item being assessed by circling the appropriate number on a scale from 1 to 5. Five possible response alternatives are presented for each item:

1 Very dissatisfied

2 Dissatisfied

3 Neither (dissatisfied nor satisfied)

4 Satisfied

5 Very satisfied

The short form Minnesota Satisfaction Questionnaire has intrinsic, extrinsic, autonomous and general satisfaction scales. The items comprising these scales are illustrated in table 3.3.

TABLE 3.3 Minnesota Satisfaction Questionnaire - scales and satisfaction items

SCALE	ITEM	SATISFACTION ITEM
INTRINSIC	1	Activity
	3	Variety
	4	Social status
	7	Moral values
	8	Security
	9	Social service
	10	Authority
	11	Ability utilisation
	20	Achievement
EXTRINSIC	5	Supervision - human relations
	6	Supervision - technical
	12	Company policies
	13	Compensation
	14	Advancement
	17	Working conditions
	18	Co-workers
	19	Recognition
AUTONOMOUS	2	Independence
	15	Responsibility
	16	Creativity
GENERAL SATISFACTION	1 to 20	Includes all items

(Weiss *et al* 1967: 4)

Permission to use the short form of the Minnesota Satisfaction Questionnaire was given by Professor A.B. Boshoff of the Graduate School of Management, University of Pretoria, South Africa. This permission is granted under the umbrella of research being undertaken by him and for which permission from the authors has been received.

3.4.4 Time documentation record

This instrument was based on a time documentation record developed in the United States by Robichaud and Hamric (1986: 34) to examine how clinical nurse specialists spent their time. The time documentation record in the present study listed the same functions as those found in section 2 of the questionnaire which was used to measure activities performed by chief professional nurses (see appendix B). On the instrument the functions appear as a vertical listing and the days representing a month's time documentation appear horizontally. A block was provided for each function on each day for four weeks. Time spent on daily activities was filled in in the appropriate block in periods of hours or half hours. From this record it was anticipated that a complete profile of the chief professional nurses' activities would be obtained which could then be compared with activities listed in the section 2 of the questionnaire.

3.5 PRETESTING THE INSTRUMENT

The questionnaires and diary were tested for face and content validity on nurse leaders and lecturers in the field of nursing administration. In this way it was possible to check the document for translation, to detect ambiguities in wording, and repetition of items. It was also possible to

establish whether the instrument was sufficiently comprehensive in seeking the proper range of responses, whether it was appropriate in terms of space and length, whether it was adequate and whether there were any redundant response categories which might be superfluous. As a result of this pretesting some questions were discarded and others were reworded to give greater clarity. The statistical reliability of the procedure was verified by a professional statistician.

3.6 ETHICAL ISSUES

The research proposal and instruments were submitted to the Committee for Research on Human Subjects (Humanities) of the University of the Witwatersrand for permission to undertake the research. A clearance certificate was issued once this had been approved by the committee (see appendix D).

The research proposal, questionnaires, the time documentation record and a covering letter were sent to the Director of Hospital Services of the Transvaal Provincial Administration requesting permission to undertake the study at the academic hospitals under his control (see appendix E). Permission to undertake the research was obtained from the Deputy Director of Hospital Services of the Transvaal Provincial Administration (see appendix F). The instruments and a covering letter were then sent to the medical superintendents of the relevant hospitals (see appendix G). At two of these hospitals permission was denied. The letters received from the Medical Superintendents appear as appendix H.

The author undertook not to identify the hospitals or the participants involved in the study. The participants were assured of confidentiality,

their participation was voluntary and they were given permission to withdraw from the study at any time should they so wish.

3.7 PILOT STUDY

A pilot study to test the face validity of the instruments was carried out in September 1993 at two academic hospitals in the Transvaal. These were chosen because they covered the language groups officially recognised at the time. The chief professional nurses employed at these two hospitals represented eleven percent of the total population of chief professional nurses in academic hospitals in the Transvaal. There were fourteen chief professional nurses in the pilot study which is a relatively large group when compared with the number of thirty seven who participated in the final survey. At the time of the pilot study it was not known that permission to do research would be refused at some of the hospitals, despite the acquiescence the deputy director of Hospital Services. Had it been known at that stage that permission would not be forthcoming, only one hospital would have been used which would have resulted in a larger study group.

Appointments were made to interview the chief professional nurses, the questionnaires were handed to the respondents, they were completed in the presence of the author and collected immediately. The procedure for completing the time documentation record was explained to the participants after the questionnaires had been completed. All queries that arose concerning various aspects of the instruments were noted and these were accommodated. The time documentation records were collected a week later.

Responses to the questions were edited, coded, categorised and filed for

statistical analysis. The SAS (Statistical Analysis Software) computer package was used for data processing and a printout of frequencies and percentages of responses was made. Data on the printouts were reviewed and analysed.

As a result of queries regarding the instruments, and following discussions with the chief professional nurses, adjustments were made to the first two questionnaires (sections 1 and 2) and to the time documentation record (section 4). This was mainly because some activities done by chief professional nurses had been omitted, especially in the section dealing with administrative functions. There were also ambiguities in some questions and insufficient space for dates in the spaces initially provided. The Minnesota Satisfaction Questionnaire (section 3) was not altered.

3.8 COLLECTION OF DATA

Data were collected in October and November 1993 from the three remaining academic hospitals that granted permission for the research. Appointments were made to meet the chief professional nurses on a day and at a time when they usually met together. The instruments were delivered to and collected from each of the hospitals by the author. An explanation of the research was given to them and a covering letter requesting their cooperation and explaining the nature, relevance and importance of the research was also included with the instruments (appendix I).

Originally it was intended that data for sections 1 and 2 would be collected by means of a structured interview, since it would have made possible the clarification of questions which could have been misinterpreted by the

subjects. However, this intention was modified because the participants were reluctant to spend time being interviewed and requested permission to fill in the questionnaires in their own time. The author was at hand to assist with questions which posed problems for the participants, both when the questionnaires were distributed and when they were collected a week later. The three questionnaires took approximately forty five minutes to complete. Data collection by means of a questionnaire had an advantage over a structured interview because it ensured anonymity. Participants also indicated that they would be more at ease and would be able to record their feelings more truthfully without them being recorded by the author. One disadvantage of the questionnaire was that the author was unable to check whether all aspects of the questionnaire had been completed satisfactorily. Despite the fact that questionnaires were handed personally to all participants, some were not returned, a situation which would not have occurred with a structured interview. Participants were visited once a week to check their time documentation records and to answer questions regarding problems they might be experiencing. They were also given the researcher's telephone numbers should they have had a query about the time documentation record. No telephonic queries were received.

The questionnaires were collected one week after they were distributed. The time documentation record was collected three weeks later.

TABLE 3.4 Number of time documentation records handed out, number returned by participants at the three academic hospitals and number used for the study

HOSPITAL	NUMBER OF TIME DOCUMENTATION RECORDS GIVEN TO RESPONDENTS	NUMBER OF TIME DOCUMENTATION RECORDS RETURNED	NUMBER OF TIME DOCUMENTATION RECORDS USED
A	12	6	3
B	18	7	6
C	11	11	3
Total	41	24	12

Although twenty four time documentation records were returned, only twelve could be used as the others had been filled in inadequately, incorrectly or unrealistically. In this last regard some participants recorded working more than three hundred hours in one week.

3.9 DATA ANALYSIS

Data was transferred from questionnaires to the SAS programme and processed by the Department of Computer Services at the University of South Africa. Most of the questions had been precoded as they were close-ended. The open-ended questions were coded after they had been transcribed by hand onto data coding sheets.

Analysis was carried out from results produced by the SAS programme. Data was displayed in tables which indicated frequencies and percentages in the case of sections 1 and 2. The data analysed for section 3, the Minnesota Satisfaction Questionnaire, were presented in the form of raw scores and means for ranking the items. The intrinsic, extrinsic, autonomous and general satisfaction means and their standard deviations were calculated. A t-test was used to compare the Minnesota Satisfaction Questionnaire results of nurses in South Africa in general with those of the author's study.

These data constituted the material needed to analyse the results, to present the findings, to draw conclusions and to make recommendations for further research.

CHAPTER 4

ANALYSIS AND PRESENTATION OF DATA

The present chapter is devoted to the analysis, interpretation and discussion of the responses to the questionnaires. The purpose is to present the information which was obtained from the responses and from these to address the objectives of the study as outlined in chapter 1 (see section 1.6).

The statistics were derived from the responses to thirty seven questionnaires which were completed by chief professional nurses at three academic hospitals.

4.1 BIOGRAPHICAL INFORMATION

The biographical information provides the research worker with the profile of respondents. It yields valuable and necessary insights into the demographic structure of the sample, a natural starting point since it is from this that any departure from anticipated norms will emerge which may prejudice or alter the conclusions which are finally drawn from the responses.

4.1.1 Personal particulars

4.1.1.1 Item 1.1 Age

The first item examines the age structure of chief professional nurses in the sample. The ages of the respondents were grouped at intervals of ten years from 40 to 70 years (60 to 70 years was included to incorporate those retiring at 65 years).

TABLE 4.1 Age distribution of chief professional nurses

AGE GROUPING	FREQUENCY	PERCENTAGE
31 - 40	2	5,4
41 - 50	6	16,22
51 - 60	28	75,68
61 - 70	1	2,7
	(n=37)	100,00

The ages of the chief professional nurses ranged from 40 to 63 years, the average age being 53,5 years. An uneven age distribution in the sample is apparent with over three quarters of the respondents being between fifty one and sixty years. One notes the relatively advanced ages of the chief professional nurses (retirement age for most is sixty years). Since flexibility of mind and physical stamina are sometimes negatively correlated with advancing years, this may have important consequences for some of the questions put to the respondents.

The advanced age structure of chief professional nurses in the sample can be traced to the relatively few posts in management which have been available during the past two decades. If this is a correct interpretation, it follows that those appointed during this period would persist in their posts, and would represent an ageing middle management community as indeed is the case.

4.1.1.2 Item 1.2 Sex

All the respondents were female.

4.1.1.3 Item 1.3 Marital status

The question on marital status of respondents was used in the questionnaire so that changes in social trends among nurses in middle management could be determined.

TABLE 4.2 Frequency distribution of marital status of chief professional nurses

MARITAL STATUS	FREQUENCY	PERCENTAGE
Single	6	16,22
Married	23	62,16
Divorced	3	8,11
Widowed	5	13,51
	(n=37)	100,00

The majority of the respondents were married. This is a contemporary trend which contrasts with matrons of the mid twentieth century many of whom were single women who devoted their lives wholly to nursing. The modern matron is called upon to play several roles at the same time among these being those of wife, mother, and professional person. She is not infrequently the sole breadwinner of the family.

4.1.2 Item 2 General education

The purpose of this item was to establish an educational profile of the respondents (table 4.3).

TABLE 4.3 Frequency distribution of educational standards of chief professional nurses

GENERAL EDUCATION	FREQUENCY	PERCENTAGE
Standard 8	2	5,41
Matriculation	27	72,97
Degree	6	16,21
Post grad. degree	2	5,41
	(n=37)	100,00

Apart from two respondents who had attained standard eight certificates, the other thirty five were matriculated. Seven respondents had nursing degrees, two at post graduate level (honours). One of the chief professional nurses had a degree in social work.

The number of chief professional nurses who were matriculants was exceptionally high. While matriculation was not a requirement for nurses until the mid nineteen sixties, when most of these respondents commenced their basic nursing training, it is probable (on the basis of their present age) that many, if not most, were matriculated before they entered the nursing profession. Others would have matriculated once they had trained. Apart from a few older respondents, matriculation would have been a requirement for promotion for the majority to their present positions. Matriculation would also have been required of those respondents who wished to register for diploma or degree courses.

A university degree was not a requirement when most of the chief professional nurses were promoted to their present posts. A degree was also not common

among nurses before the advent of nursing departments at universities in South Africa. Although a qualification in nursing administration is at present only a recommendation for promotion to management posts, it may well become a requirement in the future.

4.1.3 Item 3 Nursing education

4.1.3.1 Item 3.1 Basic nursing qualifications

The respondents were asked whether they had completed their basic nursing qualification at diploma or degree level, in which year and at what institution.

TABLE 4.4 Frequency distribution of basic nursing qualifications of chief professional nurses

YEAR OBTAINED	QUALIFICATION		
	GENERAL	MIDWIFERY	PSYCHIATRY
1956 - 1960	11	2	0
1961 - 1970	21	24	1
1971 - 1980	5	11	1
1981 - 1985	0	0	2
Total	37	37	4

All the respondents had completed their basic nursing training at the diploma level. Most respondents (twenty one) had obtained this between 1961 and 1970. This once more reflected the relatively advanced age of respondents.

The chief professional nurses in the sample were drawn from a wide variety of different training hospital environments although most (eleven) had completed their basic training at the H.F. Verwoerd Hospital in Pretoria. Six had trained at Baragwanath Hospital, five at Coronation Hospital, two at Elim Hospital, and one each at Benedictine, Jane Furse, King Edward VIII, Moroka Mission, Natalspruit, Pelonomi and St. Konrads hospitals. Six respondents failed to respond to the questions relating to their training school.

4.1.3.2 Item 3.2 Other basic qualifications

All the respondents had fulfilled the requirements for the diploma in midwifery, and twenty eight found that midwifery was still applicable in their present post. Midwifery was accepted as an essential promotional qualification at the time that most of the respondents completed it.

Of the four who had acquired the diploma in psychiatry, three were in positions in which the qualification was used. In passing, one should note that psychiatry has only recently become a basic nursing qualification, and that those respondents with this qualification trained at a time when psychiatry was a post basic diploma.

4.1.3.3. Item 3.3 Post basic qualifications

Of the thirty seven chief professional nurses who participated in the study, thirty two had obtained post basic qualifications. Of these twelve had one post basic qualification, seven had two, eight had three, three had four, and two had five post basic qualifications. Five respondents had no post basic qualifications, all of whom were from the older group of chief professional nurses, their ages being from forty eight to sixty three years.

TABLE 4.5 Frequency distribution of post basic nursing qualifications of chief professional nurses

POST BASIC NURSING QUALIFICATIONS OF RESPONDENTS	FREQUENCY
Nursing Administration	20
Nursing Education	7
Community Nursing Science	14
Orthopaedic Nursing Science	2
Operating Theatre Nursing Science	8
Intensive Nursing	2
Ophthalmological Nursing	1
Paediatric Nursing Science	1
Oncological Nursing	1
Spinal Cord Nursing	1
Advanced Midwifery and Neonatology	3
Clinical Care Administration and Instruction	6
Ward Administration	2
General Nurse Instructor	1
Family Planning	2

(Note: There may be more than one post basic nursing qualification per chief professional nurse).

Relevant particularly to the present study is the fact that twenty of the chief professional nurses had a qualification in nursing administration while two were pursuing degrees in the subject. Seven had qualifications in nursing education and one was registered for a degree in nursing education. Fourteen chief professional nurses had completed diplomas or degrees in community

nursing science and two were involved in such courses. Nine of the older respondents (aged between fifty four and fifty nine) had a qualification (subsequently discontinued) in clinical care administration and instruction. These were obtained between 1967 and 1979. Other qualifications were in clinical specialities, the most common of which was operating theatre nursing science with eight chief professional nurses holding this qualification. At present a qualification in nursing administration (at diploma or degree level) and a qualification in a clinical speciality are recommended as requirements for promotion to the post of chief professional nurse.

4.1.4 Item 4 Experience

Respondents were asked how much experience they had received prior to their present post of chief professional nurse (figure 4.1).

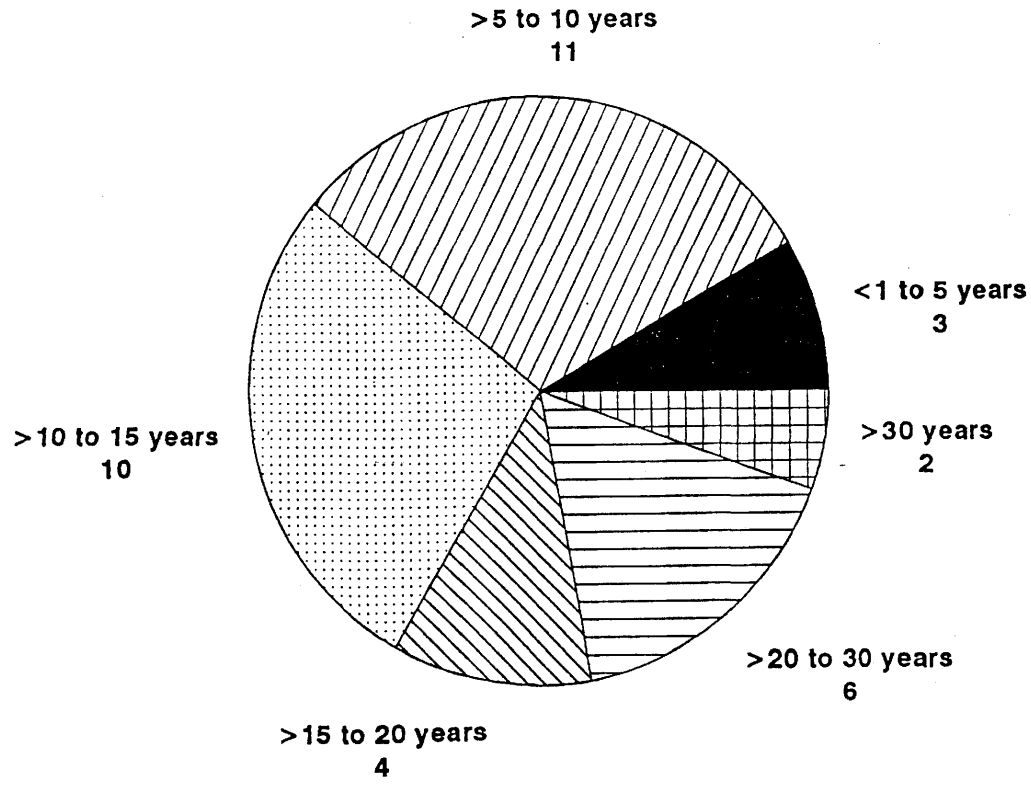


FIGURE 4.1 Length of experience prior to promotion as a chief professional nurse

The length of experience prior to promotion to the position of chief professional nurse ranged from eight months to thirty four years. The average length of experience was thirteen years and eight months. It is not surprising that the group was experienced given their relatively advanced age. Most had clearly been in nursing for many years.

Respondents were asked how much experience they had gained in the post of chief professional nurse (figure 4.2).

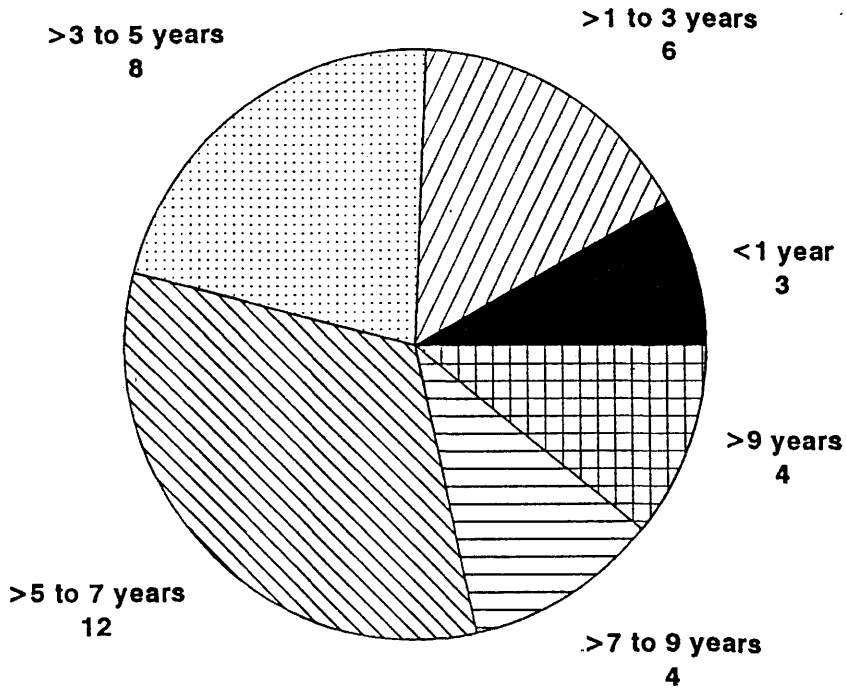


FIGURE 4.2 Length of experience gained as a chief professional nurse

The time spent in the chief professional nurse posts ranged from ten months to eighteen years and two months. Most chief professional nurses had been in their posts for less than ten years, and only three had been in their posts for over ten years. The average time spent in the post according to the respondents was five years and nine months.

The post of chief professional nurse has been in place for the past eleven years. Despite this, many respondents claimed that they had been in their posts for more than eleven years. In explaining this apparent anomaly one should point out that under the new dispensation for nursing which was implemented in 1982, service posts were renamed and the post of chief professional nurse replaced that of senior matron which had been a middle management position for some time. Those who indicated they had held their posts for more than eleven years were senior matrons under the old dispensation.

4.1.5 Item 5 Type of administrative orientation or training for chief professional nurse posts

The type of administrative orientation or training the respondents received for their positions as chief professional nurses is shown in table 4.6.

TABLE 4.6 Attendance at administrative orientation or training programme and number of respondents who found these programmes adequate

ORIENTATION OR TRAINING PROGRAMME	NUMBER OF RESPONDENTS	NUMBER OF RESPONDENTS WHO FOUND PROGRAMMES ADEQUATE
Administration diploma	15	12
Administration degree	5	5
Formal orientation	19	17
Junior management course	29	26
Senior management course	1	1
Mentor or buddy system	6	6
Client liaison	1	1
No orientation or training	1	-

(Note: More than one type of training may have been indicated).

Of the thirty seven chief professional nurses, twenty had a qualification in nursing administration, fifteen at diploma level and five at the graduate level. One of the chief professional nurses had a degree in a field other than nursing administration (see page 93). Of the fifteen with nursing administration at diploma level, twelve claimed that this qualification prepared them adequately for their management position. All the graduates shared this view. Nineteen chief professional nurses had received some formal orientation which had contributed to their preparation for their present position in the hospital in which they worked. Twenty nine had a Junior Management course with one having completed such a course at Senior Management level. Twenty six found this to be sufficient preparation for the position they held. Six had, in addition some other form of orientation since they had

experienced working with a colleague in the mentor or buddy system, and all these had found this an adequate orientation. One chief professional nurse had completed a client liaison course, and one respondent had no orientation or administrative training.

TABLE 4.7 Combinations of administrative orientation and training programmes of chief professional nurses

COMBINATIONS	TYPE OF ORIENTATION OR TRAINING PROGRAMME	NO. OF CPNS
One type of orientation or training	Junior management	11
	Formal training	5
Two combinations of orientation or training	Junior management + formal training	13
	Junior management + buddy or mentor	3
	Junior management + client liaison	1
	Formal training + buddy or mentor	1
Three combinations of orientation or training	Junior management + formal training + buddy or mentor	2

Sixteen chief professional nurses had only a single type of orientation or training, while the remainder had various combinations of training. The most common type of orientation or training was a combination of Junior management and formal training which was done at the hospital.

4.1.6 Item 6 Types of wards supervised

Of the thirty seven chief professional nurses twenty nine were working in

clinical areas and eight were in administrative or educational positions. The types of wards supervised by the twenty eight chief professional nurses in clinical areas is shown in table 4.7. (Note: there were a variety of wards supervised, many in combination with other areas, for example obstetrics and outpatient clinics or medical wards and psychiatry.)

TABLE 4.8 Wards supervised by chief professional nurses in clinical areas

WARDS SUPERVISED	NO. OF CPNS	COMBINATIONS OF AREAS
Medical	4	2 + psychiatry, 2 + outpatients
Psychiatric	2	
Surgical	1	1 + nurses' home
Paediatric	3	2 + milk room
Neonatal	3	3 + obstetrics
Obstetric	11	2 + theatre, 4 + clinics
Gynaecology	3	3 + outpatient clinics
Orthopaedic	1	
Intensive care	1	
Trauma/casualty	2	2 + outpatient clinics
Outpatients/clinics	3	1 + infection control & theatre
Theatre	4	4 + central sterilising dept.
Renal	1	
Central steril.dept.	4	
X-ray department	1	
Milk room	2	
Infection Control	1	

(Note: more than one area or ward supervised per chief professional nurse)

The areas supervised by the eight chief professional nurses in administrative or educational positions are shown in table 4.9.

TABLE 4.9 Areas supervised by chief professional nurses in administration and education

AREA SUPERVISED OR POSITION	NO. OF CPNS	COMBINATIONS OF AREAS AND COMMENTS
Nursing personnel dept.	3	
Inservice education	2	
Staff development	2	1 + nurses' home
Clinical coordinator	1	For diploma course in Advanced Midwifery and Neonatal Nursing Science
Liaison officer	1	

Some of the chief professional nurses in administrative or educational positions were also required to do weekend duties in clinical areas.

4.1.7 Item 7 Number of wards supervised - span of control

The purpose of the questions relating to the number of wards supervised was to afford an opportunity to calculate and examine the span of control of the chief professional nurse. For this purpose only those chief professional nurses in clinical areas were assessed.

The number of wards supervised ranged from two to eleven. One chief professional nurse in charge of outpatients was responsible for forty four clinics, but these were all in one area, and were therefore not included in the calculation. The mean span of control was 4.52 wards for each chief professional nurse.

4.1.8 Item 8 Disciplines of wards supervised

Middle management positions are normally defined geographically or by territory, patient condition, specialised function or time of work (see chapter 2, section 2.4). Respondents were asked to indicate whether they worked in areas in which the disciplines were similar or whether the areas were defined by patient condition. The respondents were unanimous in the view that the wards under their control belonged to the same specialised branch of medicine. An analysis of their responses however shows that this was not always the case, and that in some instances their supervision occurred across boundaries of medical specialities. Perhaps the chief professional nurses inadvertently assumed that supervising closely related medical specialities, such as obstetrics and neonatology or medicine and psychiatry, qualified them to classify their supervision under the same discipline.

4.1.9 Item 9 Geographical situation of wards/units

As noted earlier, the geographical situation of the ward is another criterion used to determine a middle management position. This is illustrated in figure 4.3.

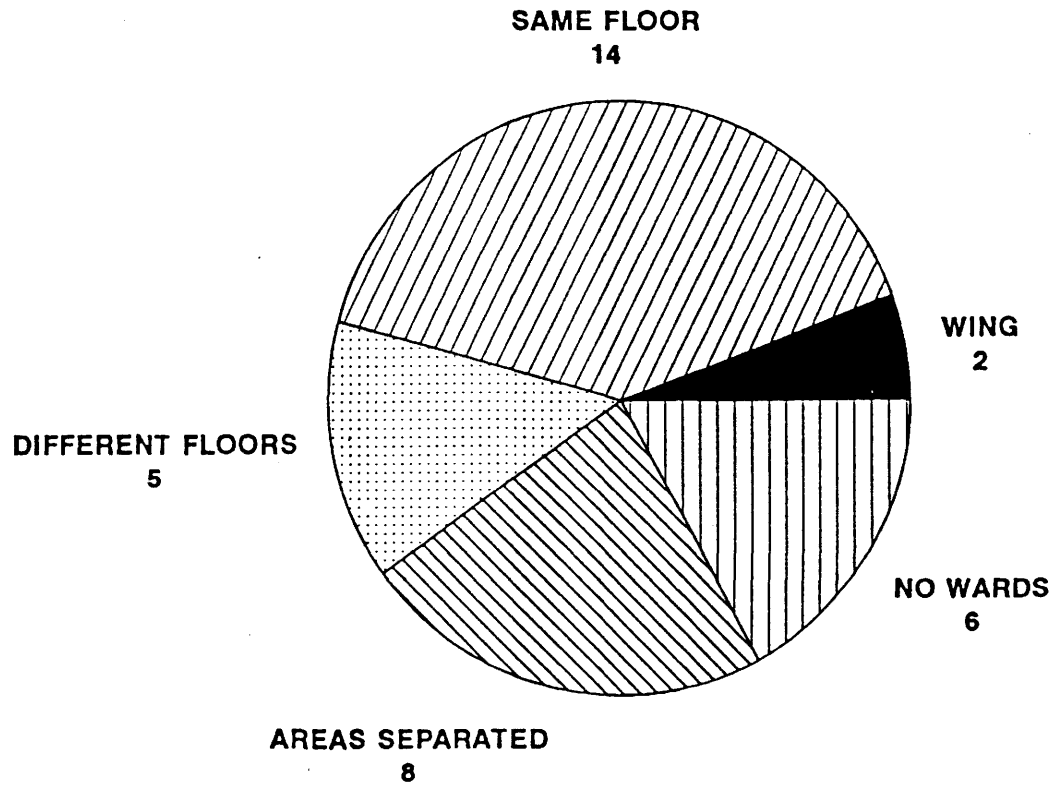


FIGURE 4.3 Geographical situation of wards supervised by chief professional nurses

Two chief professional nurses were in a wing, fourteen (with the exception of one whose discipline was beyond the hospital) were on the same floor, five worked on different floors, and eight had areas separated from each other in different buildings or geographical locations as for example wards in one area, and clinics in another.

4.1.10 Item 10 Job description

Item 10, the job description items, consists of both coded and uncoded sections (open ended responses). It is divided into four parts and has three principle objectives. The first establishes whether the respondent has been

given a job description (item 10.1), and the second whether the job description adequately describes the job which is performed (item 10.2). The third objective is to discover what they do (item 10.3) and what is not done (item 10.4) over and above the job description. From these responses it is possible to establish those activities which the respondent is undertaking but which should be done by other categories of staff. Secondly, the converse of this situation should be revealed when the respondent describes those activities which appear on the job description but for whatever reason are not performed by her.

For item 10.1 all thirty seven chief professional nurses who responded to the questionnaire confirmed that job descriptions for their posts were in place (see appendix I). Thirty three of these acknowledged that they were familiar with the contents and specifications described in these (item 10.2). Of particular significance however, is the fact that despite the acknowledgement noted above, all but four of the respondents (all drawn from the clinical group) specified a variety of activities which they performed which did not fall within the ambit of their job descriptions. This will now be examined.

In dealing with item 10.3 a brief analysis and appraisal is made of activities which fall outside the chief professional nurse's job descriptions. As was the case with item 6 (see 4.1.6, page 101), a division is once again made here between the twenty nine respondents who work in clinical areas (table 4.10) and the eight respondents in administration and education positions (table 4.11).

TABLE 4.10 Activities not listed in the chief professional nurses' job description but performed by them - clinical areas

ACTIVITIES NOT LISTED IN THE JOB DESCRIPTION	NUMBER OF RESPONDENTS
NON-NURSING DUTIES	
Supervision of non-nursing personnel - mainly at weekends, after hours and on night duty:	
• General - supervision of the hospital	3
• Porters	6
• Messengers	1
• Clerks	4
• Artisans and labourers	8
• Mortuary personnel	3
• General assistants/cleaners	5
• X-Ray personnel	2
• Drivers	1
Performing the work of non-nursing personnel:	
• General non-nursing administration	6
• Issuing drugs after hours and at weekends	11
• Collecting supplies during strikes	1
• Cleaning and dusting during strikes	5
• Acting as porters	2
• Sorting out laundry problems	1
• Maintenance e.g. replacing light bulbs	2
• Linen - checking and packing	4
• Inventory	4
• Duties for doctor's quarters - keys, accommodation	2
• Finding keys for ECG machine	1
• Making beds	2
• Bed allocation	1
CLERICAL WORK	
• New staff appointments	1
• Quarterly reports for staff on probation	1
• Motivations for night duty allowances	1
• Motivations for new equipment	1
MISCELLANEOUS	
• Scrubbing for operations	1
• Assisting relatives looking for relatives	1
• Doing statistics	1
• Counselling	1
• Education - on the job training, inservice education, organisation of workshops	4

(Note: more than one answer per respondent: n = 24)

Within the realm of non-nursing care a recurring theme involves the supervision of non-nursing personnel. In this regard most respondents noted

that in addition to their own work they were required to supervise clerks, messengers, labourers, general assistants, domestic workers and porters. The chief professional nurses were also sometimes called upon to perform routine maintenance operations, for example, the replacement of light bulbs. Of particular importance was the additional load placed on chief professional nurses by politically motivated strikes and disturbances during which they were required, amongst other things, to organise and perform cleaning duties, to do the work of porters and to make patients' beds.

Many respondents drew attention to the problem of issuing drugs and pharmaceutical preparations at times when the dispensary was closed. This placed an additional burden on them particularly at week ends and at night.

Laundry problems which included the checking of linen, the packing of linen for theatre packs, and seeing to the adequacy of linen for the hospital were also identified as areas or activities which did not appear on job descriptions. Evidence was presented by some respondents which suggested that some chief professional nurses were called upon to perform trivial tasks, such as seeking accommodation for newly appointed doctors, and finding keys for ECG machines for doctors after hours. Such intrusions on the time of senior personnel suggest the need for more control, a question which will be answered in the final chapter of this study.

Under the general heading of clerical work, respondents drew attention to problems associated with the preparation of quarterly reports for staff on probation and for new staff appointments. They also identified the preparation of motivations for new equipment and for night duty allowances, all of which fell beyond their job descriptions.

Not surprisingly, those aspects of their work which fell over weekends received particular attention, and while some of these have been mentioned before they should be noted again here. Respondents found sufficient cause to complain about their relationships with hospital artisans, the transport department, the hospital mortuary, the x-ray department, hospital labourers and clerical staff, porters, general assistants and the issuing of pharmaceutical preparations over weekends. Chief professional nurses indicated that being required to supervise the entire hospital over a weekend fell beyond their job description and greatly contributed to the psychological and physical stresses of their jobs.

Of lesser importance, in the sense that such complaints were not universally alluded to by respondents, were activities such as scrubbing for operations, assisting visitors and the community in finding relatives, completing statistics for other hospitals (where chief professional nurses are employed), and counselling and training staff in the use of different machines. These were all regarded as being beyond the job descriptions of respondents, but should in fact be included in them. This will be discussed further in the last chapter.

In encapsulating the foregoing description and itemisation of activities, one notes that although these are largely non-nursing functions, some of them are managerial functions. The findings on non-nursing functions are corroborated by van Tonder (1987: 336) where it was established that professional nurses spent 46.3 percent of their time performing non-nursing duties. Her sample consisted of 22 nurse managers, 59 senior professional nurses and 196 registered nurses.

Table 4.11 lists the work done by the chief professional nurses employed in administrative and educational areas which are not listed in their job descriptions.

TABLE 4.11 Activities not listed in the chief professional nurses' job description but performed by them - administration and education

ACTIVITIES NOT LISTED IN THE JOB DESCRIPTION	NUMBER OF RESPONSES
CLERICAL WORK	
• Charting leave	2
• Maintaining inservice education records	2
• Compiling statistics	1
• Filling in on duty schedule sheets	1
OTHER	
• Drawing up inservice education programmes	1
• Photocopying	1
• Running errands	1
• Issuing salary advice slips	1
• Controlling hospital keys	1
• Supervising domestic staff	1

(Note: more than one answer per respondent: n = 4)

It is readily apparent that the emphasis here is on different work areas (table 4.10). Among these problems are the charting of inservice education records, the clerical work and charting associated with student's leave, the compilation of statistics and the preparation of monthly duty rosters. All these fall within the ambit of clerical work and are unrelated to clinical responsibilities. In the same way these respondents also complained of being given errands to run, being given the control of hospital keys and being burdened with the supervision of domestic staff.

The respondents were directed in item 10.4 of the questionnaire to list those activities which appear in the job description, but which for some reason are

not done. As was the case with the previous response the thirty seven respondents are again treated as two groups. Only ten respondents in the clinical group, and six from the smaller group who were in administration and educational positions answered this question. This poses a problem of drawing conclusions from such a small response.

TABLE 4.12 Activities listed in the chief professional nurses' job description but NOT performed by them - clinical

ACTIVITIES LISTED IN THE JOB DESCRIPTION BUT NOT DONE	NUMBER OF RESPONSES
PATIENT CARE	
• Direct patient care	1
• Emergency care	1
• Welcoming patients on admission	1
• Doctors' ward rounds	1
EDUCATION	
• Ward education	1
• Teaching and evaluation	1
ADMINISTRATION	
Organising	
• Organisation	1
• Preparation of agenda for monthly meetings	1
Finance	
• Assisting with preparation of the budget	2
• Identification of needs for new equipment	1
• Motivating for new equipment	2
• Making salary adjustments	1
Personnel	
• Predicting staffing needs	1
• Recruitment of nursing personnel	2
• Interviewing nursing personnel	1
• Allocation of nursing personnel	1
• Counselling	1
• Follow-up and feedback on personnel matters	1
Control	
• Supervision - span of control too broad	2
• Ward inspections	1
• Checking patient records	1
• Attending weekly multi-disciplinary ward meetings	1
• Sepsis control	1
RESEARCH	
• Mini surveys on sepsis	1

(Note: more than one answer per respondent: n = 10)

The responses of the clinical group fell into four broad categories. According to the replies, the first category indicated that involvement in patient emergency care was limited. In the second category two respondents indicated that they were not involved in ward education, teaching and evaluation.

Thirdly, various aspects of the management processes are mentioned. Aspects of organising were noted, including the preparation of agenda for meetings and a lack of time to attend weekly and monthly ward meetings. A common complaint referred to was budgeting. Chief professional nurses were not involved in the hospital budget at the management level, were not involved in identifying the need for new equipment and in motivating for it, and were generally omitted from discussions on salary adjustments. Some respondents believed that the requirement in their job description that they be involved in recruiting, interviewing and allocating nursing personnel was seldom possible as this function devolved upon more senior personnel in all the hospitals surveyed. With regard to control, respondents identified a lack of time for adequate supervision, an inability to complete inspections and to check records.

One respondent said that there was little or no time for research and little motivation to become involved in it.

TABLE 4.13 Activities listed in the chief professional nurses' job description but NOT performed by them - administration and education

ACTIVITIES LISTED IN THE JOB DESCRIPTION BUT NOT DONE	NUMBER OF RESPONSES
PATIENT CARE	
• Direct patient care	3
• Setting standards for patient care	1
EDUCATION	
• Participation in the orientation of students	1
• Recording inservice education	1
PERSONNEL	
• Staff planning	1
• Selection committee work	2
• Staff allocation	1
• Follow-up of new personnel	1
• Follow-up of bridging course students	1
• Recommendations for salary increases	1
• Implementation of disciplinary action	1

(Note: more than one answer per respondent: n = 6)

Turning to the second group of chief professional nurses, those involved in administrative and educational positions, one has a similar set of factors to consider. This group also identified some aspects of direct patient care, which is anomalous in their case and was possibly the function of their weekend duties. Concerning education, the recording of inservice education and participation in student orientation was not done. With regard to personnel, staff planning and allocation, selection committee work, the follow-up of new personnel and bridging course students, participation in salary adjustments and the implementation of disciplinary action, were all items mentioned as appearing in the job description which were not done. Also identified in this regard were nursing audits.

As there were not many responses, it would appear that job descriptions closely matched their jobs.

4.1.11 Item 11 Positive and negative aspects of the job

Item 11 in the questionnaire is divided into two parts, and seeks responses to positive and negative aspects of the job. The first question poses the question: "What aspects of your work do you like the most?" The responses are, as in the case of some of the preceding items divided between the twenty nine respondents whose jobs are clinically orientated and the eight respondents whose orientation is towards administration and education.

A superficial scrutiny allows one to classify the responses into four broad categories under the headings of patient care, education, administration and research. As this was an open-ended question, many of these responses could have been included under one heading, but the exact wording of the respondents was transmitted.

TABLE 4.14 Frequency distribution of clinically orientated respondents' replies as to what aspects of their work they liked most

ASPECTS LIKED	NUMBER OF RESPONSES
PATIENT CARE	
• Patient care	17
• Bedside nursing	1
• Counselling patients	1
EDUCATION	
• Education	7
• Teaching	18
• Training	2
• Inservice training	3
• Intensive ward rounds	1
• Orientation	1
• Preparation for and conducting Junior Management courses	1
• Staff development	3
ADMINISTRATION	
PLANNING AND ORGANISING	
• Administration	9
• Staff allocation	1
• Programming night duty for nursing staff	1
• Processing leave forms	1
• Meetings	2
• Liaison with medical staff	1
• Committee work	1
FINANCE	
• Motivating for new equipment	1
PERSONNEL	
• Communication with staff, patients, community	1
• Communication with doctors, staff and students	1
• Liaison with the media	1
• Personnel evaluation	2
• Preparation of reports	1
• Counselling (personal staff problems)	2
• Problem solving	1
• Problem solving meetings (education, student training, administration)	8

TABLE 4.14 (continued)

ASPECTS LIKED	NUMBER OF RESPONDENTS
CONTROL	
• Supervision	6
• Ward rounds	1
• Ward inspections	1
• Inventory	1
• Auditing	3
• Checking and replenishing equipment	1
• Control	1
• Control (drugs - checking, counting, recording)	1
• Control of equipment	2
RESEARCH	
• Research	2
PROFESSIONAL DEVELOPMENT ACTIVITIES	
• Attending inservice education workshops and symposia	1
OTHER	
• Night duty	4

(Note: more than one comment per respondent: n = 23)

From the responses in the clinical group of chief professional nurses, it is apparent that the strictly nursing aspects of the chief professional nurse's functions are highly placed within their scale of preferences. More specifically, they point to patient care, especially solving patient's problems, and the supervision and coordinating of nursing, bedside nursing and patient counselling as areas of great professional reward. This is an aspect of the response pattern which bears further scrutiny because these individuals who have become chief professional nurses have moved away from patient care and bedside nursing towards administrative and supervisory activities.

This response therefore conflicts with the career path which they have chosen since by virtue of their promotion from the ward to middle management they have had to abandon those aspects of nursing to which they are most attracted.

This follows from the fact that the highest grade of professional activity with a patient care orientation is the senior professional nurse, a position which does not have the remuneration, the authority or the status of the chief professional nurse.

The second broad area of professional interest which acquires a favourable rating from the questions posed falls within the general area of education. Most respondents identified teaching, bedside education, education in workshops, informal teaching and orientation, and staff development as activities which they found rewarding. This is not surprising when one recalls that one of the main components of the job description of the chief professional nurse is teaching and education in general. It is also not remarkable since over twenty per cent of the respondents are either educationally qualified (in nursing education) or proceeding to become so (see item 3.3).

The third area in which some uniformity of response is apparent is that of administration. The responses range widely across many facets of administration, but for ease of analysis they can be grouped under the categories of the generic or administrative processes. One therefore notes an appreciation for staff allocation processes and committee work in the first instance (policy and planning), staff programming, processing of leave applications and meetings in the second (organising), and the preparation of reports and financial services in the third (finance). Fourthly, many respondents derived considerable satisfaction from counselling, from solving problems, from communicating with staff and from doing evaluations of personnel (personnel). Finally, and perhaps most importantly widespread congruency emerged with regard to control, an area in which supervision, ward

rounds and inspection, inventory and auditing, checking and replenishing of equipment and checking, counting and recording of drugs was apparent (control).

Very few respondents found satisfaction from doing research, in fact the evidence points more to its total absence in the professional lives of any of the group than to its presence. In quantitative terms only two of the twenty nine respondents in the first group (clinical) referred to research as an area of interest and fulfilment. This is an important omission since research activities are a corner stone of the job description of chief professional nurses in the type of hospital investigated. It is also not improbable that many of this group of respondents are inadequately prepared to undertake research in their areas of professional interest, and this may well be an important area for staff development which will be referred to in the final chapter of this study.

Some responses fell beyond the categories identified above, one such being the frequent preference for night duty and the rewards gained from attending inservice educational workshops and symposia.

Turning to the second group of respondents, those in administration and educational areas, one finds their responses conforming closely to their professional activities.

TABLE 4.15 Frequency distribution of administrative and educationally orientated respondents replies as to what aspects of their work they liked most

ASPECTS LIKED	NUMBER OF RESPONSES
EDUCATION	
• Education	1
• Teaching	2
• Inservice training	2
• Clinical teaching	2
• Orientation	2
• Doing practical examinations	1
ADMINISTRATION	
• Administration	2
• Organisation - management meetings	1
• Problem solving	1
• Meetings	1
• Selection of student nurses	1
• Interviewing	1
• Disciplining	1
• Counselling	1
• Evaluation of proficiency	1
RESEARCH	
• Research	2
LIAISON OFFICER	
• Student contact	1
• Student conferences	1
• Bridge between college and hospital	1

(Note: more than one comment per respondent: n = 8)

Formal and informal teaching, inservice education, the demonstration of procedures in clinical situations, orientation and conducting practical examinations were all part of a general educationally orientated profile of interest. The second broad category of interest converged upon organisation, problem solving, selection procedures, interviewing and counselling, conducting disciplinary hearings, and evaluating efficiency, all of which would fall under the general heading of nursing administration. Unlike the

first group (the clinical group), research interests played a much greater role among respondents of the second group with a quarter of respondents showing interest and gaining personal rewards from this facet of their work.

The final item in the questionnaire, 11.2, poses the question: "What aspects of your work do you like least?". As with previous items, consideration is given in the first instance to the responses of the twenty nine chief professional nurses in clinical areas (see table 4.16).

TABLE 4.16 Frequency distribution of clinically orientated respondents' replies as to what aspects of their work they disliked

ASPECTS DISLIKED	NUMBER OF RESPONSES
PATIENT CARE	
• Poor standard of patient care	1
• Coping with death	1
EDUCATION	
• Teaching general workers - negative attitudes	1
ADMINISTRATION	
• Clerical work	3
• Inventory and condemning equipment	2
• Supervision, ordering of supplies and stock	1
• Ward inspections	1
• Checking emergency trollies	1
Personnel	
• Staff allocations	1
• Staff evaluations	8
• Disciplining staff	3
• Counselling staff- solving personnel problems	3
• Conflict with personnel	1
• Supervision of non-nursing personnel	3
OTHER	
• Working in other areas	8
• Doing unpleasant shifts - evenings, weekends, night duty	3
• Meetings	1
• Porter's work	1
• Control of keys	1
ROLE CONFLICT	
• Middle man between management & subordinates	1
• Conflict between zonal duties and nursing administration department	2

(Note: more than one comment per respondent: n =25)

Immediately apparent is an overt hostility to requirements and demands from individuals and in areas which are considered beyond the scope of the job description. There is a general dislike for working in geographical areas which are remote from the chief professional nurses' designated localities, caring for other disciplines, supervising non-nursing personnel, especially labourers and house-keepers, and having responsibility for keys for areas which are unrelated to the chief professional nurses' areas of responsibility. Also within this area many respondents cited the irritation of solving problems after hours such as attending to the pharmacy, to problems of the transport department and solving problems in other areas, one of which cited frequently was in the x-ray department.

Another broad area of consensus emerged in the realm of interpersonal relationships. Also mentioned was the problem of insubordination, a problem which may have its roots in the newfound militancy of student nurses and other assistants, which is probably part of the surfacing of politically related and labour dominated issues in South African society. Possibly unrelated to this, but within the same general area of dissatisfaction was the respondents' dislike of conflict with paramedics and administrative staff. They disliked investigating irregularities, even in their own geographical area of control, and also disliked giving reprimands and imposing discipline, counselling and interviewing.

Eight respondents believed that their time was wasted on clerical work, much of which was described as being of the "essay type", but which in reality encompassed appraisals, evaluations, and assessments. Few respondents enjoyed night duty, possibly a reflection of their age, and most shunned weekend duties and evening shifts. A common denominator appears to be a general

antagonism towards non-nursing staff who many chief professional nurses found had a negative attitude to their work, a lack of understanding, no respect for professional nurses, and a destructive affinity with the trade union NEHAWU (National Educational Health and Allied Workers Union). Some went so far as to say that all forms of discipline are futile. A similarly repetitive theme of responses is a dislike of being sandwiched between management and subordinates. This, which some call "the neither fish nor fowl syndrome", places the chief professional nurse in an invidious position with too much authority for what falls below but not enough for that which comes from above.

TABLE 4.17 Frequency distribution of administrative and educationally orientated respondents replies as to what aspects of their work they disliked

ASPECTS DISLIKED	NUMBER OF RESPONSES
EDUCATION	
• Inservice education - due to poor attendance and negative attitude	1
ROUTINE	
• Checking on student absenteeism	1
• Planning off duties	1
• Compiling annual hospital reports	1
• Staff allocation	1
• Writing incident reports	1
• Compiling statistics	1
• Correspondence	1
OTHER	
• Meetings with management and with members other than nurses	2
UNPLEASANT DUTIES	
• Termination of services	1
• Breaking news to students about their unsuccessful examination results	1

(Note: more than one comment per respondent: n = 8)

Turning to the second group of respondents, those in administration and education, one finds the most noteworthy dislikes are those associated with routine activities. In fact it seems that the day to day similarities and consequences of routinely practised activities such as checking on student absenteeism, planning off duties, compiling annual hospital reports, doing staff allocation, writing incident reports, dealing with correspondence and compiling statistics are collectively the factors which, to quote one respondent, "destroy an enquiring mind", and "eliminate the challenge from the job".

Two respondents in this group pointed to the tedium of meetings with members of their hospital staff who were not part of the nursing staff. They pointed particularly to their dislike of meetings with management which they found psychologically disruptive and an intrusion of and an impediment to their normal activities. Some disliked inservice education because of poor attendance and a negative attitude, while evident from the responses was a uniformly negative attitude to clerical work. Unpleasant duties such as terminating services and breaking unpleasant news to students were also disliked.

Encapsulating this item, one notes many similarities between the two groups, so much so that these tend to outweigh the differences, but of greater significance is the apparent congruency between the responses noted here and those recurrent themes which became evident in the literature survey described earlier. This congruency must however not be taken for granted, but must in each case be established. It will be the subject of the following chapter.

4.2 CHIEF PROFESSIONAL NURSE ACTIVITIES

The second section of the questionnaire contains five sub sections which are designed to provide insights into the amount of time spent by chief professional nurses on their daily activities. Each respondent was required to code the time devoted to patient care/consultation, education, administration, research and professional development activities. The questions concerning patient care/consultation are divided into three parts, namely direct patient care, indirect patient care and consultation. Those relating to administration are divided into planning, organising, finance, personnel, procedures and control (see page 78).

A five point Likert scale was used to establish a daily and/or weekly estimate of the amount of time spent on each of the activities listed in the questionnaire. The time period for each rating on the scale was averaged to obtain the mean number of minutes for that period. These are designated below:

0 - occupies none of your time = 0 minutes
1 - less than 1 hour per day = 30 minutes
2 - between 1 and 2 hours per day = 90 minutes
3 - between 2 and 3 hours per day = 150 minutes
4 - more than 3 hours per day = 300 minutes
(an eight hour day)

These time periods were multiplied by the scale item indicated for each activity on the questionnaire given by the respondents (see appendix J). From this figure the total number of minutes spent on each activity per day per

nurse was calculated. These totals were then converted to percentages. The percentages of the activities are represented as bar charts.

Chief professional nurses are required to work a forty hour week (2400 minutes), and although they may work six, eight or twelve hour shifts, these average to five eight hour days a week (an average of 480 minutes per day). The totals established using the data above greatly exceeded this. This was to be expected for the reasons explained below:

1 There were a large number of activities to which responses were required (seventy four). This made it difficult for the respondents to allocate their time realistically.

2 Respondents did not realise that time spent on all the activities in this section constituted one day's work. Most allocated a greater amount of time to each activity than they should have.

3 Some activities which are performed once a week or once a month, were shown as if done on a daily basis.

4 Some chief professional nurses inadvertently based their responses on a twelve hour day.

5 The questions in section 2 might have been mutually exclusive so there may have been some overlap in what was asked.

The percentages shown are of the time spent on each activity relative to the others. As there were seventy four activities, the percentages for individual activities are small, however, when the main categories of activity are compared one to another the differentiation is realistic.

4.2.1 Patient care/consultation

Figure 4.4 indicates the amount of time spent by the respondents on direct patient care, indirect patient care and consultation (see page 78). As there are many items, they are not listed in a key, but each item is discussed in the ensuing discussion.

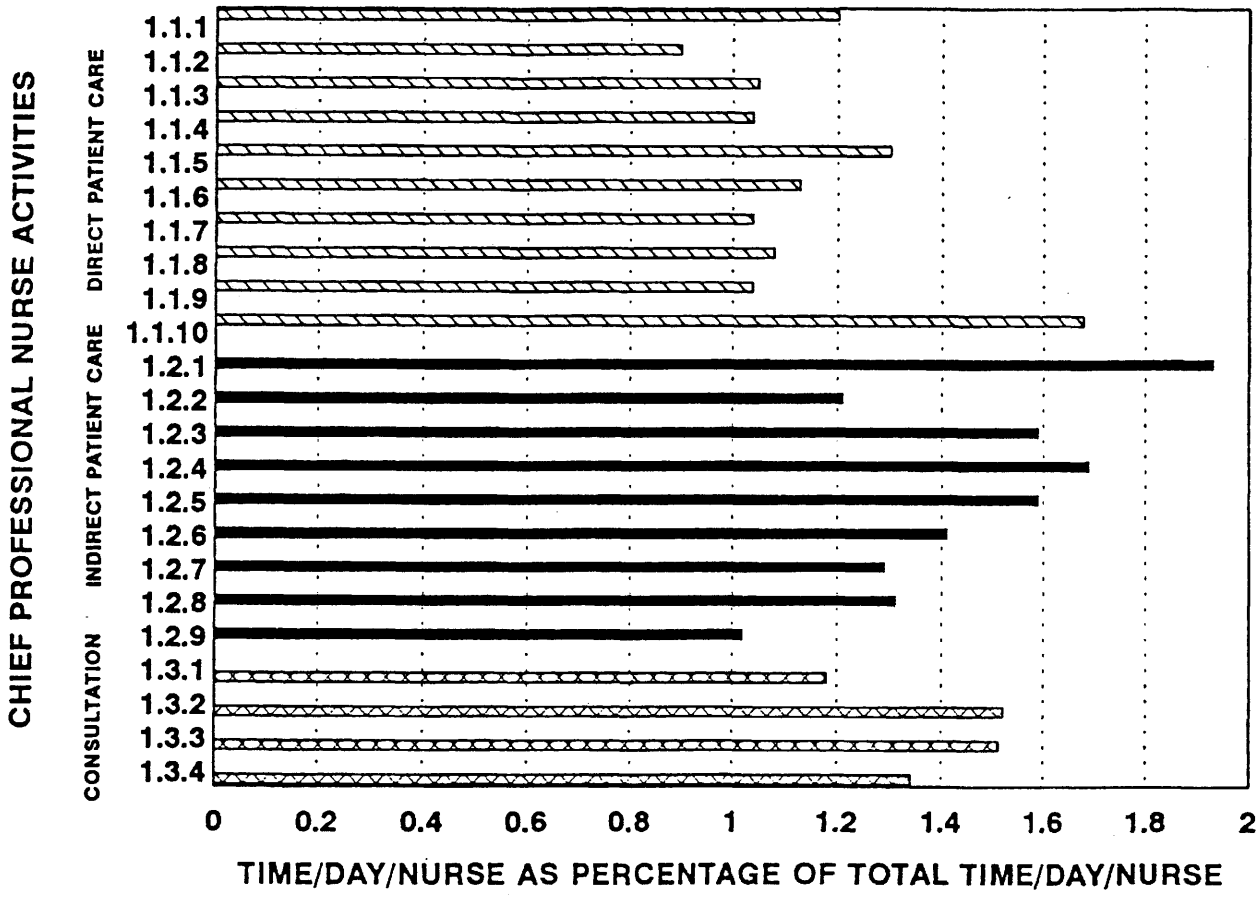


FIGURE 4.4 Percentage time spent by chief professional nurses in direct patient care, indirect patient care and consultation.

4.2.1.1 Direct patient care

In direct patient care most time (1,68 %) was devoted to communicating direct care information to medical and nursing staff and other disciplines (activity 1.1.10). This was followed by a response to which chief professional nurses indicated the time (1,3 %) devoted to performing and recommending nursing measures which enhanced the physical comfort of patients (activity 1.1.5). Third, was the time (1,20 %), they were involved in assessing and planning nursing care (activity 1.1.1). Next was the amount of time (1,12 %) spent functioning as a role model at the bedside (activity 1.1.6). Of least importance was the activity (0,89 %) devoted to the assessment of the psychological needs of patients and their families (activity 1.1.2). The five other direct patient care response times fell within these parameters and were characterised by a high degree of similarity ranging from 1.03 % and 1,08 %.

From these results it is apparent that the chief professional nurse has considerable input into the coordination and guidance of staff and in providing quality nursing care. Much of this is done at the bedside or on patient rounds.

4.2.1.2 Indirect patient care

Considerable time in terms of indirect patient care (1.93 %) was devoted to developing and raising standards of nursing practice (activity 1.2.1). This contrasted with the last question in this section (activity 1.2.9) which called for an estimate of the time spent interpreting, evaluating and communicating research findings to nursing staff (1,01 %). This confirms the findings alluded to earlier (see page 118) and also in a subsequent section

of the questionnaire, that research forms a very small part of the chief professional nurses' daily activities. Other responses to this question revealed a close convergence between time spent on other indirect care activities (ranging from 1.60 % to 1,21 %). In all but two of these indirect patient care activities, figures were higher than those given in response to time spent on direct patient care.

4.2.1.3 Consultation

In the third part of this question respondents were asked how much of their time was spent on consultation. From these responses it is apparent that most time (1,52 %) was spent offering specialised knowledge in clarifying and solving problems of patient care, in nursing diagnostic formulations, in clinical recommendations for care, and in attending to the informal learning needs of staff (activity 1.3.2). Approximating this response (1,15 %) was the amount of time spent offering specialised knowledge and skill in assisting with the management of difficult patients and family problems (activity 1.1.3). These last two remaining activities in this section on consultation were both demanding of the chief professional nurses' time and ranged between 1,34 % and 1,18 %.

4.2.2 Education

The second part of the second section of this questionnaire sought to establish the time chief professional nurses spent on educationally related activities.

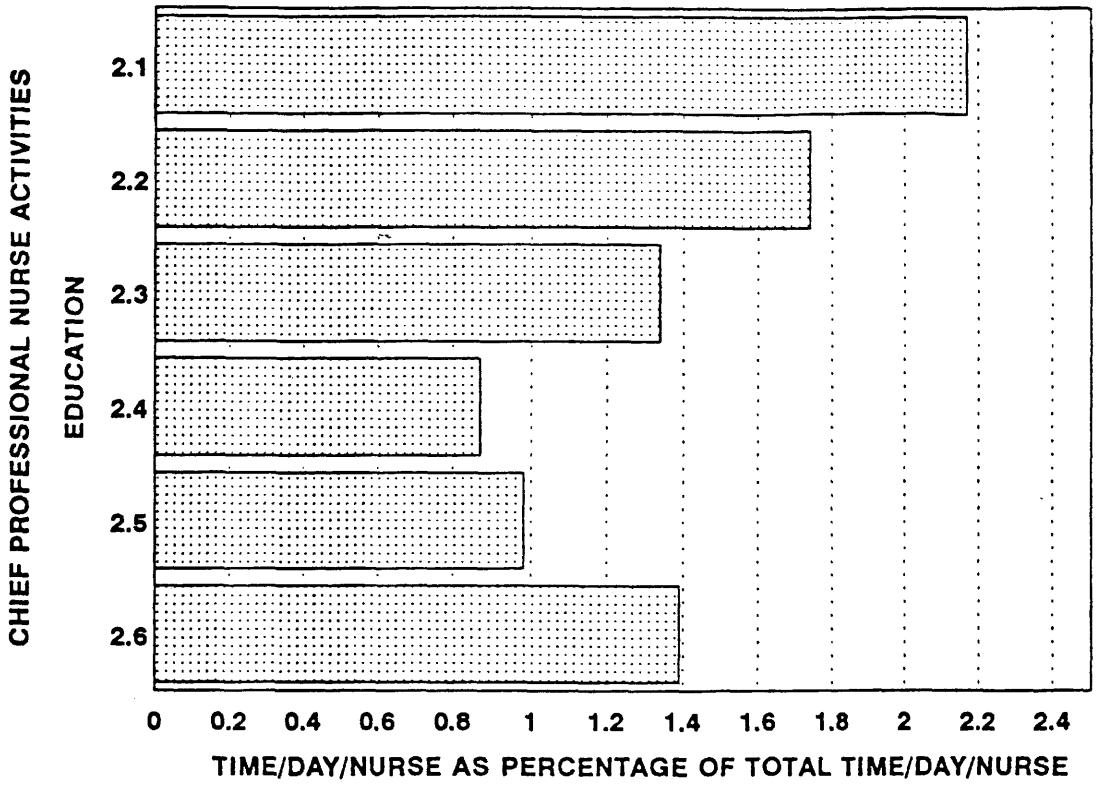


FIGURE 4.5 Percentage time spent by chief professional nurses in education

Responses to these questions fluctuated widely and ranged from 2.17 % of time spent on inservice educational activities in the ward or unit (activity 2.1), to 0.86 % of time spent on activities in the nursing school relating to the evaluation of practical examinations (activity 2.4). Chief professional nurses also devoted considerable time (1,74 %) to participation in the assessment, planning and implementation of educational activities and programmes departmentally, and to those sponsored by nursing education departments (activity 2.2). Another item which attracted considerable time (1,34 %) was the direction and orientation of new employees (activity 2.3).

4.2.3 Administration

Administrative activities were reviewed in the third section of the second questionnaire and are illustrated in figure 4.6.

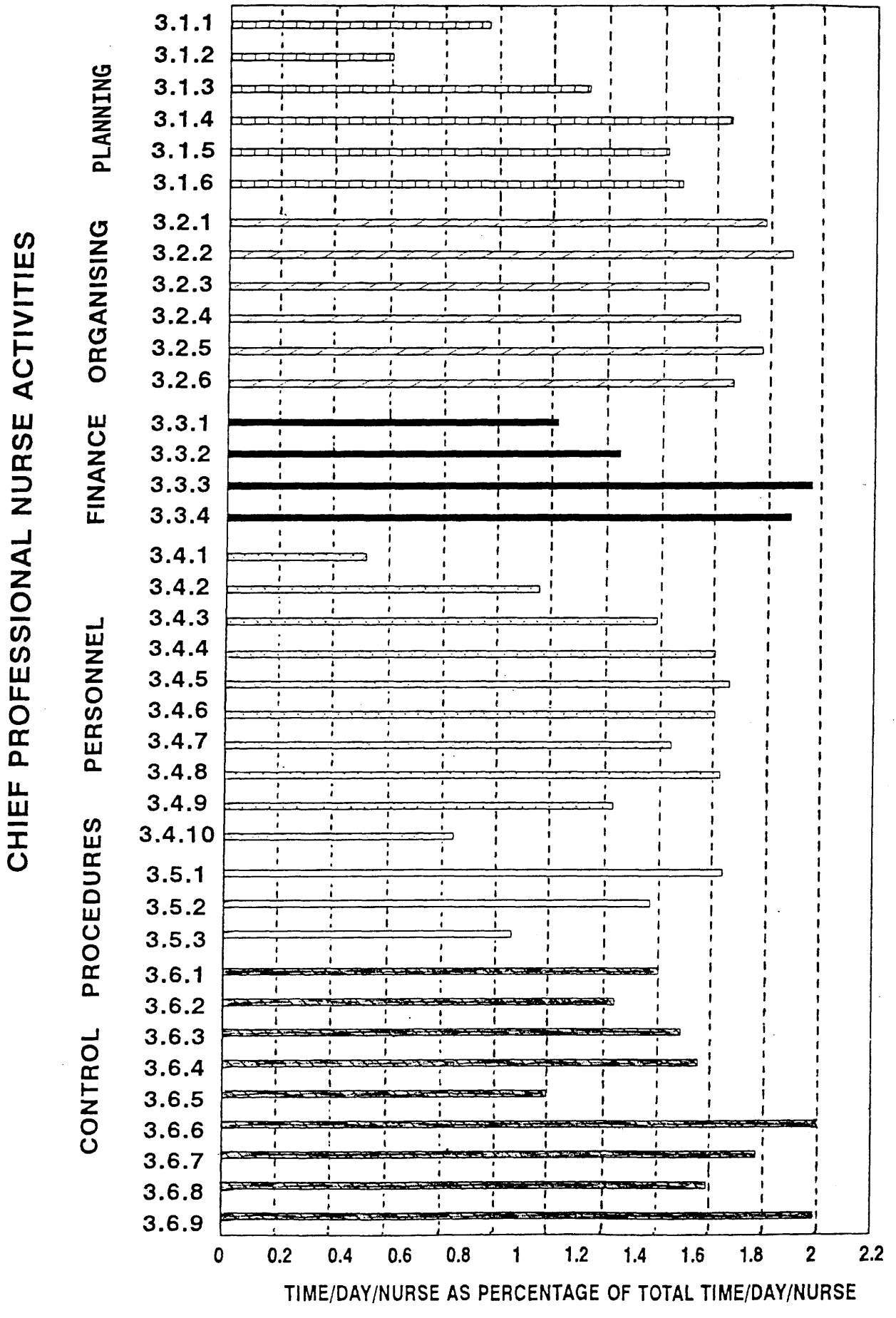


FIGURE 4.6 Percentage time spent by chief professional nurses in administration

Of the six administrative processes identified, that process relating to control was most demanding in terms of the chief professional nurses' time. The highest individual response (2%) of all the management processes was found within this process of control. This relates to the inspection of wards/units and the assessment of the environmental and safety conditions in the areas supervised (activity 3.6.6). Next in order was personnel, followed by organising, planning, finance and procedures. Each subsection is elaborated below.

Within the administrative process of planning, most time was spent on ways of solving problems and making improvements in the delivery of patient care (activity 3.1.4). This was followed by setting nursing service objectives for wards/units (activity 3.1.6), participation in departmental committee work and administrative meetings (activity 3.1.5) and designing methods to implement policy (activity 3.1.3). Least time was allocated to membership of nursing service committees such as those on infection and standardisation (activity 3.1.1) and those on hospital planning (activity 3.1.2).

The time given to each of the organising activities was similar. Most time was spent on attending chief professional nurse meetings and related administrative activities (activity 3.2.1). Rather less was devoted to the following: participation in the decision making process at the unit level (activity 3.2.2), keeping senior nursing personnel informed on reportable situations (activity 3.2.5), supporting personnel to implement policy (activity 3.2.4), recognition of performance, creativity and utilising crisis situations to effect positive change (activity 3.2.6) and implementing change (activity 3.2.3).

The most important of the finance activities was that of ensuring cost effective performance of personnel (activity 3.3.3), followed by cost containment (activity 3.3.4). Less time was spent on budget preparation (activity 3.3.1) and motivating for new equipment (activity 3.3.2).

The time devoted to personnel functions showed a wide range of variation from conducting performance appraisals (activity 3.4.5) to the appointment of personnel (activity 3.4.1). Much the same attention was given to report writing (activity 3.4.8), counselling (activity 3.4.6) and performance evaluation (activity 3.4.4). In descending order were managing grievances (activity 3.4.7), organising staffing (activity 3.4.3), assembling statistics (activity 3.4.9), allocating staff (activity 3.4.2) and involvement in labour relation disputes (3.4.10).

The most demanding aspect of work procedures was monitoring the updating of policy manuals and South African Nursing Council regulations (activity 3.5.1) followed by interpreting nursing policies (activity 3.5.2) and evaluating these (activity 3.5.3).

Most time on control was devoted to ward rounds (activity 3.6.9) and safety inspections (activity 3.6.6), while least was spent on emergency evaluation (activity 3.6.5). An even distribution of time is evident among other activities such as nursing audits (activity 3.6.2), evaluating records (activity 3.6.3), analysing ward statistics (activity 3.6.4), controlling drugs (activity 3.6.7) and handing over reports (activity 3.6.8).

4.2.4 Research

Time devoted to research is shown in figure 4.7

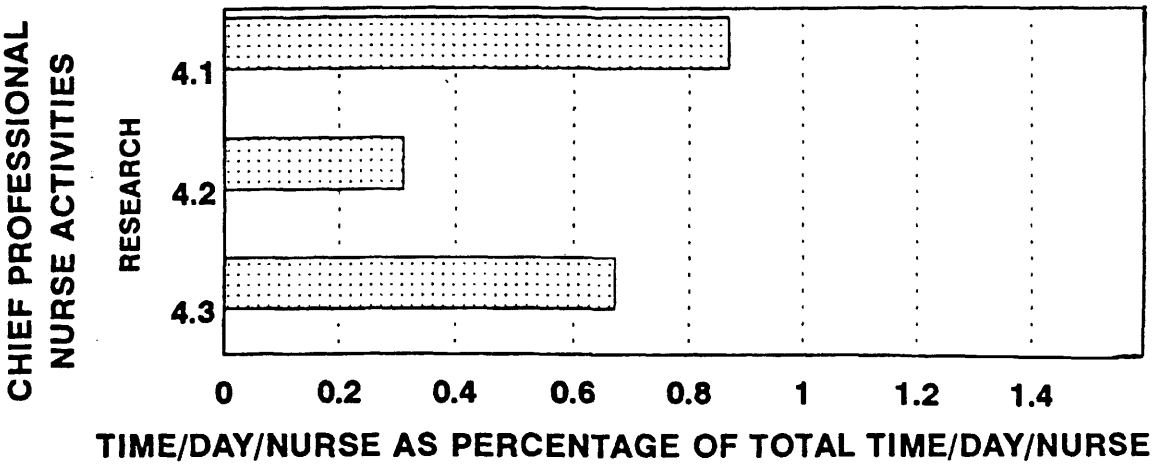


FIGURE 4.7 Percentage time spent by chief professional nurses in research

These times were the lowest of all the activities and ranged from 0.31 % for research activities in which the individual either generated the study or tested known research findings (activity 4.2) to 0.86 % where the chief professional nurse adopted the position of a collaborator, usually in a joint research project (activity 4.1). The time taken to fill in the questionnaire for this study would have been included under collaboration.

4.2.5 Professional development activities

Finally time devoted to developing personal, professional qualities and characteristics is shown in figure 4.8.

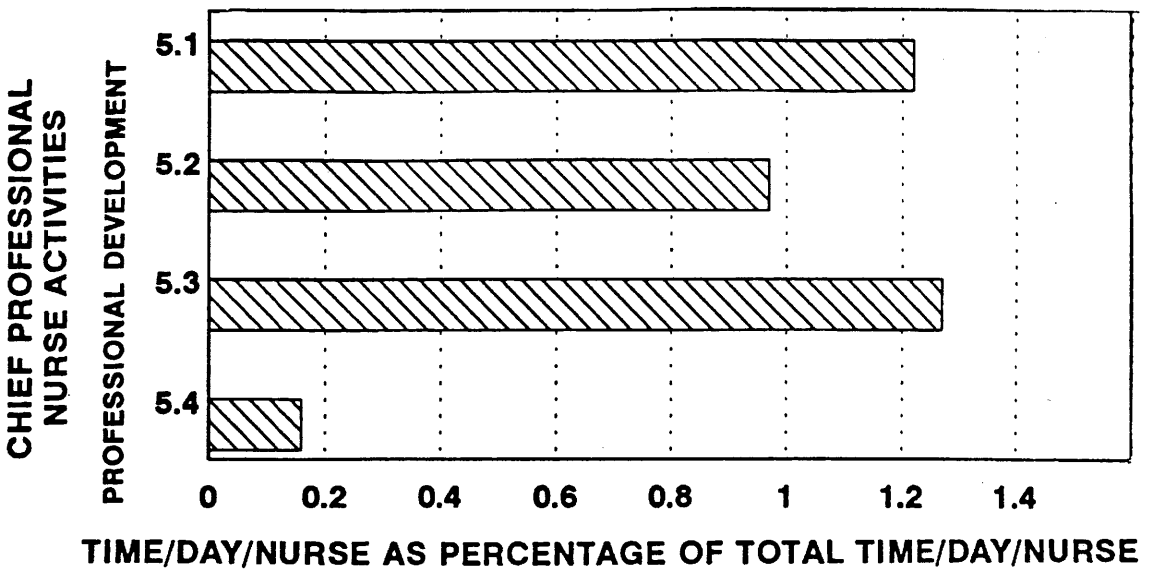


FIGURE 4.8 Percentage time spent by chief professional nurses in professional development

These results fluctuated widely (1.27 % to 0.16 %) from writing for publications other than those associated with research (activity 5.4) to continuing educational activities beyond the work environment (activity 5.3).

4.2.6 Summary of chief professional nurse activities

Figure 4.9 encapsulates the responses of all the questions in Section 2.

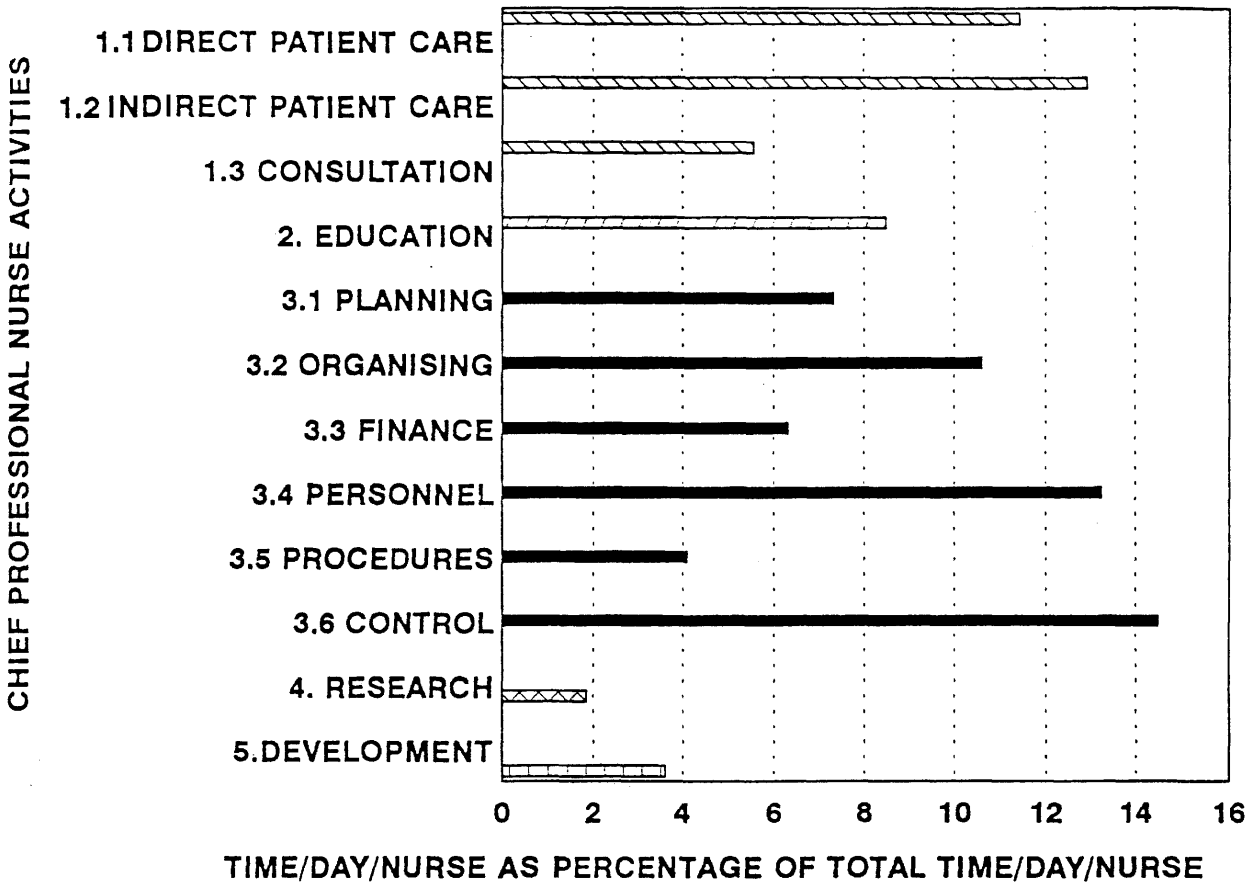


FIGURE 4.9 Time spent by chief professional nurses in the main functions

Of the twelve main functions, the administrative process of control absorbed the most time (14,50 %), followed by activities dealing with personnel (13,25 %). Indirect patient care (12.95 %) was followed by direct patient care (11.45 %). Education came sixth (8,49 %). Penultimate was professional development (3,62 %) and finally research (1,85 %).

It is evident that most of the chief professional nurses' time in the sample of respondents was devoted to administration (56.09 %), followed by patient care/consultation (29.95 %) and education (8,49 %). Much less time was spent on the professional development activities (3,62 %) and research (1,85 %).

4.3 MINNESOTA SATISFACTION QUESTIONNAIRE

The third section of the questionnaire employs the shorter version of the Minnesota Satisfaction Questionnaire in obtaining responses to the statement "In my present job, this is how I feel about ...". The Minnesota Satisfaction Questionnaire has been described in chapter 3 with its applications in South Africa (see page 80).

The Minnesota Satisfaction Questionnaire has twenty items and in the present analysis in which all thirty seven respondents participated, the means were used to rank the satisfaction items (see table 4.18 and figure 4.10). Each response carried a scoring weight ranging from 1 for **very dissatisfied** to 5 for **very satisfied**. Raw scores (totals) were determined for each scale by adding the scoring weight for each respondent. The means of raw scores were then calculated. Item 1 '**activity**' is used as an example of how raw scores and means are calculated in table 4.18.

Raw score = sum of (frequency x scoring weight) of each response

= (1 x 1) + (5 x 2) + (6 x 3) + (19 x 4) + (6 x 5)

= 135

Mean = $\frac{\text{Raw score}}{\text{Sum of frequencies}}$

= $\frac{135}{37}$

= 3.65

(Frequency = number of chief professional nurses choosing a particular response)

The twenty items were ranked according to the means and in this way the rankings indicated areas of relatively greater, or lesser, satisfaction.

TABLE 4.18 Results of responses to the Minnesota Satisfaction Questionnaire completed by chief professional nurses

ITEM	SCALE TITLE	NUMBER OF RESPONSES					RAW SCORE	MEAN
		VD 1	D 2	N 3	S 4	VS 5	(TOTAL)	
1	Activity	1	5	6	19	6	135	3,65
2	Independence	1	5	9	14	8	134	3,62
3	Variety	1	4	5	17	10	142	3,84
4	Social status	0	3	7	17	9	140	3,89
5	Supervision - human	2	5	13	16	1	120	3,24
6	Supervision - technical	3	4	17	12	1	115	3,11
7	Moral values	2	5	2	20	7	133	3,69
8	Security	2	3	7	18	7	136	3,68
9	Social service	1	6	3	17	10	140	3,78
10	Authority	1	6	5	20	5	133	3,59
11	Ability utilisation	1	2	4	14	16	153	4,14
12	Company policies	2	10	12	13	0	110	2,97
13	Compensation	15	15	6	1	0	67	1,81
14	Advancement	7	8	13	9	0	98	2,65
15	Responsibility	5	11	4	13	4	111	3,00
16	Creativity	3	8	8	14	4	119	3,22
17	Working conditions	7	13	7	10	0	94	2,54
18	Co-workers	1	11	13	12	0	110	2,97
19	Recognition	5	6	10	11	4	111	3,08
20	Achievement	0	8	7	13	8	129	3,58

Key to abbreviations: VD = Very dissatisfied, D = Dissatisfied, N = Neutral, S = Satisfied, VS = Very satisfied.

Scoring weights: VD = 1, D = 2, N = 3, S = 4, VS = 5.

The means of the respondent's job satisfaction are represented graphically in figure 4.10.

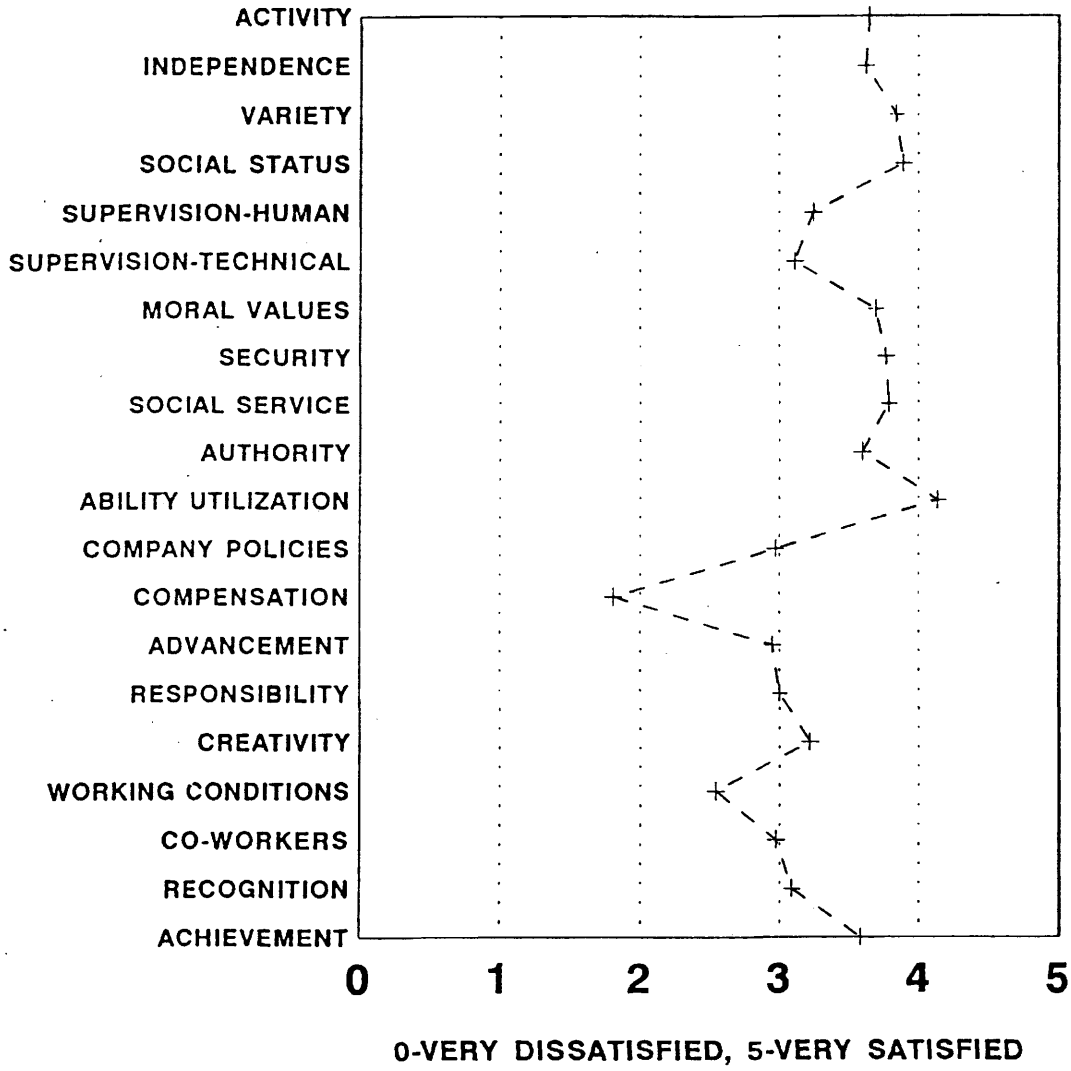


FIGURE 4.10 Graphic representation of the means of the chief professional nurses' job satisfaction

The means range from a low of 1,8 for item 13 (My pay and the amount of work I do) to a high of 4,1 for item 11 (The chance to do something that makes use of my abilities). At this point the approach will be to group the means in terms of their position in the table in an attempt to reveal the dimensions which these show at different levels of response.

Items 3 and 4 with means of 3,84 and 3,89 respectively reflect the responses to the statements "The chance to do different things from time to time", and "The chance to be somebody in the community". These high means confirm the satisfaction derived from the variety of activities within the job description on the one hand and the status which is afforded senior professional nursing personnel in the African urban community in South Africa on the other. It is also significant to note (as has been said earlier in this study), that all the respondents in the sample were African (black) women, all suffered the same depredations of the political dispensation of the time, and as a consequence of this they, in common with their community have placed a premium status on the nursing profession. This view of the nursing profession is not necessarily shared by other racial or ethnic communities in South Africa.

Also placed fairly high in the list of statements with a mean response of 3,78 is item 9, "The chance to do things for other people". This is followed by items 1, 2, 7 and 8 which had means which ranged from 3,62 to 3,69. These statements refer to being kept busy, being able to work alone, being able to do things which are not contrary to one's conscience, and having steady employment. Apart from item 2 which is an autonomous factor, the others are intrinsic factors and can be interpreted as psychological dimensions of job satisfaction, encapsulated in the word 'security'. All show a desire to be allowed to work in a professional environment.

The intrinsic item 10 revealing satisfaction derived from the use of authority "The chance to tell other people what to do", has a mean score of 3,59. This shows that most chief professional nurses in the sample derive considerable satisfaction from the authority that is inherently associated with their positions.

Scoring almost the same amount was item 5, "The way my boss handles his/her workers", where the mean was 3,24. Rather less satisfaction came from item 6, "The competence of my superiors in making decisions", where the score was 3,1 and item 15, "The freedom to use my own judgement", where the mean was 3,0.

Finally relegated to the lower quartile of the scores were the following extrinsic items: item 12, "The way policies are put into practice", with a mean score of 2,97; item 17, "The working conditions", with a mean score of 2,54 and item 13 which refers to remuneration, with a mean score of only 1,81. This is the lowest of all the scores, indicating considerable dissatisfaction with remuneration. However, the questionnaire does not reveal the underlying dimensions and reasons for this dissatisfaction.

The figure in appendix K shows a comparison between the mean scores of all the satisfaction items of American supervisors which was done by Weiss *et al* in 1967 and those of their counterparts in South Africa, the chief professional nurses in 1993. The research by Weiss *et al* was done some time ago so contemporary comparisons may or may not be valid. More recent responses could elicit job satisfaction scores of a different order.

Using a t-test, a comparison was made between the relevant portion of research done by Kaplan *et al* (1991) on a group of South African professional nurses, and the results of the present study with regard to intrinsic, extrinsic, autonomous and general job satisfaction scales. A t-test is a statistical test used to determine whether the means of two groups are significantly different from each other. The means of the various satisfaction items were added to obtain the sum of the means for intrinsic, extrinsic, autonomous and

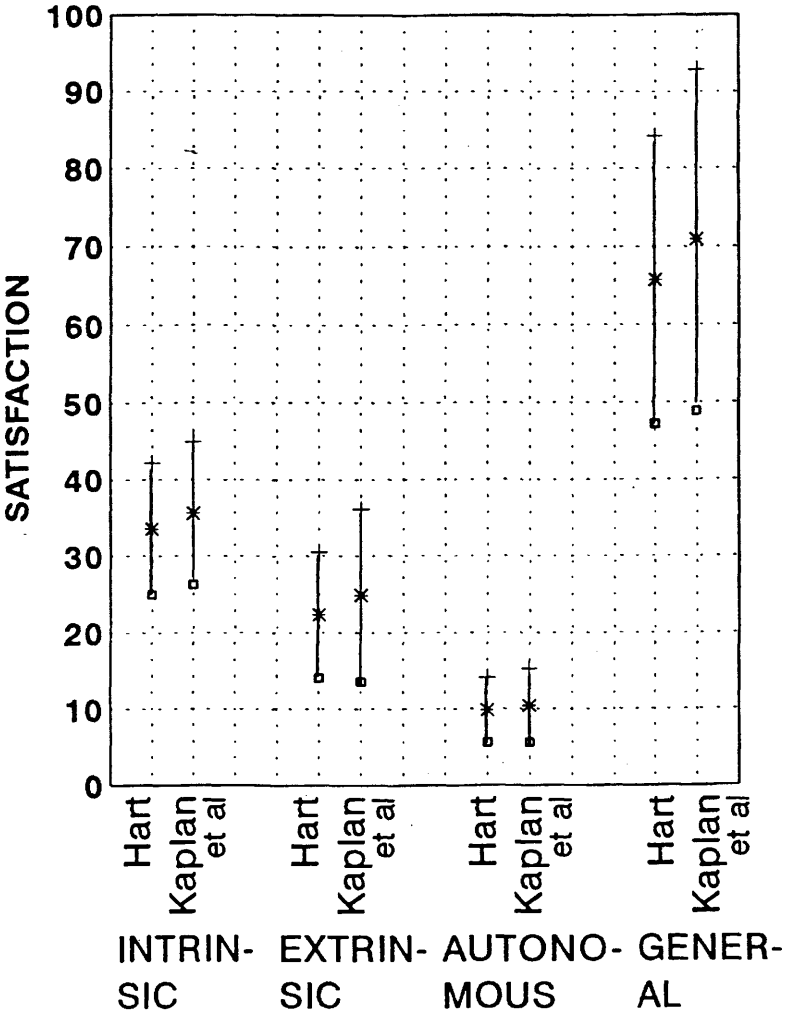
general satisfaction scales. The standard deviation (a measure of spread of points) was calculated for each scale. A formula utilising the sum of the means and standard deviations was used to calculate the t-value for each scale so that the two studies could be compared statistically (appendix L). A table was consulted to ascertain whether the t-values were statistically significant. The critical value of the t-value at the 90 percent level of significance is 1.65 (Polit & Hungler 1991: 141).

TABLE 4.19 Comparison of South African professional nurses' and chief professional nurses' job satisfactions

	SOUTH AFRICAN NURSES IN GENERAL (n = 114)		CHIEF PROFESSIONAL NURSES (n = 37)		
SCALE	SUM OF THE MEANS	STANDARD DEVIATION	SUM OF THE MEANS	STANDARD DEVIATION	t-VALUE
INTRINSIC	35,39	5,64	33,54	5,21	0,52
EXTRINSIC	24,85	6,85	22,30	4,98	0,40
AUTONOMOUS	10,42	2,92	9,84	2,57	0,20
GENERAL SATISFACTION	70,87	13,31	65,68	11,21	0,41

(Kaplan *et al* 1991: 5).

These results are also represented graphically in figure 4.11.



KEY: 90% Confidence intervals

\+ Upper

* Mean

▫ Lower

FIGURE 4.11 A graphical representation of the comparison of South African professional nurses' and chief professional nurses' job satisfactions

Although the means of the present study were all lower than those found in the study of Kaplan *et al*, the calculated t-values were well below the critical value of 1,65. This indicates that there was no significant difference between the intrinsic, extrinsic, autonomous and general satisfaction scores of South African nurses in general (Kaplan *et al*) and the chief professional nurses. However, this is not the case when the scores of nurses are compared with those of other professional groups. Here they are significantly lower and this points to a major and perhaps deep seated problem within nursing (see page 68).

4.4 TIME DOCUMENTATION RECORD

The fourth section of the instrument deals with the time documentation record in which chief professional nurses recorded the time they spent on their professional activities for a period of one month (see page 83 and appendix M). The object at this point is to demonstrate the degree of congruency between these activities as recorded in the time documentation record and those as posed in the second section of the questionnaire in which the same information was asked of respondents (see appendix B, section 2). A close correlation between these two responses would confirm the appropriateness of the research procedure which has been followed in this study to establish the way in which chief professional nurses devote time to their various activities.

Of the thirty seven respondents, twenty four returned time documentation records and of these, only twelve had been accurately recorded. Nine were from the clinical group and three from the administrative and educational group. The time allocated to each subsection was summed and calculated as a

percentage of the total, as was the case with the second questionnaire (see page 124). These data are presented graphically as bar charts in figure 4.12.

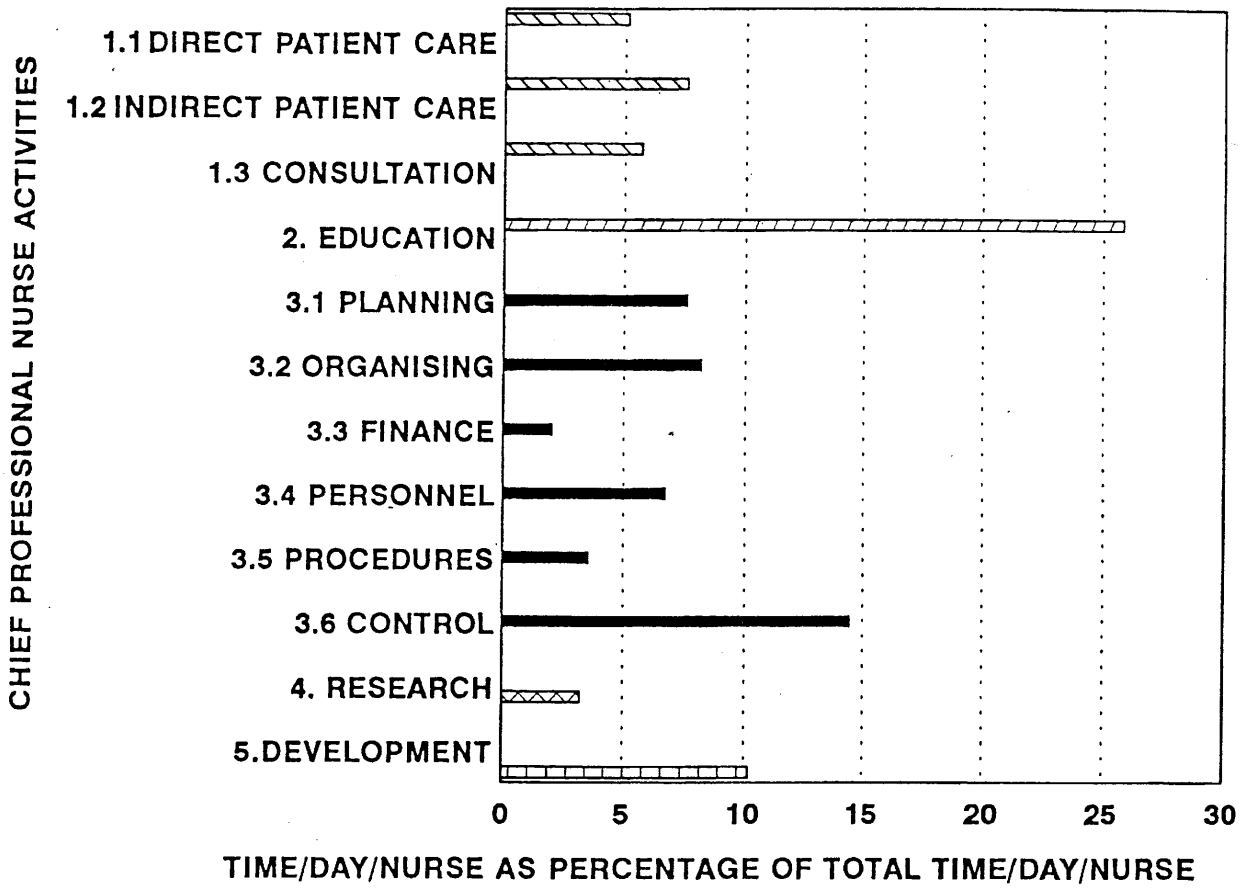


FIGURE 4.12 Percentage time spent by chief professional nurses in the various functions according to the results of the time documentation record

Conclusions can be drawn from the records of the twelve respondents who completed their time documentation records fully and comprehensively. Most time was spent in administrative activities followed by education, patient care, professional development and research.

The results from the time documentation record have been set against those that emerged from section two of the earlier questionnaire and the results of this procedure are set out in table 4.20.

TABLE 4.20 Comparison of the results of the activity questionnaire and the time documentation record

FUNCTIONS	QUESTIONNAIRE RESULTS	TIME DOCUMENTATION RECORD RESULTS
Patient care	29,95%	18,40%
Education	8,49%	25,84%
Administration	56,09%	42,53%
Research	1,85%	3,22%
Professional development	3,62%	10,17%

These results are represented graphically as bar charts in figure 4.13.

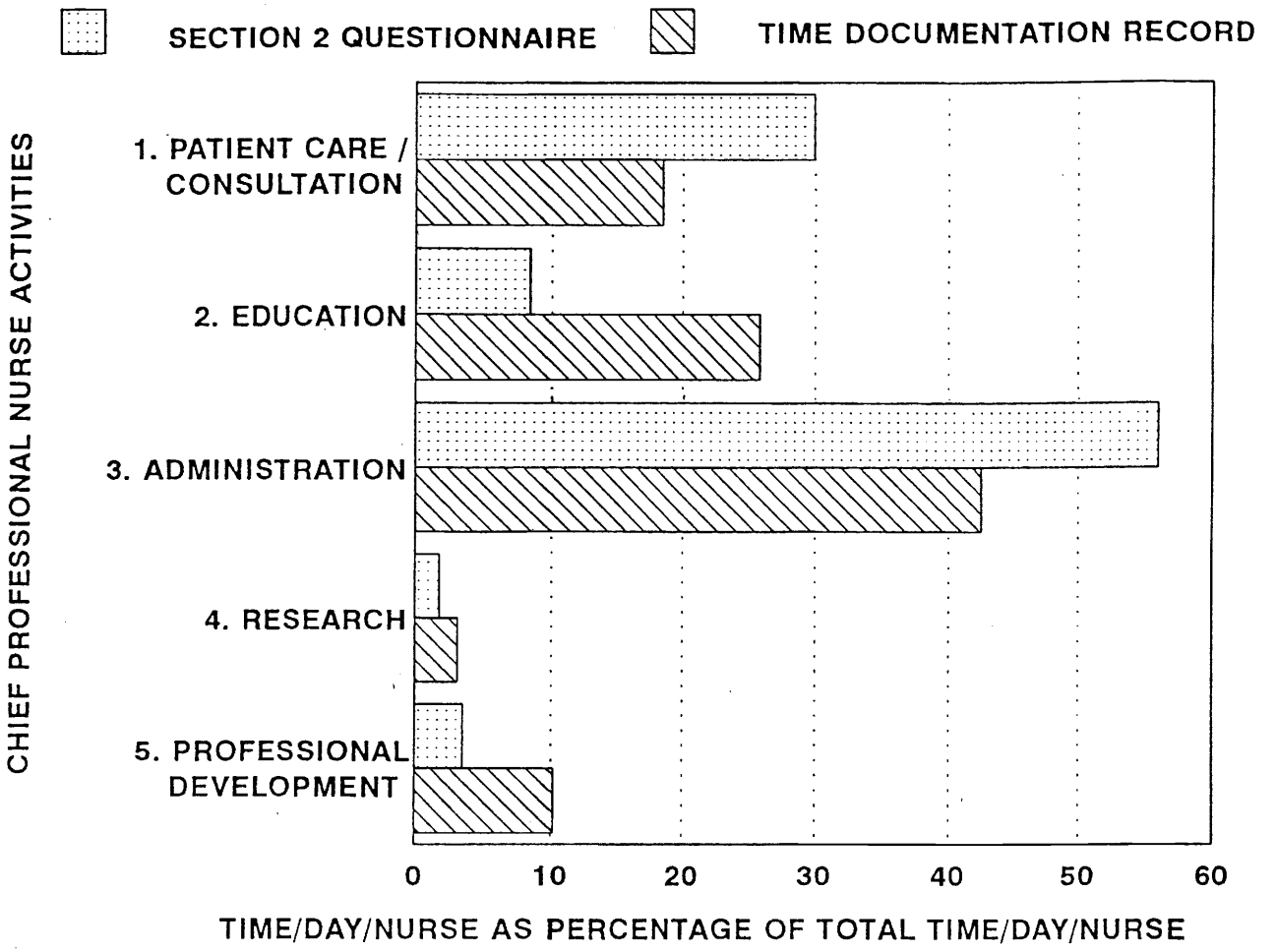


FIGURE 4.13 Comparison of the results of the activity questionnaire and the time documentation record

This suggests that there are many dimensions which show a close accordance between the results which came from the questionnaire and those from the time documentation record. The areas showing this congruency, as shown in figure 4.13, are administration, research and professional development. However, patient care, which was perceived to be the second most important of the activities of the respondents in the questionnaire, was rated the third most important item in the time documentation record. The opposite is true of

education which ranked only third among the activities in the questionnaire, but second highest in the time documentation record. One inescapable conclusion that can be drawn from this is that the respondents are very much more involved in the educational process than they themselves are aware.

4.5 CONCLUSION ENCAPSULATING THE FINDINGS

In concluding this section one notes from the findings which emerge that the respondents comprise a group of middle managers who were characterised by relatively advanced age, relatively high levels of education and more than adequate clinical and administrative qualifications. They also show a general approval of chief professional nurse status and position of authority but a widespread hostility towards non-nursing duties.

The second instrument showed that the respondents time spent most of their time on administration, followed by patient care/consultation, education, professional development and research.

Through the application of the Minnesota Satisfaction Questionnaire, the third instrument, the findings which emerged showed high levels of dissatisfaction with remuneration and working conditions. It was also apparent from the results that the levels of job satisfaction among the respondents were very much lower than those found in similar studies elsewhere.

The final instrument, a time documentation record, confirmed some aspects of the findings of the second questionnaire, but was at variance in other respects.

CHAPTER 5

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

A brief summary of the findings, the conclusions drawn from the study and recommendations for the chief professional nurse have been included in this chapter.

5.1 THE PURPOSE AND METHOD OF THE STUDY

The purpose of this study was to identify the current role and function of the chief professional nurse in academic hospitals of the Transvaal Provincial Administration. Through questionnaires and a time documentation record, the chief professional nurses who responded indicated which activities occupied their time. The job satisfaction of these nurses was measured using the Minnesota Satisfaction Questionnaire.

5.2 PROFILE OF THE CHIEF PROFESSIONAL NURSE

The group of respondents in the present study were all women, all Black and largely over the age of fifty years. Most were married.

All but one of the respondents had matriculated. The majority had clinical and administrative diplomas and eight held university degrees (two at the honour's level).

All respondents were general nurses and midwives. Four had in addition psychiatry as a basic nursing qualification. All but five had a post basic nursing qualification, and most had more than one. Within the group most of

the post basic clinical qualifications were represented, the most popular being operating theatre nursing science, followed in descending order by advanced midwifery and neonatology, intensive nursing and orthopaedic nursing science. Qualifications in nursing administration were held by fifty four per cent of the respondents.

The most common form of managerial preparation which the respondent's received was in nursing administration and in Junior Management courses, both before and during their appointments. Most felt these courses were adequate for their positions as chief professional nurses.

All but one had many years of experience prior to promotion to their present position. Well over fifty per cent had over ten years of experience, the average being thirteen years and eight months.

The respondents fell into two groups, those supervising clinical areas (seventy eight percent) and those involved in education and administration (twenty two percent).

All the chief professional nurses had job descriptions and performed both nursing and non-nursing duties. Many of the non-nursing duties which they performed did not appear in their job descriptions. They generally liked activities which involved patient care and education, but disliked some of the more tedious and unpleasant tasks in administration.

The chief professional nurses were responsible for professional, educational, administrative and research functions. They were also involved in professional development and generally had low levels of job satisfaction.

5.3 LIMITATIONS OF THE STUDY

The study was subject to a number of limitations, one of which was the state of the hospital system in South Africa at the time of the research. The country was part of a wider political transformation which took place during the first years of the decade of the nineties. Many senior nursing personnel were reluctant to involve their staff in research programmes of this kind because of the additional burden to staff who were affected by this political change and internecine conflict. Consequently only three hospitals were used in the study. Despite this, a return of almost fifty percent of the possible number of respondents was achieved.

Another limitation was the appropriateness of the instruments used to obtain data on the activities of the chief professional nurse (the questionnaire and the time documentation record). A more appropriate method, but one requiring a large and qualified research team, would have been direct observation which was used by Brownlee in her research on sisters-in-charge of wards in hospitals in South Africa (Brownlee 1983: 7). In the absence of this type of research support, this method could not be used in this case and recourse to the questionnaire was inevitable with its accompanying shortcomings. The limitation noted here does not however invalidate the conclusions or the recommendations.

The study was confined to responses from chief professional nurses. In a study done by Tarsitano, Brophy and Snyder (1986: 4) in the United States of America, clinical nurse specialists and nurse administrators were used to establish a data base concerning the role of the clinical nurse specialist. Extending and broadening the investigation to categories above and below the

chief professional nurse might have offered more information and given useful insights with further conclusions being drawn. To do this would have increased both the scope and extent of the research.

5.4 DISCUSSION OF FINDINGS RELATED TO THE INSTRUMENTS

Over three quarters of the respondents were in the final decade of their professional lives, and will most probably retire within the next ten years. The retirement age for nurses is sixty or sixty five years, depending upon whether they were employed before or after 1 July 1986. It was at this time that all provincial hospitals and their employees were placed under state control and the age of retirement for permanent staff was raised from sixty to sixty five years.

The respondents were a well educated group both with regard to general education and nursing education. Most had a qualification in one of the clinical specialities and over half had a qualification in nursing administration. The Public Service Commission (PAS 1986: 13) does not specify the need for post basic qualifications for promotion to chief professional nurse posts, but the individual hospitals normally require these as a recommendation. Most had attended Junior Management courses both before and during their appointments and when questioned on the suitability of their preparation for management positions found little or no cause for concern. In fact, in this sense, the responses of the group diverged markedly from the findings of research workers noted in the literature review. In the latter, a recurrent theme, especially in British nursing, was that their training did not equip them to become managers (Forrest 1983: 139).

Those in the clinical field supervised areas which were prescribed by patient condition (for example obstetrics), or specialised function (for example operating theatres). None managed areas in which patient conditions were diverse, but many supervised wards which were remote from one another because both wards and clinics were supervised, for example obstetric wards and ante and post natal clinics. The number of wards supervised was small averaging 4,52.

From the results of the questionnaire, most time was spent on administrative functions, followed by patient care, education, professional development and research. The time documentation record, although confirming the responses given to similar questions in the questionnaire, showed some variation in that it revealed that more time was spent on education than on patient care. However very few respondents returned the time documentation record, so this is probably not an accurate reflection of how their time was actually spent.

In so far as the administrative function was concerned, most time was spent on supervision and especially on control. This was followed by time spent on personnel and finally time spent on organising. Planning, finance and procedures played a minor role. These results correlated closely with those of the open ended questions which sought answers to those aspects of the work which chief professional nurses liked. These were control, personnel management, planning and organising.

The question relating to patient care indicated that indirect patient care took most time, followed closely by direct patient care, and finally by consultation (see page 78).

With regard to their educational function, respondents spent most of their time in unit or ward activities associated with inservice education followed by area or departmental education. The educational function was placed third in the questionnaire, but second in the time documentation record. In their responses to the open ended questions the chief professional nurses indicated that they enjoyed their teaching and educational duties.

Respondents spent very little time on staff development and even less on research. The type of research activities they were involved with were collaborative in nature, assisting medical personnel with clinical research projects or completing questionnaires for other researchers. No research papers were presented or published.

The results of the Minnesota Satisfaction Questionnaire reveal dissatisfaction among chief professional nurses in certain aspects. The highest scores were given for ability utilisation, social status and variety at work, while the lowest were for compensation (remuneration) and working conditions (see pages 137 and 138).

5.5 DISCUSSION OF FINDINGS RELATED TO THE LITERATURE

The last objective sought to determine whether appropriate use was being made of the chief professional nurse. In dealing with this topic, some aspects of her role and function which emerged from the review of the literature will be examined because of incongruity which is evident between the facts revealed there and the responses of the respondents. These are problems with linkage, role fulfilment and role ambiguity, role impotence, line and staff functions, preparation for administrative positions and the elimination of the middle manager.

In so far as linkage (linking top management and first-line management) is concerned, some respondents referred to problems which they experienced with management. They particularly disliked meetings with management which they found psychologically disruptive. None elaborated further on this problem.

Problems of role fulfilment and role ambiguity (which feature prominently as decisive issues in the literature) were also present in the responses of the sample. One observation was the discomfort felt by being sandwiched between management and subordinates. Here the responses relate to the double role syndrome in which they acted as managers on the one hand and as nurses on the other.

The feelings of impotence or disempowerment so commonly expressed by middle managers in Britain (particularly after the publication of the Salmon Report in 1967), and in the United States from about the same period, do not find a parallel in the present study. Here the respondents were comfortable in their positions of authority, a perception which must not be seen to detract from the objectives identified in the paragraphs above. Clarifying this one should note that the authoritative position of respondents, and their role fulfilment and ambiguity, are not mutually exclusive positions.

Authors from other countries (Stevens 1980: 225; Babich 1988: 10) regard problems between line and staff positions as important issues in middle management, however only one of the respondents in this study referred to this problem. Most of the chief professional nurses are in line positions where they play an important linkage function between upper and lower management. Being in this position their authority is not threatened.

The practical component plays a very small part in administration or orientation courses. Very little time is spent in the actual work situation learning managerial skills such as interviewing, dealing with conflict or preparing written reports. The South African Nursing Council only requires a minimum of eighty hours practical work for diploma or degree courses (Regulation No. R. 1501, paragraph 7(b)(i)). The Junior Management course which consists of theoretical instruction is only of two weeks duration, and this does not allow sufficient time for putting into practice what has been learnt. Only six respondents had experienced the mentor or buddy system through which one is exposed to on the job training which is practically orientated. Many of the administration diplomas or degrees presently being pursued by chief professional nurses and those aspiring to middle management positions are obtained from the University of South Africa which is a distance teaching university where the qualification emphasises the theoretical aspects of management. This is also the case at most universities and colleges who offer qualifications in administration.

5.6 CONCLUSIONS

The mature age of respondents may have important implications as adapting to new circumstances is more difficult as age advances. If changes are instituted, individual capabilities and circumstances will have to be taken into account. As many of the chief professional nurses are middle aged it is reasonable to suppose that they will not be in their present positions in the near future. This is therefore an opportune time to plan for changes.

Although there are several courses in nursing administration to orientate and educate nurse managers, the practical component is lacking. It is clear that

non-nursing functions are not stressed sufficiently when chief professional nurses receive their administrative orientation and training. There are also administrative responsibilities which they do not like which may be due to a lack of training in those aspects.

From this study it is not possible to determine the exact nature of the duties performed in patient care by the chief professional nurse. As the amount of time spent on patient care featured prominently in the responses (it was second to administration), this should be further investigated to establish whether this is a duplication of the functions performed by other nurses or whether correct use is being made of the individual's expertise. Although the questionnaire failed to reveal the underlying causes and reasons for the relatively insignificant role played by staff development, the answers can be gleaned from the biographical profile of the respondents. With an average age of fifty three years, the incentive to acquire further educational, managerial and technical skills appears to have a low priority.

Many of the dislikes are centred around non-nursing duties, such as the supervision of porters and cleaning staff. Unless non-nursing personnel are appointed for non-office hours, the nursing personnel in charge of the hospital will continue to be responsible and remain frustrated by continual interruption of nursing functions.

From the results of the questionnaire and the time documentation record, one can conclude that most of the chief professional nurse's time is still spent on administration, an aspect of the job which has not changed since the previous study was done in 1984. It must be remembered however, that the study on this category of nurse in 1984 was done not only in academic

hospitals but on senior matrons in all types of hospitals. At that time some were in charge of hospitals, so their functions had a larger administrative component. Despite the fact that most time is spent by chief professional nurses on the administrative component, there are many administrative duties which they dislike. Their preferences are for patient care and teaching.

A number of authors (Darling & McGrath 1983; Marchetti 1985; Strasen 1989) writing on problems of middle management elsewhere mention the issues of stress, poor communication, and low recognition. While it is difficult to translate these elements directly to the sample of respondents in the present study, there are recurrent themes which reflect these items. These relate to activities which usually fell beyond the job description and were non-nursing in character. These issues may be responsible for the low scores in job satisfaction.

In the clinical areas there were no problems with line or staff function because most of the respondents were in line positions, and their authority was not open to challenge either from above or below. Those in education (who were in a staff position), found that their positions attracted an element of ambiguity because of negative attitudes and poor attendance.

The experience in recent years of hospitals in the Cape Province where chief professional nurses have successfully returned to charge positions in hospital wards leads one to consider that a similar position could be adopted in the present case. The timing is appropriate in view of the age structure of the chief professional nurses in the academic hospitals of the Transvaal Provincial Administration. It would cause little disruption if the older managers were allowed to retire and a new dispensation along the lines of

those introduced in Cape hospitals was put into effect in the Transvaal. If the chief professional nurses were to move back to the wards, one would have older, mature and more experienced nursing personnel in charge of wards than is the case with the present senior professional nurses. They would have more autonomy and require less supervision. The supervisor would therefore have a larger span of control.

5.7 RECOMMENDATIONS

Organisational and financial constraints lead one to recommend the removal of one or more of the managerial ranks from the hierarchy of categories which at present has six managerial components.

As most chief professional nurses will be retiring in the next ten to fifteen years, it is appropriate that planning for a future generation of chief professional nurses is initiated. If changes are to be made as envisaged above these should be done in good time for the new group of chief professional nurses, whose training should have more emphasis on clinical rather than administrative elements. This would also create more opportunities for promotion in the clinical field.

In future, candidates seeking promotion to chief professional nurse posts should be required to possess a qualification in nursing administration and a clinical speciality. If more emphasis is placed on the clinical qualification it should help to keep the chief professional nurse in the clinical field. In the United States, much emphasis has been placed on the necessity for a masters degree for all senior nursing personnel. In South Africa, many nurses have post basic nursing qualifications which equip them

adequately for their positions, and therefore there has not been the need for higher qualifications.

A recommendation is that there should be more emphasis on the practical component of orientation and training.

It is recommended that the amount of time spent by chief professional nurses on their various functions be investigated by doing time and motion studies or by direct observation as was the case in Brownlee's 1983 study on sisters-in-charge of hospital wards.

In instances where there is a conflict of professional interest between the senior professional nurse and the chief professional nurse (in so far as the latter is simply duplicating the work of the former), it is recommended that the functions associated with the position should be clearly identified. The chief professional nurses' role should be orientated towards indirect patient care and consultation rather than direct patient care if she is to remain in a supervisory position.

Some of the dislikes such as imposing discipline, counselling and interviewing are aspects which need attention and here it is recommended that staff development should assist in the practical training appropriate to this function. Education in writing skills is recommended for aspects of clerical work which are disliked such as preparing reports, evaluations and memoranda.

Since most respondents were critical of demands made on their time where they were required to solve non-nursing problems, there is a case for placing these responsibilities in the hands of an individual who is not part of the nursing management of the hospital.

If the chief professional nurses are indeed as dissatisfied as the scores would suggest, further investigation should be done to determine exactly what the cause of their dissatisfaction is and how this can be remedied.

The chief professional nurses' research component needs to be increased. Incentives should be offered to personnel who produce papers for journals much as is the case with university personnel in South Africa. Competitions should be organised at hospitals with the authors of the best research projects being appropriately rewarded. Assistance should be given to allow chief professional nurses to present, defend and debate their research findings at conferences both locally and internationally. A recommendation is that a culture of writing and debating issues needs to be nurtured.

If the middle manager or the chief professional nurse is expected to undertake research, training in research methods are a recommendation, as also training in the presentation of research reports. Also important in this regard is the need to formalise and coordinate research at the middle management level, a process which must emanate from top management. Attention should also be focused on the research component in Junior Management courses and in orientation and inservice education procedures.

Because the present study was confined solely to chief professional nurses, it is recommended that top management and first line managers contribute to research to establish the time needed by chief professional nurses on their various functions.

One of the most important educational functions should be to develop the chief or senior professional nurse in charge of wards. This would lessen the

supervisory role of the manager to whom she is responsible and enable the manager to cope with an enlarged span of control.

5.8 RECOMMENDATIONS FOR FURTHER RESEARCH

The following areas require further investigation:

- to establish which of the chief professional nurse's administrative functions are really necessary and which can be omitted or delegated

- to establish how much time the chief professional nurse spends on the various functions using the observation method or time and motion studies

- the extent to which the chief professional nurse duplicates the activities of the senior professional nurse and the nursing service manager

- to establish a data base about the chief professional nurse role from the perspective of senior professional nurses, nursing service managers and the chief professional nurses themselves

- to determine the reasons for the Minnesota Satisfaction Questionnaire scores

5.9 FINAL COMMENTS

Although the present study by its nature is an investigation of the problems of middle management among a relatively small group of middle managers in the South African nursing service, it is not impossible that these recommendations may be relevant to the country's nursing service at large.

While middle management forms a part of most nursing services, some hospitals have elected to follow the American model described earlier and remove the chief professional nurse altogether. Cases in point are the academic hospitals of the Cape Provincial Administration where chief professional nurses have been placed in first line management positions in charge of hospital wards and have greatly increased the direct patient care component of their work. Indications are that the programme has been successful and if this proves to be the case in the longer term, one should pose the question: If there, why not elsewhere? From this other questions follow, for example: Is this outcome the result of better quality staff in the Cape Provincial Administration than elsewhere? Is it a question of the ages of middle managers in the Cape contributing to its success? Is it a question of top management in the Cape being prepared to make a greater effort to bridge the gap between itself and the first line manager than elsewhere? Would it not be efficacious to remove the nursing service manager and retain the chief professional nurse as has been suggested by some professionals? These and other such questions arise from the situation described here where the apparent success of the changes initiated in the Western Cape academic hospitals are at variance with findings in hospitals in other parts of South Africa.

While suggestions for eliminating the middle manager altogether have been implemented, especially in the United States, where head nurses have been given more authority, this could have disruptive effects in the hospitals under consideration in South Africa. As noted earlier, most of the respondents are fifty years of age or older and a rationalisation of this sort would eliminate a large number of nurse administrators and would be attended by obvious financial implications. The service could not afford to lose such a group of highly qualified and competent personnel and it is unlikely that government could sustain the costs of early retirement. The chief professional nurses who are all middle managers would view their return to wards as a demotion and would resent the change because of their age and status. Brownlee (1984: 81) has contributed another dimension to this problem in an earlier study on sisters-in-charge of hospital wards, where she found that thirty eight per cent of senior sisters (senior professional nurses) had been in charge of the unit they worked for less than a year. If this situation still obtains, their lack of experience would make it inadvisable and inappropriate to pass the responsibilities of middle management to them as was done in the United States. Another factor which has been raised (O'Mahoney 1994) is the need, particularly in very large academic hospitals (some of which have over 2500 patients), to have the strata of middle management who play a vital role in linking top management to the clinical personnel. Without such a position, there would be no way of disseminating information and instructions downwards to the ward level, or from that level upwards to top management. This view is substantiated by Stevens (1985: 95) who states that no nurse executive can manage effectively if too many individuals report directly to her. If this should occur (for example 20 head nurses reporting to a nurse executive with no intervening management level), she has exceeded her practical span of control. Stevens (1985: 95) says that

this span is only acceptable if nurses are established expert managers who require little supervision or guidance. This is not the case in the Transvaal Provincial Administration's academic hospitals. Finally, it is worth noting in passing that the removal of the middle manager from the hierarchy of authority would concomitantly take away one of the main incentives for nurses to acquire higher qualifications in administration. Any rationalisation or changes in middle management will need careful and sensitive thought and planning, involving the personnel concerned, brainstorming, think tanks, conferences and workshops.

The final arbiter will no doubt be the question of sufficient funding. This is particularly so when seen against the stated policy of politicians that funding in future will be directed towards the primary health care sector at the expense of medicine's technocratic frontier, the academic hospital.

There are also other political implications. Regions have replaced the old provincial boundaries of South Africa and the area in which the academic hospitals used in this study now find themselves fall within the Pretoria - Witwatersrand - Vereeniging region. Any new dispensation and the employment practices which they follow have to be viewed against a background comprising the policies of the new health authorities, and also of the relative financial and economic strength in which they find themselves. These will be the factors which will determine, to a great extent, the future of the chief professional nurse, her job description and her role and function.

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APPENDIX A

JOB DESCRIPTION

1. POST: Chief Professional Nurse
2. IMMEDIATE SUPERVISOR: Nursing Service Manager.
3. DATE: 90.05.31
4. SALARY: As stated in the Letter of Appointment.
5. CONDITION OF SERVICE: Refer to Hospital Policy Manual.
6. HOURS OF DUTY: Fourty hours on day.
   Fourty hours per week or eighty hours in two weeks, maximum of two months per year.
   Evening shift, night duty and weekend duty.
7. PURPOSE OF POST:

   Delivery of high standard of patient care, as well as formal and informal teaching of subordinates.
   Personnel development according to the philosophy of the hospital.
8. PROFESSIONAL REQUIREMENT

   - Registered general nurse and midwife.
   - Knowledge of the rules and regulations pertaining to a registered and enrolled nurse.
   - Extra qualification would be a recommendation.
   - Knowledge of the scope of practice of a registered nurse and midwife.
   - Registration with South African Nursing Council and Association.
9. PERSONAL REQUIREMENTS

   - Display positive attitude.
   - Maintain good working relationship.
   - Emotional maturity and stability.
   - Be a good listener.
   - Communication skill.
10. RESPONSIBILITY

    10.1. Professional Responsibility

    - Provide comprehensive nursing care which is consistent with the philosophy, objectives and policy of the organisation.
    - Ensure implementation of the scope of practice according to different nursing categories.
    - Project positive professional image.
    - Facilitate and maintain a holistic approach in patient care.
    - Ensure that the nursing staff are knowledgeable about SANC and SANA.
      . purpose and functions.
      . rules and regulations.
      . policy re:- annual subscriptions.

    10.2. Educational Responsibilities

    Contribute to the development and growth of the staff

    - Personnel
      . Plan, programme, implement and evaluate inservice training.
      . Orientate.
      . Write appraisal reports six monthly.
      . Workshops.
      . Symposia.

2/.....

. Facilitate teaching of student in clinical setting.
. Keep abreast with the latest developments through formal and informal education.

- To the Patient

. Plan and give health education to patients and families according to health needs.

10.3. Administrative Responsibilities

- Deputise Nursing Service Manager when off duty.
- Interprets hospital policy to the staff and other health professionals and patients.
- Contributes to the management of units according to the goals of the organisation.
- Is accountable for all professional, subprofessional and nonprofessional on designated shift.
- Supervise keeping of accurate statistics.
- Check control count and record scheduled drugs and check drug registers.
- Evaluate patient care by auditing patients records.
- Ensure that nursing personnel wear prescribed uniform and distinguishing devices.
- Report, investigate and give feedback on any irregularities and grievances.
- Compile and submit estimates for new equipment in the different departments.
- Ensure that all staff are trained and are familiar with the emergency, disaster and contingency plans.

10.4. Research Responsibilities

- Identify aspects in the department that need to be researched.
- Participates in research projects.

Medico Legal Risks

- Prevent medico legal incidences.
- Ensure that all reports are obtained when any incident occurs and submit to the Nursing Service Manager.

Budget

- Supervise use of stock, equipment, personnel and maintenance of equipment.
- Assist in the planning and budgetting for the financial year.

NB. Job description to be reviewed at regular intervals.

DUTY SHEET: CHIEF PROFESSIONAL NURSE - HIS/HER ROLE AND FUNCTIONS

RESPONSIBLE TO THE NURSING SERVICE MANAGER FOR:

A high standard of nursing practice in his/her area.
This includes Nursing programmes
Nursing Care Plans
Teaching all staff about nursing

A. ADMINISTRATIVE FUNCTIONS

1. SUPERVISION AND CONTROL

a) All applicable legislation is complied with
b) Departmental and Hospital Policies are carried out
c) SANC and SANA Regulations are adhered to
d) Procedure Manuals in regard to the above are kept current and all staff are made aware of their importance
e) Procedure Manuals are up to date and standardization is maximized.

2. EFFECTIVE UTILIZATION OF MANPOWER AND RESOURCES

A. Manpower
- Staff coverage is kept at a safe level
- Daily rounds to check on work in progress
- Act as a resource person for staff to consult with problems that may arise
- Assist in conflict situations
- Manage, if necessary, grievances
- Foster good interpersonal relationships
- Work and teaching milieu are both therapeutic for staff and students

B. Resources
- Equipment and supplies must be available when required - assist with motivations where necessary
- Economic use of all issues to be fostered
- Investigate excessive usage if this occurs
- Assist with estimates

3. FINANCIAL RESPONSIBILITY

- Hours of duty must be strictly adhered to
- Economic use of storage and equipment
- Respect for State and patient's property must be maintained

4. CONTROL

- Supervisors' reports to be written timeously
- Statistical data recorded
- Work rosters/Duty sheets updated
- Regular check on upkeep and maintenance of wards
- Safe keeping of patient's records
- Quarterly reports are completed
- Stock and inventory up to date
- Proper usage of all supplies

2/..

5. ATTENDANCE AT MEETINGS

Nursing Management
Matron's Meeting
Standardization Committee
Patient's Rec. Fund
Condemning
Edco meeting
CORNE meeting

B. EDUCATIONAL FUNCTION

PATIENTS - Health education is fostered and given where necessary

STAFF
- Orientation of new employees
- Attend In-service training
- Motivate staff re continuous education
- On the job training
- Clinical teaching

STUDENTS
- Be aware of specific needs
- Awareness of learning opportunities
- Assist with learning environment
- Training programmes for all

C. CLINICAL FUNCTION

Indirect but includes
- High standards of nursing care
- Therapeutic milieu
- Hygiene
- Safe environment
- Protection of patient's name, property, rights
- Disaster programme
- Fire drill
- O.T. Programmes in wards
- Social Programmes in wards
- Interpersonal relationships
- Team approach is fostered
- Research is encouraged and supported

(A Transvaal Academic Hospital)

APPENDIX B

THE ROLE AND FUNCTION OF THE CHIEF PROFESSIONAL NURSE IN ACADEMIC HOSPITALS IN THE TRANSVAAL PROVINCIAL ADMINISTRATION

SECTION 1 BIOGRAPHICAL INFORMATION

Questionnaire ☐☐☐ 1 2 3

Card number ☐1 4

Please answer the questions in this section either by placing the appropriate number in the answer box or by providing the information requested.

1 Personal particulars

1.1 Age in years: ☐☐ 5 6

1.2 Sex:
KEY: Male = 1 Female = 2 ☐ 7

1.3 Marital status:
KEY: Single = 1 Married = 2
Divorced = 3 Widowed = 4 ☐ 8

2 General Education

2.1 Highest educational qualification obtained, other than nursing:
KEY: Std 8 = 1 Matric = 2
Degree = 3 Post grad. degree = 4 ☐ 9

2.2 Year obtained: e.g. 74 for 1974 ☐☐ 10 11

3 Nursing Education

3.1 Basic nursing qualifications:

KEY: Diploma = 1 Degree = 2 ☐ 12

3.1.1 Year completed: e.g 82 for 1982 ☐☐ 13 14

3.1.2 Where obtained/Institution

(specify)..... ☐ 15

3.2 Other basic qualifications:

KEY: 1st block: If obtained = 1, if not = 0
2nd and 3rd blocks: Date obtained e.g. 85 for 1985
4th block: If still applicable to present post = 1,
if not applicable to present post = 0

	1	2 3	4	
Midwifery	☐	☐☐	☐	16-19
Psychiatric nursing	☐	☐☐	☐	20-23
Other (specify)	☐	☐☐	☐	24-27

3.3 Post basic qualifications:

KEY: 1st block: If obtained = 1, if not busy studying = 0, if busy studying: degree = 2, diploma = 3
2nd and 3rd blocks: Date obtained e.g. 90 for 1990
4th block: If still applicable to present post = 1, if not applicable to present post = 0

	1	2 3	4	
Nursing administration	☐	☐☐	☐	28-31
Nursing education	☐	☐☐	☐	32-35
Community nursing science	☐	☐☐	☐	36-39
Orthopaedic nursing science	☐	☐☐	☐	40-43
Operating theatre nursing science	☐	☐☐	☐	44-47
Intensive nursing	☐	☐☐	☐	48-51
Ophthalmological nursing	☐	☐☐	☐	52-55
Paediatric nursing science	☐	☐☐	☐	56-59
Geriatric nursing science	☐	☐☐	☐	60-63
Oncological nursing	☐	☐☐	☐	64-67
Other (specify)	☐	☐☐	☐	68-71
Other (specify)	☐	☐☐	☐	72-75
Other (specify)	☐	☐☐	☐	76-79
Card number			2	1

4 Experience

	Years Months	
4.1 Length of time in post prior to CPN post: e.g. 9 years and 10 months = 09 10	☐☐☐☐	2-5
4.2 Length of time in Chief Professional Nurse post: e.g. 3 years and 4 months = 03 04	☐☐☐☐	6-9
4.3 Total length of experience in present post: e.g. 2 years and 11 months = 02 11	☐☐☐☐	10-13

5 Type of orientation or training for Chief Professional Nurse post:

KEY: 1st block: If done = 1, if not done = 0
2nd block: If orientation/training sufficient = 1, if not = 0

	1 2	
Formal orientation period	☐☐	14-15
Nursing administration diploma	☐☐	16-17
Nursing administration degree	☐☐	18-19

1st Level management course ☐☐ 20-21

Mentor or 'Buddy' system ☐☐ 22-23

Other (specify) ..... ☐☐ 24-25

6 Are you supervising any of these wards/units?

KEY: Yes = 1 No = 0

Medical ☐ 26

Surgical ☐ 27

Psychiatric ☐ 28

Paediatric ☐ 29

Obstetric ☐ 30

Gynaecological ☐ 31

Orthopaedic ☐ 32

Intensive care ☐ 33

Casualty/Trauma ☐ 34

Outpatients ☐ 35

Theatre ☐ 36

Other (specify) ..... ☐ 37

Other (specify) ..... ☐ 38

Other (specify) ..... ☐ 39

7 Number of wards supervised: ☐☐ 40-41

8 Are the wards/units supervised according to disciplines?

KEY: Yes = 1 No = 0 ☐ 42

9 Geographical situation of wards/unit:

KEY: Wing = 1

All on the same floor = 2

On different floors = 3

Other = 4 (specify) ..... ☐ 43

10 Job description:

KEY: Yes = 1 No = 0

10.1 Do you have a job description? ☐ 44

10.2 Does the job description adequately describe your job? ☐ 45

10.3 Please list the activities you do which are **not** listed in your job description e.g. non-nursing duties.

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..... ☐ 46-52

10.4 Please list the activities which **are** listed in your job description but which you do **not** do.

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..... ☐ 53-59

11 Positive and negative aspects of the job?

11.1 What aspects of your work do you like most?

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..... ☐ 60-69

11.2 What aspects of your work do you like least?

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..... ☐ 70-79

ECTION 2 CHIEF PROFESSIONAL NURSE ACTIVITIES

ndicate by circling the appropriate number on a rating scale from 0 to 4 which activities ccupy most of your time as a chief professional nurse.

EY: 0 - occupies none of your time
1 - less than 1 hour per day - less than 5 hours per week
2 - between 1 and 2 hours per day - 6-10 hours per week
3 - between 2 and 3 hours per day - 11-15 hours per week
4 - more than 3 hours per day - more than 15 hours per week

Card number 3 1
(Columns 2-14)

Patient care/consultation

1.1 Direct patient care. Provides direct care to select patients and families requiring specialist clinical nursing care.

1.1.1	Assesses physiological needs of patients, and assumes responsibility for the formulation of nursing diagnosis and careful planning.	_0_1_2_3_4_
1.1.2	Assesses psychological needs of patients and families, and assumes counselling and/or referral responsibility.	_0_1_2_3_4_
1.1.3	Facilitates assessment of learning needs of patients/families and provides educational follow-up.	_0_1_2_3_4_
1.1.4	Provides education to patients and families both formally and informally through ward rounds, discussions and patient conferences.	_0_1_2_3_4_
1.1.5	Performs and recommends nursing measures which enhance physical comfort of patients.	_0_1_2_3_4_
1.1.6	Functions as role model at bedside (psychomotor skills, nursing measures, patient/family interaction, evaluation of care).	_0_1_2_3_4_
1.1.7	Establishes contracts of care with patients and families.	_0_1_2_3_4_
1.1.8	Initiates both physiological and psychological crisis intervention.	_0_1_2_3_4_
1.1.9	Participates in patient transfer and discharge planning and provides direct follow-up care following transfer when appropriate.	_0_1_2_3_4_
1.1.10	Communicates direct care information (verbally and/or written) with medical and nursing staff, and other disciplines.	_0_1_2_3_4_

1.2 Indirect patient care
Assists and guides staff in providing quality nursing care through indirect activities.

1.2.1	Participates in developing and effecting standards of nursing practice.	_0_1_2_3_4_
1.2.2	Coordinates transfer or discharge planning to enhance continuity of care.	_0_1_2_3_4_
1.2.3	Assists nursing staff in obtaining and recording comprehensive and useful nursing history and physical assessment data.	_0_1_2_3_4_

(Col.15-31)

1.2.4 Functions as patient/family advocate. Role models patient advocacy through interdisciplinary and medical rounds, patient care conferences, and informal discussions with health care staff. _0_1_2_3_4_

1.2.5 Participates in the development, modification and evaluation of nursing plans of care and teaching plans. _0_1_2_3_4_

1.2.6 Identifies needs for patient teaching outlines, and works with staff on development or revision. _0_1_2_3_4_

1.2.7 Enhances the quality of patient's care through interactions with other members of the multi-disciplinary team (doctor, social worker, occupational therapist, physiotherapist, dietician, chaplain and others). _0_1_2_3_4_

1.2.8 Assists staff with appropriate strategies for crisis intervention involving patients, families and staff. _0_1_2_3_4_

1.2.9 Interprets, evaluates and communicates to nursing staff research findings pertinent to their fields of specialisation. _0_1_2_3_4_

1.3 Consultation

1.3.1 Evaluates patients referred by medical staff, nursing staff, and other disciplines, contributes to care planning, and provides follow-up. _0_1_2_3_4_

1.3.2 Provides clarification of patient care issues, nursing diagnostic formulations, clinical recommendations for care, and informal learning need assessment for the staff. _0_1_2_3_4_

1.3.3 Offers specialised knowledge and skill for assistance with management of difficult patient and family problems. _0_1_2_3_4_

1.3.4 Establishes contracts of care with staff. _0_1_2_3_4_

Education

2.1 **Unit/ward.** Assesses and participates in unit-based educational activities. e.g. Inservice training. _0_1_2_3_4_

2.2 **Area/department.** Participates in assessment, planning and implementation of educational activities and programmes departmentally, and sponsored by nursing education department. _0_1_2_3_4_

2.3 **Nursing service.** Directs and assists with orientation of new employees. _0_1_2_3_4_

2.4 **Nursing school.** Participates in the evaluation of practical examinations. _0_1_2_3_4_

2.5 **Outside education.** Provides educational offerings/consultation outside primary work environment. _0_1_2_3_4_

2.6 **Preceptor.** Functions as clinical preceptor for nursing students (basic or post-basic). _0_1_2_3_4_

Administration

3.1 Planning

3.1.1 Assumes membership on nursing service committees e.g. infection control, standardisation committees. _0_1_2_3_4_

(Col.32-56)

3.1.2	Serves on hospital's planning committee, revises and recommends policies and procedures that affect overall hospital operations.	0 1 2 3 4
3.1.3	Designs methods to implement policy in her areas.	0 1 2 3 4
3.1.4	Plans ways to solve problems and to make improvements in the delivery of patient care in collaboration with nursing service managers and professional nurses.	0 1 2 3 4
3.1.5	Participates in departmental committee work and administrative meetings.	0 1 2 3 4
3.1.6	Participates in setting nursing service objectives for wards/units.	0 1 2 3 4

.2 **Organising**

3.2.1	Participates in decision-making process at unit level on issues which impact on clinical practice.	0 1 2 3 4
3.2.2	Attends chief professional nurse meetings and administrative related activities.	0 1 2 3 4
3.2.3	Directs, supervises and participates in implementing planned changes and activities to improve nursing service in collaboration with senior nursing personnel.	0 1 2 3 4
3.2.4	Supports personnel to implement the organisation's policy.	0 1 2 3 4
3.2.5	Keeps senior nursing personnel informed on reportable situations.	0 1 2 3 4
3.2.6	Recognises good performances creativity and utilises crisis situations to effect positive change.	0 1 2 3 4

3.3 Finance

3.3.1	Assists with the preparation of the budget for wards/units.	0 1 2 3 4
3.3.2	Motivates for new equipment in the areas supervised.	0 1 2 3 4
3.3.3	Ensures cost effective performance in the areas supervised e.g. the correct person for the job, adherence to hours of duty.	0 1 2 3 4
3.3.4	Promotes/ensures cost containment by checking on ordering, delivery, security,controletc.of supplies and equipment.	0 1 2 3 4

3.4 Personnel

3.4.1	Recruits, interviews and advises on appointment of personnel.	0 1 2 3 4
3.4.2	Allocates staff according to skills, experience and interests.	0 1 2 3 4
3.4.3	Assesses the number and level of personnel needed to provide quality care and adjusts staffing assignments appropriately.	0 1 2 3 4
3.4.4	Evaluates the performance of professional nurses in charge of wards/units for merit-rating.	0 1 2 3 4
3.4.5	Conducts performance appraisals on professional nurses in charge of wards/units.	0 1 2 3 4
3.4.6	Counsels nurses in her wards/units.	0 1 2 3 4
3.4.7	Manages grievances and disciplines personnel.	0 1 2 3 4
3.4.8	Writes reports, memoranda, etc. on nursing personnel.	0 1 2 3 4
3.4.9	Keeps relevant statistics on nursing personnel.	0 1 2 3 4
3.4.10	Is involved in labour relations disputes.	0 1 2 3 4

3.5 Procedures (Col.57-75)

3.5.1	Ensures the wards/units have the necessary policy manuals and SANC regulations and that these are kept up to date.	_0_1_2_3_4_
3.5.2	Interprets, supports and recommends administrative and nursing service policies for employees.	_0_1_2_3_4_
3.5.3	Evaluates policies and procedures and recommends the need for revision.	_0_1_2_3_4_

3.6 Control

3.6.1	Evaluates the achievement of nursing service objectives.	_0_1_2_3_4_
3.6.2	Participates in nursing audits.	_0_1_2_3_4_
3.6.3	Evaluates nursing records.	_0_1_2_3_4_
3.6.4	Analyses ward/unit statistics to assist with planning, evaluation and setting standards of patient care.	_0_1_2_3_4_
3.6.5	Evaluates emergencies and any hospital disaster and recommends revisions in policies and procedures and/or need for improvement in employee performance.	_0_1_2_3_4_
3.6.6	Inspects wards/units to assess the environmental and safety aspects in the areas supervised.	_0_1_2_3_4_
3.6.7	Checks control of drugs administered in her wards/units (ordering, storage, administration, recording, etc.).	_0_1_2_3_4_
3.6.8	Attends handover of reports.	_0_1_2_3_4_
3.6.9	Does rounds in ward(s)/unit(s) to check on patients, personnel and the quality of care given.	_0_1_2_3_4_

Research

4.1	Research collaborator - works with others on research projects. Specify.....	_0_1_2_3_4_
4.2	Research generator/replicator - conducts original studies or tests on known research findings. Specify.....	_0_1_2_3_4_
4.3	Research preceptor - guides students/staff research in their wards/units. Specify.....	_0_1_2_3_4_

Professional development activities

5.1	Self-directs learning activities (library, ward rounds). Specify.....	_0_1_2_3_4_
5.2	Seeks educational opportunity within primary work environment. Specify.....	_0_1_2_3_4_
5.3	Attends continuing education outside primary work environment. Specify.....	_0_1_2_3_4_
5.4	Writes for publication other than research. Specify.....	_0_1_2_3_4_

SECTION 3 MINNESOTA SATISFACTION QUESTIONNAIRE

The purpose of this questionnaire is to give you an opportunity to tell **how you feel about your present job**, the aspects you are **satisfied** with and those things you are **not satisfied** with.

On the basis of your answers and those of people like you, we hope to get a better understanding of the things people **like and dislike about their jobs.**

On the next page you will find statements about your **present** job.

- Read each statement carefully.
- Decide **how satisfied you feel with the aspect of your job** described by the statement.

  Keeping the statement in mind:

  - if you feel that your job gives you **more than you expect**, circle the 5 under **"Very Sat"** (Very Satisfied);
  - if you feel that your job gives you **what you expect**, circle the 4 under **"Sat"** (Satisfied);
  - if you **cannot make up your mind** whether or not the job gives you what you expect, circle the 3 under **"N"** (Neither Satisfied nor Dissatisfied).
  - if you feel that your job gives you **less than you expect**, circle the 2 under **"Diss"** (Dissatisfied);
  - if you feel that your job gives you **much less than you expect**, circle the 1 under **"Very Dissat"** (Very Dissatisfied).
- Remember: Keep the specific statement in mind when deciding **how satisfied you feel about that aspect of your job.**
- Do this for **all** statements. Please answer **every** item.

Be frank and honest. Give a true picture of your feelings about your **present job.**

Ask yourself: How **satisfied** am I with this aspect of my job?

Very Sat	means I am very satisfied with this aspect of my job.
Sat	means I am satisfied with this aspect of my job.
N	means I can't decide whether I am satisfied or not with this aspect of my job.
Diss	means I am dissatisfied with this aspect of my job.
Very Dissat	means I am very dissatisfied with this aspect of my job.

SECTION 3

Card number 4 1

Columns 2-21

In my present job, this is how I feel about...

		Very Dissat	Diss	N	Sat	Very Sat
1	Being able to keep busy all the time	1	2	3	4	5
2	The chance to work alone on the job	1	2	3	4	5
3	The chance to do different things from time to time	1	2	3	4	5
4	The chance to be "somebody" in the community	1	2	3	4	5
5	The way my boss handles his/ her workers	1	2	3	4	5
6	The competence of my superiors in making decisions	1	2	3	4	5
7	Being able to do things that don't go against my conscience	1	2	3	4	5
8	The way my job provides for steady employment	1	2	3	4	5
9	The chance to do things for other people	1	2	3	4	5
10	The chance to tell other people what to do	1	2	3	4	5
11	The chance to do something that makes use of my abilities	1	2	3	4	5
12	The way policies are put into practice	1	2	3	4	5
13	My pay and the amount of work I do	1	2	3	4	5
14	The chances for advancement on this job	1	2	3	4	5
15	The freedom to use my own judgement	1	2	3	4	5
16	The chance to try my own methods of doing the job	1	2	3	4	5
17	The working conditions	1	2	3	4	5
18	The way my co-workers get along with each other	1	2	3	4	5
19	The praise I get for doing a good job	1	2	3	4	5
20	The feeling of accomplishment I get from the job	1	2	3	4	5

SECTION 4 TIME DOCUMENTATION RECORD: CHIEF PROFESSIONAL NURSE ACTIVITIES

	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	S	M	T	W	T	F	S	TOTAL
1 Patient care/Consultation																													
1.1 Direct patient care (no.pts seen)																													
1.2 Indirect patient care (pt. educ.)																													
1.3 Consultations (no. of requests)																													
1.4 Other																													
2 Education (Planning/implementation)																													
2.1 Unit-based																													
2.2 Departmental																													
2.3 Nursing service																													
2.4 Other disciplines																													
2.5 Outside prim. work environment																													
2.6 Preceptor/school of nursing																													
2.7 Other																													
3 Administration/leadership																													
3.1 Planning																													
3.2 Organising																													
3.3 Finance																													
3.4 Personnel																													
3.5 Procedures																													
3.6 Control																													
3.7 Other																													
4 Research																													
4.1 Research collaborator																													
4.2 Research generator/replicator																													
4.3 Research preceptor																													
5 Professional development																													
5.1 Self directed learning activities																													
5.2 Within primary work environment																													
5.3 Outside primary work environment																													
5.4 Writing for publication																													
TOTAL HOURS:																													160

APPENDIX C

MINNESOTA SATISFACTION QUESTIONNAIRE SCALE TITLES AND CORRESPONDING SATISFACTION ITEMS

1 **Activity.** Being able to keep busy all the time.

2 **Independence.** The chance to work alone on the job.

3 **Variety.** The chance to do different things from time to time.

4 **Social status.** The chance to be "somebody" in the community.

5 **Supervision - human relations.** The way my boss handles his/her workers.

6 **Supervision - technical.** The competence of my superiors in making decisions.

7 **Moral values.** Being able to do things that don't go against my conscience.

8 **Security.** The way my job provides for steady employment.

9 **Social service.** The chance to do things for other people.

10 **Authority.** The chance to tell other people what to do.

11 **Ability utilisation.** The chance to do something that makes use of my abilities.

12 **Company (hospital) policies and practices.** The way hospital policies are put into practice.

13 **Compensation.** My pay and the amount of work I do.

14 **Advancement.** The chances for advancement on this job.

15 **Responsibility.** The freedom to use my own judgement.

16 **Creativity.** The chance to try my own methods of doing the job.

17 **Working conditions.** The working conditions.

18 **Co-workers.** The way my co-workers get along with each other.

19 **Recognition.** The praise I get for doing a good job.

20 **Achievement.** The feeling of accomplishment I get from the job.

APPENDIX D

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (RESEARCH)

COMMITTEE FOR RESEARCH ON HUMAN SUBJECTS (HUMANITIES)
Ref: R14/49/1 (Registry)

CLEARANCE CERTIFICATE PROTOCOL NO: 28/8/91

PROJECT: AN INVESTIGATION OF THE ROLE AND FUNCTION OF THE CHIEF PROFESSIONAL NURSE IN SELECTED ACADEMIC HOSPITALS IN THE TRANSVAAL PROVINCIAL ADMINISTRATION

INVESTIGATORS: MISS MH HART

DEPARTMENT: NURSING EDUCATION

DATE CONSIDERED: 20 AUGUST 1991

RECOMMENDATION OF THE COMMITTEE: APPROVED

Date: 20 AUGUST 1991 Chairman:.....
Prof W D Hammond-Tooke

Guidelines for written "Informed Consent" attached where applicable.

DECLARATION OF INVESTIGATOR/S

be completed in duplicate and **ONE** copy returned to Miss S M Boshoff Room 10-002, 10th Floor, Senate House, University.

we fully understand the conditions under which I am/we are thorised to carry out the abovementioned research and I/we guarantee ensure compliance with these conditions. Should any departure be ntemplated from the research procedure as approved I/we undertake to submit the protocol to the Committee.

Date: 91.09.06 Signature: M Hart

APPENDIX E

70 The Valley Road
Parktown
JOHANNESBURG
2193

7 July 1993

The Director of Hospital Services
Attention: Director of Nursing Mrs E Malan
Private Bag X221
PRETORIA
0001

Dear Mrs Malan

MASTERS STUDY : THE ROLE AND FUNCTION OF THE CHIEF PROFESSIONAL NURSE IN ACADEMIC HOSPITALS IN THE TRANSVAAL PROVINCIAL ADMINISTRATION

I am presently registered for a MSc degree in nursing at the University of the Witwatersrand.

The purpose of the study is to explore and describe the Chief Professional Nurse's perceptions of her role and function in academic hospitals in the Transvaal Provincial Administration. Criteria will also be developed for evaluating the activities of Chief Professional Nurses and recommendations will be made with regard to the position in which she could best utilise her resources.

Respondents will be required to complete the relevant questionnaires which will be in either English or Afrikaans. A 10% sample of Chief Professional Nurses will be asked to keep a diary for a month.

May I please have permission to conduct the necessary interviews on Chief Professional Nurses at the following hospitals: Baragwanath, Garankuwa, HF Verwoerd, Johannesburg and Kalafong. I would also like to request permission to perform a pilot study to test the reliability of the instruments at Coronation and JG Strijdom hospitals.

A copy of the proposal and questionnaires is appended.

Yours sincerely,

MHHart

(MRS) MH HART

APPENDIX F

ALGEMENE
VINSIALE DIENSTE
ERAL PROVIN-
SERVICES BRANCH

TRANSVAAL PROVINCIAL ADMINISTRATION
TRANSVAALSE PROVINSIALE ADMINISTRASIE

'RAE / ENQUIRIES: Mnr. J.W. Horn

W / REFERENCE:

:PHONE NUMBER:
:FOONNOMMER: 201-3134

v. M.H. Hart
e Valley Weg 70
RKTOWN
93

agte Mev.Hart

VORSING: DIE ROL EN FUNKSIE VAN HOOF VERPLEEGKUNDIGES BY AKEDEMIESE HOSPITALE.

t doen hierdie Administrasie genoë om u mee te deel dat u versoek om navorsing die volgende Hospitale te doen goedgekeur is:

ragwanath, Ga-Rankuwa, H.F. Verwoerd, Johannesburg en Kalafong.

e goedkeuring is onderworpe aan die volgende voorwaardes:

U moet die Superintendente van die onderskeie Hospitale self nader om toesteming om navorsing te mag doen te verkry.

Die navorsing mag nie inmeng met die betrokke Hospitaalpersoneel se dienslewering nie.

Die Superintendente van die onderskeie Hospitale moet ten alle tye ingelig wees aangaande die projek.

'n Afskrif van die voltooide verhandeling moet aan die Administrasie beskikbaar gestel word.

Die vertrouensposisie sowel as die vertroulikheid van die verhandeling moet nie uit die oog verloor word nie.

word alle sukses toegewens met die projek.

ie/ uwe

OJUNK-DIREKTEUR-GENERAAL:GESONDHEIDSDIENSTE 93/E/20

RIVAATSAK X218, PRETORIA, 0001. TELNO:
RIVATE BAG X218, PRETORIA, 0001. TELNO:

FAKS: 3257720
FAX: 3257720

APPENDIX G

70 The Valley Road
Parktown
JOHANNESBURG
2193
25 August 1993

The Medical Superintendent
.....
.....
.....

Dear Sir

RESEARCH: THE ROLE AND FUNCTION OF THE CHIEF PROFESSIONAL NURSE IN ACADEMIC HOSPITALS IN THE TRANSVAAL PROVINCIAL ADMINISTRATION

I am registered for a MSc (Nursing) degree at the University of the Witwatersrand and request permission to interview Chief Professional Nurses at your hospital to collect data for my research project.

The study includes all Chief Professional Nurses and appointments will have to be made with them for a structured interview. They will also be asked to complete a short job satisfaction questionnaire. In addition to this, they will be required to keep a record of the time spent on various functions they perform for a period of one month. Explanations and instructions as to how to complete this time documentation record will be explained to them at the interview. I will also need to follow up respondents to make sure that the time documentation record is being kept up to date. All information obtained will be confidential and the anonymity of the hospital and the personnel concerned will be ensured.

A copy of the letter from the Deputy Director General: Health Services granting permission for the research is enclosed as well as a copy of the questionnaire and time documentation record.

Your assistance in this matter will be very much appreciated.

Yours sincerely

M.H. Hart (Mrs)

CC CHIEF NURSING SERVICE MANAGER: .....

APPENDIX H

T.P.H. 49

TRANSVAALSE PROVINSIALE HOSPITALE

Telegrafiese Adres
Telegraphic Address.....

Telefoon Nr.
Telephone No. .....

IN ANTWOORD VERMELD ASB.
IN REPLY PLEASE QUOTE

XX No. _____ ____

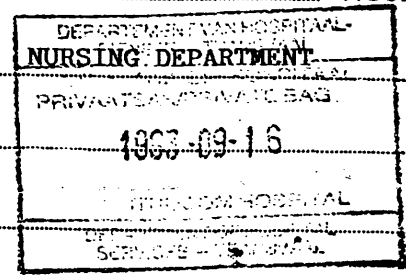
Alle korrespondensie moet aan die Superintendent gerig word.

All communications to be addressed to the Superintendent.



TRANSVAAL PROVINCIAL HOSPITALS

HOSPITAAL
HOSPITAL



MRS.M.H. HART
70 THE VALLEY ROAD
PARKTOWN

2193

RESEARCH: ROLE AND FUNCTION OF C.P.N. IN ACADEMIC HOSPITALS IN THE T.P.A.

Permission has been granted as requested, Chief professional nurses at Hospital may take part in abovementioned research project.

Any enquiries re. suitable dates and times may be directed to:

Nursing Service Manager

SEN. NURSING SERVICE MANAGER
FOR: CHIEF SUPERINTENDENT

1993/09/16

APPENDIX I

Department of Nursing Science
P O Box 392
UNISA
PRETORIA
0001
1 October 1993

Dear Colleague

I am undertaking a study of the role and function of the chief professional nurse in academic hospitals in the Transvaal Provincial Administration. The chief professional nurse holds a middle management position in academic hospitals, coordinates nursing activities of several units and plays a critical role in the provision and improvement of patient care.

The supervisory position in a hospital setting is a difficult and demanding one as the supervisor is the person in the middle serving as the principal link between the employee and the administration. As the chief professional nurse has a responsibility towards both the employees of the areas she is supervising and towards the administration of the organisation, her role is a difficult one. The roles played by the chief professional nurse and the difficulties she experiences in this post will be examined. The chief professional nurse has several functions and I wish to clarify which these functions are and gauge how much time is spent on each of them. In addition to this, I wish to see what satisfaction you obtain from your work.

Will you please complete the attached questionnaire. The time documentation record will need to be filled in for a period of a month and the guide of various functions should help you to complete this section.

You are assured of complete confidentiality. Neither you nor your hospital will be identified. If you wish to make any additional comments you may do so at the end of the questionnaire.

Thank you for your participation.

Yours sincerely

M H Hart

M H Hart

GUIDELINES FOR THE COMPLETION OF THE TIME DOCUMENTATION RECORD

SECTION 2 CHIEF PROFESSIONAL NURSE ACTIVITIES

Patient care/consultation

1.1 **Direct patient care.** Provides direct care to select patients and families requiring specialist clinical nursing care.

- 1.1.1 Assesses physiological needs of patients, and assumes responsibility for the formulation of nursing diagnosis and careful planning.
- 1.1.2 Assesses psychological needs of patients and families, and assumes counselling and/or referral responsibility.
- 1.1.3 Facilitates assessment of learning needs of patients/families and provides educational follow-up.
- 1.1.4 Provides education to patients and families both formally and informally through ward rounds, discussions and patient conferences.
- 1.1.5 Performs and recommends nursing measures which enhance physical comfort of patients.
- 1.1.6 Functions as role model at bedside (psychomotor skills, nursing measures, patient/family interaction, evaluation of care).
- 1.1.7 Establishes contracts of care with patients and families.
- 1.1.8 Initiates both physiological and psychological crisis intervention.
- 1.1.9 Participates in patient transfer and discharge planning and provides direct follow-up care following transfer when appropriate.
- 1.1.10 Communicates direct care information (verbally and/or written) with medical and nursing staff, and other disciplines.

1.2 **Indirect patient care.** Assists and guides staff in providing quality nursing care through indirect activities.

- 1.2.1 Participates in developing and effecting standards of nursing practice.
- 1.2.2 Coordinates transfer or discharge planning to enhance continuity of care.
- 1.2.3 Assists nursing staff in obtaining and recording comprehensive and useful nursing history and physical assessment data.
- 1.2.4 Functions as patient/family advocate. Role models patient advocacy through interdisciplinary and medical rounds, patient care conferences, and informal discussions with health care staff.
- 1.2.5 Participates in the development, modification and evalution of nursing plans of care and teaching plans.
- 1.2.6 Identifies needs for patient teaching outlines, and works with staff on development or revision.
- 1.2.7 Enhances the quality of patient's care through interactions with other services (doctor, social worker, occupational therapist, physiotherapist, dietician, chaplain and others).
- 1.2.8 Assists staff with appropriate strategies for crisis intervention involving patients, families and staff.
- 1.2.9 Interprets, evaluates and communicates to nursing staff research findings pertinent to their fields of specialisation.

1.3 Consultation

1.3.1 Evaluates patients referred by medical staff, nursing staff, and other disciplines, contributes to care planning, and provides follow-up.

1.3.2 Provides clarification of patient care issues, nursing diagnostic formulations, clinical recommendations for care, and informal learning need assessment for the staff.

1.3.3 Offers specialised knowledge and skill for assistance with management of difficult patient and family problems.

1.3.4 Establishes contracts of care with staff.

2 Education (personnel)

2.1 **Unit/ward.** Assesses and participates in unit-based educational activities (orientation, inservice education, skills training).

2.2 **Area/department.** Participates in assessment, planning, and implementation of educational activities and programmes departmentally, and sponsored by nursing education department.

2.3 **Nursing service.** Directs and assists with orientation of new employees.

2.4 **Nursing school.** Participates in the evaluation of practical examinations.

2.5 **Outside education.** Provides educational offerings/consultation outside primary work environment.

2.6 **Preceptor.** Functions as clinical preceptor for nursing students (basic or post-basic).

3 Administration

3.1 Planning

3.1.1 Assumes membership on nursing service committees e.g. infection control, standardisation committees.

3.1.2 Serves on hospital's planning committee, revises and recommends policies and procedures that effect overall hospital operations.

3.1.3 Designs methods to implement policy in her areas.

3.1.4 Plans ways to solve problems and to make improvements in the delivery of patient care in collaboration with nursing service managers and professional nurses.

3.1.5 Participates in departmental committee work and administrative meetings.

3.1.6 Participates in setting nursing service objectives for wards/units.

3.2 Organising

3.2.1 Participates in decision-making process at unit level on issues which impact on clinical practice.

3.2.2 Attends chief professional nurse meetings and administrative related activities.

3.2.3 Directs, supervises and participates in implementing planned changes and activities to improve nursing service in collaboration with senior nursing personnel.

3.2.4 Supports personnel to implement the organisation's policy.

3.2.5 Keeps senior nursing personnel informed on reportable situations.

3.2.6 Recognises good performances creativity and utilises crisis situations to effect positive change.

3.3 Finance

3.3.1 Assists with the preparation of the budget for wards/units.

3.3.2 Motivates for new equipment in the areas supervised.
3.3.3 Ensures cost effective performance in the areas supervised e.g. the correct person for the job, adherence to hours of duty.
3.3.4 Promotes/ensures cost containment by checking on ordering, delivery, security, control etc. of supplies and equipment.

3.4 Personnel

3.4.1 Recruits, interviews and advises on appointment of personnel.
3.4.2 Allocates staff according to skills, experience and interests.
3.4.3 Assesses the number and level of personnel needed to provide quality care and adjusts staffing assignments appropriately.
3.4.4 Evaluates the performance of professional nurses in charge of wards/units for merit rating.
3.4.5 Conducts performance appraisals on professional nurses in charge of wards/units.
3.4.6 Counsels nurses in the wards/units.
3.4.7 Manages grievances and disciplines personnel.
3.4.8 Writes reports, memoranda, etc. on nursing personnel.
3.4.9 Keeps relevant statistics on nursing personnel.
3.4.10 Is involved in labour relations disputes.

3.5 Procedures

3.5.1 Ensures the wards/units have the necessary policy and procedure manuals and SANC regulations and that these are kept up to date.
3.5.2 Interprets, supports and recommends administrative and nursing service policies for employees.
3.5.3 Evaluates policies and procedures and recommends the need for revision.

3.6 Control

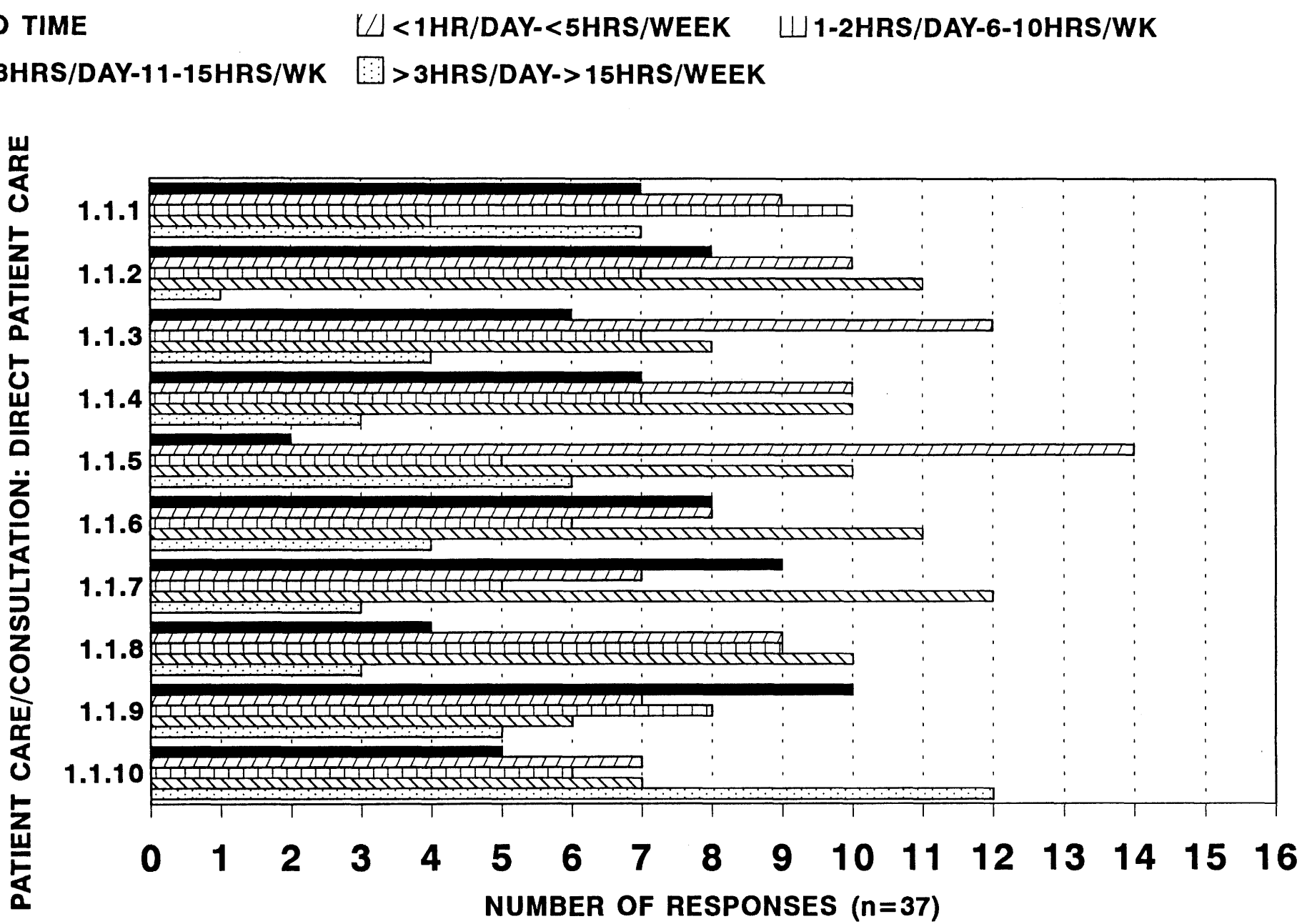
3.6.1 Evaluates the achievement of nursing service objectives.
3.6.2 Participates in nursing audits.
3.6.3 Evaluates nursing records.
3.6.4 Analyses ward/unit statistics to assist with planning, evaluation and setting standards of patient care.
3.6.5 Evaluates emergencies and any hospital disaster and recommends revisions in policies and procedures and/or need for improvement in employee performance.
3.6.6 Inspects wards/units to assess the environmental and safety aspects in the areas supervised.
3.6.7 Checks control of drugs administered in the wards/units (ordering, storage, administration, recording, etc.).
3.6.8 Attends handover of reports.
3.6.9 Does rounds in ward(s)/unit(s) to check on patients, personnel and the quality of care given.

4 Research

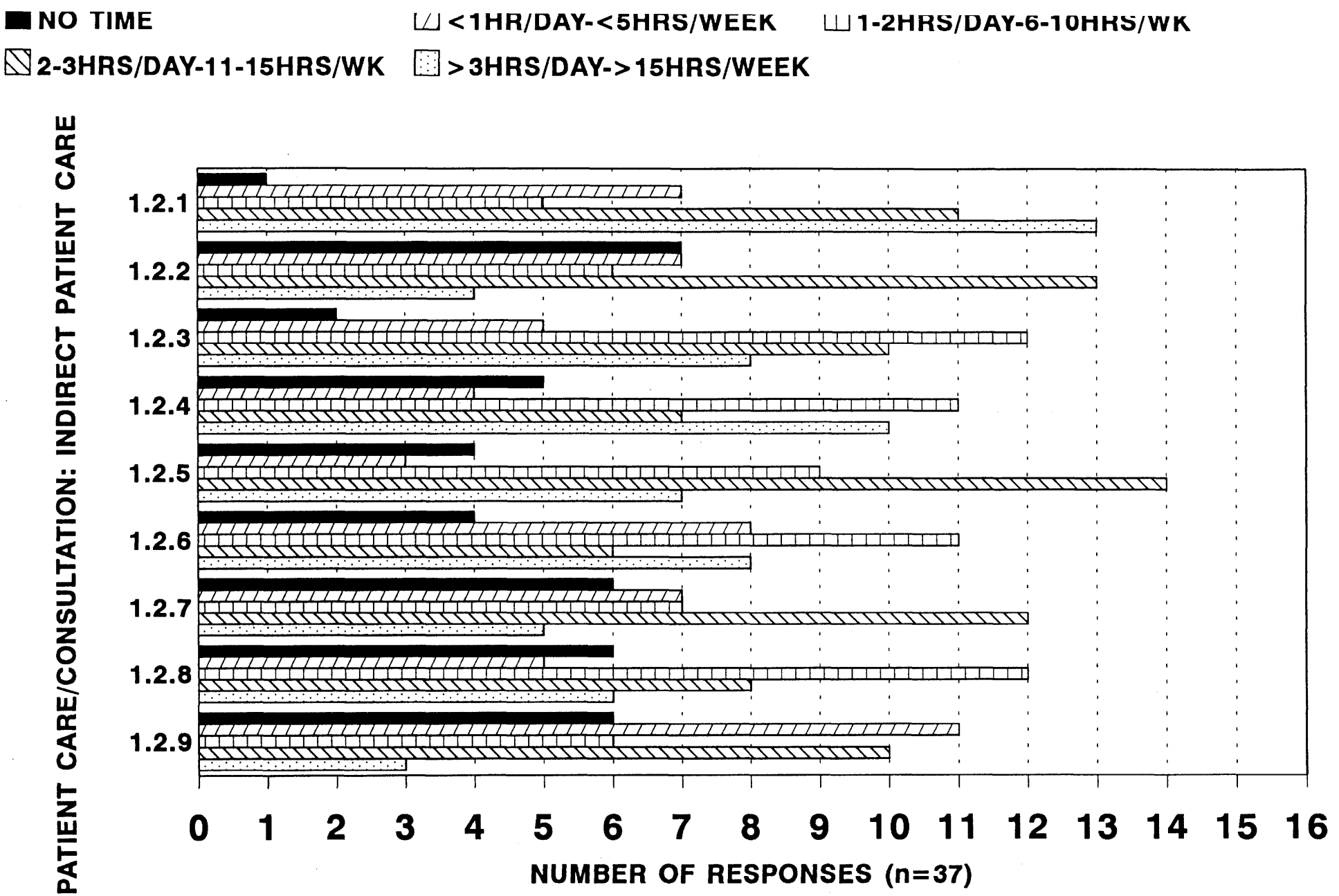
4.1 Research collaborator - works with others on research projects.
4.2 Research generator/replicator - conducts original studies or tests on known research findings.
4.3 Research preceptor - guides the process of student/staff research.

5 Professional development activities

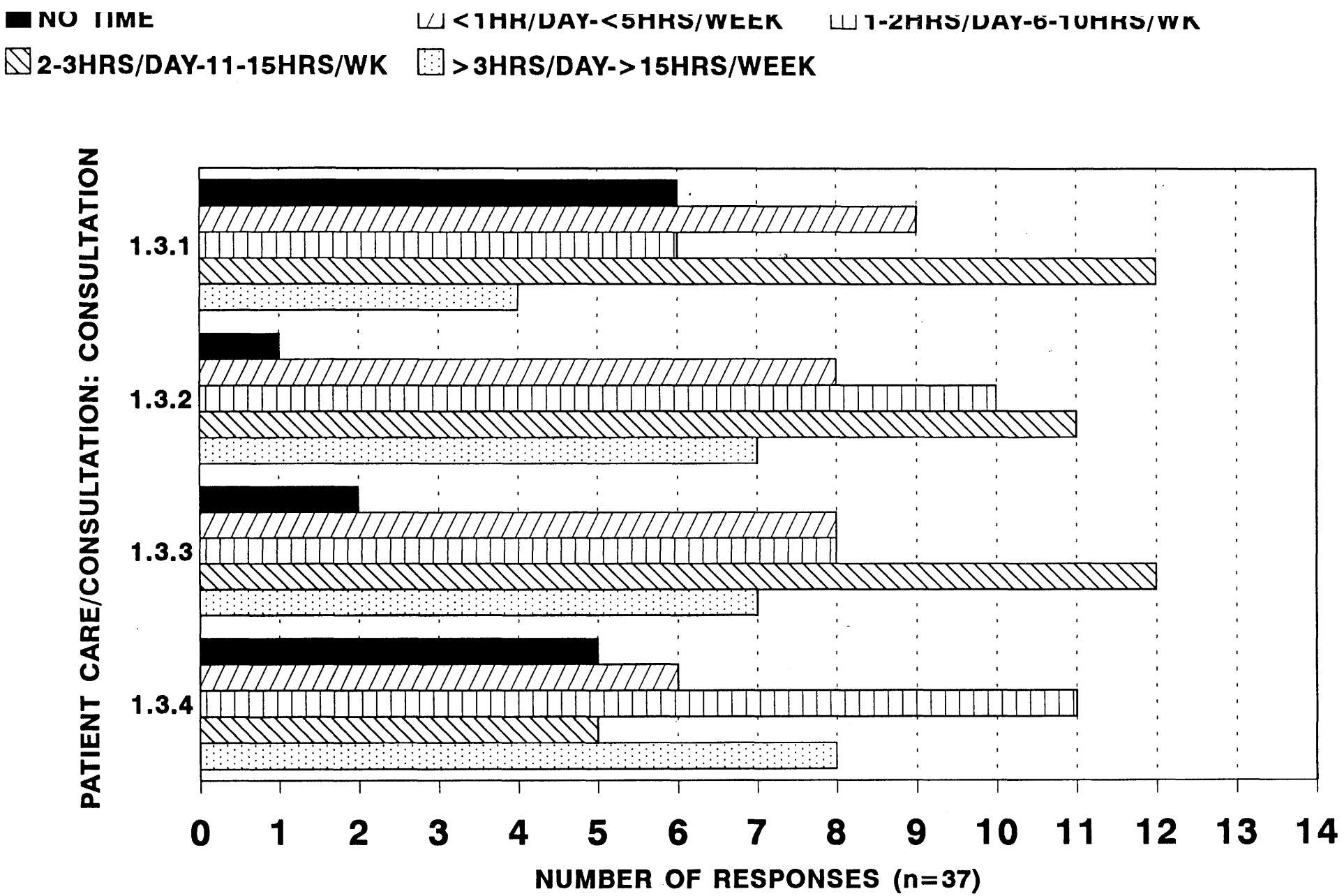
5.1 Self-directs learning activities (library, ward rounds).
5.2 Seeks educational opportunity within primary work environment.
5.3 Attends continuing education outside primary work environment.
5.4 Writes for publication other than research.



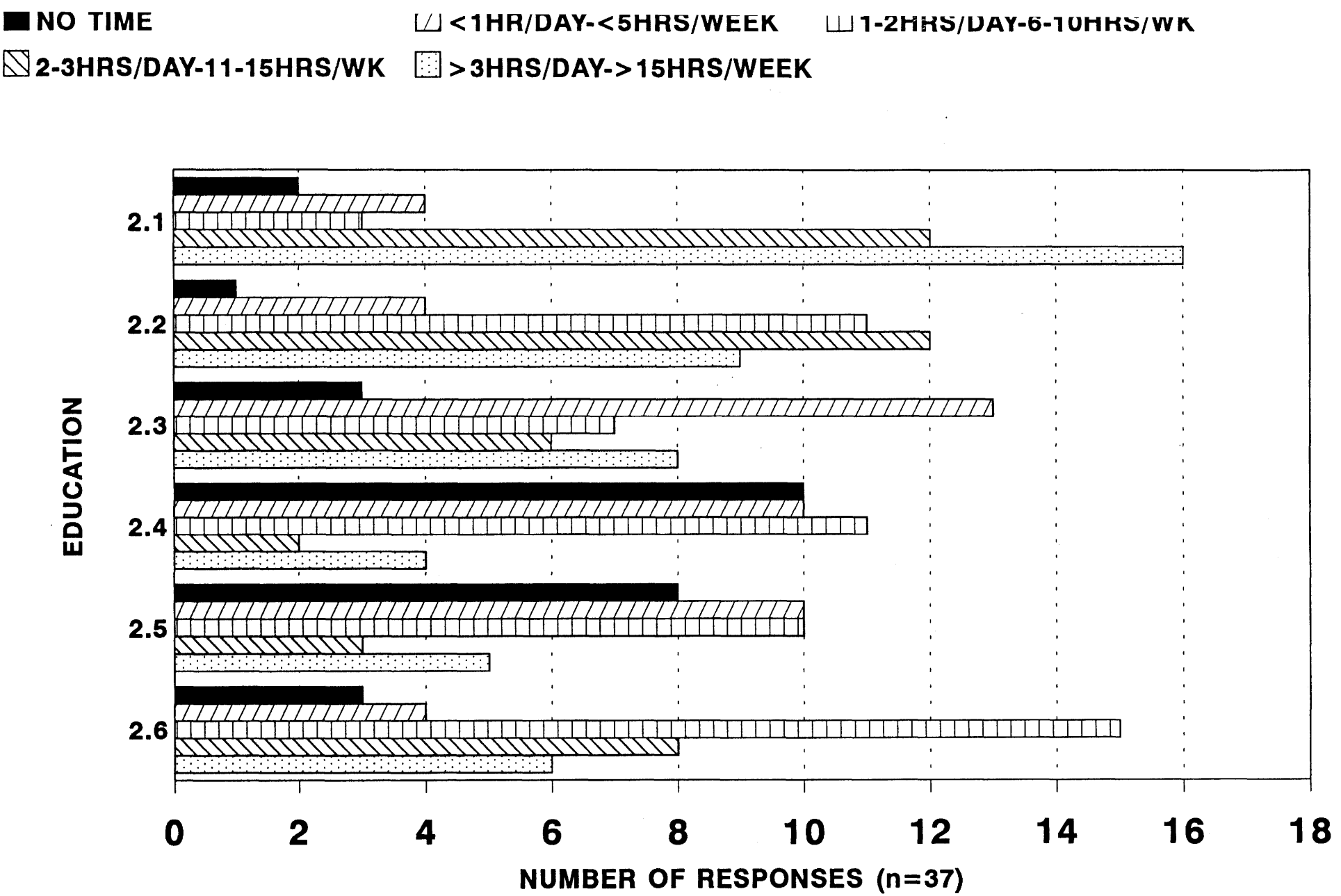
GRAPHIC REPRESENTATION OF DATA FROM SECTION 2: CHIEF PROFESSIONAL NURSE ACTIVITIES



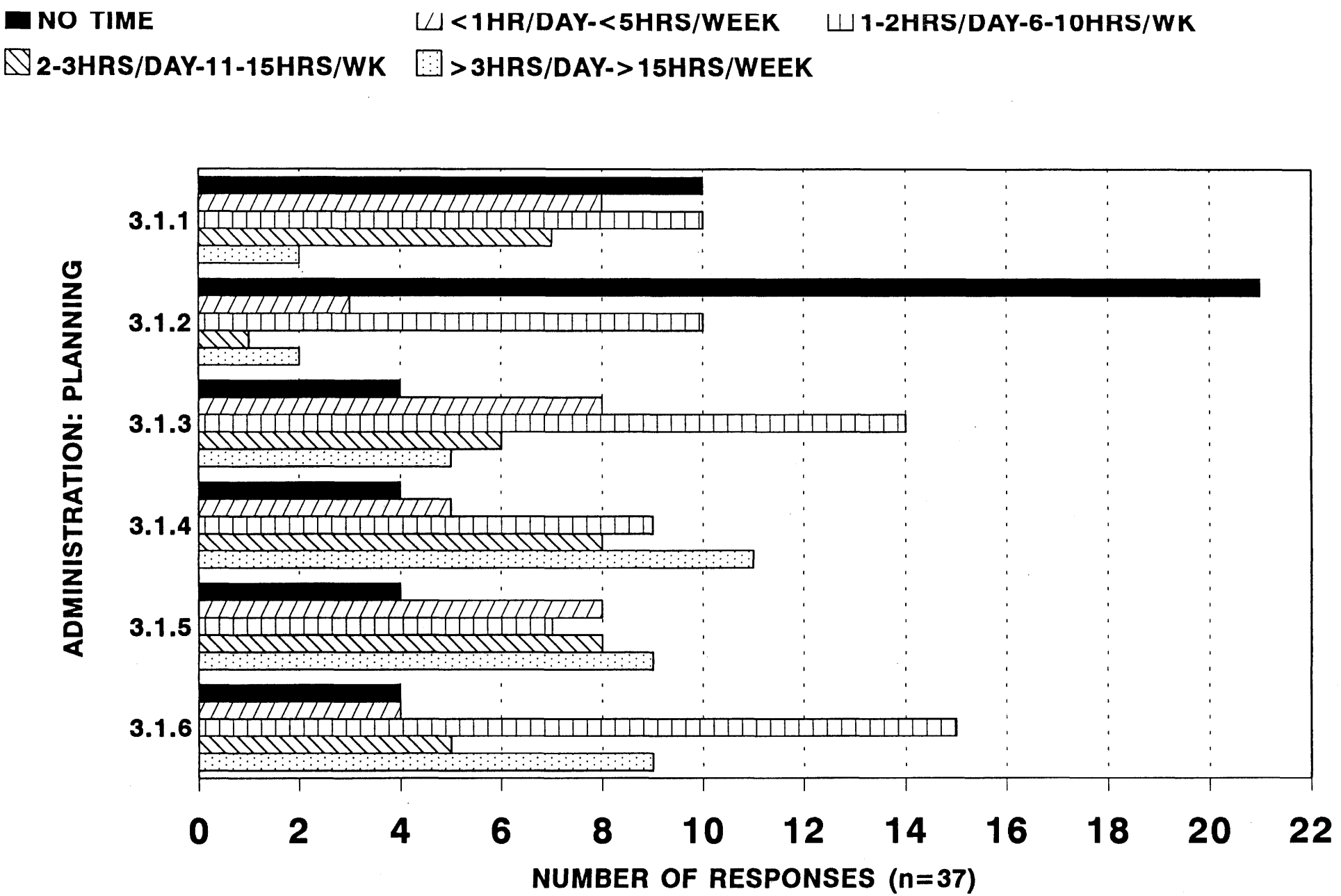
GRAPHIC REPRESENTATION OF DATA FROM SECTION 2:
CHIEF PROFESSIONAL NURSE ACTIVITIES



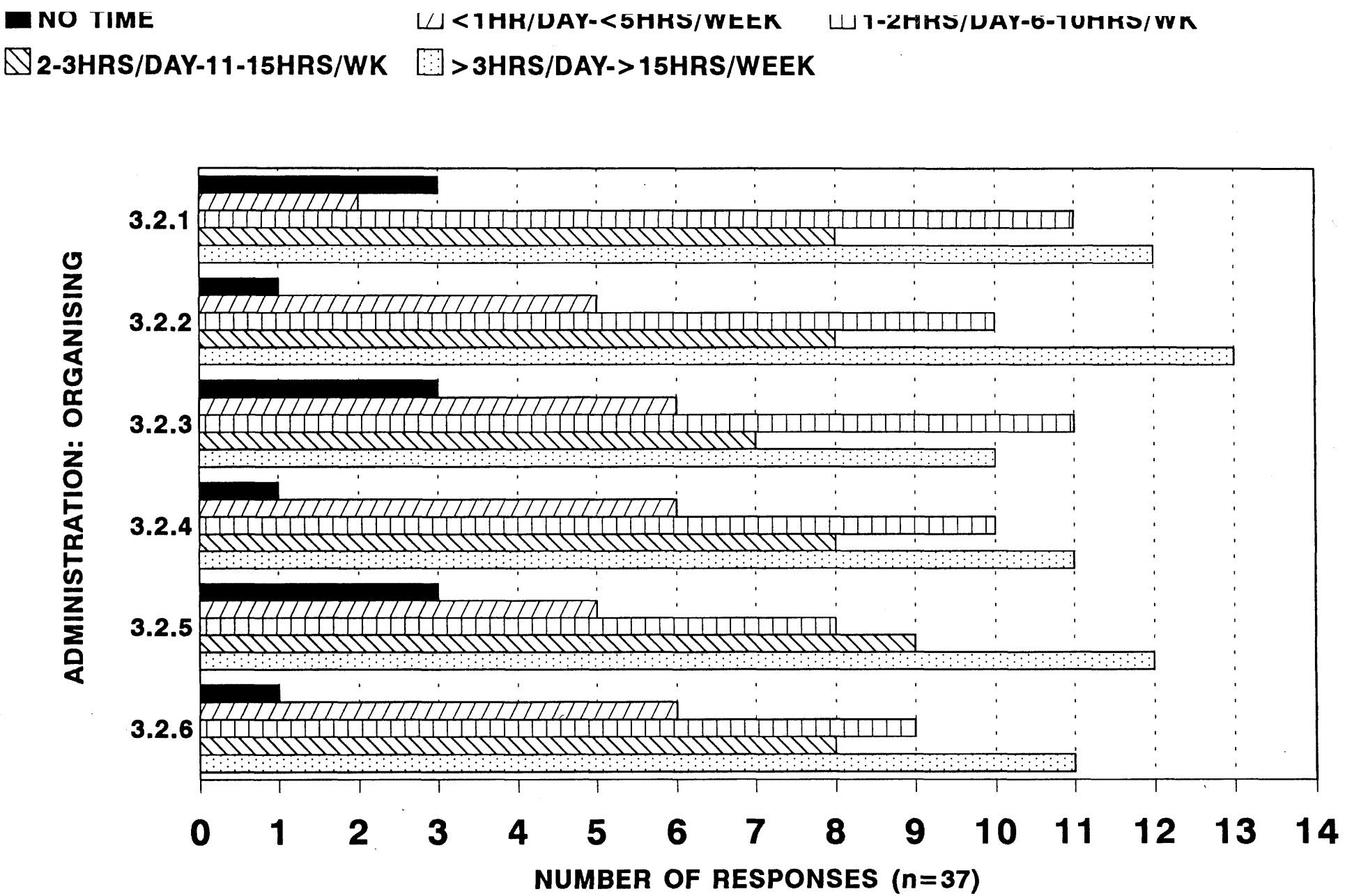
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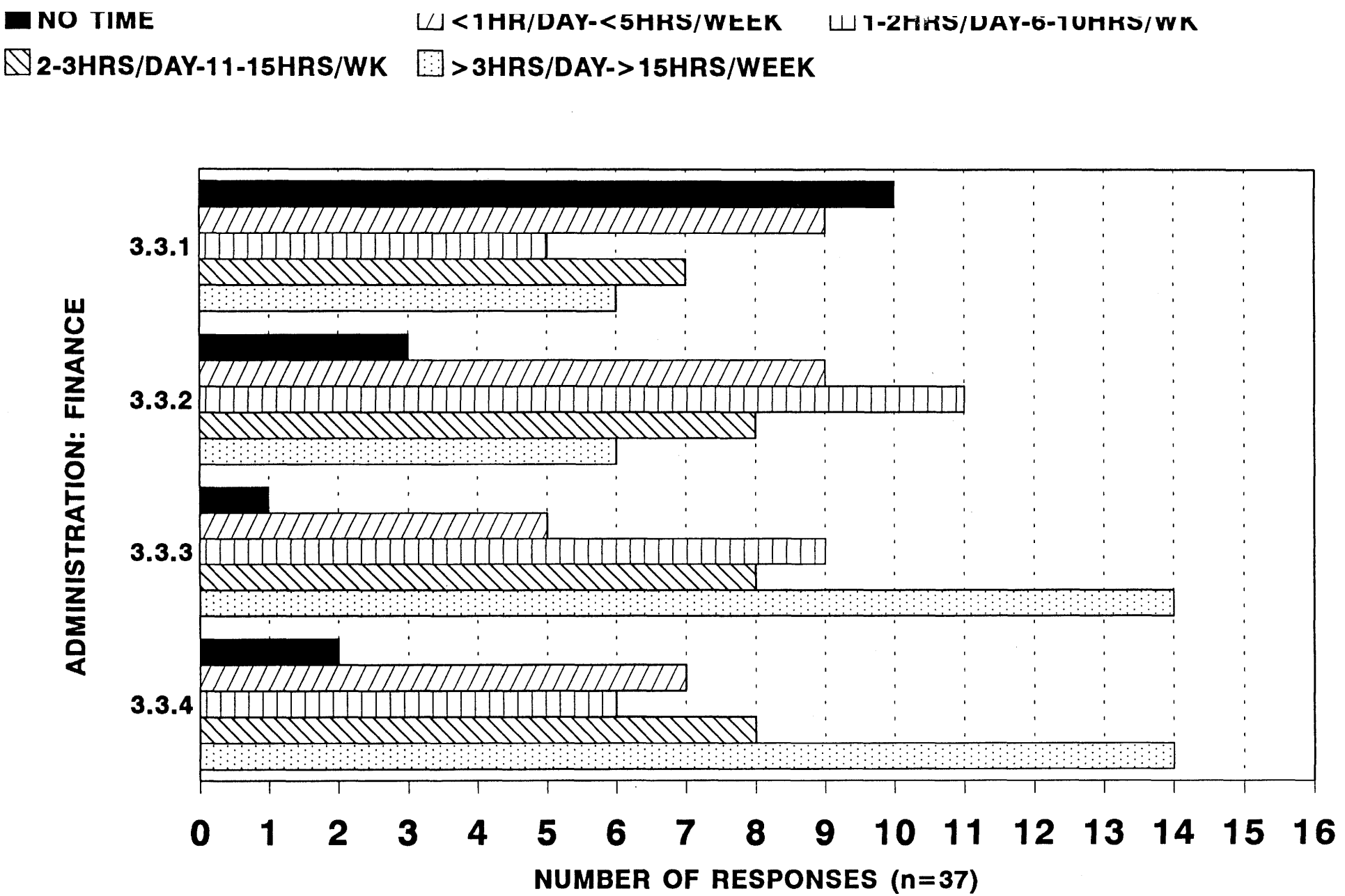
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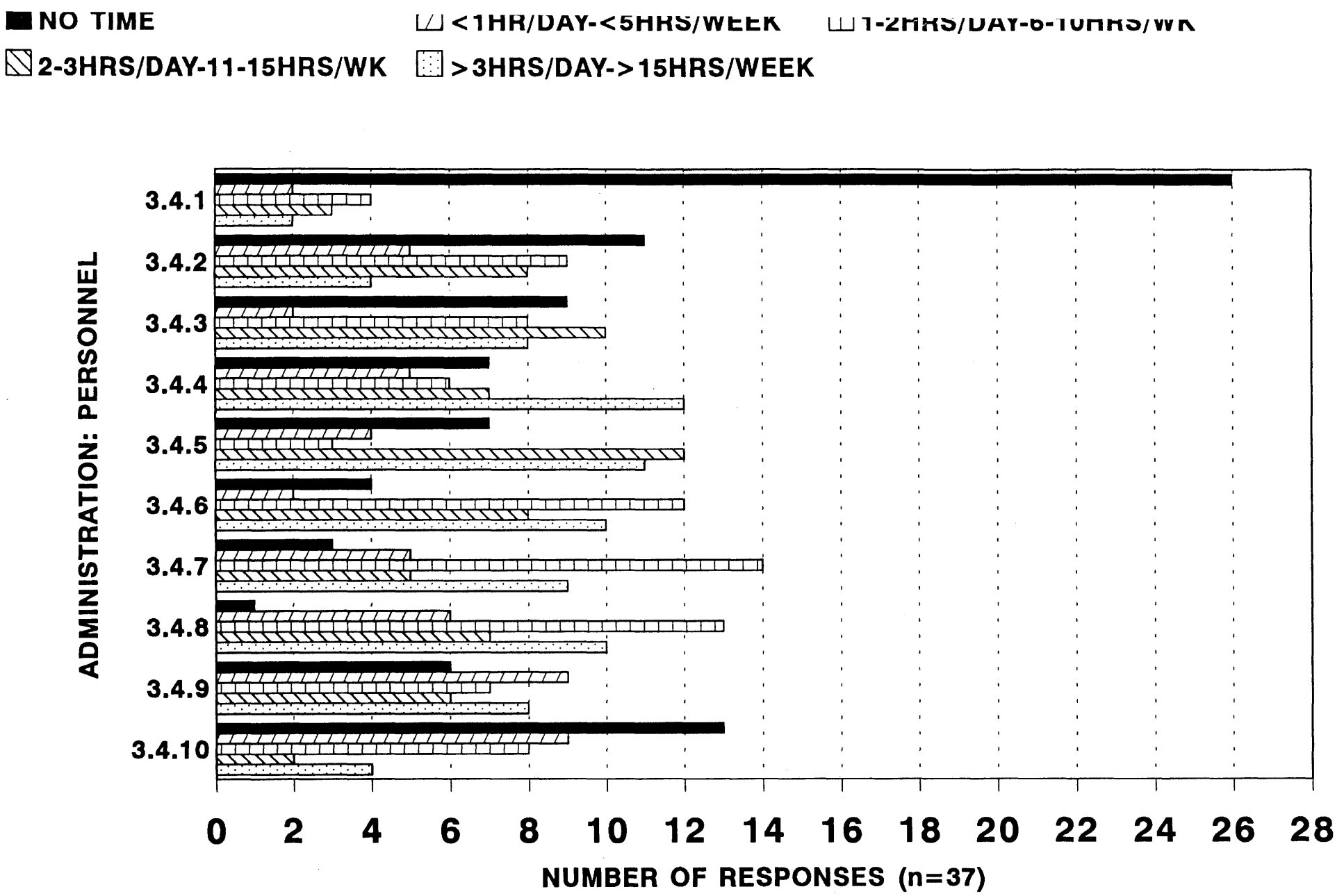
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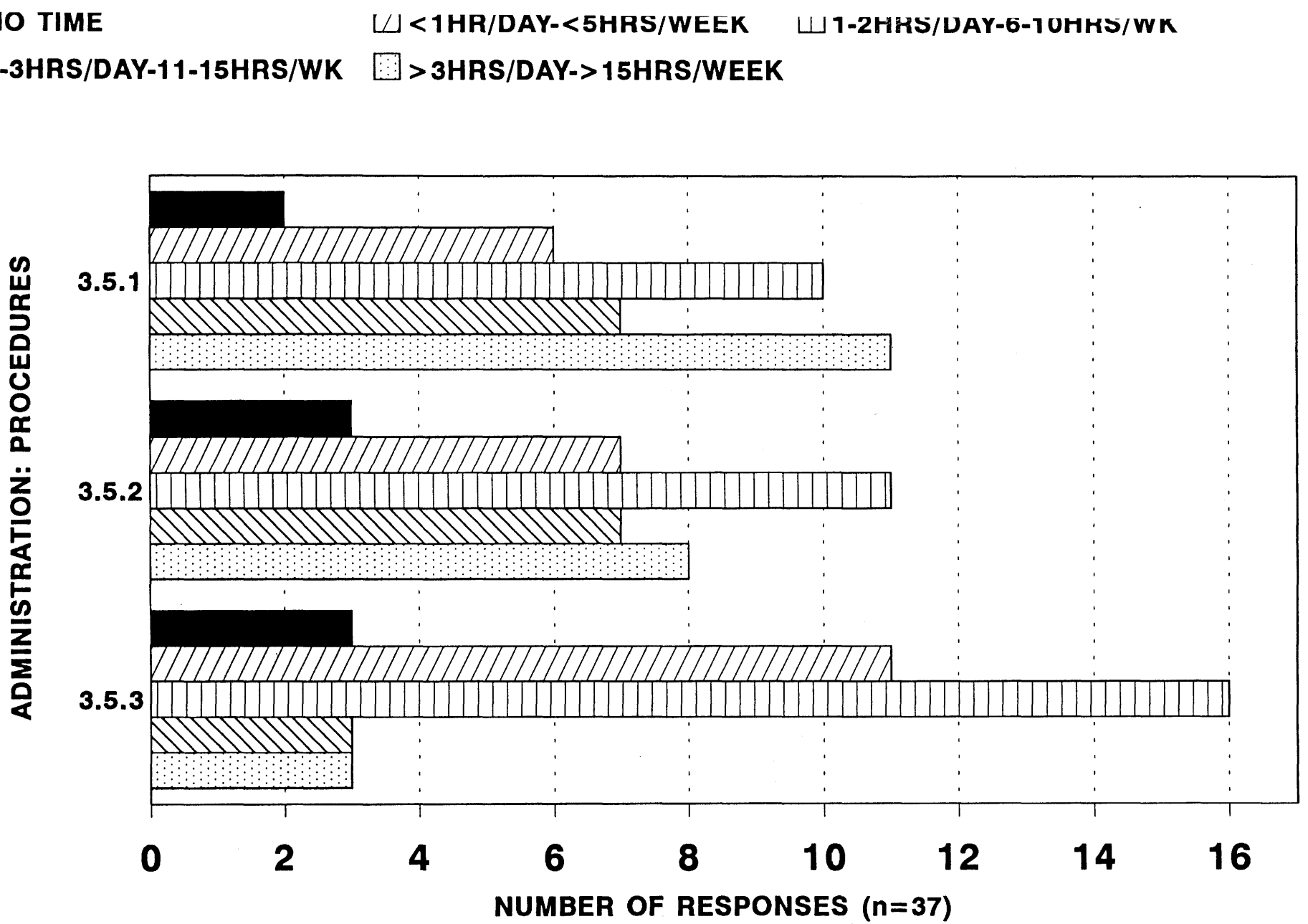
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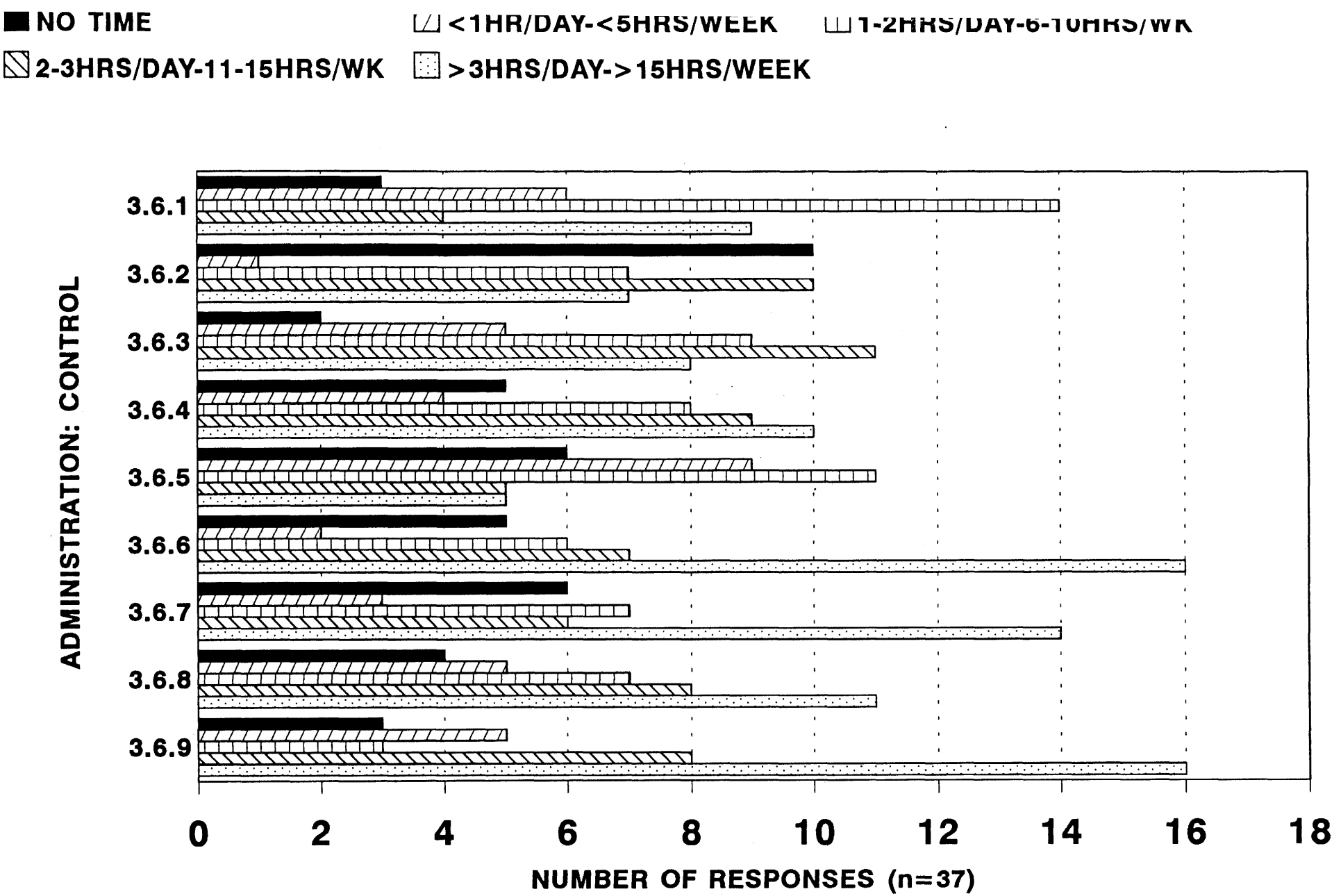
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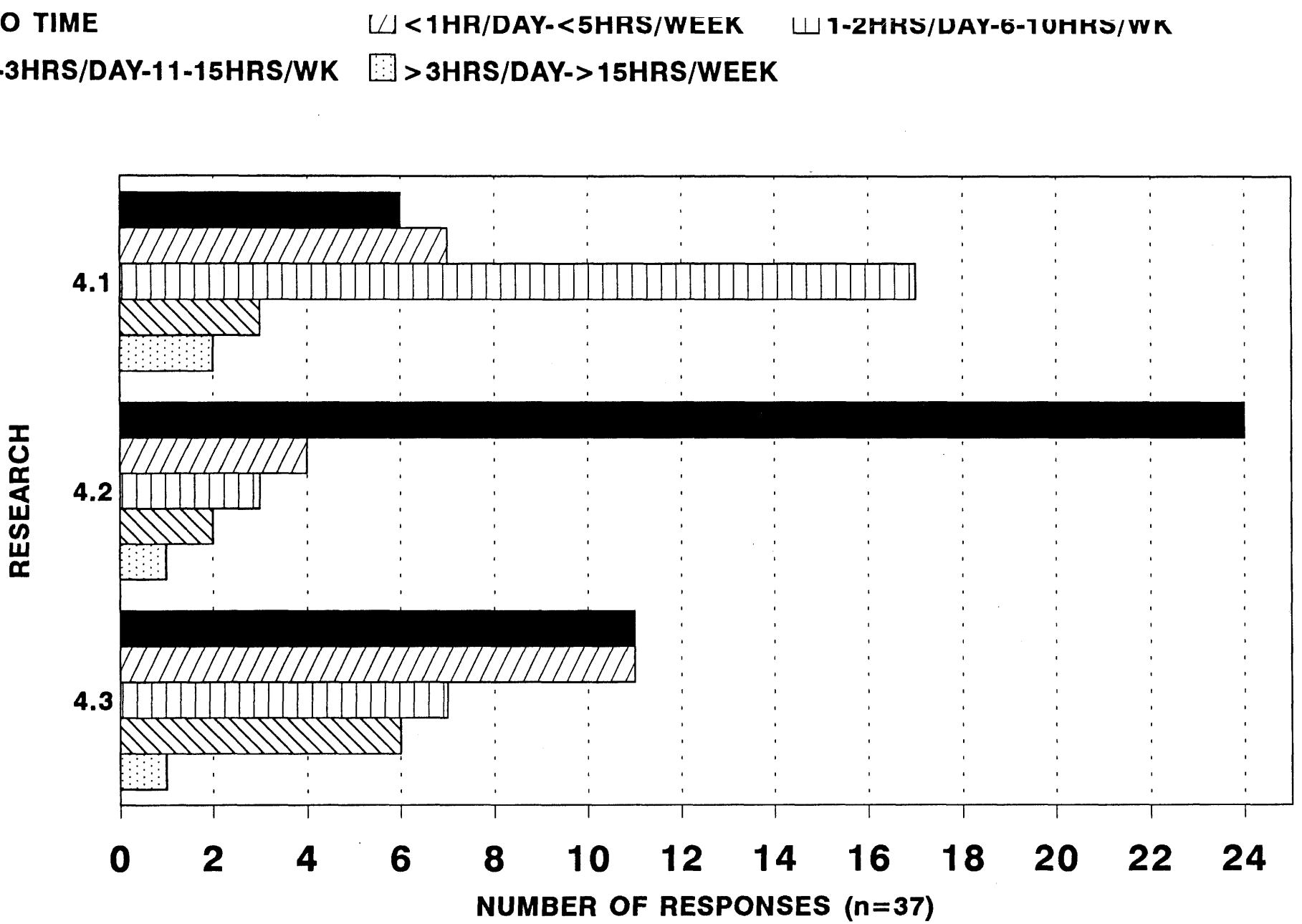
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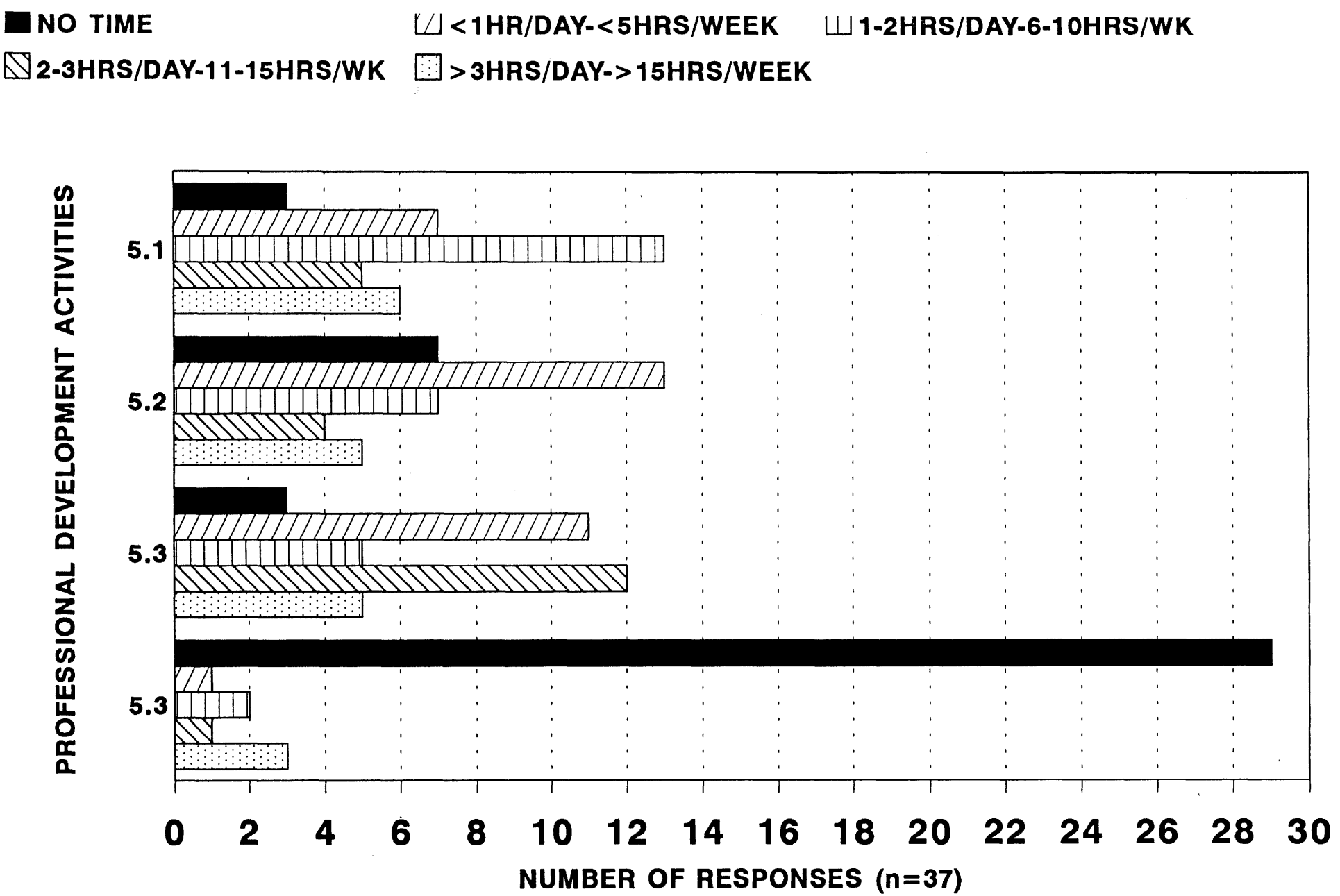
GRAPHIC REPRESENTATION OF DATA FROM SECTION 2:
CHIEF PROFESSIONAL NURSE ACTIVITIES



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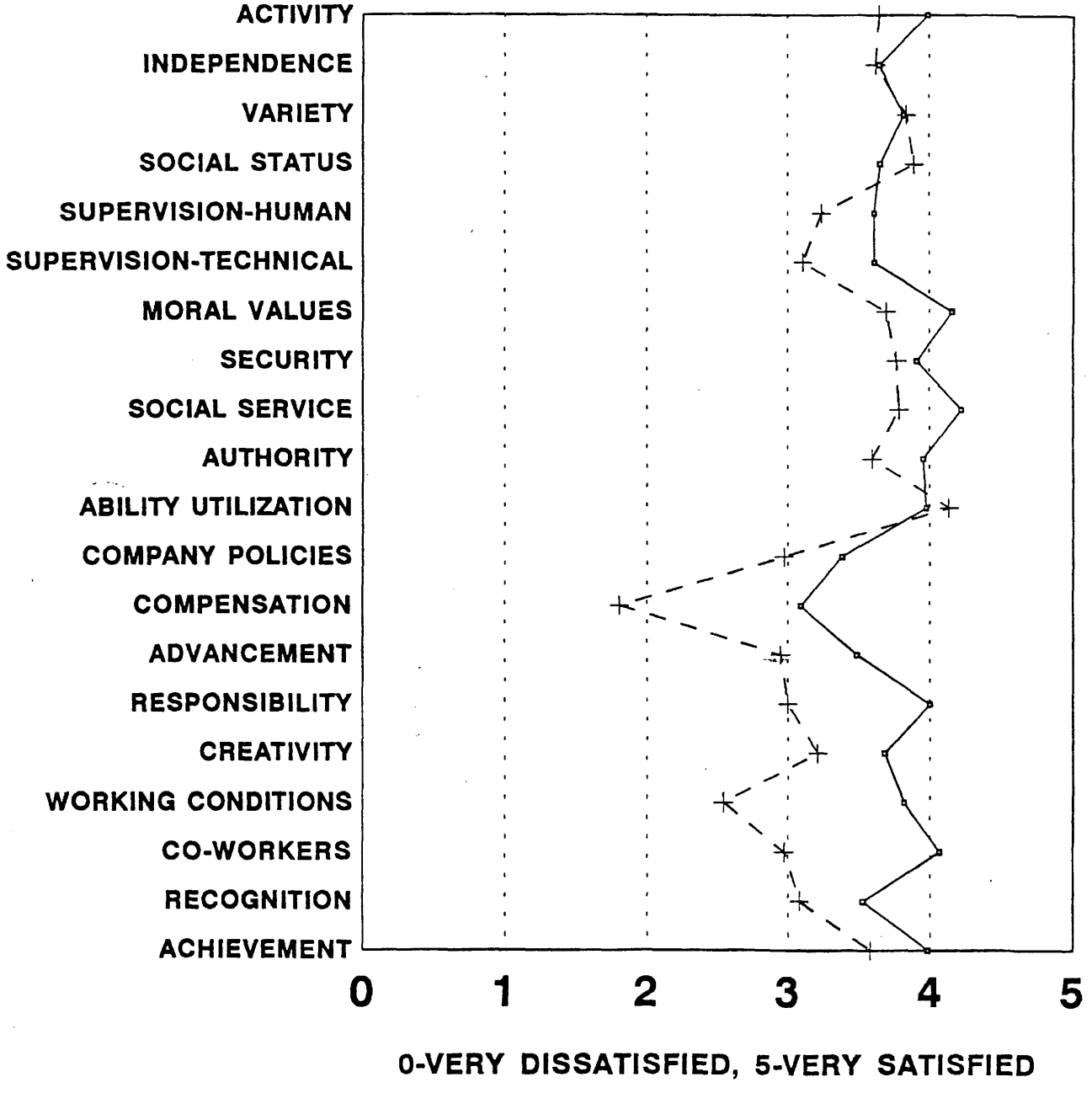


GRAPHIC REPRESENTATION OF DATA FROM SECTION 2:
CHIEF PROFESSIONAL NURSE ACTIVITIES



GRAPHIC REPRESENTATION OF DATA FROM SECTION 2:
CHIEF PROFESSIONAL NURSE ACTIVITIES

APPENDIX K



A comparison of the means of job satisfaction scores of American Nurse Supervisors (Weiss *et al* 1967) and chief professional nurses.

APPENDIX L

Minnesota Satisfaction Questionnaire scales - means and standard deviations

SCALE AND SATISFACTION ITEMS		MEAN	SUM OF THE MEANS	STANDARD DEVIATION
INTRINSIC				
1	Activity	3,65		
3	Variety	3,84		
4	Social status	3,89		
7	Moral values	3,69		
8	Security	3,68	33,84	5,21
9	Social service	3,78		
10	Authority	3,59		
11	Ability utilisation	4,14		
20	Achievement	3,58		
EXTRINSIC				
5	Supervision - human relations	3,23		
6	Supervision - technical	3,11		
12	Company policies	2,97		
13	Compensation	1,81	22,30	4,98
14	Advancement	2,65		
17	Working conditions	2,54		
18	Co-workers	2,97		
19	Recognition	3,08		
AUTONOMOUS				
2	Independence	3,62		
15	Responsibility	3,00	9,84	2,57
16	Creativity	3,21		
GENERAL SATISFACTION				
1 to 20		65,68	65,68	11,21

(Weiss *et al* 1967: 4)

APPENDIX M

QUESTIONNAIRE RESULTS: SECTION 4

TIME DOCUMENTATION RECORD: TIME SPENT ON CHIEF PROFESSIONAL NURSE ACTIVITIES

CHIEF PROFESSIONAL NURSE ACTIVITIES	TOTAL HOURS n=12	MEAN PER-CENT	MEAN PER-CENT (TOTAL)
1 PATIENT CARE/CONSULTATION			
1.1 Direct patient care	89,75	5,125	
1.2 Indirect patient care	132,50	7,567	18,403
1.3 Consultations	100,00	5,711	
2 EDUCATION (PLANNING/IMPLEMENTATION)			
2.1 Unit-based	75,25	4,297	
2.2 Departmental	96,00	5,482	
2.3 Nursing service	97,50	5,568	25,84
2.4 Other disciplines	60,50	3,455	
2.5 Outside prim. work environment	46,50	2,655	
2.6 Preceptor/school of nursing	76,75	2,133	
3 ADMINISTRATION/LEADERSHIP			
3.1 Planning	133,00	7,59	
3.2 Organising	143,00	8,166	
3.3 Finance	35,50	2,027	42,53
3.4 Personnel	118,50	6,76	
3.5 Procedures	58,75	3,555	
3.6 Control	252,75	14,434	
4 RESEARCH			
4.1 Research collaborator	40,25	2,298	
4.2 Research generator/replicator	5,25	0,299	3,22
4.3 Research preceptor	11,00	0,628	
5 PROFESSIONAL DEVELOPMENT			
5.1 Self directed learning activities	94,50	5,396	
5.2 Within primary work environment	54,00	3,083	10,17
5.3 Outside primary work environment	27,00	1,541	
5.4 Writing for publication	2,75	0,15	
TOTAL	1751,00	100,00	100,00